aggressive neoplasm with poor prognosis which might be of interest for the clinicians.

**Case presentation** We herein report a case of a 14-year-old girl suffering from cough and back pain for one week. Computerised tomography showed bilateral pleural effusions and mediastinal axillary lymph nodes. The specimen from pleural effusion showed a transudate character with no tuberculosis or no sign of malignancy. Because of increasing dyspnea, a chest tube was inserted and pleural and lung parenchyma biopsy was performed and no definite diagnosis was done. After two weeks, chest tube was drawn. 4 days later, the patient admitted to our emergency room with dyspnea and back pain. Because of increased pleural effusion, the patient was intubated immediately and was referred to paediatric intensive care unit. Detailed diagnostics tests showed anaemia, thrombocytopenia, hypoechoic lesions on spleen and liver, intraabdominal multiple lymph nodes, sclerotic lesions on vertebrae. A tru-cut biopsy was performed by interventional radiology and malignant infiltration was reported. Chemotherapy was initiated to the patient however, the patient’s status was altered and died.

**Conclusion** We present a case of primary pulmonary NK cell lymphoma. The course of the disease was fulminant although the patient received aggressive chemotherapy and other symptomatic treatments. Our case who had difficulty in diagnosis may help to clinicians to identify other cases with NK cell lymphoma, their treatment and outcomes.

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**PO-0273 COMMUNITY-ACQUIRED URINARY TRACT INFECTIONS (UTI) WITH EXTENDED-SPECTRUM BETA-LACTAMASE (ESBL) BACTERIA IN A FRENCH PAEDIATRIC EMERGENCY DEPARTMENT (PED)**

**Background** The prevalence of ESBL bacteria in community-acquired UTIs is increasing. This is of concern, since antibiotic therapy would be restricted to a few antibiotics, including carbapenems (in turn, the frequent use of penems leads to carbapenem-resistance), aminoglycosides, colimycin and fosfomycin.

**Aims** To describe the prevalence of ESBL among Gram-negative bacteria causing community-acquired UTIs managed in a tertiary care PED serving an active Department of paediatric urology.

**Methods** Retrospective study of all UTI episodes diagnosed between 1st January and 31th December, 2012. UTIs were retrieved by using the PED and Bacteriology databases.

**Results** 457 (0.6%) community-acquired UTIs have been identified among 78,152 visits in the PED in 2012. 358 (78%) were diagnosed as acute pyelonephritis based on clinical signs and elevated CRP and/or PCT, and 99 (21%) as acute cystitis. Whereas no ESBL bacteria was identified among episodes of cystitis, 16 acute pyelonephritis cases were due to ESBL E.coli (i.e., 4.5% of all E.coli and 3.4% of all UTIs). 13/16 (81%) UTIs occurred in children suffering urinary tract abnormalities. Moreover, one child with vesico-ureteral bilateral reflux had 3 distinct episodes of UTIs due to ESBL K.pneumoniae in 2012.

**Conclusions** The incidence of ESBL E. coli causing community-acquired UTIs remains low (~5%) in a tertiary hospital PED. This reassuring finding comforts the French UTI current recommendations of using as a first-line therapy iv ceftriaxone for 4 days followed by oral cefixime for 6 additional days. However, ESBL bacteria causing UTIs are favoured by urinary malformations, previous hospitalisations and prophylactic antibiotics.

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**PO-0274 THE FIRST POLISH STUDY ON PARENT SATISFACTION IN PAEDIATRIC INTENSIVE CARE UNIT - THE EMPATHIC-30 POLAND STUDY**

**Aim** The aim of the EMPATHIC-30 Poland study was to implement a validated parent satisfaction questionnaire.

**Material and method** The EMPATHIC-30 questionnaire was used with a written permission of author. The study has been performed at the 10 beds PICU. Inclusion criteria were all parents whose child was admitted to the PICU for at least 24 h and not died in this unit.

**Results** During 4 months 62 children (including 10 deaths) have not died in this unit.

**Conclusion** Propofol offered good intubation conditions without significant side effects. Doses needed to obtain sufficient sedation varied widely.
present during hospitalisation. Twenty five questionnaires have been collected (response rate 53%). Among patients there were 18 infants and toddlers, 3 children and 4 adolescents. Mean length of stay in the PICU was 11 days, 60% of admissions were unplanned. Questionnaires were completed mainly by mothers (84%). Not satisfactory opinions have been given mainly for understandable information on examinations and tests (12%) and on possibility to stay close to the child during intensive procedures (16%). All of parents declared that the team worked efficiently and the team showed respect for the patients but only 72% of parents responded that during stay in the PICU the staff regularly asked for parent’s experiences.

Conclusions The EMPATHIC-30 empowers parents to provide feedback on their experiences in paediatric intensive care and may facilitate health care professionals to improve quality of care. Following a single centre experience the EMPATHIC 30 Poland study should be continued as a national project.

**Methods**

SBI diagnosis was based on urine, blood and CSF cultures and chest radiographs. For children aged 1 to 36 months, the Lab-score and the CPM (2013) combines clinical and laboratory tools in detecting SBI in febrile young children. CPM--Other SBI showed less performance than Lab-score and CPM--≥10% were

**Results**

From 134 children, SBI was diagnosed in 31 (23.13%): 11 pneumonia and 20 other SBI, mostly urinary tract infections. Positive and negative likelihood ratios for Lab-score (≥3), CPM-Pneumonia (≥10%) and CPM-Other SBI (≥10%) were 7.25/0.25, 22/0.65 and 5.23/0.50 and the post test probabilities were 69%, 66% and 48% for the same cut-off values.

**Conclusions**

Both the Lab-score and CPM-Pneumonia are valuable tools in detecting SBI in febrile children. CPM-Other SBI showed less performance than Lab-score and CPM-Pneumonia, possibly due to the lack of urinalysis value in CPM--Other SBI, which are mostly UTI.

**Aims**

We undertook this audit to review the management of febrish children in our emergency departments (ED) compared to The College of Emergency Medicine (CEM) standards.

**Methods**

The data was collected using a tool designed by CEM. Entry criteria: under 5 years old and temp >38°C on arrival. Total number of patients was 50. The assessed risk profile for this population (using NICE guidelines) were 24 low risk, 14 intermediate risk, 11 high risk and 1 we were unable to risk stratify from the clinical notes. Nine children were prescribed antibiotics (5 low risk, 2 intermediate and 2 high risk).

Of the 11 patients who were high risk, 7 had a clear source of infection. Of the 4 who had no source identified, one had bloods and urine performed in ED but these were not recorded in the notes, 2 had bloods performed on the paediatric ward.

For the 14 patients in the intermediate risk, 8 had a source of infection, 5 had no obvious source identified and one was not clearly documented. No patients without a source were prescribed antibiotics. No documentation was recorded about discharge advice.

18 patients (36%) did not have a blood pressure (BP) or a capillary refill time (CRT) documented in the notes and 10 patients (20%) did not have their GCS or APVU recorded.

**Conclusions**

There are areas that require review. Improvements must be made to ensure a full set of observations are recorded, emphasising the importance of BP/CRT as well as GCS/AVPU.