Associate Pediatric Professions

1 UPS AND DOWNS OF PARENTAL COMPLIANCE

A Goleš*, D Vuković Lerga, I Vlašić-Cicvarić. *Klinički bolnički centar Rijeka*

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Interaction between a patient (child) and expert is defined by the state of the patient's addiction and knowledge of all persons involved in their treatment, as well as the capacities of their caregivers. It is exceptionally important that none of these components are lacking, i.e. that mutual efforts focus on achieving the common goal which is the child's well-being. In order to ensure that, daily work with child patients is inseparable from establishing an alliance with parents. The lack of an encouraging (primarily familial) environment can have a disruptive effect on a child's development, confirming the importance of cooperating with parents who are pivotal allies in the treatment process.

If, for any reason, there is a lack of or interruption of parental cooperation, it can cause a higher risk of losing the patient or an inadequate approach towards the child's health issues. In order to avoid those outcomes, it is important to recognize and solve some of the potential obstacles.

In this paper we present different types of active and passive non-cooperation, observed in a continuum where negative and/or positive shifts can take place depending on various factors such as type and method of communication, respecting differences, timely reactions, and many other factors.

2 SOLITARY MASTOCYTOMA IN NEONATE MANIFESTING WITH SYSTEMIC SYMPTOMS

Suzana Ozanic Bulic*, Navratil Marta, M Ulamec, Z Barcot, A Bonevski, N Pustisek. *Children's Hospital Zagreb*

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Mastocytosis is a group of disorders characterized by excessive mast cell accumulation in the skin known as cutaneous mastocytosis (CM), or in extracutaneous organs in systemic mastocytosis (SM). Mast cells are a key component of the innate and adaptive immunity and are the main effector cells in allergy. Cutaneous solitary mastocytoma (CSM), the most common form of CM, presents as an indurated, erythematous, yellow-brown-reddish macule, papule, plaque or nodule with peau d'orange appearance and a rubbery consistency, measuring up to 5 cm in diameter. CSM may urticate or blister spontaneously or when stroked or rubbed (Darier sign) as a result of mast cell vasoactive mediator release (1).

8-week-old baby boy presented with 7 weeks history of erythematous-brownish infiltrated, nodular, rubbery, blistering, and growing lesion measuring 30x20mm in diameter on the dorsal lateral aspect of the left hand (figure 1).

Skin biopsy was performed and histopathology and immunohistochemistry (CD117 positive cells) confirmed a mastocytoma (figure 2). Recurrent febrile episodes started in early neonatal period followed by enterocolitis, acute bronchitis, nausea, and vomiting. Baseline laboratory investigations and abdominal ultrasound were normal. Serum tryptase was elevated on baseline and repeated blood tests.

Although systemic symptoms such as flushing, dyspnoea, hypotension, nausea, vomiting, and abdominal pain along with increased serum tryptase are more common in patients with SM, they can also occur in patients with SCM resulting from mechanical irritation of the lesion (2). This would explain some of the symptoms our patient experienced probably resulting from persistent activity of the lesion. Nevertheless recurrent febrile episodes and unprovoked elevated serum tryptase increased the risk of SM therefore patient was referred to oncologists for further assessment.

3 MODE OF DELIVERY AND PERINATAL OUTCOMES IN PREMATURE INFANTS WITH NEURODEVELOPMENTAL RISK FACTORS IN CROATIA IN 2018

¹Željka Draušnik*, ¹Urelja Rodin, ¹Daria Jezdić, ²Aida Mujkić, ³Andrija Štampar, ¹Ivan Cerovečki. ¹Croatian Institute of Public Health; ²University of Zagreb School of Medicine; ³School of Public Health

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Investigate the association between mode of delivery and perinatal outcomes in premature infants with neurodevelopmental risk factors.

Using Croatian Institute of Public Health childbirth database records, outcomes of preterm infants born in 2018 and diagnosed with pathological conditions associated with neurodevelopmental risk were analysed with regard to mode of delivery (vaginal, caesarean section – CS). Common pathologic findings/conditions associated with neurodevelopmental risk included:

5-minute Apgar score below 7, intrapartum hypoxia or asphyxia, intracranial haemorrhage (grade 3 or 4) and pulmonary pathology (respiratory distress, pulmonary haemorrhage, pneumothorax, other respiratory disorders). In some premature infants, multiple neurodevelopmental risk factors were reported.

Other causes of morbidity were included in a common subgroup – Other entities. Data on early neonatal death (END) of premature infants caused by aforementioned conditions were also analysed.

In 2018, 2,232 premature infants were born in Croatia (6% of all live-births). Pathological conditions were reported in 1,926 (86.2%) preterm infants, whereof 430 (19.3%) were primarily diagnosed with entities related to neurodevelopmental risk. 5-minute Apgar score below 7 was observed in 176

(7.9%) children, whereof 68.2% were delivered by CS and 31.8% vaginally.

Hypoxia or asphyxia were the primary diagnosis in 33 (1.5%) and a secondary diagnosis in 107 (4.8%) children (140 in total – 6.3%); 58.6% were delivered by CS and 41.4% vaginally. Intracranial haemorrhage (grade 3 or 4) was the primary diagnosis in 19 (0.9%) children and a secondary diagnosis in 102 (4.6%), a total of 121 (5.4%); 92.5% were delivered by CS and 7.5% vaginally. Pulmonary disorders were the primary diagnosis in 378 (16.9%) children and a secondary diagnosis in 424 (19.0%) – a total of 802 (35.9%); 55.7% were born by CS and 44.3% vaginally. Other conditions were the primary cause of morbidity in 1,496 children (66.8%), whereof 50.5% were delivered by CS and 49.5% vaginally. Among 306 (13.7%) children recorded without any pathological condition, 41.5% were born by CS and 58.5% vaginally. Among 78 END cases, conditions related to

neurodevelopmental risk (pulmonary pathology, intracranial haemorrhage) were the cause of death in 15 (19.2%); however, in additional 44 (56.4%) cases causes of death were indirectly associated with neurodevelopmental risk, except 19 (24.4%) deaths caused by congenital malformations.

