Febrile Seizure and New Onset Afebrile Seizure

This pathway was developed through the Evidence-Based Outcomes Center at Dell Children’s Medical Center of Central Texas. The objectives of this guideline were to standardize care and reduce practice variation. Methods used to build the pathway included: systematic literature review of relevant PICO (population, intervention, comparison, and outcome) questions, rapid cycle improvement occurring in multiple cycles with multidisciplinary feedback, and use of default consensus from pediatric experts where evidence was lacking.

The guidelines presented in this pathway are based on recommendations of care for the majority of patients. Special care should be taken in considering treatment, as each patient has individual symptoms and treatment needs. Use of the Febrile Seizure and New Onset Afebrile Seizure Guideline should be based on individual patient assessment and provider discretion. Should the provider feel that the child’s treatment would be better-suited using a more individualized treatment plan; the clinician’s decision should be honored and the rational documented.

Definition:
Febrile seizures usually occur between three months and six years of age, associated with fever but without evidence of intracranial infection or defined cause. Febrile seizures are further divided into simple or complex, based on clinical features. Simple febrile seizures are the most common type, characterized by generalized seizures, last less than 15 minutes, and do not recur in a 24-hour period. Complex febrile seizures are characterized by episodes with a focal onset, last longer than 15 minutes, or occur more than once in 24-hours. (1-4)

Etiology:
Nearly any insult to the cerebral cortex can cause a seizure, most are self-limited, and resolve with the inciting process. Febrile seizures are the most common seizure disorder in childhood, affecting 2% to 5% of children between the ages of three months and six years. Seizures can arise from any site in the brain but typically are localized to the neocortical gray matter and the limbic system, particularly the hippocampus and amygdala.

Genetic predisposition:
- Monozygotic twins have a 70% concordance for febrile seizures, versus 20% in dizygotic twins.
- Having a first degree relative (sibling or parent) with febrile seizures increases the risk 4-5 times that of the general population.
- Four distinct loci have been nominated as candidate genes and multi-gene inheritance is suspected.

Various specific infectious agents have been more strongly associated with a risk of febrile seizures, particularly HHV-6.

Differential Diagnosis:
Most concerning possibility is meningitis/encephalitis as cause of seizure in context of febrile illness

Children with a seizure predisposition might be triggered by an intercurrent illness, especially with fever, such as children with pre-existing neurological injury, autistic children, previously established epilepsy patients, and VP shunt patients

Guideline Inclusion Criteria:
- Greater than 3 month of age
- Clinical findings of convulsive or nonconvulsive seizures

Guideline Exclusion Criteria:
- Newborn to 3 months of age
- Greater than 18 years of age
- Prior neurological insult

Diagnostic Evaluation:
History: Assess for
- Seizure onset
- Known seizure disorder
- Ingestion
- Fever
- Signs of serious infection
- Medications
  - Received prior to presentation (type, dose, dosage, route)
  - Current anticonvulsant medications
  - Use of psychopharmacologic medications
  - Toxic/subtherapeutic anticonvulsant levels
  - Nonadherence and/or recent change
- Vagus Nerve Stimulation
- Metabolic abnormalities
- Trauma
- Dietary therapies

Physical Examination:
- Careful examination for source of fever, especially ear, throat and lung exam
- Check for meningeal signs
- Exam for specific rashes
- Mental status assessment (after allowing post-ictal recovery) to look for signs of acute encephalopathy possibly indicative of meningitis or encephalitis
- Motor, reflex and gait assessment for focal motor deficit and/or ataxia

Last updated: 4/27/2015
Seizure Classification: [13]

Simple febrile seizures:
- Age 6 months – 5 years (lower limit of age defined by clinical practice guidelines)
- Generalized convulsion (tonic-clonic)
- Duration <15 minutes
- No recurrence within 24 hours
- No evidence of acute symptomatic etiology (e.g., acute CNS infection, trauma, etc)
- Although neurologically impaired children qualify for a diagnosis of febrile seizures, the clinical practice guidelines specifically exclude this subpopulation from their recommendations

Complex Febrile seizures:
- Seizure behavior differs from GTC (e.g., focal onset, asymmetry, staring, collapse, etc)
- Duration > 15 minutes (prolonged)
- Recurrence within 24 hours

Partial/Focal/Localization related:
Initial Clinical or EEG changes originating within networks limited to a region of or one hemisphere
- Focal – Description of the seizure semiology without attempting to fit it into a specific category. Level of alertness should be a part of the description and documentation.

