Ultra-rare genetic variation in the common epilepsies: a case-control sequencing study

Epi4K & Epilepsy Phenome/Genome Project

Correspondence to Epi4k@columbia.edu

Institute for Genomic Medicine
701 West 168th St., Suite 1408
New York, NY 10032

ABSTRACT

BACKGROUND
Despite progress in understanding the genetics of rare epilepsies, the more common epilepsies have proven less tractable to traditional gene-discovery analyses. We aimed to assess the contribution of ultra-rare genetic variation to the common epilepsies.

METHODS
We did a case-control sequencing study using the exome sequence data from unrelated individuals clinically evaluated for one of the two most common epilepsy syndromes: familial genetic generalized epilepsy (GGE) or familial sporadic non-acquired focal epilepsy (NAFE). Individuals were recruited between Nov 26, 2007 and Aug 2, 2013 through the multicentre Epilepsy Phenome/Genome Project and Epi4K collaborations, and were sequenced at the Institute for Genomic Medicine, Columbia University (New York City, USA) between Feb 6, 2013 and Aug 18, 2015. To identify epilepsy risk signals, we tested all protein-coding genes for an excess of ultrarare genetic variation among the cases compared to unrelated individuals of European ancestry selected for control purposes through unrelated studies.

FINDINGS
We separately compared the sequence data from 640 individuals with familial GGE and 525 individuals with familial NAFE to the same group of 3,877 controls, and found significant excess of ultra-rare deleterious variation in genes established as causative for dominant epilepsy disorders (familial GGE: OR 2.3 [95% CI 1.7–3.2]; \(p=9.1\times10^{-8}\)) (familial NAFE: OR 3.6 [95% CI 2.7–4.9]; \(p=1.1\times10^{-17}\)). Comparing an additional collection of 662 individuals with sporadic NAFE to controls did not identify study-wide significant signals. For the familial NAFE cases, we found that five previously known epilepsy genes ranked as the top five genes enriched for ultra-rare deleterious variation. After accounting for the control carrier rate we estimate that these five genes contribute to the risk of epilepsy in approximately 8% of familial NAFE cases. Our analyses showed that no individual gene was significantly associated with epilepsy; however, known epilepsy genes achieved lower \(p\)-values relative to the rest of the protein-coding genes (\(p=5.8\times10^{-8}\)).

**INTERPRETATION**

We identified excess ultra-rare variation in known epilepsy genes, which establishes a clear connection between the genetics of common and rare severe epilepsies, and shows that the variants responsible for the observed epilepsy risk signal are exceptionally rare in the general population. Our results suggest that the emerging paradigm of targeting treatments to the genetic cause in rare devastating epilepsies may also extend to a proportion of common epilepsies. These findings might allow clinicians to broadly explain the aetiology of these syndromes to patients, and lay the foundation for possible precision treatments in the future.

**FUNDING**

National Institute of Neurological Disorders and Stroke (NINDS), Epilepsy-Research UK.
INTRODUCTION

Next generation sequencing has proven successful in identifying genetic contributions to rare Mendelian disorders and cancers,\textsuperscript{1,2} creating widespread optimism that treatments can be targeted to underlying causes of disease.\textsuperscript{3} Although epilepsy is a common complex disease, it is emerging as a group of disorders with precision medicine opportunities similar to those in rare Mendelian disorders and cancers.\textsuperscript{4} Unlike many common diseases, epilepsy genetics research is identifying not only the genes responsible, but also the genetic variants contributing to disease in individual patients. This is most apparent in the role of \textit{de novo} mutations in the epileptic encephalopathies.\textsuperscript{5,6}

Traditional heritability studies of the common epilepsies consistently show strong genetic effects in non-acquired focal epilepsy (NAFE) and in genetic generalized epilepsy (GGE), with both shared and distinct genetic contributions to these broadly defined epilepsies.\textsuperscript{7,8} Two important unresolved questions are the extent to which the genes responsible for rare severe epilepsies contribute to common epilepsies, and whether, as in the rare epilepsies, genetic risk arises primarily from ultra-rare variants of large effect including \textit{de novo} mutations,\textsuperscript{5,6} or from a constellation of common variants each conferring small or modest effect.\textsuperscript{9-13}

Exome sequencing of large case and control cohorts followed by genome-wide collapsing analyses provide a hypothesis-free approach to discovering novel disease genes and better understanding the overall contribution of ultra-rare genetic variation to disease.\textsuperscript{14} Here, we assess the contribution of ultra-rare genetic variation to common epilepsies while controlling for background variation in the general population.
METHODS

Participants

For this case-control study, participants with familial or sporadic NAFE or familial GGE were recruited between November 26, 2007 and August 2, 2013 through the international Epilepsy Phenome/Genome Project (EPGP) and Epi4K collaborations (appendix), as previously described. The case samples were sequenced between February 6, 2013 and August 18, 2015 by the Institute for Genomic Medicine, Columbia University (New York City, NY, USA). To be clinically classified as having NAFE, patients were required to have focal seizures and no evidence of an epileptogenic lesion on clinical imaging; however, hippocampal sclerosis was not considered an exclusion criterion. To be clinically classified as having GGE, patients were required to have a diagnosis of generalized epilepsy with absence, myoclonic or tonic-clonic seizures and generalized spike-and-wave on an EEG, and no or mild intellectual disability. All patients were clinically evaluated by their local clinician or the clinical team at recruiting centres. Individuals with unclassifiable epilepsy or classified as having both GGE and NAFE were excluded from the analyses.

To be classified as a familial case, at least one reported relative (up to third degree) who had been diagnosed with epilepsy was required. The sporadic NAFE cohort included participants who self-reported no known epilepsy family history and were recruited from international hospital, outpatient, and epilepsy clinics (appendix). Written informed consent was collected at the time of recruitment at each of the clinical sites. Patient collection and sharing of anonymised specimens for research was approved by site-specific Institutional Review Boards and ethic committees.

The control cohort comprised of unrelated individuals of European ancestry that had been selected for control purposes and sequenced through unrelated studies not focused on neurodevelopmental, neuropsychiatric or severe paediatric disease (appendix).
Procedures

Sequencing was performed at the Institute for Genomic Medicine, Columbia University (New York City, NY, USA). Samples were exome sequenced using the Agilent All Exon (50MB or 65MB; Agilent Technologies, Santa Clara, CA, USA) or the Nimblegen SeqCap EZ V2.0 or 3.0 Exome Enrichment kit (Roche NimbleGen, Madison, WI, USA) or whole genome sequenced using HiSeq 2000 or 2500 (Illumina, San Diego, CA, USA) sequencers according to standard protocols.

