Infective Causes of Epilepsy

M. Bonello, MBBS, MRCP, B.D. Michael, MBChB, MRCP, PhD, T. Solomon, MBBS, FRCP, PhD, DTM&H

1 The Walton Centre NHS Foundation Trust, Liverpool, United Kingdom
2 The Institute of Infection and Global Health, University of Liverpool, Liverpool, United Kingdom

Semin Neurol 2015;35:235–244.

Abstract

A wide range of infections of the central nervous system are responsible for both acute seizures and epilepsy. The pathogenesis and clinical semiology of the seizure disorders vary widely between the infective pathogens. The exact mechanisms underlying this are poorly understood, but appear, at least in part, to relate to the pathogen; the degree of cortical involvement; delays in treatment; and the host inflammatory response. The treatment of infective causes of seizures involves both symptomatic treatment with antiepileptic drugs and direct treatment of the underlying condition. In many cases, early treatment of the infection may affect the prognosis of the epilepsy syndrome. The greatest burden of acute and long-term infection-related seizures occurs in resource-poor settings, where both clinical and research facilities are often lacking to manage such patients adequately. Nevertheless, education programs may go a long way toward addressing the stigma, leading to improved diagnosis, management, and ultimately to better quality of life.

Keywords

- infection
- encephalitis
- epilepsy

Infectious Agents Causing Epilepsy

Any infection of the cortex can potentially result in seizures. This primarily relies upon the structural damage occurring during the infection, although secondary inflammatory processes may also provoke seizures. Certain conditions, including viral encephalitis and parasitic infections—such as “cerebral” malaria and neurocysticercosis—are inherently associated with seizures and the risk of developing epilepsy. Other conditions, such as bacterial meningitis, can cause seizures in the acute setting, although this is less frequent and they rarely result in long-term epilepsy. Here we will review the most common central nervous system (CNS) infectious disorders causing epilepsy, specifically focusing on viral encephalitis and parasitic infections.

Viral Encephalitis

Encephalitis encompasses a broad range of pathophysiologic process that result in inflammation of brain parenchyma and therefore the diagnosis is fundamentally a histopathological one. In view of the impracticality of obtaining brain tissue, surrogate markers of brain inflammation are routinely used to make the diagnosis. These include elevated cerebrospinal fluid (CSF) leukocyte counts, raised protein, evidence of viral nucleic acid in the CSF by polymerase chain reaction (PCR), or intrathecal synthesis of antiviral antibody. Neuroimaging can also help (►Fig. 1). Encephalitis usually presents with an encephalopathy syndrome for which there is often a broad differential diagnosis. Features raising suspicion for infective encephalitis include a history of fever or coryzal illness, recent travel, and inadequate vaccination. A wide range of pathogens can cause encephalitis. Antibody-associated encephalitis, which may be paraneoplastic or de novo, is of increasingly recognized importance, but it is beyond the scope of this article and is covered elsewhere in this themed edition.

Encephalitis results in roughly 19,000 hospitalizations and 1,400 deaths per year in the United States with a reported incidence between 0.7 to 13.8 per 100,000 per year. It is an important condition as delays in diagnosis and in starting treatment can result in significant morbidity and mortality. Acute symptomatic seizures occur in 2 to 67% of patients with a diagnosis of encephalitis overall. The incidence of acute symptomatic seizures and the subsequent development of
against epilepsy (ILAE).

unprovoked seizures as described by the International League
acute setting, but are also more likely to develop later
poor settings.

they are prone to underestimate, particularly in resource-
available data are mainly from passive surveillance; therefore,
and the long-term outcome for encephalitis are limited and
limited.

is approximately the same as that due to head injuries, even
incidence of epilepsy due to encephalitis in the United States
likely to develop later unprovoked seizures. The annual
seizures during the acute viral encephalitis are 10 times more
acute encephalitic illness, the risk is higher at a 22 times more


Most commonly, seizures develop within the first 5 years
of the acute encephalitic illness, but they may occur up to
20 years after the acute event. The pathogen may be impor-
tant in determining whether a person subsequently develops
epilepsy in the long term. For example, encephalitis caused by
La Crosse virus has a cumulative incidence of epilepsy of 10 to
12% while Nipah virus encephalitis has an incidence of
approximately 2.2%.4

