GP114 A 5 YEAR AUDIT OF DENTAL CARIES EXPERIENCE OF 5 YEAR OLD CHILDREN ATTENDING THE DUBLIN CLEFT CENTRE

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It is well recognised that children with a cleft of the lip, palate or both, are at increased risk of and from dental caries. Children attending the Dublin Cleft Centre for cleft care are referred by their first birthday to community/primary care dental services for prevention of dental disease. These children also attend the paediatric specialist dental service at their tertiary hospital while attending multidisciplinary team clinics, and/or if advanced dental treatment is required.

As well as joint review and planning clinics, the service also runs audit clinics throughout the year. A measure of dental caries is recorded (by calibrated specialists and consultants in Paediatric Dentistry) for the dental component of the multidisciplinary audit. Dental caries is recorded using the dmft index (decayed, missing, filled, teeth). We report on the dental caries experience of five year old children (born 2007, 2008, 2009, 2010 and 2011) with a cleft of the lip, palate or both.

The mean dmft of the 277 children included in the audit was 3.25. Excluding children who were caries free, the mean dmft was 5.4. The mean dmft (per year cohort) has reduced from 3.8 for children born in 2007 to 2.1 for children born in 2011. The percentage of children who are caries free (dmft=0) has increased from 32% of children born in 2007 to 66% of children born in 2011. The percentage of children who are dentally fit (d=0) has increased from 46% of children born in 2007 to 77% of children born in 2011.

It is clear that the prevalence of dental caries (mean dmft) has reduced over the 5 year timeframe. There has also been a significant increase in the number of children who are caries free (dmft=0), and in the number of children who are dentally fit (d=0). This improvement in oral health may be as a result of improved tertiary care dental service resources and/or improved communication and follow up with the primary care dental services.

GP115 TODDLERS, TEENS AND EVERYTHING IN BETWEEN. SHOULD ALL CHILDREN BE ADMITTED TO THE SAME WARD?

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Aims To define the adolescent population admitted to the Paediatric Ward in Sligo University Hospital. To determine the attitude of adolescents and all parents towards room sharing between children of different age groups and to examine the use of recreational facilities on the Paediatric Ward.

Methods A retrospective review of patients admitted to the Paediatric Ward from October 2018 to December 2018 was performed. We defined adolescents as patients ≥ 13 years of age (yoa). Three separate questionnaires were designed for three defined groups (adolescents aged ≥ 13 yoa, parents of adolescents ≥ 13 yoa, parents of children < 13 yoa).

Questionnaires were distributed to each of these three groups admitted to the Paediatric Ward.

Results 529 patients were identified. 158, 192 and 179 in October, November and December respectively. In October 27/158 (17%) of admissions were adolescents. In November 36/192 (19%) of admissions were adolescents. In December 16/179 (9%) of admissions were adolescents. During time of questionnaire distribution participants were admitted to single rooms and shared rooms with patient's ages ranging from 4 months to 17 yoa. All those surveyed, including patients > 16 yoa (our normal age cut-off for admission to Paediatric Ward) expected to be admitted to the 'Children's Ward'. Most adolescents and their parents were 'not bothered' by the ages of children sharing the same room as them. Most adolescents and their parents claimed that they would be happy to share a room with older adolescents, i.e. 16 to 17-year olds. However, parents of younger children (< 13 yoa) generally did mind adolescents sharing the same room as their children and would prefer if children within the same age bracket only were sharing the room. No adolescents used the Playroom during their stay. More children < 13 yoa tended to use the Playroom. Most of the adolescents and their parents felt that their recreational needs were not met. Parents generally advocated for the presence of a 'Teen Den' as opposed to Playroom. All adolescents either preferred the idea of a Teen Den or were indifferent towards it. Some parents of children < 13 yoa were 'bothered' that adolescents could have use of the same Playroom as their children.

Conclusion The establishment of an adolescent-specific recreational area for adolescents admitted to the Paediatric Ward in Sligo University Hospital should be established to cater for their recreational needs and well-being. Adolescents on the Paediatric Ward should have different accommodation to younger children.

GP116 APPROACH TO MANAGING SPASTICITY IN HEREDITARY SPASTIC PARAPLEGIA

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Aim We aim to provide a guidance in the management of spasticity in children with Hereditary Spastic Paraplegia (HSP).

Introduction Hereditary spastic paraplegia is a group of clinically and genetically diverse disorders that result in progressive and generally severe lower extremity weakness and spasticity. Spinal and brain MRI and exome sequencing are the most useful investigations for diagnosing HSP. There is a lack of evidence base and guidance for the use of anti-spasticity drugs and uncertainty about the place of other modalities such as intrathecal baclofen (ITB), selective dorsal Rhizotomy (SDR) and botulinum toxin in HSP.

Method A guideline was prepared based on consultation with experts and regional specialist practice (Level D Evidence) supported by Level A-C evidence for individual treatment options. The guideline includes mode of action, dosage suggestions, side effect profile and cautions for the treatment modalities and summarises key management steps in a flow chart.

