Abstract 849 Table 2

Weeks ->	Pre				Adolescent Month				Post				Frequency
HEEADSSS questions asked per interaction					1 HEEADSSS	2 CAMHS	3 Sexual health	4 Gangs/ CSE					
1	20	23	19	9	20	14	5	6	16	17	15	13	35%
2	12	22	22	13	22	16	5	7	10	10	12	20	33%
3	4	4	5	14	4	3	3	2	3	7	7	9	13%
4	2	3		1	1	3	2	3	3	4	2	4	5%
5	2	1	2		3	2	1	1		1	2	2	3%
6					2	1	1	1	1		2	1	2%
7	1		1		1			1	1	1	3	1	2%
8		1	1	1	2	1	1		3	5	5	3	4%

scenarios. This needs assessment generated ideas for an 'adolescent awareness month', whereby each week corresponded to a new theme with multi-modal teaching occurring each week. The survey was repeated to ascertain confidence levels post intervention. Data on the number of HEEADSSS screenings carried out was obtained from electronic records, pre, during and post this month.

Results The needs assessment showed an improved confidence in using the HEEADSSS tool after adolescent month (table 1). The post survey feedback demonstrated improved confidence in caring for those requiring Child and Adolescent Mental Health (CAMHS) input and how to approach talking about sex. It also identified areas where further teaching was required.

There were 783 potential encounters to undertake a HEEADSSS assessment; in 1/3 of presentations no HEEADSSS questions were asked. In most interactions 1–2 questions were asked (table 2). An increase in the number of HEEADSSS questions asked was seen and sustained (table 2). The most common questions asked were home and/or education, with eating and safety most commonly missed.

Conclusions This project helped promote a culture of awareness around adolescents and their requirements. An increased in confidence levels in approaching and managing their needs was reported post interventions. However, there is still more work to do in this area to translate this confidence into regular practice.

British Society of Paediatric Endocrinology and Diabetes

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MANAGEMENT OF CONGENITAL ADRENAL HYPERPLASIA IN A PAEDIATRIC ENDOCRINOLOGY CENTER OVER THE PAST 20 YEARS

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Background Congenital adrenal hyperplasia (CAH) is a group of autosomal recessive disorders in adrenal cortical steroidogenesis. It is the commonest cause of genital ambiguity in newborn and primary adrenal insufficiency during childhood. The most common form of CAH is owing to

steroid 21-Hydroxylase deficiency (21-OHD). Affected individuals have to receive lifelong corticosteroid replacement. It can be fatal if left untreated. Patients often suffer from the long-term complications resulting from either overtreatment or undertreatment. There are many different daily schedules of steroid replacement therapies and formulations, yet there is no unified approach in clinical practice with regard to the clinical management of CAH, with temporal and geographical variation despite existent international guidelines.

Objectives

- To describe the clinical characteristics and medical management of a local cohort of classic CAH patients
- To examine the delivery of corticosteroid replacement in the treatment of children and adolescents with classic CAH due to 21-OHD

Methods

Design and setting

Retrospective chart review of 23 patients with classic CAH due to 21-OHD who were longitudinally followed up in a local paediatric endocrinology center over the past 20 years.

Main outcome measures

Outcome variables of interest include demographics, clinical characterization of CAH subtypes (salt-wasting SW and simple virilizing SV), laboratory investigations at diagnosis and on monitoring, genetic testing (karyotyping and genotyping), treatment including type of glucocorticoid replacement, glucocorticoid daily schedules and dose levels, CAH-associated complications and details of genital surgery undertaken.

Results Among our 23 patients with classic CAH, 12 were females (52.2%). All except one patient were Chinese (95.7%). 11 were salt wasting (SW) subtype (47.8%) and 12 were simple virilizing (SV). There were 8 patients with SW CAH were male (72.7%) and 9 patients with SV CAH were female (75%). The mean age of diagnosis in SW CAH (0.66 month) was younger than in SV CAH (3.14 years). Their initial presentations are presented in figure 1.

The most popular glucocorticoid remained Hydrocortisone but recently more patients were put on Prednisolone. There showed a gentle decline in the mean total daily hydrocortisone (or equivalent) dose throughout the years. Glucocorticoid was prescribed from 2–3 times a day to more often 4 times a day recently (if not on Prednisolone) (figure 2).

Five patients (3 boys and 2 girls) were diagnosed central precocious puberty confirmed by LHRH stimulation test. Four had SV CAH whereas one had SW CAH. All were treated with GnRH analogue to control their premature pubertal development. Other complications are listed in figure 3.

