echocardiograms was low. The study has shown a wide disparity in antimicrobial choice and duration for SAB even within one hospital, and the need for central line infection prevention and management guidelines, better central line-associated infection surveillance outside critical care, and improved documentation of long antibiotic courses. It is hoped that further research could be done to optimise paediatric SAB management.

British Association of Perinatal Medicine and Neonatal Society

1657 NEONATAL DRUG WITHDRAWAL FROM INTRAUTERINE EXPOSURE TO ANTIEMETICS

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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 systems (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 also 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.

1658 TRANSCUTANEOUS BILIRUBIN MONITORING CLINICAL PATHWAY FURTHER REDUCES SEVERITY OF HYPERBILIRUBINAEMIA AT READMISSION OF HEALTHY TERM JAUNDICED BABIES

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Background Neonatal jaundice presents in approximately 60% of all term-babies. Management of jaundice contributes a significant proportion of up to 17.9/1000 babies readmitted in the first 28 day of life. In 2011 we adopted a unique whole systems approach for jaundice managing neonatal jaundice. This approach christened JETSET has been shown to reduce admissions, length of stay and severity of jaundice in healthy term jaundiced babies. In 2020, we implemented routine transcutaneous bilirubin (TcB) monitoring of jaundiced babies in community and hospital settings to complement our long-established clinical pathway.

Objectives We carried out a before and after study comparing the outcomes of jaundiced babies who met JETSET criteria 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 $\geq 36+0$ weeks with a birth weight of ≥ 2500 g who developed jaundice after 24 hours.

Results A total of 1423 (1372 $\geq 36+0$ 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%) patients 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

Abstracts

Abstract 1658 Table 1 Table showing data of all babies assessed for jaundice

Title	2019	2020	P value
Total Number of babies assessed	24	27	NS
No of babies excluded	6	4	NS
JETSET Babies referred from community	8	12	NS
JETSET Babies referred from A/E	4	3	NS
JETSET Babies without phototherapy	6	6	NS

Abstract 1658 Table 2 Table showing outcome data for JETSET babies who were admitted but no phototherapy

Title	2019	2020	P value
No of JETSET babies without phototherapy	6	6	NS
Age at Assessment (day)	6±3	4±1	0.16
Percentage weight loss at admission (%)	-8±5	-9±5	0.72
Maximum bilirubin at assessment(μmol/l)	299±43.5	262.3±41.8	0.03*
Length of Stay (hrs)	46.5±30.5	31.1±14.5	0.12

this study. The tables below highlight key comparative data in the two cohorts

Compared with 2019, 33% more babies were referred in for assessment from the community in 2020 (table 1). Jaundiced babies in 2020 were referred earlier, had significantly lower maximum serum bilirubin levels at referral and had reduced length of hospital stay if readmitted (table 2).

Conclusions This study has shown that the introduction of TcB led to a significantly reduced maximum SBR level at readmission. In addition, we showed a trend towards a streamlined pathway across care settings for healthy jaundiced babies with earlier hospital assessments and improved outcomes for the babies that were admitted to TCU.

1660 PILOT POTENTIAL ORGAN DONOR AUDIT IN THE NEONATAL POPULATION WITH REFERENCE TO THE NATIONAL PAEDIATRIC AND NEONATAL DECEASED DONATION STRATEGY (NHSBT, 2019)

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Background This retrospective audit over 4 years reviewed all neonatal deaths in a large tertiary neonatal unit (University Hospitals of Leicester NHS Trust).

Objectives To review the potential for organ donation in patients that met the criteria for donation after death confirmed by neurological criteria (DBD) or circulatory death (DCD) in a large tertiary neonatal unit.

Methods The perinatal mortality review database and Badger-net were used to identify all early neonatal (END), late neonatal (LND) and infant deaths (ID) in the time period. Patients were identified that met the NHS Blood and Transplant (NHSBT) eligibility criteria for referral: >36 weeks corrected gestational age (CGA). Badger-net data was used to review cause and modality of death to determine potential for organ donation.

Results There were 125 END, LND and ID identified. 28 patients (22.4%) were identified as meeting the above mentioned NHSBT criteria. Out of these 28 patients, 9 patients were potential organ donors (2 potential DBD following neurological death testing and 7 for potential DCD). One patient was referred for DCD, but this did not proceed as the patient continued to gasp for a prolonged period of time.

Conclusions The true potential for neonatal organ donation is not yet known, as identified in the NHSBT strategy.¹ A greater understanding of this potential will allow for better resource management and influence treatment options, thus impacting the transplantation and organ donation process. This pilot audit shows that in a large tertiary neonatal unit, there were approximately 2 potential organ donors per year. A larger potential donor audit is required to establish national numbers and associated resources needed to offer organ donation routinely as part of end of life care for our patient population.

REFERENCE

- 1.. UK Paediatric and Neonatal Deceased Donation A Strategic Plan by the Paediatric Subgroup of the National Organ Donation Committee. June 2019.

Paediatric Special Interest Group: British Society of Haematology

1664 VITAMIN D DEFICIENCY AND SUPPLEMENTATION IN SICKLE CELL DISEASE

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Background Optimising bone health is of upmost importance in sickle cell disease (SCD) patients given the risk for bony involvement in SCD. These patients are at an increased risk of Vitamin D deficiency given the known higher prevalence of Vitamin D deficiency in those with dark skin from African/Afro-Caribbean/Asian/Middle Eastern backgrounds. In addition to this, Ireland is located in a northerly latitude and is at risk of suboptimal Vitamin D levels because of reduced sunlight exposure. Osteopenia and osteoporosis has been reported in up to 80% of SCD patients with other studies indicating a link between Vitamin D deficiency and chronic pain in SCD patients. We wanted to examine Vitamin D levels in our SCD population and establish what supplements our SCD patients were taking, comparing our findings to NICE and Sickle Cell Society and Public Health England (2019) guidelines.

Objectives To identify how many SCD patients in a tertiary unit are Vitamin D deficient and to identify the number of patients currently on a recommended dose of Vitamin D.

Methods Using our database of registered SCD patients, all Vitamin D level results within the past year were reviewed. Members of the haematology team concurrently asked each patient or parent/carer what Vitamin D supplementation, if any, they took regularly when they attended the hospital for review or over telephone clinic across a 4 month period. The patients' charts were then reviewed on a daily basis after clinic and during/after hospital attendances.

Results 93.43% (313/335) of SCD patients had a vitamin D level taken in the preceding 12 months. The average vitamin D level was 52.94 nmol/L (median=51nmol/L). 13% of