G476(P) THE IGNORED PERVERSE FORM OF EMOTIONAL ABUSE: INTIMIDATING YOUNG CHILDREN FROM DOCTORS AND INJECTION

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Background Every child seems to have the normal level of fears towards certain subjects that started in early childhood and act as an assurance policy to protect the child from harm. Parents play the major role in reassuring their children and protecting them from fear and anxiety, on the other hand, they may behave to cause child fear by overprotection or sometimes by intimidating them to obey certain commands or to stop the annoying act. The acts of child intimidating behaviour by their parents constitute a pervasive and ignored form of emotional abuse. The aims of this study were to assess the psychological impact of the parenting trends towards intimidation of their children from doctors and injections and to assess its relation to some demographic variables (parenting relationship, parental ages, parental level of education, sex of the child, and if the child has chronic illness) and to the refusal of the medications.

Methods The study followed the descriptive analytical method and included the parents of 103 kindergarten children aged 3–6 years. Data collected using the scale of parenting trends in the period of September 2015 to January 2016.

Results Intimidating child from doctor and injections has a highly negative impact on the child psychologically. There are no significant differences in the degree of intimidation of the child from doctors and injections attributable to the parenting relationship (father, mother), the age of the parents, their educational level, the child sex, and the presence of chronic illness. 59% of the parents link between this trend and the child refusal of the medications.

Conclusions Intimidation of the children from doctor and injections has a highly negative impact on the children psychologically and may contribute to their refusal of medications. No significant differences attributable to the demographical variables.

G477(P) NON-BLANCHING RASH: THINKING OUTSIDE THE BOX

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An 11-year-old girl presented to the Paediatric department with a non-blanching rash, which was vasculitic in appearance and tender to touch, but not pruritic. The typical feature was hyperaesthesia, starting on her left forearm. The child was well and afebrile, with no history of: musculoskeletal problems; red eyes; mouth ulcers; trauma or insect bites. The girl lived with her parents and two siblings, and had neither a past medical history nor family history of vasculitis.

At initial presentation, the paediatrician corroborated the GP's working diagnosis of shingles with neuropathic pain; the patient was given an extended course of acyclovir, plus amitriptyline. During follow up, the patient reported improved pain, whilst the rash had completely subsided.

However, two weeks later, the girl returned with a similar painful rash. Upon dermatological review, she received IV

antibiotics for suspected chronic meningococemia. Over the next eight months, the rash waxed and waned, and often healed completely.

She received, at various stages, diagnoses of: shingles with neuropathic pain; chronic meningococemia; segmented pigmented dermatosis; cutaneous vasculitis; atypical Henoch-Schönlein purpura; and potential urticarial vasculitis.

Altogether, this patient had 13 paediatric outpatient appointments, one admission, two reviews in the acute paediatric unit and two tertiary dermatology referrals.

She had 29 blood tests, and numerous urine dipsticks. Her full blood count, coagulation screen, inflammatory markers and autoimmune screen were normal.

She received three courses of acyclovir, one course of antibiotics, regular analgesia, amitriptyline and six weeks of prednisolone.

She also had two skin biopsies, which reported an element of purpura without any vasculitis.

Given purpura without vasculitis, the revelation that our patient was a teenager going through a stressful period at school caused us to consider and discuss an exogenous cause (deliberate self-infliction). The rash's subsequent complete resolution within a few months strengthens this hypothesis.

Clinicians frequently care for children with complex or unconventional presentations. In an era of defensive medicine, we request a plethora of investigations and specialist opinions before diagnoses like self-inflicted injuries are considered. This case raises ethical questions about how far we should go in our pursuit of an intellectually satisfying definitive diagnosis.

G478(P) WE WANT EVERYTHING DONE

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Background Increasingly we are faced with some parents who want everything done for their babies in neonatal units although their neurodevelopmental outcome is likely to be extremely poor. This results in conflict with parents regarding the best interest of these babies and moral distress caused among the neonatal staff looking after them.

Case studies **Case A:** A 23 week infant who developed major parenchymal haemorrhagic infarct with midline shift and clinical seizures on day 3 of life. Parents were counselled of the very poor prognosis but declined re-orientation to palliative care. Baby never demonstrated a suck or gag reflex. Baby remained in low flow oxygen and required nasogastric feeds. Baby was eventually transferred to a paediatric ward and died following an aspiration episode.

Case B: A 24 week infant who became extremely sick before and following NEC surgery. We were never able to establish any enteral feeds. Despite multiple discussions with parents from neonatologists, paediatric surgeons and second opinion from another independent tertiary neonatologist, they refused re-orientation to palliative care. Baby subsequently died from multi-organ failure.

Case C: A 28 week infant with multi-organ failure and severe periventricular leukomalacia following a severe case of NEC requiring surgery. Despite seeking second opinions and multiple attempts at counselling parents, palliative care was declined. This case eventually went to court and the judgment