Elements of abdominal obesity noted in one patient. Facial features was represented flat nose, epicanthic folds, broad nose tip, long filtrum.

EEG was performed in 3 patients. Typical epileptiform activity was not registered. Two children had cardiac arrhythmias: recurrent ventricular tachycardia in one patient, recurrent ectopic atrial tachycardia, transient AV block- in another.

Conclusion Duplication 15q11.2 - q13 was diagnosed in 5 patients with behavioral problem. Two patients have cardiac arrhythmias.

P114 RECURRENT A&E ATTENDANCES? REMEMBER THE PSYCHOSOCIAL HISTORY

Emily Field-Lucas, Carl Leith-van Heyningen*. *Leicester Royal Infirmary, Leicester, UK*

10.1136/archdischild-2019-epa.469

In cases of recurrent hospital attendances it is important to stop and think. In cases of recurrent diabetic ketoacidosis it can be a matter of life and death as each subsequent episode is associated with a higher mortality. It is easy to be focused on managing the acute medical emergency but unless we broaden our horizon and consider the psychosocial aspects of our patients we will miss important risk factors for comorbid mental ill health. Here we present a case of diabulimia where the recognition of an eating disorder in the context of type 1 diabetes was the essential step in stopping a recurrent pattern of life threatening diabetic ketoacidosis.

P115 OVARIAN TORSION IN CHILDREN: CASE REPORT AND DISCUSSION

¹Andreea Stroeescu*, ¹Caoimhe Byrne, ¹Jennifer Hennebry, ¹Mark Bolger, ²Yusra Sheikh, ¹Julita Stepien. ¹University Hospital Waterford, Waterford, Ireland; ²Children's University Hospital, Temple Street, Dublin, Ireland

10.1136/archdischild-2019-epa.470

Ovarian torsion is an uncommon cause of acute abdominal pain in the paediatric population and extremely rare in early childhood. The presentation can be non-specific, mimicking other pathologies such as acute appendicitis, resulting in diagnostic delay. The aetiology, diagnosis and management can differ from those in adults. Misdiagnosis of adnexal torsion is not uncommon in children and may cause loss of the ovary or fallopian tube. In the case of acute abdominal pain, ultrasonography is usually the most routinely used diagnostic tool, alongside colour-Doppler for evaluation of blood circulation in the ovarian pedicle.

With the aid of a case report we will discuss the common presentation and examination findings of adnexal torsion along with the causes and risk factors. We will illustrate the normal adnexal anatomy and show the common imaging findings of ovarian torsion. Further imaging and management options will also be reviewed.

The literature has reported up to an 80–90% rate of ovarian salvage with early intervention. Early and accurate diagnosis of ovarian torsion and early intervention with restoration

in blood flow is imperative in avoiding irreversible damage to the ovary and long term fertility issues.

P116 EXPECTING THE UNEXPECTED: AN EPISODE OF PARADOXICAL SINUS BRADYCARDIA SECONDARY TO ATROPINE ADMINISTRATION IN A PRE-TERM NEONATE

¹Kate Skehin*, ²Bharathi Rao. ¹Royal Belfast Hospital for Sick Children, Belfast, UK; ²Royal Belfast Hospitals, Belfast, UK

10.1136/archdischild-2019-epa.471

Background We present the case of a preterm neonate who received two separate doses of Atropine (20 micrograms/kg, no minimum dosing) with subsequent unexpected episodes of bradycardia immediately post administration.

Case presentation A 34+1 male triplet, birth weight 1.8 kg, required intubation for surfactant administration at approximately 16 hours of life. The infant was being treated for RDS and early onset sepsis. No episodes of apnoea or bradycardia had been noted. As per local policy, doses of Atropine (20 micrograms/kg), Fentanyl (3 micrograms/kg) and Suxamethonium (2 mg/kg) were prepared and independently checked by an experienced neonatal nurse. Before anaesthesia, IV Atropine was administered via a peripheral IV line. Within 5 seconds of administration, the infant became bradycardic to a rate of 50bpm which was confirmed on auscultation. The infant also appeared apnoeic, unresponsive and mottled, requiring bag-mask ventilation until heart rate recovery at approximately 30 seconds. Intubation attempt was abandoned and the Consultant Neonatologist on-call was asked to attend. Once in attendance, the Consultant prepared for intubation and a further dose of IV Atropine (20 micrograms/kg) was administered. Again immediate bradycardia to <60bpm was observed. Intubation was attempted without use of anaesthetic drugs but was unsuccessful. The infant was subsequently intubated with Fentanyl and Suxamethonium, both having their expected sedative and paralysing effects. Surfactant was administered and the infant was managed on conventional ventilation until extubation the following morning.

Discussion Bradycardia is a relatively common occurrence during paediatric intubation. This is usually secondary to hypoxaemia, vagal stimulation during laryngoscopy or the pharmacologic effect of anaesthetic drugs. There is much debate regarding the use of prophylactic Atropine during the pre-medication routine to reduce the incidence of bradycardia or collapse. The evidence for its use is largely observational and somewhat conflicting. The American Heart Association's 2015 PALS Guideline update no longer supports the routine use of Atropine in the pre-intubation of critically ill infants though it may be considered as pre-medication in infants where there is a higher risk of bradycardia. Furthermore, if Atropine is being used, the previous recommendation of a minimum dose of 100 micrograms (largely based on the findings from Dauchet et al) to avoid paradoxical bradycardia is no longer observed. A dose of 20 micrograms/kg, as given to our patient, may be considered.

This case report illustrates the potential complication of paradoxical sinus bradycardia with low dose Atropine. European paediatricians should bear this unexpected complication in mind when deciding to administer this drug.