

and prioritised by hospital staff and the "little things" that are extremely important to these patients are not overlooked. Their need for routine, familiarity and sensory and play facilities was evident. Without their care and treatment being individualised to meet their very specific needs, CYP with LD can experience unnecessary emotional distress and physical harm.

G197(P) NEUROIMAGING IN NEUROFIBROMATOSIS TYPE 1: OUTCOMES FROM A TARGETED APPROACH- EXPERIENCE OF A SINGLE TERTIARY CENTRE

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Aims Routine imaging is not recommended for patients with neurofibromatosis 1(NF1) and a clinical approach is used to guide need for investigations. We aimed to determine clinical characteristics and symptoms which were most commonly associated with abnormalities on neuroimaging in children with NF1.

Methods We analysed 100 consecutive patients with an established diagnosis of NF1 seen in a tertiary NF1 clinic. Records of patients who had undergone imaging studies were reviewed to determine clinical presentation and associated comorbidities, along with neuroimaging results.

Results 59/100 children with NF1, (M:F =55:45; median age 11.6 years (range 9 months–21 years) underwent cranial MRI scanning. The most common indications for MRI request being visual disturbance or abnormal fundoscopy (37%), concerns regarding growth or puberty (13.5%) and headaches (10%). 91% had an abnormality on MRI, 66% of which were UBOs (unidentified bright objects). 13(22%) optic pathway gliomas, 7 (11.8%) non-glioma CNS tumours, 8(13.5%) had other CNS abnormalities. 10/59 (17%) required surgical intervention. In 5/59 (8%) children the scan was normal. Patients with learning difficulties and neuro-developmental disorders (such as ASD/ADD) had a significantly higher incidence of UBO (90% vs. 40%; $p < 0.001$). There was a higher incidence of non-UBO CNS lesions amongst the group with learning difficulties. 2 asymptomatic patients had incidental findings on scans done for other reasons; 1 of them required surgical intervention.

32/100 children had MRI spine, common indications being scoliosis (40%) and back/neck pain (28%). 34% of these scans were abnormal. Chiari malformation, cervical syrinx and dural ectasia were the most common abnormalities. 5/27 (18%) needed scoliosis surgery.

Conclusion Targeted imaging in our cohort identified a significant proportion of abnormalities. Children with NF1 and associated neurodevelopmental conditions (learning difficulties, ASD, ADHD) were more likely to have an abnormality on the scans, thus warranting a lower threshold for neuroimaging. For the efficient use of resources, a high index of clinical suspicion is essential for early identification of NF1 related complications.

G198(P) CHILD AND ADOLESCENT PSYCHIATRY TRAINING DURING NEURODISABILITY GRID: AN EXPERIENCE BY THE TRAINEES IN THE UK

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Aim The neurology and neurodisability grid trainees should have a child and adolescent psychiatry experience equivalent to three months full time during their grid programme. The aim of our survey was to gather information and analyse the child and adolescent psychiatry training experience by the current paediatric neurodisability trainees.

Method This was a questionnaire based survey which was sent out to the existing neurodisability grid trainees in the UK via email. Total 10 questions were asked related to the child and adolescent psychiatry training experience.

Results Out of total 26 trainees to whom the survey was sent out, 16 responded (61.5%). 60% were working as ST8. The neurodisability grid programme was of two years for 60% of the trainees. Most of them (73%) had already started their neuro-psychiatry placement. Only 6% found easy but 26% thought that it was very difficult to access the training. 15% had to have a separate honorary contract with the child and family mental health (CAMHS) department. None was on a separate 3 month contract. In terms of satisfaction, one third seemed dissatisfied for various reasons and only 6% were very satisfied.

Some of the comments were- "CAMHS team members are reluctant to have the neurodisability trainee in the clinic unless it was a pre-school child with possible developmental problems"; "No learning disability CAMHS consultant in the service"; "CAMHS services were not sure of the competencies needed to be achieved"; "Difficult to get the placement and the service was quite stretched"; "Spent a lot of time chasing sessions"; "CAMHS consultants should be involved while submitting the grid posts to RCPCH"

Conclusion Child and adolescent mental health services (CAMHS) are lacking in the expertise and resources required to provide comprehensive assessments and ongoing management for those with developmental disabilities. Our survey highlights the need for the CAMHS service to engage the neurology and neurodisability grid trainees by understanding the competencies they need to achieve in child and adolescent psychiatry. Equally, the respective CSACs could also work in partnership with the child mental health CSAC to design a smooth and well-structured programme for these trainees.

G199(P) AUDIT OF INFORMATION PROVIDED TO PARENTS OF CHILDREN WITH EPILEPSY

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Introduction Epilepsy is common in children. Diagnosis may impact negatively on the family. Witnessing a seizure can be very frightening. A wide range of emotions and reactions from the parents are reported once the diagnosis is made. High quality information for the family provided on time can be very beneficial. Involving the child and family in decision making is associated with good outcome and improve compliance.

Aim There are risks associated with epilepsy. Many professionals pay attention to medical management (medication) once a diagnosis is made. However, needs of the child and family for high quality information is ignored. NICE guideline has highlighted what information needs to be provided to the family and what safety measures to be taken. As with no epilepsy clinic locally, I performed an audit to look into our practice and to check it against the standards set by the NICE and National service