Methods All patients had either a single or double lumen external catheter (Hickman) or Portacath inserted. The choice of catheter for each patient is individualised. The Lothian Surgical Audit System, TRAK, iLAB and case notes were reviewed for patient demographics, surgical details of line insertion, line-associated complications and reasons for removal of line.

Results 140 patients underwent 215 line insertions, with 80 (57.1%) patients experiencing a line-associated complication (total number of episodes n = 145). Proven infection was the most common complication (77 episodes, 53.1%), followed by blockages (45 episodes, 29.7%), dislodgement (12 episodes, 8.3%), fracture (7 episodes, 4.8%), kinking (2 episodes, 1.4%), migration (1 episode, 0.7%), extravasation (1 episode, 0.7%), atelectasis (1 episode, 0.7%) and skin breakdown over Portacath (1 episode, 0.7%). The median (range) number of catheter days for single CVL was 399.5 days (range 9–1837 days) for Portacaths and 82.5 (15–218 days) for Hickman lines. The median catheter duration for double CVL was 198.5 (1–582) days and 112 (0–882) days for Portacaths and Hickman lines respectively. Single Hickman lines had the highest rate of premature removal (42.9%), followed by double Hickman lines (42.6%), double Portacaths (55.7%) and single Portacaths (22.9%). The presence of severe thrombocytopenia (<50 × 10^9/L) and severe neutropenia (<0.5 × 10^9/L) at insertion were associated with higher rates of premature removal due to infection (20.0% and 19.6% respectively), compared with CVL with platelet count ≥50 × 10^9/L and neutrophils ≥1.0 × 10^9/L (18.3% and 18.2% respectively).

Conclusion Single Portacaths are the longest surviving central venous lines. The presence of thrombocytopenia and/or neutropenia at the time of insertion may be associated with an increased risk of line sepsis and premature removal.

G179 | LONG TERM FOLLOW-UP FOR PAEDIATRIC ONCOLOGY PATIENTS AT A PAEDIATRIC DEPARTMENT OF A GENERAL HOSPITAL

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1SM Murphy, 2KM Husselbee. 1Ninewells Hospital and Medical School, Dundee University, Dundee, UK; 2Tayside Children’s Hospital, Ninewells Hospital, Dundee, UK

Aims
1. Establish how national Long Term Follow Up recommendations can be implemented locally in a paediatric department of a large general hospital.
2. Establish the number of patients who currently have an end of treatment summary in their notes.
3. Determine how many patients are attending appointments.
4. Identify if the appropriate patients are attending clinics.

Methods The medical notes for all patients appointed to attend the long term follow up clinic over the preceding two years were reviewed (95 patients).

It was noted whether each patient had an end of treatment summary present in their notes.

Attendance at clinic over the past two years was noted.

Patients were assigned into different groups according to the ‘Therapy-based recommended levels of follow-up’.

Abstract G179(P) Table 1

<table>
<thead>
<tr>
<th>Level</th>
<th>Treatment</th>
<th>Follow up</th>
<th>Frequency</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Surgery alone, Low risk Chemotherapy</td>
<td>Postal or telephone</td>
<td>1–2 years</td>
<td>Low risk Wilms’ LCH (single system)</td>
</tr>
<tr>
<td>2</td>
<td>Chemotherapy, Low dose cranial irradiation (&lt;24 Gy)</td>
<td>Nurse-led or primary care</td>
<td>1–2 years</td>
<td>Majority of patients (eg ALL)</td>
</tr>
<tr>
<td>3</td>
<td>Radiotherapy (&gt; 24 Gy)</td>
<td>Medically supervised LFTU Clinic</td>
<td>Annually</td>
<td>Brain tumours, post BMT, Any stage 4 patients</td>
</tr>
</tbody>
</table>

Results
The majority (91%) of patients did not have an end of treatment summary in their notes.

The majority of patients were in treatment ‘level 2’ (47%). Those in levels 2&3 will require long term medically supervised follow-up (nurse led or GP if level 2).

Attendance at clinic was noted & of those attending clinic, those with the best ‘full time’ attendance were those deemed to be ‘level 2’ patients. Followed by level 3 and 1 respectively.

Conclusion An ‘End of Treatment Summary’ should be implemented in the notes of all patients who have completed their treatment for childhood cancer.

Review current attendance of those deemed to be level 2 or 3 patients with the view to implementing a postal questionnaire in order to re-engage patients currently lost to follow-up.

REFERENCE