Participating countries were the UK, Germany, Switzerland, Australia and New Zealand. Infants were randomised to receive either hormonal therapy and vigabatrin or hormonal therapy alone. A second stage randomization allowed hormonal treatment to be allocated as either prednisolone or tetracosactide depot. Minimum doses were: vigabatrin 100 mg/kg/day, prednisolone 40 mg per day, or IM tetracosactide depot 0.5 mg on alternate days. Hormonal treatment was continued for 2 weeks and then weaned over 2 weeks. Vigabatrin was continued for 3 months and then weaned over a month. The early primary outcome measure was cessation of spasms on and between days 14 and 42. Analysis is by intention to treat. 377 children were enrolled and early clinical outcome data will be available on 376 (1 case withdrew). 186 were allocated hormonal therapy and vigabatrin and 191 were allocated hormonal therapy alone. We will report on the primary clinical outcome and serious adverse clinical events. Developmental outcome at 18 months of age will be reported in a subsequent paper. To date this is by far the largest treatment study of infantile spasms ever undertaken.

**G60** STARTING ANTI-EPILEPTIC MEDICATIONS BY NON SPECIALISTS: WHAT ARE THE HAZARDS?

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**Background**

Initial prescription of antiepileptic drugs (AEDs) for newly diagnosed epileptic children should be done by a specialist. However many new patients start their treatment by paediatrician without expertise in epilepsy.

**Aim**

To study the prescription of (AEDs) in children before they were referred to specialist (paediatric neurologist).

**Methods**

This was a prospective study. Six hundred children referred for the first time to the epilepsy clinic in a tertiary university hospital were recruited. Detailed (AEDs) history was retrieved from the parents in their first visit regarding the number of seizure after which they start treatment, AEDs prescribed at the beginning of diagnosis and in the following 12 months, if the drug has changed and the reasons. Patients were classified as truly epileptic and non epileptic after being reviewed by 2 neurologists.

**Results**

Truly epileptic patients represented 65% of the newly referred patients. Of those, 45% have started one or more of AEDs before referral. Thirty nine percent started after their first seizure. Monotherapy was initiated in 65% of epileptic patients. Sodium Valproate (65.1%) was the most frequently prescribed AED followed by Levetiracetam (41.0%) and topiramate (38.0%). The combination between Sodium valproate and Levetiracetam as a starting therapy was the most common. Twenty five percent of patients have changed the initial (AEDs) in the first 3 months of starting treatment. Worsening of seizures and non availability of the medication were the most common causes of changing (AEDs).

The non epileptic patients included diagnosis of: febrile seizures, breath holding attacks, pallid attacks and self stimulating. When offered to withdraw treatment after explanation of the condition by two neurologists, 28% refused to stop AEDs.

**Conclusion**

Starting AEDs by non specialist paediatrician has the hazards of wrong diagnosis, inappropriate starting and changing of AEDs.