Possible Benign Partial Epilepsy

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I read with interest the recent case series in *Indian Pediatrics* [1]. I appreciate the efforts of the authors for publishing this under-reported epileptic syndrome in India. Through this communication, I wish to seek certain clarifications:

1. Seizure semiology of these patients was not included in the study. Semiology may be helpful to further classify these patients as benign partial epilepsy in infancy with complex partial seizures *versus* benign partial epilepsy in infancy with secondary generalized seizures (SGS). Though, proposal was made to combine these syndromes in the past, some subtle differences exist such as predominant seizures during wakefulness, and temporal ictal onset with the first entity, but mostly extratemporal seizure onset was noted with the latter.
2. Did they have a normal magnetic resonance imaging of brain? Focal cortical dysplasia is the most common cause of symptomatic focal epilepsy in infants and should be ruled out in these patients.
3. If any metabolic or genetic work-up was performed? Caution should be exercised to rule out inborn error of metabolism and chromosomal disorders, especially if differentiation between prolonged post-ictal state and underlying encephalopathy is difficult.
4. If any of these patients have gastroenteritis? The other entity with similar presentation is 'Benign convulsion with mild gastroenteritis', first described in Japan [2]; though rare in other countries, directed history of diarrhea should to taken in infants with clusters of seizures.
5. Though I agree with the authors' finding that recognition of this syndrome helps in avoiding long term anti-epileptic therapy and treatment with antiepileptic medication is not mandatory, benign nature of the condition is extremely difficult to ascertain during initial presentation; and rather than non-initiation of antiepileptic drugs, treatment for shorter time period may be justifiable. Though suspicion of this entity is possible to some extent, definite diagnosis can only be possible at age 5 years in presence of normal psychomotor development [3].

REFERENCES

1. Mishra D, Nikunj NK, Juneja M, Talukdar B. Benign infantile seizures. Indian Pediatr. 2015;52:151-2.
2. Uemura N, Okumura A, Negoro T, Watanabe K. Clinical features of benign convulsions with mild gastroenteritis. Brain Dev. 2002;24:745-9.
3. Okumura A, Hayakawa F, Kato T, Kuno K, Negoro T, Watanabe K. Early recognition of benign partial epilepsy in infancy. Epilepsia. 2000;41:714-7.

Possible Benign Partial Epilepsy: Authors' Reply

We thank the author for his comments. An abbreviated description of these cases had been provided because these cases were part of a larger study, which is under publication. The purpose of the report was to highlight this relatively under-reported entity [1]. Our responses follow:

1. We agree with the author's contention. Two of the cases had secondary generalization, as mentioned in the original article also [1].
2. Three infants had a normal MRI brain (1.5T), whereas, due to financial constraints, one child underwent a non-contrast CT head. Normal neuroimaging had been mentioned in the original article [1].
3. We are unclear about what the authors mean by a metabolic and a genetic work-up. There is no single metabolic/genetic panel that may be ordered in all children with seizures. We followed standard guidelines for evaluation; metabolic profile to rule out inborn errors of metabolism was done only when indicated on the basis of history or examination findings, or results of other investigations. Genetic testing was only done, if there was a suspicion of a disorder on the basis of dysmorphology, seizure semiology, family history, and associated clinical findings. Otherwise, genetic testing is likely to be a low-yield strategy.
4. We agree that we should take a directed history of diarrhea in infants with clusters of seizures. None of these had such a history. In fact, we have previously