Clinical Risk Index for Babies score II (CRIB II score) is a five-items scoring system to predict initial risk of mortality among neonates less than 32 weeks of gestation. Thus, making it an easy, quick and economical tool for early detection of preterm neonates' mortality risk in resource limited busy centres in India.

Objectives Objective:

To validate the efficacy of **Clinical Risk Index for Babies score II** in predicting pre-discharge neonatal mortality in *early preterm neonates* needing intensive care in a high resource tertiary care centre providing referral services in central India.

Methods Methods:

In this **prospective observational study**, after taking informed consent of parents and ethical committee clearance, the CRIB-II scores, which include birthweight, gestational age, sex, body temperature, and base excess, were recorded within the first hour of admission for 140 neonates of gestational age ranging between 28–31 weeks and birth weight ranging from 1000 g to 2499 g; of both sexes born in a tertiary care institute of central India and admitted to its neonatal intensive care unit (NICU). Babies of gestation <28 weeks and >31 completed weeks, birth weight < 1000 g, having lethal congenital malformations, delivery room deaths and those admitted after 1 hr of birth were excluded. Outcome measure was *in hospital death* or *discharge*. The sensitivity and specificity of CRIB-II scores and its cut off point to predict mortality were examined using **Receiver Operating Characteristic curves** (ROC) with area under curve (AUC) indicating predictive accuracy. Its association with mortality was determined by **Cox Regression Hazard analysis**. Clinical parameters were compared between Non-survivors and survivors by performing *independent t-test*. A **p<0.05** was considered as statistically significant.

Results Results:

Male: female ratio was 0.92:1. The mean Gestational age was 30.27 ± 0.89 weeks, mean birth weight being 1599.75 ± 282.35 g. CRIB II score ranged from 1–19 with a **mean of 13.16 ± 25.56 among non survivors and mean of 5.66 ± 2.24 among the survivors (p value = <0.0001)**. The **total mortality** in the study was **47.1%** (66/140). There was a progressive increase in mortality with increasing CRIB II score (p=0.001) and increase in survival with increasing birth weight, gestational age, body temperature and hospital stay (p < 0.0001 for each variable). **CRIB II score ≥9 cut off** was found to be significantly associated with neonatal mortality with **sensitivity, predictive value and specificity of 95.65%, 95.65% and 95.77% respectively** (p<0.001; 95%CI 0.98 (0.96–1.00); hazard ratio = 1.38). The ROC curve for CRIB II score was suggestive of **AUC of 0.9868** ie 98% predictive accuracy.

Conclusions Conclusion:

The present study shows that the CRIB II score is a useful and reliable tool to **prioritize the interventions** in NICUs and will help to **reduce the neonatal mortality rate** and improve preterm neonates' survival in India if used appropriately in tertiary care centres.

250 NEONATAL ECTOPIC ATRIAL TACHYCARDIA- MIND THE GAP (PR INTERVAL)!

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Background Whereas SVTs are well recognised in neonates with early diagnosis and management occasionally ectopic atrial tachycardia in neonates do happen infrequently and could be mis diagnosed as sinus tachycardia particularly if in the slower range

Objectives The tachycardia in these instances often tend to be incessant and can lead to tachycardia induced cardiomyopathy if the rate remains uncontrolled. The ECG changes are subtle and needs a trained eye to pick up this diagnosis.

Methods We present a case of a male infant who presented acutely to the hospital at age of 19 days with blood in the stool. He was born at term baby with mild intra uterine growth retardation but otherwise well at birth. He was noted to have hypospadias and was diagnosed as a case of cow's milk protein intolerance. During the admission he was incidentally noted to be tachycardic with a heart rate consistently between 180 and 200 beats per minute while otherwise being well and afebrile. His ECG showed narrow complex tachycardia at a rate between 180 to 200 beats per minute. Blood tests were overall satisfactory with an elevated troponin level and negative viral serology studies. An echocardiography done suggested mild left atrial and left ventricular dilatation with mild impairment of function. The case was discussed with the tertiary Cardiac team who felt this was more likely to be a sinus tachycardia and the patient was subsequently discharged. At age of 6 weeks, the child was seen in the outreach cardiac clinic. The ECGs (Current and previous were reviewed). It was noted that P waves were normal axis but negative in aVL, the PR interval was disproportionately long for the tachycardia. This suggested atrial tachycardia which was persistent. An echocardiogram showed a structurally normal heart with mild left heart volume overload and mildly impaired left ventricular function. The child was stuck in a slow atrial tachycardia rhythm which contributed towards the impaired function. Propranolol was started at a dose of 1 mg/kg TDS.

Results At further follow up at 7 months, the child was thriving and well, echocardiography showed that the cardiac dimensions were normal and the function had improved. ECGs and ambulatory monitoring showed normal rates and rhythms. The beta blockers were continued with a plan to wean in future.

Conclusions Ectopic atrial tachycardia (EAT) in a neonate can present with incessant tachycardia but can be in a slower range of 180–200 bpms. The ECG changes can be subtle with normal p waves (P wave axis could be abnormal) but the persistent tachycardia, disproportionately long PR interval for the tachycardia and impairment of ventricular function could be useful pointers towards this diagnosis. EAT could lead to impairment of ventricular function if poorly controlled. Medications to control the tachycardia can help with eventual recovery of ventricular function as this case has highlighted.

251 NEONATAL READMISSIONS TO THE PAEDIATRIC WARDS DURING THE FIRST WAVE OF THE PANDEMIC: 3 CENTRE STUDY IN NORTHERN IRELAND

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Background Readmissions of infants younger than 28 days back into hospital are highly undesirable. It is upsetting for the families and puts babies at risk of hospital acquired