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# Antiepileptic Drug Response, Treatment Pattern, and QOLCE-55 Scores Among Children with Epilepsy

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## Abstract

**Background:** Epilepsy is one of the most prevalent chronic childhood neurological conditions and has important implications for neurodevelopment, treatment adherence, and quality of life (QoL). This study aimed to assess the antiepileptic drug (AED) response, treatment pattern, and QOLCE-55 scores and associated factors in children with epilepsy among Bangladeshi children.

**Methods:** This cross-sectional study was carried out at the National Institute of Neurosciences and Hospital, Dhaka, from January 2023 to December 2023, on 95 children aged 6–15 years with confirmed epilepsy. Clinical and demographic information, AED treatment patterns, drug response, EEG, neuroimaging findings, and developmental history were documented. The validated QOLCE-55 instrument was used to assess the quality of life. Data were entered and analyzed on SPSS version 26.

**Results:** Most children were aged in the range of 6–9 years, and there was a male predominance (55.8%). The most common type of epilepsy was focal (63.2%), and 47.4% had delayed developmental milestones. Monotherapy was used in 61.1%, and 70.5% had a good response to the AED. The overall mean QOLCE-55 score was 71.6 ± 18.8, and the lowest domain score was for cognitive functioning (63.9 ± 25.6). Early age at seizure onset ($P = 0.025$), prolonged epilepsy duration ($P = 0.040$), delayed development ($P = 0.001$), abnormal neuroimaging ($P = 0.001$), polytherapy ($P = 0.005$), and poor AED response ($P = 0.001$) were significant associated factors of lower QoL.

**Conclusion:** Epilepsy negatively affects the quality of life of children in Bangladesh, especially in cognitive functioning. Seizure control, preference for monotherapy, and early intervention for developmental delay are important areas for improving QoL outcomes in this population.

**Keywords:** Epilepsy, antiepileptic drugs, QOLCE-55, quality of life

## Introduction

Epilepsy ranks among the most prevalent chronic neurological disorders in children, affecting approximately 10.5 million young individuals globally. This condition imposes a considerable strain on the affected individuals, their families, and the healthcare infrastructure.[1] It is marked by repeated, spontaneous seizures caused by irregular electrical activity in the brain, frequently starting during the crucial developmental stages of childhood.[2] The prevalence of childhood epilepsy is 3–10 per 1000 children worldwide, consistently higher in low and middle-income countries (LMICs), including Bangladesh.[3] Epilepsy in children is a public health problem in South Asian settings, frequently underdiagnosed, undertreated, socially stigmatized, disrupts education, and poor long-term outcomes.[4] The effects of childhood epilepsy are not just limited to seizures; children with epilepsy may also suffer from cognitive impairment, behaviour problems, emotional problems, poor school performance, and restricted participation in daily activities. Antiepileptic drugs (AEDs) are the mainstay of epilepsy treatment in children. About 60–70% of children with epilepsy can be controlled with the appropriate use of AEDs, and the other 30–40% have drug-resistant epilepsy, which requires polytherapy or other therapeutic approaches.[5] Monotherapy is typically the first-line treatment approach, due to its good tolerability, reduced potential for drug interactions, and ease of adherence.[6] Several factors, however, influence the selection of AED, such as seizure type, electroencephalographic results, neuroimaging results, and patient-specific factors including age, weight, comorbidities, developmental status, and potential adverse effects.[7] Other factors such as drug availability, affordability, adherence to treatment, awareness of caregivers, and access to specialized pediatric neurology services can also influence treatment decisions in resource-limited settings. In addition to seizure control, the quality of life (QoL) of children with epilepsy is now acknowledged as an important outcome measure. The Quality of Life in Childhood Epilepsy (QOLCE-55) is a validated, disease-specific tool that measures QoL in children with epilepsy in cognitive, emotional, social, and physical domains.[8] Children with epilepsy have consistently been found to have significantly poorer QoL than healthy children, due to factors including seizure frequency, AED regimen, developmental delay, response to treatment, school-related limitations, caregiver anxiety, and psychosocial stressors.[9] Thus, measurement of QoL offers a wider perspective of disease burden and enables the clinician to assess the impact of epilepsy in a patient-centred and family-centred way. A variety of factors are associated with poor QoL in children with epilepsy, such as early age at seizure onset, long duration of epilepsy, abnormal neuroimaging, polytherapy, and poor seizure control.[10] Children who need more than one AED may have more severe or difficult-to-control epilepsy, and may also be at higher risk for adverse effects of medication, which can also affect physical, cognitive, and emotional functioning. Evidence from Bangladesh and other LMICs, however, is limited, and findings from high-income countries may not be generalizable.[11] The relationship between treatment patterns, AED response, and QoL outcomes in Bangladeshi children is crucial for clinical decision making, optimizing treatment strategies, identifying vulnerable subgroups, and providing patient-centred care. The objective of this study was to evaluate the antiepileptic drug response, treatment patterns, and QOLCE-55 scores among Bangladeshi children with epilepsy.

