Sample Protocol #3: Medication reduction to increase seizure yield

Epilepsy Monitoring Unit Protocols

AED Reduction to Maximize a Yield Of Monitoring

- Each patient's plan has to be individualized according to their clinical scenario and specific goals of admission to the EMU.
- An EMU attending is ultimately responsible to address an AED Reduction issues for all patients under their care.
- All patients have to be counseled in detail about a likely necessity for and associated risks involved in AED reduction or discontinuation in the EMU.
- Only in the case of well-known patients who are being re-admitted to the EMU AEDs may be reduced or rarely stop Ped before their EMU admission.
- Considering different referral sources and level of specific patients' instructions, it is necessary to verify and document when the patient took their last doze of each AED.
- All patients in the EMU irrespective of AED regimen must have an IV in place and a written benzodiazepine rescue protocol.
- Once in the EMU, it is generally preferred to reduce or stop an AED with a shorter half-life and/or one that can be easily loaded via IV.
- Generally, it may be acceptable to stop one medication first day if the patient is on polytherapy. In patients on monotherapy, a reduction by 30-50% may be appropriate. Subsequent AED reduction should be customized according to the clinical development.
- Carbamazepine is one AED whose fast reduction or abrupt discontinuation may lead to different seizures that are not habitual seizures of the patient.
- In principle, the patients are restarted on their outpatient doses of AEDs if they are to be continued upon discharge.
- The patient has to receive at least their daily dose of all AEDs before discharge unless otherwise specifically agreed by the patient and EMU attending.