abnormal high-level duodenal compartment. When duodenum coarsens between the abdominal aorta and superior mesenteric artery (duodenal interposition), the left renal vein entrapment occurs even at < 90 aortomesenteric degrees.

Three-dimensional PEEK printed extravascular stent was chosen to elevate the superior mesenteric artery and lower the duodenum position, thus relieving left renal vein compression. This extravascular application has significant advantages over open surgery, endovascular stenting and artificial vessel procedures with expanded polytetrafluoroethylene. It provides better cellular vitality by ensuring soft tissue proliferation. By reducing external acceleration and centrifugal force, a three-dimensional printed PEEK extravascular stent reduces adverse side effects. Such a stent has a distinctive personalized design, good stiffness, and durability that allows blood vessel growth, preventing stent migration and thrombosis. Therefore, it is suitable for both adult and pediatric patients. According to the abdominal ultrasound and MSCT scan, the post-operative follow-up results are satisfactory one year after surgery. The patient feels well, the blood flow in the left renal vein is not obstructed, and the blood flow velocity was average. The external stent is in place.

370 COMPARING POINT OF CARE URINALYSIS TO LABORATORY URINALYSIS AT MATER DEI HOSPITAL

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A Study was done to analyse the reliability of point of care urinalysis done at Mater Dei Hospital Paediatric Emergency Department, which is the main hospital in Malta.

Data was collected over a 6 week period, starting from the 18th of January 2021. Reliability was assessed through comparison of the result from the point of care test to the result from the laboratory.

Furthermore if there was evidence of a Urinary Tract Infection (UTI) a urine culture and sensitivity test was performed.

Data was collected by going through the documentation of all the patients that attended the Paediatric Emergency Department during that time period.

If urine was collected for urinalysis and tested by both point of care urinalysis and official laboratory urinalysis, this was included in the data. In the presence of evidence of a UTI data regarding the culture and sensitivity was recorded. The data obtained from the laboratory was then converted to the same units as those obtained from the urinalysis done at the Paediatric Emergency Department. These were then compared and a Chi squared test was performed obtaining a P value for each of the subset of data collected.

Null Hypothesis – ‘There is no significant difference in the values obtained from a urinalysis done at the Paediatric Emergency department and that done at the Laboratory’

P values obtained for each category were as follows:

Leukocytes – 0.757 Nitrites – 1 Proteins – 0.312 Erythrocytes – 0.766 Ketones – 0 Glucose – 1

The Null hypothesis could be accepted for Leukocytes, Nitrites, Proteins, Erythrocytes and Glucose and rejected for ketones with a confidence of $p = 0.05$

A point of care urinalysis performed at the Paediatric emergency department is reliable to determine the presence and

give a measure respectively of WCC, erythrocytes, protein and glucose. It is also reliable to detect nitrites.

The identification and quantification of ketones from a urinalysis at the Paediatric Emergency department should be backed up by a formal urinalysis performed by the laboratory.

371 ARE THESE REALLY STONES?

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Introduction Nephrolithiasis' recurrence is frequent and increases if an underlying metabolic abnormality is present. Although in up to 15-25% of affected children there is no risk factor identified, suspicion should be raised in the presence of exaggerated clinical manifestations with no reasonable explanation.

Case Report A eleven-year old uncircumcised adolescent male, with a family history of IgA Nephropathy, was referred to a pediatric nephrology consultation after being seen multiple times in the emergency department with chief complaint of recurrent episodes of dysuria with emission of up to seventeen 3-4mm black calculus. He had no lumbar or abdominal pain, nor gross hematuria. On physical examination, Murphy's sign was negative bilaterally and rectal examination was normal. His laboratory evaluation, urinalysis and ultrasound were unremarkable and did not reveal any morphological or functional alterations. A 24-hour urine collection was performed with an elevated concentration of urinary urea but no other noteworthy alterations.

Homocysteine, methionine and homocystic acid dosing were within normal ranges. Multiple laboratory evaluations of the stones weren't able to determine its composition. No metabolic or infectious cause for a calculus was identified.

Due to the recurrence of this situation he repeated both 24-hour urine collection and ultrasound with no significant results. The calculus was eventually sent to an outside laboratory and rubber elastomer was detected.

Careful examination of the patient's past medical history revealed he had already been evaluated in a Pedopsychiatric consultation before. After determining the stones were self-induced, the adolescent was once more referred to Pedopsychiatry appointment. No further signs or symptoms of nephrolithiasis were reported.

Discussion Although Factitious Diseases (FD) caused by proxy have been increasingly recognized, there is a significant less awareness that children and adolescents can intentionally falsify symptoms. Even though urinary tract involvement is rare, any unexplained medical condition warrants the exclusion of self-induced FD.

372 EVOLUTION OF EPIDEMIOLOGICAL AND BACTERIOLOGICAL PROFILES OF FEBRILE URINARY TRACT INFECTIONS IN CHILDREN

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