- Appropriate reduction in laboratory investigation 2018 vs 2020 (both by surgical team from 90% to 58% and Paediatric team from 43% to 17%)
- Optimization of imaging resources by surgical team from 33% to 17%
- 88% of patients with abdominal pain had a medical diagnosis at discharge.

Conclusion:

- Abdominal pain is a common presentation in the paediatric population, mostly benign and self-limiting.
- Abdominal pain should be assessed by General Paediatrician first and then referred to surgical colleagues to avoid unnecessary investigations and imaging and improve timeliness of their assessment.

British Academy of Childhood Disability

158 TRIHEXYPHENIDYL FOR TREATMENT OF DYSTONIA IN CHILDREN WITH NEWLY DIAGNOSED CEREBRAL PALSY: A RANDOMIZED PLACEBO-CONTROLLED TRIAL

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Background Cerebral palsy is a common and a lifelong disabling neurodevelopmental disorder, we attempted to address the relative lack of evidence on the role of Trihexyphenidyl in the management of dystonia in children with cerebral palsy

Objectives To study the short-term effect of trihexyphenidyl on dystonia and motor functions in children with newly diagnosed Cerebral Palsy.

Methods A randomized, double-blinded, placebo-controlled, parallel-group trial was conducted in consecutive children aged 6 months-5 years at a tertiary care hospital. Following baseline evaluation, the study participants were randomized into two groups and were started on medication. Assessments were performed at baseline, 3, 6, and 12 weeks. A total of 50 children completed the study.

Results After 12 weeks of medication, statistically significant improvement in median scores of GDS was seen in 10 body regions in the intervention group as compared to only 4 body regions in the control group and significant improvement in GMFM 88 in both the groups. The motor status assessed using GMFCS showed that there was a reduction in GMFCS level in 4 children in the intervention group as compared to 1 child in the control group. DQ calculated using EDP-2 showed a significant change in the intervention group (p-value 0.026) at the end of 12 weeks but no change in the control group (p-value 0.218). However, no statistically significant difference was seen in the median change in outcome scores between the two groups.

Conclusions This study could not document a statistically significant change between the two groups for the effect of trihexyphenidyl. A larger placebo-controlled trial, preferably multi-centric and with a longer follow-up period is needed to provide definitive results regarding the place of trihexyphenidyl in the management of dystonia in children with Cerebral Palsy.

British Society of Paediatric Endocrinology and Diabetes

159 THE RISE OF DISORDERED EATING PATTERNS IN PAEDIATRIC DIABETES: A LITERATURE REVIEW

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Background Type 1 Diabetes Mellitus (T1DM) is one of the most common chronic childhood illnesses, with life-long implications for the child or young person (CYP). A preoccupation with food, eating and weight, integral to optimal diabetes care, coupled with a peak diabetes onset in early adolescence, inevitably increases the propensity of this cohort to develop disordered eating behaviours (DEB) and/or eating disorders (ED). Current UK diabetic services grossly underestimate the problem with our own service capturing only a 0.08% ED rate among 620 CYP with T1DM across three trusts, compared to study prevalence rates ranging from 10–30%. This discrepancy urgently needs addressing so CYP vulnerable to DEB/ED can be identified and offered appropriate therapeutic interventions.

Objectives The aim of this literature review is to identify, summarise and critically appraise works evaluating the development, impact and management of DEB/ED in paediatric diabetes, with the hopes of increasing awareness of a clinically important, but scarce discussed phenomenon.

Methods A search was conducted on Embase, MEDLINE and PsycINFO for studies concerning T1DM, ED/DEB and CYP, published between 2000 and 2020. Cross-referencing searches were conducted for articles not detected in the original keyword search; key national guidelines and diagnostic criteria were also reviewed.

Results 35 studies met the inclusion criteria. T1DM was shown to be a key contributor to the complex and multifactorial aetiology of DEB/ED. The majority of studies showed increased DEB/ED among CYP with T1DM compared to their peers, and where they did not, rates of sub-threshold ED were still higher. Studies were limited by small sizes, variable DEB/ED definitions, cohorts extending to young adult populations, participant recall bias and diverse screening tools, ranging from generic ED surveys to diabetes-specific measures, which though showing greater sensitivity, made control comparisons more challenging. Only 9 intervention trials were included, exploring a range of strategies from family therapy, nutritional psychoeducation, individual and group cognitive behavioural therapy (CBT), and inpatient stays. All strategies emphasised the need for a collaborative approach between medical and psychiatric teams. The detrimental impact of DEB/ED on quality of life, metabolic control, secondary complications, and life expectancy, only highlighted the necessity of timely therapeutic intervention.

Conclusions Disordered eating can be a significant problem in T1DM, beginning in early pre-teen years, becoming more prevalent in adolescence and often extending into adulthood, where it becomes significantly more challenging to manage. In the first instance, we must begin to identify risk factors for disordered eating in our diabetic clinics; referring those who are concerned about for a more rigorous psychological assessment. The gold standard, time and financial pressures permitting, would be for universal screening from age 10, with a