Determining the type of seizure that has occurred is essential for focusing the diagnostic approach on particular etiologies, selecting appropriate therapy, and providing information regarding prognosis. The International League Against Epilepsy (ILAE) Commission on Classification and Terminology updated their approach to classification of seizures in 2017 **(Table 425-1)**. This system is based on the clinical features of seizures and associated electroencephalographic findings. Other potentially distinctive features such as etiology or cellular substrate are not considered in this classification system, although this will undoubtedly change in the future as more is learned about the pathophysiologic mechanisms that underlie specific seizure types.

TABLE 425-1 Classification of Seizures[a]

1. **Focal Onset**
   (Can be further described as having intact or impaired awareness, motor or nonmotor onset, or evolve from focal to bilateral tonic clonic)
2. **Generalized Onset**
   a. Motor
      Tonic-clonic
      Other motor (e.g., atonic, myoclonic)
   b. Nonmotor (absence)
3. **Unknown Onset**
   a. Motor, nonmotor, or unclassified

[a]Based on the 2017 International League Against Epilepsy classification of seizure types (Data from RS Fisher et al: Operational classification of seizure types by the International League Against Epilepsy: Position Paper of the ILAE Commission for Classification and Terminology. Epilepsia 58:522, 2017.)

A fundamental principle is that seizures may be either focal or generalized. *Focal seizures* originate within networks limited to one brain region (note that the term *partial seizures* is no longer used). *Generalized seizures* arise within and rapidly engage networks distributed across both cerebral hemispheres. Focal seizures are often associated with structural abnormalities of the brain. In contrast, generalized seizures may result from cellular, biochemical,