

AMERICAN SEEG CONSORTIUM (ASC)
MINUTES OF CONFERENCE CALL
WED APR 14 & FRI APR 16, 2021

Introduction

Dr Kalamangalam (UF) introduced the idea of ASC arising from informal discussions amongst a few ACNS members and a formal proposal to set up an ACNS-supported 'Consortium' – modelled along the lines of other such consortia such as the CCEMRC – that was subsequently approved by the ACNS Council. The first meeting of the ASC was a small in-person meeting at the annual ACNS meeting in Las Vegas (Feb 2019). It was decided that the ASC would be coordinated initially from the University of Florida with an email ID, an office and some administrative assistance. Though the ASC is not part of the ACNS, it is supported by it. The ACNS website has links to the ASC website, and meeting time and space as needed will be provided for in-person meetings at ACNS conferences. As quoted before, the idea behind the ASC is: *The technique of SEEG is largely supplanting the subdural grid approach in the invasive evaluation of epilepsy surgical candidates in American centers. As experience of SEEG builds, so do unresolved questions regarding its technical, clinical and scientific aspects. The SEEG Consortium of the ACNS will address several priority items and attempt to create new clinical and scientific knowledge and practical consensus regarding SEEG utilization in epilepsy.* It was emphasized that the initial goals of the ASC would be to evaluate evidence and practice protocols across US centers experience and integrate those into ACNS-endorsed position statements and guidelines that would be submitted for publication in the Journal of Clinical Neurophysiology (JCNP). The first such publication by Gavvala and co-authors appeared in JCNP in 2020.

Following this introduction, ASC members on the call briefly introduced themselves.

Initial commentary

Dr Pederson (Emory): The practice of SEEG is clearly complicated and variable from patient to patient, and amongst centers. It is not clear that a Consortium along the lines of CCEMRC is appropriate.

Dr Sheth (Baylor): Agreed, but diversity could be a strength. The differences of practice could be put together to create a synthesis that represents the best of among the participating centers.

Dr Curry (Baylor): Centers differ in their access to technology and also with respect to techniques used.

Dr Tandon (UT-Houston): Agree with all above, but certain practices can be systematized by introducing methods that we can all agree on. For instance, we have developed an electrode visualization and signal analysis software that we would be happy to share and have other centers use and provide feedback. On the other hand, consensus in certain domains may be difficult or impossible: e.g. surgical strategy.

Dr Thompson (UT-Houston): Guidelines have been drawn up in Europe (the French guidelines).

Dr Alwaki (Emory): A further issue is regulation of practice. How can standards even if they are developed be implemented?

Dr Alick-Lindstrom (UT-SW): Agree there is a lot of diversity of practice. But there are also places of convergence.

Dr Kalamangalam (UF): The disease process we deal with is the same, regardless of where we practice, and the end-goals of SEEG are the same everywhere. The uniformity and convergence in practice would appear to be larger than the places of divergence. And the objectives of the ASC are precisely to delineate these, and create areas of agreement, while leaving out also areas where consensus is more difficult. To identify commonalities and differences would be part of the mission of the ASC.

Dr Jayakar (Miami): Developing guidelines is a good idea. Where would these be published?

Dr Kalamangalam (UF): JCNP is the natural choice. The JCNP publishes all the other guidelines for clinical neurophysiology.

Run-down of focus areas and leads

- Current practice survey (Gavvala: completed and published)
- History and cultural shift to SEEG (Willie)
- Technical standards (Schuele: Invasive EEG guidelines are already being developed through another effort by ACNS members. Will have to see how to relate that effort to an ASC initiative)
- Syndromes and canonical placements (Kalamangalam)
- SEEG nomenclature (Stone)
- Electrode placement and visualization (Tandon). Dr Novotny (UW): we have developed a freeware pipeline for SEEG electrode visualization and would be happy to take that further on behalf of ASC.
- Electrical stimulation (Sinha: The literature is variable on this topic. Guidelines based on the summary of existing practice are likely to be descriptive, and not prescriptive)
- Data interpretation (Park)
- Surgery (Gonzalez-Martinez)
- Pediatric SEEG (Kheder)
- Case-based tutorials (Raghupathi). Dr Wabulya (UNC): These would be illustrations. It is difficult for case-based tutorials to serve as a comprehensive teaching source.
- Patient care and protocols (Alick-Lindstrom)

General discussion

Dr Raghavan (MCW): Important to set timescales for progress. And though recommendations and literature may continue to evolve, suggest bringing out a set of preliminary guidelines, and addending those in subsequent years as necessary.

Dr Kalamangalam/Schuele/Kheder/Novotny: Would target a special issue of JCNP for the publication of guidelines. They may not constitute official 'guidelines' in a formal sense, but could be 'recommendations' instead. Pediatric SEEG could be included as an addendum or perhaps have its own issue of JCNP.

Dr Gotman (MNI): I would advise care and caution in designing guidelines. Expert opinion should be sought whenever possible. The IFCN and ILAE collaboration for clinical neurophysiology procedures is an example, but neither of these is likely they have any resources for SEEG.

Dr Schuele (Northwestern): The ASC could evolve to include research collaborations, just like CCEMRC.

Dr Kalamangalam (UF): Thank you all.

Next conference call

TBA
