GI bleeds requiring endoscopy (UGIB) and/or other emergency upper endoscopies (OEE). Cases were reported in REDCap.

**Results** 28 centres provided denominator data with regard to the services they provide (covering 90% of the UK population). 22 provided prospective data for UGIB and 18 for OEE covering 70 and 60% of the UK population respectively.

98 cases were reported over a 6 month period: 34 UGIB, 55 OEE, (38 foreign body and 17 others); 9 less severe UGI bleedings not fitting the definitions were excluded from further analysis.

Of 25 centres reporting, 14(56%) had 0 UGIB and 20/25 (80%) had ≤2 over the 6 months. Endoscopic interventions for GI bleed were undertaken in only 6/25 centres.

The mean age of the UGIB group was 6.7 years, 29% were ≤1 year. 19(56%) had significant co-morbidities. Presenting symptoms were one or both of melaena and haematemesis. Of the 20 providing sufficient data for a Sheffield score, 25%(4/20) were high (≥8) at presentation (median score 2.5, range 1–24, interquartile range 3.25). Main findings at endoscopy; 8(24%) had no abnormalities, 14(41%) had UGI ulcers (6 duodenal, 6 gastric and 2 oesophageal), 9(26%) oesophagitis and gastritis, 8(24%) varices.

13(38%) required endoscopic treatment, 6 for varices, 4 for GU, 2 DU, 1 for blood in upper GI tract. 3 required surgery. Two patients died, one within 48 hours of the bleed in PICU in the context of sepsis and multi-organ failure. 14 patients required inter-hospital transfer, median time from hospital presentation to endoscopy was 97 hours for patients needing transfer and 24 hours for those not.

For the OEE (N=55), mean age was 6.3 years, 26% ≤1 year. 21(38%) had significant co-morbidities. Main indications were foreign bodies (25, 45%) - coins (15), battery (2), button battery (5), magnets and a toy. 13(24%) food bolus obstruction, 11(20%) caustic substance ingestion, 5 oesophageal stricture. 9(16%) endoscopies revealed no significant findings, 37(65%) required treatment at endoscopy. 50% (27 patients) had required inter-hospital transfer. Median time from first hospital presentation to endoscopy was 21 hours in those requiring transfer and 14 hours in those not.

**Conclusions** This is the first national prospective study of its kind examining the most urgent and severe endoscopy cases in under 16s. These data indicate that very small numbers of centres are performing endoscopic treatments for severe UGI bleeds. Inter-hospital transfers appear to be much quicker for surgical indications than UGIB although we did not find evidence of poor outcomes in the UGIB due to delayed transfer. The planning, location and skill mix of national emergency medical services are crucial not only for the patient but also to the family and a step-up approach appears helpful in these patients, reducing burden of excessive exclusions and also reduced number of endoscopies when considering reintroduction of these foods. Growth appeared unaffected with no concerns with BMI. All patients on diet therapy had regular input with the dietitian. Children were 3 female, 1 male with a mean age of 7.4 years at diagnosis. Two patients commenced a milk free diet, one had a milk and soya free diet and the fourth had a milk, wheat and soya free diet. Three of four of these patients achieved remission. Three of four patients had trialled drug therapy (PPI) first with no histological remission. BMI z-score did not change between when the children were first diagnosed to achieving disease remission (mean BMI z-score -0.28 to -0.29). All patients had regular access to a dietitian.

**Conclusion** In this small service evaluation, medicine was the preferred treatment choice for families. This is likely due to the burden of changing the diet has on a family and a patient’s quality of life. However, 75% of this cohort achieved histological remission on diet therapy. PPI appeared ineffective in this small patient group. Empirical food elimination via a step-up approach appears helpful in these patients, reducing burden of excessive exclusions and also reduced number of endoscopies when considering reintroduction of these foods.

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**FIBRATES: AN ADJUVANT THERAPY FOR CHOLESTASIS IN PAEDIATRIC AGE GROUP**

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**Introduction** Bile formation is a delicate process. This is illustrated by inherited liver diseases caused by mutations in one of the genes involved in the formation of bile. Some of these genes encode proteins that are essential for the normal function of the liver, and the absence of these proteins leads to the development of liver disease. Bile formation involves the synthesis and secretion of the bile acids, which are then conjugated with glycine or taurine to form water-soluble conjugates. These conjugates are then transported across the canalicular membrane and into the lumen of the bile ducts. The bile acids are then secreted into the duodenum, where they are reabsorbed and recycled. This process is known as enterohepatic circulation. This is the first national prospective study of its kind to examine the most urgent and severe endoscopy cases in under 16s. These data indicate that very small numbers of centres are performing endoscopic treatments for severe UGI bleeds. Inter-hospital transfers appear to be much quicker for surgical indications than UGIB although we did not find evidence of poor outcomes in the UGIB due to delayed transfer. The planning, location and skill mix of national emergency medical services are crucial not only for the patient but also to the family and a step-up approach appears helpful in these patients, reducing burden of excessive exclusions and also reduced number of endoscopies when considering reintroduction of these foods. Growth appeared unaffected with no concerns with BMI. All patients on diet therapy had regular input with the dietitian. Children were 3 female, 1 male with a mean age of 7.4 years at diagnosis. Two patients commenced a milk free diet, one had a milk and soya free diet and the fourth had a milk, wheat and soya free diet. Three of four of these patients achieved remission. Three of four patients had trialled drug therapy (PPI) first with no histological remission. BMI z-score did not change between when the children were first diagnosed to achieving disease remission (mean BMI z-score -0.28 to -0.29). All patients had regular access to a dietitian.

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