numbers, different neurological conditions, cost-effectiveness, and patient satisfaction responses were analysed.

**Results** We started visits to regional hospitals in 2017 and 2018 before upscaling in 2019, to provide quarterly visits to 7 regional and district hospitals who had previously had no access to any paediatric neurology service provision aside from tertiary referral. Altogether, 1327 children with different neurological problems were seen in 2019. This included 712 children (54%) with epilepsy, 155 children (12%) with cerebral palsy and 100 children (8%) with other developmental problems.

The costs of facilitating the clinics were compared to the equivalent cost of the patients travelling to a tertiary centre for the same level of specialist assessment and treatment. Percentage of cost-saving was from 81% to 98% depending on the distance between the regional hospital and Yangon where the tertiary centre is located.

We conducted a small survey of parents attending the clinic. Respondents felt that the outreach clinics provided a more accessible point of care. Many highlighted the lifting of a significant financial burden, particularly in low-income households. The reduction of financial cost is felt particularly in cases such as epilepsy which require multiple clinic visits and ongoing specialist care. Many comments have also identified the quality of specialist care in the new model, comparable to a tertiary hospital.

**Conclusions** Paediatric neurology outreach and virtual clinics can provide a model for other specialties across many fields of healthcare, especially in countries with good internet, but poor transport. Interval telemedicine services also provided a continuation of care. To achieve specialist care at greater scale new approaches, such as the blended outreach and telemedicine structure described here, should be actively developed and evaluated.

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**328 IMMUNOSUPPRESSIVE THERAPIES IN CHILDREN WITH BIOPSY-PROVEN IGA VASCULITIS NEPHRITIS: A TERTIARY CENTRE EXPERIENCE**

Hon Lam Matthew Lee, Eugene Yu-hin Chan, Hong Kong

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**Background** IgA Vasculitis Nephritis (IgAVN) can lead to severe presentation including nephrotic syndrome. Data pertaining to the treatment outcomes of IgAVN with persistent moderate or nephrotic range proteinuria in children are, however, limited.

**Objectives** The aim of this study is to determine the response to immunosuppressive therapies in this patient population.

**Methods** We conducted a retrospective review on all children presenting with IgAV before 18 years between January 2009 and December 2019 in the Paediatric Nephrology Centre in Hong Kong. Patients with biopsy-proven IgAVN developing persistent moderate or severe nephrotic-range proteinuria despite ACE-inhibitor (ACEi), and followed for 24 months or more were included. Patient demographics, clinical and laboratory data, therapies received, and treatment outcomes were evaluated.

**Results** Of the 177 patients with IgAV, 42 children developed proteinuria. 21 Chinese patients (76% boy) had persistent proteinuria despite ACEi and kidney biopsy confirmed IgAVN at a median age of 8.5 years (IQR 5.8–11.2). At baseline, 3 (14%), 14 (66%), 3 (14%) and 1 (4%) patients had moderate proteinuria, nephrotic-range proteinuria, nephrotic syndrome and nephritic-nephrotic syndrome, respectively. All patients had normal kidney function, except one child with an estimated GFR of 31 ml/min/1.73 m². Median urine protein to urine creatinine ratio (UPCR) was 4.4 mg/mg (IQR 2.4–9.0) and serum albumin was 32 g/L (IQR 28–33.5). Histological findings were classified according to International Study of Kidney Diseases in Children (ISKDC): Class II (n=5, 24%), Class IIIa (n=9, 42%), Class IIIb (n=6, 29%), Class IV (n=1, 5%).

All patients received corticosteroid at a median time of 33 days (IQR 12–52) since kidney involvement. Whereas 7 children (33%) with severe disease received monthly intravenous cyclophosphamide as induction therapy, 12 patients (57%) and 2 patients (10%) received calcineurin inhibitors and azathioprine, respectively. The maintenance therapy consisted of corticosteroid and one additional immunosuppression, including calcineurin inhibitors (n=16, 76%), azathioprine (n=4, 19%) and mycophenolate mofetil (n=1, 5%).

Over a median follow-up period of 3.6 years (IQR 2.8–5.6), 18 patients (86%) attained complete remission at a median of 139.5 days (IQR 102–225) since immunosuppressants initiation. The other 3 patients achieved partial remission. Three patients (14%) relapsed in 7.5 months (IQR 1.2–16.2) following complete remission but resolved promptly with treatments. At last follow-up, all patients had normal kidney function and the median UPCR was 0.11 mg/mg (IQR 0.10–0.16).

**Conclusions** Immunosuppressive therapies were associated with favourable renal outcomes in children with biopsy-proven IgAVN presented with persistent moderate or nephrotic range proteinuria despite ACEi. Further studies are required to determine the optimal treatments in this patient population.