Despite the availability of more than 20 different antiseizure drugs and the provision of appropriate medical therapy, 30% of people with epilepsy continue to have seizures.1,2 The approval of many new antiseizure drugs during the past two decades, including several with novel mechanisms of action, has not substantially reduced the proportion of patients with medically refractory disease.1 The safety and side-effect profile of antiseizure drugs has improved, but side effects related to the central nervous system are common and affect quality of life.3 Patients need new treatments that control seizures and have fewer side effects. This treatment gap has led patients and families to seek alternative treatments. Cannabis-based treatment for epilepsy has recently received prominent attention in the lay press4 and in social media, with reports of dramatic improvements in seizure control in children with severe epilepsy. In response, many states have legalized cannabis for the treatment of epilepsy (and other medical conditions) in children and adults (for a list of medical marijuana laws according to state, see www.ncsl.org/research/health/state-medical-marijuana-laws.aspx).

Cannabis has been used medicinally for millennia and was used in the treatment of epilepsy as early as 1800 B.C.E. in Sumeria.5 Victorian-era neurologists used Indian hemp to treat epilepsy and reported dramatic success.5,6 The use of cannabis therapy for the treatment of epilepsy diminished with the introduction of phenobarbital (1912) and phenytoin (1937) and the passage of the Marijuana Tax Act (1937). The discovery of an endogenous cannabinoid-signaling system in the 1990s7 rekindled interest in therapies derived from constituents of cannabis for nervous system disorders such as epilepsy (see ClinicalTrials.gov numbers, NCT02091375, NCT02224690, NCT02324673, NCT02318537, and NCT02318563). This review addresses the current preclinical and clinical data that suggest that compounds found in cannabis have efficacy against seizures. The pharmacokinetic properties of cannabinoids and related safety and regulatory issues that may affect clinical use are also discussed, as are the distinct challenges of conducting rigorous clinical trials of these compounds.

More than 545 distinct compounds have been isolated from cannabis species; the most abundant are the cannabinoids, a family of molecules that have a 21-carbon terpenophenolic skeleton and includes numerous metabolites.8 The best studied of these cannabinoids (termed “phytocannabinoids” if derived from the plant) are Δ9-tetrahydrocannabinol (Δ9-THC) and cannabidiol and their metabolites. (See Fig. 1 for the structure of Δ9-THC, cannabidiol, and one other cannabinoid, cannabidi-varin, as well as their targets in the central nervous system, and their actions.) Most of the psychoactive effects of cannabis are mediated by Δ9-THC. Many of the noncannabinoid molecules in cannabis plants may have biologic activity. This review focuses on cannabinoids, since other cannabis-derived compounds have been less well studied.

Dan L. Longo, M.D., Editor

Cannabinoids in the Treatment of Epilepsy

Daniel Friedman, M.D., and Orrin Devinsky, M.D.
CONTROL OF NEURONAL EXCITABILITY

The major cannabinoid receptor in the central nervous system is cannabinoid receptor 1 (CB₁R), a presynaptic, G-protein–coupled receptor that activates voltage-gated calcium channels and enhances potassium-channel conduction in presynaptic terminals. The cloning of CB₁R, the confirmation that Δ⁹-thc binds CB₁R, and the discovery of two endogenous ligands — 2-arachidonoylglycerol (2-AG) and anandamide — that bind CB₁R has stimulated investigations intended to elucidate the role of the endocannabinoids both in normal brain function and in disease states. CB₁R is activated by the activity-dependent synthesis of 2-AG and is involved in the retrograde control of synaptic transmission. Anandamide can also affect excitability in neuronal networks by activating the transient receptor potential cation channel, subfamily V, member 1. As modulators of neuronal excitability, endogenous cannabinoids are well poised to affect the initiation, propagation, and spread of seizures.

Preliminary studies have identified defects in...
The endocannabinoid system is strongly activated by seizures, and the upregulation of CB1R activity has antiseizure effects. In mice, hippocampal anandamide levels rise after seizures induced by the intraperitoneal injection of kainic acid. In cultures of neurons from the hippocampus, CB1R antagonists induce prolonged, seizure-like discharges, whereas CB1R agonists eliminate these discharges. These studies support the suggestion that the endocannabinoid system plays a role in the inhibition of seizures in humans with epilepsy.

