Outcome Score (GOS). The head was the most severely injured body part in 75% of falls (15/20). Injury severity score was greater than 15 in 65% (13/20) indicating moderate to severe injury. Although data was not available for all children, it was noted that high falls occurred more often in the home than in public places (9 vs. 3 cases) and were onto concrete (14 cases). The two deaths were associated with falls from fourth and fifth floor windows.

Conclusions High falls from windows and balconies, although infrequent, do occur and are preventable. Boys and children under 5 are at highest risk. Education on fall prevention, and environmental modifications such as window guards and alteration of surfaces below windows and balconies may prevent death and serious injury in young children.

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G352(P) THE PREVALENCE OF BACTERAEMIA IN CHILDREN PRESENTING TO THE ED

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Aim To determine the point prevalence of bacteraemia in a large paediatric emergency department.

Methods From a database of all blood cultures taken from children in our institution in 2016, we identified those taken in the Paediatric Emergency Department. To manage the scope of enquiry and allow for seasonal variability all those taken in January and May 2016 had in depth analysis. Blood culture results and discharge summaries were reviewed using the hospital's internal systems.

Results In January and May 2016, there were 3310 and 3781 attendances at our Paediatric Emergency Department, respectively (7091 total).

203 (2.9%) children who were admitted through our emergency department in the 2 month period had a blood culture taken. 13 were positive, of which 10 were considered clinically insignificant contaminants (predominantly coagulase-negative Staph.). Of the true positives, 2 were Streptococci, the other was *Neisseria meningitidis*. Prevalence of confirmed bacteraemia (3/7091) was 0.04%.

100/203 (49.2) were discharged less than 48 hours after blood culture was taken. The most common discharge diagnosis was lower respiratory infection (56/203, 27.6%), followed by viral infection (31/203, 15.3%). 23/203 (11.3%) had a diagnosis of presumed or suspected sepsis.

Conclusions This point prevalence study confirms previous work that there is a low yield of positive blood cultures in Paediatric Emergency Departments. Extrapolation would suggest that there may be as few as 18 cases of confirmed bacteraemia presenting annually to a department seeing nearly 50 000 children. It is also impossible to ascertain with this methodology how many children were actually bacteraemic (i.e. high clinical suspicion but no isolated cultures) however it would suggest the incidence of sepsis is extremely low.

Whilst the low yield may cause to examine our use of blood cultures, in particular in lower respiratory infections, the fact that 49.2% were discharged in under 48 hours offers

encouragement that the practice of routinely waiting for negative blood cultures before stopping IV antibiotics is being phased out. Also the 11.3% positive rate (similar to positive CT findings in head injury) suggests sepsis recognition processes are effective despite increasing presentations.

G353(P) EVALUATION OF A PROCEDURAL SEDATION SERVICE USING KETAMINE (PSK) IN THE PAEDIATRIC EMERGENCY DEPARTMENT (PED)

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Background/aims Around 7500 children with injuries present yearly to our PED, many necessitating a general anaesthetic for repair. PSK is safe and efficient for facilitating management of painful procedures. Patients are selected according to our protocol for procedures predicted to last ≤ 20 min. The service runs during PEM consultant supervised hours (80% of the time during a week). Trainees receive direct supervision in delivering PSK on three occasions before completing a work based assessment to practice independently. Our primary aims were to evaluate safety, efficacy and patient satisfaction of PSK. Our secondary aim was to evaluate cost savings.

Methods Data were collected between May and July 2017 on all procedures performed using PSK using an Electronic Patient Record. Patients were followed up by telephone using a validated survey to assess satisfaction. The financial cost of each procedures, PED and theatre times were obtained from our hospital finance department.

Findings Overall 12 procedures were performed (4 laceration repairs, 7 fracture manipulations and 1 hernia reduction). All procedures were successfully completed. 10 cases were discharged home, while 1 forearm fracture successfully manipulated and casted required admission for close observation and the emergency inguinal hernia reduction required definitive management. There were no significant adverse effects noted. Average procedure time was 18 min (CI: 14 to 23 min; $p=0.05$) and the average recovery time was 64 min (CI: 50 to 79 min; $p=0.05$). Average total time in department was 314 min (CI: 270 to 358 min; $p=0.05$) with 10 cases exceeding 4 hours in the department. The trust saved as much as £1470/patient for orthopaedic MUAs. Average parent satisfaction score overall was 9.2/10.

Conclusion PSK in the PED is a safe, cost effective service which benefits the patient by avoiding fasting periods, delays in injury management and general anaesthesia. PSK has high patient satisfaction. It is efficient in facilitating procedures, has a short recovery although efficiency in timing of patient selection could be improved to potentially avoid 4 hour breaches. There is still potential to expand the service activity, especially with regards to management of lacerations.

G354(P) ARE UNNECESSARY FLUID CHALLENGES SLOWING THE FLOW OF A&E DEPARTMENTS?

