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Review

Management of Febrile Seizures in Children: Current Views

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Abstract

Febrile seizures are short-lasting convulsive episodes that develop in infants and young children during a fever but are unrelated to infections or structural diseases of the central nervous system. This condition occurs in roughly 2–5% of children aged 6 months to 5 years and represents one of the most frequent causes of seizure activity in pediatric practice.

The purpose of this review is to analyze current practical recommendations intended for emergency physicians when providing care to children with febrile seizures.

Recent studies emphasize that distinguishing between simple and complex febrile seizures is critical for identifying children at higher risk of recurrence or progression to epilepsy. Early and accurate categorization also aids in counseling parents, reducing their anxiety by providing clear information about prognosis. In addition, awareness of vaccination status remains a key factor when deciding on further investigations, particularly the need for lumbar puncture. Clinical guidelines recommend that healthcare providers educate families about the generally benign nature of most febrile seizures and the importance of prompt fever management. Ongoing research continues to refine risk stratification models, helping clinicians tailor follow-up and intervention plans for each child more effectively.

Keywords: febrile seizures, children, management, frequency, risk factors.

1. Introduction

Febrile seizures represent the most frequent type of convulsive event in children under five years of age [1]. They are characterized as seizure episodes occurring in the setting of fever—defined as a body temperature of at least 38°C (100.4°F), in the absence of central nervous system infection or acute neurological disease [2]. While generally considered benign and self-limiting, these seizures often appear alarming to parents, who may perceive them as a life-threatening emergency, making them one of the leading reasons for pediatric emergency visits [3].

Epidemiological data indicate that the incidence of febrile seizures ranges between 2% and 5% among children in the United States and Western Europe [4], while several studies suggest that the prevalence may be as high as 8–10% in various Asian populations [5]. The peak frequency is observed during the second year of life, with nearly 90% of first-time febrile seizures occurring before the age of three.

Recent data emphasize that early recognition and proper counseling can significantly reduce parental anxiety and unnecessary hospital admissions. Evidence also suggests that accurate differentiation between febrile seizures and other acute neurological conditions is critical to avoid misdiagnosis and overtreatment. Public health education regarding fever management and seizure first aid can further help families respond appropriately during an episode. Moreover, continuous training of emergency staff in evidence-based protocols ensures timely intervention and minimizes the risk of complications. Finally, strengthening communication between emergency departments and primary care providers supports follow-up care and the prevention of recurrent febrile seizure episodes.

The purpose of this review is to present practical guidance for emergency care physicians who manage such patients in day-to-day clinical settings.

2. Materials and methods

For the preparation of this review, 48 recent scientific articles addressing the diagnosis, management, and prognosis of febrile seizures in children were carefully analyzed, but in our paper only 28 articles were selected, as they provided a more detailed description of febrile seizures in children. The literature search encompassed sources indexed in leading international databases—including PubMed, Scopus, Web of Science, and eLibrary—covering the years 2020 to 2025. This paper summarizes current classifications of febrile seizures and examines key challenges in their recognition, therapeutic strategies, and long-term outcomes.

3. Results

Recent evidence shows that the risk is slightly higher in boys compared with girls, although the reasons for this difference remain unclear. Geographic variability in incidence is thought to reflect a combination of genetic predisposition, differences in healthcare practices, and environmental factors such as exposure to specific viral pathogens [6]. The role of familial history is significant, with studies demonstrating that children with first-degree relatives who experienced febrile seizures have a markedly increased risk of developing the condition themselves. Seasonal patterns have also been documented, with incidence peaking during winter months when respiratory and viral infections are more prevalent. Early identification of at-risk populations may facilitate timely preventive measures and parental education, ultimately reducing both morbidity and anxiety associated with febrile seizure episodes.

Children with pre-existing neurological conditions, such as cerebral palsy or neurodevelopmental delays, show an increased likelihood of experiencing febrile seizures. [7,8]. Viral infections represent the leading cause of febrile illnesses linked to febrile seizures, being identified in up to 82% of affected children. Certain viral pathogens are particularly associated with a higher rate of febrile seizures [9]. Vaccinations can also act as a risk factor, with the period of increased susceptibility differing depending on the vaccine type [10]. Nevertheless, the risk of febrile seizures following vaccination remains lower than that associated with natural viral infections prevented by these vaccines [11]. Additionally, fevers exceeding 38°C and those of shorter duration are more likely to trigger febrile seizures [12,13].