The endocannabinoid system is strongly activated by seizures, and the upregulation of CB1R activity has antiseizure effects. In mice, hippocampal anandamide levels rise after seizures induced by the intraperitoneal injection of kainic acid. In cultures of neurons from the hippocampus, CB1R antagonists induce prolonged, seizure-like discharges, whereas CB1R agonists eliminate these discharges. Conditional knockout mice that lack pyramidal-cell CB1R in their forebrain have more severe and prolonged seizures than wild-type mice in response to kainic acid; in contrast, viral-vector–mediated overexpression of CB1R in hippocampal pyramidal cells is protective. Reducing the metabolic degradation of endocannabinoids ameliorates experimentally induced seizures.

**EVIDENCE OF ANTISEIZURE EFFECTS IN HUMANS**

Despite the preclinical data and anecdotal reports on the efficacy of cannabis in the treatment of epilepsy that include reports from epileptologists, a recent Cochrane review concluded that “no reliable conclusions can be drawn at present regarding the efficacy of cannabinoids as a treatment for epilepsy” owing to the lack of adequate data from randomized, controlled trials of Δ9-THC, cannabidiol, or any other cannabinoid (Table 1). This assessment was confirmed in a recent systematic review by the American Academy of Neurology.

Limited epidemiologic evidence supports the view that cannabinoids have antiseizure properties in humans. In a case–control study of illicit drug use and new-onset seizures in Harlem,
New York, men who used cannabis within 90 days before hospital admission were at a significantly lower risk for presenting with new-onset seizures than men who did not use cannabis (odds ratio, 0.36; 95% confidence interval, 0.18 to 0.74).48

Several patient and caregiver surveys have examined the effects of cannabis in epilepsy. In one survey, 28 of 136 patients in an epilepsy center that provided tertiary care reported cannabis use. Most of these patients associated use with a reduction in seizure frequency and severity.45 A 2013 survey of caregivers of 19 children with severe epilepsy who were receiving cannabidiol-enriched cannabis extracts indicated that 2 of the children had become seizure-free and 8 others had a reduction in the frequency of seizures of 80% after taking the extract.42 In a 2015 survey of 75 parents whose children were treated with oral cannabis extracts in Colorado, the parents reported that one third of the children had a reduction in seizures of more than 50%.34 However, electroencephalograms were obtained for 8 of these children before and after the administration of cannabis, and none showed improvement in background activity.

Case reports support the antiseizure effects of cannabis in patients with epilepsy6,32-34,49 and show exacerbation of seizures after abrupt discontinuation.50 However, in a survey conducted in Germany among adults with epilepsy who used cannabis, the substance had no apparent effect on seizure control,46 and some case reports have shown an exacerbation of seizures among patients who used cannabis41,51 or a synthetic cannabimimetic.52

Few prospective therapeutic trials have been performed that involve the isolated use of cannabinoids to treat epilepsy. A study conducted in 1949 indicated that two of five institutionalized children with refractory epilepsy achieved seizure control after receiving treatment with a Δ9-THC analogue.56 To our knowledge, only four placebo-controlled studies of the use of cannabinoids for the treatment of epilepsy have been performed (reviewed in Gloss and Vickrey59). All the studies were considerably underpowered and had methodologic problems, including the lack of blinding. Two studies showed a reduction in the number of seizures in patients treated with cannabidiol, whereas the other two studies showed no effect.

Since 2013, a consortium of 10 epilepsy centers has been collecting prospective data on children and young adults with severe epilepsy who are receiving Epidiolex, a purified cannabis extract containing 99% cannabidiol and less than 0.10% Δ9-THC (GW Pharmaceuticals), through an expanded-access program authorized by the Food and Drug Administration (FDA). A preliminary report from this open-label study, initiated by investigators to assess the safety and dosing of cannabidiol, noted that among 137 patients who had received at least 12 weeks of treatment, the median reduction in the number of seizures was 54%.40 Randomized clinical trials of Epidiolex are now being conducted for the treatment of two forms of severe, childhood-onset epilepsy: Dravet’s syndrome (a severe myoclonic epilepsy of infancy) (NCT02091375) and the Lennox–Gastaut syndrome (a childhood-onset, treatment-resistant epilepsy characterized by multiple types of seizures and developmental delay) (NCT02224690). Although some of the anecdotal evidence described above suggests that cannabidiol-rich treatments may ameliorate seizures in patients with these disorders, no evidence suggests that the antiseizure effects of cannabidiol are limited to the treatment of these conditions. The clinical development of synthetic forms of cannabidiol is also in progress (NCT02318563). Table 1 summarizes the current clinical evidence for the use of cannabinoid-containing compounds in the treatment of epilepsy.