Generalized:
Both hemispheres involved at seizure onset (originating within and rapidly involving networks of both hemispheres)
- Tonic – Clonic
- Absence
  1. Typical
  2. Atypical
  3. Absence with special features
     - Myoclonic absence
     - Eyelid myoclonia
- Myoclonic
  1. Myoclonic
  2. Myoclonic atonic
  3. Myoclonic tonic
- Clonic
- Tonic
- Atonic

Unknown:
Unclear if Focal (Partial, Localization related) or Generalized
- Epileptic Spasms (Spasms may outlast or begin after infancy)

Electroclinical Syndromes and other Epilepsies:
(Epilepsy and Epilepsy Syndromes)
Electroclinical Syndromes: A complex of clinical signs and symptoms that define a specific and recognizable clinical disorder.
Other Epilepsies are recognized based on clinical features and investigative findings (i.e., mesial temporal lobe epilepsy). These are sometimes coined Constellations.

Seizure type(s) are dependent on the specific Epilepsy Syndrome identified and may be:
1. Exclusively Focal
2. Exclusively Generalized
3. A mixture of both generalized and focal
- Genetic – Results from a genetic defect (Known or presumed based on a complex of specific clinical and investigative findings). i.e. Juvenile Myoclonic Epilepsy
- Structural/Metabolic – A specific associated structural or metabolic condition with a direct link to the Epilepsy or Epilepsy syndrome described.
- Unknown – The underlying cause is unknown. (No structural, Metabolic, or Genetic cause have been identified.)

Critical Points of Evidence

Evidence Supports
Use of lumbar puncture for febrile children with signs and symptoms of meningitis or encephalitis

Evidence Lacking/Inconclusive
Use of lumbar puncture for febrile children 6 to 12 months of age with deficient or unknown immunization history
Use of lumbar puncture for febrile children pretreated with antibiotics

Evidence Against
Use of electroencephalogram (EEG) in neurologically healthy children with simple febrile seizure
Use of neuroimaging in children with simple febrile seizure

Last updated: 4/27/2015
Laboratory Testing
Lumbar puncture should be performed in children with clinical signs or symptoms concerning for meningitis. (5)
(Strong recommendation; High quality evidence.)

Lumbar puncture should be considered for infants between 6 and 12 months of age who present with a seizure and a fever when considered
deficient or unknown immunization history. (5)
(Weak recommendation; Low quality evidence.)

Lumbar puncture should be considered for any child who presents with seizure and fever and is pretreated with antibiotics. (5)
(Weak recommendation; Low quality evidence.)

Additional laboratory tests may be indicated depending on clinical scenario. (5)
(Strong recommendation; Moderate quality evidence.)

Consider Comprehensive Metabolic Panel in children of any age who present with afebrile seizures and any of the following:
- Dehydration
- Vomiting
- Diarrhea
- Persistent altered mental status

Consider toxicology screen in children of any age who present with afebrile seizures and suspected drug use or persistent altered mental status.

Imaging
Neuroimaging with Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) is not indicated for children with simple febrile seizures. (5,6,8)
(Strong recommendation; Moderate quality evidence.)

Neuroimaging with CT or MRI of the brain w/wo contrast should be considered for children with complex febrile seizures presenting with focal motor
onset, focal deficit, or abnormal focal exam. (6,8,9)
(Strong recommendation; Moderate quality evidence.)

Neuroimaging with CT should be considered for children with complex febrile seizures presenting with focal motor onset, focal deficit, or abnormal focal exam only if emergent concerns and MRI is not available.

Neuroimaging with urgent MRI or CT should be considered in children of any age with afebrile seizure and any of the following:
(Refer for consideration of outpatient brain MRI if none of the factors below apply.)
- Focal seizure
- Persistent encephalopathy
- Focal exam
- < 6 months of age
- Closed head injury
- Recent shunt revision
- Neurocutaneous disease
- Sickle cell disease
- AIDS
- Malignancy
- Travel to location endemic for cystercicosis

Diagnosis
Electroencephalogram (EEG) should not be performed in the evaluation of a neurologically healthy child with a simple febrile seizure. (6)
(Strong recommendation; Moderate quality evidence.)

EEG should be performed in a child with complex febrile seizure presenting with complex focal motor seizure, abnormal focal exam, and persistent
encephalopathy in house.

EEG should be performed in children of any age who presents with suspected, probable, or definite afebrile seizure, but can be performed in
outpatient setting if patient returns to baseline.

Consults/Referrals:
All patients with afebrile seizures should be referred to neurology.
Feverile seizures should only be considered for referral if recurrent, persistent encephalopathy, or abnormal focal exam.
Patient Disposition

Admission Criteria

Simple Febrile Seizure

Only indicated in ill appearing child, extreme parental anxiety or social concerns.

