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**THE EFFICACY OF A MULTIDISCIPLINARY INTERVENTION STRATEGY FOR THE TREATMENT OF BENIGN JOINT HYPERMOBILITY SYNDROME (BJHS) IN CHILDHOOD. A RANDOMISED, SINGLE CENTRE PARALLEL GROUP TRIAL (THE BENDY STUDY)**

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**Introduction** Joint hypermobility is common in childhood and can be associated with musculoskeletal pain and dysfunction. Current management is delivered by a multidisciplinary team but evidence of efficacy is limited. This clinical trial aimed to determine whether a structured multidisciplinary intervention resulted in improved clinical outcomes compared with standard care.

**Method** A prospective randomised, single centre parallel group trial comparing an 8-week individualised multidisciplinary intervention programme with current standard management (advice and a physiotherapy appointment). Children and young people (CYP) were assessed for pain, function, coordination and strength at baseline, 3 and 12 months.

**Results** 119 children, aged 5 to 16 years, with symptomatic hypermobility were randomised to receive targeted multidisciplinary intervention (I) (n = 59) or standard management (S) (n = 60). Of these, 105 were followed to 12-months. There was a significant improvement in child and parent reported pain, coordination and strength. However, no added benefit could be shown from the intervention (Table 1). The number of CYP showing significant pain reduction ( $\geq 40\%$ ) was 27 (50.0%) (I) vs 21 (41.1%) (S). Those pain free at 12 months were 29 (56.9%) (I) vs 20 (45.5%) (S). The response was independent of the degree of hypermobility.

**Conclusions** This is the first RCT to compare a structured multidisciplinary intervention with standard care in symptomatic childhood hypermobility. The study demonstrates significant improvement among subjects but no additional benefit from targeted intervention. The findings emphasise the benefit of informed diagnosis and management according to clinical need, but highlight the difficulty in demonstrating subtle benefit from

specific interventions without better tools for case definition and outcomes assessment.

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**EPILEPSY12 – UNITED KINGDOM COLLABORATIVE CLINICAL AUDIT OF HEALTH CARE FOR CHILDREN AND YOUNG PEOPLE WITH SUSPECTED EPILEPTIC SEIZURES**

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**Objective** To assess changes between 2012 and 2014 in the quality of paediatric clinical and nursing care for UK children and young people affected with seizures and epilepsies.

**Methods** Epilepsy12, a UK wide audit, commenced in 2009 with the aim of evaluating epilepsy care against NICE and SIGN guidelines. All NHS hospital and community paediatric services managing children with epilepsy were invited to participate. National key recommendations and local action plans were made after Round 1. Round 2 was undertaken between 2013 and 2014 to assess changes since Round 1 and results are reported here.

Children referred for first EEG were used to find a new cohort of eligible children aged 1 month to 16 years receiving a first paediatric assessment between January and April 2013 for afebrile paroxysmal episodes. Retrospective case-note analysis was undertaken using a specifically designed web-based platform and audit pack. Service descriptor data were collected from secondary services on census day, 1 January 2014. Patient reported experience measure (PREM) questionnaires were collected from sequential children with epilepsy and their carers/parents attending clinics between February and March 2014.

**Abstract G282 Table 1** The rate of change in primary and secondary outcomes over 12 month follow-up period, this data includes analysis from multilevel modelling

Outcome variable	Baseline score	Rate of change over 12 months (95% CI)			
		Intervention group		Control group	
Child pain assessment (Wong-Baker Faces pain scale, 0-5, zero is the best) n=103. Median (IQR)	2 (1-3)	-1.42	(-1.78 to -1.06)	-1.31	(-1.75 to -0.85)
Parent observed pain assessment (0-100 VAS, zero is the best) n=105, mean (SD)	35.90 (26.46)	-6.09	(12.90 to 0.73)	-6.22	(-13.62 to 1.18)
Child health assessment questionnaire (CHAQ) (0-3, zero is the best) n=104, mean (SD)	0.82 (0.63)	+0.0	2 (-0.12 to 0.16)	-0.03	(-0.13 to 0.64)
Child health 9 dimensional utility (CHU9D) (0-1, zero is the worst) n=104, mean (SD)	0.85 (0.11)	+0.0	2 (-0.01 to 0.04)	+0.00	2 (-0.02 to 0.03)
Movement assessment battery for children (M-ABC) (0-100, zero is the worst) n =104, mean (SD)	34.56 (28.61)	+2.6	0 (-2.92 to 8.11)	+8.51	(3.17 to 13.86)
Grip Strength (Dynamometer) n= 104, mean (SD)	57.29 (28.30)	+4.5	5 (0.16 to 8.94)	+6.75	(2.85 to 10.66)