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Absence seizures in children

You might be worried if you've been told your child has absence seizures. But there are treatments that can help. Many children grow out of absence seizures by the time they're teenagers.

This information is about absence seizures caused by childhood absence epilepsy. You can use our information to talk to your doctor and decide which treatments are best for your child.

What are absence seizures?

During an absence seizure, children ‘shut off’ for a few seconds. They stare blankly into space and don't know what's going on around them. This usually lasts for 5 to 10 seconds. Although the seizure is brief, children may have several absence seizures each day. Some children have dozens.

There are two types of absence seizures: typical and atypical. This information is about **typical** absence seizures caused by a condition called **childhood absence epilepsy**. These seizures used to be called petit mal seizures.

What are the symptoms of absence seizures?

It can be hard to tell if your child has absence seizures. The symptoms aren't always clear. Your child might appear to be careless or just not paying attention. They might have problems learning at school.

Here are some signs you can look for. Your child might:

- stare into space and not respond to anything
- stop talking in the middle of a sentence
- flutter their eyelids, smack their lips, or fidget with their hands.

When an absence seizure ends, the child usually continues doing whatever they were doing before the seizure. They have no memory of what happened.

If your doctor thinks your child is having absence seizures, they will send you to see an epilepsy specialist. This doctor will probably recommend your child has a test called an **electroencephalogram (EEG).** This measures the electrical activity in your child's brain.

The doctor may also ask your child to breathe very quickly (known as **hyperventilation**). If your child has childhood absence epilepsy, hyperventilation can often trigger a seizure.

Occasionally, a child's absence seizures are caused by a genetic disorder called **glucose transporter type 1 (GLUT1) deficiency syndrome**. When someone has this syndrome, their brain doesn't get enough glucose, which it needs for energy. This can cause absence seizures, among other problems.

Your child's doctor may recommend testing for GLUT1 deficiency syndrome if your child is under 4 years old.

What are the treatment options for absence seizures?

The main goal of treatment is to reduce the number of absence seizures your child has, or to stop them altogether. Medicines can't cure childhood absence epilepsy, but they can help with the seizures.

Doctors usually prescribe one of the following medicines: **ethosuximide**, **valproic acid**, or **lamotrigine**. They all can work well for absence seizures.

Doctors normally recommend trying ethosuximide first. This is because research suggests that ethosuximide and valproic acid work better than lamotrigine. Ethosuximide is less likely to cause side effects than valproic acid.

The medicines can come as tablets or liquids. Your child will need to take their medicine every day. Their doctor will start the treatment at a low dose and gradually increase it. You should not change your child's dose or stop the treatment without speaking with your doctor.

All the medicines for childhood absence epilepsy can cause side effects. However, serious problems are rare. You can discuss the benefits and risks of these treatments with your doctor to decide what's best for your child.

- Common side effects from ethosuximide include an upset stomach and weight loss. There's a chance your child could get problems with their liver, blood, or kidneys. But these problems are rare.
- Valproic acid may make your child feel tired, gain weight, and lose some hair temporarily. Less commonly, it can cause more serious problems with a child's blood, pancreas, or liver.
- Common side effects with lamotrigine include difficulty sleeping (insomnia), headaches, and feeling dizzy. If your child gets a rash or flu-like symptoms while taking lamotrigine, take them to hospital straight away. They could be having a serious reaction to the medicine called Stevens-Johnson syndrome.

If one of these medicines doesn't reduce your child's seizures, or if it causes worrying side effects, your doctor will probably recommend switching medicines. Your child's doctor will carefully monitor their treatment to reduce their chance of serious problems.

Sometimes other epilepsy medicines are also used. Some children will need to take more than one medicine.

If your child has been diagnosed with GLUT1 deficiency syndrome, their doctor will probably recommend trying a **ketogenic diet**. This diet is designed to provide more energy to the brain. The diet is high in fat and low in carbohydrates, and includes a moderate amount of protein. It should only be started under close medical supervision and it may take a couple of months to have an effect.

Children with GLUT1 deficiency syndrome usually continue taking their epilepsy medicine when starting a ketogenic diet. Eventually, however, children may be able to gradually decrease, or stop, their epilepsy medication.

What happens next?

Medicines work well to control absence seizures for most children. Your child's doctor will aim to find a treatment that reduces or stops your child's seizures with few, if any, side effects.

If the seizures stop, your doctor may eventually reduce your child's medication, to see if the seizures start again.

To be safe, your child may need to avoid potentially dangerous activities until their seizures are under control. This might be things like climbing, swimming unsupervised, or riding a bike on busy roads.

As children get older, they are often able to stop taking their epilepsy medicine completely. As many as 8 in 10 children with childhood absence epilepsy no longer have seizures by the time they are teenagers.[1]

References

1. Grosso S, Galimberti D, Vezzosi P, et al. Childhood absence epilepsy: evolution and prognostic factors. Epilepsia. 2005 Nov;46(11):1796-801.

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