SUSTAIN- briefing/debriefing virtually has been embedded within the routine of the working day. However, ongoing PDSA and feedback from the ever changing team updates and changes are occurring

Results We measured qualitative data for 2 months after the introduction of virtual briefing/debriefing. Some examples were 'helps with team morale' and 'worthwhile but would be better if we could do it as a whole team'.

Conclusions The process of virtual briefing/debriefing has been well received by the team with improved situational awareness, learning and education while creating an open space for debrief and reflection. As patient demographics and numbers change, we continue to make adaptations to our process with repeated feedback. Team engagement when implementing change has been key to its success.

British Association of Perinatal Medicine and Neonatal Society

1071 IS LOW PLATELET COUNT AT START OF MEDICAL TREATMENT FOR PATENT DUCTUS ARTERIOSUS (PDA) LIGATION A PREDICTOR OF REQUIREMENT FOR SURGICAL LIGATION?

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Background Previous research has suggested that platelet count could be important in patent ductus arteriosus (PDA) presence¹ and possibly closure.²

Objectives To understand the characteristics of patients with a PDA, and identify if platelet count at the start of medical treatment for PDA is a predictor of failure of treatment and need for surgical ligation.

Methods We reviewed all babies from our unit who had medical or surgical treatment for a PDA over a 1-year period (1st April 2019 - 31st March 2020). This was a retrospective review of the BadgerNet database and clinical notes.

Results We identified 26 babies who underwent successful medical treatment, and 6 babies who required a surgical ligation. This analysis excluded a baby with PDA/VSD where data was incomplete. Table 1 shows a comparison of the two groups. Those who had successful medical treatment had greater median gestational age (27 vs 25+4 weeks) and higher birthweight (888grams vs 605grams, $p < 0.05$). More male babies required ligation ($n = 5$, 83% male), but this was not statistically significant. There were no statistical differences in antenatal steroid administration or in timing of first course of medical treatment (median 5 vs 4.5 days respectively). We also reviewed platelet count at the start of first medical treatment. The platelet count was significantly higher in the group who had successful medical treatment compared to those who went on to surgical ligation (median of 235 vs 119, $p < 0.05$).

Conclusions Previous research has found that low platelet count during medical treatment is associated with failed medical treatment.² Our findings differ: Platelet count at the start of treatment was associated with failed medical treatment and requirement for PDA ligation. Other characteristics of babies who required surgery for a PDA were observed. On average they were male, 25+4 weeks gestation at birth and 604 grams

Abstract 1071 Table 1 Comparison of surgical ligation and successful medical treatment

	Surgical	Ligation	Successful Medical Treatment	Statistical	
Variable	Range	Median	Range	Median	Significance
Gestation at birth (Weeks +Days)	23+2 - 27 +6	25+4	23+2 - 30+0	27+0.5	NA
Birthweight (Kg)	0.485–1.053	0.605	0.600–1.462	0.888	** $p=0.009$
	Number	Percentage	Number	Percentage	NA
Gender					
Female	1	16.7	10	38.5	$p=0.424$
Male	5	83.3	16	61.5	NA
Antenatal Steroids					
Complete	6	100	19	73.1	$p=0.322$
Incomplete	0	0	4	15.4	NA
None	0	0	3	11.5	NA
	Range	Median	Range	Median	(Medical Treatment vs Ligation)
Median Age at First Medical Treatment (days)	3–16	4.5	2–21	5	$p=0.386$
Platelet Count at First Medical Treatment ($10^9/L$)	43–277	119	89–536	235	* $p=0.043$

in birthweight. Could we avoid exposing these babies to the risks and delays of medical treatment and do surgery more directly? These data are also useful for counselling parents and managing expectations of clinicians. Further research into this group specifically and may highlight a more tailored medical treatment strategy that might be successful.

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Paediatric Critical Care Society

1073 RARE CASK GENE MUTATION WITH CEREBELLOPONTINE HYPOPLASIA AND TETRALOGY OF FALLOT – END OF LIFE CARE CONSIDERATIONS IN PICU

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Background CASK gene mutation is very rare and is associated with microcephaly, cerebellar and pontine hypoplasia (MICPCH).

Objectives It is essential to understand the life-limiting nature of the genetic mutation and the role of End of Life Care considerations, including family support. We would like to describe our experience in providing care for a child with the

above mutation. We are highlighting the consideration for End of Life Care provisions early in the management together with a multidisciplinary approach.

