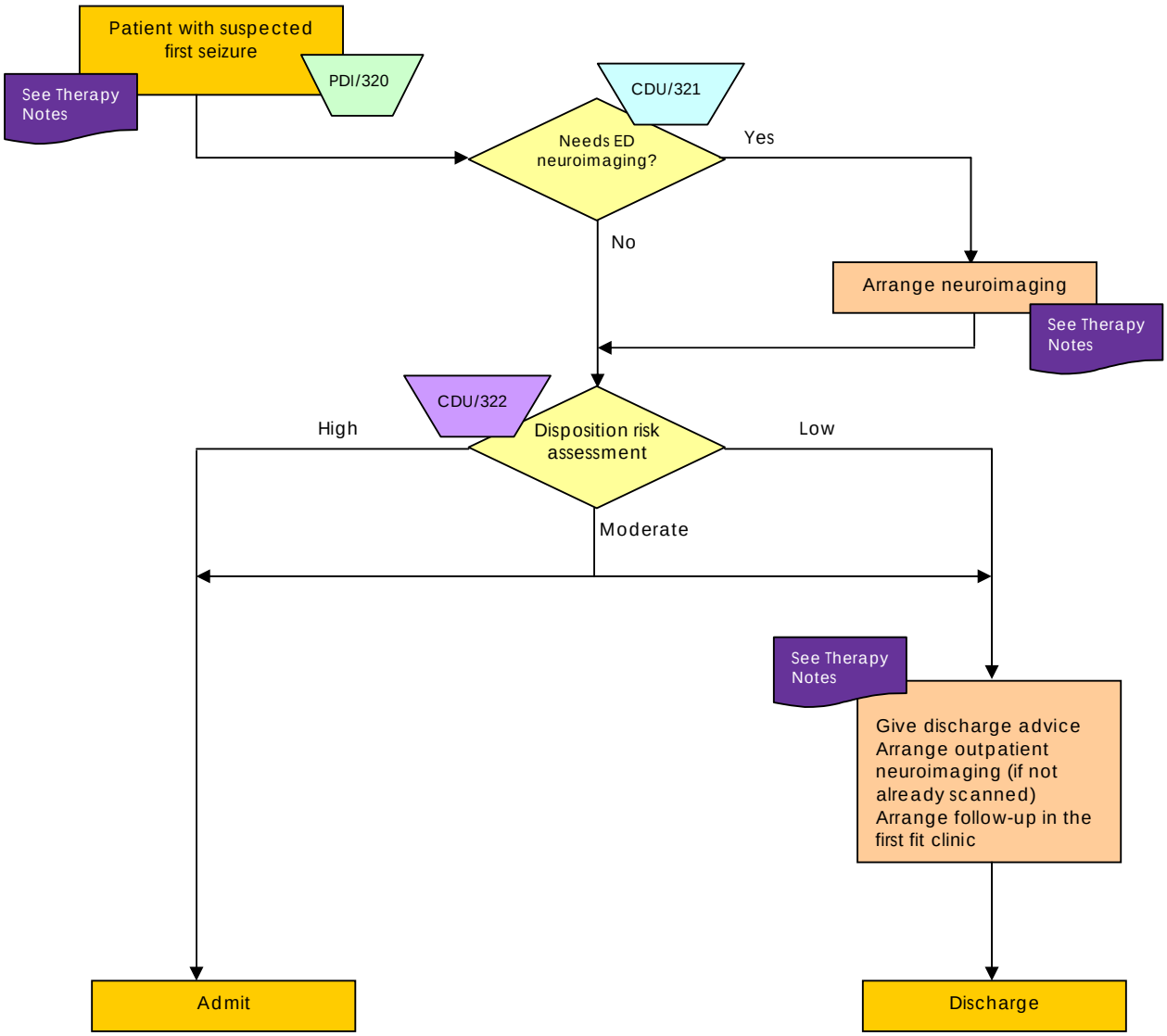
Evidence-based flowchart for the Management of First Seizure in the Emergency Department



PDI/320: SUITABILITY FOR PROTOCOL DRIVEN INVESTIGATION (ALL YES)

16 years old or over	Yes
Suspected first seizure, convulsive	Yes
Not status epilepticus	Yes
Seizure not related to head injury or eclampsia	Yes

Order: T, P, R, BP, SpO_2
serum glucose and sodium
ECG
breath alcohol test
pregnancy test
Other investigations:
other bloods, CXR, LP, toxicology *only if clinically indicated*

CDU/321: NEED FOR NEUROIMAGING PRIOR TO DISCHARGE (ANY YES)

New focal deficit	Yes
Persistent altered mental status	Yes
Fever or persistent headache	Yes
Focal or partial onset seizure	Yes
History of cancer, HIV, immunosuppression, head injury, anticoagulation or bleeding diathesis, or alcoholism	Yes
Follow-up cannot be ensured	Yes

CDU/322: DISPOSITION RISK ASSESSMENT
(High if any HIGH, low if no HIGH and no MOD, otherwise moderate)

	Yes	No
Simple fit with full recovery		HIGH
No neurological deficit		HIGH
Normal initial investigations		HIGH
History of/suspected alcoholism	MOD	
Poor social circumstances	MOD	
No responsible adult to supervise	MOD	
Unlikely to return for follow-up	MOD	

THERAPY NOTES

Laboratory Investigations & Bedside Tests: Laboratory investigations other than those outlined in PDA/320, toxicology screening, bedside tests, chest x-ray and lumbar puncture should only be done if clinically indicated.

Choice of neuroimaging modality: MRI preferable to CT, if readily available within an acceptable time period, in a patient who has fully recovered. CT should be used if MRI is not readily available or in an individual who has not fully recovered. CT is the modality of choice if the patient is critically ill, requires monitoring or MRI is not available/contraindicated.

Treatment: AEDs should not routinely be prescribed in the ED. If AEDs are to be prescribed, this should only be after consultation with an epilepsy specialist

Discharge: Patients with a normal neurological examination and normal baseline investigations can be safely discharged from the ED with outpatient follow-up. Consider admitting those patients without a responsible adult to stay with, or patients who are unlikely to attend out-patient investigations and follow-up.

Advice: Give discharge advice (including first aid, driving, occupation and hazardous activities), document advice in notes and give advice leaflet. Advice given to patients should be documented in the medical notes.

Follow-up: Arrange follow-up in the first fit clinic, ideally within 2 weeks. Arrange outpatient neuroimaging if not already scanned or early follow-up cannot be ensured.