G351(P) ABSTRACT WITHDRAWN

G352(P) REACH FOR THE SKY: IDENTIFYING AND MANAGING GROWTH FAILURE IN CHILDREN WITH CHRONIC RENAL INSUFFICIENCY

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Background Growth retardation is well documented in children with chronic kidney disease (CKD). Figures from the UK Renal Registry indicate that 29% of children who undergo renal transplantation and 41% of children on dialysis are below the 2nd percentile for height. Short stature is associated with increased morbidity and mortality. NICE guidance recommends growth hormone as a treatment option for children with growth failure associated with chronic renal insufficiency (CRI).

Aims

- To increase recognition of growth failure in children with CRI by ensuring regular plotting of height in all patients on renal replacement therapy (RRT) and >80% of those with CKD stage 3–5.
- All eligible children with CRI and growth failure should be offered growth hormone.

Methods Data was collected in 2018 from patients on RRT or who had underwent renal transplant within the previous 5 years. Results were presented at the renal MDT meeting to improve awareness and highlight where improvements could be made. In line with BSPED and BAPN endorsed guidelines, practical changes were introduced and audited using Plan-Do-Study-Act cycles. These included ensuring patients' current notes have an up-to-date growth chart, and the introduction of a mid parental height and growth velocity monitoring proforma. A hospital guideline was designed which included a standardised referral letter to endocrinology for patients who should be considered for growth hormone.

Results The 2018 audit showed that 60% of the 15 patients on RRT or who had undergone recent renal transplantation demonstrated growth failure. Despite this, only two patients had been referred for growth hormone treatment. On re-audit, all children currently on RRT were assessed for growth hormone and referred to Endocrinology as appropriate. Regular growth monitoring improved from 60% to >80% also. The new proforma continues to highlight patients with CKD stage 3–5 meeting criteria for growth hormone and referral to endocrinology is improving as a result.

Conclusion With heightened awareness in the renal team, and a renewed focus on regular growth monitoring, children with CRI and growth failure, are being more promptly recognised and offered growth hormone in line with NICE guidance.

G353(P) PROFILE OF HAEMOLYTIC UREMIC SYNDROME FROM A TERTIARY CARE CHILDREN'S HOSPITAL IN INDIA

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Aims Haemolytic Uremic syndrome is one of the leading causes of AKI in children. Aim of this study was to review the profile of children with Haemolytic Uremic syndrome.

Methods This is a Retrospective case series of Children admitted with HUS to a tertiary Indian PICU between January 2011 and November 2016. The analysis was done as a part of my audit being a PICU core trainee then. Clinical course, aetiologies and outcomes at discharge and at 3 months follow up were noted.

Results Out of 3958 PICU admissions, 19 children had HUS (Incidence 4.8 per 1000). 9 children (47%) had D+ HUS & 10 (52%) had D- HUS. Various D- HUS aetiologies included Anti Factor H antibody (1), Severe Dengue (1), ADAMTS 13 deficiency (1), necrotising pancreatitis (1), pneumococcal empyema (1) and unknown (5). Sixteen (84%) required Renal replacement therapy. Haemodialysis was done in 10 children, peritoneal dialysis in 3 children and 3 children received Haemodialysis after initial PD. Immunotherapy was given to 5 (26%) children. This included plasmapheresis in 4(21%), steroids in 5(26%) and Rituximab in 4(21%) children. Major complications during ICU stay were seizures (52%), PRES (42%), Bleeding (31%) and secondary infections (15%). 9 out of 10 children (90%) with D-HUS had complications compared to 3 out of 9 children (33%) with D+HUS. 4 children died (mortality was 21%). Median RRT days were 8 in D+ versus 23 in D- HUS. RRT was needed in 9 (48%) children at ICU discharge. Overall main Follow up outcomes included hypertension in 85% and neurological deficits in 42%.

COMPARISON OF D+ and D- HUS

Conclusion Need for RRT was similar in both groups however Median RRT days were much longer in D- HUS. Complications and mortality were higher in D – HUS.

G354(P) EXPERIENCE OF USING ANTI-TNF INFlixIMAB IN PAEDIATRIC INFLAMMATORY BOWEL DISEASE- SINGLE TERTIARY

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Background The BSPGHAN and ESPGHAN 2018 standards on management of IBD advocate optimising the use of biological therapy by correlating infliximab drug and anti-body levels with clinical presentation, and subsequently altering treatment if sub-optimal. We aimed to evaluate the infliximab practice at the Royal Manchester Children's Hospital (RMCH), United Kingdom against these recently published standards.

Methods A retrospective study was performed on patients with IBD who had infliximab drug and antibodies levels measured between Oct-2017 and Oct-2018 at RMCH. We collected data on each patient's current status including stage of disease, infliximab drug and antibody levels, and changes in management if taken. These results were divided into 3 categories for analysis according to infliximab levels: sub-therapeutic (≤ 4 ug/ml), medium therapeutic (4–7.9 ug/ml) and high therapeutic (≥ 8 ug/ml). These were then further divided into negative/low level antibodies (≤ 20 ug/ml) and high level antibodies (≥ 21 ug/ml) subgroups. Each data set was examined to check for adherence to standards.