number of adopted Kazakh children. As most were not underweight and nutritional supply is adequate, this could be attributed to emotional deprivation in orphanages.

164

INVASIVE GROUP A STREPTOCOCCAL INFECTIONS: THE LIVERPOOL EXPERIENCE 2009

A. Timmis, K. Parkins, I. Kustos, E. Carrol

*Alder Hey Children's NHS Foundation Trust,
Liverpool, UK*

Background: Winter '08-'09 saw an increased incidence of invasive Group A Streptococcus infections (iGAS) above seasonal average, with an unusually high fatality rate (HPA data 25%).

Method: Eleven patients presented to our PICU between November 2008 and June 2009. Many of these children deteriorated very quickly despite full supportive measures, often after initial stabilisation. We aim to highlight the lessons we have learnt in their management.

Results: We treated 10 cases with toxic shock syndrome and 2 cases of necrotising fasciitis (NF) due to iGAS. 1 patient had both. Risk factors were identified in 9/11 (2 recent Varicella, 2 neonates, 3 chronic disease, 7 NSAIDs and 1 trauma). All patients with septic shock were under 9 years, with 4/10 (40%) under 1 year (European surveillance data shows risk highest under 1 yr). Both patients with NF only stabilised after extensive surgical debridement. Our male: female ratio was 1:1.6 which is at odds with surveillance data suggesting higher rates in males. *Emm* type reflected those circulating in the community (1,3,4,6,12,18, 75 & 89). 3 patients (27%) have died despite aggressive PICU management (including CVVH, HFOV), none of these patients received intravenous clindamycin. All those who survived have been treated with clindamycin in addition to cefotaxime. Clindamycin decreases cytokine and exotoxin production and is recommended in iGAS in addition to cefotaxime or benzylpenicillin.

Conclusion: We have learnt to act quickly when treating suspected iGAS with aggressive management (adding clindamycin to cefotaxime), and involving surgical team for early debridement when NF suspected.

165

JUVENILE IDIOPATHIC ARTHRITIS (JIA); HOW DO CLINICIANS DEFINE REMISSION AND WITHDRAW ETANERCEPT?

T. Broughton¹, K. Armon²

¹University of East Anglia, ²Norfolk and Norwich University Hospital, Norwich, UK

Aims: To determine how clinicians define disease remission in JIA, how long is required in remission prior to DMARD withdrawal, and what strategies are used for etanercept withdrawal.

Methods: A 10 part, piloted questionnaire was sent by email to 86 consultant members of BSPAR with one reminder.

Results: 31 clinicians (36% response rate) completed the questionnaire. To define remission, all clinicians required an active joint count of 0, 96% required no extra-articular features and 93% required no active uveitis. More than 75% rated these criteria as 'very' or 'extremely' important. ESR and CRP were less important, with only 41% rating these as 'very' or 'extremely' important as these values were deemed too non-specific. There was no agreement on other criteria. The duration of remission before withdrawing DMARD treatment varied from 6 months to 2 years with 41% responders stating 1 year and 41% 2 years. The duration required was most significantly affected by a previous failed trial off DMARDs, although only 45% rated this as 'very' or 'extremely' important. The method of etanercept withdrawal varied, half weaning to once weekly injections before stopping and 39% stopping from full dose twice weekly. 17 clinicians had withdrawn etanercept entirely. 65% of clinicians had restarted or increased etanercept in some patients.

Conclusions: Clinicians are not using the consensus remission criteria in full. Most clinicians required at least 1 year in remission before DMARD withdrawal. Several methods of etanercept withdrawal were used. 65% of clinicians had restarted or increased etanercept because of disease relapse.