Introduction

Epilepsy is a common disease. The cumulative lifetime risks for epilepsy and for any unprovoked seizure are 3.1% and 4.1%, respectively. **(Mac et al, 2007)**.

Idiopathic epilepsies are a relatively new category of disorders defined by strict clinical and electroencephalogram (EEG) features proposed by the International League Against Epilepsy (ILAE) **(Engel, 2001)**.

The international classification of epileptic syndromes has proposed strict clinical and EEG criteria to individualize idiopathic epilepsies. Clinical experience has shown that these criteria are not always fulfilled by every patient every time and that idiopathic epilepsies represent a heterogeneous condition in which many factors, such as age of onset, external factors, role of medications, and sleep, interact. **(Nordli, 2005)**.

Some syndromes in childhood, which are completely described by strict electroclinical criteria such as the absence epilepsies, juvenile myoclonic epilepsies are usually included and analyzed in epidemiologic studies; however, other epileptic syndromes observed in infancy, such as benign familial infantile seizures and benign myoclonic epilepsy in infancy, are quite rare and are usually excluded from epidemiologic surveys because they are difficult to describe completely in electro-clinical terms. Another strong limitation in the study of epidemiology of idiopathic epilepsies is the lack of EEG data, either because EEG is not available or the routine EEG is normal. **(Waaler, 2000)**.

Idiopathic epilepsies encompass several different syndromes, and a few patients shift from one phenotype to another. The overlapping of some syndromes during infancy and adolescence increased the difficulty to individualize strictly the correct syndrome. **(Berg et al, 1999)**