

Surgical treatment of epilepsy

Surgical treatment of epilepsy is considered in **drug-resistant epileptics**. According to the International League Against Epilepsy, these are patients who have more than one seizure per month for two years with a combination of at least three antiepileptic drugs at therapeutic doses, and the seizures also adversely affect the patient's quality of life. Currently, every epileptic should have an MRI scan to rule out an organic cause of epilepsy, such as low-grade glioma, arteriovenous malformations, cavernous or intertemporal intertemporal sclerosis.

Examination

An epileptic considered for surgical treatment must undergo:

1. Ictal and interictal EEG examination;
2. Structural examination (MRI);
3. Functional examination (Wada test, PET, SPECT, fMRI);
4. Psychiatric and neuropsychological examination.

Operational performance

The operation is indicated by a neurologist-epileptologist. Performed by:

- Anterior two-thirds **temporal lobectomy** with **amygdalohippocampectomy** (AHE) (70%) - the extent of lobectomy is determined by intraoperative EEG with respect to the functional cortex, it is the basic procedure for intertemporal sclerosis in patients with partial complex seizures.
- Extratemporal resection, most often **topectomy** (20%) - according to the detection of structural topical abnormality on MRI, after temporal resection in 70% of patients there is a complete regression of epilepsy, after extratemporal resection in 60% of patients.
- **Callosotomy**, **hemispherectomy**, **vagus nerve stimulation** and **multiple subpial transections** (10%) - indicated for non-focal epileptic seizures.

Links

Related articles

- Epilepsy
- Epilepsy/PGS
- Epileptic seizures
- Classification of epileptic seizures
- Epileptic lesion
- Antiepileptics

References

- ws:Chirurgická léčba epilepsie
-