## Methods

This cross-sectional study was conducted in the Department of Paediatric Neurology, National Institute of Neurosciences and Hospital, Sher-E-Bangla Nagar, Dhaka, from January 2023 to December 2023 on 95 children with epilepsy. The children with epilepsy aged 6–15 years attending the outpatient department were selected by consecutive sampling. Children were included regardless of sex if they had a history of epilepsy supported by seizure semiology and/or video

evidence from caregivers, EEG, and had been diagnosed for at least one year and were on regular antiepileptic drug therapy. Children with cerebral palsy, autism, attention deficit hyperactivity disorder, epileptic encephalopathy, or developmental and epileptic encephalopathy, unknown epilepsy, chronic medical illnesses, or serious medical or surgical problems unrelated to epilepsy were excluded. Data were collected with informed written consent from parents/caregivers, face-to-face interviews, clinical examination, treatment records, seizure diaries, and available CT or MRI results. Seizure type was determined using the ILAE 2017 classification, and seizure frequency was determined by the average number of seizures over the last three months. Demographic, anthropometric, clinical, treatment-related, electroencephalographic, and neuroimaging variables were documented on a structured data collection form. The parent-reported QOLCE-55 questionnaire was used to assess quality of life, which was translated and pretested in Bengali before data collection and included cognitive, emotional, social, and physical functioning. Drug-responsive epilepsy was defined as seizure freedom for at least 12 months or three times the longest preintervention inter-seizure interval, whichever was longer. The data were analyzed using SPSS version 26. Continuous variables were expressed as mean and SD, and categorical variables as frequency and percentage. Student's t-test and ANOVA were used as appropriate, and $P < 0.05$ was deemed statistically significant.

## Results

The sociodemographic and anthropometric data of 95 study children are given in Table 1. The majority were aged 6–9 years (51.6%) and male (55.8%). The majority of children (51.6%) lived in rural areas. Over half of both mothers (50.5%) and fathers (54.7%) had a higher education than high school. A body surface area below 1.33 m² was found in 85.3%, while 62.1% had a BMI below 18.5 kg/m². In 84.2% of children, the occipitofrontal circumference was normal [Table 1].

The clinical features of the children in the study with seizures are described in Table 2. The age at onset of the epilepsy was most frequently 1–5 years (46.3%), and over half had an epilepsy duration of more than 5 years (52.6%). Only 3.2% had a family history of epilepsy. The most common frequency of seizures was 1–5 seizures per month (51.6%). Focal epilepsy was most common (63.2%), and 47.4% had a history of developmental delay [Table 2].

