British Society of Paediatric Gastroenterology, Hepatology and Nutrition

1652 WHAT IS THE IMPACT OF CO-EXISTENT FAECAL AND URINARY INCONTINENCE?

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Background What is the impact of co-existent faecal and urinary incontinence?

Objectives Urinary incontinence (UI) can occur concurrently with chronic constipation (CC) with or without faecal incontinence (FI) in children. The understanding of the pathophysiology of these patients and the impact of their wellbeing remains scarce.

Methods Prospective data of 283 children attending to our service were analysed, including demographics, bowel assessments: St Mark's Incontinence Score (SMIS) and Cleveland Constipation Score (CCS), risk of distress (PI-ED) and QoL (PedsQL 4.0). The use of the Wong Baker Smile faces (scale of 0–10 [10 most severe]) assessed patient perspective on symptom severity. High resolution anorectal manometry (HRAM) and transit marker studies (TMS)

were performed to assess pathophysiology. Data of all children were both analysed with χ^2 test and Pearson's r , both at significance levels of 0.05. Percentages not included ($n = 97$).

Results In total, 97 (34.0%) patients with symptoms of CC/FI and UI were identified (46 boys; median: 8 years; range, 2–17 years). Patients presented with organic pathologies (16): Hirschsprung disease (7); anorectal malformations (8) and spinal injury (1) and 81 (83.5%) with functional CC/FI. HRAM demonstrated abnormal physiology in 44/95 (46.3%). TMS was abnormal in 39/90 (43.3%): slow transit in 14 (14.4%), rectal evacuatory disorder in 25 (26%). Symptom severity was a median of 6; (range 0–10). Abnormal SMIS scores in 78/95 (82.1%) and 91/95 (95.8%) CCS scores were found. Poor QoL was demonstrated in 51 patients (52.6%) and patients were at risk of distress in 32 (33.0%). There were no significant differences found between patients with and without UI regarding assessments, physiology and symptom severity (table 1). However, patients with both demonstrated significantly higher means on the SMIC ($p < 0.05$) compared to patients with GI only.

Conclusions

- The addition of urological symptoms does not appear to adversely affect HRAM, TMS, PI-ED
- Either the consequences of GI symptoms are so severe that the addition of UI symptoms does not resolve in worse outcomes, or we have underestimated the urological symptoms.

We look forward to adding questionnaires and including urologist in the multi-disciplinary team.

Abstract 1652 Table 1 Comparison of patients with GI (only) and GI with UI symptoms

(Note: total numbers are dependent on those patients who underwent the test/questionnaire).

NS: not significant

HRAM	GI [both]	GI [only]	p value
Normal	51	75	
Abnormal	44	94	
Total	95	169	
TMS			NS
Normal	53	74	
Rectal Evacuatory disorder	22	53	
Slow Transit Constipation	16	36	
Total	91	163	NS
PI-ED			
No risk	62	127	
Risk of distress	32	46	
Total	94	173	NS
PedsQL			
Good-Excellent QOL	43	107	
Poor QOL	51	66	
Total	94	173	$P < 0.05$
CCS			
Normal	4	15	
Abnormal	91	156	
Total	95	171	NS
SMIS			
Normal	17	33	
Abnormal	78	136	
Total	93	169	NS

Paediatric Educators' Special Interest Group

1653 'BEDSIDE' TEACHING FROM HOME – USING REMOTE WORKING TECHNOLOGY TO MAXIMISE UNDERGRADUATE CLINICAL EXPOSURE IN THE COVID-19 PANDEMIC

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Background The COVID-19 pandemic necessitated a review of risks versus benefits of face-to-face (F2F) clinical contact for medical students, patients and families. Social distancing reduced teaching-group sizes, universities advised against students seeing higher-risk patients and self-isolating students missed clinical time. In parallel, remote consultations became an accepted part of medical practice. We designed and introduced remote bedside teaching sessions in paediatrics.

Objectives A pilot project to test whether ward-based bedside teaching sessions run remotely via Microsoft Teams™ were:

1. Educationally useful for students
2. Acceptable to patients and families
3. Practical for education faculty
4. Information governance (IG) secure