Management of spasticity Management of spasticity in HSP is based on identifying clear and realistic goals in the following three areas: improving mobility, increasing range of motion and relieving spasticity. These goals can be achieved through a

combination of physiotherapy, medical agents and, occasionally, surgery.

An early and regular physical rehabilitation program is recommended with use of assistive devices such as ankle-foot orthoses.

As a first step, a trial of Dopamine should be considered if the diagnosis of HSP is in doubt. Furthermore some forms of HSP have shown response to Dopamine. Oral Baclofen is used as a first-line anti-spasticity drug followed by oral Gabapentin and Tizanidine. Intrathecal baclofen in selected patients has shown promising results; this should be considered early in eligible patients if oral medication is failing to achieve desired spasticity control or side effects limit oral dosing.

The evidence for the use of botulinum toxin in HSP is limited and unclear. Its benefits are greatest when combined with therapy and splinting. Diazepam can be used as an adjunct to other oral medications to improve symptom control.

Selective Dorsal Rhizotomy is not routinely offered for HSP and should only be considered for uncomplicated stable HSP when all other treatments have failed and quality of life is severely affected.

Conclusion Managing spasticity well in patients with HSP can immensely improve their quality of life. We propose a standardised referral and management pathway that summarises the approach to medical and surgical options for patients with HSP.

GP117 LUMBAR PUNCTURE PERFORMANCE AND THE PAEDIATRIC PATIENT, ONE HOSPITAL'S EXPERIENCE

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Aim To evaluate the frequency, indications, success rate and clinical impact on the performance of lumbar punctures (LP) in a paediatric population attending a general hospital.

Methods Utilising the Mayo University Hospital Microbiology database the number of CSF samples analysed was determined over a 1 year period. Failed LPs were determined using blood Polymerase Chain Reaction (PCR) testing as a surrogate marker of sepsis. Data abstracted included 1) age 2) indication for LP 3) physician performer 4) procedure quality 5) number of attempts 6) CSF analysis and 7) final diagnosis. The charts of those patients with blood PCR requested were reviewed to discern the indication for the test and an evaluation of why the LP procedure failed.

Results The number of procedures where CSF was obtained was 18, the indications for LP were a) 5 newborns with suspected sepsis, b) 2 neonates from home with fever without focus, c) 8 infants (29–90 days) with fever without focus and irritability, d) 3 over 3 months of age; 1 with 3 afebrile seizures and 2 with fever and an unwell appearance.

? Registrars performed 94% of the procedures ? Only 1 SHO attempted a LP but had a failed attempt ? The numbers of LP with 1 attempt was 15 (83%), 2 attempts 3 (17%). The number of atraumatic CSF was 15 (83%).

The final diagnoses on the CSFs were: 13 sterile cultures and 5 positive for viruses. Of the 7 children who had Blood PCR performed, 1 had LP attempted and failed after 2 trials in a child who later proved to have pneumococcal sepsis.

Conclusion LP is performed in infants rather than children. Consequently, attaining competency in LP performance will

elude many Basic Specialist Trainees on their general paediatric rotations. Teaching LP performance using simulation techniques is required. Although bacterial meningitis is rare nowadays, LP is still required to evaluate cases of suspected Serious Bacterial Infection especially if no focus is found after initial assessment.

GP118 FLUID PRESCRIBING FOR CHILDREN BY NON-PAEDIATRIC CLINICIANS

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Background The prescription and monitoring of fluids for paediatric patients has been very much in the forefront of paediatricians' minds within Northern Ireland over the last number of years.

Regional fluid prescription charts and guidelines have been created and compulsory learning modules, teaching and audits are common place within the paediatric setting, ensuring safe prescribing practices.

However paediatricians and paediatric trainees are not the only medical staff who may prescribe fluids for children. We aimed to examine whether doctors within other specialties who treat children are as aware or focused on the issues with paediatric fluid prescribing as we are.

Methods An anonymous questionnaire was handed out to emergency department and surgical doctors. Based on a simple, common paediatric presentation respondents were asked how they would prescribe bolus and maintenance fluids to include type of fluid, volume, rate of administration and monitoring. The answers given were assessed based on the regional paediatric fluid prescribing guidelines.

Results There were a total of 15 respondents (10 emergency department and 5 surgical) over a range of grades (F2/SHO/ST1/ST4/staff grade/specialty doctor).

27% respondents would prescribe inappropriate bolus fluid. 64% respondents would prescribe inappropriate bolus volumes. 47% respondents would prescribe inappropriate maintenance fluid. 40% respondents would prescribe maintenance fluids at an inappropriate rate. 36% respondents would check electrolytes too infrequently.

Conclusion This highlights that although much emphasis is placed on safe fluid prescribing within paediatrics the same weight may not be placed on this issue across other clinical specialties. Further teaching and training is required for all specialties involved in paediatric fluid prescribing to ensure patient safety.

GP119 ANTIBIOTIC STEWARDSHIP: DETERMINING THE EXTENT OF E. COLI RESISTANCE TO CO-AMOXICLAV IN CHILDREN WITH URINARY TRACT INFECTION IN MAYO UNIVERSITY HOSPITAL

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Introduction A urinary tract infection is an infection in any part of the urinary system. Common symptoms in children