Complex Febrile Seizure

Admit for any of the following:
- Persistent encephalopathy
- Focal exam
- Ill-appearing

Consider observation for any of the following:
- Recurrence within 24 hours
- Extreme parental anxiety or social concerns

Consider outpatient neurology referral:
- Multiple recurrent febrile seizures (in different illnesses)
- Focal seizures without focal deficits
- Parental anxiety

Afebrile Seizure

Admit for any of the following:
- Recurrent seizures at onset
- Persistent encephalopathy
- Focal deficit
- Parental anxiety
- Concerns regarding follow-up

Discharge Criteria

Seizure cessation
- Appropriate mental status; return to baseline mental status
- Appropriate support system (e.g. primary care physician, caregiver/family)

Prevention

No routine treatment is recommended for prevention of recurrent simple febrile seizures in new onset patients.

Diastat should be prescribed for recurrent febrile seizures.

Prolonged febrile seizure patients should be prescribed Diastat for home use in the event of recurrence with prolonged febrile seizure of > 5 minutes duration.

Scheduled diazepam during febrile illnesses (0.33 mg/kg Q8 hours) is the recommended chronic anti-epileptic drug treatment for secondary prevention in patients with multiple recurrent febrile seizures.

Follow-Up Care

Children diagnosed with simple febrile seizures should follow up with their PCP.

Children with referral should follow up with a Neurologist within 14 days.

Addendums
1. DCMC Seizure Diagnostic Evaluation
2. DCMC Status Epilepticus Acute Care & IMC Pathway
3. DCMC Seizure Clusters Acute Care & IMC Pathway

Outcome Measures
1. Readmission rate to the Emergency Department
2. Inpatient average length of stay
3. Time to outpatient Neurology clinic follow-up
4. Utilization of Computed Tomography
5. Utilization of Magnetic Resonance Imaging
6. Utilization of Electroencephalogram
### Seizure Diagnostic Evaluation

#### Evidence Based Outcome Center

<table>
<thead>
<tr>
<th>Afebrile Seizure (New Onset)</th>
<th>Simple Febrile Seizure</th>
<th>Complex Febrile Seizure</th>
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</thead>
<tbody>
<tr>
<td><strong>Lumbar Puncture</strong></td>
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<tr>
<td>Not Indicated</td>
<td>A lumbar puncture should be performed:</td>
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<td></td>
<td>- Following a simple febrile seizure if the child is ill-appearing or if there are clinical signs or symptoms of concern</td>
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<td>A lumbar puncture should be considered:</td>
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<td></td>
<td>- Child 6 to 12 months of age who is deficient in immunizations or for whom immunization status is unknown</td>
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<td>- Child of any age who has been pretreated with antibiotics</td>
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<td><strong>Laboratory</strong></td>
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<td>Consider CMP for any of the following:</td>
<td>Not Indicated</td>
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<tr>
<td>- Dehydration</td>
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<td>- Vomiting</td>
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<td>- Persistent altered mental status</td>
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<td>Consider toxicology screen for any of the following:</td>
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<td>- Suspected drug use</td>
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<td><strong>EEG</strong></td>
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<tr>
<td>OUTPATIENT</td>
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<tr>
<td>Obtain in all cases of suspected, probable or definite seizure.</td>
<td>Not Indicated</td>
<td>Not indicated if only prolonged or recurrent within 24 hours.</td>
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<td>Neurology follow-up within 1 week.</td>
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<td>Consider for focal motor seizure, persistent encephalopathy or abnormal focal exam.</td>
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<td><strong>Neuroimaging</strong></td>
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<td>Consider urgent MRI (if available) or CT for any of the following:</td>
<td>Not Indicated</td>
<td>Consider for focal motor seizure onset, focal deficit or abnormal focal exam:</td>
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<td>- Focal seizure</td>
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<td>- Obtain CT only if emergent concerns and MRI is not available.</td>
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<td>- Concerns regarding follow-up</td>
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<td>Contact Neurologist on call if STAT EEG read is required.</td>
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</table>
Inclusion Criteria
- Age ≥ 3 months to 18 years of age
- Convulsive seizure lasting > 5 minutes
  OR
- Non-convulsive seizure lasting > 10 minutes

