Conclusions Further research evaluating quality of life in cCMV is needed. To assess quality of life in cCMV, quality of life measures should be selected based on their relevance to sequelae of cCMV (for example, inclusion of a hearing-specific measure to assess the effect of sensorineural hearing loss), but generic quality of life measures are also important for comparison to the general population. Researchers should consider the importance of spillover effects on quality of life of family members as well as effects on the child's own quality of life. A national multi-informant cross-sectional questionnaire-based study in the UK is being undertaken, aiming to describe quality of life of children with cCMV and their families. Quality of life data could be used to inform health economic analyses and decision-making regarding cost-effectiveness of interventions for cCMV prevention and treatment.

1186 PSEUDOMONAS IN THE 'HOT TUB'

Anupama Mallappa, Catriona Middleton, Stewart Cox, Aditi Majethia, Lynne McDonald.
Royal Aberdeen Children's hospital

10.1136/archdischild-2021-rcpch.458

Background *Pseudomonas* hot-foot syndrome is a skin infection of the soles caused by *Pseudomonas aeruginosa*. It is characterized by painful erythematous plantar nodules, typically occurring in children following use of *Pseudomonas*-contaminated pools. Similar involvement of the palms has been reported less frequently. It is clinically distinct from folliculitis caused by *Pseudomonas*.

Objectives To report a case of hot foot.

Methods Electronic records were used to collect data

Results A previously well 8yr old presented to his GP with history of acute onset of blanching rash on most of his torso and excruciating painful lesions on his feet. Had been jumping on the trampoline bare feet and subsequently had been in the hot tub afterwards. This was 12 hours prior to the presentation. Interestingly his 5-year-old sister had similar rash, but no feet complaints and young uncle developed both similar rash and the feet complaints as our patient. All the three were on the trampoline and in the pool.

The pain was severe in nature despite being on regular paracetamol and ibuprofen. He was unable to weight bear.

He also developed high grade fever and headache prior to presentation.

On examination: He was bright . Not systemically unwell . No mucosal involvement.

Had a cold towel on his feet to 'ease the pain'. The rash on his torso including buttocks, was widespread, maculo-papular erythematous blanching rash. Few of them looked like white head pimples.

Both feet -widespread rash both feet, including sole margins. Red, papular, lumpy nodular, more prominent on the balls of the toes and the base of the metatarsals.

No joint involvement

The working diagnosis was Hot Foot syndrome

His bloods showed a mildly elevated CRP 29mg/l. He was initially treated with IV antibiotics and changed to oral ciprofloxacin for a duration of 10 days. He remained well during the stay

Discussion This condition typically occurs in young children. It is thought that children may have a thinner epidermis on

their palms and soles compared with adults, and also that they may be more active in pool areas; this increases the risk for friction injuries and susceptibility to infection.

Symptoms typically occur 6–48 hours following exposure to contaminated pools and include intense pain followed by swelling, redness, and warmth in the affected areas. Clinical course is usually benign, with rapid resolution. The condition does not typically require antibiotic therapy; however, leukocytosis and low-grade fevers may occur with infection, and antibiotics may be given in more severe cases.

Infections typically occur as outbreaks, with history revealing use of the same contaminated pool or hot tub.

Conclusions Patients and their parents should be informed of the self-limiting nature of pseudomonas hot-foot syndrome and its likelihood to reoccur with re-exposure to the contaminated water. Recall of the exposure source is important in order to notify other individuals who may be affected. Suspected water may also be tested for *Paeruginosa*; its treatment may be adjusted to obtain an optimal pH and chlorine level. Prevention may be achieved with the use of rubber pool shoe.

