conducted to severe dilated cardiomyopathy 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 propranolol 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.

Methods Design and setting: A pragmatic randomised controlled trial in a level III NICU including infants born at 32 weeks gestation and their parents. Exclusion criteria were infant major congenital abnormality and maternal low level of fluency in English. Intervention: comprised reflective interview, observation of infant cues and Video Interaction Guidance (VIG). The primary outcome, maternal sensitivity during playful interaction with her infant was measured by the Child Adult Relationship Evaluation (CARE-Index). Secondary outcomes were infant social-emotional problems measured by the Ages and Stages Questionnaire-Social-Emotional version (ASQ-SE) and self-reported parental mental health. Modification of the effect of the programme on the primary outcome, maternal sensitivity, was explored using general linear model univariate analysis of sociodemographic, maternal and infant characteristics. Significant interactions are presented.

Results Eighty mothers and their preterm infants were randomized to the intervention and standard care groups. The groups were similar in baseline sociodemographic and perinatal characteristics, although more mothers in the intervention group had completed higher-level education and subsequent analyses were adjusted accordingly. At 12 months corrected age (CA) infants in the intervention group had fewer self-regulation problems at 12 months of age (Chi-Square 3.84, $df=1$, $p=0.05$, partial eta squared=0.07) and infants whose mothers had received VIG had significantly fewer communication problems (Chi square=20.41, $df=6$, $p=0.002$, $\phi=0.61$), however there was no statistically significant difference between the intervention and standard care groups in maternal sensitivity during play at 9 months CA or measures of maternal mental health. Fathers in the intervention group had lower depression scores at follow up. There was modifying effect of maternal ethnicity ($B=4.179$, $CI=0.921-7.437$, $p=0.013$); there was a significant difference in mean sensitivity of mothers of infants with IVH, (1.85 points) ($CI=0.083-3.614$, $p=0.041$) but there was no significant interaction with group assignment.

Conclusion This early attachment focused intervention integrating VIG for mothers and their very preterm infants had significant positive effects on infant social-emotional problems at 12 months CA. Maternal ethnicity modified the intervention effect

GP82

PREVALENCE RATES FOR AVOIDANT RESTRICTIVE FOOD INTAKE DISORDER (ARFID) IN TERTIARY FEEDING CLINIC IN UK

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We present the prevalence rates of Avoidant Restrictive Food Intake Disorder (ARFID) in our tertiary feeding service. ARFID is a relatively recent DSM-V 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 co morbid neurodevelopmental issues, nutritional adequacy, diet range and fed by enteral means i.e. NG/PEG.

GP83

FOETAL VALPROATE SYNDROME, DEVELOPING A NEW SERVICE

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Introduction A Paediatric valproate clinic at Our Lady's Children's Hospital Crumlin was established to assess those children who were exposed to sodium valproate antenatally in Ireland and to determine if this exposure is the contributing factor to their developmental delay, autism or skeletal malformations.

Antiepileptic drugs (AEDs) have been associated with a two to three fold increase in major malformations in children exposed to AEDs in-utero, compared to the general population.¹⁻²

Children exposed to sodium valproate compared to other AEDs had the highest level of risk of a malformation at 10.93%.³

Methods A national referral service was established via the HSE Valproate Support Team. GP were advised to refer all children less than sixteen years of age exposed to valproate antenatally. Thirteen children from six families were reviewed in the first six weeks. Background diagnosis, developmental history, maternal valproate history and full clinical examination findings were noted. Data was collected and recorded via a proforma.