Characteristic symptoms of the disease – disosmia, nausea, vomiting, loss of appetite were reported to occur 2 weeks prior to hospitalization and were only mild or barely causing any concern to the parent. Children were admitted with symptoms of mild to moderate dehydration, metabolic acidosis and often constipation. The classical laboratory findings of elevated inflammatory response, leucopenia and lymphopenia were absent. Abdominal ultrasound was negative. Repeated surgical exams revealed no signs of acute abdomen. Qualitative antibody testing showed either presence of both IgM and IgG antibodies against SARS CoV-2 or only IgG antibodies. Some children had pathologic urinary findings, such as hematuria. Signs of autonomic dysfunction were observed since all of the patients had bradycardia and variations of blood pressure. No respiratory symptoms were registered and no children had no history of pre-existing conditions.

Symptomatic medication was effective only in some patients. Empiric AB-treatment proved to be much more successful, though no causative agent of intestinal infection was isolated.

Manifestations of post-infectious MIS-C, associated with COVID-19 often include gastro-intestinal symptoms. For definitive diagnosis of the condition, tests for COVID-19 should be administered, since not all laboratory findings might be consistent with case definitions.

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CHILDREN'S PERSPECTIVE: HOW TO STAY 'NORMAL' IN 'ABNORMAL' WORLD

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The coronavirus pandemic has conquered the world in 2020 and had an outstanding impact on our everyday lives. Face mask mandates, constant use of disinfectants, social distancing, limited movement, working from home and online teaching are only some of the changes that we had to incorporate in our lives. Regardless of age, gender, occupation or socio-economic status, there is no single individual who was not challenged to adapt to the new circumstances.

Children and adolescents are much more vulnerable to the effects of any event that disrupts or limits how they function. This can cause long-term damage to the health and quality of their upbringing, as well as their proper socio-emotional and physical development.

In order to gain insight into the effects of the pandemic on the emotional status of children and adolescents, an online questionnaire was distributed to participants aged 10 to 18 in two periods – spring of 2020 and spring of 2021.

We believe that the acquired data can contribute to a better understanding of the effects of the pandemic on the lives of children and adolescents by analyzing any disruptions in mood, consequences on interpersonal relations, capacity to adapt and assessing quality of life.

Better understanding leads to a better ability to define the critical areas in which to provide professional help and support. It can also provide key guidelines for preventing developmental disruptions in vulnerable groups such as children and adolescents.

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HOW ACTIVE IS ACTIVE? PHYSICAL ACTIVITY LEVELS IN CHILDREN LIVING WITH OBESITY

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Background and Aims Physical activity is essential for healthy growth and development. Being active is an important tool for the prevention and treatment of childhood obesity. Physical activity can benefit children with obesity by helping them build a healthier body composition including stronger bones and muscles and increasing their energy expenditure. Other benefits for physical activity in children with obesity include improving mental wellbeing, sleep, gross motor skills and energy levels.

The UK Chief Medical Officers (CMO) recommend that children aged 5-18 years should engage in moderate-to-vigorous intensity physical activity for at least 60 minutes per day. Moderate-to-vigorous intensity activities are defined as requiring effort and noticeably raising the heart and breathing rates. Examples include cycling, jumping and active play.

This aim of this project was to assess physical activity levels in a population of children aged 5-16 years living with obesity and survey parental knowledge of the CMO guidelines.

Methods Families with a child aged 5-16 years living with obesity (defined by a BMI greater than the 98th centile on the RCPCH Growth Charts) were interviewed by a paediatric physiotherapist. Parents/carers were asked 3 questions.

'Do you consider your child to be physically active?' 'How many minutes of physical activity do you think are recommended by the UK CMOs for your child based on his/her age?' The third question was 'Can you describe your child's daily routine including any physical activities?'

Families described their child's daily routine including play, sport, and active travel. Answers were recorded by the physiotherapist, anonymously compiled, and analysed by the authors.

Results Families of 47 children living with obesity participated. 53% of parents/carers answered 'Yes' that they considered their child to be physically active. 47% answered 'No.' Only 19% of parents answered correctly when they were asked how many minutes of daily activity was recommended by the UK CMO. Upon analysis of the family accounts of their child's daily activities only 5 of the 47 children (12%) were achieving their daily physical activity targets.

Conclusions Encouraging children who are living with obesity to engage in physical activity is a fundamental treatment goal. This project highlights that a low percentage of children (12%) living with obesity are achieving the recommended daily activity levels. Many parents of children with obesity are not aware of the correct CMO recommendations for physical activity and overestimate how active their child is. As healthcare professionals we should promote and educate parents about the CMO recommendations.