British Association of General Paediatrics

1187 A MULTI-CENTRE SERVICE EVALUATION OF THE IMPACT OF THE COVID-19 PANDEMIC ON PRESENTATION OF NEWLY DIAGNOSED CANCERS AND TYPE 1 DIABETES IN CHILDREN IN THE UK

¹David Walker, ²Ross McLean, ³Jo-Fen Liu, ⁴Timothy Ritzmann, ⁵Madhumita Dandapani, ⁶Dhurgshaarna Shanmugavadeivel, ⁷Pooja Sachdev, ⁸Mark Brougham, ⁹Rod Mitchell, ¹⁰Nicholas Conway, ¹¹David Walker, ¹²James Law, ¹³Alice Cunnington, ¹⁴Gbemi Ogunnaike, ¹⁵Karen Brougham, ¹⁶Elizabeth Bayman, ¹⁷Gemma Williams. ¹Children's Brain Tumour Research Centre, University of Nottingham; ²University Hospital Wishaw, NHS Lanarkshire; ³Children's Brain Tumour Research Centre, University of Nottingham; ⁴Children's Brain Tumour Research Centre, University of Nottingham; Nottingham University Hospitals NHS Trust, Nottingham; ⁵Children's Brain Tumour Research Centre, University of Nottingham; Nottingham University Hospitals NHS Trust; ⁶Division of Child Health, School of Medicine, University of Nottingham; ⁷Department of Paediatric Diabetes and Endocrinology, Nottingham University Hospitals NHS Trust; ⁸Royal Hospital for Sick Children, Edinburgh; ⁹MRC Centre for Reproductive Health, The University of Edinburgh; Department of Paediatric Diabetes and Endocrinology, Royal Hospital for Sick Children, Edinburgh; ¹⁰Tayside Children's Hospital, NHS Tayside; Division of Population Health and Genomics, University of Dundee; ¹¹Nottingham University Hospitals NHS Trust, Nottingham, UK; ¹²Nottingham University Hospitals NHS Trust; ¹³Department of Paediatric Oncology, Royal Hospital for Sick Children, Edinburgh; ¹⁴Department of Paediatric Diabetes and Endocrinology, Royal Hospital for Sick Children, Edinburgh; ¹⁵Leeds Children's Hospital, Leeds Teaching Hospital NHS Trust

10.1136/archdischild-2021-rcpch.459

Background The COVID-19 pandemic led to changes in patterns of presentation to Emergency Departments. Child health professionals were concerned that this could contribute to the delayed diagnosis of life-threatening conditions, including childhood cancer (CC) and type 1 diabetes (T1DM).

Objectives Our multicentre, UK-based service evaluation assessed diagnostic intervals and disease severity for these conditions.

Methods We collected presentation route, timing and disease severity for children with newly diagnosed CC in three principal treatment centres between January-June 2020 and T1DM in four centres between January-July 2020. We compared these to the corresponding period in 2019. The impact of

Abstract 1187 Table 1 Summary of time to diagnosis and disease severity of the study population (253 childhood cancer and 187 T1DM incident cases)

	2019		Jan-Mar 2020		Apr-Jul 2020		p-value
	n	%	n	%	n	%	
Childhood cancer (Jan-Jun)	138		59		56		
Diagnostic intervals (median, P25-P75)							
Total diagnostic interval (weeks)	4.5 (2.3–10.9)		5.6 (3.4–15.3)		4.6 (2.7–11.9)		0.351
Patient interval (weeks)	0.9 (0.1–2.1)		2.7 (0.7–4.4)		1.1 (0.3–4.7)		0.006
System interval (weeks)	2.1 (0.6–5.7)		2.0 (0.4–6.1)		2.1 (0.7–8.0)		0.825
ICU stay							
No	120	87%	55	93%	48	86%	0.275
Yes	17	12%	3	5%	6	11%	
Not known	1	1%	1	2%	2	4%	
Type 1 diabetes (Jan-Jul)	98		43		46		
Diagnostic intervals (median, P25-P75)							
Total diagnostic interval (days)	16.0 (8.0–28.0)		21.0 (13.5–31.5)		14.5 (7.0–22.0)		0.119
Patient interval (days)	14.0 (7.0–28.0)		21.0 (14.0–32.0)		14.0 (7.0–22.0)		0.054
Symptom interval (days)	0 (0–1.0)		0 (0–0)		0 (0–0)		0.083
DKA							
No	59	61%	26	60%	27	59%	0.624
Mild/Moderate	25	26%	12	28%	9	20%	
Severe	13	13%	5	12%	10	22%	
ITU stay							
No	90	92%	39	93%	40	87%	0.625
Yes	8	8%	3	7%	6	13%	

lockdown on total diagnostic interval (TDI), patient interval (PI), system interval (SI) and disease severity were evaluated.