### Safety in Humans

Much of the available data regarding the safety and side-effect profile of cannabinoids, especially with long-term use, come from studies examining the effects of recreational use.53,54 The short-term side effects of cannabis use may include impairment of memory, judgment, and motor performance. High levels of Δ9-THC are associated with psychosis and an increased risk of motor-vehicle accidents. With long-term use there is a risk of addiction, which occurs in approximately 9% of long-term users. Other effects of long-term use include cognitive impairment, decreased motivation, and an increased risk of psychotic disorders.

Cannabis-based treatment with Δ9-THC may have irreversible effects on brain development.
Table 1. Clinical Trials, Case Series, and Case Reports on Cannabinoids in the Treatment of Epilepsy.

<table>
<thead>
<tr>
<th>Compound and Study Type</th>
<th>Dose*</th>
<th>No. of Participants</th>
<th>Results</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Isolated oral cannabinoids</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>THC isomers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case series of institutionalized children with intellectual disability and epilepsy treated for 3–7 wk</td>
<td>5</td>
<td>One patient was seizure-free and one patient nearly seizure-free</td>
<td>Davis and Ramsey36</td>
<td></td>
</tr>
<tr>
<td><strong>Cannabidiol</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective, placebo-controlled, 3-mo trial involving adults with treatment-resistant epilepsy</td>
<td>200 mg/day</td>
<td>Treatment: 4 Placebo: 5</td>
<td>Two patients in the cannabidiol group were seizure-free and one showed partial improvement</td>
<td>Mechoulam and Carlini37</td>
</tr>
<tr>
<td>Prospective, placebo-controlled trial involving teenagers and adults with treatment-resistant convulsive seizures (at least 1 per wk) in which participants had 8–18 wk of exposure</td>
<td>200–300 mg/day</td>
<td>Treatment: 8 Placebo: 7</td>
<td>Four patients in cannabidiol group and 1 in placebo group were seizure-free; somnolence was a reported side effect</td>
<td>Cunha et al.38</td>
</tr>
<tr>
<td>Prospective, placebo-controlled, 3-wk trial involving institutionalized adults with intellectual disability and epilepsy</td>
<td>200–300 mg/day</td>
<td>Treatment: 6 Placebo: 6</td>
<td>No significant difference between groups Somnolence was a reported side effect</td>
<td>Ames and Cridland39</td>
</tr>
<tr>
<td>Prospective randomized, double-blind placebo-controlled, 6-mo crossover study involving adults with treatment-resistant epilepsy</td>
<td>300 mg/day</td>
<td>12</td>
<td>No significant difference between cannabidiol and placebo Somnolence was a reported side effect</td>
<td>Trembly and Sherman40</td>
</tr>
<tr>
<td><strong>Purified oral cannabidiol extract</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective, open-label, 12-wk trial involving children and young adults with severe, childhood-onset epilepsy</td>
<td></td>
<td>137</td>
<td>Median reduction in weekly rate of convulsive seizures of 54% Somnolence and diarrhea were the most common side effects</td>
<td>Devinsky et al.41</td>
</tr>
<tr>
<td><strong>Oral cannabis extracts</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cannabis indica extract</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case report of a 40-yr-old man with focal epilepsy who was resistant to bromides</td>
<td>32 mg/day</td>
<td>1</td>
<td>Seizure-free for 6 mo followed by recurrence; when cannabis extract was discontinued; seizure control resumed with resumption of cannabis several months later</td>
<td>Gowers6</td>
</tr>
<tr>
<td><strong>Cannabidiol–Δ9-THC-containing extracts of varying composition</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Survey among participants in a Facebook group for parents of children with severe epilepsies</td>
<td>Cannabidiol: Up to 28 mg/kg body weight/day Δ9-THC: Up to 0.8 mg/kg body weight/day</td>
<td>19</td>
<td>Improvement with cannabidiol–Δ9-THC reported by 16 patients (84%); 2 patients (11%) became seizure-free</td>
<td>Porter and Jacobson42</td>
</tr>
<tr>
<td>Compound and Study Type</td>
<td>Dose*</td>
<td>No. of Participants</td>
<td>Results</td>
<td>Reference</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------</td>
<td>---------------------</td>
<td>---------</td>
<td>-----------</td>
</tr>
<tr>
<td>Oral cannabis extract, with high ratio of cannabidiol to Δ9-THC</td>
<td>Reduction of &gt;90% in frequency of generalized tonic–clonic seizures, which allowed for reduction of other drugs taken for epilepsy</td>
<td>75</td>
<td>Seizures were exacerbated after smoking marijuana</td>
<td>Keeler and Reifler</td>
</tr>
<tr>
<td>Oral cannabis extract</td>
<td>Reduction of &gt;50% in frequency of seizures in 25 patients (33%)</td>
<td>1</td>
<td>Seizures were exacerbated after daily cannabis use</td>
<td>Consroe et al.</td>
</tr>
<tr>
<td>Cannabis</td>
<td>Nearly seizure-free after daily cannabis use with suppression of complex partial seizures with cannabis use and exacerbation of seizures on withdrawal</td>
<td>1</td>
<td>Nearly seizure-free after daily cannabis use</td>
<td>Consroe et al.</td>
</tr>
<tr>
<td>Cannabis</td>
<td>Reduction of &gt;90% in nocturnal seizures and tonic–clonic seizures</td>
<td>1</td>
<td>Reduction of &gt;90% in nocturnal seizures and tonic–clonic seizures</td>
<td>Gross et al.</td>
</tr>
<tr>
<td>Cannabis</td>
<td>Reduction in frequency of seizures reported by 19 patients (68%); 15 patients (54%) reported reduction in frequency of seizures</td>
<td>28</td>
<td>Reduction in severity of seizures reported by 2 active users (15%); increase in frequency and severity of seizures reported by 7 former users (0.2%)</td>
<td>Hamerle et al.</td>
</tr>
</tbody>
</table>

