Conclusions The systematic reviews will provide evidence of common presentations and will form the basis for clinical guidelines on the assessment and investigation of children presenting with suspected tumours. The results of the awareness survey highlight a potential gap of awareness amongst medical students and further work in other regions and medical professionals will be needed in order to provide more insight on this topic.

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British Society for Rheumatology

1204

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

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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 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 used 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.

British Association of Perinatal Medicine and Neonatal Society

1205

FAMILY INTEGRATED CARE FROM THE DELIVERY ROOM: A MULTICENTRE APPROACH

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Background Having a baby requiring admission to a neonatal intensive care unit (NICU) can be very distressing for families and there may be a significant period after birth where parents do not see or hold their baby. Facilitating delivery room cuddles (DRC) allows family integrated care to begin at the earliest opportunity.

Objectives A collaborative project to facilitate cuddles at delivery for infants born <32 weeks gestation, or with congenital anomalies requiring NICU admission, without impacting safety or factors affecting mortality (such as hypothermia or hypoglycaemia).

Methods Education was delivered to all staff attending deliveries to ensure safe facilitation prior to implementing the initiative. Data was collected, across three tertiary units, between 2018 and 2019 for infants <32 weeks gestation. One unit collected data over six months, expanding the initiative to consider DRC for all infants with a congenital anomaly requiring NICU admission.

The decision to facilitate cuddles was at the discretion of the clinical team at delivery following assessment of stability of the infant.

Results 161/224 infants (72%) received DRC. Details of the preterm and congenital anomaly groups are presented in table 1. During DRC, 61% received non-invasive respiratory support and 16% were ventilated. 82% of cuddled infants were normothermic (36.5–37.5°C) on admission compared to 68% of those not cuddled. Rates of normothermia in the cuddled infants were higher than the national average.¹ There was no increase in rate of hypoglycaemia for the cuddled infants.

Of those with congenital anomalies who received DRC, 42% had congenital heart disease, 9% had a congenital diaphragmatic hernia, 27% had another surgical gastrointestinal condition (including gastroschisis and exomphalos), and 9% had renal abnormalities.

Adverse events were mild and infrequent. There was one interruption to the ventilator tubing which was rectified immediately with no change to the infant's vital signs. Two infants had a decrease in temperature promptly recognised; both were normothermic on admission. The most frequent reason for no DRC was maternal general anaesthetic (27/63;43%), followed

Abstract 1205 Table 1

x	Preterm < 32 weeks	x	Congenital anomaly	
Total number of infants	174	X	54	
Median gestation (weeks)	29	X	38	
Median birth weight (grams)	1190	X	3013	
X	Preterm < 32 weeks, received DRC	Preterm < 32 weeks, no DRC	Congenital anomaly, received DRC	Congenital anomaly, no DRC
Number of infants	117/174 (67%)	57/174 (33%)	45/54 (83%)	9/54 (17%)
Infants at non-GA deliveries	116/146 (79%)	30/146 (21%)	44/53 (83%)	9/53 (17%)
Hypothermic on admission	13/116 (11%)	7/57 (12%)	5/44 (11%)	1/9 (11%)
Normothermic on admission	95/116 (82%)	39/57 (68%)	37/44 (84%)	6/9 (67%)
Median initial blood glucose	3.3	2.9	2.8	3.9
Cuddled on non-invasive respiratory support	89/117 (76%)	X	10/45 (22%)	
Cuddled and ventilated	18/117 (15%)	x	8/45 (18%)	

by clinical instability (16/63, 25% received extensive resuscitation or had a significant oxygen requirement).

Conclusions With appropriate monitoring and good thermal care, delivery room cuddles can be facilitated for infants requiring admission to NICU due to prematurity or congenital anomaly whilst maintaining normothermia and adequate glycaemic control.

REFERENCE

1. National Neonatal Audit Programme (NNAP) 2020 annual report on 2019 data. RCPCH: London, 2020.

Child Protection Special Interest Group

1206

RETROSPECTIVE REVIEW OF PATIENTS UNDERGOING SKELETAL SURVEY FOR SUSPECTED CHILD ABUSE

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Background Physical abuse can present as bruises, fractures or head injuries. Abusive fractures are sometimes occult and skeletal survey helps to detect clinically unsuspected fractures. Physical abuse is rarely a single event. Early recognition of child maltreatment by systematic evaluation and detailed investigations is important to prevent life threatening injuries and death. RCPCH guidelines help in thorough evaluation and reduce differences in practice.

Objectives To assess the use of skeletal survey in evaluating suspected child abuse and to describe the clinical presentation, demographics, results of other investigations and the outcome of these children.

Methods Patients who underwent skeletal survey in our trust from July 2015 to June 2020 for suspected abuse was identified from our Radiology database. Data on demographic profile, clinical presentation, results of other investigations recommended by RCPCH and outcome were collected from the electronically archived notes. The skeletal surveys were reviewed independently by a specialist radiologist again for the purpose of this study.

Results During the study period, 89 children had skeletal survey. More than half (57%) were younger than 6 months. Majority (75/89) did not have significant medical history. The family of 36 children were known to social services. Suspicious abusive head injury (42.6%) was the most common reason for skeletal survey followed by allegations of violence (17%) and suspicious fractures of long bones (17%).

Skeletal survey helped in identifying unsuspected fractures in 11 out of 89 of children (12.4%). Majority of them (8/11) had multiple fractures with tibial fracture being the most common. The presentation of these children were: Suspicious head injury: 7/11, Fracture humerus =1/11, Unexplained bruise - 2/11, Unexplained vomiting (rib fracture as incidental finding) - 1/11. About 64% had follow up imaging which helped in identifying new abnormalities in 3 patients.

CT brain showed abnormalities in 35 patients. All but one had clinical presentation suspicious of head injury. Parietal fracture was the most common fracture and the Subdural haemorrhage was the most common intracranial haemorrhage.

Abnormal ophthalmological examination was noted in 14 children. All of these children presented with head injury and had intracranial bleed in the CT head.

The blood investigations showed Vitamin D deficiency in 15 of the patients. All of them except one had fracture of the skull or long bones. Two had abnormal coagulation and were found to have factor 12 and factor 7 deficiency on further investigations. Both these children had intracranial bleed.

Safeguarding concerns were identified in 56% of the children.

Four children from the study cohort died of fatal abusive head injuries. All of them presented with Acute life threatening event or seizures. Skeletal survey identified occult fractures in three of them.

Conclusions Head injury was the most common reason for requesting skeletal survey. The yield of skeletal survey in identifying occult fractures is 12.4%. Occult fractures are high in children less than 6 months old and those presenting with head injuries. We noted an age-related trend in presentation with younger children presenting with head injuries and older children presenting with fractures and bruises.