

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

R. Mc Namara<sup>1</sup>, P. Keenan<sup>1</sup>, M. Mc Kay<sup>2</sup>

<sup>1</sup>Paediatrics, <sup>2</sup>Emergency Medicine, Children's University Hospital, Dublin, Ireland

**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?

N. Ganjoo<sup>1</sup>, D. Stanciu<sup>2</sup>

<sup>1</sup>Department of Paediatrics,, Addenbrookes Hospital, Cambridge, <sup>2</sup>Department of Paediatrics, Colchester University Hospitals NHS Trust, Colchester, UK

**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

clinical assessment and follow up with a head injury advice booklet

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**THE EPIDEMIOLOGY OF ACUTE CHILD POISONINGS IN KALAMATA, GREECE: A 3 YEAR STUDY**

D. Konstantelos, **A. Koulouri**, P. Giannakopoulou, T. Syriopoulou, M. Papoula, E. Karachanidi, N. Karli

*Pediatrics, General Hospital of Kalamata, Kalamata, Greece*

**Background and aims:** Our objective was to examine the epidemiology of poisonings among children hospitalized in a public Greek hospital in Kalamata.

**Methods:** All children up to 14 years of age, hospitalized with a main diagnosis of acute poisoning at the General Hospital in Kalamata, Greece between 2007 and 2010 were included in our study.

**Results:** A total of 214 children were admitted for poisoning. 73,8% were Greek, 16.8% were Roma and 9.4% of other ethnicity. The majority of patients were children under 3 years of age (79,9 %), while 58,9% were boys. The most common toxic agents were medications (48,1 %). Household products accounted for 30,4 %, such as household cleaning products (43,1%), petroleum products (9,2%) and rodenticides (7,7%). Another 21,5 % of hospitalizations involved tobacco. The majority of cases were accidental (97,2%). Only one suicidal case was recorded. The median length of stay was 1 day and all children survived without sequelae. The most commonly used treatments were gastric lavage and activated charcoal.

**Conclusions:** Despite the fact that the majority of the poisonings were mild and with a good clinical outcome however, acute paediatric poisonings represent a relatively frequent, life-threatening problem. The high proportion of tobacco poisonings highlights the necessity to develop more effective primary prevention programs as well as a better caregivers education.

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**THE PAEDIATRIC EARLY WARNING TOOL IN COMBINATION WITH A NURSE-LED OUTREACH TEAM: IMPACT ON OUTCOMES FOR CRITICALLY ILL CHILDREN**

**S. Sandhu**, T. Ralph, K. Bradbury, J. Reid, A. Wolfe, A. Mayer

*Paediatric Intensive Care Unit, Sheffield Children's Hospital, Sheffield, UK*

**Introduction:** Paediatric early warning tools (PEWT) were developed to identify clinical deterioration in acutely ill patients. Deviations from defined physiological parameters are used to initiate medical review and intervention. PEWT was incorporated into observation charts at a UK tertiary referral hospital and an outreach response team was trialled providing immediate high dependency care.

**Aims:** An audit was undertaken to determine the effectiveness of the outreach team combined with PEWT and assess the impact on patient outcome.

**Method:** A nurse-led outreach team was trialled for 3 months during 2009. Patient observation charts were reviewed for all inpatients over one week. Data was collected to determine: number of patient triggers, actions taken and patient outcome (133 patient observation charts reviewed). Data collection was repeated once the trial had finished (n=167).

**Results:** 28% (n=37) of patients triggered when team available ((133 charts); mean age 6.3 years (SD=5.5)) which was comparable to the period without the team 28% (47/167, p=0.1); 5.8 years (SD=5.6)) when triggered. Help was requested on 12 (32%) occasions compared with 8 (17%, p< 0.05) with and without teams respectively. No arrest calls occurred during the period with the team; 2 occurred during the period without. A reduction in critical incident reporting was observed during team availability.

**Conclusions:** Decreased emergency team calls and critical incidents were observed by introduction of an outreach team and PEWT. The outreach team received a positive response from all staff, providing immediate high dependency care. Use of the PEWT allowed earlier review and prompt medical intervention.