EEG and neuroimaging results are presented in Table 3. The most common EEG pattern was

**Table 1:** Sociodemographic and anthropometric characteristics of the study children, $N = 95$

| Variable | Category | *n* (%) |
|---|---|---|
| Age, years | 6–9 | 49 (51.6) |
| | 10–12 | 29 (30.5) |
| | 13–15 | 17 (17.9) |
| Gender | Male | 53 (55.8) |
| | Female | 42 (44.2) |
| Residence | Urban | 46 (48.4) |
| | Rural | 49 (51.6) |
| Mother's educational status | Illiterate | 6 (6.3) |
| | Up to high school | 41 (43.2) |
| | Above high school | 48 (50.5) |
| Father's educational status | Illiterate | 8 (8.4) |
| | Up to high school | 35 (36.8) |
| | Above high school | 52 (54.7) |
| BSA, m² | <1.33 | 81 (85.3) |
| | ≥1.33 | 14 (14.7) |
| BMI, kg/m² | <18.5 | 59 (62.1) |
| | 18.5–24.9 | 27 (28.4) |
| | 25.0–29.9 | 7 (7.4) |
| | ≥30.0 | 2 (2.1) |
| OFC | Normal | 80 (84.2) |
| | Microcephaly | 14 (14.7) |
| | Macrocephaly | 1 (1.1) |

**Table 2:** Seizure-related clinical characteristics of the study children, $N = 95$

| Variable | Category | *n* (%) |
|---|---|---|
| Age at onset of epileptic seizure | <1 year | 14 (14.7) |
| | 1–5 years | 44 (46.3) |
| | >5 years | 37 (38.9) |
| Duration of epilepsy | 1–2 years | 7 (7.4) |
| | 3–5 years | 38 (40.0) |
| | >5 years | 50 (52.6) |
| Family history of epilepsy | Yes | 3 (3.2) |
| | No | 92 (96.8) |
| Seizure frequency | <1/month | 22 (23.2) |
| | 1–5/month | 49 (51.6) |
| | >5/month | 24 (25.3) |
| Type of epilepsy | Focal | 60 (63.2) |
| | Generalized | 22 (23.2) |
| | Focal to bilateral tonic-clonic | 12 (12.6) |
| | Combined generalized and focal | 1 (1.1) |
| Developmental history | Age-appropriate development | 50 (52.6) |
| | Delayed development | 45 (47.4) |

**Table 3:** Electroencephalographic and neuroimaging findings among the study children

| Investigation | Finding | *n* (%) |
|---|---|---|
| Electroencephalographic findings, $n = 95$ | Focal discharge | 48 (50.5) |
| | Generalized discharge | 29 (30.5) |
| | Focal with secondary generalization | 6 (6.3) |
| | Normal | 12 (12.6) |
| Neuroimaging findings, $n = 68$ | Normal findings | 43 (63.2) |
| | Abnormal findings | 25 (36.8) |

**Table 4:** Treatment pattern and antiepileptic drug response among the study children, $n = 95$

| Variable | Category | *n* (%) |
|---|---|---|
| Medication pattern | Monotherapy | 58 (61.1) |
| | Polytherapy | 37 (38.9) |
| Response to AED | Yes | 67 (70.5) |
| | No | 28 (29.5) |

**Table 5:** Overall and domain-specific QOLCE-55 scores among the study children, $n = 95$

| QOLCE-55 domain | Range | Mean ± SD |
|---|---|---|
| Cognitive functioning | 8.0–100.0 | 63.9 ± 25.6 |
| Emotional functioning | 25.0–100.0 | 74.4 ± 17.2 |
| Social functioning | 10.7–100.0 | 78.8 ± 24.9 |
| Physical functioning | 19.4–100.0 | 68.8 ± 14.3 |
| Overall QOLCE-55 score | 20.0–96.6 | 71.6 ± 18.8 |

focal discharge (50.5%), followed by generalized discharge (30.5%) and normal EEG (12.6%). Neuroimaging was done in 68 children, 63.2% of whom had normal results and 36.8% of whom had abnormal results, including structural brain lesions [Table 3].

Treatment pattern and AED response are shown in Table 4. Sixty-one percent of children received monotherapy, and 39% received polytherapy. Seizure freedom for at least one year was seen in 70.5% of children, and in 29.5% of children, adequate seizure control was not achieved [Table 4].

Overall and domain-specific scores of QOLCE-55 are shown in Table 5. The mean overall QOLCE-55 score was 71.6 ± 18.8. The mean scores for the domains were: social functioning (78.8 ± 24.9), emotional functioning (74.4 ± 17.2), physical functioning (68.8 ± 14.3), and cognitive functioning (63.9 ± 25.6) [Table 5].

