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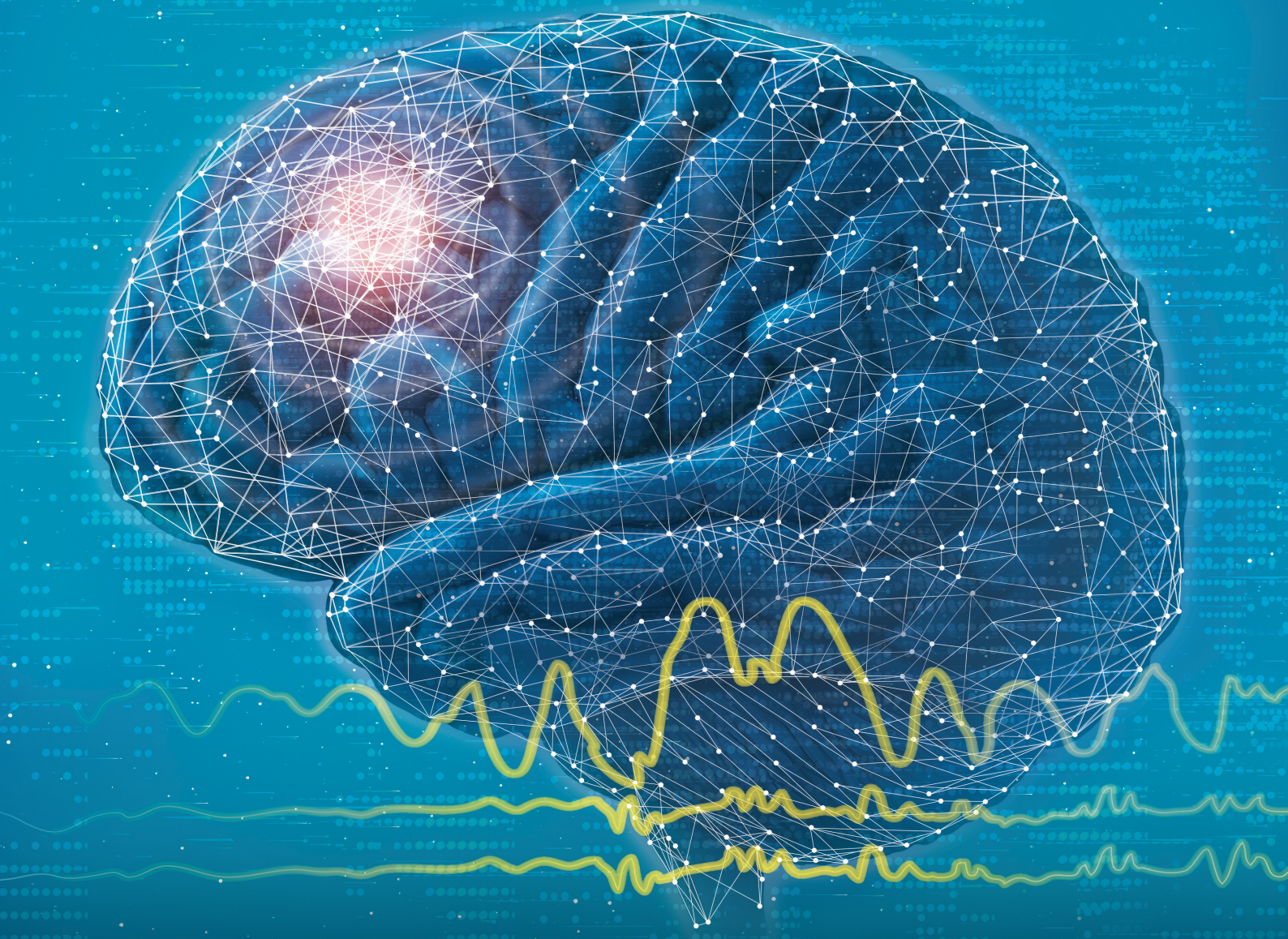

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SUPPLEMENT ARTICLES

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a parent, to attempt IV access, and to determine the type of seizure. About half of the nurses correctly defined the epileptic seizure type in the case report. The nurses responded to the medical therapy they applied in the EDs, according to the phases of seizure intervention. According to the responses; in the first-line therapy; rectal diazepam was applied after that IM midazolam, IV diazepam, and IV midazolam were applied. In the second-line therapy; IV diazepam was applied after that IM midazolam, IV phenobarbital, and rectal diazepam were applied.