The sequence data from patients with epilepsy and controls were processed using the same Institute for Genomic Medicine bioinformatics pipeline (appendix). We focused on 18,668 consensus coding sequence (CCDS; release 14) protein-coding genes. On average, at least 10-fold coverage was achieved for 95.8% (familial GGE), 96.8% (familial NAFE), 97.1% (sporadic NAFE) and 95.6% (controls) of the 33.27 Mbps of the CCDS. For each protein-coding site in the CCDS—inclusive of two base intronic extensions to accommodate canonical splice variants—we determined the percentage of cases and controls that had ≥10-fold coverage at the site. To alleviate confounding due to differential coverage we used a site-based pruning strategy similar to our previously described exon-pruning strategy. Individual CCDS sites were excluded from analysis if the absolute difference in the percentage of the cases compared to controls with adequate coverage of the site differed by greater than 5.19% (familial GGE vs. controls), 5.14% (familial NAFE vs. controls) and 6.39% (sporadic NAFE vs. controls) (appendix). Site-based pruning resulted in 8.9% (GGE), 8.3% (familial NAFE) and 8.3% (sporadic NAFE) of the CCDS bases excluded from the respective analyses to alleviate issues from differential coverage. Thus, all gene tests were performed on the pruned CCDS where cases and controls had similar opportunity to call gene variants (appendix).
STATISTICAL ANALYSIS

To search for genes that confer risk for common epilepsy syndromes, we implemented a
genic collapsing analysis,\(^ \text{17} \) in which only a single affected individual (the index case) from
each family was included. We applied standard procedures to address potential bias due to
relatedness and population stratification (appendix). The analyses focused on CCDS protein-
coding sites with minimal variability in coverage between the case and control populations.

As in our earlier work,\(^ \text{17} \) the term “qualifying variants” has been adopted to refer to the subset
of variation within the sequence data that meets specific criteria designed to enrich for
pathogenic variants. We defined qualifying variants in four ways (Table 1). Our primary
analysis focused on ultra-rare variants where a combination of internal (the test samples) and
external data (the Exome Variant Server [EVS]\(^ \text{18} \) and Exome Aggregate Consortium [ExAC; 
release 0.3]\(^ \text{19} \)). The test cohort was used to identify variants with a minor allele frequency
(MAF) <0.05% among our combined case and control population being tested. The EVS and
ExAC external databases were used to identify variants found among the test samples and
absent (i.e., MAF=0%) among the two external reference control cohorts. The MAF was set
to <0.05% in the combined case and control test collection to accommodate the possibility of
multiple instances of a risk variant among cases. The two freely available EVS and ExAC
external databases were solely used to support the rarity of the identified variants and did not
contribute as control samples to the tests themselves.

For the primary analysis, functional annotation focused on single nucleotide substitution and
insertion or deletion variants annotated as having a loss-of-function, inframe insertion or
deletion, or a “probably damaging” missense effect by PolyPhen-2 (HumDiv).\(^ \text{20} \) Three
secondary analyses were performed to evaluate the contribution to epilepsy risk from: rare
loss-of-function variants with an internal and external population MAF up to 0.1%; rare non-
synonymous variation in the general population with an internal and external MAF up to
0.1%; and a presumed neutral model that imposed similar MAF thresholds as our primary analysis, but focused specifically on protein-coding variants predicted to have a synonymous effect. The purpose of the presumed neutral model was to further confirm that no cryptic factors might be increasing qualifying variant calling among one of the groups.

For each of the four models, we tested the complete list of 18,668 CCDS genes. For each gene, an indicator variable (1/0 states) was assigned to each individual based on the presence of at least one qualifying variant in the gene (state 1) or no qualifying variants in that gene (state 0). We used a two-tailed Fisher’s exact test to identify genes where there was a significant enrichment of qualifying variants in the case or control group. To control for the type-I error rate within each epilepsy phenotype, we defined study-wide significance as p=8.9x10^{-7}, correcting for 18,668 CCDS genes studied across three models (0.05/[3x18668]).

We did not correct for the neutral control model.

All collapsing analyses were performed using an in-house package, Analysis Tool for Annotated Variants (ATAL). Binomial tests were used to evaluate whether there was an enrichment of previously reported pathogenic variants among the case collection of qualifying variants. Hypergeometric tests were performed to assess whether among the collapsing analysis results the known epilepsy genes preferentially achieved lower p-values relative to the rest of the genome. Cochran-Mantel-Haenszel tests were adopted to combine the results of the gender stratified sex chromosome collapsing analyses.

We also used the primary analysis results from each of the patient groups to assess enrichment among six biologically informed gene-sets that were chosen and described in our earlier studies of the epileptic encephalopathies,\textsuperscript{5,21} including a list of 43 established dominant epilepsy genes (appendix).\textsuperscript{3} To account for background variation in gene-set tests we applied a logistic regression model (appendix).
To assess the contribution to epilepsy risk coming from variants with increasing minor allele frequencies (MAF), we developed a multivariable logistic regression model that focuses on the known epilepsy genes and relates disease risk to the presence of variants among increasing MAF bins (appendix).

These additional binomial, hypergeometric, Cochran-Mantel-Haenszel, and logistic regression tests were completed using R package ‘stats’ version 3.2.2.

**ROLE OF THE FUNDING SOURCE**

The funders of the study had no role in study design, data collection, data analysis, data interpretation or writing of the report. The corresponding author had full access to the data in the study and had final responsibility for the decision to submit for publication.

**RESULTS**

We sequenced the exomes of 1,827 patients with epilepsy—640 unrelated individuals with a diagnosis of familial GGE and 525 unrelated individuals with a diagnosis of familial NAFE of European ancestry. We also sequenced an additional 662 individuals with sporadic NAFE. We compared these three groups of patients with epilepsy to 3,877 controls, who were unrelated individuals of European ancestry with no known epilepsy diagnosis.

Among our familial GGE cohort, no individual gene achieved study-wide significant enrichment for qualifying variants (Figure 1, appendix). Of the total 76,313 qualifying variants in the GGE primary analysis, 15.0% were found among cases in the familial GGE cohort. We then found that among the 76,313 qualifying variants, four unique variants overlapped a codon previously reported to have a pathogenic-classified epilepsy variant.
190 based on the disease-associated variant catalogues of ClinVar, the Online Mendelian
191 Inheritance in Man (OMIM), or the Human Gene Mutation Database (HGMD). All four
192 variants (two SCN1A, one GABRG2, and one SCN1B; appendix) were found among the
193 familial GGE cohort, an improbable enrichment given the expected proportion of 15.0%
194 (p=5.1x10^{-4}, two-tailed exact binomial test). Through an evaluation of the scientific literature,
195 these four cases were confirmed as unrelated to those families reported in the literature.

196 While no single gene attained study-wide significance in the familial GGE analysis, three
197 known epilepsy genes (KCNQ2, GABRG2, and SCN1A), were among the top ten case-
198 enriched genes in the primary analysis (Figure 1). A hypergeometric test was run at each of
199 the gene ranks occupied by one of the 43 established epilepsy genes (appendix), and we
200 found that the enrichment was greatest at rank 151 whereby seven of the 43 known epilepsy
201 genes had been accounted for (hypergeometric p=5.8x10^{-8}; appendix).