Table 6 shows factors significantly associated with the overall QOLCE-55 score. Children who had the onset of seizures after 5 years of age had higher mean scores than children with onset below 1 year (76.6 ± 15.7 vs. 60.9 ± 23.7, $P = 0.025$). Each of the following factors was

significantly associated with higher QOLCE-55 scores: shorter duration of epilepsy, age-appropriate development, normal neuroimaging, and response to AED (all $P < 0.05$) [Table 6].

## Discussion

This study demonstrates significant information on the clinical and therapeutic picture of pediatric epilepsy in a resource-limited environment, where access to specialized neurology care, regular follow-up, neuroimaging, and structured quality-of-life assessment may be limited. The results suggest that epilepsy in childhood is not just a seizure disorder but a chronic neurological disorder with developmental, functional, psychological, and treatment implications.[12] EEG results showed that 50.5% of children had focal discharges, while 36.8% of the children who had neuroimaging had abnormal findings, highlighting the structural etiology of many childhood epilepsies in this context. The findings suggest that thorough electroclinical assessments and suitable neuroimaging are crucial for detecting underlying conditions, categorizing epilepsy types, and devising personalized treatment plans.[13] The complexity involved in managing seizures is evident in the treatment approaches, with 61.1% of children receiving monotherapy and 38.9% undergoing polytherapy. The predominance of monotherapy is clinically anticipated, as it is typically the initial choice for seizure management due to its higher tolerability, reduced drug interactions, and improved adherence. The high percentage of children who were taking more than one drug, however, indicates that a significant number of children had more refractory epilepsy or ongoing seizure burden despite treatment. The treatment response rate in children was 70.5% (AED response), which is similar to the treatment response rate reported in pediatric epilepsy.[14] Children taking polytherapy had significantly lower QOLCE-55 scores than children taking monotherapy (64.9 ± 19.4 vs. 75.8 ± 17.2, $P = 0.005$), consistent with Aldenkamp et al., who reported that children taking multiple AEDs have poorer cognitive and emotional outcomes than children taking a single

**Table 6:** Factors associated with the overall QOLCE-55 score among children with epilepsy

| Variable | Category | Total, *n* | Overall QOLCE-55 score / Mean ± SD | *P*-value |
|---|---|---|---|---|
| Age at onset of epileptic seizure | <1 year | 14 | 60.9 ± 23.7 | 0.025 |
| | 1–5 years | 44 | 70.7 ± 18.3 | |
| | >5 years | 37 | 76.6 ± 15.7 | |
| Duration of epilepsy | 1–2 years | 7 | 79.8 ± 14.2 | 0.040 |
| | 3–5 years | 38 | 76.0 ± 15.6 | |
| | >5 years | 50 | 67.1 ± 20.5 | |
| Developmental history | Age-appropriate development | 50 | 77.9 ± 13.4 | 0.001 |
| | Delayed development | 45 | 64.5 ± 21.4 | |
| Neuroimaging findings | Normal findings | 43 | 80.1 ± 9.8 | 0.001 |
| | Abnormal findings | 25 | 55.1 ± 18.6 | |
| Medication pattern | Monotherapy | 58 | 75.8 ± 17.2 | 0.005 |
| | Polytherapy | 37 | 64.9 ± 19.4 | |
| Response to AED | Yes | 67 | 76.5 ± 16.0 | 0.001 |
| | No | 28 | 59.6 ± 19.8 | |

