

124 (95%) reported this as viral-induced, 25 (19%) had more than 3 attacks of wheeze, 31 (24%) were prescribed inhalers and 20 (15.4%) reported having disturbed sleep once or more nights per week. 156 (17%) infants required hospital admission in their first 6 months of life, with 36/938 (4%) requiring more than one admission. Of the children experiencing any hospital admission, 17% received oral antibiotics, while 24% received intravenous antibiotics. 646 (69%) infants had visited the GP at least once, of whom 93 (14%) received antibiotics for probable infections. 95% of the participants returning the 6-month questionnaire were fully immunised.

Conclusion Despite the possible bias of those returning questionnaires, our interim results indicate a high prevalence of infection and wheeze during the first 6 months of life in UK infants. Approximately 14% had experienced wheeze, 14% received oral antibiotics from the GP and 17% reported being admitted to hospital. We wish to further explore the association of genetic variations and their interactions in the context of childhood infections and atopy.

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G395(P) EXPERIENCES OF PATIENTS ON LONG TERM VENTILATION TRANSFERRING TO ADULT SERVICES

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Aims Medical advances mean that more children with serious illnesses are surviving into adulthood. Recent legislation and guidelines stress the importance of delivering improved joined-up services for children undergoing transition to adult services.^{1,2} A qualitative study was performed to explore the experiences of patients receiving long-term ventilation (LTV).

Methods Questionnaire-based telephone interviews were conducted with 21 patients (14 males, median age 26 years, range 14–57) on LTV or their carers. All had previously been within children's services and were now under adult respiratory care at a UK teaching hospital. The underlying causes for LTV included: Duchenne muscular dystrophy (9), other muscular dystrophies (6), congenital central hypoventilation syndrome (4) and other (2).

Results Thematic analysis of the data identified 3 main themes:

- Variability:** the age at which transition occurred varied (17–25), as did the option to attend combined clinics, which was only given to 3 of the 21 patients. There were discrepancies in the provision of community services, which was described as being “post-code dependent”.
- Unfamiliarity:** patients expressed concerns about the unfamiliarity of adult doctors with their background and condition, which was often interpreted as insensitivity or lack of knowledge. They expressed frustration at having to repeat their story to numerous health care professionals.
- Separation of services:** care under children's services was reported as being more holistic when compared with the single organ approach in adult services. However, the thoroughness of adult physicians in patient management was appreciated.

Conclusion Our study highlights the gap that needs to be bridged between children and adult services for patients on LTV. Early transition planning should occur to alleviate the unfamiliarity commonly experienced. This should include information

about adult care and the differences in service provision. The utilisation of health care passports can do much to avoid physician unfamiliarity with the patient's situation. These changes need to be uniformly adopted in order to improve patient satisfaction, care and long term outcome.

REFERENCES

- Care Act 2014
- Care Quality Commission. From the pond into the sea: Children's transition to adult healthcare services. June 2014

G396(P) IS INFANTILE LARYNGOMALACIA ASSOCIATED WITH EARLY ONSET ADENOTONSILLAR HYPERTROPHY: A RETROSPECTIVE PILOT STUDY

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Introduction Laryngomalacia has been associated with gastroesophageal reflux (GOR), which may cause adenotonsillar hypertrophy leading to early onset obstructive sleep apnoea (OSA). We aim to assess this proposed relationship, with adenoidectomy <4 years as our primary endpoint.

Method 78 children seen in the airway clinic at the Glasgow Royal Hospital for Sick Children during September 2009 to August 2010 with a diagnosis of infantile laryngomalacia and for whom four years of follow up data was available were included, and their medical notes analysed.

Results We found a significantly increased incidence of OSA in our cohort of 11.5%, compared to a reported population incidence of 0.7–1.8% ($p = < 0.0001$). The rate of adenoidectomy <4 years in this sample was 12.8%. We found that children who undergo adenoidectomy are more than 4x likely to also undergo a supraglottoplasty procedure than those who do not, 70% vs. 16.2% ($p = 0.0008$). Significant increase in the presence of neurodisability in the group of children who underwent an adenoidectomy was also seen, 40% vs. 2.9% ($p = < 0.002$).

Conclusion Outcomes following adenoidectomy +/- tonsillectomy are suggestive of adenotonsillar hypertrophy being the leading cause of OSA. Our results also support an emerging link between GORD and OSA, as although there are a number of causes of adenotonsillar hypertrophy there was little evidence to suggest that any of these patients could have developed hypertrophy due to alternative mechanisms. Children with more severe laryngomalacia appear to be at higher risk of developing sleep disordered breathing symptoms, and subsequently requiring adenoidectomy.

G397(P) HYPOXIC CHALLENGE TESTING – WHICH CHILDREN ARE WE ASSESSING?

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Aim Hypoxic challenge testing (HCT) is the method used to assess whether a patient with stable respiratory disease requires in-flight oxygen. A national guideline, published by British Thoracic Society in 2011, makes recommendations on which children ought to undergo HCT prior to undertaking air travel. Identified are: infants under 1 year with neonatal history of