conditions. The WHO define QoL as 'the individual's perception of their position in life, in the context of culture and value systems in which they live, and in relation to their goals, expectations, standards and concerns'. In attention-deficit hyperactivity disorder (ADHD), there may be some difficulties in self-reporting outcomes due to the children's concentration difficulties. However, the impressions of parents can also be used to reflect changes in a child's quality of life over time. QoL outcomes are not routinely measured, but one could argue that such subjective results can be used to demonstrate the effectiveness of our medical interventions better than an observational assessment of symptomatology.

Objectives To review the quality of life for patients prescribed medication for the management of attention deficit hyperactivity disorder (ADHD) initiated by the community paediatric team, using the PaedsQL™ Paediatric Quality of Life inventory 'core scales'.

Methods Suitable patients were selected by treating clinicians over a 6 month period from May 2019. Children with a diagnosis of ADHD who were started on stimulant medications were identified by each prescribing clinician and approached for inclusion in the study. Parents were asked to complete an age-appropriate PaedsQL™ questionnaire during the appointment when the child was first prescribed stimulant medications. The questionnaire was repeated after 6 weeks of continued medical therapy. The PaedsQL™ ratings were compared for each child before and after medical treatment.

Results A total of 19 parents completed questionnaires over the 6 month study period. Of these 1 questionnaire was excluded as less than half of the questions were completed. For one questionnaire less than 50% of questions in the physical functioning section were completed, so this section was excluded.

Scores were stratified in accordance with PaedsQL™ guidance, with a maximum of 100. Scores were divided into four QoL subgroups: physical functioning; emotional functioning; social functioning and school functioning.

QoL subgroup	Mean score pre-treatment	Mean score post-treatment	Difference
Physical	53.93	54.91	+0.97
Emotional	40.55	48.61	+8.06
Social	45.27	56.38	+11.11
School	48.33	51.38	+3.09
TOTAL	46.88	51.32	+4.44

The total QoL score improved by an average of 4.44 points after starting medical treatment for ADHD. An improvement was seen across all subgroups, with the greatest increase seen in the social subgroup (+11.11).

Conclusions Our study found there was an improvement in QoL scores for children diagnosed with ADHD following initiation of medical management. The greatest improvement was seen for social functioning. Unfortunately there was no statistically significant difference in these results, due to the small number of cases included. Further follow-up of these children would be useful to assess if the QoL improvements are maintained over time.

Down Syndrome Medical Interest Group

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AUDIT OF MEDICAL SURVEILLANCE FOR THE CHILDREN WITH DOWN SYNDROME AGAINST DMSIG GUIDELINES

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Background Down syndrome (DS) is one of the commonest chromosomal abnormalities, overall prevalence 10/10,000 live births. Down Syndrome Medical Surveillance guidelines (DSMIG) are designed for optimal care for this group of children.

Objectives We audited our clinical practice in line with the guidelines. We also looked at the prevalence of co-morbidities and other important issues in this group in order to develop a locally agreed revised guideline.

Methods Children with DS were identified from Electronic records. Study period: January 2018-January 2019. Last two clinic letters (or one if new) were reviewed. Audit components: surveillance of cardiac disease, thyroid disorders, hearing, vision, cervical spine, growth, sleep, coeliac screen. We also looked at the prevalence of co-morbidities, educational placement and acute paediatric input.

Results 54 children were identified. Surveillance of *Cardiac*: Echocardiogram 100%, CVS examination in clinic: 55%. Prevalence of cardiac disorders: 44%; *Thyroid*: 100% of children < 2 years old vs 89% in > 2 years. 33% had thyroid disorders; *Hearing*: 100%, prevalence of hearing impairment: 33%; *Vision*: <4 years: 100%, > 4 years: 90%, prevalence of visual impairment: 81%; *Cervical spine*: 31% had evidence of discussion of warning signs; *Growth*: 88% had documented height and weight, 65% were plotted in the DS growth charts. 29% were documented underweight or overweight; *Sleep*: 70% had documented sleep history, 24% had confirmed obstructive sleep apnoea; *Gastrointestinal*: 63% had coeliac screen, 1 had a confirmed diagnosis. 11% had congenital GI anomalies; *Neurodevelopmental*: ADHD (n=1), ASD (n=4), Tic disorder (n=1). *Educational placement*: School aged children n=80%, 67% at special school.

Conclusions In addition to improving our own practice with the DSMIG, we made additional recommendations on surveillance of sleep: complete sleep questionnaire at 3–4 years of age; coeliac screen as per BSPGHAN recommendation; hip X rays if not weight bearing by 2 years of age.

British Association for Community Child Health

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AUDIT OF MEDICAL SURVEILLANCE FOR THE CHILDREN WITH DOWN SYNDROME AGAINST DSMIG (DOWN SYNDROME MEDICAL INTEREST GROUP) GUIDELINE

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