

phenotype was not stable, unlike asthma, neutrophilic was the most common inflammatory phenotype in infants with wheezing, and it was no business of eosinophilia.

O-167b INFLUENCE OF MONTELUKAST ON THE RELIABILITY OF SKIN PRICK TESTING WITH INHALANT ALLERGENS

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Background and aims There is not much data in the literature about the effects of montelukast on the skin reactivity to inhaled allergens. We analysed whether the skin reactivity to allergens significantly changed after 30 days of daily application of montelukast.

Methods Thirty children with asthma (7–14 y) and with skin reactivity to inhaled allergens were receiving 5 mg of montelukast daily for 30 days. Skin prick testing was done before and after therapy. Size of the papule was measured at twentieth minute after allergen application as quantitative (mean of the largest and normally set diameter on it) and qualitative-bimodal: positive/negative (cut-point: 3 mm). The control group consisted of children of the same age (n = 30) with positive skin reactivity who did not receive any medication and has been tested in the same way. The size of the papule, and the number of positive/negative tests for both groups were compared before and after therapy. The frequency of test conversion in both directions (crossing of positive to negative and vice versa) in the experimental group was compared to the control group.

Results After thirty days of montelukast therapy the size of the papule in both groups was not significantly changed ($p > 0.05$). Compared to the control group, in the experimental group, there was no significant difference in the change of skin reactivity to allergens, either quantitatively ($p > 0.05$), or qualitatively ($p > 0.05$) evaluated.

Child Protection

O-168 RISK AND RESILIENCE FACTORS FOR EARLY CHILD DEVELOPMENT: A COMMUNITY-BASED COHORT STUDY IN ALBERTA, CANADA

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Background and aims One in six children experience developmental problems at school entry. Early intervention is more effective than later remediation; however, to date, we lack a comprehensive understanding of risk and protective factors. The objectives of this study were to describe the key risk factors for poor child development at age 12 months and to identify factors that reduce the potentially adverse influence of poor maternal mental health and low socioeconomic status on child development.

Methods We used data from the All Our Babies (AOB) study, a prospective pregnancy cohort in Calgary, Alberta. Five domains of child development at age 12 months were assessed via parent report using the Ages and Stages Questionnaire (ASQ) from

approximately 1500 mothers. The associations between putative risk factors and poor child development were examined in bivariate and multivariable analyses. A bivariate resilience analysis was also conducted to identify factors related to positive child development in the presence of maternal mental health or socio-demographic risk.

Results Key risk factors for poor child development at age 12 months included poor maternal mental health during pregnancy, and low community resource use and lack of adult interaction in the first postpartum year. In addition to parenting efficacy, uptake of community resources and increased adult interaction were protective of poor child development among children most at risk for this outcome.

Conclusions As many of the identified risk and protective factors are modifiable, these results can inform community based strategies to optimise early childhood development.

O-168a YOUNG PEOPLE AND FAMILY INVOLVEMENT IN PAEDIATRIC RESEARCH NETWORKS: OUTCOMES OF A SURVEY AMONG ENPR-EMA NETWORKS

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Background and aims Engaging and involving young people in clinical research has many benefits including greater understanding of young people's perspectives and improvements in study design and the quality of clinical research.¹ The nature and extent of support for the engagement of young people in research in Europe is unclear.

Methods A survey was sent to members of the European network of paediatric research at the EMA (Enpr-EMA),² (Figure 1).

Results While more than half of the responding networks (N=17) actively involve young people/families, only 3 networks have dedicated resources and strategies in place to support this activity,^{3–5} (Table 1). Activities undertaken with young people/families in Enpr-EMA networks are summarised in Table 2.

Conclusions The majority of networks requested guidelines on establishing and maintaining young people's advisory groups and/or identified the need for training for this activity. Responsible and effective involvement of young people/family in paediatric clinical research has been established only in some European networks and should be generalised urgently.

Acknowledgements Not applicable.

Abstract O-168a Table 1 Engagement of young people and family members in Enpr-EMA networks

Young people/family members engagement	Total	Yes	No
Involvement/consultation with young people/family	17	8	9
Dedicated staff for young people/family involvement	17	7	10
Specific budget for young people/family involvement	17	3	14
Specific strategies for young people/family involvement	17	3	14