Initiate Anti-epileptic Medication

IV Access:
- Lorazepam 0.1 mg/kg/dose (Max: 4 mg/dose)
  - Dilute medication 1:1 with Normal Saline. Infuse over 2-5 minutes
    (maximum infusion rate: 2 mg/minute)
  OR
- No IV Access: Choose one of the following
  - Diazepam 0.5 mg/kg/dose PR
  - Midazolam – Use IV Formulation
    - Intranasal: 0.2-0.5 mg/kg/dose (Max: 10 mg/dose)
    - Use 5 mg/mL concentration, if ≥ 1 mL give half in each nare
    - Buccal: 0.2-0.5 mg/kg/dose (Max: 10 mg/dose)

Establish IV access

Notify attending physician and Pharmacy prepare next step medications

IV Access: Administer or Repeat
- Lorazepam 0.1 mg/kg/dose (Max: 4 mg/dose)
  OR
- No IV Access: Repeat one of the following
  - Diazepam 0.5 mg/kg/dose PR
  - Midazolam – Use IV Formulation Intranasal or Buccal

Fosphenytoin 20 mg PE/Kg/dose IV
- 1:1 with Normal Saline or D5W – infuse no faster than 3 mg PE/kg/minute (Max infusion rate: 150 mg PE/minute)
- Call emergency response team and PICU to evaluate for transfer and/or respiratory assistance

Phenobarbital 20 mg/kg/dose IV x 1 dose at a rate of 2 mg/kg/minute (Max: 30-60 mg/minute)

Transfer to PICU

Electroencephalographic (EEG) Seizure Cessation Process: Choose one of the following
- Midazolam 0.2 mg/kg/dose IV bolus (Max: 10 mg/dose) – Continue to bolus as necessary
- Midazolam 0.2 mg/kg/dose IV continuous infusion
  - Titrate to effect (usual range: 0.2-0.6 mg/kg/hour up to recommended max: 1.5 mg/kg/hour)
  - If seizure persists push Midazolam IV dose to achieve burst suppression on EEG

Consider if unable to suppress epileptiform activity:
- Phenobarbital 5-15 mg/kg/dose slow IV infusion over 1-2 hours
- Continue as IV continuous infusion at 1-3 mg/kg/hour to maintain burst suppression on EEG if necessary

EXCLUSION CRITERIA
- AGE < 3 Months
- Age > 18 Years
- Prior neurological insult
**Seizure Clusters Acute Care & IMC Pathway**

**Evidence Based Outcome Center**

**Inclusion Criteria**
- Age ≥ 3 months to 18 years of age
- 3 Seizures (each lasting less than 5 minutes) in 1 hour
- OR
- 3 repetitive Infantile Spasm Clusters or Infantile Spasms lasting for > than 15 minutes total

**Initiate Anti-epileptic Medication**

**IV Access:**
- Lorazepam 0.1 mg/kg/dose IV (Max: 4 mg/dose)

**No IV Access:** Choose one of the following
- Diazepam 0.5 mg/kg/dose PR
- Midazolam – Use IV Formulation
  - Intranasal: 0.2-0.5 mg/kg/dose (Max: 10 mg/dose)
  - Use 5 mg/mL concentration, if ≥ 1 mL give half in each nare
  - Buccal: 0.2-0.5 mg/kg/dose (Max: 10 mg/dose)

**Establish IV access**

**4th Seizure OR Additional Cluster of Spasms**

**YES**

Notify attending physician and Pharmacy prepare next step medications

Monitor blood pressure and respiratory function

Administer one of the following:

1) Lorazepam 0.1 mg/kg/dose (Max: 4 mg/dose)
2) Diazepam PR / Midazolam Intranasal/Buccal (if no IV available)
3) Fosphenytoin 20 mg PE/Kg/dose IV
   - 1:1 with Normal Saline or D5W – infuse no faster than 3 mg PE/kg/minute (Max infusion rate: 150 mg PE/minute)
   - Call emergency response team and PICU to evaluate for transfer and/or respiratory assistance

Phenytoin/fosphenytoin Allergy OR physician request:
Levetiacetam 30-60 mg/kg/dose IV (Max: 3 g/dose) **Infuse over 15 minutes**
Valproic Acid 20 mg/kg/dose IV (Max: 40 mg/kg/dose up to a max of 2 g/dose) **Infuse at a rate of 1-6 mg/kg/minute**

**NO**

**Manage OFF Pathway**

Consult Attending

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**EXCLUSION CRITERIA**
- AGE < 3 Months
- Age > 18 Years
- Prior neurological insult

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For questions concerning this pathway, Click Here

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References

EBOC Project Owner: Meena Iyer, MD

Approved by the Febrile Seizure & New Onset Afebrile Seizure Evidence-Based Outcomes Center Team

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