AED.[15] This association could be due to the severity of the epilepsy that needs polytherapy, or to the cumulative effects of polytherapy, such as sedation, attention difficulties, behavior changes, and poor school performance. The mean overall QOLCE-55 score in this study was 71.6 ± 18.8. Social functioning was the least impaired domain (78.8 ± 24.9), and cognitive functioning was the most impaired domain (63.9 ± 25.6). Previous research has also shown that cognitive functioning is the area most affected in children with epilepsy, which can be due to the direct neurological impact of seizures, AED side effects on cognition, disruption of education, and underlying developmental vulnerabilities.[16] Children with epilepsy can experience cognitive problems that impact memory, attention, learning capacity, and academic performance, and these effects can persist beyond seizure control.[17] Thus, the frequency of seizures should not be the only focus of routine clinical care, but should also involve developmental screening, educational assessment, and counseling of caregivers. This study found several clinical factors to be significantly associated with QoL. Children with longer duration of epilepsy had lower scores on the QOLCE-55 (67.1 ± 20.5 for >5 years vs. 79.8 ± 14.2 for 1–2 years, $P$ = 0.040), which is consistent with findings by Reilly et al., who showed that the chronic burden of seizure activity and prolonged AED exposure is associated with poorer child wellbeing.[18] A lower overall QoL was also associated with early age at onset, indicating that epilepsy that starts at critical periods of brain development may have more functional consequences. Additionally, 47.4% of children were found to have developmental delay, which was also a significant predictor of lower QoL (64.5 ± 21.4 vs. 77.9 ± 13.4 in age-appropriate children, $P$ = 0.001). This is an important observation that suggests that delayed development in children with epilepsy is a reflection of underlying neurological pathology and that there are bidirectional relationships between epilepsy and brain maturation.[19] Therefore, integrated management by pediatric neurologists, developmental specialists, rehabilitation professionals, psychologists, and educators is needed. Marked differences in QOLCE-55 scores were also observed among those with abnormal neuroimaging findings (55.1 ± 18.6 vs. 80.1 ± 9.8, $P$ = 0.001), consistent with Fayed et al., who showed that structural brain lesions are among the strongest associated factors for poor functional and quality-of-life outcomes in pediatric epilepsy.[20] Children exhibiting abnormal neuroimaging results are prone to experiencing more intense epilepsy, along with motor and cognitive impairments, and may show resistance to treatment, all of which can affect their everyday activities. Those who responded well to AEDs demonstrated notably higher quality of life (QoL) scores compared to those who did not respond (76.5 ± 16.0 vs. 59.6 ± 19.8, $P$ = 0.001), indicating that effective seizure management is the key modifiable factor for enhancing QoL in this group.[21] However, merely controlling seizures might not suffice to boost quality of life, particularly for children with developmental delays, abnormal imaging, or persistent epilepsy.[22] These findings underscore the intricate nature of QoL in pediatric epilepsy and emphasize the importance of optimizing AED treatment while also addressing neurodevelopmental, familial, and psychosocial care aspects. In Bangladesh, improving early diagnosis, making informed AED choices, avoiding unnecessary polytherapy, educating caregivers more effectively, and incorporating QoL assessments into regular follow-ups can improve long-term outcomes. The study also endorses the QOLCE-55 as a useful tool for identifying children at risk of poor functioning and guiding more patient-focused epilepsy care.

## Limitations of the Study

The study was performed in a single tertiary center, and the number of the study population was small ($N$ = 95), which may restrict the generalizability of the results to other children with epilepsy in Bangladesh.

## Conclusion

The overall study demonstrates that the quality of life of children with epilepsy in Bangladesh is moderate, with the cognitive functioning domain being the most affected as assessed by the QOLCE-55 instrument. Most children received monotherapy, and around 70% had a good AED response and were seizure-controlled. Factors that were associated with poor quality of life were early seizure onset, longer epilepsy duration, delayed developmental milestones, abnormal neuroimaging findings, polytherapy use, and failure to respond to antiepileptic drug therapy. The results of this study reinforce the multidimensionality of epilepsy outcomes in children and the need for early and effective treatment of seizures. To enhance QoL in this vulnerable pediatric population, comprehensive care that includes neurodevelopmental, therapeutic, and psychosocial care is necessary.

## Recommendations

Longitudinal designs with larger, multi-center cohorts should be used in future studies to better define the trajectory of changes in QoL in children with epilepsy over time and in response to changes in treatment. Furthermore, the inclusion of parental mental health and socioeconomic factors could offer a more holistic view of the factors that predict QoL in this population.

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