202 When we assessed enrichment among six biologically informed gene-sets, we found that the
203 familial GGE cohort had a significant enrichment of ultra-rare functional variation among 43
204 known dominant epilepsy genes (p=9.1x10^{-8}, OR=2.3 [95% C.I. 1.7–3.2]; Table 2) and a
205 subset of 33 genes known to contribute to epileptic encephalopathy (p=2.6x10^{-7}, OR=2.6
206 [95% C.I. 1.8–3.6]). We confirmed that the signal of enrichment for qualifying variants
207 among known epilepsy genes was consistently greater than the control rate across groupings
208 of the familial GGE cohort, reflecting the number of affected relatives (appendix). While they
209 did not achieve study-wide significance (defined as p< 8.9x10^{-7}), we also investigated
210 qualifying variant enrichment among the fragile X mental retardation protein associated
211 genes, the genes encoding the NMDA receptor (NMDAR), and neuronal activity-regulated
212
cytoskeleton-associated protein, postsynaptic signalling complexes, mouse seizure-associated orthologs, and ion channel protein-coding genes (Table 2). None of these gene-set tests reported enrichment of neutral variation.

Among the primary analysis of our familial NAFE cohort (figure 2A), DEPDC5 achieved study-wide significance (OR 8.1 [95% C.I. 3.6–18.3], p=1.8x10^{-7}). LGII did not achieve study-wide significance (OR 29.9 [95% C.I. 6.0–288.0], p=1.4x10^{-6}). Established epilepsy genes PCDH19 (OR 22.4 [95% C.I. 4.0–226.4], p=6.4x10^{-5}), SCN1A (OR 5.5 [95% C.I. 2.3–12.9], p=9.0x10^{-5}) and GRIN2A (OR 7.5 [95% C.I. 2.2–25.1], p=5.3x10^{-4}) occupied the 3rd – 5th genome-wide ranks (appendix), but were not study-wide significant after correcting for the 56,004 tests (Bonferroni corrected p = 1). A hypergeometric test indicated that it was highly improbable for five of the 43 known dominant epilepsy genes to occupy the top five positions of the primary analysis by chance (p=5.7x10^{-14}) (appendix).

Of 74,272 qualifying variants identified in the primary analysis of 525 individuals with familial NAFE and 3,877 controls, 9,092 (12.2%) of these were found among the familial NAFE cases. Among the 74,272 qualifying variants, nine variants overlapped a codon of a ClinVar, OMIM, or HGMD literature-reported pathogenic variant in a confirmed unrelated family. All nine unique variants (three DEPDC5, three PCDH19, one CHRNB2, one GRIN2A and one LGII variant; appendix) were found among nine distinct NAFE cases of the combined 4,402 unrelated samples used in the familial NAFE collapsing analysis, despite the expected proportion being 12.2% (exact binomial test p=6.2x10^{-9}).

The known dominant epilepsy gene-set (OR=3.6 [95% CI 2.7–4.9], p=1.1x10^{-17}) and the epileptic encephalopathy gene-set (OR=3.3 [95% CI 2.3–4.7], p=5.0x10^{-11}) were study-wide significantly enriched for qualifying variants among the primary analysis of familial NAFE cases (Table 2). As observed in the familial GGE cases, the signal of enrichment for
qualifying variants among known epilepsy genes remained consistently greater than the control rate across groupings of the familial NAFE cohort stratified by the number of affected relatives (appendix). Presumably neutral variation was not significantly enriched among any gene-set. Under the loss-of-function model, DEPDC5 achieved study-wide significance (OR=53.07, [95% C.I. 12.1–481.3], p=9.6x10^{-12}), with 14 (2.7%) of familial NAFE cases having a DEPDC5 loss-of-function variant compared to only two (0.05%) controls. Focusing solely on PolyPhen-2 ‘probably damaging’ missense DEPDC5 qualifying variants showed that they were non-significant for enrichment (3 [0.6%] of 525 cases vs. 12 [0.3%] of 3877 controls; OR=1.9 [95% C.I. 0.3–6.9], p=0.41; Figure 2B and appendix). Results from the list of 43 known dominant epilepsy genes that achieved an uncorrected p<0.05 in the primary or loss-of-function models are listed in the appendix.

Sanger sequencing was used to validate a subset of qualifying variants found among 19 established and 13 candidate epilepsy genes (appendix). Our rate of Sanger validation was 97.0% (128/132) of the qualifying variants identified through the collapsing tests (appendix). When available, we also Sanger sequenced qualifying variants among affected first-degree relatives of index cases used in the collapsing analyses. We looked at six genes where we had enough affected first-degree relatives to be sufficiently powered to achieve an uncorrected p<0.05 from a test of preferential segregation (appendix). Comparing to the expected rate of 50%, SCN1A (88.2% co-occurrence; p=1.2x10^{-3}), DEPDC5 (100% co-occurrence; p=4.9x10^{-4}) and GRIN2A (100% co-occurrence; p=7.8x10^{-3}) had significant co-occurrence among affected first-degree family members, after correcting for the six studied genes (adjusted α=8.3x10^{-3}; appendix).
To explore which variants, as a function of MAF, are most important to the observed risk signal we performed conditional analyses (appendix). These analyses show that among the observed epilepsy risk signal, beyond the ultra-rare qualifying variants (i.e., absent in EVS and ExAC) there is no significant contribution from variants with minor-allele frequencies up to 0.1% population MAF. This was true for both the familial GGE and familial NAFE populations (Figure 3; appendix).

Comparing 662 sporadic NAFE cases to controls did not identify study-wide significant genes across any of the three models (appendix). Of the five previously described familial NAFE top ranked genes, we found that only LGI1 achieved an uncorrected p-value of less than 0.05, (OR 8.8 [95% C.I. 1.0–105.7], p=0.025). None of the tested gene-sets were significantly enriched with qualifying variants among sporadic NAFE cases (Table 2, Figure 3).

DISCUSSION

In this study, we demonstrate the presence of clear genetic risk signal for common epilepsies across genes established as responsible for familial and rare severe epilepsies. In our analysis of a cohort of individuals with familial NAFE, we found that five established epilepsy genes (DEPDC5, LGI1, PCDH19, SCN1A and GRIN2A) occupy the top five positions genome-wide, and after correcting for background variation, the collection of these five genes contribute to approximately 8% of patients with familial NAFE. Sampling from a similarly sized familial GGE collection identified three established epilepsy genes (KCNQ2, SCN1A, and GABRG2) ranking among the top ten genes. Power estimates highlight the potential for new epilepsy gene discovery using this framework on larger sample sizes (appendix). Using
the example from \textit{LGII}, while we found only two qualifying variants among 3,877 controls (0.05%), identifying eight familial NAFE case carriers in the primary analysis (1.5% of the familial NAFE cohort) was still inadequate to achieve study-wide significance (p<8.9x10^{-7}) for this known familial NAFE gene. Assuming the sampled rates for \textit{LGII} case and control carriers remain the same, we estimate that \textit{LGII} would achieve study-wide significance with the inclusion of approximately twice as many controls and 70 more unrelated familial NAFE cases.