Causes of Infectious Encephalitis

Acute infections causing encephalitis group broadly into
those occurring either sporadically or epidemically. The
most common sporadic cause is herpes simplex virus, usually
type 1, although 10% are type 2.1 Others include varicella
zoster virus and enteroviruses. Epidemic encephalitis most
commonly occurs in geographically restricted seasonal epi-
demics and is caused by arthropod-borne viruses (arbovi-
ruses), although clinicians need to be vigilant to the potential
for advances in the geographical distribution of these patho-
gens. Globally, the most important epidemic cause is Japanese
encephalitis virus, while others include West Nile virus, tick-
borne encephalitis virus and Nipah virus (→ Table 1).5

Herpes Simplex Virus Encephalitis

Herpes simplex virus (HSV) encephalitis has an annual inci-
dence of 1 in 250,000 to 500,000, although this may be an
underestimate.8 Herpes simplex virus type 1 is an α herpes
double-stranded DNA virus with which most people are
infected by adulthood.8 It is transmitted by droplet spread
and crosses the mucous membranes of the naso-oral cavity
and then travels by retrograde axonal transport to sensory
ganglia, predominantly the trigeminal ganglion. There it
achieves latency, but reactivates periodically, traveling by
anterograde axonal transport to the cutaneous nerve end-
ings, resulting in spread of the virus, in some cases associated
with a localized vesicular eruption, “herpes labialis.” Triggers
for viral reactivation include stress, local trauma, fever,
immunosuppression, menstruation, or hormone imbalance.
The mechanisms resulting in latency and reactivation are not
fully understood, but toll-like receptors and the type 1 and 2
interferon response probably play a crucial role in initially
establishing and subsequently maintaining latency.9 Rarely,
the virus replicates in the brain, causing encephalitis although
it is unclear whether this result from further retrograde
axon transport after reactivation in the trigeminal ganglion,
or whether this is due to reactivation of HSV already latent
within the brain (→ Fig. 2).

Herpes simplex virus type 1 encephalitis has a bimodal age
distribution, with one-third of cases occurring in young
adults and one-half of cases occurring in people older than
50 years.10 Seizures occur in approximately 40% of people
with HSV 1 encephalitis during the acute illness and may be
the presenting symptom.11 The seizures are typically focal,
with and without cognitive involvement, reflecting temporal
lobe and to a lesser extent frontal lobe infection. Clinical
features that typically precede seizures include alterations in
cognition, consciousness, personality, or behavior, in the
context of an intercurrent or recent febrile illness.3 However,
approximately 11% of patients with HSV encephalitis are
afebrile on admission.12 Associated clinical features include
headache, nausea, vomiting, and features suggesting menin-
gism and raised intracranial pressure.12 The presence of acute
symptomatic seizures was associated with a worse outcome
in a series of patients with HSV encephalitis; furthermore,
the development of status epilepticus is associated with a worse
outcome in encephalitis more broadly.4,13 In addition, a
greater impairment in consciousness, older age, and a delay
in starting acyclovir treatment of > 48 hours are each asso-
ciated with a worse outcome.4

Approximately 45 to 60% of people with HSV encephalitis
develop epilepsy later in life.4,5,8 Initial treatment should be
with an antiepileptic medication effective for focal-onset

Fig. 1  Magnetic resonance image of brain (coronal T2-weighted)
showing typical temporal lobe changes in confirmed herpes simplex
virus type 1 (HSV1) encephalitis.
Table 1 Causes of acute viral encephalitis

