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.
elevated transcutaneous bilirubin (TcB) monitoring of jaundiced babies and admitted to Transitional Care Unit but did not receive phototherapy.

Methods We retrospectively analysed data from Transitional Care Ward records for patients assessed for jaundice over 4-month time periods, 1 Aug to 30 Nov 2019 (pre-intervention) and 1 Aug to 30 Nov 2020 (post-intervention). Relevant demographic and clinical outcome details were collected and analysed. We used comparative statistical methods to compare the results from the two time periods. JETSET criteria were: Healthy term baby born at ≥36+0 weeks with a birth weight of ≥2500g who developed jaundice after 24 hours.

Results A total of 1423 (1372 ≥36+0 wk) babies were born between 1 Aug 2019 and 30 Nov 2019 compared with 1441 (1384) babies in 2020. 137 babies were admitted to the Transitional Care Ward in the 2019 cohort compared with 157 in 2020. A total of 51 babies (26.2%) were assessed for jaundice and admitted to the Transitional Care Unit across both time periods. 10 (19.6%) patients were excluded for incomplete data sets. Data from 41 babies were included in

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1657 NEONATAL DRUG WITHDRAWAL FROM INTRAUTERINE EXPOSURE TO ANTIEMETICS

Signe Thiesen, Andrew MacDonald, Sheena Kirmond, Althaf Ansary. Crosshouse University Hospital; University Hospital Crosshouse

Background Neonates exposed to a variety of substances in-utero can develop transient signs and symptoms of toxicity or withdrawal after birth. Whilst the neonatal abstinence syndrome (NAS), typically observed after gestational exposure to physically addictive substances such as opioids, benzodiazepines and illicit drugs is well described, other substances affecting the central nervous system (CNS) can also cause withdrawal but symptoms may differ from those observed in NAS. This is unsurprising given their different pharmacodynamic properties, yet clinical guidelines and scoring systems focus heavily on withdrawal from addictive substances.

There is a general lack of systematic data on medication during pregnancy, as pregnant women have traditionally been excluded from clinical trials. Current knowledge is thus largely based on data obtained from case reports and voluntary reporting systems such as the yellow card system. It is likely that toxicity or withdrawal from substances other than those implicated in classic NAS is underrecognized by health care professionals (HCP). This in turn will result in underreporting, and may adversely affect clinical care through over-investigation of transient symptoms and parental anxiety due to diagnostic uncertainty and well as disconcertment within the team. Furthermore, symptoms clinically consistent with withdrawal, but not considered attributable to maternal medication history may result in suspected information withholding about maternal substance use with resulting negative consequences.

Objectives Review of cases of suspected neonatal drug withdrawal from intrauterine exposure to antiemetics and review of literature.

Methods Descriptive case series of neonates admitted to the neonatal unit in Crosshouse between August 2020 and November 2020, having been exposed to antiemetics in-utero and showing altered psycho-motor behaviour not explained otherwise.

Results Two babies were identified 1) A term baby had been exposed to regular metoclopramide, cyclizine and prochlorperazine in-utero and developed severe respiratory distress requiring invasive ventilation shortly after birth. The baby was subsequently noted to be hypotonic and jittery, with poor feed tolerance. Within a week all symptoms resolved and breastfeeding was established. 2) A baby was delivered at 32 weeks for maternal hypertension and had also been exposed to cyclizine in-utero. The baby required non-invasive respiratory support for 3 days. Full enteral feeds were established within 5 days, and marked jitteriness was noted from day 2 of life but gradually resolved throughout the 2 weeks stay. Investigations to excluded other causes in both cases included cranial USS, CXR, blood tests for hypoglycaemia and electrolyte abnormalities, as well as investigations and treatments for suspected infection. Maternal history was scrutinized for exposure to other substances. The observed neonatal transient signs and symptoms were consistent with those previously described for drugs of the same drug group, namely jitteriness due to antihistamines (cyclizine; previous case report) and hypotonia, respiratory and feeding difficulties due to antipsychotics (prochlorperazine; summary of product characteristics).

Conclusions Whilst causality cannot be inferred from a case series, these cases highlight the need for more systematic research into medication during pregnancy to improve drug safety, and as well as the need to increase awareness and understanding of antenatal drug exposure amongst HCPs.

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