SCD and can occur with both infection (bacterial and viral,) and sickle cell crises. This study aimed to look at the incidence of bacteraemia and bacterial infections in children with SCD presenting to a North-East London district hospital with a fever of 38.5 degrees or higher.

Methods A retrospective analysis was performed on all children (aged under 16 years,) with SCD presenting with a fever of 38.5°C or higher over a 1-year period. Data was collected for each febrile episode on age of child, type of SCD, final clinical diagnosis, initial White cell count (WCC) and C-reactive protein (CRP) levels, blood culture and microbiology results, length of stay and clinical outcome. Children were divided into those having a definite bacterial infection, suspected bacterial infection (clinically suspected but no microbiological confirmation,) or no bacterial infection. Definite bacterial infection was defined as bacteraemia (the isolation of a non-contaminant bacterial from the blood culture,) or other bacteraemic infection with positive microbiological confirmation.

Results Over the 1-year period there were 88 episodes analysed in 59 children. Definite bacterial infection occurred in 8% of febrile episodes of which 3.4% had bacteraemia. (Streptococcus pneumonia, Salmonella hartford, Salmonella typhimurium.) Suspected bacterial infection occurred in a further 53% of episodes. In 59% of episodes the final diagnosis was either a sickle cell crisis or viral illness (no bacterial infection.) Diagnosis did not vary significantly by haemoglobinopathy. One death occurred from Salmonella typhirium septicaemia. Average length of stay varied from 3.6 days in the group with no bacterial infection to 8.9 days in the group with definite bacterial infection.

Conclusion Bacterial infections continue to be a significant problem in children with sickle cell disease. Salmonella infection is a growing concern in this group of children. Further work is required to identify risk factors and predictors for bacterial infection, and ascertain optimal prevention and management strategies.
for cerebrovascular, metabolic and thrombotic risk factors. This is
expensive and it is unclear how often a positive result alters clinical
management.

Aim To investigate the (i) diagnostic yield and (ii) impact on treat-
ment of a extensive panel of investigations for childhood AIS risk
factors in patients seen in a single tertiary paediatric neurology unit.

Methods Children (>28 days old) with radiologically confirmed
AIS seen at our centre 2000 – 2011 were eligible. Since 2000 local
guidelines have recommended a standard panel of investigations1
and patients have been managed according to national clinical
guidelines. Results and impact on treatment were abstracted from
case notes.

Results Data from 51 children was reviewed (24 male, age
6 months – 16 years, median 5 years). Cerebrovascular imaging and
screening for prothrombotic disorders was most comprehensive;
metabolic and infection investigations were largely incomplete.

8/51 patients had prothrombotic risk factors (4 MTHFR homozy-
gous, 1 positive lupus anticoagulant, 2 protein S deficient, 1 Factor
V Leiden heterozygous) but these did not alter clinical manage-
ment. 1 patient was anaemic (requiring blood transfusion) and
another had hypercholesterolaemia (treated with statins). Evidence
of past infection was frequently identified but did not alter manage-
ment. In contrast, magnetic resonance angiography (of the circle of
Willis and cervical vasculature) was abnormal in 41/51, and influ-
enced onward management in 43 cases. Echocardiography was
abnormal in 11/35 available reports. 1 patient had infective endocar-
ditis to which their stroke was attributed and 3 patients had con-
genital structural abnormalities of varying significance.

Conclusions Laboratory investigations for paediatric AIS patients
have a low diagnostic yield and rarely alter treatment decisions.
Cerebrovascular imaging is often fruitful and is key to manage-
ment. These data may contribute to prioritisation of health care spending
related to the investigation of childhood AIS. Wider laboratory eval-
uation may, however, be indicated in individual cases, dependent on
the clinical circumstances.

REFERENCE


Introduction Intestinal volvulus can cause potentially fatal bowel
ischaemia and/or obstruction. Diagnosis can be difficult and easily
missed. Presenting symptoms are variable and there are no published
studies describing the clinical presentation in children. Earlier diag-
nosis may reduce morbidity and mortality. Malrotation is a com-
mon underlying cause of volvulus and can be asymptomatic, or
present with varied gastrointestinal symptoms at all ages[i].

Aims To describe our experience over 15 years of the present-
ing symptoms, age and past history of children presenting with
volvulus.

Methods This study is based on a case notes review of: All children
on the gastroenterology data base presenting with volvulus over the
past 15 years.

Results 30 cases were reviewed. The age at presentation was vari-
able with 24/30 (80%) presenting by 11 years, leaving a significant
minority not presenting until adolescence. The majority of children
(90%) presented with vomiting but in a third of cases it was non-
hilious. Only 6/30 (20%) of children presented with all the classic
symptoms and signs of volvulus: bilious vomiting, abdominal pain,