* Data on dosage has been provided when available.
The endocannabinoid system undergoes development in childhood and adolescence; long-term exposure to endocannabinoids, especially Δ⁹-THC, may lead to cognitive and behavioral changes. Imaging studies of the brain reveal altered structure and function in long-term adult users, including impaired connectivity of the prefrontal cortices and precuneus and decreased volume in the hippocampi and amygdalae. Long-term use of cannabis in childhood may be associated with lower-than-expected IQ scores (although socioeconomic status may be a confounding factor; see Rogeberg). It is unknown whether adverse effects on the brain are mediated solely by psychoactive cannabinoids, such as Δ⁹-THC, or whether long-term exposure to cannabidiol and cannabidivarin also have deleterious effects. Until more data become available, the neurodevelopmental risks of cannabinoid-based therapies should be weighed against the potential benefits for seizure control, since seizures also affect brain development. Notably, scientific data on the potential long-term developmental effects of FDA-approved antiseizure drugs are also limited.

Many antiseizure drugs are associated with teratogenicity and neurodevelopmental impairments in children who are exposed in utero. Little is known about the effects of fetal exposure to cannabinoids. Studies of children born to parents who are recreational cannabis users have not shown an increased risk of congenital abnormalities, but difficulties with attention, impulse control, and executive function have been reported. However, potential confounding factors, such as socioeconomic status and coexisting maternal psychiatric illness, limit the extent to which these findings can be interpreted.

