Changes in Cardiorespiratory Parameters during the Management of status Epilepticus in Children: A Prospective Randomized Controlled Study

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ABSTRACT

Introduction: Status epilepticus is a common pediatric neurological emergency that requires immediate and vigorous management and at times poses a therapeutic challenge to the treating physician. If not managed promptly, it may result in significant neuromorbidity and mortality.¹² The correct management strategy involves initial stabilization of vitals and prompt control of seizures, followed by evaluation and treatment of the underlying etiology.³⁴ The standard protocol for treatment of pediatric status epilepticus involves use of a benzodiazepine first followed by a long acting drug like phenytoin. Phenytoin remains the drug of choice for second-line therapy in status epilepticus that does not respond to lorazepam or diazepam and is also used for maintaining anti seizure effect after the initial therapy with diazepam.⁵⁻⁶ But phenytoin carries high chance of potential side effects, medication interactions.⁷ Despite the availability of a number of antiepileptic drugs that are approved for pediatric use, additional antiepileptic drugs that are effective and well-tolerated in children are still needed.

Results: The mean time to regain consciousness in phenytoin, levetiracetam and valproate groups was 122.3(±45.4) minutes, 120.8(±42.8) minutes and 75.0(±30.7) minutes (mean±S.D) respectively. There was no significant difference in the three groups in various vital parameters like heart rate, systolic blood pressure, spo₂, and respiratory rate recorded at regular intervals in the acute stage (p value > 0.05).

Conclusion: All the three anticonvulsants studied are safe and efficacious, and there is no significant difference in the cardiorespiratory parameters of three groups, and the time to regain consciousness was less in valproate group in comparison to other groups.

Keywords: Cardiorespiratory Parameters, Levetiracetam, Phenytoin, Valproate, Status Epilepticus And Childhood Seizures

INTRODUCTION

Status epilepticus is a common pediatric neurological emergency that requires immediate and vigorous management and at times poses a therapeutic challenge to the treating physician. If not managed promptly, it may result in significant neuromorbidity and mortality.¹² The correct management strategy involves initial stabilization of vitals and prompt control of seizures, followed by evaluation and treatment of the underlying etiology.³⁴ The standard protocol for treatment of pediatric status epilepticus involves use of a benzodiazepine first followed by a long acting drug like phenytoin. Phenytoin remains the drug of choice for second-line therapy in status epilepticus that does not respond to lorazepam or diazepam and is also used for maintaining anti seizure effect after the initial therapy with diazepam.⁵⁻⁶ But phenytoin carries high chance of potential side effects, medication interactions.⁷ Despite the availability of a number of antiepileptic drugs that are approved for pediatric use, additional antiepileptic drugs that are effective and well-tolerated in children are still needed.

The present study was devised to compare changes in hemodynamic parameters during the management of pediatric status epilepticus using different first line anticonvulsants.

MATERIAL AND METHODS

This prospective, randomized controlled study was conducted in the department of Pediatrics at Sher-i-Kashmir Institute of Medical Sciences, Srinagar during 2014-2017. Pediatric patients in the age group of 1 month to 16 years who present actively convulsing (focal motor status or generalized convulsive status) to the emergency department of pediatrics were included in the study. All the concerned parents of the patients were informed about the purpose of the study and written informed consent was obtained from them. Also approval was taken from the hospital ethics committee.

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committee for the study.

**Randomization**
The patients who consented to participate in the study were then randomized into three groups. Randomization was done using a computer derived random-number sequence. One hundred and fifty pediatric patients of either sex, in the age group of 1 month to 16 years, who consented were enrolled in the study. The patients with following characteristic were excluded:
1. Age below 1 month
2. Children already receiving antiepileptic drugs
3. Children with evidence of meningitis or head trauma
4. Known hypersensitivity to drugs in study
All the enrolled patients were actively convulsing at admission. After proper assessment of airway and breathing IV access was established and iv diazepam @ 0.3mg/kg was given to control the seizures. Standard monitoring with recording of heart rate, blood pressure, respiratory rate and pulse oximetry (spo2) was established in the mean time. After obtaining written consent, a detailed assessment regarding type of seizures, any previous drug intake, and any history suggestive of meningitis and head trauma was recorded. After initial stabilization, patients were randomly assigned to three groups-
1. Phenytoin group – received iv phenytoin loading dose @20 mg /kg diluted in NS at a rate <1mg/kg/minute followed by maintenance dose of 5mg/kg day in two divided doses
2. Levetiracetam group – received iv levetiracetam loading dose 25mg/kg @ 3mg/kg/min followed by maintenance 25mg/kg/day divided 12hrly.
3. Valproate group- received iv valproate loading dose 25mg/kg @ 3mg/kg/min, followed by maintenance 20mg/kg/day in divided doses 12hrly.

