AN AUDIT TO CHECK THE AWARENESS AMONG NCHD ABOUT DOCUMENTATION OF CHILDHOOD DEVELOPMENT IN CLINIC LETTERS IN WEXFORD GENERAL HOSPITAL

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Introduction Development is the period of physical, cognitive and social growth that begins at birth and continues through childhood. Between 1–3% of children suffer from global delay. Maximum development occurs in the first two of years of life. Early recognition of developmental issues is important to have a better outcome, appropriate referral and involvement of other services.

Aim Aims of the audit is to see the awareness among NCHD (non consultant hospital doctors) towards development assessment and documentation in clinical letters of patients coming to clinic from Jan 2018 to July 2018.

Methodology Retrospective audit was done from January 2018 to July 2018.

A Proforma was designed and random clinic letters of patients attending paediatric clinic were screened for documentation of all six areas of childhood development (gross motor, fine motor vision, hearing, speech and language and social) seen by NCHD.

Results
1. Total 70 patients were included in the audit.
2. 45 male and 55 female patients.
3. Age range varies from 3 months to 13 years.
4. 35 (50%) of the patients were below 5 years of age.
5. Childhood development was mentioned in 30 (43%) of patients.
6. 40 (57%) patients have no records of being screened for appropriate age related developmental milestones.
7. Out of 70 only 6 patients (8%) have their proper documentation about the development indicating all six areas of development.
8. Regarding different areas of development documentation was as follows:

Gross motor 14 (20%) Fine motor 10 (14%) Vision 07 (10%)
Speech 12 (17%) Hearing 06 (08%) Social 11 (15%)

Conclusion Developmental assessment is a neglected area in general paediatrics clinic settings.

Outcome about the documentation of general paediatric development assessment was very poor as 57% of the patients have no records of any development assessment in clinic.

Recommendations
1. Awareness should be raised among NCHDs about the importance of developmental assessment in children coming to clinic.
2. A regular training session for new doctors about routine developmental screen at the start of rotation may be helpful.
3. There should be a brief developmental check list and clinic letter layout displayed in clinic area settings.
4. More opportunities should be given to NCHDs to attend developmental clinics.

IMPACT OF CHRONIC PAIN ON ADOLESCENTS’ SCHOOL FUNCTIONING: A SYSTEMATIC REVIEW

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Background Chronic pain that persists for more than three months and continues beyond the normal period of tissue healing is considered as a significant health problem among children. Chronic pain has a significant impact on children and adolescents’ daily activities. Importantly, school functioning including school attendance, academic achievement, perceptions of self and teacher towards academic competence, classroom attention, participation in school activities, and social functioning, appears to be influenced by paediatric chronic pain. It is therefore important to manage the pain of children and adolescents in the school settings in order to minimise impact on school functioning.

Objective This aim of this review was to critically synthesise current empirical studies on the impact of chronic pain on

Introduction
Partial trisomy 3p results from an unbalanced translocation or de novo duplication. Clinical features include of structural brain abnormalities, dysmorphic facies, congenital heart defects, learning disability and hypoplastic genitalia. We report the clinical manifestations of a case of partial trisomy 3p.

Case report
The female proband, now 3 years and 9 month old, was born to a 33 year old Caucasian mother with 2 neurodevelopmental normal male children. Intrauterine growth restriction and microcephaly identified antenatally prompted investigation. Fetal MRI at 21 weeks gestation demonstrated dilation of the occipital horn of the right lateral ventricle. Amniocentesis confirmed partial trisomy of chromosome 3

The infant was born at term with no resuscitation or respiratory support required. Echocardiogram revealed a secundum atrial septal defect, muscular ventricular septal defect and a restrictive patent ductus arteriosus. Neonatal MRI demonstrated several structural abnormalities:

1. A parieto-occipital encephalocele measuring 2 x 3.7 cm containing brain tissue and cerebrospinal fluid
2. Dilation of the occipital horn
3. Bilateral atresia of lateral ventricles
4. Areas of cortical malformation
5. An abnormal corpus callosum

Abdominal and hip ultrasound examination were normal. The encephalocele was successfully repaired in the neonatal period. Post operative recovery was complicated by development of hydrocephalus requiring a ventriculo-peritoneal shunt. At 10 and 18 months the patient had seizures related to intercurrent illness and fever. She has never had an afebrile seizure.

At present this child is 3 years 9 months with global developmentally delay in all domains. She can walk unaided but has difficulty running. She can use stairs with support but has not progressed to cycling a tricycle. She is visually impaired secondary to a cortical impairment, requiring corrective lenses. She has bilateral sensorineural hearing loss with a cochlear implant. E has remained medically well to this point and has avoided hospital admissions. She requires intensive multidisciplinary involvement by community allied health professionals including physiotherapy, speech and language therapy and occupational therapy. Her parents hope she will be able to access mainstream education with support.

Given the rarity of her condition with few reported cases in the medical literature, her long term developmental outcome remains unclear.

REFERENCES
1. Partial 3p trisomy and different rearrangements involving chromosome 3 in the proposita’s family, De Pinto Neto et al, American Journal of Medical Genetics, 1980

Background
An infant with hypotonia and dysmorphic features.

Case report
A pre term baby boy born to Irish traveller parents at 32 weeks gestation. Mom was Gravida 5 Para 4

Baby was born by Emergency LSCS because of premature rupture of membranes and absent liquor with birth weight of 2.19 kg. Baby required intubation and surfactant at admission for RDS. Baby was extubated next day. On examination baby was noticed to have depressed nasal bridge, hypertelorism, high forehead, bilateral reducible inguinal hernias, posterior plagiocephaly with hypotonia. A normal male genitalia with both testis in scrotum identified. Hypotonia persisted with poor feeding requiring NG feeds. X rays showed thoracic scoliosis with curvature convex to right along with hemivertebra T4-T9. Infant was also having left sided hydronephrosis with hydroureter and normal right kidney. He had normal newborn hearing screen. Ophthalmologic examination showed underdeveloped macula and hypoplasia of fovea. MRI examination showed evidence of Agenesis of corpus callosum. In view of multiple congenital anomalies microarray was requested that confirmed the diagnosis of 8p 23 deletion. There was no family history of note. Currently baby is 14 weeks old and still requiring nasogastric feeds.

Discussion
8p 23 deletion is a rare syndrome that was first described in 1976 by Weleber et al. It has an estimated prevalence rate of about 1:20000 newborns. Patients display moderate to severe developmental delay, characteristic facial features, congenital heart defects, hypotonia, skeletal abnormalities such as scoliosis and agenesis of the corpus callosum. Diagnosis is mainly dependant upon the severity of the signs and symptoms and its associated complications.