Data regarding the outcomes of short-term and long-term exposure to cannabinoids in recreational users are often confounded by the factors that drive a person to use cannabis. More valid data regarding the safety of short-term use comes from randomized clinical trials of cannabinoid-containing medications, including purified cannabis extracts (Cannador, Society for Clinical Research, Germany; 2:1 ratio of Δ⁹-THC and cannabidiol), nabiximol (Sativex, GW Pharmaceuticals; 1:1 ratio of Δ⁹-THC and cannabidiol), and the synthetic Δ⁹-THC analogues dronabinol (Marinol, Unimed Pharmaceuticals), and nabilone (Cesamet, Valeant Pharmaceuticals). These trials involved the systematic collection of data on safety. In a pooled analysis that included 1619 patients in short-term placebo-controlled studies who received cannabinoids for the treatment of pain and tremor and for spasticity related to multiple sclerosis, 6.9% withdrew because of adverse effects, as compared with 2.2% who withdrew in the placebo groups. Adverse effects that occurred in more than one study included nausea, weakness, mood changes, psychosis, hallucinations, suicidal ideation, dizziness or light-headedness, fatigue, and feeling of intoxication. No deaths from overdose were reported in association with cannabinoid-containing medications. In small studies of cannabidiol use in healthy volunteers and in patients with multiple disease conditions, serious side effects have been associated with either long-term or short-term administration of doses of up to 1500 mg daily. In the preliminary results of an open-label study of the use of cannabidiol oral solution for severe, refractory, childhood-onset epilepsy, the most common side effects were somnolence (occurring in 21% of the participants), diarrhea (17%), fatigue (17%), and decreased appetite (16%). Increased frequency or severity of seizures, weight loss, diarrhea, pneumonia, and abnormal results on tests of liver function were less common, occurring in 1 to 7% of patients.

Long-term recreational use of cannabis is associated with a risk of dependence. Little is known regarding the potential for the abuse of cannabinoid-based treatments when they are administered in a clinical setting. A single-dose, double-blind, crossover study involving 23 recreational cannabis users showed higher scores on scales of drug preference for dronabinol and high-dose nabiximols but not for low-dose nabiximols, which suggests that there may be a potential for abuse associated with cannabinoid-based therapies, at least when the compounds used contain Δ⁹-THC or its analogues. Few data are available on the effects of other cannabinoids, although the relative absence of psychoactive effects reported for cannabidiol and cannabidivarin suggests that the potential for abuse of these compounds is low.

Some safety concerns have been raised with regard to the pharmacokinetic interactions of cannabinoids in patients with epilepsy who are long-term users. Cannabinoids can inhibit cytochrome P-450 (CYP) enzymes. Both Δ⁹-THC and cannabidiol inhibit the CYP2C family of isozymes.
ISSUES RELEVANT TO USE IN EPILEPSY TREATMENT

The delay between initial reports of the antiseizure efficacy of cannabinoids in preclinical models in the 1970s and the recent start of clinical studies reflects, in part, the classification of cannabis and any product derived from it as a Schedule I drug by the Drug Enforcement Agency. Schedule I drugs are defined as having a high potential for abuse. Synthetic cannabinoids, since they are not derived from the cannabis plant, are sometimes subject to less restrictive scheduling if clinical evidence supports medical usefulness. For instance, the synthetic Δ9-THC isomer dronabinol is a Schedule III medication and is often prescribed for the treatment of chronic nausea and vomiting in patients with the autoimmune deficiency syndrome. The rationale for the discrepancy between restrictions governing naturally occurring cannabinoids and synthesized cannabinoids is not clear. Cannabis-based drugs such as nabiximols (cannabidiol and Δ9-THC) have been approved by regulatory bodies in more than 20 countries on the basis of the results of clinical trials that have established efficacy and a favorable safety profile, including a low potential for abuse. The Schedule I category limits the availability of pure cannabidiol, Δ9-THC, and other cannabinoids derived from cannabis while placing a high regulatory burden on investigators who want to study these agents in cell cultures, animal models, or patients. This burden includes the need to purchase and find space for expensive and heavy safes, add locks and security systems to the laboratory or clinic, and complete a long and complex process to apply for and then pass multiple inspections in order to possess these compounds. Paradoxically, as more state legislatures give the lay community access to diverse strains and preparations of cannabis and federal policy continues to limit the access of scientific and clinical investigators to compounds such as cannabidiol, a dissociation is created between an exponential rise in use and a slow rise in scientific knowledge.

