their patients' use of internet as part of routine history taking. Internet & ICT use is like the two faces of the coin, with both their positive or health threatening aspects. Among the positive features, one should cite an easy access to educational and health information, the promotion of socialization enhancing activities-including those directed at youngsters with chronic conditions -, opportunities for leisure activities which can be quite creative. Isolation, health symptoms, exposure to violence & pornography, incitement to delinquent behavior or self-harm all belong to the darker side of the coin. The assessment of internet use and of situations of problematic use of ICT should not be restricted to the number of hours spent on the computer but should also tackle the impact of the use on the adolescent's school and social life, as well as the nature of the relation between the young person and ICT: adolescents who use internet for social contacts, to build new worlds or to learn are much less at risk then those who are on line gamers or/and sensation seekers. The presentation will close with some universally exploitable advices for parents.

39 BINGE DRINKING: NOT AN INNOCENT PROBLEM

doi:10.1136/archdischild-2012-302724.0039

[1]J De Dooy, [2]G Van Hal, [3]G Van Laecke, [4]J Ramet. *[1]Paediatric Intensive Care, University of Antwerp, Antwerp University Hospital, Edegem; [2]Epidemiology and Social Medicine; [3]Faculty of Medicine, University of Antwerp, Antwerpen; [4]Paediatrics, University of Antwerp, Antwerp University Hospital, Edegem, Belgium*

More and more paediatricians are confronted with teen drinking and the problems that result from it. A new trend is the so called "binge-drinking". This means consumption of excessive amounts of alcohol in a very short period of time with the goal of getting drunk as fast as possible.

Within 1 hour after ingestion, alcohol is absorbed in the stomach and small intestine. Toxic effects of alcohol can occur from a plasma concentration of 0.5–1‰ (= 500–1000 mg/l) or an intake of 600 mg/kg alcohol. This is equal to ingestion of 120 ml liquor (alcohol concentration 30%) in an adolescent of 40kg. The effects are caused by a suppression of the central nervous system and they occur faster in younger people than in adults due to less extracellular volume. Also individual factors like gender, use of other medications or drugs and drinking habits play a role. All this factors can result in a broad spectrum of symptoms (relaxation, altered perception of the environment, prolonged reaction time, amnesia, nausea, vomiting and in more severe cases respiratory depression, coma and death).

When a child with possible alcohol intoxication is admitted to the emergency department, general "APLS" guidelines (Advanced Pediatric Life Support) should be followed.

After the "acute" event of the alcohol intoxication, multidisciplinary follow-up of the patient is very important.

In Belgium, no objective data exist on the problem of binge drinking whilst among paediatricians there is great concern about it. Therefore, we will conduct a national survey on this topic.

40 UPDATE ON TUBERCULOSIS FOR THE GENERAL PAEDIATRICIAN

doi:10.1136/archdischild-2012-302724.0040

MJ Mellado. *Pediatric Infectious and Tropical Diseases, Hospital Carlos III. Servicio de Pediatria, Madrid, Spain*

About one million of TB cases by year still occur in children. TB childhood diagnosis is an urgent task and even suspected TB disease should also be treated. Clinical features; thorax-x-ray; TST; smear/culture/PCR from gastric aspirated-induced sputum are diagnosis tools.

Children Key-recommendations:

1. Anti-TB drugs new doses in children, supported by pharmacokinetic (WHO):
   Isoniazid (H) 10 mg/kg (10–15) max. 300 mg/day
   Rifampicin (R) 15 (10–20) 600
   Pyrazinamide (Z) 35 (30–40) 2000
   Ethtambutol (E) 20 (15–25) 2500
2. All children have to be included in one of:

   Exposure or Latent-TB-infection, or TB disease; because need different management. Although children, usually not been infectious, family prophylaxis interrupts disease's dissemination.
3. TB management:
   1 **TB exposure:** H 2 months; repeat TST, if positive action as LTBI,
   2 **LTB infection:** H 6–9 months or HR 3 months,
   3 **TB disease:**

Children living in high-HIV-prevalence or high-H-resistance area, with pulmonary/lymphadenitis TB; or children with extensive pulmonary disease in low-HIV-prevalence o low-H-resistance area, should be treated: 2 months HRZE + 4 months HR. - In meningitis TB: 2HRZE + 10 HR. - HIV-negative children and low-HIV-prevalence and low-H-resistance area, could be treated: 2HRZ + 4HR. - Maintenance period: thrice-weekly regimens can be considered, only if well established Directly Observed Therapy. HIV-infected children or living in HIV-high-prevalence area should not be treated with intermittent regimens. - Streptomycin should not be used as a part of firs-line regimen in pulmonary/lymphadenitis TB. Children with TB-MDR should be treated: fluoroquinolones + aminoglucoside guide by an expert.

41 PEDIATRIC TUBERCULOSIS IN TWO TERTIARY HOSPITALS IN ROME: A 20-YEAR RETROSPECTIVE STUDY

doi:10.1136/archdischild-2012-302724.0041

[1]D Buonsenso, [2]L Lancella, [1]P Valentini. *[1]Catholic University of the Sacred Heart; [2]Bambino Gesù Children's Hospital, Rome, Italy*

Background and aims Tuberculosis is among the top 10 causes of child death worldwide. We aimed to describe epidemiological, clinical and microbiological features of patients with active tuberculosis admitted in two tertiary hospitals in Rome.

Methods Retrospective study of patients < 16-year-old evaluated between 1990 and 2009.

Results 214 cases of active tuberculosis were identified (132 definite, 82 probable). Pulmonary involvement was the most common form (75.5%), followed by lymphadenopathy (15.4%) and central nervous system tuberculosis (11%). Fever (51.86%) and cough (40%) were the most common presenting symptoms. 23.4% children were asymptomatic on admission. Sensitivities for Tuberculin Skin Test and Quantiferon test were 93.4% and 97% respectively. Both tests were performed in 52 children agreeing in 49 cases (94%). Sensitivities for culture, Ziehl-Neelsen staining and polymerase chain reaction were 58%, 25% and 66.3% respectively. The adult source case was identified in 28% cases. History of contact with a patient with active tuberculosis was associated with pulmonary tuberculosis (P=0.0014), while negative history of contact was associated with lymph nodal (P=0.0064) and central nervous system tuberculosis (P=0.05).

Conclusions Our study emphasize the difficulty in managing children with suspected tuberculosis, since the absence of constitutional symptoms cannot exclude tuberculosis and bacteriological confirmation is the exception. Immunological diagnosis can be valuable tool to identify tuberculosis infected children since quantiferon