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| Question |
| **Status epilepticus on electroencephalogram (EEG) for prediction of poor neurological outcome in adults with cardiac arrest (Subsection of Prognostication ETD)** |
| **Population:** | Adults who are comatose after resuscitation from cardiac arrest (either in-hospital or out-of-hospital), regardless of target temperature management. |
| **Intervention:** | Status epilepticus on EEG, assessed within one week after cardiac arrest.  |
| **Comparison:** | *None.* |
| **Main outcomes:** | Prediction of poor neurological outcome defined as Cerebral Performance Categories (CPC) 3-5 or modified Rankin Score (mRS) 4-6 at hospital discharge/1 month or later. |
| **STUDY DESIGN:** | Prognostic accuracy studies where the 2 x 2 contingency table (i.e., the number of true/false negatives and positives for prediction of poor outcome) was reported, or where those variables could be calculated from reported data. are eligible for inclusion. Unpublished studies, reviews, case reports, case series, studies including less than 10 patients, letters, editorials, conference abstracts, and studies published in abstract form will be excluded.  |
| **TIMEFRAME:** | In 2015, an ILCOR evidence review identified four categories of predictors of neurological outcome after cardiac arrest, namely clinical examination, biomarkers, electrophysiology and imaging. In the last four years, several studies have been published and new predictors have been identified, therefore the topic needs an update.The most recent search of the previous systematic reviews on neuroprognostication was launched on May 31, 2013. We searched studies published from January 1, 2013 onwards.  |

# ASSESsment

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| ProblemIs the problem a priority? |
| Judgement | Research evidence | Additional considerations |
| ○ No○ Probably no○ Probably yes● Yes○ Varies○ Don't know | Cardiac arrest is common and has a very high mortality, with neurologic injury as the most common cause of death. The vast majority of these deaths occur as a result of withdrawal of life-sustaining treatment (WLST) based on prediction of poor neurological outcome. Prognostication is of utmost importance because futile treatments for unsalvageable patients can be avoided and realistic expectations can be given to relatives.  |  |
| Desirable EffectsHow substantial are the desirable anticipated effects? |
| Judgement | Research evidence | Additional considerations |
| ○ Trivial● Small○ Moderate○ Large○ Varies○ Don't know | Status epilepticus was investigated in six studies [Oh 2015 1094, 130 pts; Leao 2015 322, 67 pts; Zhou 2019 343, 226 pts; Amorim 2016 121, 373 pts; Dragancea 2015 (b) 173, 122 pts; Beretta 2019 *in press*, 166 pts].In these studies ***Status Epilepticus within 5 days*** predicted poor neurological outcome from hospital discharge to 6 months with specificity ranging from 82.6% to 100% and sensitivity ranging from 1.8% to 50% (certainty of evidence low or very low).In three studies [Leao 2015 322, 67 pts; Zhou 2019 343, 226 pts; Amorim 2016 121, 373 pts] specificity was 100%. EEG was recorded within 72h from ROSC. In another study [Dragancea 2015 (b) 173] specificity was 100% only when status epilepticus originated from a discontinuous or burst-suppression background. |   |
| Undesirable EffectsHow substantial are the undesirable anticipated effects? |
| Judgement | Research evidence | Additional considerations |
| ○ Large○ Moderate● Small○Trivial○ Varies ○ Don't know | A false positive result of EEG may suggest that poor neurological outcome is likely in patients with an eventually good neurological recovery. The false positive rate of status epilepticus on EEG was 0% in half of the studies included in our review, while in one of the remaining studies it reached 17.4%.  |  |
| Certainty of evidenceWhat is the overall certainty of the evidence of effects? |
| Judgement | Research evidence | Additional considerations |
| ● Very low○ Low○ Moderate○ High○ No included studies | The certainty of evidence about status epilepticus was low or very low in most studies, because of the risk of self-fulfilling prophecy, and low precision.In addition, the lack of a consistent definition is a major issue for status epilepticus. In all studies we included the treating team was aware of the presence of status epilepticus. In most of these studies, status epilepticus was part of a multimodal set of criteria for deciding on treatment limitations. | Like other EEG-based predictors, epileptiform activity may be MODIFIED BY sedative agents. .LINK TO COSTR ON SEIZURE TREATMENTThe interpretation of EEG-based predictors is prone to interrater variability. |
| ValuesIs there important uncertainty about or variability in how much people value the main outcomes? |
| Judgement | Research evidence | Additional considerations |
| ○ Important uncertainty or variability● Possibly important uncertainty or variability○ Probably no important uncertainty or variability○ No important uncertainty or variability | Neurological outcome is generally accepted as a critical outcome after cardiac arrest. However, CPC from 3 to 5 (severe neurological disability, persistent vegetative state, or death) as a threshold for defining poor neurological outcome is not universally accepted. In a minority of prognostication studies in literature, a threshold of CPC 4-5 is used instead. We defined prediction as imprecise when the upper limit of 95% confidence intervals (CIs) for false positive rate (FPR) was above 5%. However, there is no universal consensus on what the acceptable limits for imprecision should be. A recent survey (Steinberg 2019 190) among 640 medical providers showed that 56% felt an acceptable FPR for withdrawal of life sustaining treatment from patients who might otherwise have recovered was ≤0.1%. In addition, 59% of respondents felt that an acceptable FPRs threshold for continuing life sustaining treatment in patients with unrecognized unrecoverable injury was ≤1%. |  |
| Balance of effectsDoes the balance between desirable and undesirable effects favor the intervention or the comparison? |
| Judgement | Research evidence | Additional considerations |
| ○ Favors the comparison○ Probably favors the comparison● Does not favor either the intervention or the comparison○ Probably favors the intervention○ Favors the intervention○ Varies○ Don't know | The presence of status epilepticus on EEG predicted poor outcome with 100% specificity in most studies.  |  |
| Resources requiredHow large are the resource requirements (costs)? |
| Judgement | Research evidence | Additional considerations |
| ○ Large costs○ Moderate costs○ Negligible costs and savings○ Moderate savings○ Large savings○ Varies ●  Don't know | We did not include any specific studies about costs of assessing Status Epilepticus on EEG. However, specific equipment and skills are required for assessing it.  |  |
| Certainty of evidence of required resourcesWhat is the certainty of the evidence of resource requirements (costs)? |
| Judgement | Research evidence | Additional considerations |
| ○ Very low○ Low○ Moderate○ High● No included studies | We did not identify any studies specifically assessing costs of Status Epilepticus on EEG.  |  |
| Cost effectivenessDoes the cost-effectiveness of the intervention favor the intervention or the comparison? |
| Judgement | Research evidence | Additional considerations |
| ○ Favors the comparison○ Probably favors the comparison○ Does not favor either the intervention or the comparison○ Probably favors the intervention○ Favors the intervention○ Varies● No included studies | We did not identify any studies addressing cost-effectiveness of Status Epilepticus on EEG.  |  |
| EquityWhat would be the impact on health equity? |
| Judgement | Research evidence | Additional considerations |
| ○ Reduced● Probably reduced○ Probably no impact○ Probably increased○ Increased○ Varies○ Don't know | According to a review published in 2015 (Friberg et al, Resuscitation 2015; 90:158-62) , EEG was the most commonly used tool for prognostication after cardiac arrest. However, the specific equipment and skills needed to assess EEG may not be available everywhere anytime. This can create a problem in terms of equity.  |  |
| AcceptabilityIs the intervention acceptable to key stakeholders? |
| Judgement | Research evidence | Additional considerations |
| ○ No○ Probably no● Probably yes○ Yes○ Varies○ Don't know | We have not identified any research that assessed acceptability of EEG. However, acceptability is likely. |  |
| FeasibilityIs the intervention feasible to implement? |
| Judgement | Research evidence | Additional considerations |
| ○ No○ Probably no● Probably yes○ Yes○ Varies○ Don't know | Feasibility was not specifically addressed in any of the studies included in this review. Evaluating Status Epilepticus on EEG for prognostication purposes requires a specific equipment for recording EEG and the ability to interpret the tracing. |  |

