

nausea/vomiting, headache and dizziness was negligible.^{1 2} No complications were accounted in using the lowest dose (<25mg).² Another study specifically mentioned no adverse reactions observed in children when 0.1ml/kg of 5% fluorescein was administered.³ The case report presented a paediatric patient (16 months) with CSF leak who was administered 0.125ml (6.25mg) of 5% IT to identify the leak.⁴ The potential dosage for Miss. AB was decided as between 10mg to 25mg balancing the increasing risk of adverse reactions with higher doses and possibility of false-negative result with lower doses.

The neurosurgical team used this evidence to present the patient's case to the chairman's board for an off-label use approval at the trust. Upon enquiring various manufactures, the 5% unlicensed injection was unavailable to purchase and the 10% injection is unsuitable for intrathecal use. Therefore, the 20% fluorescence sodium injection which is an unlicensed 'specials' product usually used in adults was recommended by pharmacy. The smallest measurable dose of 0.1ml (20mg) of 20% fluorescein sodium, diluted in 10ml CSF with 5ml infused via a 0.2micron filter was recommended. The batch number and pyrogen free certificate was obtained from pharmacy procurement and application was submitted.

Upon receiving the panel approval, IF was used and a CSF leak was identified. This has aided the surgeons to confirm diagnosis and repair the rhinorrhea. With this successful intervention, the use of IF can be an established option to diagnose CSF rhinorrhea prior to surgery in the trust. These findings will be used in submitting a formulary application and drafting trust guidance for extending the use of IF to paediatrics as a diagnostic tool in neurosurgery.

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P03 PARACETAMOL DOSING IN HOSPITALISED CHILDREN – A NATIONAL SURVEY

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Aim The purpose of this survey was to establish how closely paracetamol prescribing for paediatric inpatients reflects dosing guidance in the British National Formulary for Children (BNFC).¹ The project was a collaboration between the Neonatal and Paediatric Pharmacists Group (NPPG) and the Paediatric Pain travelling Club (PPTC).

Method An electronic survey was developed jointly by members of the NPPG and PPTC and emailed to the memberships of both organisations (430 NPPG members, 155 UK sites and 293 PPTC members, 54 UK sites) in July 2020. A reminder was circulated 1 week afterwards and the survey was open for 3 weeks in total. Survey Monkey software was used to

generate the e-survey. Descriptive statistics and thematic analysis were used to describe the data.

Results 169 people responded to the survey (response rate 23.4%). 103 NPPG members responded (response rate 23.9%). 66 PPTC nurses or anaesthetists responded (22.5% response rate).

76 UK sites were represented, 57.4% of all UK PPTC sites and 43.9% of all UK NPPG sites. Between 1 and 7 people per site responded (mean 1, IQ range 1-2).

51 (67%) sites reported use of locally developed guidelines to dose oral paracetamol rather than the BNFC. For example, 34% of sites use weight-based dosing for all inpatients, whereas the BNFC recommends a mixture of age-banded and weight-based doses, depending on the indication. 'Appropriate dosing' of oral paracetamol for children over 1 month of age generated the most variation, frustration, confusion and disagreement between respondents both within sites and between sites. Strong views on avoiding sub-therapeutic doses in children with pain and not wanting to overdose children of low weight for age were voiced. In some cases the views of the PPTC members were very different to the pharmacists, probably reflecting the difference between prescribing for post-operative or severe pain vs treatment of pyrexia or mild to moderate pain.

65% of respondents adhere to BNFC regimen for IV paracetamol. Of the 16 (21.3%) sites which did not use the BNFC for IV dosing, 15 (93.8%) had a specialist paediatric pain team. Variation in dosing of IV paracetamol was mainly seen for neonates and patients over 50kg. For neonates, respondents reported using the recommended maximum daily dose in the BNFC but many altered the individual dose and/or frequency to optimise analgesia. For example 30mg/kg/day might be achieved using 7.5mg/kg every 6 hours vs the recommended 10mg/kg every 4 hours which would leave a large part of the day without doses able to be given. Patients over 50kg were often prescribed weight-based IV doses rather than the recommended 1g every 6 hours.

Conclusion Paracetamol dosing for inpatients is highly variable and does not reflect dosing guidance in the BNFC. Clinical concerns of safety vs efficacy contribute to the variation identified and must be addressed in future dosing guidance to optimise treatment for paediatric inpatients.

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P04 VARIABILITY IN CONCENTRATION OF ORAL LIQUID MEDICINES PRESCRIBED FOR CHILDREN IN ENGLAND- AN ANALYSIS

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Aim Liquid medicines are commonly prescribed for children. Multiple concentrations are in use for many drugs, increasing the risk of error. This project aimed to describe the variability in the concentrations prescribed for children in England.

Method The NHS Business Authority (NHSBA) was contacted to obtain details of all liquid medicines dispensed against FP10 prescriptions for patients aged under 18 years across a twelve month period from 1st February 2019 and 31st