participation. The information pack was introduced in 2010 which may explain why under half reported receiving it. Notably the majority of those that received it found it useful, suggesting that it is an important component of transition. The age that the topic of transition is introduced could be optimised and standardised, as it is widely thought that beginning the transition process early is an essential element for successful transfer to adult care.

G410(P) ARE ADOLESCENTS WITH SICKLE CELL DISEASE SATISFIED WITH THEIR OUT-PATIENT CLINIC EXPERIENCE?

[1]S Mohun Kemp, [2]H Sivaguru, [1]R Crowley, [1]DA Yardumian, [1]M Roberts-Harewood, [1]O Wilkey, [1]G Hann. *[1]North Middlesex University Hospital, London, UK; [2]University College London, London, UK*

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Aims Adolescents with chronic conditions can prove difficult to engage. Each clinical encounter must be maximised to provide a positive experience that encourages continued attendance and a collaborative relationship between doctor and patient. This project investigated the out-patient experience of adolescents with sickle cell disease.

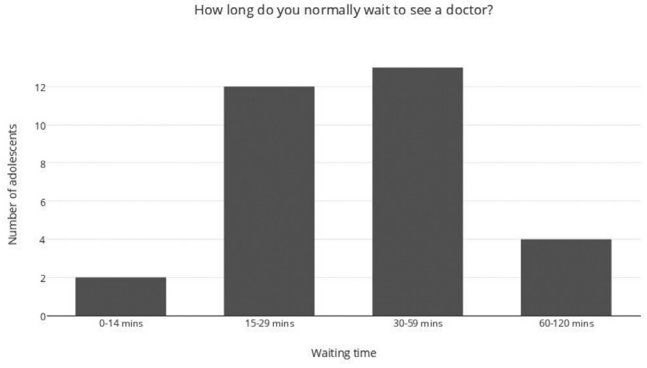
Methods A questionnaire comprising both qualitative and quantitative questions was distributed to patients aged 13 to 21 years who attended haematology clinics between January and April 2014.

Results 31 adolescent patients completed the questionnaire (response rate of 94%).

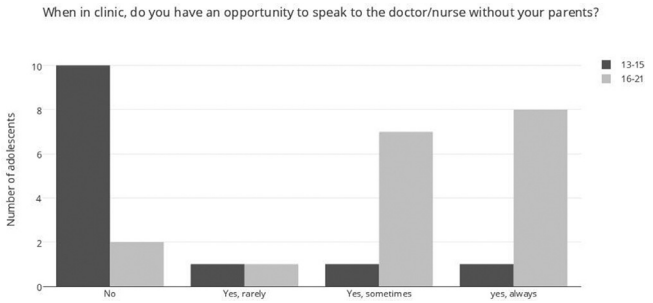
When asked to rate their out-patient experience, the mean score was 6.7/10. Qualitative questioning highlighted themes of dissatisfaction around long waiting times and lack of waiting room activities. There was a wide variation in reported waiting times (see Figure 1). There was a significant relationship between higher waiting times and lower overall out-patient experience score.

Positive comments were made about 'friendly and helpful' health professionals with a rating score of 8.1/10 for staff friendliness.

During the consultation the majority of patients felt they had enough time to discuss their concerns. Older patients were more likely to have the opportunity to speak to the doctor or nurse without a parent present (see Figure 2). Of those who did not have this opportunity, 23% stated they would like to talk to a doctor alone.



Abstract G410(P) Figure 1 Waiting times



Abstract G410(P) Figure 2 Discussion with doctor

Conclusion There is room to improve the out-patient clinic experience for patients with sickle cell disease. Specifically, reducing waiting times should be given priority. Both clinicians and patients need to arrive promptly to prevent a backlog delay. The clinic environment could be modified to provide a more comfortable and stimulating place for adolescents. Although financial and spatial constraints limit refurbishment, patient feedback suggests simple measures such as installing a water dispenser in the paediatric waiting room may improve patient satisfaction. Finally adolescent patients could be given more opportunity to speak to clinicians without a parent present and this could be introduced at a younger age. However, both our doctors and the adolescents themselves reported that there is often parental resistance to this, which needs to be overcome.

G411(P) A RARE CASE OF PRIMARY ANTIPHOSPHOLIPID SYNDROME

R Onita, C Reynolds, A Joshi. *Luton and Dunstable University Hospital, Luton, UK*

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Introduction Antiphopholipid syndrome (APS) is a systemic autoimmune condition characterised by venous or arterial thrombosis, hypercoagulability and pregnancy comorbidities in the presence of circulating antibodies directed against phospholipids. Cerebrovascular disease including sinus vein thrombosis and ischaemic stroke are the presenting features in approximately 30% of cases. Primary APS in the paediatic population is very rare with the exact incidence unknown. A significant number of cases of APS will be associated with autoimmune disease, particularly systemic lupus erythematosus. There are no studies on the management of paediatric APS, which makes the management of these children a challenge for the paediatrician

Case description A 2 year old girl, with no comorbidities presented to the local hospital with one episode of tonic-clonic seizure. Of note, is that for the previous days she became more lethargic, decreased appetite and decreased speech. She was developing normally and there was no family history of note. She had a full septic screen but this showed no evidence of acute infection. An MRI head showed left transverse sinus thrombosis with bilateral thalamic infarcts and right basal ganglia infarction. In view of these findings she had a full thrombophilia screen. The results showed evidence of APS with positive anti cardiolipin antibodies. There was no laboratory features of a secondary autoimmune disease, so a diagnosis of primary APS was made (ANA, ANCA, R. F., C3, C4, IG A, G, M-, Direct Antiglobulin test, PR3, MPO,-negative). She has been anticoagulated with warfarin but her ongoing management has been difficult.