<table>
<thead>
<tr>
<th>Groups</th>
<th>Viruses</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sporadic causes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Herpes viruses (Family Herpesviridae)</td>
<td>Herpes simplex virus type 1</td>
<td>Most commonly diagnosed sporadic encephalitis</td>
</tr>
<tr>
<td></td>
<td>Herpes simplex virus type 2</td>
<td>Causes meningitis in adults; meningoencephalitis typically occurs in the immunocompromised; radiculitis</td>
</tr>
<tr>
<td></td>
<td>Varicella zoster virus</td>
<td>Postinfective cerebellitis, or acute infective encephalitis or vasculopathy</td>
</tr>
<tr>
<td></td>
<td>Epstein–Barr virus</td>
<td>Encephalitis in the immunocompromised</td>
</tr>
<tr>
<td></td>
<td>Cytomegalovirus</td>
<td>Encephalitis in the immunocompromised; retinitis, radiculitis</td>
</tr>
<tr>
<td></td>
<td>Human herpes viruses 6 and 7</td>
<td>Febrile convulsions in children; encephalitis in the immunocompromised</td>
</tr>
<tr>
<td>Enteroviruses (Family Picornaviridae)</td>
<td>Enterovirus 70</td>
<td>Epidemic hemorrhagic conjunctivitis, with CNS involvement</td>
</tr>
<tr>
<td></td>
<td>Enterovirus 71</td>
<td>Epidemic hand, foot, and mouth disease, aseptic meningitis, brainstem encephalitis, myelitis</td>
</tr>
<tr>
<td></td>
<td>Poliovirus</td>
<td>Myelitis</td>
</tr>
<tr>
<td></td>
<td>Coxackie viruses, echoviruses, parechoviruses</td>
<td>Aseptic meningitis</td>
</tr>
<tr>
<td>Paramyxoviruses (Family Paramyxoviridae)</td>
<td>Measles virus</td>
<td>Acute postinfective encephalitis, subacute encephalitis, subacute sclerosing panencephalitis</td>
</tr>
<tr>
<td></td>
<td>Mumps virus</td>
<td>Parotitis, orchitis, pancreatitis are associated with meningoencephalitis</td>
</tr>
<tr>
<td>Others (rarer)</td>
<td>Influenza viruses, adenovirus, parvovirus B19, lymphocytic choriomeningitis virus, rubella virus</td>
<td></td>
</tr>
<tr>
<td><strong>Arthropod-borne and zoonotic viruses</strong></td>
<td>West Nile virus</td>
<td>North America, Southern Europe, Middle East, West and Central Asia associated with flaccid paralysis and parkinsonian movement disorders</td>
</tr>
<tr>
<td></td>
<td>Japanese encephalitis virus</td>
<td>Asia, associated with flaccid paralysis and parkinsonian movement disorders</td>
</tr>
<tr>
<td></td>
<td>Tick-borne encephalitis virus</td>
<td>Eastern Europe, Former USSR; upper limb flaccid paralysis</td>
</tr>
<tr>
<td></td>
<td>Dengue viruses (types 1–4)</td>
<td>Causes fever, arthralgia, rash and hemorrhagic disease; occasional CNS disease</td>
</tr>
<tr>
<td>Alphaviruses (Family Togaviridae)</td>
<td>Western, Eastern and Venezuelan equine encephalitis viruses</td>
<td>Found in the Americas; associated with human and equine encephalitis</td>
</tr>
<tr>
<td></td>
<td>Chikungunya virus</td>
<td>Asia Pacific, Africa</td>
</tr>
<tr>
<td>Bunyaviruses</td>
<td>La Crosse Virus</td>
<td>Encephalitis in America</td>
</tr>
<tr>
<td>Coltiviruses</td>
<td>Colorado tick fever virus</td>
<td>North America</td>
</tr>
<tr>
<td>Rhabdoviruses</td>
<td>Rabies, virus other lyssaviruses</td>
<td>Non-arthropod-borne zoonotic viruses transmitted by dogs, cats, bats depending on location</td>
</tr>
<tr>
<td></td>
<td>Chandipura virus</td>
<td>Transmitted by sand-flies, causing outbreaks in India</td>
</tr>
<tr>
<td>Henipaviruses</td>
<td>Nipah virus</td>
<td>Transmitted in feces of fruit bats in Malaysia, Bangladesh</td>
</tr>
</tbody>
</table>


Abbreviations: CNS, central nervous system.

