period. Timing of first full blood count, frequency of repeat full blood counts and the lab values were documented.

Results 42 babies with T21 were born from 2016–2018; 41 babies had a FBC within 5 days (see table 1).

Abstract P455 Table 1

Hb	WCC	Platelets
21.1 (16.9–25.8)	15.7 (9.3–24)	140 (34–271)

1/42 babies warranted an automatic referral to a tertiary haematologist because of significantly elevated blast cells on film (13%). Five other babies had evidence of blasts cells of 5% or less on their initial FBC with three of these babies having resolution of the blast cells to 0%. One baby was due follow up in a regional centre and one did not have a repeat FBC.

Conclusion The association of T21 with acute leukaemia is well documented. In keeping with international guidelines, our policy is to carry out a full blood count on all babies born with T21. We see that our incidence is less than the 10–15% reported case load of TAM¹ with only 1 baby reaching the criteria. This disorder develops over the first five years of life; meaning it is essential these children get annual blood tests for monitoring through their community paediatrician.

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MANAGEMENT OF CYSTIC LYMPHANGIOMAS IN THE NEWBORN: A STUDY OF 6 CASES

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Background Cystic lymphangiomas are rare congenital benign malformations of the lymphatic system. They are commonly located in the cervicofacial region. Clinical presentation depends on localization. Through this study we aim to identify epidemiology, clinical features, management and outcome of cystic lymphangiomas in the newborn.

Methods It's a retrospective study of all cases of cystic lymphangiomas registered in the neonatal intensive care unit of Sfax between 2008 and 2018.

Results Six full term newborns were included with a female: male ratio of 4:2. Prenatal diagnosis was performed in all cases. At birth all newborns was asymptomatic. Post natal diagnosis was based on the ultrasound study in all cases. Magnetic resonance imaging was performed in three cases. We registered cervical localization in three cases, cervicomediastinal localization in one case, carvicomediastinal localization associated to multiple lesions of the right arm in one case and perirenal localization in one case. The mean size of masses was 8.6 cm (5 to 15 cm). Total resection was performed successfully for the perirenal lymphangioma at day 22 of life. In the post operative course the newborn developed a transient hypertension and an urinoma that regressed after 10 days of drainage. Incomplete resection was performed in one newborn

having cervicomediastinal localization with close relation to the atrium leading to severe respiratory distress at day 4 of life. The patient died of severe sepsis on the post operative course. Embolization was proposed for two newborns but they rapidly died. For the two other cases we opted for monitoring. Spontaneous regression was then noted. No recurrence was registered in all surviving newborns.

Conclusions Cystic lymphangiomas can arise in any organ or soft tissue. Mediastinal and abdominal localization are rare. Management and outcome depends on localization and relationship with adjacent structures. Less invasive therapeutic option and new therapies continue to emerge. However till now there are not uniform therapeutic protocols.

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TRANSCATHETER ARTERIAL EMBOLIZATION AS AN INNOVATIVE MANAGEMENT STRATEGY IN A PRETERM NEONATAL CASE OF COMPLICATED INFANTILE HEPATIC HAEMANGIOENDOTHELIOMA

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Infantile hepatic haemangioendothelioma (IHH) is the commonest benign vascular tumour occurring in the first six-months of life. Medical treatment is first-line but a transcatheter arterial embolization (TAE) was also used in this preterm neonatal case; this is an innovative procedure used to reduce hepatic shunting by occluding the feeding vessels.

Case report A 2.09 kg male infant was delivered at 31⁺3 weeks by emergency C-section. There were antenatal concerns regarding ascites and dilated bowel loops and at delivery he was noted to have hydrops. He required intubation and high frequency oscillatory ventilation. Extensive bruising and active bleeding from multiple sites was noted, so the massive blood transfusion protocol was initiated. An ejection systolic murmur was heard and he had hepatomegaly.

Initial blood-work showed anaemia and disseminated intravascular coagulopathy. Thrombocytopenia was likely from Kasabach-Merritt syndrome (KMS). He also had deranged liver enzymes, jaundice and an acute kidney injury. AFP, thyroid function tests and urinary VMA were reassuring. Echocardiography demonstrated a small PDA and moderately impaired biventricular function. Abdominal ultrasound showed a mixed lesion involving both liver lobes, measuring 8.2×5.7 cm with dilated hepatic veins and ascites. MRI was not possible due to his unstable clinical condition.

A large number of blood products were required including recombinant factor 7. Regular vitamin K and broad-spectrum antibiotics were initiated. Propranolol and dexamethasone were commenced to try to shrink the lesion. On day 3 of life he had embolization of his AVM, this was a novel procedure and involved accessing the coeliac axis via the umbilical artery and releasing micro-particles. Satisfactory devascularisation was achieved.

Despite this innovative technique, he deteriorated secondary to high-output CCF, pulmonary oedema, anuria and hepatic failure. It was apparent to his parents and the multidisciplinary team that he would not survive and life-sustaining care was withdrawn on day 6.

Discussion It is clear that a multidisciplinary approach is required for the best treatment options. Corticosteroids