As in earlier studies, our data show that \textit{SCN1A} contributes to risk in both the familial GGE and familial NAFE epilepsy cohorts\textsuperscript{11} and this enrichment is not explained by diagnoses of generalized epilepsy with febrile seizures plus (GEFS+). \textit{SLC9A2} was also among the top 20 genes in both the familial NAFE and familial GGE cohort analyses; however, it did not reach study-wide significance. No clear risk signal for epilepsy was found among the sporadic NAFE cohort. This might be explained by the possibility that non-genetic (acquired) causes play a more important role among individuals with sporadic NAFE, leading to substantially reduced power but otherwise similar genetics. Other unexplored genetic contributions to the sporadic NAFE cohort include somatic mutations arising later in development, limited to the brain or at undetectable levels in blood-extracted DNA using conventional whole-exome sequencing.

Among the most important findings in this work is our ability to identify clear risk signal in these data and subsequently show that the observed risk signal is concentrated among the rarest variants in the human population. In fact, among the 43 established dominant epilepsy genes we have shown that there is no evidence of risk contribution from variants observed at greater than 0.005% allelic frequency. This, however, does not preclude any other contributions to risk being present among currently unrecognized epilepsy risk genes. This work not only illustrates the value of large reference control variant databases,\textsuperscript{19} but provides
clinically relevant information concerning the frequency spectrum of risk variants for a common complex disease.

A new paradigm is emerging for the treatment of rare devastating epilepsies, where treatments are being targeted to the precise genetic cause of disease.\textsuperscript{3, 26-28} For example, children with \textit{KCNT1} gain-of-function mutations have been treated with quinidine\textsuperscript{27, 29} while patients with \textit{GRIN2A} gain-of-function mutations have been treated with memantine, a specific NMDA receptor blocker.\textsuperscript{28, 30} As this paradigm becomes more established, a critical question for the field is whether the approach will also apply to common epilepsies. If so, the field, which is currently accustomed to undertaking large randomised controlled trials in broad phenotypes, needs to rapidly develop a framework for classification based on ultra-rare variants in what is effectively a collection of rare genetic diseases. The work presented here demonstrates that many genes responsible for devastating rare and familial epilepsies also contribute to more common epilepsies, and it is still the ultra-rare variants that are relevant in those genes. This suggests that the emerging precision medicine paradigm of targeting treatments to the underlying causes of disease in the rarest epilepsies may also find application among the common epilepsies.
Evidence before this study

The genetic underpinnings of the common epilepsies are largely unknown, especially the relative contributions of common variants of small effect size versus rare variants of large effect, where opportunities for novel therapeutic strategies may be greater. We searched PubMed for the terms “exome sequencing” and “common epilepsy” for reports published before June 28, 2016, with no language restrictions. There were no reports of exome sequencing of large case collections of common complex epilepsies. Although exome sequencing studies have been successful in implicating numerous genes and finding the relevant mutations for individuals with rare severe paediatric epilepsies, including epileptic encephalopathies, estimating the risk contribution from the ultra-rare protein-coding variants has been less clear for many of the common epilepsy syndromes.

Added value of this study

We used whole-exome sequencing on a large collection of two common epilepsy syndromes, genetic generalized epilepsy (GGE) and non-acquired focal epilepsy (NAFE), to search for an excess of ultra-rare deleterious qualifying variants, and compared the qualifying variant rates found among cases to background rates estimated from sequenced controls. Among familial index cases sampled from the common epilepsies, we found a significant excess of ultra-rare deleterious variation within known epileptic encephalopathy genes. We also demonstrate that the epilepsy risk signal observed in the known epilepsy genes is accounted for by the ultra-rare class of variants that are absent among large reference control cohorts, such as ExAC and EVS. Variants in known epilepsy genes that were predicted to be deleterious, but found at very low frequencies among the population reference cohorts, showed no evidence of contribution to the observed epilepsy risk signal.
Implications of all the available evidence

The present findings provide three key conclusions important to our understanding of the common epilepsies. First, identifying significant enrichment of ultra-rare deleterious variants among established epilepsy genes illustrates that there are genuine signals to be found using the analysis framework presented here. Secondly, we showed that the precision medicine framework that is emerging for rare epilepsies can be expected to find applications among more common epilepsies. Finally, we showed that the risk signals among the common complex forms of epilepsy come from the rarest variants in the human population, providing the clearest insight currently available into the genetic variants underlying this common complex disorder. Further research is warranted to understand to what extent these findings can be applied to clinical practice.
CONTRIBUTORS


R.H.T. Bioinformatics processing: J.Br., S.Petrov., Z.R. and Q.W. Sequencing and
segregation of variants: M.S.H. and C.M. Sequence data analysis and Statistical
interpretation: lead analyst S.Petrov with A.S.A., D.B.G. and E.L.H. Writing of manuscript:

DECLARATION OF INTERESTS

DBG reports personal fees from Pairnomix and EpiPM /Clarus outside the submitted work.
DA reports grants from NINDS during the conduct of the study. EA reports grants from
NINDS/NIH during the conduct of the study, and grants from Sunovion Pharmaceuticals Inc.
outside the submitted work. FA reports grants from NINDS/NIH during the conduct of the
study, and grants from Sunovion Pharmaceuticals Inc. outside the submitted work. SFB
reports grants from National Health and Medical Research Council and NINDS during the
course of the study; grants from UCB Pharma, Novartis Pharmaceuticals, Sanofi-Aventis,
Jansen Cilag, outside the submitted work; In addition, SFB has a patent for SCN1A testing
held by Bionomics Inc and licensed to various diagnostic companies. No financial return
although was a consultant to Bionomics and Athena diagnostics over 4 years ago; Patent
pending for DEPD5 testing applied for by University of South Australia and University of
Melbourne. JLC reports personal fees from Shire, and grants from UCB Pharma, outside the
submitted work. PC reports grants from NINDS (NS053998) during the conduct of the study.
OD served on the scientific advisory board of Pairnomix during the conduct of the study. DD
reports grants from NIH/NINDS during the conduct of the study. MPE reports grants from
NIH/NINDS during the conduct of the study. EBG reports grants and personal fees from
Neupace Inc outside the submitted work. TG reports grants from NIH (NS053998) during
the conduct of the study, and personal fees from AssureX Health, outside the submitted work;
also has a patent (PCT/US2006/045631) with royalties paid by AssureX Health. EHK served
on the Data Safety Board of GW Pharma, served on the Scientific Advisory Board of Atkins
Nutritionals, and reports grants from Nutricia outside the reported work. RK reports grants
from NINDS (NS053998) during the conduct of the study. HCM reports grants from
NINDS/NIH during the conduct of the study. RO reports other from Trigeminal Solutions Inc
outside the submitted work. KP reports grants from NIH during the conduct of the study.
SPetrou reports equity from Pairnomix outside the submitted work; a patent for the diagnosis
and treatment of epilepsy (WO2004/085674) issued to Bionomics Ltd, and a patent for
treatment and diagnosis of epilepsy by detecting mutations in the SCN1A
gene(WO2006/133508) issued to Bionomics Ltd. SPetov reports interests in Pairnomix
outside the submitted work. IES reports grants from NHMRC and NIH during the conduct of
the study; personal fees from UCB, Transgenomics, GlaxoSmithKline, Sanofi, and Eisai
outside the submitted work; patent for Epilepsy and Mental Retardation Limited to Females
with royalties paid (WO/2009/086591), and a patent for treatment, and diagnosis of epilepsy
by detecting mutations in the SCN1A gene licensed (WO/2006/133508). RAS reports grants
from NIH, Pediatric Epilepsy Research Foundation, and American Sleep Medicine
Foundation outside the submitted work; reports personal fees from UpToDate outside the
submitted work. EHS reports personal fees from Invitae outside the submitted work. JJS
reports grants from NIH during the conduct of the study. SS reports personal fees from
Accorda, AstraZenica, Neurelis, Questcor, Upsher Smith, and Xeris outside the submitted
work. LLT reports grants from NIH, Epilepsy Study Consortium, and Eisai outside the
submitted work. RT has received personal fees for speaking from UCB Pharma and Eisai
outside the submitted work; personal fees for consulting from Sanofi outside the submitted
work.

