

MANAGEMENT OF ABSENCE EPILEPSY: PRE-CONCEPTION TO POST-PARTUM: A CLINICAL CASE REPORT

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Patient Presentation & History:

A 28-year-old female with a long-standing history of **Childhood Absence Epilepsy (CAE)** presented for obstetric consultation. While many cases of CAE resolve in adolescence, her condition persisted into adulthood, characterized by brief (5–10 second) episodes of impaired consciousness and staring spells.

Pre-Pregnancy Counselling:

Strategic planning was initiated six months prior to intended conception to optimize maternal seizure control and minimize fetal risk.

Pharmacological Transition: The patient was successfully transitioned from Valproate to **Ethosuximide**. This transition was managed over a 16-week period with serial EEG monitoring to ensure no breakthrough seizures occurred.

Folic Acid Supplementation: In accordance with high-risk epilepsy guidelines, the patient commenced **5 mg of Folic Acid daily** to mitigate the risk of major congenital malformations.

Lifestyle Optimization: Counseling focused on the “Seizure Threshold” emphasizing regular sleep cycles and the avoidance of known triggers like hyperventilation.

Antenatal Management:

Trimester	Clinical Focus	Interventions & Outcomes
First	Organogenesis	Early morphology scans confirmed absence of neural tube defects. No increase in absence seizure frequency was reported.
Second	Dose Titration	Due to increased volume of distribution and renal clearance, serum Ethosuximide levels were monitored monthly. Dosage was increased by 15% to maintain therapeutic levels.
Third	Birth Preparedness	Serial growth scans showed fetal parameters at the 50th percentile. Anesthesia consultation was completed to discuss pain management.

Intrapartum Period (Labor & Delivery):

The primary goal during labor was to minimize physiological stress that might lower the seizure threshold.

Postpartum Care & Safety:

The immediate post-partum period (0-72 hours) involved rapid physiological shifts requiring close vigilance.

Dose Adjustment: The medication dose was reduced to pre-pregnancy levels within 48 hours to prevent maternal toxicity as plasma volume contracted.

Infant Safety Protocol: Diaper changes and dressing performed on floor-level mats. Supervised bathing of the infant to prevent accidents during potential “blank stare” episodes. Promotion of side-lying breastfeeding to reduce fall risks.

Key Management Strategies:

Continuous Analgesia: Early epidural placement was utilized to minimize hyperventilation, associated with severe pain.

Medication Adherence: The patient’s regular morning dose of Ethosuximide was administered at the start of induction.

Outcome: Successful spontaneous vaginal delivery of a healthy neonate. APGAR scores were 8 and 9 at 1 and 5 minutes, respectively.

Clinical Summary: This case highlights that with proactive medication management and strict safety protocols, patients with absence epilepsy can achieve excellent maternal and neonatal outcomes. The focus remains avoiding Valproate during the first trimester and managing the physiological triggers of labor.