PERCEIVED THERAPEUTIC BENEFIT

Another obstacle to scientific inquiry into cannabinoids for the treatment of epilepsy is the perception among many patients and caregivers that sufficient evidence of their safety and efficacy already exists. The gap between patient beliefs and available scientific evidence highlights a set of factors that confound cannabinoid research and therapy, including the naturalistic fallacy (the belief that nature’s products are safe), the conversion of anecdotes and strong beliefs into facts, failure to appreciate the difference between research and therapy, and a desire to control one’s care, including access to therapies of perceived benefit. In one study of children with epilepsy in Colorado, the rate of response to therapy reported by parents who had moved their family to the state to receive cannabinoid therapy was more than twice as high as that reported by parents who were already residing in the state (47% vs. 22%). This finding...
suggests that the stronger the belief that the drug will be beneficial and the greater the sacrifice involved to obtain the drug, the greater the reported response. In the future, randomized, controlled studies of cannabinoids will have to contend with large placebo effects that may actually prevent researchers from demonstrating the efficacy of cannabinoids over placebo.

The currently planned randomized clinical trials of cannabidiol will target primarily children with severe epilepsy. Placebo response rates are high among children and adolescents with a wide variety of conditions, including pain-related disorders (e.g., migraines and gastrointestinal disorders), medical disorders (e.g., asthma), and psychiatric disorders (e.g., anxiety, major depression, obsessive-compulsive disorder, and attention-deficit disorder). The issue of high response rates to placebos in studies of children is especially relevant to epilepsy and emphasizes the importance of placebo-controlled trials. A meta-analysis showed that among patients with treatment-resistant focal epilepsy, children had more improvement with placebo than did adults (19.9% vs. 9.9%), although there was no significant difference in the response to active treatment, which the science never caught up to the hype and was drowned out by unverified claims, sensational testimonials, and clever marketing. If randomized clinical trials show that specific cannabinoids are unsafe or ineffective, those preparations should not be available. If studies show that specific cannabinoids are safe and effective, those preparations should be approved and made readily available.

Preclinical and preliminary data from studies in humans suggest that cannabidiol and Δ9-THC may be effective in the treatment of some patients with epilepsy. However, current data from studies in humans are extremely limited, and no conclusions can be drawn. Relaxation of the regulatory status of cannabis-derived drugs, especially those containing a high proportion of nonpsychoactive cannabinoids, for which the potential for abuse is low, could help to accelerate scientific study. Despite the power of anecdote and the approval of medical cannabis by many state legislatures, only double-blind, placebo-controlled, randomized clinical trials in which consistent preparations of one or more cannabinoids are used can provide reliable information on safety and efficacy. The use of medical cannabis for the treatment of epilepsy could go the way of vitamin and nutritional supplements, for which the science never caught up to the hype and was drowned out by unverified claims, sensational testimonials, and clever marketing. If randomized clinical trials show that specific cannabinoids are safe and effective, those preparations should be approved and made readily available.

Dr. Devinsky reports receiving grant support from GW Pharmaceuticals and Novartis and serving on the scientific advisory board of MiaMed; and Dr. Friedman, receiving fees for serving on an advisory board for Marinus Pharmaceuticals and consulting fees from Eisai, Marinus Pharmaceuticals, SK Biopharmaceuticals, Upsher-Smith Laboratories, and Pfizer, all of which were paid to the Epilepsy Study Consortium. No other potential conflicts of interest relevant to this article were reported.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

REFERENCES

10. Pertwee RG, Cascio MG. Known pharmacological actions of delta-9-tetrahydrocannabinol and of four other chem-
Cannabinoids in the Treatment of Epilepsy

57. Rogeberg O. Correlations between cannabis use and IQ change in the Dune cohort are consistent with confounding from socioeconomic status. Proc Natl Acad Sci U S A 2013;110:4251-4.
72. Mathern GW, Benisng L, Nehlig A. Fewer specialists support using medical marijuana and CBD in treating epilepsy patients compared with other medical professionals and patients: result of Epilepsia’s survey. Epilepsia 2015;56:1-6.

Copyright © 2015 Massachusetts Medical Society.