All other authors declare no competing interests.

ACKNOWLEDGEMENTS

We are grateful to the patients, their families, clinical research coordinators and referring
physicians for participating in the various recruitment sites that provided the phenotype data
and DNA samples used in this study. We thank the following professional and lay
organizations for substantial assistance in publicizing EPGP and therefore enabling us to
recruit participants effectively: AED Pregnancy Registry, American Epilepsy Society,
Association of Child Neurology Nurses, California School Nurses Organization, Child
Neurology Society, Citizens United for Research in Epilepsy, Epilepsy Alliance of Orange
County, Epilepsy Foundation, Epilepsy Therapy Project, and Finding a Cure for Epilepsy and
Seizures. We thank the EPGP Administrative Core (K.F. Schardein, R. Fahlstrom, S.
Cristofaro and K. McGovern), EPGP Bioinformatics Core (G. Nesbitt, K. McKenna, V.
Mays), staff at the Coriell Institute – NINDS Genetics Repository, and members of the
Institute for Genomic Medicine (C. Malone, B. Krueger, S. Kamalakaran, C. Davidson, B.
Copeland, S. Kisselev, D. Collado, D. Fernandez, J. Charoensri and P. Cansler) for their dedication and commitment to this work. We also thank R. Stewart, K. Gwinn, R. Corriveau, B. Fureman and V. Whittemore from the National Institute of Neurological Disorders and Stroke for their careful oversight and guidance of both EPGP and Epi4K. This work was supported by grants from the National Institute of Neurological Disorders and Stroke (The Epilepsy Phenome/Genome Project NS053998; Epi4K—Administrative Core NS077274; Epi4K—Sequencing, Biostatistics and Bioinformatics Core NS077303; Epi4K—Multiplex Families & Pairs Project NS077367 and Epi4K—Phenotyping and Clinical Informatics Core NS077276) and project grant (P1104) to R.H.T. from Epilepsy-Research UK.

The authors would like to thank the NHLBI GO Exome Sequencing Project and its ongoing studies which produced and provided exome variant calls for comparison: the Lung GO Sequencing Project (HL-102923), the WHI Sequencing Project (HL-102924), the Broad GO Sequencing Project (HL-102925), the Seattle GO Sequencing Project (HL-102926) and the Heart GO Sequencing Project (HL-103010). The authors would like to thank the Exome Aggregation Consortium and the groups that provided exome variant data for comparison. A full list of contributing groups can be found at http://exac.broadinstitute.org/about.
REFERENCES

18. EVS. Exome Variant Server, NHLBI GO Exome Sequencing Project (ESP). Seattle, WA.
19. ExAC. Exome Aggregation Consortium (ExAC). Cambridge, MA.


<table>
<thead>
<tr>
<th>Cohort</th>
<th>Model</th>
<th>Internal MAF(%)</th>
<th>External MAF(%)</th>
<th>Variant Effects</th>
<th># Genes with &gt;0 qualifying variant(s)</th>
<th>CCDS represented in the tests (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Familial</td>
<td>Primary^</td>
<td>0.05%</td>
<td>0%</td>
<td>LoF</td>
<td>15,515</td>
<td></td>
</tr>
<tr>
<td>GGE</td>
<td>LoF</td>
<td>0.1%</td>
<td>0.1%</td>
<td>LoF</td>
<td>10,712</td>
<td>30.3Mbp (91.1%)</td>
</tr>
<tr>
<td></td>
<td>Common (0.1% MAF)</td>
<td>0.1%</td>
<td>0.1%</td>
<td>LoF</td>
<td>17,118</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Presumed Neutral</td>
<td>0.05%</td>
<td>0%</td>
<td>Synonymous substitution</td>
<td>14,959</td>
<td></td>
</tr>
<tr>
<td>Familial</td>
<td>Primary^</td>
<td>0.05%</td>
<td>0%</td>
<td>LoF</td>
<td>15,438</td>
<td></td>
</tr>
<tr>
<td>NAFE</td>
<td>LoF</td>
<td>0.1%</td>
<td>0.1%</td>
<td>LoF</td>
<td>10,601</td>
<td>30.5Mbp (91.7%)</td>
</tr>
<tr>
<td></td>
<td>Common (0.1% MAF)</td>
<td>0.1%</td>
<td>0.1%</td>
<td>LoF</td>
<td>17,089</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Presumed</td>
<td>0.05%</td>
<td>0%</td>
<td>Synonymous substitution</td>
<td>14,871</td>
<td></td>
</tr>
<tr>
<td>Sporadic NAFE</td>
<td>Neutral</td>
<td>Primary^</td>
<td>0.05%</td>
<td>0%</td>
<td>LoF inframe insertions or deletions PolyPhen-2 (HumDiv) “probably” damaging</td>
<td>15,507</td>
</tr>
<tr>
<td>--------------</td>
<td>---------</td>
<td>----------</td>
<td>-------</td>
<td>----</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>LoF</td>
<td>0.1%</td>
<td>0.1%</td>
<td>LoF</td>
<td>10,729</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Common</td>
<td>0.1%</td>
<td>0.1%</td>
<td>LoF inframe insertions or deletions PolyPhen-2 (HumDiv) “probably” damaging</td>
<td>17,108</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presumed</td>
<td>0.05%</td>
<td>0%</td>
<td>Synonymous substitution</td>
<td>14,956</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 1. Qualifying variant criteria in the four models.

