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 After a discussion with parents, care withdrawn.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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