serum bilirubin. Most prognoses were poor or very poor. The commonest prescriptions were antibiotics and fluids; common route of drug administration was intravenous and mortality ranged from 20-30%. Malaria parasite examination was very low.

Conclusion: Accurate diagnosis of neonatal infectious diseases poses a dilemma to clinicians in ICU. Modern instrumentation for quick diagnosis and life-support system will support improved neonatal health care delivery system and reduce high mortality rate in this period of life.

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THORACOABDOMINAL TRAUMA EPIDEMIOLOGY ON THE PEDIATRIC POPULATION OF THE HOSPITAL UNIVERSITARIO DE PUEBLA DURING THE PERIOD AUGUST 2008 - 2009

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Background: In Mexico, trauma is the leading cause of death in children older than 5 years.

Justification: Thoracoabdominal trauma is an underdiagnosed phenomenon, since it is commonly associated with politrauma and head injury, diagnoses with which the patients are coded.

Objective: To describe the epidemiologic characteristics of thoracoabdominal trauma in the pediatric population.

Methods: A prospective, descriptive, observational, and longitudinal study.

Results: A total of 276 patients were hospitalized, 163 (59%) of them were for trauma. Thoracoabdominal trauma occurred in n=19(6.88%) of all patients and in n=19(11.66%) of all trauma patients. Distribution by gender was male n=15(78.9%). Age range was 1 to 18 years, with a mean of 9.5 years. Isolated thoracic trauma was found in n=9(63%), isolated abdominal trauma in n=6(22%), and both traumas in n=4(15%). Automobile accidents were the most frequent cause of lesion n=7(35.84%). The most frequently injured structures were the lungs n=10(52.63%). Surgery was performed in

n=7(36.84%). The most frequent surgery was pleural drainage n=3(42.86%). The mean duration of hospital stays was 5.37 days with an interval of 1 to 23 days. Mortality was n=3(15.79%)

Conclusions: In our environment traumas occupy more than half of inpatients. Most patients did not require surgery and the most frequent surgery performed was pleural drainage. Most of the cases fall in the field of clinicians, therefore the effort to train healthcare providers in the understanding of the anatomic, physiologic and psychosocial differences proper of the pediatric age is justified. In our unit we are a multidisciplinary team.

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CARDIAC OR NOT CARDIAC - THAT IS THE QUESTION?

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Aims: To determine the diagnosis and current management of chest pain in the Emergency Department (ED.)

Methods: A retrospective analysis of children presenting to the Emergency Department with chest pain over a one year period.

Using the Symphony System those presenting with "chest pain" or "pain in chest" from October 2008-October 2009 were identified. Variables recorded were referral pattern, age, sex, vital signs, investigations, final diagnosis and follow up.

Results: There were 239 presentations, which was 0.5% of total presentations. Sex distribution was equal. Mean age was 10.7 yrs (range 2 -16yrs)

232 (97%) had a normal cardiac examination; the remaining had a cardiac murmur related to underlying cardiac disease.

97 (41%) of children had an ECG performed, only one of which was abnormal. 73 (31%) had a CXR, of those which were abnormal all had a respiratory illness.

Seven children had a pre existing cardiac condition and 4 were re referred to cardiology services. Thirteen children with no pre existing cardiac condition were referred for cardiology review with no new diagnosis to date.

47 (19%) of those reviewed had a final diagnosis of musculoskeletal chest pain, 41 (17%) had a diagnosis of normal child, 22 (9%) had a Lower Respiratory Tract Infection, 18(7.5%) had Gastro oesophageal reflux.

No child required immediate cardiology review.

Conclusions: Chest Pain is a common presentation to the ED, our series supports evidence that it is rarely cardiac in origin.

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BELL'S PALSY: TO TREAT OR NOT TO TREAT

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Objective: To audit management of children presenting with Bell's Palsy to a paediatric Emergency Department (ED) in a tertiary referral centre.

Methods: Retrospective chart review of children presenting with Bell's palsy from October 2006 to February 2009. Information was gathered on investigations carried out, treatment prescribed, referral to neurology and follow up.

Results: In total 46 children presented with Bell's palsy from Oct 06 to Feb 09, F:M, 1.7:1.

The median age was 9.29 with an interquartile range of 6.26 - 12.2.

Of interest median weight was 39.2Kg which at 9.29 years is > 91st centile for both boys and girls.

16 of 46 (34%) patients received prednisolone. The duration of treatment varied from 3 days to two weeks.

Four children received acyclovir.

An MRI brain was carried out in seven children. All MRIs were normal.

Three children were referred to neurology, in two instances referral was sent for recurrent episodes, the third child had torticollis associated with facial palsy.

Follow up telephone contact with 35 of 46 parents revealed that in all of these patients the condition had resolved, including the 3 children referred to neurology. However interestingly 7 parents can still

notice slight facial asymmetry particularly when the child is tired.

Conclusion: In uncomplicated Bell's Palsy in a child with a normal examination, further investigations are generally not necessary. From our experience steroids and aciclovir are not required for Bell's Palsy in children.

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HEAD INJURIES IN CHILDREN : IS IT NICE TO CT SCAN?

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Introduction: Trauma is commonest cause of hospital admission in children and head injuries account for 75% of children admitted. Head injury is a common cause of acquired neurological and cognitive disability in childhood. Indications for CT scan in children with head injury are well documented in NICE Guidelines,UK.

Aim: To evaluate our practice for children attending A&E department with head injury at district general hospital in comparison with NICE guidelines.

Method: This was a retrospective audit of case notes of children over a 2months period, attending the emergency department with head injury. Case notes were analysed to record Glasgow coma scale, children admitted for neurology observation and whether the NICE guidelines for CT scan was followed.

Results: Of 120 children with head injury who attended A&E, 107 full case notes were available. In total 13/107 children (12%) met the criteria for CT scan. However 6/13 children (46%) were sent home after clinical assessment by a doctor. 7/13 (54%) were admitted for 24 hours neurology observation of which 3/13 underwent CT scan. Head injury leaflet was given to all children sent home.

Conclusions: This study reiterates continual awareness of NICE guidelines amongst physicians for highest quality care. However as evident in this study, it may require a four fold increase in the number of CT scans done. This may not be possible at a district general hospital due to local constraints of radiology and can be circumvented by proper