The primary outcome variables included changes in respiratory rate, heart rate, blood pressure, and oxygen saturation at various time points in the three groups. Venous blood samples were drawn under aseptic conditions for measurement of a baseline haemogram, a liver function test, and analyses of blood urea, serum electrolytes, and blood sugar. Weight, height, and body mass index were calculated, and patients were examined for any neurologic deficits.

**Monitoring**

Pulse rate, respiratory rate, blood pressure, oxygen saturation, consciousness, and recurrence of seizures were monitored for a 24-hour period every 30 minutes for 1 hour, then hourly for 3 hours, and then every 2 hours for 12 hours, and then every 4 hours until 24 hours had passed. Patients were also monitored for development of any adverse to the given drugs.

**STATISTICAL ANALYSIS**
The observed data was entered in the computer to analyze with the help of MS, Excel and SPSS version 15 for windows. The primary outcome measure is presented as mean and SD and statistically significant difference was evaluated using one way ANOVA. Statistically significant difference of qualitable variables among three groups was evaluated using Chi square/ Fischers exact test. A p value of <0.05 was considered as significant and a p-value less than .001 (p<0.001) as highly significant.

**RESULTS**
A total of 150 patients with status epilepticus were included in the study under three groups: phenytoin, valproate and levetiracetam groups. The mean(±SD) age of patients was 4.87(±3.84 years, 104 were males and 46 were females. The mean weight and height of our patient population were 14.27±6.83 kgs and 101±39.9 cms respectively. The most common type of seizure in our patients was generalized in 113 patients and focal in 37 patients. The demographic and clinical characteristics of the patients in different groups are given in table-1.

The cardiorespiratory parameter were: heart rate, systolic BP, respiratory rate and spo2, recorded at 0(basal), 30 and 60 minutes. The comparison of these parameters in different groups is given in table-2. The mean time to regain consciousness was 105.7±39.2 minutes in our patients, with intergroup comparison given in table-3 and table-4. The patients in valproate group regained consciousness earlier than both phenytoin and levetiracetam group patients on overall comparison and also in generalized seizure group. The time to regain consciousness after focal seizures was less in patients of valproate group as compared to the patients from phenytoin group. Although sample size is too small to draw any conclusions in focal seizures.

**DISCUSSION**
Standard management of seizures involves initial control of active seizures, followed by use of longer acting drugs, most

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Phenytoin (n=50)</th>
<th>Levetiracetam (n=50)</th>
<th>Valproate (n=50)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age(years)±SD</td>
<td>5.17±3.71</td>
<td>4.98±4.14</td>
<td>4.45±3.68</td>
<td>0.624</td>
</tr>
<tr>
<td>Gender</td>
<td>M=35, F=15</td>
<td>M=36, F=14</td>
<td>M=33, F=17</td>
<td>0.803</td>
</tr>
<tr>
<td>Weight(kg)±SD</td>
<td>14.73±6.4</td>
<td>14.68±7.15</td>
<td>13.55±7.03</td>
<td>0.62</td>
</tr>
<tr>
<td>Height(cm)±SD</td>
<td>107.5±44.96</td>
<td>99.69±40.87</td>
<td>96.54±35.20</td>
<td>0.38</td>
</tr>
<tr>
<td>Head Circumference (cm)±SD</td>
<td>45.65±4.56</td>
<td>46.05±4.64</td>
<td>45.69±4.57</td>
<td>0.89</td>
</tr>
<tr>
<td>BMI(kg/m²)</td>
<td>14.08±1.45</td>
<td>14.18±1.91</td>
<td>14.37±1.36</td>
<td>0.65</td>
</tr>
<tr>
<td>Seizure type</td>
<td>G=37, F=13</td>
<td>G=37,F=13</td>
<td>G=39,F=11</td>
<td>0.87</td>
</tr>
</tbody>
</table>