A family history of febrile seizures or epilepsy significantly elevates the likelihood of developing febrile seizures and is reported in approximately 25–40% of affected children [14]. The familial epilepsy syndrome known as Generalised Epilepsy with Febrile Seizures Plus (GEFS+) can present with febrile seizures in some individuals, potentially explaining part of the hereditary susceptibility [15].

A summary of the major risk factors for febrile seizures is presented in Table 1.

Table 1 - Risk factors of first febrile seizure

Risk factor	Odds ratio (95% CI)
Family history of febrile seizures*	4.5 (2.09–9.83)
Family history of afebrile seizures and epilepsy	2.6 (0.5–14.3)
Developmental delay*	4.9 (1.55–15.5)

Table 1 (continued) - Risk factors of first febrile seizure

Risk factor	Odds ratio (95% CI)
Viral infection*	3.5 (2.2–5.6) for respiratory or enteric virus detection in children with febrile seizures compared to healthy controls.
High fever temperature*	1.8 (1.3–2.5) for every degree above 101°F.
Maternal smoking	3.0 (1.0–9.0) if child exposed to any perinatal smoking.
Neonatal discharge >28 days	5.6 OR (1.55–20.5)
Low serum zinc*	1.5 (1.1–2.3) (21)
Low serum iron*	1.84 (1.02–3.31) (22)

**Denotes statistically significant risk factors*

Febrile seizures tend to occur more often during the winter season, a pattern that parallels the rise in febrile illnesses during colder months. While some investigations report a slightly higher incidence in boys, other studies have not demonstrated any statistically significant differences between sexes. A strong genetic component is also recognized, with approximately one-third to one-half of affected children having a positive family history of seizures. The most frequent infectious precipitants are viral pathogens, including influenza, adenovirus, parainfluenza, and human herpesvirus type 6 (HHV-6), the latter being the causative agent of roseola in infants [16]. Among bacterial infections, acute otitis media remains the leading condition associated with the onset of febrile seizures. Febrile seizures can also occur in response to vaccination, particularly following administration of vaccines containing a measles component (such as the measles, mumps, and rubella vaccine), as well as combination vaccines for diphtheria, tetanus, and pertussis, the 13-valent pneumococcal conjugate vaccine (PCV13), and the influenza vaccine [17].

Earlier theories suggested that a rapid increase in body temperature was the key factor provoking febrile seizures. More recent evidence, however, indicates that the absolute peak of the fever plays a more decisive role. In practical terms, the higher the child's temperature, the greater the likelihood of a seizure. One study demonstrated that the risk of febrile seizures nearly doubles with each degree Fahrenheit above 101°F [18].

Clinically, febrile seizures may present with sudden loss of consciousness, irregular or labored breathing, skin pallor or cyanosis, frothing at the mouth, upward eye deviation or a fixed stare, and generalized or focal jerking of the extremities. Facial involvement is common, and episodes may also include atonic or tonic motor patterns. After the convulsive event, a postictal phase often follows, characterized by drowsiness, confusion, irritability, or temporary changes in consciousness that can last up to 30 minutes. In some children, transient postictal paralysis, known as Todd's paresis, may occur [19].

Based on duration, the presence of focal neurological features, and recurrence within the same febrile episode, febrile seizures are classified into three main categories: simple, complex, and febrile status epilepticus. Simple febrile seizures account for roughly 70% of cases, complex febrile seizures for about 25%, and febrile status epilepticus for approximately 5%. Notably, febrile status epilepticus remains the leading cause of status epilepticus in the pediatric population [20].

The assessment of a child presenting with febrile seizures should begin with a detailed medical history and a comprehensive physical examination to determine the source of the fever. History-taking should include careful documentation of the seizure characteristics—such as duration and type—as well as any recent illnesses, prior use of antibiotics, personal or family history of seizures or epilepsy, recent vaccinations, and the child's immunization status for Haemophilus influenzae type B and Streptococcus pneumoniae.

