> 40% of patients had been sent by their GP to the ED and so were not eligible, although they fulfilled all other criteria.

Conclusions: Although some parents choose to come to the ED, many patients have been told to attend by their GP.

Most parents wished to remain in the ED.

These results may reflect a lack of confidence by families in their GP, or a lack of knowledge of paediatrics in primary care.

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TRANSFUSION REQUIREMENTS IN PAEDIATRIC TRAUMA: A SINGLE CENTRE EXPERIENCE

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Aims: To describe the transfusion requirements in children following major trauma.

Methods: We retrospectively analysed the local paediatric trauma database of all children following trauma call activation on arrival to the Emergency Department in a major urban trauma centre in London. We studied over a period of 15 months, May 2008 - August 2009. We defined massive transfusion as packed red cells >40ml/kg in the first 4 hours or >80ml/kg in the first 24 hours.

Results: 227 children presented to the Emergency Department following major trauma call activation. Twenty-eight (12.2%) children were transfused within the first 24 hours, of which 13 were massive transfusions. Majority (23) were males. Blunt trauma occurred in 22 and penetrating injury in 5. The median Injury Severity Score (ISS) was 28 (IQR 39). Majority (22) required surgical interventions and 2 underwent embolisation of major vessels.

Of the 28 transfused patients, 15 (54%) patients received packed red cells alone and 13(46%) received various combinations of additional blood products (Fresh Frozen Plasma, platelets and Cryoprecipitate). However, no patient received the ratio of blood products of RBC:FFP of 1:1 as practised in adult trauma. Majority (16) did not have either pre or post-transfusion blood tests done. Post-transfusion coagulopathy was observed in 2 patients.

Ten deaths occurred in the transfused group of which 8 (80%) received massive transfusion.

Conclusions: Massive transfusion is associated with a very high mortality in severely injured children. There is a need for a massive haemorrhage policy to initiate and guide transfusion in paediatric trauma.

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PRIAPISM IN CHILDREN WITH SICKLE CELL DISEASE: A CASE REPORT

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Background: Priapism is a complication that affects children with sickle cell disease the mean age of presentation being 12 years, around puberty. It is reported to affect up to 50% of all males with sickle cell disease. Ischaemic or low flow priapism commonly seen in sickle cell patients may be acute (fulminant) or stuttering (recurrent short episodes) and is associated with substantial risk of erectile dysfunction and psychogenic sexual aversion.

Summary: We present two cases of fulminant priapism in children with sickle cell disease. Both boys were prepubertal and presented more than 24 hours after onset of symptoms.

Case 1: Four years old achieved detumescence after 5 days, with two venesections, a top up and two exchange transfusions, two corpus carvenosus irrigation and aspiration and two distal cavernosa-spongiosum shunts. There was possibility of erectile dysfunction at six week follow up.

Case2: Eight years old, was managed conservatively with top up and exchange transfusion, corpus carvenosus irrigation and aspiration with intra-cavernosal injection of etilefrin.

There is little evidence based treatment in the literature. Endothelial activation in penile tissue is suggested as the main cause of priapism rather than vasocclusion with sickle cells. Traditional treatment like exchange transfusion is being questioned especially in view of the so called ASPEN syndrome i.e. association of SCD, priapism, exchange transfusion and neurological events.