*Most are zoonotic with the exception of dengue and chikungunya viruses. Viral causes of chronic encephalitis like JC virus are not included.*
seizures, although these patients frequently require multiple antiepileptic medications. If a patient has early recurrent seizures, evolving seizure types—particularly with a facio-brachial dystonic semiology—or has associated progressive cognitive decline or neuropsychiatric symptoms, clinicians should consider an early relapse of the encephalitis. This may be due to resurgent viral infection or a postinfective primarily immunomedi- ated process that may be associated with specific antibodies directed against CNS antigens. Early relapses may develop in up to 10 to 26% of patients, especially those who received insufficient acyclovir.11 However, patients occasionally develop relapses up to 2 years after the initial event.14 Therefore, UK guidelines recommend that immunocompetent patients older than 12 years should receive intravenous acyclovir for 14 days, and then undergo a repeat HSV PCR of the CSF.1,2 If there is still evidence of HSV infection, they should receive another 7 days of treatment with further CSF sampling thereafter, and acyclovir continued until the CSF PCR is negative. These guidelines also recommend that a minimum treatment duration of 21 days for immunocompromised patients or those younger than 12 years before repeating CSF sampling.1,2

Japanese Encephalitis Virus

An estimated 70,000 cases of encephalitis due to Japanese encephalitis virus (JEV) occur per year, causing 20,500 deaths.16 Although responsible for seasonal epidemics mostly centered around South East Asia, some cases also occur in the Western Pacific and Eastern Mediterranean.17 Japanese encephalitis virus is a flavivirus that has a zoonotic transmission with infection between a wide range of vertebrates by Culex mosquitoes, and the predominant cycle is between wading birds, such as egrets, and pigs (Fig. 3). Pigs act as amplifying hosts.
hosts due to high, prolonged viremia. This cycle can spill over to humans who are a dead-end host following a mosquito bite. Therefore, the major risk factors for JEV infection are close proximity to rice fields and pigsties. Acute infection results in a transient, non-specific febrile viremic illness; in some people, the virus crosses the blood–brain barrier resulting in viral replication in the CNS. This leads to leukocyte transfer into the brain with perivascular cuffing. Treatment is generally supportive and includes management of the complications such as seizures and raised intracranial pressure. Importantly, Japanese encephalitis is a vaccine-preventable illness; thus, delivering broad and comprehensive vaccination programs is of utmost priority.

Japanese encephalitis virus causes acute symptomatic seizures in up to 85% of children and in 10% of adults. Generalized tonic–clonic seizures are more frequent than focal motor seizures; however, the clinical signs may be subtle and seizures can be easily missed, especially if there is limited access to electroencephalography (EEG). In one large cohort study, half of the patients with generalized tonic–clonic seizures and all of those with subtle seizures were in status epilepticus. Moreover, of patients with confirmed encephalitis due to JEV, those who had acute symptomatic seizures while hospitalized were at least 4 times more likely to have a poor outcome. Around half of patients who survive the acute illness are left with severe neurologic sequelae, including motor impairment, and cognitive and language dysfunction. Approximately 20% of survivors are thought to develop long-term seizures, but we need more detailed studies assessing longer-term consequences with a particular focus on late unprovoked seizures and the health economic and social implications.

Role of Human Herpes Virus 6

The relatively recently identified lymphotropic β herpes DNA virus human herpes virus 6 (HHV6) is now realized to be the most common cause of roseola infantum in children aged under 2 years (Fig. 4). More broadly, HHV6 may account for 20% of emergency department admissions for all febrile illnesses in children aged 6 to 12 months, of whom approximately 13% may develop acute seizures. In one study of children aged below 5 years presenting with febrile status epilepticus to an emergency department, 32% had HHV-6B viremia. HHV6 is found by PCR of the CSF in 10% of cases of suspected viral CNS disease, regardless of age. In addition, four studies have reported HHV6 viral DNA in some samples of resected hippocampi from people with mesial temporal lobe sclerosis. HHV6 viral DNA was found in nine (28%) hippocampal samples that were resected for mesial temporal lobe epilepsy in a Chinese study, but only in one (8%) of the control patients. In other studies, there was HHV6 DNA in 15 (62.5%), 4 (50%), and 3 (9%) patients with mesial temporal sclerosis, although there was no control group. This wide variability may reflect patient populations sampled; clearly, we need further work on a larger well-defined cohort with an appropriate control group. In addition, as HHV6 viral DNA can show chromosomal integration, the finding of viral DNA in CSF or brain parenchyma needs confirmation of its significance, for example, through establishing a high or rising viral load, an intrathecal antibody response, and excluding chromosomal integration.

Parasitic Infections

Seizures can complicate parasitic infections of the CNS and may develop both as an acute phase response as well as long-term consequence, although establishing the causality of some organisms can be difficult. Seizures develop through several mechanisms, including local pressure effects from parasitic growth in the brain parenchyma (e.g., hydatid disease), from inflammation after larval migration, or as part of a diffuse encephalopathy (e.g., African trypanosomiasis). Two major infections associated with a high frequency of seizures and epilepsy are cerebral malaria and neurocysticercosis.