Discussion Evidence for the treatment of APS is based on adult studies and the treatment itself comes with it's own

complications. Warfarin dosage is age and weight dependent, so needs to be carefully monitored to achieve the correct dosing. The 2 year old has experienced symptoms of transient ischaemic attacks with an INR of 1.8 and extensive bruising with an INR >2.7. There is also the psychological and emotional impact involved with the frequent hospital admissions and blood tests. This is all in addition to the impact of the neurodisability, which has resulted from the initial thrombotic insult.

G412(P) TO EVALUATE THE MANAGEMENT OF ACUTE PAINFUL CRISIS, OUTCOMES OF SAFETY AND EFFICACY OF CODEINE IN CHILDREN WITH SICKLE CELL DISEASE

[1]O Almossawi, [2]O Wilkey. [1]*Pharmacy, North Middlesex University Hospital NHS Trust, London, UK;* [2]*Paediatrics, North Middlesex University Hospital NHS Trust, London, UK*

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Method A retrospective audit was performed on all admissions with diagnosis of sickle cell pain from January to December 2013. Case notes of 54 patients were reviewed using pre-specified audit criteria. Types of analgesics administered at home and in hospital and pain scores were recorded where available from the case notes.

Results Over the one-year period, 91 admissions were recorded. The average age was 6.6 years (±4.1), with the majority of children (45%) aged between 1 and 5 years. The most prevalent haemoglobinopathy was HbSS (82%). The majority of patients (61%) had a single painful crisis admission, 33% had 2–3 admissions, and the remainder presented with four or more admissions.

Most patients (93%) received one or more analgesics prior to admission. The drug of choice varied, with paracetamol and ibuprofen been the most frequently utilised combination (43%), while 22% received opioids (20% had codeine). Similar to the pre-admission trends, a wide range of analgesics were utilised in hospital with the majority of patients receiving paracetamol and ibuprofen combination (43%). The doses utilised at home were considerably less than those given on admission, suggesting inadequate pain management at home. Codeine was given in 37% of the cases in and it was observed that patients who received codeine had significantly higher initial pain scores on admission compared with those who did not receive codeine. However the administration of codeine did not greatly improve the pain scores and additional step up analgesia was required in 10% of cases who received codeine in hospital.

Conclusion Clear analgesic benefits could not be demonstrated for codeine use with regards to the outcome of efficacy. Although dihydrocodeine is now the weak opioid of choice at our unit added safety measures similar to those with codeine are in place. The audit was limited by poor documentation which have been addressed by the introduction of clearer updated local documents.

G413(P) PROSPECTIVE STUDY OF PROCALCITONIN LEVELS IN CHILDREN WITH CANCER PRESENTING WITH FEBRILE NEUTROPENIA

[1]V Hemming, [2]B Phillips. [1]*General Paediatrics, Bradford Royal Infirmary, Bradford, UK;* [2]*Paediatric Oncology, Leeds General Infirmary, Leeds, UK*

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Febrile neutropenia is an important cause of morbidity and mortality in children receiving treatment for cancer. Although cases of severe infection need inpatient treatment with broad-spectrum antibiotics there are a number of children with non-severe infection who are over treated. Previous meta-analysis showed further research is needed into the use of biomarkers, such as procalcitonin, as part of risk prediction in febrile neutropenia. No previous studies have looked at the use of biomarkers as an addition to existing clinical decision rules. Procalcitonin is currently being reviewed by NICE as part of it's diagnostics assessment programme.

Aims To determine if procalcitonin can be used to diagnose or exclude severe infection on presentation with febrile neutropenia and if it has additional benefit when used with existing clinical decision rules.

Method This is a prospective cohort study of a diagnostic test. Patients between birth and 18 years old were who were admitted to the paediatric oncology and haematology wards with febrile neutropenia were included. Blood was taken for a procalcitonin level at admission as well as routine investigations.

Results Forty-one episodes were included from 26 patients. Procalcitonin level of >2 ng/dL has a likelihood ratio of 14.6 [95% CI 1.8, 120.4] and a sensitivity of 43% and specificity of 97%. For none of the clinical decision rules did the procalcitonin odds ratio reach significance although all of the odds ratios were over one.

Conclusion This study does not show a benefit in using procalcitonin in febrile neutropenia. The cut off of 2 ng/dL has a high likelihood ratio for severe infection but poor sensitivity. There is no significant additional benefit of procalcitonin when used with existing clinical and laboratory features in clinical decision rules.

G414(P) A RETROSPECTIVE ANALYSIS OF STEROID INDUCED BRADYCARDIA IN CHILDHOOD MALIGNANCY: CLINICAL RELEVANCE?

[1]N Canfield, [2]V Bharadwaj, [2]R Ramanujachar. [1]*Faculty of Medicine, University of Southampton, Southampton, UK;* [2]*Paediatric Haematology-Oncology, Southampton Children's Hospital, University Hopsital Southampton NHS Foundation Trust, Southampton, UK*

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Aims Determine incidence, clinical significance and management of steroid induced bardycardia in children undergoing cancer chemotherapy

Methodology Retrospective, observational, case note review of children treated at a tertiary paediatric oncology centre between 1st January 2013 and 1st September 2014 (21 months). Patients were subdivided into four groups based on steroid type, dose and indication.

- High dose dexamethasone (10 mg/m^2/day)
- Standard dose dexamethasone (6 mg/m^2/day)
- Non-Hodgkin Lymphoma prednisolone (60 mg/m^2/day)
- Other (variable dosing)

Simultaneous data collected on age, baseline heart rate (HR) at presentation, lowest HR on steroids, blood pressure (BP), ECG and intra-ocular pressure (IOP).

Statistics: P values calculated

Bradycardia of ≥30% was considered significant as it correlated with a Paediatric Early Warning Score (PEWS) of 2.