encouraging families to consider a biopsy in asymptomatic patients. However, there are many occasions when serological tests have been omitted by clinicians, probably due to a lack of awareness.

Improvements are needed to reduce the length of time from diagnosis to dietician follow up, and follow up at 12 months needs to include repeat tTG assessment.

Finally, increased awareness is needed on the national policy to transition celiac patients to adult secondary care.

G44(P) BIOELECTRIC IMPEDANCE VECTOR ANALYSIS (BIVA) AND CLINICAL OUTCOME IN HOSPITALISED CHILDREN

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Aims Bioelectric impedance analysis (BIA) is a widely used, simple bedside technique, but clinical use is limited by the need to convert raw measurements to body composition, using equations that are potentially inappropriate. The use of the raw bioelectric impedance vectors (BIV), resistance (R), reactance (Xc) and phase angle (PA) – suggested to indicate body fluid, cell mass and cell health respectively – may be an alternative for monitoring disease progression/treatment. However, clinical experience of BIV in children is limited and previous studies have not standardised for age. We investigated predictors of BIV and their ability to predict clinical outcomes in children with complex diagnoses admitted to a children's hospital.

Methods R, Xc and PA were measured using BODYSTAT Quadscan 4000 on admission in 70 children aged 4.6–16.8 years (mean 10.0). R and Xc were indexed by height (H) and BIVSDS generated for age and sex using data from healthy children. Potential predictors (activity, wheelchair use, steroid treatment, enteral/parenteral nutrition) and clinical outcomes (greater-than-expected length-of-stay (LOS), complications (unplanned transfer to ICU, increased artificial nutrition, infection requiring antibiotics)) were recorded at discharge.

Results Mean R/HSDS was significantly higher (0.99 (SD 1.32)) and PASDS significantly lower (−1.22 (1.51)) than the population mean, with a wide range for all BIVSDS. No significant predictors of BIVSDS were identified. BIVSDS were not significantly different in patients with or without adverse outcomes although R/HSDS was higher in children with increased LOS (mean difference mean difference 0.42 (95% CI=−0.26 to −1.11) or complications (mean difference 0.49 (95% CI −0.34 to 1.33)).

Conclusion This group of complex patients had abnormal mean BIVSDS suggestive of reduced hydration and poor cell health. However, factors considered as clinical predictors showed no significant association, and BIVSDS were not significantly related to clinical outcomes; possibly reflecting the necessary use of generic predictors and outcomes in this heterogeneous population. Children with adverse outcomes showed a trend towards higher R/HSDS, suggesting lower hydration. Further investigation in specific patient groups, including those

with acute fluid shifts and using disease-specific outcomes, may help to better define the clinical role of BIV.

G45(P) AN AUDIT OF WEANING PREMATURE INFANTS AT CORRECTED AGE AND ASSOCIATED ORAL FEEDING OUTCOMES

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Aim To assess feeding outcomes when weaning infants born <32 weeks gestation at 4–6 months corrected age (CGA).

Background There is limited evidence to support weaning pre-term infants at 4–6 months CGA. Developmental Supportive Care is an integral part of treatment for premature infants at our site and we consider oral feeding to be a developmental skill. Our approach is to advise weaning at 4–6 months CGA, in line with other developmental skills. This is in contrast to the Consensus statement on weaning preterm infants produced in 2011. BLISS have recently (2017) updated their weaning guidelines and our audit provides evidence to support this. Our audit was carried out to ensure practice is associated with good oral feeding outcomes.

Method Data for 69 infants born <32 weeks gestation was collected using a specific proforma from August 2010 to October 2012, by a Speech and Language Therapist at developmental clinic.

Results 91% (63 infants) had not started weaning by 4 months CGA (i.e. by 17 weeks CGA). Of the 9% (6 infants) who had started weaning, median age was 14.5 weeks CGA (range: 13–16 weeks CGA). In the 63 infants weaned at CGA there were no reported problems in progression through textures up to 12 months CGA.

Conclusion In our cohort no increase in feeding related problems or aversions was identified in those weaned at 4–6 months CGA. We feel this supports our current weaning advice and highlights the importance of our Developmental Care programme. We acknowledge sample size is small and recognise that larger prospective data collection with a broader range of feeding related outcomes is required.

G46(P) OUTCOME OF CHILDREN WITH INFLAMMATORY BOWEL DISEASE AFTER SURGERY

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Aim To investigate the outcome after surgery in children with inflammatory bowel disease (IBD).

Method Case notes of patients who had surgery for IBD between November 1999 and January 2011 at a tertiary hospital in the UK were reviewed. Data related to relapses, acute readmissions, weights and heights one year before and up to a maximum of three years after surgery were collected. Mean Standard Deviation scores (SDS) were calculated for weights and heights. Outcomes were analysed using the paired t test.

Results 38 patients were eligible for the study. Of these case notes were available for 31 patients. 61% (n=19) had Crohn's Disease (CD) and 39% (n=12) had Ulcerative Colitis (UC).