Cerebral Malaria

There are an estimated 1 million deaths attributed to malaria per year—with half of these resulting from cerebral malaria—of whom 90% are children. The World Health Organization has defined cerebral malaria as unexplained coma in patients with a parasitemia without any other explanation. In addition, cerebral malaria may be suspected clinically by a malaria-specific retinopathy, which is 95% sensitive and 90% specific for children who are comatose secondary to cerebral malaria. The epidemiology and clinical phenotype of the condition varies by age and geographical location. Cerebral disease most commonly develops with falciparum malaria and affects mostly African children below the age of 5 years with a rapid onset of coma and focal motor seizures. Adults normally develop cerebral dysfunction in conjunction with dysfunction of other organs.

Up to 30% of African children have some neurologic sequelae following cerebral malaria; up to 10% develop
epilepsy. The mechanism by which cerebral malaria results in epilepsy is not fully understood, but it probably involves a parasite-driven inflammatory process causing cortical damage, which may predominantly affect the occipital neocortex and can be confirmed as focal atrophy on neuroimaging months to years later. However, one case report described hippocampal sclerosis and mesial temporal lobe epilepsy following cerebral malaria. Clinical seizures are occasionally generalized at onset, but more often are focal with or without subsequent secondary generalization; approximately 20% of children have subclinical seizures. Moreover, status epilepticus can occur in up to 28% of patients and having acute seizures is associated with an increased risk of both mortality and long-term neurologic disability.

Treatment involves standard antimalarial medication and best supportive care, which may require intensive care input where available. Therefore, clinicians should be vigilant for the potential for seizures in patients with cerebral malaria, and should consider an EEG, where available, to detect subtle motor or nonconvulsive status epilepticus, especially in those with altered and/or fluctuating consciousness. However, even having identified status epilepticus, the optimal treatment regimen is unclear. In one study, neither phenytoin nor fosphenytoin controlled status epilepticus in 36 to 64% of children with cerebral malaria, despite therapeutic antiepileptic blood concentrations.

**Neurocysticercosis**

Neurocysticercosis is the infection of the CNS by the larval stage of the tapeworm *Taenia solium*, and is the most common helminthic infection of CNS globally. *Taenia solium* is endemic in most developing countries and as such is a major public health problem. Millions of people living in the developing world are infected by the larval form of *T. solium*, and many of these will experience some degree of clinical consequence of the infection. It is rare in northern Europe, Canada, Australia, Japan, New Zealand, and in many countries with a predominant Muslim population. However, immigration from endemic countries has increased the incidence in these countries more recently. The increasingly widespread use of cysticidal drugs, improved sanitation, and public health educational measures have been associated with a decreasing prevalence of clinical infection. However, neurocysticercosis remains an important cause of hospital admission and a major cause for acquired epilepsy in many areas.

The life cycle of *T. solium* involves humans, as the only definite hosts for the adult “cestode,” and pigs, which act in conjunction with humans as intermediate hosts for the larval form or cysticercus. The parasite’s lifecycle passes through four stages including the vesicular stage, the colloidial stage, the granular stage, and finally the calcified stage (Fig. 5).

Approximately 80% of patients with symptomatic neurocysticercosis develop recurrent seizures. Other manifestations include focal neurologic deficits, increased intracranial pressure, and cognitive decline. Neurocysticercosis is a leading cause of acquired epilepsy in endemic areas and is partly responsible for the increased prevalence of epilepsy in the developing world. These patients probably have focal-onset seizures with rapid generalization. Seizures occur predominantly when the parasites begin to degenerate; calcified lesions have been considered to be inert. However, recent reports suggest that calcified lesion may cause seizures in some people when parasitic antigens trapped in the calcium matrix are exposed to the host immune system during calcification remodeling (Fig. 6). Neurocysticercosis has also been associated with hippocampal scarring. In an appropriate patient with acute symptomatic seizures and exposure to an endemic region, *T. solium* can be detected on a simple plain radiograph of the quadriceps (Fig. 7).

