

8.00) for RSV-negative compared to 9.76 days, 95%CI. I. (8.31–11.21) for other non-RSV. The p value was 0.723 when comparing the length of stay in infants who tested positive RSV to those tested negative RSV, while the p-value was (0.059) when comparing RSV-positive to other non-RSV viruses. There was a statistically significant difference in length of stay for RSV negative compared to other non-RSV viruses ( $p = 0.010$ ).

**Conclusions** Our data showed, there is no difference in length of stay in infants hospitalised with RSV-positive bronchiolitis compared to the group with RSV-negative; however the length of stay was statistically significant longer with Non-RSV viruses compared to RSV-negative infection.

#### PO-0012 MANAGING CHILDREN WITH PROTRACTED BACTERIAL BRONCHITIS

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10.1136/archdischild-2014-307384.692

**Introduction** It is important that health professionals consider a list of differential diagnoses when faced with a child with chronic cough (acute cough usually lasts less than three weeks). Potential causes include: asthma, cystic fibrosis, foreign body aspiration, anatomical abnormalities of the airways and other disorders.

Studies have shown that children with chronic wet cough often have bronchitis and this is evident on bronchoscopy. Protracted bacterial bronchitis (PBB) is defined as persistence of isolated wet cough lasting more than four weeks and responding to antibiotic treatment.

**Diagnosis** Clinical is achieved by presence of wet cough lasting >4 weeks. It is primarily a neutrophilic disease and presence of respiratory bacterial pathogens has been demonstrated in bronchoalveolar lavage. Prolonged course of oral antibiotics of 2–3 weeks is suggested as the initial therapy. Treatment is likely to result in symptom resolution and may minimise the risk of developing bronchiectasis. Chest X-ray may be performed in some cases and will be found to be normal in most instances. Sputum culture may also be sent in older children.

Diagnosis may be confirmed by bronchoscopy with BAL followed by bacterial study; however, such an invasive approach may not be deemed necessary or may not be readily available in most cases.

**Treatment** The British Thoracic Society (BTS) advises using four to six weeks of oral antibiotics.<sup>4</sup> In the absence of a bacterial culture a prolonged course of either amoxicillin or a macrolide antibiotic is suggested in most children with PBB.

#### PO-0013 THERAPEUTIC PRACTICE OF ACUTE RESPIRATORY INFECTIONS IN YOUNG CHILDREN

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10.1136/archdischild-2014-307384.693

**Background** In Moldova, acute respiratory infections (ARI) constitute 2/3 of infant morbidity and are in the top causes of mortality in last 20 years.

The aim of the study was to analyse the practical aspects of ARI treatment in young children in the light of national and international guidelines.

**Materials and methods** It was performed a retrospective study of 100 medical records of inpatients with IRA hospitalised in 2012. Mean age of patients was  $12.58 \pm 1.09$  months, including 66% of infants. Analysis included: clinical signs of disease onset, clinical outcome and cause of hospitalisation, laboratory tests, home and in hospital treatment, treatment compliance with guidelines.

**Results** The most common syndrome at admission was fever (36% patients), but antipyretics were administered at lower levels than considered febrile, contrary to international guidelines.

In 93% cases were given anti-viral drugs, mucolytics, topical treatment, in 45% cases – antibacterial treatment. The antibiotics used at home were not according to local protocols in 31% cases. The average length of home treatment was  $4.6 \pm 0.3$  days.

Serum levels of leukocytes ( $8.9 \pm 0.35 \times 10^9/l$ ) at admission were not suggestive of bacterial aetiology.

Antibacterial treatment was applied in all patients. Antibiotic was changed within the first 24 h in 35.3% of children, after 48 h of hospitalisation – in 14.7% children, and after 72 h or more – in 50% children. Unjustified polypharmacy was found in 51% cases.

**Conclusion** Antibacterial treatment of ARI is not always according national and international protocols, but there are divergences between national and international guidelines.

#### PO-0014 OTITIS MEDIA IN CHILDREN WITH RECURRENT SOMATIC PATHOLOGY

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10.1136/archdischild-2014-307384.694

**Background and aims** Subclinical evolution of otitis media (OM) in childhood predetermines late diagnostics and treatment, chronicity and complications. We compared incidence and clinic evolution of otitis media in children with recurrent somatic pathology and healthy children.

**Methods** We monitored middle ear status of children at the age between 1 and 7 years with recurrent respiratory pathology (Group R), recurrent gastrointestinal pathology (Group G), and healthy children (Group H) by tympanometry and otoscopy during 1 year. Complete audiological assessment and otomicroscopy were carried out in children who failed the screening tests during 3 months. Treatment approaches included medical and surgical methods and treatment of somatic pathology. Surgical findings in different groups were compared.

**Results** There were significant dependence of OM development and evolution from somatic pathology and age of children. OM chronicity rate was 35% in group R, 16% in group G and 4% in group H. Chronic and recurrent forms of OM correlated to respiratory tract infection-prone children, aged younger than 5 years of life. Chronic inflammatory changes of tympanic cavity were most evident in Group G.

**Conclusions** High rate of OM chronicity was predetermined by somatic pathology. These groups of patients needed comprehensive diagnostics and intensive treatment, including the surgical