Methods Term Neonate with low birth weight admitted in PICU with Tetralogy of Fallot with critical pulmonary stenosis post-emergency BT shunt procedure.

Post cardiac procedure developed chylothorax and started on a monogen diet along with chest drain insertion. Due to multiple failed extubations, a respiratory review was sought. CT chest found no bronchomalacia or vascular ring but unable to comment on tracheomalacia as the baby was intubated. He had a difficult grade 3 airway requiring ENT assessment which later revealed a large tongue base constricting 80% of the airway with a normal larynx. MRI brain showed disproportionate cerebellar hemisphere, pontine and midbrain hypoplasia. The corpus callosum is hypoplastic. These appearances favour pontocerebellar hypoplasia.

Due to concerns of aspiration and reflux, he was NJ fed. Blood culture grew *E Coli* and received antibiotics for 21 days as LP was unsuccessful and unable to rule out CSF involvement. Immunoglobulin levels were within a normal range. T and B lymphocyte subsets showed relatively mild CD4+ T lymphopenia, with normal CD8+ T, NK, and B cells.

Genetic results showed that the child has a de novo deletion of exon 15–27 of the CASK gene (Xp11.4). Deletions in this gene are associated with two syndromes: microcephaly with pontine and cerebellar hypoplasia (MICPCH) and FG syndrome. Both these disorders are exceedingly rare.

He noted to have seizures with jerky movements of the right arm associated with apnoeas and desaturations and initially treated with phenobarbitone loading dose only. But did not have further epileptic episodes.

MLB assessment revealed that to extubate, he would require a tracheostomy. MDT discussion suggested that, given severely abnormal brain imaging plus multiple other congenital anomalies, it would not have been in his best interest to have undergone tracheostomy. After a discussion with parents, care withdrawn.

Results An early and ongoing multidisciplinary team approach was vital in managing the complex genetic condition. A multidisciplinary approach involving intensivists, cardiologist, cardiothoracic surgeons, geneticist, ENT, and respiratory were involved. In rare genetic disorders, the early involvement of the genetic team is constructive in the overall management.

One of the difficult aspects of management was the language barrier, and it posed challenges while having difficult discussions. The interpreter overcame this barrier.

Conclusions End of Life care is an essential aspect of Paediatrics and intensive care units. In rare genetic disorders, the early involvement of the genetic team is constructive in the overall management. Discussion with parents and geneticists together helps in the decision-making process while dealing with rare genetic diagnoses.

Background The initial thought for causes of prolonged fever in children is infection. It is important to get thorough history and clinical examination working towards the correct diagnosis. There is a question of effectiveness of remote consultation (telephone or video) how the correct diagnosis can be made.

Objectives To find out the role of remote consultation and delayed diagnosis during COVID 19 pandemic

Methods Retrospective review of hospital case note and GP SystemOne.

Results A 14 year old girl presented with six days history of high fever without chest or abdominal symptoms. There was no history of recent weight loss apart from initial loss of appetite. The family contacted their family doctor on day three of illness who advised to go to A&E. Her fever started a month prior. She had remote consultation with family doctor five times during this period and she was reassured that could be viral illnesses. COVID test was negative. She was seen in emergency department of DGH was the first time, examined clinically. She had negative urine dip test and COVID test and discharged home with the diagnosis of possible flu like illnesses. She was referred to paediatric assessment by her family doctor 3 days later as ongoing symptoms. She was febrile with significant tachycardia 165 bpm with high blood pressure 160/87 mmHg. There was some abdominal fullness with vague mass in central abdomen. Investigation revealed significantly high inflammatory marker (CRP>200, ESR 120) with anaemia and normal liver and renal function. Ultrasound scan of the abdomen revealed multi-cystic mass, possibly arising from kidney. Subsequently, MRI abdomen confirmed large cystic neoplasm arising from the right kidney. She also had multiple lung nodules and bone lesions on staging assessment CT scan of the chest. She was referred to primary treatment centre and diagnosed with advanced stage renal cell carcinoma. She was started treatment with immunotherapy.

Conclusions Our case is one of the examples of collateral effect of the COVID 19 pandemic. The study from Italy highlighted that number of children diagnosed with cancer was double during the post lockdown period.² Remote consultation (telemedicine) has quickly established and has positive points such as risk of cross infection and able to get medical advice without increase risk of exposure.⁴ It is important to remember clinical examination cannot be replaced by remote consultation. The need of guidelines for remote consultation is unquestionable.

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NOT JUST SIMPLE FEVER DURING COVID 19 PANDEMIC

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