**Management of Seizures**

At the moment, no evidence supports the use of antiepileptic medication as primary prophylaxis in patients with a CNS infection. Indeed, there is limited evidence to guide treatment of seizures that occur during or after the acute CNS infection. There have been no randomized or quasirandomized controlled trials for the primary or secondary prophylaxis of seizures in viral encephalitis; therefore, there is currently no evidence to support primary prophylaxis, although secondary prevention is routine practice. A further complicating factor is the management of iatrogenic respiratory failure in the setting of limited resources, as identified in one study of phenobarbital in patients with cerebral malaria. We need large multicenter randomized controlled trials, but before this, we need risk stratification...
tools to identify those at high risk of developing seizures and status epilepticus.

Convulsive status epilepticus should be treated in the same way as that due noninfective causes, but depends upon local resources. It is important to keep in mind parainfectious processes that complicate brain infections, including cerebral venous sinus thrombosis and electrolyte abnormalities such as hyponatremia. Nonconvulsive status epilepticus should be excluded in comatose patients, particularly if there is fluctuation in consciousness and/or subtle motor features.

Epilepsy following CNS infections remains a challenge especially in resource-poor settings. The treatment, to some extent, depends upon the natural history of the disease; at the moment, there are no clear predictors of postinfective epilepsy. In HSV encephalitis the timing of antiviral medication can reduce the short-term mortality; however, there are few data assessing early antiepileptic medication and the prevention of long-term sequelae. Regardless of the cause, seizure treatment is targeted toward seizure semiology, although many patients with seizures following CNS infections require a combination of antiepileptic medications.

The WHO has produced guidelines specifically targeted at resource-poor settings. These include the assertion that the diagnosis of epilepsy is clinical and that there should not be...
an overreliance on neuroimaging and EEG. They also state that nonspecialist health care workers should be trained to recognize and to treat convulsive seizures. Patients should be offered monotherapy with any standard antiepileptic drug—which can be made available sustainably—and the WHO recommends phenobarbital for patients with generalized-onset and carbamazepine for focal-onset epilepsy. Other first-line medications to consider include lamotrigine, given its efficacy for both focal and generalized seizures, and levetiracetam, given the low rates of drug interactions and utility in managing convulsive status epilepticus (provided sustainable availability can be achieved).

Charities, such as the Encephalitis Society, can provide support for patients and their family globally, including supplying information. In resource-poor settings, education programs directed at the patient, their family, and the wider community as to the nature of epilepsy and the basic management of seizures are pivotal in addressing the social stigma that can significantly limit adherence and seizure control, result in injury, and more broadly impact on quality of life.

Conclusion

Infections of the CNS are an important cause of both acute seizures and later epilepsy. The exact mechanisms underlying this are poorly understood. However, they appear, at least in part, to relate to the pathogen, the degree of cortical involvement, delays in treatment, and the host inflammatory response. The greatest burden of acute and long-term infection-related seizures occurs in resource-poor settings, where there may be inadequate clinical and research facilities to manage such patients. Nevertheless, education programs may go a long way toward addressing the damaging stigma, and so lead to improved diagnosis, management, and ultimately quality of life.

Acknowledgments

BDM received Doctoral Fellowship funding from the National Institute for Health Research (NIHR) and is a NIHR Academic Clinical Lecturer. TS received support from the NIHR Health Protection Research Unit in Emerging and Zoonotic Infections at Liverpool. BDM is a Trustee for the Encephalitis Society and TS is Chair of their Scientific Advisory Panel.

References

4 Misra UK, Tan CT, Kalita J. Viral encephalitis and epilepsy. Epilepsia 2008;49(Suppl 6):13–18
10 Tyler KL. Herpes simplex virus infections of the central nervous system: encephalitis and meningitis, including Mollaret’s. Herpes 2004;11(Suppl 2):57A–64A

Fig. 7 Plain radiograph of the thighs of a patient with disseminated cysticercosis (www.ijmm.org/article.asp?issn=0255-0857;year=2011; volume=29;issue=2;spage=180;epage=183;aulast=Banu).


Marson AG, Al-Kharusi AM, Alwaidh M, et al.; SANAD Study group. The SANAD study of effectiveness of carbamazepine, gabapentin, lamotrigine, oxcarbazepine, or topiramate for treatment of partial

LeCL000243