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G311(P) ABSTRACT WITHDRAWN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.

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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.

Childhood arterial ischaemic stroke is rare, with an incidence of 1.6 per 100,000.¹ As demonstrated in our patient, early recognition is key for thrombolysis to be effective. The publication of the Stroke in Childhood: Clinical guideline for diagnosis, management and rehabilitation (2017)² advocates the importance FAST (Face, Arms, Legs and Time) which has already proved to be successful for early diagnosis in adult patients. Effective collaboration with our adult counterparts is vital to share resources and implement guidance locally.

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G314(P) A RARE NEUROLOGICAL CAUSE OF LIMPING AND HIP DYSPLASIA

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Introduction Limping is a common presentation in children. It has many aetiologies, from trauma, infection, haematological conditions and malignancies. We would like to present a rare cause of limping. Syringomyelia describes a longitudinal fluid cavity of the spinal cord, whether a dilatation of the central canal or cavitation of the grey matter. There is a paucity of data, particularly of paediatric cases. Clinical manifestations depend on the location and size of the syrinx. They typically involve segmental signs, with wasting of the small muscles of the hand, sensory deficits and absence of tendon reflexes. It can also cause lower limb spasticity, and a loss of pain and temperature sensation.

Case report A previously fit and well 18 month girl was referred with a 3 month history of dragging the left foot and limping. The mother's pregnancy and child's neonatal period was uneventful. Her growth was between the 9th-25th centile, and developmental milestones were appropriate. She was passing urine normally, and was constipated for 4 months. On initial assessment she was noted to have birth marks on her lumbar spine. She had normal tone, power and reflexes in both lower and upper limbs. She had no wasting of the small muscles of the hands. Her left foot appeared to be larger than the right, and when walking she was dragging her left foot. At this point the parents were advised how to manage the constipation and the child was sent for physiotherapy, hip X-rays and MRI of the brain and spine. The hip X-ray showed mild loss of coverage of the left femoral head. The cranial MRI was normal. MRI without contrast showed a cystic abnormality in the conus medullaris most likely due to Syringomyelia; MRI contrast excluded spinal tumour. The radiologist felt the abnormal development of the left hip could be secondary to the syrinx, or evolution of developmental dysplasia.

Learning points/conclusion This case highlights the need for full examination, and appropriate investigation of the spine, hips, abdomen and lower limb from a musculoskeletal and neurological perspective.

G315(P) TREATMENT OF ANTICARDIOLIPIN ANTIBODY MEDIATED CHOREA IN AN ADOLESCENT MALE

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Background Anti-phospholipid antibody associated chorea is a rare cause of this movement disorder, with a higher incidence in females and children. Other causes include Wilson's disease, Sydenham's chorea and ataxia-telangiectasia. Aetiology is uncertain, but may involve anti-phospholipid mediated dysfunction of the basal ganglia. We report an unusual case of anticardiolipin antibody related chorea in an adolescent male presenting to secondary care services.

Case report Our patient is a 14 year old male who became unwell in December 2016 with gradual onset of uncontrolled movements in his arms, and behavioural changes. There was a notable history of minor head injury, preceding sore throat and recurrent tonsillitis. Over the next six months, he reported worsening of choreoathetoid movements affecting his gait and upper limb function.

He presented in April 2017 with acute slurring of speech three weeks after starting baclofen. He was then referred to tertiary paediatric neurology services. No features of Lupus were present on examination. His functioning was monitored after baclofen was stopped, and he progressed to treatment with high dose steroids, penicillin V and sodium valproate. He improved following significant rehabilitation with multidisciplinary involvement from occupational therapy, physiotherapy and the school team. His final diagnosis was revised to anticardiolipin antibody related chorea following results of immunological tests and consideration of the chronic progressive history. He was treated successfully with aspirin and mycophenolate mofetil, and has been discharged home with ongoing clinic review.

Results 12 lead ECG, echocardiogram and MRI brain normal.

ASO Titre: 400 units/ml (50–200)

Anti-DNAse B: 100 units/ml (<240 units/ml)

Anti-Mitochondrial Ab: positive

Anti-Nuclear Ab titre: 1:320 (Positive)

Anti-cardiolipin IgG Ab 1184.2 units/ml (0–19.9)

Anti-B2-GP-1 IgG 4269.7 units/ml (<20)

Conclusion As a patient's disease continues to evolve, so should our diagnostic approach. Atypical progression of disease should prompt review. Generally, treatment of anticardiolipin related chorea falls into 2 pathways; anticoagulation and immunosuppression, with evidence limited to case reports and small case series.

Acknowledgements to the local medical illustration team for performing serial videos showing improvement in function.

G316(P) COPY NUMBER VARIATION (CNV) IN A PATIENT WITH EPILEPSY AND HYPOTHYROIDISM: A RARE ASSOCIATION WITH RBFOX1 MICRODELETION

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