patients (41/313) had a vitamin D level $<25\text{nmol/L}$ (deemed deficient as per NICE guidelines).

We reviewed 184 patients in-person/over the telephone in a 4 month period during the COVID pandemic and asked about their current supplementation. 49.45% (91/184) of patients reviewed reported taking 400 international units (IU) daily with 26% (48/184) taking $>400\text{IU}$ daily. 12.5% (23/184) of these patients reviewed had a vitamin D level $<25\text{nmol/L}$. In those with a level $<25\text{nmol/L}$, 30.43% (7/23) were taking 400IU, 26% (6/23) were taking $>400\text{IU}$ daily and 34.78% (8/23) were on no supplements at all. The average age was much higher at 16.86 years in this group compared to the overall average age of 12.34 years.

Conclusions In our audit we established that 56.52% (13/23) patients reviewed in-person or over the telephone who were Vitamin D deficient as per the NICE definition ($<25\text{nmol/L}$), were taking at least 400IU of Vitamin D daily (the recommended dose for children at increased risk of Vitamin D deficiency). This highlights the need for further studies and clearer international guidance re. prevention of and management of Vitamin D deficiency in these high risk SCD patients. The Sickle Cell Society and Public Health England (2019) guidelines recommend that Vitamin D deficiency be identified and treated according to local guidelines in all SCD patients. Those identified as Vitamin D deficient during the audit process were prescribed a higher dose of Vitamin D where possible with regular input from our hospital pharmacy team. We continued our policy of aiming to check Vitamin D levels twice per year with increased frequency of checks for those who required high dose Vitamin D treatment. Given the above findings, a plan was placed to make a more concerted effort to continuously ask patients re. vitamin D supplements during clinic and hospital visits.

British Society of Paediatric Gastroenterology, Hepatology and Nutrition

1665 ADHERENCE TO ESPGHAN GUIDELINES FOR DIAGNOSING PAEDIATRICS COELIAC DISEASE IN AN ENGLISH DISTRICT GENERAL HOSPITAL

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Background Coeliac disease (CD) is a systemic immune-mediated disorder caused by the ingestion of gluten and related prolamines in genetically predisposed individuals. The 2012 ESPGHAN guidelines suggested a no-biopsy pathway (NBP) for symptomatic children with IgA-based Tissue Transglutaminase (TGA-IgA) $\geq 10\times$ Upper Limit of Normal (ULN). Biopsy confirmation remained mandatory for all other cases.

Objectives This retrospective case note study was aimed at evaluating the extent of adherence to the ESPGHAN 2012 guidelines for diagnosing CD in our unit.

Methods 179 cases with positive TGA-IgA were identified from the laboratory database between January 2013 to December 2020. 17/179 (9%) patients were not referred to secondary care after the finding of positive TTG in primary care. Data was collected on the diagnostic pathways followed, and

adherence was compared with the existing ESPGHAN 2012 guidelines.

Results 129 cases assessed for CD were included and 124 children diagnosed with CD. 68/129 (53%) were diagnosed via the NBP. 57/68 were diagnosed via NBP until December 2019 and 24/57 (42%) children did not meet triple criteria as per 2012 ESPGHAN guidelines. HLA-DQ2/DQ8 testing wasn't done for 16/57 NBP cases and other 3/57 had a negative EMA result. In 2020, 13 patients were diagnosed via NBP, 11 in adherence to the 2020 ESPGHAN guidelines, other 2 [TGA-IgA $<10\times\text{ULN}$] were via regional interim COVID-19 pathway.

Conclusions Adherence to the recommended diagnostic guidelines need to be tightened up to ensure firm diagnosis of CD. Regular educational sessions at regional/local level are needed to improve the referral, understanding and implementation of the diagnostic pathways. The revised 2020 ESPGHAN guidelines which excluded HLA-DQ2/DQ8 and allows NBP for asymptomatic children with TGA-IgA $\geq 10\times\text{ULN}$ thus simplifying the diagnostic process.

Child Protection Special Interest Group

1666 RADIOLOGICAL INVESTIGATIONS FOR SUSPECTED PHYSICAL ABUSE IN CHILDREN: AN AUDIT OF LOCAL PRACTICE

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Background In 2017, 'The radiological investigation of suspected physical abuse in children' guideline was released by the Royal College of Radiologists (RCR) and endorsed by the Royal College of Paediatrics and Child Health (RCPCH) to ensure consistency of practice across the UK. This in turn would allow children to be appropriately safeguarded by safeguarding partnerships.

Objectives To reflect the new guidance, our trust protocol was updated in March 2019. We completed an audit evaluating the impact this had on our clinical practice and whether it helped align us with the national guidance on investigating suspected physical abuse.

Methods Information on patients who had radiology imaging for suspected physical abuse between October 2018 and October 2019 was collected from trust radiology databases and electronic patient records and audited against the national guidance. Standards audited included timing and reporting of initial skeletal survey and neuroimaging, timing of follow-up surveys, sedation use and informed consent. Where possible, information on radiation dosage was collected.

Results In 12 months, 16 children had skeletal surveys, with ages ranging from 1 day to 15 months. Introduction of the local trust protocol in March 2019 in line with the RCR guidance led to improvements in nearly all aspects of radiological investigation (see table 1). For the 6 patients with suspected physical abuse occurring post protocol change, all skeletal surveys occurred within 72 hours with the majority reported within 24 hours and all having follow-up skeletal surveys. Infants who didn't undergo sedation for their skeletal survey were under 3 months old, where 'feed and wrap' techniques were appropriate and successful. Despite new guidance