In preterm infants without neurodevelopmental risk factors, the incidence of CS and vaginal delivery were similar. Premature infants with conditions related to neurodevelopmental risk were more frequently delivered by CS as a means to prevent neurological and other impairments and perinatal death.

4 TAKING REGULAR BREAKS IS IMPORTANT TO MAINTAIN THE HEALTH AND WELLBEING OF ALL STAFF MEMBERS, WHILST ENSURE THAT A HIGH STANDARD OF PATIENT CARE IS DELIVERED CONTINUOUSLY

Lizaveta Collins*, Anddrea Turner, Jalaludin Weisuddin, Sheeren Parker. *East Suffolk and North Essex NHS Trust. Colchester Hospital*

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Aim As the volume and complexity of paediatric problems, including medical and social issues continues to rise, there remains limited guidance for paediatrics doctors to strike the balance between achieving satisfactory patient care and prevent themselves from developing work fatigue. The aim of the questionnaire was to review current staff break policy and confirm that this was being adhered to within the workplace. Where this was not taking place, the questionnaire looked to identify whether there was risk to patient safety and whether the health and wellbeing of workers was being effected.

Methods We conducted a survey at the District General Hospital, which included 9 questions and where 33 Doctors were anonymously interviewed. Of these 33 Doctors, 12 were Consultant Paediatricians, whilst 21 were junior doctors FY1 FY2. The Paediatrics and GP trainees from ST1 to ST6.

Result 94% of interviewees confirmed that they had days where they would not have breaks at all. 70% admitted that they felt guilty taking breaks, whilst 79% confirmed that senior members of staff had prevented them from taking breaks. 79% answered that planning breaks during handover/takeover is not acceptable, whilst overall, 91% believe that senior members of staff should be actively seen to monitor/enforce taking of breaks. All interviewees confirmed that a break should constitute time free from holding the bleep, where they would be permitted to take fluids and food on board.

It was also pointed out that a break should constitute time outside of the unit, preferably in an environment where an individual could relax.

Conclusion Based on the findings and review of various literature, it is recommended that a 30 minute break be provided and after 6 hours of continuous work. This would comply with the Trust. Where members of staff are required to work at commuter more than 1.5hrs daily, a 10 minute break is to be taken. For each shift, a senior doctor is to be identified and who will monitor whether staff are taking breaks. To promote wider cultural awareness, a poster and flyer was put up on notice boards for all staff members to view. These visual aids encourage staff to take breaks whilst also serve as an educational piece, reminding all staff members of the importance of the having rest: to ensure a high standard of patient

care is maintained, as well as maintain individual health & wellbeing.

5 THE FREQUENCY AND MAGNITUDE OF THE IMPACT OF SOURCES OF NEGATIVE VACCINATION INFORMATION ON PARENTS' VIEWS ON VACCINE SAFETY AND EFFICACY

Željko Pavić, Giovana Armano, Vesna Bacalja, Irena Bralić, Rasema Bubica, Marija Čatipović, Sonja Horović, Matea Jelavić, Milivoj Jovančević, Zdenka Konjarik, Vlado Krmeć, Miroslav Kudlač, Anica Persoglia-Petrac, Jadranka Petrović-Schneider, Dragica Šakić, Nevena Švorinić, Aida Mujkić. *Faculty of Humanities and Social Sciences*

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The aim of the study was to determine the frequency of skepticism in relation to vaccination in parents with young children, the impact of demographic variables on skepticism, as well as the frequency of negative sources of information and the strength of their association with skepticism towards vaccination. Efforts were made to determine whether the most common sources of negative vaccination information were at the same time sources of negative information leading to the strongest skepticism.

An online questionnaire distributed by 15 pediatricians from Croatia included a sample of parents with at least one child between the ages of 1 and 4 (N = 333, with a response rate of 96%). The questionnaire was developed by the European Academy of Paediatrics Research in the Outpatient Setting Network (EAPRASnet). In the linear regression analysis, the scale obtained by summing the results to 14 Likert-type items was used as the criterion variable. The sources of negative vaccination information and demographic variables were used as predictor variables.

The arithmetic mean of scores of non-confidence in the safety and efficacy of the vaccine was 27.76 (SD = 6.87; the maximum possible score was 60 indicating higher degree of skepticism, while the lowest possible score was 14). About 13.5% of parents delayed and 6.9% refused to vaccinate their child for reasons other than illness and allergy. Negative vaccination information was received by 81.4% of parents, the most important source being the mass media (43.4%), followed by friends and family members (32.0%), the Internet (22.1%) and healthcare professionals (2.6%). Health professionals' impact on the suspicion of vaccines was the strongest (regression coefficient amounts to 9.27 relative to the mass media), followed by friends and family, the Internet, and the mass media. The total number of children was positively correlated (regression coefficient equals 0.15), while age, sex, age of the youngest child, and parental education were not associated with skepticism regarding the safety and efficacy of vaccination.

The results of the research show that it is necessary to distinguish between the frequency and the strength of influence of certain sources of negative vaccination information, that is, although very rarely present as sources of negative information, health workers appear as a particularly powerful influence factor. Friends and family are moderately frequent and moderately strong, the mass media very frequent and very weak, and the Internet moderately frequent and weak source of negative information.