Results Children with new diagnosis of CC (n=253) and T1DM (n=187) were included in the analysis. Overall there was a 17% reduction (138 vs 115) in number of incident CC cases and 9% reduction (98 vs 89) in T1DM cases between 2019 and 2020, with some regional variation. No significant differences in gender, ethnic background or age at diagnosis between study periods were observed. The route to diagnosis and severity of illness at presentation were unchanged across all time periods.

Median diagnostic interval for CCs during lockdown was comparable to that in 2019 (TDI 4.6, PI 1.1 and SI 2.1 weeks), except for an increased PI during pre-lockdown period Jan-Mar 2020 (2.7 weeks) (table 1). Median diagnostic interval for T1DM during lockdown was similar to that in 2019 (TDI 16 vs 15 and PI 14 vs 14 days), except for an increased PI in pre-lockdown period Jan-Mar 2020 (21 days) (table 2).

Conclusions There is no evidence of diagnostic delay or increased illness severity for CC or T1DM during the first lockdown in the participating centres. This provides reassuring data for children and families with these life-changing conditions. Data collection at a more comprehensive national level would provide greater clarity on diagnostic intervals.

Paediatric Mental Health Association

1188

IS IT TIME TO ACT? A QUALITATIVE STUDY OF THE ACCEPTABILITY AND FEASIBILITY OF ACCEPTANCE AND COMMITMENT THERAPY FOR ADOLESCENTS WITH CHRONIC FATIGUE SYNDROME

¹Philippa Clery, ²Jennifer Starbuck, ²Amanda Laffan, ¹Roxanne Parslow, ¹Catherine Linney, ¹Esther Crawley. ¹Centre for Academic Child Health, University of Bristol; ²Paediatric Chronic Fatigue Service, Royal United Hospitals Bath NHS Foundation Trust

10.1136/archdischild-2021-rcpch.460

Background Paediatric Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (CFS/ME) is severely disabling and relatively common. Over 15% of children do not recover by 12 months. Cognitive Behavioural Therapy for fatigue (CBT-f) is one of the only approaches with consistent evidence for improving function and quality of life. Acceptance and Commitment Therapy (ACT) is a suggested alternative therapy. It is effective in paediatric chronic pain and functional syndromes, but has not yet been trialled in paediatric CFS/ME.

Objectives We aimed to determine whether ACT is an acceptable and feasible treatment approach for children who are still disabled by CFS/ME after 12 months of treatment. This study is part of pre-trial work to inform the development of an effectiveness randomised controlled trial (RCT) of ACT.

Methods A qualitative design, using semi-structured interviews and focus groups was adopted. We recruited children (inclusion criteria: diagnosed with CFS/ME; not recovered after one year of treatment; aged 11–17 years), their parent/carer and healthcare professionals (HCPs) from one specialist UK paediatric chronic fatigue service. Interviews and focus groups were audio-recorded, transcribed verbatim and analysed using thematic analysis to identify patterns in the data.

Results Twelve adolescents, eleven parents, and seven HCPs were interviewed. All participants thought ACT was acceptable and feasible, and welcomed it as a new possibility for recovery. Participants identified reasons why ACT might be efficacious: the pragmatic approach with acceptance and compassion are valued in chronic illness; the focus on values provides motivation and direction; psychological and physical needs are both addressed; and normalising difficulties is a useful life-skill. Some adolescents preferred ACT to CBT-f as it encouraged acceptance of (rather than challenging) thoughts. However, HCPs were concerned patients might associate 'acceptance' with 'giving up' and called for clear explanations of the goals of ACT to be given to patients and parents. Interviews highlighted differing views on who might benefit from ACT and at which point during treatment it should be offered. It was agreed that ACT should be part of an individualised treatment plan that should be made on a case-by-case basis. Most adolescents said they would consent to a RCT of ACT but a key barrier to recruitment was reluctance to be randomised.

Conclusions Adolescents with CFS/ME, their parents and HCPs from a CFS/ME service thought ACT was an acceptable, feasible, and potentially efficacious treatment approach. They support a RCT of ACT, and most would consent to partake in a trial. We recommend trialling ACT in paediatric CFS/ME.