Clinical Suspicion for IS in outpatient clinic

- Routine EEG (Within 48 hrs)

Hypsarrhythmia/Spasms captured

History of known clinical cause of IS with prior MRI brain obtained?

- MRI Brain

**NO Hypsarrhythmia/Spasms captured

No further work up may be necessary

Repeat routine EEG in 1 week (may follow up via phone in 1 week)

Directed test as necessary (i.e. Serum catecholamine, TS, leukodystrophy testing, etc.)

EEG confirms IS/hypsarrhythmia or high clinical suspicion

Follow MRI brain protocol

Negative for IS/low clinical suspicion

Consider alternative diagnosis/follow development clinically if necessary

**Consider:
- Cytogenomic SNP Microarray
- Plasma Amino Acids, Serum Lactate, Pyruvate, Biotinidase, Copper, Ceruloplasmin
- Urine: Organic acids, Purine and pyrimidine panel, Sulfoctysteine
- CSF Neurotransmitter testing
- Repeat MRI brain in 6-12 months
- Whole exome sequencing

Clinical Suspicion for IS in ED

- Neurology Consult & 23 hr EEG

Clinical Suspicion for IS in ED (2019)

**If clinical suspicion remains high may consider MRI brain protocol

***If clinical suspicion is high may obtain as 1st line