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P28 PAEDIATRIC COVID TOES AND THE RECOMMENDED CARE MANAGEMENT

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10.1136/archdischild-2022-NPPG.35

Aim To define COVID toes and fingers in paediatrics, and to explain the aetiology, the assessment and investigation management, the diagnosis, the clinical presentation and the care management including the use of oral nifedipine in this newly found disease during the COVID-19 pandemic. In addition, we will illustrate the process using the multi-disciplinary approach to prepare the Paediatric COVID toes guideline in our Trust, and to cite some examples of the related patient cases seen in our hospital as well as to summarise the total number of patient cases seen to date.

Method To carry out a literature search to find out the latest related articles and clinical studies, and to summarise the findings to prepare for the drafting of the clinical guideline. This guideline was initially prepared by the medical team and was then reviewed using multi-disciplinary team (MDT) approach including the paediatric pharmacists and the consultation from the tertiary paediatric centre. We also summarised the number of paediatric patient cases that were seen in our Trust and categorised them into different age groups, ethnic background, and referral systems.

Results A number of related articles were found after the literature search. The first draft of the Paediatric COVID-toes guideline was prepared in March 2021 and it was then reviewed by the MDT in the Paediatric Clinical Guideline Group of our Trust. The paediatric pharmacist expressed her comments including the drug of choice such as oral nifedipine, the dosages below and above 2 years of age, the evidence to support the dosage recommendations, the different formulations available in the market for oral nifedipine such as oral suspension, capsule, tablet and modified-released (MR) tablet, recommended effective method for oral administration, side effects profile, monitoring such as blood pressure, patient counselling and education, and provision of patient leaflet and video-link to aid patient compliance.

Conclusion The final version of the Paediatric COVID toes guideline was prepared by the multi-disciplinary team in July, 2021, and it was uploaded in the Trust intranet in August 2021. In view of the literature search, there is limited evidence to support the use of oral nifedipine under 2 years of age for this indication. In our guideline, we recommend the dose of nifedipine to be 2.5–10 mg 2–4 times a day for children age 2 to 17 years old, starting with low doses at night and increase gradually by closely monitoring blood pressure and other side effects. The use of oral nifedipine is unlicensed for this indication in children. In our guideline, we recommend the use of oral MR nifedipine tablet after the consultation with the tertiary centre. Oral suspension is not routinely used. During counselling session, the pharmacist will advise the parent/carer to crush and dissolve the MR tablet in water and give appropriate dose accordingly. To date, 15 patients diagnosed with this disease were seen in our clinic. They are mainly referred to the clinic via the Accident and Emergency

Department. The patient ages are all above 8 years old and they are mainly of Asian ethnic background.

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P29 MEDICINE PRESCRIBING ACROSS PRIMARY, SECONDARY AND TERTIARY CARE INTERFACES IN PAEDIATRICS: A RETROSPECTIVE COHORT STUDY

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10.1136/archdischild-2022-NPPG.36

Aim Shared care agreements, commissioned by local clinical commissioning groups, are formal agreements that set out prescribing arrangements to provide a safe and cost-effective service that covers the prescribing requirements and to allow for the continued involvement of a hospital consultant alongside the provision of care in primary care settings.¹⁻³ However, primary care prescribers have often expressed hesitancy to accept responsibility for prescribing in paediatrics, leaving secondary and tertiary care providers to prescribe these medications instead,¹ resulting in inappropriate pressures on hospital pharmacies and often leaves families with difficulties in securing ongoing supply. This study aimed to investigate the volume, cost and type of hospital outpatient paediatric prescribing associated with items for which prescribing responsibility could be transferred to primary care. As well as to identify whether the current shared care agreements; traffic light rating (TLR) system and associated guidelines, encompass these medications.

Method A retrospective cohort study, involving descriptive and inferential statistical analysis, was conducted on prescription items prescribed and dispensed for paediatric patients. Prescriptions were identified by dispensary staff over a six-month period (October 2019-March 2020), at one tertiary care level hospital in southeast London. The prescription items were classified according to the TLR system defined in the South East London Joint Medicines formulary⁴ as red (specialist/hospital prescribing only); amber-1 (primary care initiation after a recommendation from a specialist); amber-2 (specialist initiation followed by maintenance prescribing in primary care); amber-3 (specialist initiation with ongoing monitoring using shared care agreement documentation); green (specialist or non-specialist prescribing).

Data were analysed using Statistical Package for the Social Sciences (IBM SPSS) Software (V27).

Results In total 217 prescribed items prescribed and dispensed for 35 children were included in the study, and all of them had the potential to be prescribed in primary care. Of these, 93.1% (202/217) were rated 'green' with most of them prescribed for children aged 6-11 years (32.2%, 65/202).

Only 3.2% (7/217) items had an 'amber-3' rating and required shared care agreements to initiate prescribing in primary care, many of them (85.7%, 6/7) had shared care