Methods Outpatient clinic lists for consultant specialist in diagnosis and management of epilepsy were obtained for one year (April 2016 – May 2017) and outpatient letters were reviewed. All patients diagnosed with epilepsy within the last ten years were included. Patients diagnosed abroad or at another hospital were excluded.

Results A total of 119 patients were audited; 65 male and 54 female.

- Seen by specialist in the diagnosis and management of epilepsy within 2 weeks of presentation with a suspected seizure? Yes=33, No=86
- Investigations (MRI/EEG) undertaken within 4 weeks of request? Yes=66, No=53
- Children meeting criteria for neuroimaging have an MRI? Yes=69, No=4, N/A=46
- Agreed and comprehensive written epilepsy plan? Yes=116, No=3
- Patients seen by epilepsy specialist nurse? No=115, N/A=4
- Agreed written emergency care plan for prolonged/repeated seizures? Yes=14, No=63, N/A=42
- Seen within 4 weeks of referral to tertiary centre if required? Yes=6, No=17, N/A=96
- Structured review with paediatric epilepsy specialist minimum annually? Yes=107, No=1, N/A=11
- Agreed transition period where care reviewed jointly by adult and paediatric services? Yes=14, No=5, N/A=100

Conclusions The results highlight our patients are having comprehensive written care plans (97%), structured reviews annually (99%) and are reviewed jointly for transition (74%). Epilepsy service enhancement is needed in the time taken to be seen by the secondary care epilepsy specialist (28%) or tertiary centre (26%) once a referral is made. Investigation time waits could also be improved (55%). Quality of care could be enriched by employing an epilepsy nurse specialist. Numerous studies have demonstrated that inadequate epilepsy care results in significant consequence. It is imperative to implement NICE quality standards to provide better quality of care to children/young people diagnosed with epilepsy.

G311(P) ABSTRACT WITHDRAWN

G312(P) DMD AUDIT ABSTRACT FOR (P) PRESENTATION

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Objective Diagnosis and management of Duchenne muscular dystrophy: Use of published standards, to audit regional service.

Background In 2010 standards of care for diagnosis and management of Duchenne muscular dystrophy were published in *Lancet Neurology*.^{1,2} Our regional neuromuscular service was set up in 2013, largely supported and driven by these standards. We evaluated the service against these standards.

Methodology Retrospective audit looking at the management of 31 DMD patients. Data was collected by reviewing case notes over a period of 14 months.

Results All patients (n=31,100%) had genetic testing to confirm the diagnosis and received chicken pox vaccination or

had their immune status checked before starting steroids. 24 patients (80%) had attended specialist clinic appointment every 6 months. North Star Ambulatory assessment recommended every 6 months was done in 3 patients (20%). Annual serum Vitamin D level was done in 17 patients (58%). Annual DEXA scan for patients on chronic glucocorticoid therapy was done in 4 patients (14%). Spinal X-ray for patients with back pain or Kypho-scoliosis was done in 77% of the patients (n=10). 30 patients (97%) received Vitamin D supplements and 28 patients (93%) had echocardiograms done as per recommendation. 71% of the ambulatory patients (n=10) received the recommended respiratory assessments but none of the non-ambulatory patients received all the recommended respiratory assessments. 75% of non-ambulatory patients with poor lung function (n=3) received the recommended awake end tidal CO₂ level measured.

Conclusions Vital areas for improvement were identified and an action plan has been formulated. Main areas for improvement included availability of the neuromuscular physiotherapist to perform 6 monthly North Star ambulatory assessment and respiratory assessment, and improving access to DEXA scan. The latter involves training radiology staff to perform scans on children. The published standards have been very helpful in the development and subsequent evaluation of the regional muscle service.

REFERENCES

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G313(P) TIME TO ADOPT ADULT STROKE GUIDELINES FAST (FACE, ARMS, LEGS, TIME)

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A previously healthy 14-year-old female was unwell for a few days with vomiting associated with mild unilateral neck pain. Whilst on the phone, she developed left sided limb weakness, slurred speech and double vision over a matter of few minutes. She was transferred to Accident and Emergency (A and E) where she had ongoing focal neurology with a left side ataxic hemiparesis and a right internuclear ophthalmoplegia. Although she was in Paediatric age-group, there was a strong suspicion of a stroke and she underwent CT imaging which showed a normal brain parenchyma. However, CT angiogram confirmed a pseudo-aneurysm in the left vertebral artery suggestive of dissection and a filling defect at the tip of the basilar artery in keeping with occlusion (likely embolus). As she was within the 4.5 hour window for thrombolysis, she was treated with Alteplase, a tissue plasminogen activator (tPA) by the on-call stroke consultant and was started on high dose Aspirin before being transferred to a tertiary Paediatric Neurology centre for ongoing care. MRI scan later confirmed bilateral pontine infarcts. At follow-up, she has a minor left sided ataxia but otherwise has recovered well. This patient presented before the publication of recent RCPCH stroke guidelines but a pragmatic decision by the A and E team ensured appropriate acute treatment.