^Primary analysis permits minor allele frequency (MAF) to be up to 0.05% (i.e., up to four alleles in the combined case and control test population) to accommodate for possible recurrent pathogenic variants that might be relevant to multiple cases. GGE = genetic generalized epilepsy. NAFE = non-acquired focal epilepsy. LoF = loss-of-function. MAF = minor allele frequency. CCDS = consensus coding sequence.
<table>
<thead>
<tr>
<th>Group</th>
<th>Gene set</th>
<th>Number of genes</th>
<th>Average qualifying variants</th>
<th>Qualifying variants enrichment p-value (Odds Ratio [95% CI])</th>
<th>Neutral variation enrichment p-value</th>
<th>Enrichment after removing the 43 epilepsy genes p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Familial GGE</strong></td>
<td>Known</td>
<td>43</td>
<td>0.052</td>
<td>$p = 9.1 \times 10^{-8}$ (OR=2.3 [95% CI 1.7 - 3.2])</td>
<td>$p = 0.86$</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Known (EE)</td>
<td>33</td>
<td>0.037</td>
<td>$p = 2.6 \times 10^{-7}$ (OR=2.6 [95% CI 1.8 - 3.6])</td>
<td>$p = 0.34$</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Ion Channel</td>
<td>209</td>
<td>0.264</td>
<td>$p = 0.028$ (OR=1.2 [95% CI 1.0 - 1.5])</td>
<td>$p = 0.73$</td>
<td>$p = 0.21$</td>
</tr>
<tr>
<td></td>
<td>FMRP</td>
<td>823</td>
<td>1.481</td>
<td>$p = 0.034$ (OR=1.3 [95% CI 1.0 - 1.6])</td>
<td>$p = 0.94$</td>
<td>$p = 0.04$</td>
</tr>
<tr>
<td></td>
<td>NMDAR &amp; ARC</td>
<td>78</td>
<td>0.067</td>
<td>$p = 0.004$ (OR=1.6 [95% CI 1.1 - 2.1])</td>
<td>$p = 0.80$</td>
<td>$p = 0.007$</td>
</tr>
<tr>
<td></td>
<td>MGI Seizure</td>
<td>235</td>
<td>0.269</td>
<td>$p = 0.003$ (OR=1.3 [95% CI 1.1 - 1.6])</td>
<td>$p = 0.97$</td>
<td>$p = 0.17$</td>
</tr>
<tr>
<td><strong>Familial NAFE</strong></td>
<td>Known</td>
<td>43</td>
<td>0.055</td>
<td>$p = 1.1 \times 10^{-17}$ (OR=3.6 [95% CI 2.7 - 4.9])</td>
<td>$p = 0.87$</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Known (EE)</td>
<td>33</td>
<td>0.037</td>
<td>$p = 5.0 \times 10^{-11}$ (OR=3.3 [95% CI 2.3 - 4.7])</td>
<td>$p = 0.65$</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Ion Channel</td>
<td>209</td>
<td>0.264</td>
<td>$p = 1.9 \times 10^{-4}$ (OR=1.5 [95% CI 1.2 - 1.8])</td>
<td>$p = 0.47$</td>
<td>$p = 0.05$</td>
</tr>
<tr>
<td></td>
<td>FMRP</td>
<td>823</td>
<td>1.466</td>
<td>$p = 0.77$ (OR=1.0 [95% CI 0.8 - 1.2])</td>
<td>$p = 0.77$</td>
<td>$p = 0.38$</td>
</tr>
<tr>
<td></td>
<td>NMDAR &amp; ARC</td>
<td>78</td>
<td>0.061</td>
<td>$p = 0.43$ (OR=0.8 [95% CI 0.5 - 1.3])</td>
<td>$p = 0.62$</td>
<td>$p = 0.40$</td>
</tr>
<tr>
<td></td>
<td>MGI Seizure</td>
<td>235</td>
<td>0.261</td>
<td>$p = 0.05$ (OR=1.2 [95% CI 1.0 - 1.5])</td>
<td>$p = 0.81$</td>
<td>$p = 0.87$</td>
</tr>
<tr>
<td><strong>Sporadic NAFE</strong></td>
<td>Known</td>
<td>43</td>
<td>0.045</td>
<td>$p = 0.27$ (OR=1.2 [95% CI 0.8 - 1.8])</td>
<td>$p = 0.27$</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Known (EE)</td>
<td>33</td>
<td>0.030</td>
<td>$p = 0.79$ (OR=0.9 [95% CI 0.5 - 1.5])</td>
<td>$p = 0.49$</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Ion Channel</td>
<td>209</td>
<td>0.251</td>
<td>$p = 0.34$ (OR=0.9 [95% CI 0.7 - 1.1])</td>
<td>$p = 0.88$</td>
<td>$p = 0.25$</td>
</tr>
<tr>
<td></td>
<td>FMRP</td>
<td>823</td>
<td>1.461</td>
<td>$p = 0.95$ (OR=1.0 [95% CI 0.8 - 1.2])</td>
<td>$p = 0.92$</td>
<td>$p = 0.94$</td>
</tr>
<tr>
<td></td>
<td>NMDAR &amp; ARC</td>
<td>78</td>
<td>0.063</td>
<td>$p = 0.65$ (OR=1.1 [95% CI 0.8 - 1.5])</td>
<td>$p = 0.49$</td>
<td>$p = 0.70$</td>
</tr>
<tr>
<td></td>
<td>MGI Seizure</td>
<td>235</td>
<td>0.254</td>
<td>$p = 0.36$ (OR=0.9 [95% CI 0.7 - 1.1])</td>
<td>$p = 0.33$</td>
<td>$p = 0.33$</td>
</tr>
</tbody>
</table>