Table-1: Comparison of clinical characteristics in study population
often intravenous. Active seizures are usually controlled with shorter acting agents like benzodiazepines. Longer acting agents are started latter to augment seizure control and to prevent recurrence. Long term anticonvulsant treatment is started after two or more generalized unprovoked seizures or focal seizures. To attain rapid antiepileptic drug levels intravenous loading doses are employed initially. Currently phenytoin is the most commonly used iv agent in the setting of acute seizure treatment in children. But phenytoin carries a high risk of side effects and drug interactions, engendering a need for newer drugs which are both effective and well tolerated. IV formulations of levetiracetam and valproate have recently been approved for use in children and can be used as alternatives to phenytoin in the treatment of seizures and epileptic syndromes, especially in patients allergic to the latter and in progressive myoclonic epilepsy. Lack of life threatening cardiovascular, neurological or local adverse effects makes them useful in emergency situation as well. The efficacy of levetiracetam and valproate in acute repetitive seizures and status epilepticus has been demonstrated in a number of studies, both in adults and pediatric patients. The present study compares changes in hemodynamic parameters during administration of iv phenytoin, iv levetiracetam and iv valproate for acute seizure management in children. We included children with a second generalized convulsive status epilepticus, without any statistically significant differences in terms of efficacy. The mean time to regain consciousness in phenytoin, levetiracetam and valproate groups was 122.3(± 45.4) minutes, 120.8(±42.8) minutes and 75.0(±30.7) minutes (mean±S.D) respectively. Patients in valproate group regained consciousness earlier than both phenytoin and levetiracetam group patients(p<0.0001). In the study by Anuradha et al in a review of five RCTs to evaluate efficacy and safety of intravenous valproate in the treatment of status epilepticus (including generalized convulsive status epilepticus), concluded that compared with phenytoin, valproate had statistically lower risk of adverse effects, with no differences in seizure freedom at 24 hours. This review suggests that IV valproate has a better tolerability than IV phenytoin in treatment of generalized convulsive status epilepticus, without any statistically significant differences in terms of efficacy. The mean time to regain consciousness in phenytoin, levetiracetam and valproate groups was 122.3(± 45.4) minutes, 120.8(±42.8) minutes and 75.0(±30.7) minutes (mean±S.D) respectively. Patients in valproate group regained consciousness earlier than both phenytoin and levetiracetam group patients(p<0.0001). In the study by Anuradha et al in which patients initially received iv diazepam, no difference in time taken to regain consciousness was observed between valproate and phenytoin groups. Yu et al found that the time taken for mental status recovery after iv valproate was less than 60 min in all patients with status epilepticus. However,
in their study iv diazepam was not used before valproate loading. To the best of our knowledge no such comparative study was available for iv levetiracetam.

There was no significant difference in the three groups in various vital parameters like heart rate, systolic blood pressure, spo₂, and respiratory rate recorded at regular intervals in the acute stage (p value > 0.05). Significant respiratory depression was not reported in any patient in this study. Our findings were consistent with the findings of Yu et al²⁹ who concluded that there was no change in cardiorespiratory parameters after rapid iv infusion of valproate. Ramael S et al used iv levetiracetam in their study and found no significant change in cardiorespiratory parameters.³²

Adverse un-wanted side effects reported in our study were somnolence in two patients in levetiracetam group at one week follow up. The age of both the patients was less than three months. The effects were not severe to warrant drug discontinuation. One patient from valproate group had drug induced hepatotoxicity (transaminitis) at three months follow up requiring drug discontinuation. The age of the patient was 11 months. Four patients in phenytoin group had drowsiness and two had episodes of ataxia after every dose of oral phenytoin at 1 week follow up.

Pharmacokinetic studies have established a benign safety profile for levetiracetam. Li et al prospectively analyzed 120 patients There was a side effect incidence rate of 47.5% which included somnolence, dysphoria, nervousness, somniphathy, astitia, and debilitation.²²⁻²⁵ Valproate is known to cause liver dysfunction on long term use, especially in children less than 3 years of age but intravenous infusions have been found to be very safe in a number of studies. When the safety profiles of valproate and levetiracetam are compared with phenytoin, the former two drugs are preferred both in emergency and long term use. In our study, patients from phenytoin group had no serious adverse effects other than drowsiness and ataxia in few. So phenytoin was better tolerated in our patients both as infusion and as long term maintenance, as compared to poor tolerance reported in other studies.¹²⁻¹⁸

CONCLUSION

There was no significant difference in the three groups in various vital parameters like heart rate, systolic blood pressure, spo₂, and respiratory rate recorded at regular intervals in the acute stage. Moreover, all the three anticonvulsants studied are safe and efficacious, although the time to regain consciousness was less in valproate group in comparison to other groups.

REFERENCES


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