

### G371(P) PRESENTING PHENOTYPE OF CROHN'S DISEASE (CD) IN CHILDREN 2010–13

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**Aims** There has been at least a two-fold increase in the incidence of paediatric-onset CD over the last 20 years; there are few recent reports of the presenting phenotype – symptoms, inflammatory markers and disease extent. We report the presenting features of a defined cohort and compare to previous data.

**Methods** Patients diagnosed with CD at University Hospitals Southampton from 2010–2013 were identified from an in-house database. Data were obtained from note review using a standardised proforma and compared to previous UK data.<sup>1</sup> Weight and height at diagnosis are presented as median SDS (95% CI).

**Results** 106 children were included. Median age 13.80 (Range 4.40–17.32 years), 79 male. The most common presenting features are seen in Table 1. The majority of patients presented with ileocolonic disease (51%) or isolated colonic disease (32%). Twenty-eight patients (26.4%) had perianal signs (5.7% abscesses/fistulae).

Inflammatory markers were raised at diagnosis—median CRP 18.0 mg/L (8.9–27.1), ESR 24.0 mm/hr (19.6–28.4); however normal inflammatory markers were frequently seen—normal CRP 26.4%, ESR 18.2%.

Weight SDS was  $-1.088$  ( $-1.35$  to  $-0.83$ ), 52% patients were below  $-1$  standard deviation (SD). Height SDS was  $-0.366$  ( $-0.60$  to  $-0.14$ ). 26.5% of patients were between  $-1$  and  $-2$  SD from the median and 4.8% were below  $-2$  SD.

Family history (3<sup>rd</sup> degree relative or closer) of IBD was seen in 27.6%.

**Abstract G371(P) Table 1** Comparison of data from Ashton (2015) with Sawczenko (2003)<sup>1</sup>

(Percentage with symptom at presentation)

|  | Sawczenko (UK) | Ashton (Wessex, Southern England) |
|--|----------------|-----------------------------------|
| No. patients                                       | 379            | 106                               |
| Abdominal Pain                                     | 72%            | 85.8%                             |
| Weight Loss  | 58%            | 55.7%                             |
| Diarrhoea  | 56%            | 78.3%                             |
| Triad of Abdominal Pain, Weight Loss and Diarrhoea | 25%            | 41.5%                             |
| Perianal signs                                     | 7%             | (5.7% abscess/fistula)            |
| Joint disease                                      | 7.4%           | 8.5%                              |
| Height SDS   | (Mean) $-1.06$ | $-0.366$ (Median)                 |
| Weight SDS   | (Mean) $-1.09$ | (Median)                          |

**Conclusion** Despite an increase in incidence of CD there does not appear to be an accrual of milder cases of disease. A significant number of patients will present with both normal growth and normal inflammatory markers.

#### REFERENCE

- 1 Sawczenko A. Presenting features of inflammatory bowel disease in Great Britain and Ireland. *Arch Dis Child*. 2003;88(11):995–1000

## British Paediatric Respiratory Society and Association for Paediatric Palliative Medicine and Paediatric Intensive Care Medicine

### G372 PROLONGED INVASIVE VENTILATION IN PAEDIATRIC INTENSIVE CARE: CHILDREN RESIDENT IN ENGLAND AND WALES, 2004–2013

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**Aims** To describe the characteristics of children resident in England and Wales admitted to a paediatric intensive care unit (PICU) who required prolonged invasive ventilation over the last decade and to compare their demographic and clinical characteristics to those who required a shorter period of invasive ventilation.

**Methods** Clinical and demographic information on all children resident in England and Wales admitted to a PICU were analysed. Prolonged invasive ventilation (PIV) was defined as receiving invasive ventilation for more than 21 days during a single admission via endotracheal tube or tracheostomy including jet or oscillatory ventilation. The cut-off of 21 days was chosen as it has been previously used in adult studies of prolonged ventilation during intensive care stay.

**Results** 99,818 of 147,709 admissions (67.6%) received invasive ventilation; of these 2,980 (3.0%) required PIV. As a percentage of all invasive ventilation, PIV has increased slightly over the previous decade from 3.1% in 2004 to 3.4% in 2013. PIV was most common in the under 1s (3.6%) and was similar in males (2.9%) and females (3.0%) (chi-squared  $p = 0.35$ ). Children receiving PIV account for over a quarter (26.5%) of all invasive ventilation bed days, median length of ventilation was 32 days (IQR: 26–48 days) and median length of stay was 37 days (IQR: 28–57) in those receiving PIV. Overall, those receiving PIV had a higher Paediatric Index of Mortality (PIM) score on admission (4.1% vs. 2.5% with a score  $>30$ %, chi-squared  $p < 0.01$ ) and an increased in-unit crude mortality (23.6% vs. 5.6%, chi-squared  $p < 0.01$ ). Multivariate logistic regression will be applied to examine whether the effect of demographic characteristics has changed over time.

**Conclusion** Children receiving PIV are only a small percentage of all admissions requiring invasive ventilation but account for over a quarter of all invasive ventilation bed days. A higher percentage of under 1s who receive invasive ventilation require PIV and it is associated with a higher in-unit mortality overall.

### G373 DIFFICULTIES WITH LIMITATION OF TREATMENT IN PAEDIATRIC INTENSIVE CARE – IMPROVING COMMUNICATION IN MULTI-PROFESSIONAL TEAMS

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End of life care in Paediatric Intensive Care Units (PICU) is a very difficult process for children, carers and healthcare professionals. Good decision-making and communication is essential. Though Trust DNAR forms are devised to be communication