



health

Department:
Health
REPUBLIC OF SOUTH AFRICA



Questions – Epilepsy Webinar – 10 February 2026

Question (As received on webinar chat)	Response
<p>1. The current use of Phenytoin by very elderly patients what to do....how to change medication</p>	<p>Always difficult, but if there are no adverse effects and no seizures, probably best left on phenytoin. The STGs, under Medicine Treatment for Epilepsy in Adolescents and Adults, state: Phenytoin is not recommended, however, it may be continued in adults whose seizures are well-controlled on phenytoin. Therapeutic drug monitoring should be conducted in patients receiving higher than usual doses of phenytoin.</p>
<p>2. When completing the risk acknowledgement form, Is Abstinence an acceptable form of contraception?</p>	<p>“Abstinence” by a person who is in a relationship is not acceptable (risk is too high). However, for people who are not sexually active and not in a relationship may be documented as “not sexually active” and contraception does not have to be forced upon them (note, risk of unintended sexual activity must be assessed).</p>
<p>3. Comment ;The use of Valproate as mood stabilizer for epilepsy is proving a bit of a barrier for implementing the SAPHRA assessment in our facility. But working on it.</p>	<p>The risks apply for all indications, the form would still have to be completed for female patients of child-bearing potential.</p>
<p>4. Afternoon colleagues. What an interesting topic. Do patients with temporal lobe Epilepsy have convulsions?</p>	<p>They have focal epileptic seizures with manifestations involving temporal lobe functions (e.g. odd sensory experiences such as déjà vu/ jamais vu/ depersonalisation; altered consciousness; olfactory hallucinations, sudden intense fear, and various disturbances in behaviour). The term ‘convulsions’ is usually used for generalised tonic clonic seizures ... people with <i>temporal lobe epilepsy (TLE)</i> may have seizures that start in the temporal lobe and progress to both cerebral hemispheres to cause generalised tonic clonic seizures and/or they may have both types of epilepsy (TLE and generalised epilepsy) with both types of seizures.</p>
<p>5. Has NEMLC considered including sodium valproate injections into the STGs and EML considering the risks with phenytoin and that phenobarbitone IV is a Section 21 medicine and supply is not stable? A previous review was not approved. There are currently a few suppliers of generic sodium valproate injections and the medicine is available at better prices. Thank you.</p>	<p>The possible need for this injection was discussed by the epilepsy subcommittee and has been flagged for consideration by the expert review committee for NEMLC.</p>

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<p>6. We had a contractor who was witnessed to have a first seizure at work. Lasted under 3 minutes with generalised whole body jerking. Sudden onset...Taken to NSH. Ambulance staff did not share all the detail (rather just mentioned the psychiatric condition) so no tests done. 3 days later saw the company doctor who gave a referral and the contractor went back to NSH. No further investigation was done. What is the next step? Private GP has indicated EEG test.</p>	<p>A detailed history is needed to rule out previous, unreported seizures and other possible causes. A diagnosis of epilepsy would not be made on a single seizure. However, an EEG is not the first option.</p>
<p>7. How does one start the titration of Lamotrigine if the pt has been Sodium Valproate, thus start Lamotrigine and reduce the Valproate concentration?</p>	<p>Low and slow, until therapeutic dose of lamotrigine, then slow withdrawal of valproate, e.g. in adults, reduce the valproate at a rate of 200mg every two weeks, monitoring for seizure recurrence.</p> <p>See PHC STGs Chapter sections 15.7.1, Table 4 for lamotrigine dosing in children <13 years and section 15.7.2 Table 6 for adolescents and adults. The STGs also give an indication of usual maintenance dose.</p>
<p>8. When switching from Valproate to lamotrigine: To titrate up the lamotrigine the add-on treatment table for lamotrigine can be used. When titrating down the valproate is it done over 6-8 weeks?</p>	<p>As above</p>
<p>9. IS epilepsy can lead to paralysis..?</p>	<p>Unclear what circumstances are being described, but the simple answer is probably no.</p>
<p>10. Epilepsy being a hereditary disease, is it a fact or myth</p>	<p>Not all are, but there may be a strong family history of some types and thus a genetic component.</p>
<p>11. Is carbamazepine/tegretol still in use fir epilepsy because we still have pt on carbamazepine and drug is no longer available</p>	<p>Yes, it is still one of the options in the STGs for focal epilepsy (e.g., temporal lobe epilepsy) with or without evolution to bilateral tonic clonic seizures, but not for other epilepsies.</p>
<p>12. what do you do in a case of seizures, like the basics to teach a person at home...cos it's very tricky. Thank you for the presentation presenters.</p>	<p>Good resource at https://www.cdc.gov/epilepsy/first-aid-for-seizures/index.html</p>
<p>13. How long after absence of seizures can possibility to stop epilepsy medication be reviewed?</p>	<p>That's a tough question and has major medico-legal implications, but usually 2-5 years. Much depends on what caused the initial seizures.</p>
<p>14. The STG states: Doses should be increased at 2-weekly intervals only. But for carbamazepine (states weekly), Levetiracetam (2-4 weeks) and valproate (3days -2 weeks). Do we not advise the general 2 weekly increase of dose or give advice as per individual ASM's.</p>	<p>Not sure which drug is being referred to.</p> <p>Use the advice per individual ASM. Thanks for alerting us to the discrepant text.</p>

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<i>15. What other conditions can valpro be prescribed for?</i>	SAHPRA approved indication is for the acute and maintenance treatment of manic episodes associated with bipolar disorders in adults, and is in the STGs for this indication
<i>16. When can you stop medication if patient was off seizure for a long time and does it depend on what type of seizures they have.</i>	See Q13
<i>17. Please advise when we can expect the circular that would have the cross-titration of valproate to lamotrigine guidance.</i>	See Q7 above.
<i>18. I'm working with intellectual disability users however i see some are put in 2 or more epileptic medication, is it advisable or a doctor must review the script of the patient?</i>	Sometimes more than one ASM is needed, especially in people with intellectual disability who may have severe epilepsy, however the prescribing must be rational. Drug-drug interactions can cause poor epilepsy control with inappropriate prescribing of increased doses or adding on more medicines. Suggest clarifying the type of epilepsy and reviewing the treatment in line with the updated STGs.

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