Case Report

G89(P) SINUSITIS: JUST ANOTHER CAUSE OF HEADACHE OR AN INNOCUOUS KILLER?

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A 13-year-old boy presented to A and E with left sided weakness, altered consciousness and right gaze deviation. His parents found him in on the morning of admission confused and aphasic. Over the preceding ten days, he had complained only of a headache with pain over the right eye but no other neurological symptoms. He had presented to the GP once prior to admission and was diagnosed with possible migraine. On examination, he was aphasic, confused with a GCS 11/15 and had left sided weakness. On initial presentation, he was afebrile with otherwise normal observations.

Investigations He had an urgent CT, which was reported as normal followed by an urgent MRI. MRI revealed right frontal subdural empyema with pneumatocoele and evidence of maxillary sinusitis. Blood investigations revealed a raised white cell count (20) with a neutrophilia (18) and raised CRP (217).

Treatment/outcome The patient received IV antibiotics, 3% saline and dexamethasone. Shortly after this, he was transferred to a neurosurgical unit and had an emergency right frontal craniotomy and drainage. Subsequently he required regular maxillary sinus washouts for four days. Bacterial culture revealed *Streptococcus milleri*. He received 6 weeks of IV antibiotics and has made a full neurological recovery. Repeat MRI reveals resolution of empyema and he has been discharged from secondary care.

Conclusions This case was chosen to highlight to paediatrician and primary care gives the potential serious sequelae of untreated sinusitis. Systematic review reports the morbidity rate as 27% and mortality rate was 3.3%.¹ Early aggressive medical, ENT and neurosurgical intervention has proven to improve neurological outcome.² Patients should also be evaluated from an immunological perspective, as serious sinogenic infections can be a sign of immunodeficiency.

REFERENCES

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G90(P) I'M SORRY, BUT WE HAVE JUST GIVEN YOUR CHILD THE WRONG MEDICINE

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Background Children are more at risk of medication errors than adults. Predisposing factors include: dosing by weight/age; multitude of dose strengths available; use of off license prescribing. The GMC and BMA encourage open, honest admission to families when errors occur.

Aims To evaluate families views on how they would like to be informed about medication errors.

Methods We devised a parental questionnaire asking if their child used medication and if they had experienced an error. Three scenarios for medication errors with; no/low/significant harm were presented along with 4 options as to how to be told:

1. Tell them over the phone immediately
2. If we can't contact them, leave an answer phone message that there is a problem
3. Tell them face to face when they return
4. Wouldn't want to be informed

Their preference for who would inform them was sought. Parents of any children attending/resident in hospital were eligible.

Results We asked 100 parents: 85 mothers and 15 fathers; 52 inpatients and 48 outpatients. 53% of the children were taking regular medications and 7% had experienced a medication error.

Abstract G90(P) Table 1

Informed by:	Scenario		
	No harm	Low harm	Significant harm
Phone	39%	69%	82%
Leave answer-phone message	6%	6%	8%
Face to face	49%	25%	10%
Not informed	6%	0	0

Parents preferred to be told by: a doctor 54%, nurse 10%, either doctor or nurse 32% and 4% did not mind. Several specified that this would depend on the severity of the error and who was most available.

Conclusions Most parents would like to be informed about a medication error by a doctor as soon as it is identified. If they are not present they would prefer to be contacted by telephone, although not via an answering machine message. Where no harm is expected, waiting until parents are present was generally acceptable to them (table 1). Trust between families and healthcare professionals is encouraged by honesty and openness. Best practice should be to provide information as soon as possible; however this may present logistical challenges to meet these expectations.

G91(P) PRESCRIBING IN OVERWEIGHT AND OBESE CHILDREN

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Aims Childhood obesity is a growing global health burden. Prescribing medications for this cohort has until now relied on empirical experience with no set guidelines to inform drug dose calculations. Standard body weight calculated dosages have led to suprathreshold doses commonly being prescribed. Recent research has highlighted the need for a new body weight adjusted approach to prescribing. This project aimed to evaluate whether these recent developments are being