- Optimization of imaging resources by surgical team from 33% to 17%
- 88% of patients with abdominal pain had a medical diagnosis at discharge.

Conclusion

- Abdominal pain is a common presentation in the paediatric population, mostly benign and self–limiting.
- Abdominal pain should be assessed by general paediatricians first and then referred to surgical colleagues if deemed appropriate to avoid unnecessary investigations and imaging.

P45 REVIEW OF DIAGNOSIS AND MANAGEMENT OF COELIAC DISEASE IN A DISTRICT GENERAL HOSPITAL IN THE NORTH WEST

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Background The guidance for Coeliac Disease (CD) has evolved over the last few years. The highlight of the ESPGHAN guidelines from January 2020 is that high serological markers (tTG and EMA) are now the requirements for confirmation of CD regardless of symptoms.

Aims

1. To review management of patients and compare it with the latest ESPGHAN/BSPGHAN guidelines.
2. To review time to confirmed diagnosis from the start of symptoms.
3. To look at provision of Gluten free products at schools and Primary Care service.

Methods Retrospective data collected from Coeliac database from January 2018 till November 2020 in a District General Hospital with provision for a dedicated Coeliac Clinic supported by a Specialist Dietician. We reviewed the presentation of symptoms, methods of confirmation of CD, time duration from onset of symptoms till diagnosis, provision of gluten free meals at schools and availability of gluten free products on prescription.

Results 35 patients were diagnosed with CD, 31 were symptomatic and 4 were asymptomatic.

27/31 of the symptomatic patients had high level tTG (>10 times the upper limit), 20 had positive EMA and HLA DQ2/DQ8 for positive confirmation. The two negative EMA were referred for biopsy.

Three had HLA typing but had high tTG on 2 separate occasions which confirms diagnosis. 2 had only one high tTG and HLA but no EMA or second high tTG so they did not meet the diagnostic criteria.

4 symptomatic patients with low tTG<10x, had biopsy confirmation. 4 asymptomatic patients had high tTG and +ve EMA.

Of 28 patients referred through Primary Care, 7 were screened and referred with symptom duration of circa 4 to 12 months, another 7 were diagnosed through screening due to positive family history or type1 Diabetes Mellitus and 14 cases had no specific duration of symptoms recorded. Remaining seven were diagnosed by hospital paediatricians due to different presentations.

Most parents stated that they were providing packed lunch box even if the school provided some gluten free meals as the menu choice lacked variety. Patients with Type 1 diabetes found a packed lunch easier for carbohydrate counting. Parents felt tailor made menu recommendation from the dietician to the school would be beneficial for families and the school.

Conclusion and Recommendation We thus identified that 82% (n=29) of patient had met the criteria for diagnosis of CD as per 2015 guidelines, but if 2020 guidelines were applied then 94.2%(n=31) would have meet the criteria.

Recommendations

1. Identifying duration of time needed for the child to be screened will help to raise awareness within primary care practice. This will be audited in the future.
2. There is a large knowledge gap in schools about CD and the importance of convenient access to gluten free meals in enhancing compliance with gluten free food in children. Offering tailor made presentations to the local schools will address this issue. A further review to identify if similar knowledge gap exists in schools regionally is planned.

P46 REVIEW THE DIAGNOSIS OF IBD IN CHILDREN WITH AILD (AUTO IMMUNE LIVER DISEASE) -8 YEARS' EXPERIENCE IN A TERTIARY CENTRE

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Background The association of autoimmune liver disease (AILD) and inflammatory bowel disease (IBD) is well documented. IBD affects about 45% of children with autoimmune sclerosing cholangitis (AISC) and about 20% of those with autoimmune hepatitis (AIH). The aim of this study was to describe the clinical features of AILD associated with IBD and to evaluate the role of fecal calprotectin and the time to look for IBD in patients with primary diagnosis of AILD.

Methods We have conducted a retrospective review of paediatric patients with primary diagnosis of AILD and IBD between 2010 and 2018. Patients who were referred or diagnosed with IBD first were excluded. Diagnosis of IBD was based on clinical history, endoscopic appearance and histology findings. AILD patients were classified to AIH or AISC according to histology, radiology results and circulating antibodies. Patients' demographics, symptoms, FC, blood tests, timing before IBD diagnosis and treatment were collected.

Results 114 patients with AILD were identified: 74 (64%) had screening with FC, 48/74 (64%) had abnormal and 26 (35%) normal test. 67% of FC performed at the diagnosis of liver disease. 48 patients had at least one endoscopy, 25 (52%) were diagnosed with IBD, 8 patients had normal endoscopy but positive FC of mean value 162, (range 60–332). 15 had no endoscopy despite abnormal FC. 6/26 patients with normal FC underwent endoscopy which was normal. Reason was persistently elevated liver enzymes, relapse of AILD or ongoing bowel symptoms. 25/114 (21%) patients were diagnosed with IBD, 14/25 (56%) had AISC, the rest AIH. 25% had family history of autoimmunity. Mean FC at diagnosis of IBD was 646 (range 60–4004). 14 were males and the mean age at diagnosis was 10 years. 18/25 (78%) had ulcerative colitis (UC), 2/25 (0.8%) Crohn's disease and 5/25 (2%) indeterminate colitis(IBDU). 12/14

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