Conclusion: As a result of this study, while some of the practices for the management of epileptic seizures are correct, there are also some wrong interventions of the nurses.

1270 | The virtual epilepsy specialist nurse in prison – a service evaluation project

M Esposito[1], L Bruce[1], R Murphy[1], M Pierri[1]
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Purpose: Many services needed to change the way health care was delivered due to the pandemic, this included the prison epilepsy clinic led by the epilepsy specialist nursing team. A service evaluation of the virtual service compared to a face to face clinic held in the prison's healthcare suite was carried out between 2020 -2023. Cardiff prison has capacity for up to 820 men aged 18 and above. People with epilepsy should have access to specialist care and support (NICE 2019, Welsh Government 2019). Quality statements support the well-being of prisoners and ensure safe and effective care (NICE 2017). Providing healthcare to people in prison has challenges and this was highlighted more so during the height of the pandemic. The prevalence of seizures and epilepsy in prison is four times higher than the general population, with lower engagement in healthcare (Marshall et al. 2001, Birmingham 2003). It is evident the prison patient population are one of the most vulnerable groups regarding healthcare.

Method: A retrospective evaluation of initial referral to time of review for face to face and virtual clinics and a retrospective review of attendance to the face to face and virtual clinic between 2020 -2023. Written feedback from prison officers, prison healthcare staff on the virtual clinic and use of the resources and feedback from the men using the clinic.

Results: Reduced waiting list times 9-42 days from referral to review by epilepsy specialist nurse compared to 3-6 months when the clinic was conducted in the prison. Improved attendance rate with the virtual clinic from 50% to 80% Positive feedback from healthcare staff and patients with a request to continue the virtual service despite the lifting and easing of restrictions.

Conclusion: Improved access to epilepsy specialist service. Reduced waiting times. Improved attendance rate. Efficient use of resources.

Paediatric Epileptology

725 | Comparison of clinical, electroentephalographic and tomographic data in children with controlled and non-controlled epilepsy

O Sukhonosova[1], T Litovchenko[1]
[1]*Kharkiv Medical Academy of Postgraduate Education, Department of Neurology and Child Neurology, Kharkiv, Ukraine*

Purpose: To analyze importance of etiology of neonatal seizures in formation of epilepsy in children of early age.

Method: There were 236 children at the age of 3 who suffered neonatal seizures under supervision. All patients underwent somatic and neurological examination, EEG, EEG video monitoring, MRI of the brain, laboratory methods with metabolic control, genetic testing and virological examination in the neonatal period and later

Results: During the survey etiological factors of neonatal seizures were determined: hypoxic-ischemic encephalopathy (47%), intracranial hemorrhage and vascular diseases (11%), prenatal infections (7%), postnatal neuroinfections (3%), metabolic electrolyte disorders (4%), developmental disorders (dysgenesis) (8%), facomatosis (2%), withdrawal syndrome (1%), congenital metabolic desorders (2%), chromosomal syndromes (1%), congenital tumors (1%), benign neonatal seizures (3%), somatic diseases (1%), postnatal trauma (1%), not specified (8%). According to the classification of etiology of epilepsy (32nd International Congress on Epilepsy, 2017) all patients were distributed as follows: structural -67%, genetic - 4%, infectious - 10%, metabolic - 4%, immunological - 1%, not specified - 8%, mixed - 6%. According to outcomes regarding the formation of epilepsy and neurological deficiency all children at the age of 3 were divided into 3 groups: (1) without seizures up to 3 years of age and without formation of a neurological deficiency (61%); (2) with formation of epilepsy, in which medication remission was achieved, and moderate neurological deficiency (16%); (3) with formation of drug-resistant epilepsy and severe neurological deficiency (23%).