**Table 2. Gene-set enrichment tests.** P-values are from a logistic regression model that regresses the case/control status of a sample on the presence (1) or absence (0) of at least one qualifying variant among the corresponding gene set (Primary model). Reported p-values are uncorrected; the study-wide multiplicity-adjusted significance threshold $\alpha = 8.9\times10^{-7}$. All tests use the individual’s gender, exome-wide tally of qualifying variants, and the individual’s gene-list-specific tally of rare neutral (synonymous) variation as correction factors (appendix). Known = 43 established dominant human epilepsy genes. Known (EE) = A subset of genes securely implicated with epileptic encephalopathies. Ion Channel = genes coding for ion
channels.\textsuperscript{25} \textbf{FMRP} = fragile X mental retardation protein associated genes.\textsuperscript{22} \textbf{NMDAR & ARC} = NMDA receptor and neuronal activity-regulated cytoskeleton-associated protein synaptic transmission genes.\textsuperscript{23} \textbf{MGI} \textbf{Seizure} = mouse orthologs linked with seizure phenotypes in the Mouse Genome Database.\textsuperscript{24}  \textsuperscript{a}Average number of qualifying variants in the corresponding gene set, per sample in the test population.
Figure 1: Familial GGE primary model analysis. 15,515 genes had at least one case or control carrier (table 1). Qualifying variants were defined as a minor allele frequency <0.05% in internal case and control, and absent among external reference cohorts. Variants are annotated as loss-of-function, inframe insertions or deletions, or missense predicted to be “probably damaging” by PolyPhen-2 (HumDiv). No gene achieved study-wide significance (adjusted $\alpha < 0.05/18668 * 3 = 8.9 \times 10^{-7}$).
Figure 2: Familial NAFE primary model analysis. (A) 15,438 genes had at least one case or control carrier (table 1). Qualifying variants have a minor allele frequency <0.05% in internal case and control, and are absent among external reference cohorts. Variants are annotated as loss-of-function, inframe insertions or deletions, or missense predicted to be “probably damaging” by PolyPhen-2 (HumDiv). Only DEPDC5, achieved study-wide significance (adjusted $\alpha < 0.05/\left[18668 \times 3\right] = 8.9 \times 10^{-7}$). (B) 10,601 genes had at least one case or control carrier (table 1). Qualifying variants are variants with a population MAF<0.1% and annotated as loss-of-function effects. Only DEPDC5 achieved study-wide significance.
Figure 3: Enrichment of qualifying variants among 43 known epilepsy genes across increasing minor allele frequency bins. The ultra-rare variation bin reflects qualifying variants from the primary analyses. The 0.005% MAF (conditional) bin represents qualifying variants with a MAF greater than 0% but no greater than 0.005% in ExAC. The 0.1% MAF (conditional) bin represents qualifying variants with a MAF greater than 0.005% but no greater than 0.1% in ExAC. The neutral (synonymous) bin represents ultra-rare putatively neutral variants across the 43 epilepsy genes. Multivariate conditional analyses for the (A) familial GGE population (B) familial NAFE population (C) sporadic NAFE
CONSORTIA

Epi4K Consortium


Epilepsy Phenome/Genome Project

Affiliations

Department of Biostatistics and Bioinformatics, Duke University, Durham, North Carolina 27710, USA.

Andrew S. Allen (PhD)

Epilepsy Research Centre, Department of Medicine, University of Melbourne (Austin Health), Heidelberg, Victoria 3084, Australia.

Susannah T. Bellows (MPsych(Ed)), Samuel F. Berkovic (MD), Rosemary Burgess (PhD), Michael S. Hildebrand (PhD), Slavé Petrovski (PhD), Brigid Regan (BSc) & Ingrid E. Scheffer (MD)

Institute for Genomic Medicine, Columbia University Medical Center, New York, New York 10032, USA.

Joshua Bridgers (MSc), David B. Goldstein (PhD), Erin L. Heinzen (PhD), Caroline Mebane (BSc), Slavé Petrovski (PhD), Zhong Ren (MSc) & Quanli Wang (MSc)

Department of Molecular and Cellular Therapeutics, The Royal College of Surgeons in Ireland, Dublin, Ireland.

Gianpiero Cavalleri (PhD), Norman Delanty (MD)

Institute of Life Science, Swansea University Medical School, Swansea University, Swansea SA2 8PP, UK

Seo-Kyung Chung (PhD), William O. Pickrell (MD) & Mark I. Rees (PhD)
Centre of Excellence in Neuromics and CHUM Research Center, Université de Montréal, CHUM-Hôpital Notre-Dame Montréal, Quebec H2L 4M1, Canada.

Patrick Cossette (MD)

Department of Neurology, Beaumont Hospital and Royal College of Surgeons, Dublin, Ireland.

Norman Delanty (MD)

Department of Neurology and Pediatrics, The Children’s Hospital of Philadelphia, Perelman School of Medicine at the University of Pennsylvania, Philadelphia, Pennsylvania 19104, USA.

Dennis Dlugos (MD)

Department of Human Genetics, Emory University School of Medicine, Atlanta, Georgia 30322, USA.

Michael P. Epstein (PhD)

Department of Neurology, University of California, San Francisco, San Francisco, California 94143, USA.

Catharine Freyer (BA), Daniel H. Lowenstein (MD), Heidi E. Kirsch (MD) & Joseph Sullivan (MD)

Centre for Clinical Translation Division of Brain Sciences, Imperial College London, London SW7 2AZ, UK.

Michael R. Johnson (MD)

Comprehensive Epilepsy Center, Department of Neurology, NYU School of Medicine, New York, New York 10016, USA.
Ruben Kuzniecky (MD), Judith Bluvstein (MD), Jacqueline French (MD) & Daniel Friedman (MD)

Department of Molecular and Clinical Pharmacology, University of Liverpool, Clinical Sciences Centre, Lower Lane, Liverpool L9 7LJ, UK.

Anthony G. Marson (MD) & Graeme J. Sills (PhD)

Department of Neurology and the Taub Institute on Alzheimer's Disease and the Aging Brain, Gertrude H. Sergievsky Center, Columbia University, New York, NY, USA

Richard Mayeux (MD)

Department of Pediatrics, Division of Genetic Medicine, University of Washington, Seattle, Washington 98115, USA.

Heather C. Mefford (MD)

Departments of Medicine and Neurology, The Royal Melbourne Hospital, Parkville, Victoria 3146, Australia.

Terence J. O'Brien (MD), Steven Petrou (PhD) & Slavé Petrovski (PhD)

Departments of Epidemiology and Neurology, and the G. H. Sergievsky Center, Columbia University; and Division of Epidemiology, New York State Psychiatric Institute, New York, New York 10032, USA.

Ruth Ottman (PhD)

The Florey Institute of Neuroscience and Mental Health, The University of Melbourne, VIC 3010, Australia.

Steven Petrou (PhD) & Ingrid E. Scheffer (MD)
The Centre for Neural Engineering, The University of Melbourne, VIC 3010, Australia.

Steven Petrou (PhD)

Division of Epilepsy and Clinical Neurophysiology, Department of Neurology Boston Children’s Hospital, Boston, Massachusetts 02115, USA.

Annapurna Poduri (MD)

Duke Hospital Neurodiagnostic Laboratory, Duke Department of Neurology, Duke University School of Medicine, Durham NC 27705, USA.

Rodney Radtke (MD)

Department of Pediatrics, University of Melbourne, Royal Children’s Hospital, Melbourne, VIC 3010, Australia

Ingrid E. Scheffer (MD)

Institute of Psychological Medicine and Clinical Neurosciences, Cardiff University School of Medicine, Cardiff CF24 4HQ, UK

Rhys Thomas (MD)

Department of Neurology, Vanderbilt University Medical Center, Nashville, Tennessee 37232, USA.

Bassel Abou-Khalil (MD), Kevin Haas (MD), & Juliann M. Paolicchi (MD)

Department of Clinical Pharmacy, UCSF School of Pharmacy, Department of Neurology, UCSF School of Medicine, San Francisco, California 94143, USA.

