accepted in clinical practice is practically excluded. At the same time, it is necessary to take into account the anatomical and physiological characteristics of the child’s body and the psycho-emotional state of the children.

To assess the severity of the child’s condition prior to the development of classic clinical signs, damage qualimetry is recommended, which is essentially a quantitative characteristic of the injury shoginess. The scoring of polytrauma is defined as the sum of points of private injury. The real threat of traumatic shock arises when the severity of damage exceeds 6 points.

The standard for providing therapeutic measures in children with traumatic shock includes: Pain relief; Venous access; Infusion therapy; Transport immobilization; Medical correction; Oxygen therapy.

The system of rendering psychological and psychiatric assistance to children and adolescents allows rendering differentiated psychiatric and psychological assistance, as well as carrying out rehabilitation activities in a more remote period. The training of pediatricians in the field of disaster psychiatry should be considered the most important condition for the further improvement of the entire system of assistance to victims and those affected by emergencies.

**Conclusions** Genetic testing may be a useful aid in the diagnosis of inherited cranial diabetes insipidus. Since these patients have progressive loss of AVP, they may initially respond normally to water deprivation testing. If the index of suspicion remains high, genetic testing is recommended to guide treatment.

### **Abstracts**

**P284 A CASE OF FAMILIAL CRANIAL DIABETES INSIPIDUS – IT’S ALL IN THE HISTORY**

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**Aims** Cranial diabetes insipidus is characterised by polyuria and polydipsia secondary to partial or complete deficiency of antidiuretic hormone. Although in most patients non-hereditary causes underlie the disorder, rarer genetic defects in arginine vasopressin (AVP) synthesis have been identified. We describe the case of a 5 year old girl who posed a significant diagnostic challenge, with a suggestive history and strong family history of cranial diabetes insipidus, but non diagnostic biochemistry.

**Methods** Our patient was reassessed and AVP gene testing was performed.

**Results** A 5 year old girl, presented with a four year history of polyuria, polydipsia and associated enuresis. Family history was remarkable for suspected familial cranial diabetes insipidus responsive to desmopressin, in the patient’s mother, maternal uncle and maternal grandfather. Genetic testing had not previously been undertaken. Our patient had previously been investigated with water deprivation test at age 3 years and was found to have normal biochemistry, without polyuria during the test. She represented at the age of 5 years to our service with ongoing symptoms and underwent repeat water deprivation testing. Serum sodium and osmolality remained normal (max 140 mmol/l and 285 mmol/kg respectively) with water deprivation but she did not concentrate her urine (urine osmolality 222 mmol/kg at the end of water deprivation test). AVP gene testing was requested and identified a heterozygous pathogenic missense mutation c.61T>C, confirming a diagnosis of familial cranial diabetes insipidus. The same mutation was identified in the patient’s mother, suggesting autosomal dominant inheritance. She was commenced on desmopressin with excellent response.

**Conclusions** Genetic testing may be a useful aid in the diagnosis of inherited cranial diabetes insipidus. Since these patients have progressive loss of AVP, they may initially respond normally to water deprivation testing. If the index of suspicion remains high, genetic testing is recommended to guide treatment.