analysis is developed through an inductive and recursive process, aimed to identify the overall sense of the described experiences.

Results
Our analysis reveals four emerging dimensions: experiences, elements of value, problems and suggestions. Within these dimensions, we identify 34 common elements similar in age groups of 6–12 year-old and 13–18 year-old children (35.3% vs 33.3% and 47.1% vs 42.2%, respectively). Around 20% (19 children) patients were prescribed with morphine to treat their chronic pain. Co-medication such as paracetamol, NSAIDs, and tramadol were widely used for acute cancer treatment, palliative program, and also end-of-life treatment. The World Health Organization (WHO) has replaced the previous three-step guidelines into the two-step approach, advising the use of low doses of strong opioid that is considered safer from using codeine or tramadol. This is a study about the use of morphine as a strong opioid agent in pediatric patient with cancer.

Methods
A retrospective study of children treated in our tertiary referral cancer hospital in 2015.

Results
There were 98 out of 263 children (37.3%) treated with morphine in the year of 2015. Forty-six (46.9%) of them needed to be administered with intravenous morphine, whether due to the contraindication of enteral intake or the need of immediate dose adjustment. The distribution of immediate oral and extended-release tablet consumption seemed similar in age groups of 6–12 year-old and 13–18 year-old children (35.3% vs 33.3% and 47.1% vs 42.2%, respectively). Around 20% (19 children) patients were prescribed with morphine to treat their chronic pain. Co-medication such as paracetamol, NSAIDs, and tramadol were also dispensed in some cases. Furthermore, palliative radiotherapy was done in 1 patient.

Conclusions
Morphine use is common in treating children with cancer. Both immediate and extended-release oral morphine utilization were more often found in children more than 5 year-old. Further study is needed, especially to evaluate the effectiveness of pain management to improve patients’ quality of life.

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EPIDEMIOLOGY OF DEATH IN PAEDIATRIC INTENSIVE CARE UNITS (PICUs) IN A DEVELOPING COUNTRY
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Aims & Objectives:
To determine the clinical factors that influence the initiation of a DNR order or withdrawal life support intervention procedure in ICU.

Methods
Retrospective study of single-institute medical record review of all death occurring in PICU over 11-year period. Subject: All patients younger than 12 years who died in the inpatient setting between January 1, 2006 and December 31, 2016.

Results
Mode of death was defined as failed cardiopulmonary resuscitation for 264 (47%), death occurred after withdrawal of life support treatment for 208 (37%), Do-not-resuscitation order for 88 (16%). Median age at death was 19.5 months and 17 months in the limitation treatment patients group and fail to resuscitation group respectively. The most common reason for death was pneumonia (33.6%), followed by sepsis (14.6%) and tumor (13.6%). 83.2% of the withdrawal LST and DNR patients were previously known underlying diseases before admission. The median time for deciding to withdraw LST and DNR order was on 4 days and 5 days after admission respectively, while the hospital stay in failed CPR group is 2.5 days. Underlying diseases, transferred from other hospitals and length of ICU stay >=6 days are the risk factors for the decision of withdraw LST and DMR (OR: 2.6, 1.6 and 1.5 respectively).

Conclusions
Withdrawing LST and DNR order were the common mode of death in PICU. Patients with known underlying disease constituted the main group in which decision to forgo life-sustaining treatment was made. Transferred history and ICU stay >=6 days are the risk factors for the decision of LST.