own, and there is much debate over the most suitable treatment type for different conditions. The main objective of the work was to form a regional guideline for common inpatient ENT conditions to help simplify current hospital and general practice protocols.

Methods We decided to review the past 5 years of ENT admissions who required hospital admission and antibiotics within our trust. This was completed through populating a list of patients using coded hospital data specifically looking at the different types of conditions, choice of medication, treatment length and where possible culture sensitivities. The aim was to them compare them with local and international protocols. A systematic literature search was completed alongside the work.

Results In the 5 year period, 3265 patients were seen as an inpatient under ENT and of those 1103 patients received antibiotics. The most common presentations were acute mastoiditis, tonsillitis, neck abscess (superficial and deep) and acute otitis media and externa infections. The most common antibiotic used was Co-amoxiclav of different concentrations with 1245 courses supplied with Co-amoxiclav 1000/200 being the most common. The next most used was Benzyl-penicillin IV with 189 courses given.

Conclusion Certain types of antibiotics are used more commonly within paediatric ENT cases that may not be in line with antimicrobial stewardship. Despite some protocols suggesting other antibiotics as first line, medications that are easier for the patient to take and administered less often are used more commonly despite being more broad-spectrum. Clearer guidelines for ENT doctors, general paediatricians and general practitioners are required to ensure the most appropriate antibiotics are prescribed. Further research is needed to identify which antibiotics are most suitable for specific ENT cases before a national guideline can be drawn up.

G608(P) SCHISTOSOMIASIS SCREENING IN UNACCOMPANIED CHILD REFUGEES

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Aims To assess our strategy for diagnosing schistosomiasis in unaccompanied child refugees in the UK. Schistosomiasis is an easily treatable infection with significant risk of long term complications if not treated.

Methods A retrospective analysis of a prospectively collected database of a health screening clinic for unaccompanied child refugees.

Urinalysis, stool microscopy and full blood count with serum save are performed for all refugee young people attending our clinic. Schistosomiasis serology is requested if microscopic haematuria or eosinophilia are found and stool and urine are negative for ova. Schistosomiasis is diagnosed on positive serology or stool/urine microscopy positive for ova. Treatment is single dose praziquantel.

Our incidence of diagnosed schistosomiasis is compared to published country prevalence data.

Results 232 unaccompanied refugees age 16–18 years (median 17 years) were assessed.

44/232 had eosinophilia >0.4 x 10^9/L (range 0.4–2.02 x 10^9/L). Of these 9 had stool positive for S.Mansoni ova, 7 had serum-positive schistosomiasis, 12 had other parasites diagnosed on stool microscopy and 16 tested negative.

20/232 had microscopic haematuria on urinalysis. Only 1/20 had S.Haematobium ova on microscopy. One had negative microscopy but had eosinophilia and serum-positive schistosomiasis.

17/217 (7.8%) patients who provided stool samples tested positive for S.Mansoni ova, 8/17 did not have eosinophilia.

Therefore a total of 25(10.7%) young refugees (24 male, 1 female) tested positive for schistosomiasis: 1 on urine microscopy, 17 on stool and 7 on serology. Countries of origin were Eritrea (10), Sudan (9) and Ethiopia (6). 10/63 (15%) of Eritrean refugees tested positive, 9/41 (22%) of Sudanese refugees and 6/26 (23%) of Ethiopian refugees. Published country prevalence rates of schistosomiasis are 41% for Eritrea and 34% for Sudan.

One further Eritrean patient who had normal stool, urine and eosinophil and was discharged, subsequently attended a Tropical Medicine clinic and tested serum-positive for schistosomiasis.

Conclusion We are diagnosing significant rates of schistosomiasis. However, the higher published prevalences for the countries of origin suggest cases may be being missed with our current screening method which relies heavily on eosinophilia and microscopy.

Our screening strategy will therefore be adjusted to include schistosomiasis serology on all young refugees from sub-Saharan Africa. We will prospectively assess the impact of this on our diagnosis rate.

G609(P) PERTUSSIS SEROIMMUNITY IN MOTHER-NEONATE PAIRS IN EGYPT

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Background Despite the widespread availability of 2 classes of effective vaccines, whole cell and acellular, pertussis has resurged as a serious public health problem. We sought to investigate the pertussis immune status of mother-neonate pairs in our country where pertussis vaccination is obligatory.

Methods This cross-sectional study was carried during the period from June 2012 to April 2014 and it included 75 healthy full term neonates and their mothers. The enrolled mothers were ensured to be free of any chronic illness and not receiving immunosuppressive drugs. Serum pertussis IgG was measured in all enrolled subjects. A positive titre was defined as >24 U/ml.

