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

Methods Two 75-minute sessions for seven and eight fourth-year medical students respectively were delivered remotely, with two Paediatric Education Fellows at the patients' bedside, and a third Fellow remotely.

Each session included two paediatric inpatients. Selection criteria:

1. Clinical stability
2. A cubicle
3. Clinical signs visible via webcam
4. Condition precluding F2F students (e.g., awaiting SARS-CoV2 results)

Families provided written consent Students on their fourth-year paediatric attachment were invited to partake voluntarily and all agreed. Students completed a confidentiality agreement. Approval was provided by the University, hospital management and Trust IG department.

Patient and parent acceptability, and educational utility for students was assessed via questionnaire. A faculty focus-group met after each session.

A large amount of quantitative and qualitative feedback data was collected.

Results Parent feedback:

(n=3, 1 lost to follow-up) All parents stated they felt adequately informed about what the session involved, they and their child felt comfortable, and they would be willing to participate again. Parents commented positively about the reduction in infection risk, and used the analogy of online school to explain the format to their children.

Student feedback:

(n=13, 2 lost to follow-up)

Twelve of the total thirteen students felt able to participate actively. Ten students reported the sessions improved their approach to history-taking, and twelve their approach to differentials, investigations and management. Seven reported the sessions improved their approach to clinical interactions. Three reported their structuring of clinical examination improved, potentially reflecting that most sessions were history-taking focused. Only one student reported technical issues significant enough to affect learning. Despite positive feedback on remote, students prefer F2F, as expected.

Themes from qualitative student feedback included:

1. Useful when self-isolating
2. More students learn from one 'interesting' patient
3. Exposure to patients not allowed to see F2F

Faculty experience:

No IG concerns identified during/after sessions, reflecting extensive pre-planning. All patients and families invited agreed to partake including an acutely unwell teenager. Sessions required considerable investment of time on the part of facilitators.

Conclusions We present an innovative approach to overcome COVID-19 limitations to medical education. This work demonstrates that bedside paediatric clinical teaching can be successfully delivered remotely to medical students. Our results highlight educational benefit for students, acceptability to patients and families, and that IG requirements are met. It is expected that student feedback on remote learning of clinical skills will improve as facilitators gain more experience and explore different session emphases. A training package for facilitators is now planned.

British Paediatric Allergy Immunity and Infection Group

1655

A REVIEW ON *STAPHYLOCOCCUS AUREUS* BACTERAEMIA PRESENTATION AND MANAGEMENT AT A TERTIARY CHILDREN'S HOSPITAL

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Background *Staphylococcus aureus* bacteraemia (SAB) is one of the most common causes of sepsis and PICU admission in children. However, there is limited research done on paediatric SAB worldwide, and thus there is a wide variation in management.

Objectives To review the demographics, presentation and management of SAB at Sheffield Children's Hospital (SCH) over a one-year period.

Methods A list of all blood cultures positive for *Staphylococcus aureus* (SA) between June 2019 and June 2020 were provided by the Microbiology department. Blood cultures taken from the same patient during the same illness were grouped together as 'patient episodes'. The patients' hospital electronic notes were then reviewed.

Results 25 positive blood cultures were analysed within the study timeframe. This represented 18 patient episodes. 9 (50%) episodes were associated with a central line. 1 episode was associated with methicillin-resistant *Staphylococcus aureus* (MRSA). 16 episodes were associated with fever.

All 9 patients with central line associated SAB had complex medical needs, and 7 out of 9 patients were under 5 years of age (77%). 5 (55%) patients had paired central and peripheral blood cultures collected, and 4 out of 5 showed SA in both cultures. None of these episodes required admission to intensive care. 5 patients developed SAB within 2 weeks of central line insertion. When reviewing line management after diagnosis, 7 patients had their lines removed within 30 days of being unwell. The remaining 2 patients experienced recurrent exit site infections that required multiple courses of antibiotics, and eventually had their lines changed.

In contrast, the patients in the non-central line associated SAB group were evenly spread below 5 years and above 10 years of age. 4 patients were fit and well prior to their illness. Sources of SAB were evenly distributed between pulmonary, skin and joint foci. 2 patients required fluid resuscitation and inotropes at presentation, resulting in intensive care admission.

In terms of investigations, 16 out of 18 patients had echocardiograms, of which 15 were normal (1 was equivocal). We found that the CRP took a similar time to peak (average 1 day), halve (5 days) and to be less than 10 (9–13 days) in both groups.

Antimicrobial choices and length of treatment in both groups varied greatly, and decisions for oral switch and antibiotic duration were often poorly documented.

Conclusions This study was limited from its small population size. However, the findings still highlighted the importance of early central line removal to treat SAB, as well as high incidence of SAB within 2 weeks of line insertion. In this evaluation it was interesting to note that positive paired peripheral cultures did not alter management, and the yield of abnormal