

Conclusions: Children suffering from pervasive developmental disorder have increased levels of fecal calprotectin, but these levels are significantly reduced by the introduction of elemental diet. We have much more to investigate by measuring calprotectin plasma levels and examine the gastrointestinal tract by other methods.

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MANAGEMENT OF CHILDREN WITH INFLAMMATORY BOWEL DISEASE- A DISTRICT GENERAL HOSPITAL EXPERIENCE

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Background: Inflammatory Bowel Disease (IBD) encompasses two related but unique disorders of as yet unknown cause. The incidence has increased substantially in recent years- 2.2 to 6.8/100 000 in paediatric/adolescent population worldwide. Current therapeutic goals in children and adolescents are to diagnose/ treat relapses early, improve clinical management and reduce morbidity.

Aim: To review the management of children with Inflammatory Bowel disease presenting to the outpatients department of a district general hospital in UK.

Methods: A retrospective clinical audit.

Recommendations of the Working group on Inflammatory Bowel Disease of the British Society of Paediatric Gastroenterology and Nutrition, 2008, formed the standards to evaluate our local practice. Data on establishing the diagnosis (history taking, examination, investigations) and treatment was collected retrospectively and compared with the standards.

Results: A total of 14 patients presented to the children's outpatient department over a 5 year period. Local practice maintained 100% standards for history taking, examination, blood tests, upper GI endoscopy with biopsy and colonoscopy. Only 28% of the patients had Barium meal and follow through and 92% had faecal tests. For their treatment, children with Crohn's disease reached 85% standard for use of elemental nutrition to induce remission and Azathioprine for maintenance of remission. Children with Ulcerative colitis fared better at achieving 100% standards. Need for

replacing Barium meal followthrough with Ultrasound abdomen was suggested.

Conclusion: Local protocol helps to maintain good management standards as recommended by the IBD working group. Service provision in the form of abdominal ultrasound was identified to improve quality of care.

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THE POTENTIAL BENEFIT OF NJ TUBE PLACEMENT AT THE TIME OF CONGENITAL DIAPHRAGMATIC HERNIA REPAIR SURGERY

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Aims: A previous retrospective review of CDH cases repaired from 1996-2007 revealed a mortality rate comparable to other centres. A follow-on study was then begun to more accurately examine mortality, morbidity and any benefit of NJ tube placement in successful feeding establishment.

Methods : Data were gathered from patient notes during their PICU and ward admissions and analysed using Microsoft Excel.

Results: From Oct 2007 to Jan 2010, there were 17 episodes of CDH repair among 15 patients. 3 patients died, giving a survival rate of 80% which is improved on the previous figure of 70%.

Patients had an average of 17 days TPN [range 0-38] with an average of one episode of CONS sepsis per patient. 7 patients had an NJ tube passed, taking an average of 5.3 days to achieve jejunal placement. One tube was sited radiologically, but successful placement failed completely in 3 patients. Mean time to establish full feeds was 21 days [range 1-65], but this was reduced to 3.8 days in patients after an NJ was successfully sited.

Conclusions: Time to achieve full enteral feeds was significantly reduced post NJ tube placement. However, the failure to place an NJ in almost one-third of patients attempted must be noted, as must the 5 day delay in attaining successful tube position. We would recommend routine placement of NJ at the time of hernia repair. This would likely reduce TPN requirements, dependence on central venous access and episodes of sepsis.