both increased odds of negative outcome. Buccal midazolam was used in the management of 28.9% of seizures and had no effect on the need for ventilatory support. The majority of seizures (69.8%) required admission to hospital and only 4.0% resulted in adverse outcome. Of 1228, there were 2 deaths (0.2%). Compared to symptomatic seizures, unprovoked seizures had a longer average duration, higher likelihood of negative outcomes and there was a higher proportion of those with other neurological diagnosis.

Conclusions Adverse outcomes have decreased and the use of buccal midazolam is promising. Identifying high-risk groups provides opportunity for early intervention. This data forms the basis for extensive evaluation of acute seizure management and monitoring long-term outcomes.

G43(P) IMPROVING ANTIMICROBIAL TREATMENT OF CHILDREN WITH SUSPECTED ENCEPHALITIS IN A TERTIARY PAEDIATRIC HOSPITAL

¹I Husain, ²D Lumsden. ¹GKT School of Medical Education, King's College London, London, UK; ²Paediatric Neurology, Evelina Children's Hospital, London, UK

10.1136/archdischild-2020-rcpch.30

Background/Aims Encephalitis is defined as 'inflammation of the brain parenchyma, manifest by neurologic dysfunction'. It is estimated that there are 2.8 cases per 100,000 children in the UK. Encephalitis can have devastating consequences and children who survive the illness can continue to experience physical, cognitive, mental and social difficulties. However, early appropriate treatment can dramatically improve outcomes. Trust antimicrobial guidelines advise giving 80 mg/kg intravenous ceftriaxone once daily, intravenous aciclovir (advised doses differ by age) and 7.5 mg/kg oral clarithromycin twice daily as empirical treatment in children aged over 1 month with suspected encephalitis.

The aim of this audit was to ascertain current management of children with suspected encephalitis in a tertiary paediatric hospital compared to local guidelines.

Methods Our sample included children aged between 28 days and 18 years old with a suspected diagnosis of encephalitis, who had received treatment at our centre over a six-month period. Children were identified from review of Pharmacy records of inpatient prescriptions for acyclovir and/or ceftriaxone. A standardised pro-forma was used to collect data on patient characteristics, investigations and management.

Results Twenty-five children were admitted to either the Paediatric Intensive Care Unit (PICU) or paediatric wards with suspected encephalitis within the six-month period. Two patients had to be excluded from the sample. Eight of the remaining twenty-three children had encephalitis treatment started at other district general hospitals prior to transfer. Only 6/23 (26.1%) patients fully received the recommended treatment

for suspected encephalitis. There were errors in prescribing of ceftriaxone, in 5/23 (21.7%) patients, aciclovir in 6/23 (26.1%) patients and clarithromycin in 14/23 (60.9%) patients. Table 1 shows an overview of the types of prescribing errors.

Conclusion Audit results identified that errors in antimicrobial prescriptions for children with suspected encephalitis were common, most frequently for macrolide therapy. We have instigated a poster to be displayed in ward areas, and a crib sheet for PICU and ward healthcare professionals, and plan to reaudit in the near future.

G44(P) SYDENHAM'S CHOREA: A FORGOTTEN ENTITY IN A MODERN WORLD

S Kurmani, A Neduvamkunil, M Prasad. *General Paediatrics, Queen's Medical Centre, Nottingham University Hospitals, Nottingham, UK*

10.1136/archdischild-2020-rcpch.31

Acute Rheumatic Fever (ARF) is a multi-system inflammatory disease which is a rare but serious complication of a Group A Streptococcus throat infection. Over the past 50 years, its incidence has fallen in developed countries due to improvements in medical care and standard of living, affecting less than 1 in 100,000 people in the UK. ARF is no longer a leading contributor to cardiovascular morbidity amongst children. Therefore, the clinical index of suspicion of ARF may be low amongst healthcare professionals, as its clinical features and symptoms may resemble those of more common conditions.

We present a case of a previously fit and well 13-year-old girl, with a history of behavioural changes, emotional lability and increasing restlessness. Initially, her symptoms were attributed to a behavioural or mental health disorder. Clinical examination demonstrated involuntary writhing movements, stereotypical of Sydenham's Chorea. Investigations included an MRI head, which showed no abnormalities, and an Antistreptolysin O titre of +400 units/ml. This revealed a diagnosis of ARF, as per the revised Jones Criteria. She was started on prophylactic penicillin V and carbamazepine. Our patient made an improvement during her admission and was discharged with Cardiology and Neurology input.

In this case, we show that diseases that are typically associated with the developing world can also present in the UK. We demonstrate the importance of recognising the neuropsychiatric symptomatology of ARF. This will aid early diagnosis and management, which can significantly reduce the risk of long-term sequelae.

G45(P) SEVERE NEUROLOGICAL IMPAIRMENT: TOWARDS AN INTERNATIONAL CONSENSUS-BASED DEFINITION

^{1,2,3}JA Allen, ^{1,2,3,4,5,6}EJ Molloy, ^{1,2,3}DM McDonald. ¹Department of Paediatrics, Children's Health Ireland at Tallaght, Dublin, Ireland; ²Discipline of Paediatrics, Trinity College Dublin, The University of Dublin, Dublin, Ireland; ³Trinity Research in Childhood Centre, Trinity College, The University of Dublin, Dublin, Ireland; ⁴Trinity Translational Medicine Institute, Trinity College, The University of Dublin, Dublin, Ireland; ⁵Neonatology, Coombe Women and Infants' University Hospital, Dublin, Ireland; ⁶Neonatology, Children's Health Ireland at Crumlin, Dublin, Ireland

10.1136/archdischild-2020-rcpch.32

Aims Following a thorough review of the literature, we have found significant inconsistency in the use of the term Severe

Abstract G43(P) Table 1 Types of prescribing errors for each medication

	Total number of prescribing errors	Not prescribed	Wrong dose
Ceftriaxone	5	2	3
Aciclovir	6	2	4
Clarithromycin	14	8	6