Results All mothers (100%) had their vaccination according to the Expanded Program of Immunization (EPI) in the health care offices of the Egyptian Ministry of Health. Their newborns were all full terms. Positive pertussis IgG levels were detected in 69 of the mothers (92%) and in 63 of their newborns (84%). Serum pertussis IgG titers among the neonates showed a significant positive correlation with the maternal titers (P=0.00001). Higher rates of pertussis seroimmunity were observed among mothers who are residents in urban and suburban areas as compared to those living in rural areas (P<0.05).
Conclusion This pilot study may suggest the presence of sufficient pertussis seroimmunity rates in the studied mothers-neonates pair. Still, there were some failures in immune acquisition probably due to waning of immunity with age. Transplacental passage of pertussis antibodies may not confer similar seroimmunity to pertussis in neonates as in mothers. Wider scale studies would allow better insight into the pertussis immune status of the females in the child bearing period in our country and hence the need for booster immunization during pregnancy.

G610(P) RETROSPECTIVE ANALYSIS OF NEONATAL DEATHS SECONDARY TO INFECTIONS IN ENGLAND AND WALES, 2013–2015
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Purpose To estimate the overall and infection related neonatal mortality rate and the pathogens responsible using electronic death registrations data.

What is already known on this topic
- The UK has one of the highest neonatal mortality rates among industrialised countries.
- Infections are associated with significant morbidity and mortality in neonates.
- Neonatal mortality rates have declined with advancements in neonatal care.

Results Total number of deaths secondary to infection per gestation. Early onset (<7 days), Late onset >7 days.

The most common pathogens responsible for neonatal mortality in each category. Gram positive: GBS (~10%), gram negative: E.Coli (~6%), viruses: HSV- 3%, Fungi: candida 1%.
- Design: retrospective analysis of national electronic death registrations data
- Setting : England and Wales
- Patients: Neonates aged <28 days
- Main outcome measures: Overall and infection related mortality rate per 1,000 live births in term, preterm (28 36 weeks) and extremely preterm (<28 weeks) neonates the contribution of infections and specific pathogens; comparison with mortality rates in 2003 05.

Conclusion Overall and infection related neonatal mortality rates have declined, but the contribution of infection and of specific pathogens has not changed.
- What this study adds
- Both the overall and infection related neonatal mortality rates have declined over the past decade.
- The contribution of infections and of specific pathogens to neonatal deaths has not changed.
- Group B Streptococcus remains the single most important pathogen associated with neonatal deaths.

REFERENCE

G611(P) SUBSIDIZED MALARIA PROPHYLAXIS FOR CHILDREN: IS IT USEFUL?
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Aim To evaluate whether a borough-wide policy change to remove subsidisation of antimalarials affected paediatric malaria rates.

Background Children are more susceptible to acquiring severe malaria and often have a delayed diagnosis in the UK. Following trends in international travel, rates of imported malaria are not diminishing in the UK, despite the existence of effective malaria prophylaxis medications. Malaria commonly affects those who are travelling to visit friends and relations (VFR); for whom multifaceted barriers to effective prophylaxis have been identified. In 2005 a nationwide policy was introduced to stop subsidization of malaria prophylaxis drugs. Some boroughs did not implement this due to large populations of VFRs. In October 2017 one borough updated their policy to remove subsidies, in concordance with national policy (and the adjacent ‘control’ borough).

Method This retrospective analysis reviewed all paediatric patients (<16 years) diagnosed with malaria in the 12 months prior and post local policy change. A comparison was made with the control hospital over the same time period. Malaria cases were diagnosed using thick and thin smear microscopy. Medical records were reviewed to assess prophylaxis use and adherence.

Results In the hospital with a recent change in policy there was no increase in patients with malaria after the subsidy was removed; in year 1, 7 patients tested positive out of 61 screens (16% positive test rate), compared to 6 positive cases in year 2 (8% positive test rate). In the control hospital there were 10 positive cases in year 1 (12% positive test rate), and 3 cases in year 2 (3% positive test rate). 14/29 positive patients had prophylaxis prescribed. Poor adherence to prophylaxis was reported in 13/14 of these cases.

Conclusion These findings demonstrate cases of paediatric malaria fell over the study period in both hospitals. It seems prophylaxis subsidization is unlikely to account for this. This study supports prophylaxis is often not taken as prescribed amongst positive malaria cases. However, it did not add weight to the argument that subsidies prevent malaria. Rather strategic interventions encompassing the spectrum of barriers to effective prophylaxis are required to improve children’s access to prophylaxis and prevent children becoming ill with malaria.

G612(P) ENTEROVIRUS D68 REAL-TIME 2-STEP PCR: A USEFUL DIAGNOSTIC TOOL IN LOWER RESPIRATORY TRACT INFECTIONS IN CHILDREN?
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Introduction EV-D68 is likely under-reported because an enterovirus PCR is usually not run for patients with respiratory symptoms; moreover 73% of rhinovirus (HRV) assays detect EV-D68, misleading clinicians as to the causative virus.