Conclusions DAH is an uncommon, life-threatening complication of dengue Fever. A high index of suspicion and early institution of supportive treatment in form of blood component transfusion, shock management and mechanical ventilation are critical to successful management of such patients.

British Association of Paediatricians in Audiology

1588 AUDIOLOGICAL COMPLICATIONS OF MENINGITIS IN CHILDREN

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Background Bacterial meningitis is the commonest cause of acquired deafness (Fortnum, 1992) resulting in permanent sensorineural hearing loss (SNHL). Therefore, early audiological assessment is essential (Rahko et al, 1984).

Currently, *Streptococcus pneumoniae* and *Neisseria meningitidis* are the most common organisms responsible for bacterial meningitis (Kutz et al, 2006). Labyrinthine ossification, a significant and rapid otological emergency, is more common after infection with *Streptococcus pneumoniae* (Douglas et al, 2008).

Objectives The primary objective was to determine the post-meningitis auditory complications.

The secondary objectives were to determine the pathogen, neuro-radiological changes and to ascertain the relationship with the auditory deficit.

Methods This was a retrospective case-note audit of children who had at least 1 audiological assessment in a tertiary children's hospital in UK following referral to the Audiovestibular Department with suspected or confirmed meningitis and/or septicaemia. Referrals made within 24-months (1st January 2018 to 31st December 2019) were considered. Patients that did not have an audiological assessment (e.g. child returned home and out of catchment area) were excluded. The audiological results (degree, type and laterality of deafness), microbiological details, radiological changes and audiological intervention were recorded.

Results During the 24-months, 44 children had at least one audiological assessment following suspected or confirmed meningitis and/or sepsis. The majority were in-patient ward referrals (n=38, 86%) and others were from various referral sources (General Paediatric clinic, Newborn Hearing Screening Programme, Speech Therapist and Health Visitor). The age on admission ranged from 2days (2 children) to 16 years. 9 (20%) babies were <1 month old and 27 (61%) were male.

As per British Society of Audiology guidelines, 39 children (89%) had satisfactory hearing on soundfield or ear-specific tests. 2 children had bilateral severe-to-profound SNHL. Further 2 had unilateral SNHL. One had unilateral conductive hearing loss due to underlying otitis media with effusion.

Of the two with bilateral SNHL, one had *Neisseria meningitidis* and bilateral significant labyrinthine ossification on neuro-radiology. The other had *Streptococcus parasanguinis* and intracranial fluid collections over the left cerebellar

hemisphere and right frontal lobe. They both eventually underwent cochlear implantation for hearing rehabilitation.

The microbiological profile of the cohort included *Neisseria meningitidis* (including the above child) (n=15, 34%), *Enterovirus* (n=8, 18%), *Streptococcus agalactiae* (n=6, 14%), *Streptococcus pneumoniae* and *E. coli* (4 each), culture negative but neutrophilia in cerebrospinal fluid samples (n=3) and 1 each with *Haemophilus influenzae*, *Streptococcus parasanguinis* (above bilateral SNHL), *Streptococcus gallalyticus* and unknown organism.

Post-meningitis neuro-radiological changes were noted in about 30% of children. These included bilateral labyrinthine ossification (n=1, above child), non-cystic focal lesions (n=5), significant intracranial fluid collections (including hydrocephalus) (n=4), subdural effusions (n=2) and gliosis (n=1).

Conclusions The most prevalent organism in our cohort was *Neisseria meningitidis* and 1 child had significant rapid cochlear ossification needing urgent cochlear implantation. Pneumococcal meningitis can result in unilateral SNHL (2 children). 30% of children had labyrinthine and intra-cranial radiological changes.

Therefore, it is vital to consider the micro-organism, radiological findings and correlate these with the audiological findings to ascertain the audiological risk and prognosis after meningitis in children.

British Association for Paediatric Nephrology

1591 URINARY ASCITES IN CHILDREN

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Background Urinary ascites (UA) is rare in children. There can be several reasons for urine leakage to peritoneum such as spontaneous rupture of bladder, a complication from surgery or trauma, and prematurity, especially in neonates. We report two cases of urinary ascites in an 11 months old and a 5 years old, with different pathologies.

Methods Case Report 1: A 11m old boy with Menke's disease presented with mild cellulitis was treated with antibiotics. He developed vomiting on the day of discharge and he was observed for 24hrs. He developed acute abdominal distention with signs of shock. His bloods revealed acute kidney injury. His abdominal imaging revealed extensive ascites. He was treated with fluid boluses and transferred to PICU. He had abdominal paracentesis which drained 400ml of clear fluid. The biochemical analysis confirmed it was urine. He had diverticulum of bladder.

Case Report 2: A 5yr old boy had appendectomy. He was observed for persisting abdominal pain following surgery. His blood revealed acute kidney injury. He had MCUG which revealed bladder leakage into peritoneum. His bladder was decompressed with catheterisation.

Results In these cases, the abnormal renal function was caused by fluids and electrolytes equilibrating across peritoneal surface, as occurs in peritoneal dialysis. In both cases the pseudo-azotaemia resolved in 24hrs with bladder decompression.