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Aims Fluid challenges are a common tool used in A and E to aid decision-making. As they can often prove time-consuming, we aimed to assess whether they impacted on the 4 hour breach target at a busy district general hospital (DGH) paediatric A and E, and whether their use was always indicated.

Methods We analysed all 4 hour breaches at a busy DGH paediatric A and E over a 24 day period in December 2016. We attempted to identify those breaches which followed an oral fluid challenge initiated by medical staff and documented in the A and E notes. We then assessed whether this cohort of patients showed the following objective signs of dehydration on presentation (from NICE guidelines): tachycardia, tachypnea, decreased skin turgor and decreased urine output. We conducted a literature search to identify evidence supporting the use of fluid challenges.

Results Of 294 breaches, 36 (12.1%) cases involved fluid challenges. Of these, 86% were discharged home.

Half of the children who breached awaiting completion of a fluid challenge had no objective signs of dehydration recorded on presentation. A further third recorded only tachycardia, although many of these were febrile.

Of those with no recorded signs of dehydration, 11% were admitted to the paediatric assessment unit for ongoing observation.

Of the 5 patients admitted, two had 2 or more signs of dehydration whilst 2 exhibited no characteristic symptoms.

Our literature search revealed no high quality evidence for the use of fluid challenges as a reliable diagnostic aid.

Conclusion Fluid challenges were implicated in a significant proportion of all paediatric breaches, half of which recorded no core objective signs of dehydration on presentation. We would therefore suggest this cohort did not require a fluid challenge yet accounted for over 6% of all departmental breaches. No strong evidence supports their use.

We advocate a more judicious use of fluid challenges limited to the small proportion of children showing objective signs of mild or moderate dehydration at presentation where their use may provide greater decision-making power. This may help reduce breaches at the busiest time of year.

A larger scale study would provide with more information to further our conclusions.

We evaluated whether our patients with BNHL with residual radiological abnormalities received follow-up imaging and biopsies, and how these investigations affected clinical outcomes.

Design/methods Data was collected for all children diagnosed with BNHL between 2006–2017 at a UK tertiary paediatric oncology centre. Measures included patient age at diagnosis, gender, histology, MYC status, and bone marrow or CNS involvement. Chemotherapy courses were recorded, including escalation of treatment from Group B to C. Follow-up imaging and clinic letters were analysed, with residual disease being categorised according to formal radiology reports.

Results 66 children aged 1 to 11 years were diagnosed with BNHL in the period studied; 57 males (86%) and 9 females (14%). 14 children had bone marrow positivity (21%), and 8 children CNS positivity (12%). 41 children (62%) had MYC positivity.

At end of treatment, 28 children (42%) did have abnormal radiological findings; 4 of them underwent biopsy to exclude active disease. None of the children undergoing follow up imaging demonstrated disease relapse. Some children received multiple repeat scans involving either significant radiation exposure or general anaesthetic risk without altering outcomes. Overall survival was 94% (n=62), with 4 deaths.

Of 4 deaths:

- 2 had good COP response on initial imaging but relapsed on treatment,
- 1 had stable residual disease on scans but died of secondary AML post BMT
- 1 did not respond to chemotherapy with clear progression of disease on imaging and palliation.

Conclusions Children with BNHL have good outcomes with intensive chemotherapy treatment. None of our patients with residual imaging abnormalities at treatment completion had disease relapse or progression, questioning the clinical need for longterm imaging, particularly if involving radiation. Biopsy provided reassurance without altering patient management. A protocol addition should be developed to guide follow up imaging where residual imaging abnormalities exist at end of treatment.

British Society for Haematology and Children's Cancer and Leukaemia Group

G355 TO IMAGE OR NOT TO IMAGE? B CELL NON-HODGKINS LYMPHOMA (BNHL) AND RESIDUAL TISSUE ON SCAN AT DISEASE REASSESSMENT IN CHILDREN UNDER 12

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Background/objectives Children with BNHL have good outcomes with intensive upfront chemotherapy. Disease relapse or progression, whilst rare, is associated with very poor outcome hence the proven need for early disease assessment and escalation of chemotherapy if lacking a radiological early-treatment response. The value of post-treatment imaging surveillance or biopsy in children with residual imaging abnormalities in detecting and preventing disease relapse/progression is unclear.

G356 DECISION MAKING MANAGEMENT GUIDELINE FOR PATIENTS (<19 Y) WITH IDIOPATHIC THICKENED PITUITARY STALK AND/OR IDIOPATHIC CENTRAL DIABETES INSIPIDUS

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Aim To develop a guideline for the investigation and management of children and young people up to the age of 19 years with idiopathic thickened pituitary stalk (iTPS) and/or central diabetes insipidus (iCDI) where the aetiology is not apparent at presentation.

Methods The guideline development group (GDG) identified the objectives and the clinical questions which needed to be addressed. These were reviewed by guideline stakeholders and