Brian K. Alldredge (PharmD)
Neurogenetics Unit, Montreal Neurological Hospital and Institute; Departments of Neurology & Neurosurgery, McGill University, Montreal QC H3A 2B4 Canada

Dina Amrom (MD)

Neurogenetics Unit and Epilepsy Research Group, Montreal Neurological Hospital and Institute; Departments of Neurology & Neurosurgery and Human Genetics, McGill University, Montreal QC H3A 2B4 Canada

Eva Andermann (MD)

Epilepsy Research Group, Montreal Neurological Hospital and Institute; Departments of Neurology & Neurosurgery and Pediatrics, McGill University, Montreal QC H3A 2B4 Canada

Frederick Andermann (MD)

Department of Neurology, Cleveland Clinic Lerner College of Medicine & Epilepsy Center of the Cleveland Clinic Neurological Institute, Cleveland, Ohio 44195, USA.

Jocelyn F. Bautista (MD)

Department of Neurology, Montefiore Medical Center, Albert Einstein College of Medicine, Bronx, New York 10467, USA.

Alex Boro (MD)

Division of Epilepsy, Mayo Clinic, Rochester, Minnesota 55905, USA.

Gregory D. Cascino (MD)

Epilepsy Center, Neurology Division, Ramos Mejía Hospital, Buenos Aires 1221, Argentina.
Damian Consalvo (MD)

Medical Epilepsy Program & EEG & Child Neurology, Children’s Hospital of Pittsburgh of UPMC, Pediatrics, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania 15224, USA.

Patricia Crumrine (MD)

NYU and Saint Barnabas Epilepsy Centers, NYU School of Medicine, New York, New York 10016, USA.

Orrin Devinsky (MD)

Department of Neurology, Epilepsy Care Center, University of Minnesota Medical School, Minneapolis 55414, USA.

Miguel Fiol (MD)

FE Dreifuss Comprehensive Epilepsy Program, University of Virginia, Charlottesville, Virginia 22908, USA.

Nathan B. Fountain (MD)

Division of Neurology, Saint Barnabas Medical Center, Livingston, New Jersey 07039, USA.

Eric B. Geller (MD) & Peter Widdess-Walsh (MD)

Division of Neurology, Cincinnati Children’s Hospital Medical Center, Cincinnati, Ohio 45229, USA.

Tracy Glauser (MD)
Department of Neurology, Comprehensive Epilepsy Program, University of Michigan Health System, Ann Arbor, Michigan 48109, USA.

Simon Glynn (MD)

Comprehensive Epilepsy Center, Montefiore Medical Center, Bronx, New York 10467, USA.

Sheryl R. Haut (MD)

The Kaiser Permanente Group, Oakland, California 94611, USA.

Jean Hayward (MD)

Neurology and Pediatrics, Emory University School of Medicine, Atlanta, Georgia 30322, USA.

Sandra L. Helmers (MD)

University of Michigan Division of Pediatric Neurology, Department of Pediatrics & Communicable Diseases, Ann Arbor, Michigan, 48109, USA.

Sucheta Joshi (MD) & Renée A. Shellhaas (MD)

Department of Neurological Sciences, Rush Epilepsy Center, Rush University Medical Center, Chicago, Illinois 60612, USA.

Andres Kanner (MD) & Michael C. Smith (MD)

Department of Radiology, University of California, San Francisco, California 94143, USA.

Heidi E. Kirsch (MD)

Neurology, University of Texas Medical School, Houston, Texas 77030, USA.
Robert C. Knowlton (MD)

Neurology and Pediatrics, Child Neurology, Pediatric Neurology Residency Program, 
Johns Hopkins Hospital, Baltimore, Maryland 21287, USA.

Eric H. Kossoff (MD)

Epilepsy Program, Children’s Hospital & Research Center Oakland, Oakland, 
California 94609, USA.

Rachel Kuperman (MD)

Comprehensive Epilepsy Center, Oregon Health and Science University, Portland, 
Oregon 97239, USA.

Paul V. Motika (MD)

Departments of Neurology and Pediatrics, University of Washington School of 
Medicine, Seattle Children’s Hospital, Seattle, Washington 98105, USA.

Edward J. Novotny (MD)

Weill Cornell Medical Center, New York, New York 10065, USA.

Juliann M. Paolicchi (MD)

Department of Neurology and Neuroscience Graduate Program, University of Michigan 
Medical Center, Ann Arbor, Michigan 49108, USA.

Jack M. Parent (MD)

Ann Arbor Veterans Administration Healthcare System, Ann Arbor, Michigan 48105, 
USA.

Jack M. Parent (MD)
Departments of Neurology and Pediatrics, University of Colorado School of Medicine, Children’s Hospital Colorado, Denver, Colorado 80045, USA.

Kristen Park (MD)

Department of Paediatrics and Child Health, University of Otago, Wellington, Newtown, Wellington, 6021, New Zealand.

Lynette G. Sadleir (MD)

University of Michigan, Pediatric Neurology, Ann Arbor, Michigan 48109, USA.

Renée A. Shellhaas (MD)

Departments of Neurology, Pediatrics and Institute of Human Genetics, University of California, San Francisco, San Francisco, California 94158, USA.

Elliott H. Sherr (MD)

Department of Neurology, Mayo Clinic, Jacksonville, Florida 32224, USA.

Jerry J. Shih (MD)

Departments of Neurology, Pediatrics, and Epidemiology and Population Health, and the Comprehensive Epilepsy Management Center, Montefiore Medical Center, Albert Einstein College of Medicine, Bronx, NY

Shlomo Shinnar (MD)

Department of Pediatrics/Division of Child Neurology, University of Alabama School Of Medicine/Children’s Hospital of Alabama, Birmingham, AL 35233, USA.

Rani K. Singh (MD)

Department of Neurology, Mayo Clinic, Scottsdale, Arizona 85259, USA.
Joseph Sirven (MD)

Department of Neurology, Division of Pediatric and Developmental Neurology, Washington University School of Medicine, St. Louis, Missouri 63110, USA.

Liu Lin Thio (MD)

Department of Pediatrics, The Children's Hospital at Saint Peters University Hospital and Rutgers University, New Brunswick, NJ 08901, USA.

Anu Venkat (MD)

Department of Neurology, Johns Hopkins Hospital, Baltimore, Maryland 21287, USA.

Eileen P. G. Vining (MD)

Division of Child & Adolescent Neurology, Departments of Pediatrics, University of Texas Medical School, Houston, Texas 77030, USA.

Gretchen K. Von Allmen (MD)

Department of Neurology, Division of Pediatric Neurology, Washington University School of Medicine, St Louis, Missouri 63110, USA.

Judith L. Weisenberg (MD)

Department of Neurology and the G.H. Sergievsky Center, Columbia University, New York, New York 10032, USA.

Melodie R. Winawer (MD)