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A PRIMARY CARE APPROACH TO PAEDIATRIC MENTAL HEALTH DISORDERS IN IRELAND

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To review the literature of increasing mental health issues and waiting times for treatment in the paediatric population To establish the most useful resources for preventing and treating mental health issues To create a toolkit that can be used to improve mental health in children The enforced isolation caused by the COVID-19 pandemic has led to an increase in mental health issues and severity of presentations to emergency departments. Prolonged waiting times for referral to psychiatry and psychology services have resulted in regression and many children are left untreated. We proposed the creation of a 'Happiness Toolkit' that can be given to children upon presentation to their primary care provider with a mental health issue. A literature review revealed six key resources that have been proven to boost self-esteem, develop resilience and promote positive mental health practices. This resource would provide immediate treatment to those children who would otherwise be forced to endure long waiting periods for referral. A leaflet detailing the practices along with a physical 'box' that the children must make were created.

A trial period of the resource took place in Mullingar Regional Hospital, Ireland, with a marked improvement in outcomes. Children reattending for clinic reported increased happiness and an unforeseen two-and-three-generational benefit was also observed as parents, grandparents and caregivers alike took part in the 'Happiness Toolkit' activities.

Although children presenting with severe mental health issues are treated immediately, those with mild to moderate conditions are placed onto waiting lists and may have to wait over a year and a half to be seen by a specialist. Our toolkit allows children and their families to engage in positive mental health practices that can not only prevent regression during this waiting period, but also lead to improved mental health or cessation of symptoms. This resource, provided free to children and parents, can play a vital role in preventing increased mental health presentations as a result of the pandemic.

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WHAT MAKES A GREAT CLINICAL TEACHER? 'THE MASTER, THE NOVICE AND THE APPRENTICE' SPEAK

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To describe the definitions of a great clinical teacher from the literature To discuss the importance of teaching at different stages of a medical career The highlight the benefits of teaching to the learner

Five medical personnel at different stages of their career in paediatric training: student, intern, trainee, consultant and surgeon discussed their experiences of great clinical teaching. The literature studied encompassed a wide variety of fields and provided varying viewpoints on the characteristics that make a teacher great in the medical field.

While personal experiences varied greatly, many of the brilliant teachers were found to possess similar traits, particularly those of positive interactions with patients. Much of what is learned from teachers is not explicitly taught but is gained from observation and experience.

The role of the teacher is changing, particularly in light of the emergence of electronic communications during the

COVID-19 pandemic. Educators must continuously evolve to meet these changes and appreciate that students are learning from them at every opportunity, whether they are explicitly teaching or not. Non-cognitive skills are as important, if not more important, than purely cognitive skills and these must be imparted to trainees by their clinical teachers.

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DO WE THINK OF SCHAMBERG'S DISEASE AS DIFFERENTIAL DIAGNOSIS OF PURPURA IN CHILDHOOD? – A CASE REPORT OF A SIX-YEAR-OLD BOY

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Introduction Purpura pigmentosa progressiva (Schamberg) is one of clinical entities of pigmented purpuric dermatoses to which joint capillary damage (capillaritis), erythrocyte extravasation and hemosiderin deposition. As possible causes of pigmented purpuric dermatosis the literature lists trauma, pressure, medications, and vascular damage caused by the immune response. It is a benign, chronic disease that most commonly occurs in adulthood and less frequently before onset puberty, although there have been described cases of the disease in infants as well.

Case Report A six-year-old, previously healthy boy, was examined in the emergency paediatric clinic due to the appearance of a purpuric rash on the skin of both legs, more pronounced on the thighs. The rest of the clinical examination was completely normal. Apart from the skin changes, he had no other symptoms and was afebrile. In months before the rash appeared the boy was taking multivitamin preparation and the parents denied taking any other medications. The boy was in contact with a relative who had hand, foot and mouth disease two weeks prior to his presentation, but no obvious symptoms of the disease developed. The boy was admitted to the observation unit on suspicion of vasculitis and complete blood count, differential blood count, coagulation panel, aspartate aminotransferase, alanine aminotransferase, lactate dehydrogenase, urea, creatinine, albumin and urine sediment as well as hemocult tested normal. Blood samples were taken for complement components C3 and C4, antineutrophil cytoplasmic antibodies (ANCA) and extractable nuclear antigen (ENA). Considering the patient was well and findings up to the point, the boy was discharged home with an outpatient follow-up recommendation. The skin changes partially receded over the next three days, but reappeared after a week. Upon arrival of normal findings of C3 and C4 components complex, and negative ENA and ANCA, a dermatological review was requested. Three months since the appearance of skin changes, they have persisted, in the form of brownish erythematous macules, especially on the medial and posterior thighs. Dermatoscopic and clinical examination concluded that the boy had pigmented progressive purpura (Schamberg disease). A topical corticosteroid therapy was prescribed, and dermatologic follow up were recommended.

Conclusion Although Schamberg's purpura is more common in adults, it is worth taking it into consideration when a paediatric patient with the purpuric skin changes presents. Schamberg's disease is a benign, chronic dermatitis in which