conducted to severe dylated cardiomyopthy with heart failure. Correction of anemia, iron administration and normal food intake slowly compensated the heart. A cardiology and hematology team was necessary to cooperate in healing this patient.

**GP79**  
IS IT A PORT-WINE STAIN?: VASCULAR BIRTHMARK ON THE FACE POSING A DIAGNOSTIC CHALLENGE

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Infantile haemangioma is a group of vascular tumours arising during infancy which has characteristic clinical and histological findings. Although this type of tumours has a typical presentation, they can mimic the appearance of other vascular lesions.

Two infants, 2 weeks and 5 weeks of age respectively were referred to the dermatology department for ‘port-wine stain’ as well as ‘orbital cellulitis’ and also considered as possible ‘Sturge Weber Syndrome’. Both infants had vascular lesions in V1 distribution of the trigeminal nerve noticed at birth and in the days prior to presentation developed significant swelling of the affected eyelid. Clinically these are telangiectatic macular lesions present on the eyelid and forehead, extending to the scalp, neck, shoulder and chest in one infant and affecting the perioral area and lower lip with ulceration in the other infant. In both infants there was a significant swelling of the upper eyelid involved resulting in complete closure of the eye. Magnetic Resonance Imaging and Angiography demonstrated intraorbital haemangioma together with abnormalities within the arterial system. One of the infants had involvement of the intracranial arteries and aortic arch qualifying for PHACES syndrome, and the other had involvement of the soft palate. Both patients were commenced on oral propanolol resulting in rapid shrinkage of the eyelid haemangioma, progressive healing of the lip ulceration and regression of the cutaneous component of the haemangioma. Treatment was well tolerated and is expected to continue for 6 to 12 months.

In summary these are two cases of segmental infantile haemangioma with involvement of internal structure mimicking capillary malformation associated with Sturge Weber Syndrome. These cases demonstrate the importance of distinguishing between infantile haemangioma and other vascular lesions to ensure early commencement of appropriate treatment as well as identification and management of internal involvement.

**GP80**  
ONCE MORE ABOUT CUSTOMIZED VERSUS POPULATION-BASED GROWTH CHARTS: HOW TO ASSESS PHYSICAL DEVELOPMENT OF THE INDIGENOUS CHILDREN OF THE NORTH?

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*Introduction* Despite evidence of race/ethnic differences in growth, the WHO’s position nowadays is based on the understanding that all children who were breastfed as infants, grow similarly and a single set of charts can be used to judge growth in any child. The population-based growth charts (PBGC) in assessing physical development of the indigenous children of the North (ICN) lead to ambiguity: pediatricians must recommend correcting their diet because of malnutrition, but to change the diet means to face many associated health issues. The aim of this study is to assess the appropriateness of PBGC for monitoring of growth of ICN.

**Methods** We compared the dynamics of body weight, height, body mass index and arterial pressure of the Nenets, Khanty, Komi and Slavic children – inhabitants of the Yamal-Nenets Autonomous region (n=5940, age 3 – 17 years) as well as of the Sakha, Slavic and 5 ethnic groups of ICN living in Yakutia (n=278793, age 0 – 17 years). For some of them, the dimensions of inner organs (sonography) and salt taste sensitivity were also analyzed. We used standard methods of parametric statistics.

**Results** We revealed that in most ICN the body length and mass, being at birth the same or higher than in non-indigenous folks, after the age of 3 years became significantly lower. Both systolic and diastolic arterial pressure in Nenets children become lower than in non-original settlers beginning from the age of 10 years although the arterial pressure in ICN living in Yakutia is higher than in non-original settlers beginning from the pre-school age. There are also differences in salt taste sensitivity (in some groups of ICN lower) as well as in the sonographically determined liver (in ICN bigger) and in the aorta (in ICN wider) sizes.

**Conclusions** Understanding that racial/ethnic-specific charts are now not recommended because the differences in growth among racial/ethnic groups are shown to be the result of environmental rather than genetic influences, we still must conclude that PBGC may not be optimal for ICN. Customized growth charts adjusted for race/ethnicity are more appropriate. Further research is needed to investigate the benefits and harms of using customized charts for monitoring the growth of ICN. The use of a single standard in ICN is not justified and the claim that ‘child populations grow similarly across the world’s major regions when their needs for health and care are met’ is probably just an assumption.

**GP81**  
EARLY INTERVENTION TO SUPPORT PRETERM INFANT-PARENT INTERACTION AND DEVELOPMENT: RESULTS OF A RANDOMISED CONTROLLED TRIAL ON MATERNAL SENSITIVITY, SOCIAL-EMOTIONAL DEVELOPMENT AND PARENTAL MENTAL HEALTH

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**Objective** To evaluate the effects of a range of modifying factors on an early attachment focused intervention for parents of very preterm infants in the NICU on maternal sensitivity and infant social-emotional development.
We present the prevalence rates of Avoidant Restrictive Food Intake Disorder (ARFID) in our tertiary feeding service. ARFID is a relatively recent DSM-5 diagnostic category that describes children with complex feeding disorders. Previous diagnoses of ‘feeding disorders of infancy or early childhood’ in the DSM-IV were limited and excluded children who maintained a healthy weight in the context of problematic eating behaviours. According to the DSM V in 2013 ARFID describes those children with an apparent lack of interest in food, food-avoidance based on its sensory characteristics and/or concerns about the aversive consequences of eating due to persistent failure to meet appropriate nutritional and/or energy needs are all symptomatic of ARFID.

The prevalence rates of ARFID are currently unknown. In specialist psychiatric and medical settings it is estimated to be between 5–13%. The clinical characteristics of children with complex feeding difficulties are currently poorly described in the literature, making it difficult to identify and plan necessary services.

Our service is a tertiary multidisciplinary feeding service that receives on average 250 referrals per annum. Of those referrals, 150 are referred to the Complex Feeding Clinic and the others are for medical, dysphagia or videofluoroscopy clinics. The Complex Feeding Service is formed of a Consultant Paediatrician, Psychologist, Occupational Therapist, Dietitian and Speech and Language Therapist. We accept referrals for children both locally and regionally, on the provision that there is a named local professional to liaise with. Our referral criteria includes children up to 18 years old with complex feeding difficulties which may cause psychosocial or nutritional impairment. Such feeding difficulties may be related to: an underlying ASD diagnosis, a developmental feeding disorder, medical disorder, sensory selectivity and/or anxiety around foods. The children who attend our clinic may be fed by enteral means or have a selective eating pattern (not otherwise stated).

We chart the emergence of this diagnosis within our cohort of patients and track its increasing use since it was included in the DSM V in 2013. We also analyse the following characteristics within the cohort of children receiving this diagnosis: gender, age, with/without a diagnosis of ASD or other comorbid neurodevelopmental issues, nutritional adequacy, diet range and fed by enteral means i.e. NG/PEG.