



Abstract G399(P) Figure 3 Mean pulse transit time arousals for each outcome category of sleep study (error bars show standard deviation)

between normal/borderline and abnormal oximetry categories ($p = < 0.005$ for both) and between normal (including primary snoring) and abnormal sleep study categories ($p = < 0.005$ for both). However, the trends are not discriminatory enough to be used as stand-alone measurements of degree of OSA as there is significant overlap between the categories (p values = > 0.05). **Conclusion** PTT is not sufficiently discriminatory if used in isolation for assessment of OSA in children, but is a useful addition when combined with pulse oximetry and other parameters.

REFERENCE

- 1 Katz ES, Lutz J, Black C, Marcus CL. Pulse transit time as a measure of arousal and respiratory effort in children with sleep-disordered breathing. *Pediatr Res*. 2003;53:580–588

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HOW USEFUL IS RECORDING PREFERRED PLACE OF END OF LIFE CARE AND PLACE OF DEATH AS OUTCOME MEASURE IN PAEDIATRIC PALLIATIVE CARE?

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Aims To evaluate the preferred place for end of life care and place of death as an outcome measure in paediatric palliative care

Methods Medical records of children dying under the care of the Paediatric Palliative Care team from January 2009 to December 2013 were audited.

Results 187 deaths were identified: mean 37.5 deaths per year. Deaths per year increased over the 5 year period ($p > 0.05$). 53% of deaths were in the 0–4 years age range and 5% were over 18 years. 58% of deaths were non oncology palliative care, 38% oncology palliative care and 5% oncology on active treatment. Oncology deaths on active treatment increased over the 5 year period ($p > 0.05$). Preferred place for end of life care was recorded in 77% children dying during palliative care. 57% oncology and 33% non oncology patients identified home as their preferred setting for end of life care. 25% non oncology and 12% oncology patients identified hospice as their preferred place of care. Increasing numbers of non oncology families chose

home and oncology families chose hospice over the 5 year period. Overall 92% children died in their preferred setting for end of life care. The number of rapid discharges required to achieve preferred place for end of life care increased ($p < 0.05$). Ten children did not die in the preferred setting for end of life care. In 3 cases the palliative care team was not aware that the patients had been admitted to hospital until after the child had died, three rapid discharges were abandoned due to rapid deterioration. Four children died suddenly. When statistics were broken down by quarter the small numbers of deaths overall resulted in large but not statistically significant swings in the percentage of children achieving death in the preferred setting for end of life care.

Conclusions Recording of preferred setting for end of life care and death in the setting of choice for end of life care is achievable. Small numbers of patients, result in large but not statistically significant swings by quarter. This measure is not appropriate for intervals of less than a year.

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LONGITUDINAL ASSESSMENT OF LUNG FUNCTION IN CHILDREN WITH SICKLE CELL DISEASE

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Aims To prospectively undertake longitudinal assessment of lung function in children with sickle cell disease (SCD) and similar aged and ethnic matched controls. Our aim was to test the hypotheses that lung function in SCD children, but not controls would deteriorate with increasing age and the rate of decline would be greater in younger children who are more likely to have suffered acute chest syndrome (ACS) episodes.