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Confusional status epilepticus in elderly

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Non-convulsive confusional status epilepticus (NCSE) is clinically characterized by prolonged impairment of consciousness of variable entity, often associated with myoclonias or automatisms. EEG shows continuous paroxysmal activity or electrographic discharges. When NCSE occurs in older patients, differential diagnosis with other conditions such as stroke or toxic/metabolic encephalopathy, may be difficult and a high degree of suspicion is required. Emergency EEG represents the most important means of investigation in such cases. According to ictal EEG, NCSE may be classified as generalized (including typical and "de novo" absence status) or complex partial status epilepticus (CPSE). Absence status, or 'petit mal' status, is the most frequently encountered form of NCSE. It can occur in the context of different types of generalized idiopathic epilepsies, or 'de novo', with onset usually in the elderly, precipitated by toxic or metabolic factors in subjects with no previous history of epilepsy [1]. Ictal EEG shows continuous or almost continuous generalized spike and polyspike and wave discharges. Clinical and EEG normalization occurs after i.v. benzodiazepines (BDZ) in most cases. The prognosis of "de novo" absence status is generally good and recurrences are rare [1]. In CPSE, impairment of consciousness may be continuous or fluctuating, but it is usually clinically very difficult to distinguish from absence status. CPSE may occur in patients with preexisting epilepsy, at times precipitated by AEDs withdrawal, or in subjects with acute or remote cerebral lesions. Ictal EEG shows continuous or rapidly recurring complex partial seizures which may involve temporal and/or extratemporal regions. CPSE tends to recur and may be difficult to treat (response to i.v. BDZ in ~ 60% of patients) [2]. Cognitive and behavioral sequelae have been rarely reported, thus prompting an early recognition and treatment of such a condition. Mortality is also rare, mostly depending on etiology, but may reach up to 26,3% in the elderly. CPSE of frontal lobe origin is a diagnostic challenge: it is rare, the symptoms are unusual, and the patients should be documented extensively [3].

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