Conclusion: Patients in the 1st group had neonatal seizures due to light hypoxic-ischemic encephalopathy, somatic diseases and transient metabolic disorders. In the 2nd group causes of neonatal seizures and further epilepsy

were moderate hypoxic-ischemic encephalopathy, postnatal neuroinfections and postnatal trauma. Patients with formation of drug-resistant epilepsy more often had severe hypoxic-ischemic encephalopathy, intracranial hemorrhage, congenital malformations, prenatal infections, congenital metabolic disorders, developmental disorders.

29 | The new ILAE definition of Lennox-Gastaut syndrome: practical implications and limitations

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Purpose: There are three major changes in the new definition of Lennox-Gastaut syndrome (LGS) compared with the traditional definition: (1) onset prior to 18 years, (2) must include tonic seizure, (3) generalized slow spike-waves (SSW) and (instead of or) generalized paroxysmal fast activity (GPFA) on electroencephalography (EEG). We investigated the practical implications and potential limitations of the new LGS definition based on a large cohort of patients in an exploratory study.
Method: This was a retrospective database study. All patients with an electro-clinical diagnosis of LGS (based on its traditional definition) at the outpatient epilepsy clinic at Shiraz University of Medical Sciences, Shiraz, Iran were included (from 2008 until 2020). Patients were reclassified based on the new definition of LGS.
Results: In total, 3737 patients were registered. Based on its traditional definition, 300 patients were diagnosed as having LGS. According to the new definition of LGS, only 96 patients (32% of the traditional cohort) had LGS. One patient had an age at onset of 21 years; 29 patients (9.7%) did not have SSW in their EEGs; 139 people (46.3%) did not have GPFA in their EEGs; and, 111 patients (37%) did not report having tonic seizures.
Conclusion: The new ILAE definition of LGS has some important practical implications and limitations. Before reinforcing and making this new definition compulsory in future research and clinical practice, more work is needed to enlighten various aspects of such changes in the definition of this epilepsy syndrome.

39 | Serial electroencephalographic findings before the onset of juvenile myoclonic epilepsy: a case series

J Tohyama[1,2], Y Kobayashi[1], A Hiraiwa[3,1], M Hojo[1]
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Purpose: We aimed to delineate the clinical and electroencephalographic transition in patients with juvenile myoclonic epilepsy who were followed-up long-term before onset of juvenile myoclonic epilepsy.
Method: We enrolled juvenile myoclonic epilepsy patients whose course of epilepsy had been observed for more than five years before the onset of juvenile myoclonic epilepsy, those who had undergone electroencephalogram recording more than twice before the onset of juvenile myoclonic epilepsy, and those who had terminated antiseizure medications for at least two years before the onset of juvenile myoclonic epilepsy. Patients who had transitioned from childhood absence epilepsy to juvenile myoclonic epilepsy were excluded. We retrospectively reviewed the medical records and neurophysiological data of the patients.
Results: Four patients met the inclusion criteria. One patient was diagnosed with febrile seizures during childhood, and the remaining three had transitioned to juvenile myoclonic epilepsy from other epileptic disorders, such as self-limited epilepsy with autonomic seizures, genetic epilepsy with febrile seizure plus, or non-specific genetic generalized epilepsy.All had generalized spike-wave discharges or photoparoxysmal responses for more than two years before onset of juvenile myoclonic epilepsy.
Conclusion: Generalized spike-waves on electroencephalogram during the course of any type of epilepsy or febrile seizure may be a risk factor for developing juvenile myoclonic epilepsy. When generalized spike-waves are present during childhood in individuals with febrile seizures or pediatric epilepsy, follow-up examinations and careful clinical interviews are crucial.

41 | Efficacy of steroids in seizure control and dipole stabilisation in drug resistant electrical status epilepticus in sleep due to structural cause

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Purpose: To devise objective measures to evaluate the role of steroids on dipole stabilisation and seizure control in Electrical Status Epilepticus in Sleep due to structural causes.
Method: 20 children aged 2-12 years with drug resistant epilepsy and ESES with Spike-wave index>50% and