

## Poster abstracts

Case4: A term newborn was appealed to our emergency service, with dyspnea and supraventricular tachycardia was diagnosed on 13th postnatal day. After intervention, multiorgan failure developed in our patient. At his postnatal day 27, vvHDF was performed. The patient died because of ventilator associated pneumonia.

**Conclusion** Continuous vvHDF application should be considered in the neonatal period, in cases where it is impossible to apply PD. Due to the technical difficulties in the neonatal period, such application is not common but it is also life saving.

### PO-0717 NEONATES WITH PARENTS WHO ARE CHILDREN: WHO CONSENTS?

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**Introduction** As neonates do not have capacity those with parental responsibility (PR) usually consent for medical interventions.<sup>1</sup> A recently delivered mother may be the only person with automatic PR, but might be unavailable in person, especially if the infant has been transferred to another hospital.

Whilst consent can be obtained through telephone<sup>2</sup> assessing capacity in this situation can be challenging, especially if the parent is under sixteen, and therefore lawfully a child themselves.

**Case presentation** A baby with bladder extrophy was delivered of a 15-year old undergoing treatment for aplastic anaemia. After transfer to the national urology unit the surgical team obtained consent by phone. On review there was rather limited exploration of mother's ability to understand suggested management and therefore consent.

**Discussion** Children are afforded the *right* to consent to medical treatment from 16-years.<sup>3</sup> Though in *Gillick v West Norfolk and Wisbech AHA*.<sup>4</sup> Fraser LJ outlined circumstances where even younger children might consent to oral contraception and Scarman LJ extended it to a general replacement of parental consent as children mature.

It is now accepted that children of any age can consent if they can demonstrate capacity. But, no child has yet been permitted by the Courts to decline medical treatment held to be in their best interests.<sup>5,6</sup>

We can find no recorded cases – e.g. Westlaw-UK – before UK Courts regarding child-parents consenting or refusing treatment for their own child.

Professionals consenting for neonatal interventions need to be aware of the law surrounding child-parents.<sup>7</sup>

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### PO-0718 TEMPERATURE MEASUREMENT DURING BODY-COOLING THERAPY IN NEWBORN BABIES WITH HYPOXIC-ISCHAEMIC ENCEPHALOPATHY

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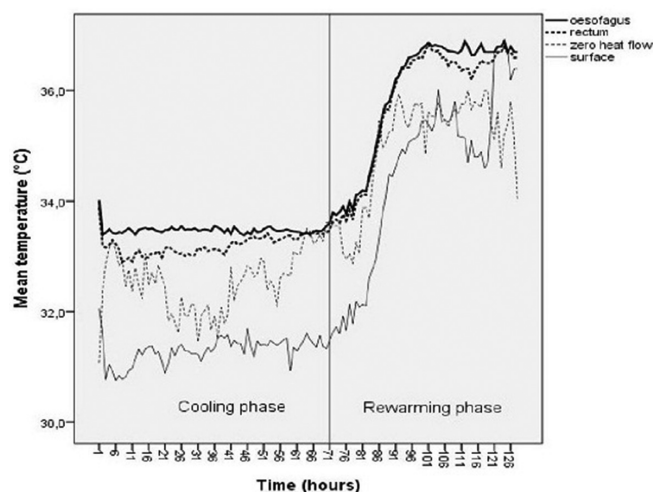
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**Background and aims** Temperature control during therapeutic hypothermia in newborns with hypoxic ischaemic encephalopathy needs to be monitored with great care since this treatment can cause serious side effects. The temperature measured in the pulmonary artery is considered the 'gold standard'; however, this is not suited to patients in the NICU. A reliable and less invasive method is the temperature measured in the oesophagus. **Aim** We hypothesised temperature measurements during hypothermia using an oesophageal probe reflects higher temperatures than measurements using a rectal probe.

**Methods** 20 newborns treated with hypothermia were provided with a continuous rectal temperature probe as well as an oesophageal temperature probe. Both measurements were registered over a period of 72 h of hypothermic therapy.

**Results** Linear multilevel regression analysis revealed significant associations between rectal and oesophageal temperatures. We recorded a mean difference per degree between rectal and oesophageal temperatures of 0.12°C. This difference is 0.17°C higher during the cooling phase when compared to the rewarming phase.

**Conclusion** The differences between oesophageal and rectal temperatures do not result in any clinical effects. Temperature control during hypothermia can be done with either an oesophageal probe or a rectal probe; however, in order to reduce the risk of inadequate cooling due to a defective or dislocated probe, it is safer to use both probes simultaneously.



**Abstract PO-0718 Figure 1** Oesophageal temperature, rectal temperature, surface temperature and zero heat flow temperature during 72 h of hypothermic treatment followed by the rewarming period



## PO-0717 Neonates With Parents Who Are Children: Who Consents?

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