- Pseudochromhidrosis is the result of colourless perspiration that acquires colour when it reaches the skin and comes into contact with an external chromogen such as chromogenic bacteria (for example *Corynebacterium* species), fungi or dye from clothing.
- Pseudochromhidrosis can present with a variety of colours depending on the aetiology. Involvement of the face, palms, or neck is most frequently reported, although it can present anywhere on the body.

Case

- A fifteen year old boy with no significant past medical history was referred to CAU with three weeks of developing blue/grey patches intermittently on his skin.
- These episodes occurred daily with differing distributions, not coinciding with a particular time of day, nor a particular activity level.
- Examination revealed blue/grey patches on the patient's hands and elbows bilaterally.
- Thorough examinations, observations and haematological/biochemical investigations to identify a cause of presumed cyanosis were all normal.
- Bacterial and fungal cultures of the skin were negative.
- The affected areas were wiped with a damp cloth – there was evidence of blue/grey staining on the cloth following this.
- Given the patient was systemically well, the transient nature of episodes and being able to wipe the coloured fluid from the skin, a preliminary diagnosis of pseudochromhidrosis was made.
- Formal diagnosis has been challenging as the patient is reluctant to undergo further investigations, including skin biopsies. In the interim, he is using antiseptic skin scrubs to help control episodes.

Learning points

- There are no known causes or associations for (pseudo) chromhidrosis.
- Diagnosis of chromhidrosis is made through identifying lipofuscin granules in a skin biopsy. Pseudochromhidrosis is a clinical diagnosis based on exclusion of chromhidrosis.
- Evidence regarding optimal therapy is limited. Satisfactory management remains challenging.
- The prognosis is good if the extrinsic cause is identified and the inciting factor (such as chromogenic bacteria) is eliminated.
- Systemic and topical antibiotics, as well as topical antiseptic scrubs, are the mainstay of treatment for pseudochromhidrosis.
- There are no known medical sequelae other than social embarrassment and psychological stress.

G345(P) IDENTIFYING CHILDREN AT RISK OF SERIOUS BACTERIAL INFECTION IN THE EMERGENCY DEPARTMENT: RISK SCORES AND GUT FEELING

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Aims To assess the utility of a validated clinical risk score (Brent *et al.* 2012) to stratify febrile children presenting to the emergency department, as high or low risk of serious bacterial infection (SBI). To further assess clinician's gut feeling in identifying those children with SBI.

Methods A prospective cohort study of children aged <17 years presenting to a children's emergency department, with an actual or reported temperature >37.5°C and requiring blood tests as part of their medical management, were recruited between February 2014–January 2017. For each participant the validated clinical risk score was completed using triage and clinician documentation. Clinician's 'Gut feeling' was recorded prior to results review and management plan formation. SBI was defined according to criteria described by the original validation study. Final diagnoses were assigned as definite/probable bacterial or viral infection or indeterminate.

Results 200 children were recruited, 9 subsequently excluded, leaving 191 (median age 2.1 years (IQR 0.9–4.2) for analysis. 164 (85%) participants had scores ≤5 suggesting low risk of SBI. Of these 46/164 (29%) had SBI. 8 participants had high risk scores >8 suggestive of an SBI and of these only 4/8 (50%) had an SBI. Where clinician's gut feeling was recorded as 'No SBI', 49% (34/69) of children had a bacterial infection. Where clinician's gut feeling was recorded as 'not sure/possibly' for SBI, 21% (22/104) had bacterial infection. Analysis of blood markers revealed total WCC and neutrophil count were not useful discriminators of SBI (AUC WCC 0.6, neutrophils AUC 0.7.) CRP was significantly higher in the groups definite and probable bacterial infection [(AUC CRP 0.86 (p<0.0001)].

Conclusions The validated clinical risk score for SBI did not effectively 'rule out' or 'rule in' serious bacterial infection in this cohort. Clinician's gut feeling was not helpful in identifying definite bacterial or probable bacterial infection. As anticipated CRP was a useful indicator of bacterial infection but has limitations as it is used as part of the categorisation of serious bacterial infection.

G346(P) DRIVING UP STANDARDS AND MINIMISING RISK: RELIEVING THE BURDEN OF JAUNDICE MANAGEMENT IN THE EMERGENCY DEPARTMENT (ED)

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Background and aims Jaundice represents a significant burden on ED workload. Long waiting times for assessment and investigation can lead to delays in treatment and discharge.

Method The team used audit and DATIX reports to assess care of babies presenting to ED with jaundice. Quality improvement initiatives were implemented based upon results, and a reaudit assessed their impact.

Results A total of 272 cases presenting in the year 2016 were analysed. Areas for improvement were found to be; time to serum bilirubin result (mean 168 min, range 28–508 min) and time spent in department (mean 245 min, range 37–716). Causes of delay included prolonged waits for medical assessment and laboratory delays in sample analysis. The DATIX system identified key cases where patient care was deemed to fall short of expected standards. Serious incident (SI) reporting identified cases where harm may have arisen.