7 girls (58%) received corrective genital surgery. All operations were performed by one stage. All except one had surgery undertaken at or before her second birthday (median age of operation 21 months).

Conclusions We highlighted the trend of more frequent and lower total daily dose of hydrocortisone (or equivalent) replacement, with the goal to achieve a normal rate of growth and puberty development and attenuate the CAH-associated complications.

Child Protection Special Interest Group

852 HOW NECESSARY IS THE SKELETAL SURVEY IN CASES OF SUSPECTED NON-ACCIDENTAL INJURY?

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Background The skeletal survey (SS) is considered to be a primary investigation in suspected physical abuse in paediatrics. This encompasses a series of x-rays of the whole body with the objective of identifying bony injuries suggestive of non-accidental injury (NAI). The essential purpose of the investigation is to discover additional, occult injuries identifying a need for further treatment and crucially providing additional evidence for inflicted injury. It is unclear how many occult fractures are detected on skeletal surveys; we therefore question whether they are always necessary for children. Although the literature suggests that skeletal surveys are positive in up to 30% or more of cases, this is at great variance with our experience.

When presented with a skeletal survey, radiologists are faced with the conundrum of deciding where there is any suggestion of NAI being a possibility and at most, a likelihood. The Royal College of Radiologists and Royal College of Paediatrics and Child Health have set guidelines to establish when a SS should be performed and there is a 72-hour window to report these - ideally they should be reported within 24 hours. Furthermore, all SSs must be double reported by two paediatric radiologists.

Objectives To determine how many additional (occult) fractures were detected in the last 5 years on SS. To compare how Watford General Hospital (WGH) is using and reporting SSs to the standards set by local and national guidelines.

Methods This retrospective audit encompasses the last five years of data to establish how many cases of NAI were detected from skeletal surveys. The included SSs were performed in children under 5 years old with the intention of excluding physical abuse.

Results One case out of 37 skeletal surveys performed with the intent of excluding NAI demonstrated additional fractures. This was a complex case where further imaging was clinically indicated. This equates to a detection rate of 2.7%. The commonest indications for a SS were unexplained bruising or a

single fracture noted on a specific x-ray. Double-reporting rates were lower than expected, at 32.4%.

Conclusions The low rate of positive results, suggests that more skeletal surveys are performed than necessary at the West Hertfordshire NHS Trust. In the absence of specific guidelines we are interpreting the need to do skeletal surveys when abuse is suspected very liberally, because the risk associated with missing additional fractures is high. Because of the litigious nature of safeguarding it is desirable that specific indications to undertake or omit a skeletal survey are produced at a national level. The double reporting pathway has been redeveloped to ensure all skeletal surveys are meeting the reporting standards. All skeletal surveys have since been double reported and no discrepancy was found when compared to the original reports. This will be re-audited in 12 months.

British Association of General Paediatrics

854 WHAT ARE HEALTHCARE PROFESSIONALS' AND PARENTS/CARERS' ATTITUDES TOWARDS ADDRESSING CHILDHOOD OBESITY WITHIN THE PRIMARY CARE SETTING IN THE UK?

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Background Currently in the UK a third of children leave primary school overweight or obese. Extensive research connects obesity to an array of debilitating comorbidities and with a growing evidence base for effective, early interventions it is now important to understand the attitudes surrounding this issue.

Objectives To explore healthcare professionals' (HCP) and parents/carers' attitudes towards addressing childhood obesity (CO) within the primary care setting in the UK.

Methods Three electronic databases were searched, followed by a cross-reference scan to identify ten qualitative and two quantitative papers that fitted with the inclusion/exclusion criteria outlined. Through the processes of Thematic Analysis and critical appraisal, four key themes emerged from the data: parent/carer and HCPs' perceptions and views on causes of CO; barriers and facilitators to both seeking and providing advice about CO; experiences of consultations between child, parent and, HCP; and finally where, how, and by whom should future CO management be carried out?

Results HCP barriers to providing advice included: limited time, the sensitive nature of the topic, lack of confidence in treatment interventions, and a view that their role is to treat the medical effects. Parental barriers to seeking advice were: lack of identification, fear of HCP response, mistrust in HCPs ability to treat, and concern that highlighting the obesity to the child may induce an eating disorder. Overall experiences of consultations about CO were negative.

Conclusions Allowing parents and HCPs to understand the others' views on CO could improve primary care consultations. Future research should aim to identify which specific interventions are most effective, to allow for evidence-based treatment of CO.