The physical examination must focus on identifying potential signs of meningitis, including altered consciousness, marked irritability, a bulging fontanelle, neck stiffness, or hypotonia. It is important to note that in very young children, clinical indicators of meningitis may be minimal or completely absent. As in any patient experiencing a seizure, serum glucose should be checked promptly to rule out hypoglycemia. For cases of simple febrile seizures, routine laboratory investigations are generally unnecessary, since significant electrolyte disturbances are exceedingly uncommon. Additional laboratory tests or imaging should be ordered selectively, guided by the child's history, clinical presentation, and any abnormal findings on examination.

The causes of fever in children who experience febrile seizures are generally the same as those seen in febrile children without seizures. Importantly, youngsters with simple febrile seizures are not at greater risk of developing serious bacterial infections—such as pneumonia, urinary tract infections, bacteremia, or bacterial meningitis—than their febrile peers [21]. According to the American Academy of Pediatrics (AAP), routine neuroimaging is not indicated in cases of simple febrile seizures. The key clinical priority in evaluating these patients is to exclude bacterial meningitis, as approximately 25% of children with meningitis may initially present with seizure activity. If any clinical signs or symptoms raise suspicion for meningitis, a lumbar puncture should be performed without delay [22].

Children experiencing febrile status epilepticus face a markedly higher risk of bacterial meningitis compared with those who have simple or complex febrile seizures, with reported meningitis rates ranging from 12% to 17% [23]. In the majority of cases, febrile seizures terminate on their own before the child reaches the emergency department. Nevertheless, if convulsive activity continues, international guidelines recommend initiating antiseizure therapy for any tonic–clonic seizure lasting more than five minutes. The management of febrile status epilepticus follows the same treatment protocols as status epilepticus arising from other causes [24].

4. Discussion

Simple febrile seizures represent roughly 70% of all episodes, complex febrile seizures account for about 25%, and febrile status epilepticus comprises approximately 5%. Febrile status epilepticus remains one of the leading causes of status epilepticus in early childhood. The primary precipitating factors are viral infections—such as influenza, human herpesvirus type 6 (HHV-6), and adenovirus—as well as certain bacterial illnesses, most notably acute otitis media. Unlike simple febrile seizures, febrile status epilepticus rarely terminates on its own and frequently requires pharmacological intervention with more than one antiepileptic drug. When seizures persist, international treatment protocols recommend administering repeated doses of benzodiazepines at five-minute intervals. If these measures fail, second-line agents such as levetiracetam, fosphenytoin, sodium valproate, or phenobarbital should be considered [25].

Because fever serves as the principal trigger for febrile seizures, it might appear reasonable to expect that antipyretic therapy could reduce the risk of recurrence. However, multiple studies have consistently shown no protective effect of antipyretics in preventing febrile seizures. Based on this evidence, the American Academy of Pediatrics (AAP) advises that antipyretic medications may enhance a child's comfort during febrile illness but do not prevent the onset of febrile seizure episodes.

Febrile seizures show a stronger association with specific viral infections compared to others [26,27,28].

One of the primary worries for parents is the potential for long-term neurological problems after a febrile seizure. Nevertheless, large population-based studies have found no clear evidence linking simple or complex febrile seizures—or even febrile status epilepticus—to later cognitive deficits or neurological disorders [26]. Recurrence, however, is relatively common and well documented. About one-third of children who experience a febrile seizure will have another episode during childhood. The strongest predictor of recurrence is the child's age at the initial event. Research indicates that if the first seizure occurs before the age of one year, the likelihood of recurrence is approximately 50%, whereas in children older than three years, the risk drops to about 20% [27].

5. Conclusion

Febrile seizures represent the most frequent form of seizures in preschool children and often provoke considerable anxiety among parents, as these episodes are commonly viewed as alarming and potentially dangerous. The widespread implementation of vaccines against Haemophilus influenzae type B and Streptococcus pneumoniae has significantly impacted the clinical evaluation of children presenting with febrile seizures, enabling physicians to limit unnecessary diagnostic procedures. Proper classification of febrile seizures according to their duration, type of convulsions, and other clinical characteristics is essential for selecting an appropriate treatment strategy and assessing the likely course of the disorder.

