Abstracts

Results Prevalence of CD in T1D children and young persons within our trust is 7.6%
All hospitals within the region used coeliac serology rather than HLA specific alleles for initial screening for CD
There is regional variation regarding the frequency of ongoing surveillance for CD reflecting a national and international lack of consensus.
HLA allele testing at diagnosis is significantly more expensive even though it reduces eventual number of surveillance serology testing.

Conclusion All hospitals within the region are compliant with guidelines regarding screening for CD in T1D in children and young people at diagnosis
Although none of the hospitals used HLA specific alleles as suggested by joint Coeliac UK and BSPGHAN,\(^3\) we felt this was not cost effective and would only reduce a small number of repeat testing
We propose a unified region wide ongoing surveillance of once every 3 to 4 years.

REFERENCES
2. NICE guideline [NG18] August 2015 [Last updated: November 2016]. Diabetes (type 1 and type 2) in children and young people: diagnosis and management.
4. European Society for Paediatric Gastroenterology, Hepatology, and Nutrition Guidelines for the Diagnosis of Coeliac Disease.
5. NASPGHAN Diagnosis and Treatment of Celiac Disease in Children.

G228(P) PAEDIATRIC TO YOUNG ADULT TRANSITION DIABETES SERVICE EVALUATION PROJECT
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Aims To explore any glycaemia changes from paediatric to young adult transition; non-attendances to young adult clinics and impact on diabetes related admissions.

Methods Data on adolescents with diabetes who went into young adult service from January to December 2016 was reviewed. Hba1c at the last paediatric clinic (PC), transition clinic (TC) and first young adult clinic (YAC) appointments were collected. Comparison between group means was done by ANOVA and paired t-test; the differences between frequencies/proportions by chi-square test and for statistical significance P value of<0.05 was used.

Results Demographics of the cohort (n=23): males 43%; Caucasian 100%. Age when diabetes diagnosed 8.0±4.5 years (mean ±sd). Age at last PC and the first YAC: 17±2.3 and 18±1.04 years respectively. Hba1c at PC correlated significantly with the Hba1c in the YAC (r=0.78, \(r^2=0.61\); p=0.001). Hba1c was higher at YAC compared to that at the last PC visit (88.4 vs. 79.4 mmol/mol; p=0.001) but not significantly different to that in TC.

Non-attendance rate in YAC was 56.5% and diabetes related admission (DKA, Hypoglycaemia) occurred in 30.4%. Hba1c at YAC was significantly higher in those hospitalised (113 vs. 76 mmol/mol; p=0.007). Comparing those with non-attendances vs. those who attended the YAC their Hba1c was 99.8 vs. 78.4 mmol/mol (p=0.13). There were no differences in the age, age diagnosed diabetes and BMI in those with or without admissions for diabetes and those with DNA compared to non-attendances. Non-attendances to the YAC had higher rates of admission (38.5% vs. 28.6%).

Discussion Non-attendance to young adult clinics is associated with higher rates of hospitalisations for diabetes related complications and possibly associated poor glycaemia. In the transition from paediatrics to young adult diabetes services and change in responsibility from parents to child, patients may struggle to deal with compliance and service attendance.