Preface

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In June 1993, neurologists, neurophysiologists and pediatricians from Austria, Belgium, Luxemburg and Switzerland met in Montreux, Switzerland, to discuss the state of the art of epilepsy. This publication is the outcome of this conference.

The past decade has witnessed the emergence of an international consensus in many areas on the assessment of epilepsy. Terminology and classifications of the varieties of epilepsy have become standardized. Many different types of epileptic seizures and syndromes have been identified. Intensive neurodiagnostic monitoring techniques have played an increasingly important role in our understanding better the individual seizure types and syndromes of epilepsy. However, electroencephalography (EEG) remains the most reliable laboratory test in the diagnosis of epilepsy. Monitoring with EEG is useful in evaluating patients who are unresponsive to medical treatment and who, thereafter, may benefit from surgical treatment.

Diagnostic progress, including neuroimaging techniques such as magnetic resonance imaging (MRI), has led to an increased understanding of the etiology of seizures. Hippocampal sclerosis and also subtle abnormalities of its structure can often be detected with MRI as well as hippocampal volume measured. Positron emission tomography and single photon emission computed tomography both provide methods for examining cerebral functions in epileptics. They may also confirm the presence of an organic cerebral abnormality and locate the dysfunctional region when surgical treatment is to be considered. Magnetoencephalography is a new diagnostic technique that remains experimental, but can be applied to epilepsy research. Over the past decade, surgery has been used increasingly to treat medically refractory epilepsy. The most effective surgical treatment is resection of the anterior temporal lobe for complex partial seizures of mesial temporal origin. Other surgical approaches include resections of the localized central cortical regions and a division of the corpus callosum. About 70-80% of patients undergoing surgical treatment become free of seizures.

At the ‘Round Table’, we discussed when and how to start therapy for epileptics. By definition, epilepsy is an illness in which more than one seizure of any type has occurred at any time. A proper identification of patients as ‘epileptic’ after their first seizure is not only a semantic problem, since the diagnosis of epilepsy must lead directly to drug treatment. Indeed, treatment would present the disadvantage of exposing 50% of all people having had their first unprovoked seizure to unnecessary drug toxicity. Therefore, it is important to identify those patients who are at higher risk of recurrence. Except for the observation that etiology and abnormal EEG which, when combined, might lead to a marked increase of the recurrence risk, no progress has been made to cluster principal prognostic factors.

The participants of the ‘Round Table’ concluded that the decision, whether or not to treat patients who have had one initial seizure, must be made individually for each case. In addition, the question whether epilepsy can be considered as a dynamic process and whether treating the first attack may lead to a significant decrease in the risk of relapse has not yet been resolved.

About 200 clinical neurologists and neuroscientists were active participants in this congress. Their interaction with invited guest speakers was highly beneficial to all the participants present. I would like to express my sincere gratitude to all the distinguished speakers who gave us such excellent presentations. Furthermore, I wish to thank Gerot Pharmazeutika GmbH, Austria; Byk Belga N.V., Belgium, and Byk AG Pharmazeutika, Switzerland for providing financial support and their staff for their organization and efforts, which made this congress possible.

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