Should we give a diagnosis of epilepsy to someone who has had only one seizure (as recommended by the ILAE)?

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NO In 2014, ILAE published a position paper recommending a change in the "practical clinical definition of epilepsy adding an additional criteria: "one unprovoked (or reflex) seizure and a probability of further seizures similar to the general recurrence risk (at least 60%)." Several studies have shown that even a lesion like mesial temporal sclerosis, often thought a harbinger of seizure recurrence, may be unreliable. Two randomized studies found differing effects of EEG and other variables on recurrence. A study of 798 patients found 59% overall recurrence risk over 10 years. remote symptomatic etiology, simple partial seizures, Epileptiform EEG abnormality, and first seizure from sleep were independent predictors. Imaging lesions were correlated with remote symptomatic etiology, and only predictive of recurrence with etiology removed from analysis. Ten year recurrence risk fell below 60% after 6-12 months of seizure freedom. No patient group had 60% or greater four-year recurrence risk. Adverse consequences of epilepsy diagnosis include cost and potential side effects of AEDs. Children may experience adverse AED cognitive consequences; the elderly are more likely to experience AED toxicity, drug interactions; women the risk of teratogenicity. Even if treatment is withheld after a single seizure, driving restrictions, serious adverse emotional, health insurance, employment, social consequences and stigma may occur.Given the difficulty of predicting seizure recurrence, suggesting that even if one of the predictive factors is present, a diagnosis of epilepsy should not be made immediately after a first seizure.