# Summary of judgements

|  | **Judgement** |
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| **Problem** | No | Probably no | Probably yes | **Yes** |  | Varies | Don't know |
| **Desirable Effects** | **Trivial** | **Small** | Moderate | Large |  | Varies | **Don't know** |
| **Undesirable Effects** | Large | **Moderate** | **Small** | **Trivial** |  | Varies | **Don't know** |
| **Certainty of evidence** | **Very low** | **Low** | Moderate | High |  |  | No included studies |
| **Values** | Important uncertainty or variability | **Possibly important uncertainty or variability** | **Probably no important uncertainty or variability** | No important uncertainty or variability |  |  |  |
| **Balance of effects** | Favors the comparison | Probably favors the comparison | **Does not favor either the intervention or the comparison** | Probably favors the intervention | Favors the intervention | **Varies** | Don't know |
| **Resources required** | Large costs | Moderate costs | Negligible costs and savings | Moderate savings | Large savings | Varies | **Don't know** |
| **Certainty of evidence of required resources** | Very low | Low | Moderate | High |  |  | **No included studies** |
| **Cost effectiveness** | Favors the comparison | Probably favors the comparison | Does not favor either the intervention or the comparison | Probably favors the intervention | Favors the intervention | Varies | **No included studies** |
| **Equity** | Reduced | **Probably reduced** | **Probably no impact** | Probably increased | Increased | Varies | **Don't know** |
| **Acceptability** | No | Probably no | **Probably yes** | Yes |  | Varies | Don't know |
| **Feasibility** | No | Probably no | **Probably yes** | Yes |  | Varies | Don't know |

# Type of recommendation

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| Strong recommendation against the intervention | Conditional recommendation against the intervention | Conditional recommendation for either the intervention or the comparison | Conditional recommendation for the intervention | Strong recommendation for the intervention |
| ○  | ● | ○ | **○**  | ○  |

# Conclusions

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| Recommendations |
| **We suggest against using Status Epilepticus to predict poor outcome in adult patients who are comatose after cardiac arrest (weak recommendation, very low-certainty evidence).**  |
| Justification |
| Specificity of Status Epilepticusfor predicting poor outcome was 100% in only half of the studies we included. In none of these studies status epilepticus was evaluated blindly, and in most of them it was included among the criteria for WLST. Although this is common for other predictors based on electrophysiology, an additional issue for status epilepticus was its largely inconsistent definition.  |
| Subgroup considerations |
| **None** |
| Implementation considerations |

Use of EEG-based predictors requires the availability of equipment, personnel, and skills. Use of consistent terminology and definitions is important for implementation of these predictors, in order to provide an objective evaluation, and limit interrater variability in EEG readings.

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| Monitoring and evaluation |
| None  |
| Research priorities |
| A standard definition of Status Epilepticus is urgently needed.  |