Recent studies emphasize that distinguishing between simple and complex febrile seizures is critical for identifying children at higher risk of recurrence or progression to epilepsy. Early and accurate categorization also aids in counseling parents, reducing their anxiety by providing clear information about prognosis. In addition, awareness of vaccination status remains a key factor when deciding on further investigations, particularly the need for lumbar puncture. Clinical guidelines recommend that healthcare providers educate families about the

generally benign nature of most febrile seizures and the importance of prompt fever management. Ongoing research continues to refine risk stratification models, helping clinicians tailor follow-up and intervention plans for each child more effectively.

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Түйіндеме

Фебрильді құрысу — бұл орталық жүйке жүйесінің ауруларымен байланысты емес, дене қызуының жоғарылауына жауап ретінде ерте жастағы балаларда пайда болатын қысқа мерзімді құрысу эпизодтары. Бұл жағдай 6 айдан 5 жасқа дейінгі балалардың шамамен 2–5 %-ында кездеседі және педиатриялық тәжірибеде құрысу ұстамаларының ең жиі кездесетін себебі болып табылады. Шолудың мақсаты – фебрильді құрылу ұстамалары бар балаларға көмек көрсету кезінде жедел жәрдем дәрігерлеріне арналған заманауи тәжірибелік ұсыныстарды талдау.

Заманауи зерттеулер қарапайым және күрделі фебрильді құрысуларды ажыратудың қайталану немесе эпилепсияға шалдығу қаупі жоғары балаларды анықтау үшін өте маңызды екенін атап көрсетеді. Ерте және дәл жіктеу ата-аналарға кеңес беруге, болжам туралы нақты ақпарат беру арқылы олардың мазасыздығын азайтуға көмектеседі. Сонымен қатар, вакцинация мәртебесі туралы хабардар болу қосымша зерттеулер, әсіресе бел пункциясы қажеттілігі туралы шешім қабылдаған кезде маңызды фактор болып қала береді.

Клиникалық нұсқаулықтар денсаулық сақтау қызметкерлерінің отбасыларға фебрильді құрысулардың көпшілігінің жалпы қатерсіз сипаты және қызбаны жедел басқарудың маңыздылығы туралы ақпарат беруін ұсынады. Жүргізіліп жатқан зерттеулер қауіпті стратификация модельдерін жетілдіруді жалғастыруда, бұл медициналық қызметкерлерге әрбір бала үшін тиімді бақылау және араласу жоспарын жасауға көмектеседі.

Түйін сөздер: фебрильді құрысу, балалар, менеджмент, диагностика, емдеу.

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Резюме

Фебрильные судороги представляют собой кратковременные судорожные эпизоды, возникающие у детей раннего возраста на фоне лихорадки и не связанные с заболеваниями центральной нервной системы. Это состояние наблюдается у приблизительно 2–5 % детей в возрасте от 6 месяцев до 5 лет и занимает ведущую позицию среди причин судорог в педиатрической практике. Цель данного обзора — проанализировать современные практические рекомендации, предназначенные для врачей скорой помощи при оказании помощи детям с фебрильными судорогами.

Недавние исследования подчеркивают, что различение простых и сложных фебрильных судорог имеет решающее значение для выявления детей с повышенным риском рецидива или прогрессирования эпилепсии. Ранняя и точная классификация также помогает консультировать родителей, снижая их тревогу за счет предоставления четкой информации о прогнозе. Кроме того, осведомленность о статусе вакцинации остается ключевым фактором при принятии решения о дальнейших исследованиях, особенно о необходимости люмбальной пункции. Клинические рекомендации предписывают медицинским работникам информировать семьи о том, что большинство фебрильных судорог, как правило, носят доброкачественный характер, и о важности своевременного купирования лихорадки. Продолжающиеся исследования позволяют совершенствовать модели стратификации риска, помогая врачам более эффективно разрабатывать планы наблюдения и вмешательства для каждого ребенка.

Ключевые слова: фебрильные судороги, дети, менеджмент, диагностика, лечение.