**Poster abstracts**

**PO-0265** NON INVASIVE VENTILATION FOR SEVERE BRONCHIOLITIS

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Introduction Non-invasive ventilation (NIV) is a relatively new ventilatory mode that has been increasingly used in the acute setting over the past 15 years, demonstrating beneficial effects in the paediatric population with different types of respiratory failure. The current health network structure and a lack of critical care facilities. In 29 facilities a dedicated transport service for critical care patients does exist but just in one hospital it’s specific for paediatric patients and it has dedicated staff. Forty facilities are equipped with a paediatric medical bag and the more involved operator is an anesthesiologist for 39% of cases, followed by the paediatrician in 13% of cases. The nurse participates to the transport in 50% of cases; in 28% of the hospitals a critical care nurse is involved, in 7% of cases the nurse is not specialised and in 4% the nurses is specialised in paediatrics. The data shows an non homogeneity management of the critical care patient secondary transport. The study's high desirable the activation of a secondary transport service with an organisational level compared to the neonatal emergency transport service because the child has its own characteristics as like as the newborn or the adult.

**PO-0266** SEPTIC SHOCK SECONDARY TO A COMMUNITY ACQUIRED INFECTION: ABOUT 51 CASES

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Introduction Septic shock in children remains one of the main causes of morbidity and mortality worldwide. Although their diagnosis and their management is largely influenced by studies done in adults. There are important considerations relevant for paediatrics.

Goal This study had for aim to evaluate epidemiology and outcome of septic shock secondary to a community acquired infection.

Patients and methods A retrospective analysis was made of patients admitted between January 2004 and December 2013, in a paediatric department for septic shock secondary to a community-acquired infection. Neonates were excluded from the study.

Results Fifty-one cases were included. The average age was 2.7 years (1 month–14 years). The average time between the observation of first disease symptoms and admission was 2.8 days (1–14 days). The average PRISM during the first 24 h was 20.3 (4–41). Multiple organ failure was present in the majority of cases (96%). Gram-negative bacteria were the predominant pathogens (50%). Respiratory infection is the most common infection site (37.3%). The empiric therapy was a combination of Cefotaxime and Aminoglycoside in 52.9% of cases. Dopamine remains the most prescribed catecholamine (72.5%). Dobutamine and Norepinephrine were used in 62.7% and 31.4% of cases. Mechanical ventilation was needed in 39 patients with an average of 2.8 days (1–16 days). The average length of hospitalisation was 12.6 ± 6.9 days (4–30 days). The mortality was 70.6%.

Conclusion Despite significant progress in the understanding and treatment, septic shock continues to be a major health problem in developing countries and around the world.

**PO-0267** SECONDARY TRANSPORT OF CRITICAL PAEDIATRIC PATIENTS: SURVEY IN LOMBARDY

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Background The current health network structure and a lack of a proper filter for pre-hospital care makes every hospital potentially involved into the management of any critical paediatric patient regardless the local experience and organisation.

Any first patient’s stabilisation will have to be followed by a secured secondary transport until the hospitalisation at the new facility.

Objective Explore the hospitals’ organisational set up concerning the secondary transport of paediatric critical care patients.

Materials and methods Structured survey delivered to 92 hospitals in Lombardy.

Results The response rate was 56%, corresponding to 52 health care facilities. In 29 facilities a dedicated transport service for critical care patients does exist but just in one hospital it’s specific for paediatric patients and it has dedicated staff. Forty facilities are equipped with a paediatric medical bag and the more involved operator is an anesthesiologist for 39% of cases, followed by the paediatrician in 13% of cases. The nurse participates to the transport in 50% of cases; in 28% of the hospitals a critical care nurse is involved, in 7% of cases the nurse is not specialised and in 4% the nurses is specialised in paediatrics.

Discussion The data shows an non homogeneity management of the critical care patient secondary transport.

Conclusions It’s highly desirable the activation of a secondary transport service with an organisational level compared to the neonatal emergency transport service because the child has its own characteristics as like as the newborn or the adult.

**PO-0268** THE PARENTAL PRESENCE DURING PAEDIATRIC CARDIOPULMONARY RESUSCITATION: EPIDEMIOLOGICAL ANALYSIS

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Background The paediatric cardiopulmonary resuscitation involves high level skills by operators in a setting characterised...
by an high complexity and a considerable emotional impact. Clinical experience shows that parents are often turned away from the emergency room because they were considered an obstacle.

Objective Investigate the behaviour of some hospitals about the management of parents during cardiopulmonary resuscitation in paediatric subjects.

Materials and Methods Deliver a questionnaire to the nurse coordinators of 19 Italian hospital.

Results The questionnaire had a response rate equal to 89.4%, corresponding to 17 hospitals.

23.5% of hospitals admit the presence of both parents during all phases of resuscitation without age limits, while 17.7% of the structures do not allow the parental presence because of the possible fear created by the anxiety of parents, for the inadequacy of the spaces within the operational units and the perception that parents can potentially be an obstacle for health professionals during the resuscitation procedures.

The remaining 58.8% have a favourable opinion about the possibility of guaranteeing to the paediatric patient, without any age limit, the presence of parents during all phases of the cardiopulmonary resuscitation but difficulties arise to make such a guarantee for the inadequacy of the spaces, for difficulties in managing the behaviour of the relatives especially in regards of anxiety and for the absence of any psychological support figure.

Conclusions It’s necessary that all the hospitals in any way involved into the primary care process shall act in conformity with common management protocols concerning this theme.