and 1 had methylmalonic aciduria). Average duration of neutropenia was 6.43 months while average age at diagnosis was 19.6 months. During this study 227 (78.82%) examinees were cured, 34 (11.81%) were still being followed up and for 27 (9.38%) of them we didn’t know outcome. 39.24% neutropenias were acute and 56.25% were chronic. According to the severity of neutropenia the distribution was 60.42% – 26.39% – 12.85% (severe, moderate, mild). Average duration of neutropenia in cases of severe neutropenia (ANC < 0.5 x 10⁹/L) was 9.14 months, in moderate neutropenia (ANC = 0.5-1.0 x 10⁹/L) 4.09 months and in mild neutropenia (ANC > 1.0 x 10⁹/L) 1.64 months. We recorded infection during neutropenia in 232 (80.56%) examinees while 88 (30.56%) had noted infections before the onset of neutropenia.

**Conclusion** This study showed that 97.57% children had benign neutropenia and 78.82% were spontaneously cured during the research which are encouraging results. We noted that children with mild neutropenias and those who had no recorded infections during neutropenia had shorter average duration of neutropenia. In conclusion, most neutropenias of the early childhood are benign and have favorable outcome.

### 326 AUTOSPLENECTOMY – CASE REPORT

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**Introduction** Autosplenectomy defines spontaneous splenic infarction leading to hyposplenism. It occurs mainly as a complication of sickle cell anemia, pneumococcal sepsis or systemic lupus erythematosus, but may also be associated with various other conditions. An anatomical variation of the spleen’s position, the wandering spleen, has been reported as an underlying cause in less than 0.5% of autosplenectomy cases.

**Case Report** A 9.5-month-old female was admitted to the Department of Oncology and Hematology of the Children’s Hospital Zagreb due to a prolonged fever of an unknown origin and splenomegaly. Laboratory findings detected profound normocytic anemia, attributed to splenic sequestration. Abdominal ultrasound detected multiple hypoechoic areas in the spleen, indicating splenic infarction, confirmed by MR angiography. An extensive work-up excluded sickle cell anemia, thalassemia, hematological malignancies, myeloproliferative disorders, thrombophelia, autoimmune vasculitis, Kawasaki disease and infection as a cause of the condition. However, repeated ultrasound examination revealed an aberrant, vertically positioned spleen, which most likely led to an inadequate blood supply and consequently splenic infarction. Antiplatelet therapy and antibiotic prophylaxis were initiated, along with pneumococcal and meningococcal vaccines. The patient is still monitored regularly, currently with normal hematological laboratory findings and none of the complications possibly attributed to hyposplenism.

**Conclusion** Autosplenectomy in children, although rarely, may result from an aberrant spleen’s position. Congenital weakness of the splenic ligaments, allowing its mobility, causes torsion of the splenic artery, leading to blood supply failure and tissue damage. Given the wide differential diagnosis of splenic infarction, it is necessary to exclude numerous underlying medical conditions, primarily sickle cell anemia. A conservative approach is currently the treatment of choice. Hyposplenism, leading to susceptibility to sepsis caused by encapsulated bacteria, requires appropriate antibiotic prophylaxis and vaccination of such patients.

### Paediatric Intensive and Emergency Medicine

### 327 DIFFICULTIES EMERGING FROM THE END-OF-LIFE CARE IN THE PEDIATRIC INTENSIVE CARE UNITS


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Working in ICUs that involves care for critically ill children is inherently demanding. The intricacy of end-of-life issues in this setting adds additional layer of high demands that health care professionals are inadequately prepared for. An interpretative, qualitative inquiry based on thematic data analysis using focus groups as data collection method was used in order to