

Recommendations Education programme to raise awareness of complications of pre-septal/orbital cellulitis.

- Involve ophthalmology and otolaryngology at the earliest.
- Twice daily assessment of colour vision, eye movements and pupil reflexes, for early identification of complications.
- Ensure adequate analgesia.
- Re-audit, preferably with the use of one antibiotic combination, also looking at indications for changing from IV to oral along with total duration.

950 C-REACTIVE PROTEIN, LEUKOCYTES AND ESR AS IDENTIFIERS OF INVASIVE BACTERIAL INFECTIONS

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Background C-reactive protein (CRP), erythrocyte sedimentation rate (ESR) and leukocyte count are used in several studies, for evaluation of invasive bacterial infections.

Aim Aim of the study to evaluate the usefulness of leukocytes, CRP and ESR as identifiers of invasive bacterial infections at children.

Methods We have prospectively evaluated 705 patients divided into two groups: 1) group A with 110 patients having invasive bacterial infections and 2) group B with localized bacterial infections comprised of 595 patients.

Results Mean values for leucocytes was $12536 \pm 6642/\text{mm}^3$ for invasive bacterial infections versus $11263 \pm 5285/\text{mm}^3$ for localized bacterial infections ($p < 0.05$).

Mean ESR for invasive infections was $31, 13 \pm 29, 11 \text{ mm/hr}$ versus $25, 94 \pm 22, 93 \text{ mm/hr}$ for localized infections ($p < 0.08$). Mean CRP for invasive infections was $42, 57 \pm 25, 45 \text{ mg/dl}$ versus $24.10 \pm 13.58 \text{ mg/dl}$ ($p < 0.04$) for localized bacterial one.

Conclusion This study suggests that CRP, ESR and leucocytes are good indicators in diagnose of invasive bacterial infections.

951 RECURRENT PRIAPISM PRESENTING WITH A RARE CAUSE IN AN INFANT

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Discitis in children is an important infective cause of morbidity and often has an insidious presentation, which creates difficulty in making a prompt diagnosis and instigating appropriate treatment.

Priapism in the paediatric population is a rare urological emergency. It is most commonly associated with sickle cell disease and leukaemia, causing a vaso-occlusive priapism, and rarely with spinal shock. To the authors' knowledge, priapism secondary to discitis has not previously been described in the literature.

We present a case of a 12 month old Caucasian child presenting with a three-week history of regular episodes of seemingly painful, persistent erections. He was noted to have a reluctance to sit or walk. Clinical examination was unremarkable other than priapic episodes. Neurological and haematological causes were considered but initial investigations were normal.

An MRI of his spine, performed due to a later rise in erythrocyte sedimentation rate and a clinical deterioration with complete refusal to mobilise, demonstrated inflammatory changes at the L3/L4 level with a seven-millimetre collection, thus indicating discitis. He was treated with intravenous antibiotics and after ten days made a full recovery with complete resolution of his symptoms.

This is the first reported case of discitis presenting as recurrent priapism in an infant. We feel that this case highlights the need to

consider infective causes in children presenting with priapism, so that diagnosis and treatment of a significant underlying cause is not delayed. Early spinal imaging may be worthwhile in cases of unexplained priapism, particularly when haematological causes have been excluded.

952 ENCEPHALITIS DUE INFLUENZA A (H1N1) IN A SEVEN YEAR-OLD GIRL WITH GOOD RESPONSE TO OSELTAMIVIR

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Background and Aims Human infection with the novel H1N1 influenza virus was first reported in April 2009. Novel Influenza A (H1N1) virus produces higher mortality in young people. Different clinical manifestation of Influenza A (H1N1) has been reported. We present encephalitis due influenza A (H1N1) with good response to oseltamivir.

Patient The patient was a seven year-old girl presented with mood change and gait ataxia from 5 days before admission. She also had fever, delusion, and lethargy. She had history of common cold several days before admission. She was treated with acyclovir with impression of encephalitis without improvement. In physical examination (P/E) she was febrile, there was no nuchal rigidity. P/E of chest, abdomen and extremities were normal. Lumbar puncture was performed. Cerebrospinal fluid (CSF) was normal. CSF culture showed no growth after 48h. CBC, FBS, BUN, Cr, Na, K, ALT, AST, CRP and procalcitonin were all normal. HSV PCR was negative. Electroencephalography (EEG) was performed that suggested encephalitis. Brain MRI was normal. Throat culture was obtained for the diagnosis of influenza A (H1N1) that was positive. The patient was treated with oseltamivir. The patient recovered after treatment and tests for equilibrium became normal.

Conclusions Encephalitis due to influenza A (H1N1) should be considered in every patient with signs and symptoms of encephalitis during influenza A (H1N1) pandemic.

953 MILIARY TUBERCULOSIS IN AN IMMUNOCOMPETENT CHILD

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Background Miliary tuberculosis (MT) refers to clinical disease resulting from lymphohematogenous dissemination of *Mycobacterium tuberculosis*. It affects primarily younger and immunocompromised children. Clinical presentation is highly variable and multiorgan involvement is common.

Clinical Case A nine-year Gypsy girl with a mild development delay and a history of epilepsy was presented to our hospital with a 19-day history of fever. She had completed two antibiotic treatments for suspected tonsillitis. Two years before she had had meningococcal meningitis. Family history was irrelevant. On admission, physical examination was normal and it was performed a chest radiography which revealed diffuse, bilateral, small lung nodules (Panel A). Ophthalmology diagnosed tubercular choroiditis in the right eye. An acute MT diagnosis was made. Lumbar puncture was normal and cranial magnetic resonance imaging showed several small nodular lesions - tuberculomas. Mantoux test: 14mm. In gastric aspirate cultures grew *Mycobacterium tuberculosis* without antibiotic resistance. Immune deficiency was excluded. She received

antituberculosis therapy and fever resolved after 45 days. A nurse is going to her house daily to check the patient's adherence during the one year treatment.



Abstract 953 Figure 1 Chest radiography of miliary tuberculosis

Conclusion The diagnosis of MT can be clearly invoked with a simple and inexpensive investigation, even in an immunocompetent child. The typical image in the chest radiography is the most important reason to report this case.

954 PLEURAL EFFUSION AND ASCITES: AN UNUSUAL COMPLICATION OF HEPATITIS A

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Background and Aims To the best of our knowledge, we are reporting the first case from United Arab Emirates in the literature of Hepatitis A associated with pleural effusion and ascites. Hepatitis A is the most common cause of viral hepatitis in childhood and a major health problem in the developing world. Pleural effusion and ascites are very rare extrahepatic complications of hepatitis A. There have been only a few case reports in the literature of the two complications. The etiology is not clearly understood, but they tend to undergo spontaneous resolution and do not warrant specific diagnostic or therapeutic measures.

Methods Information collected from the hospital electronic case notes (Cerner).

Results Our case is a three years old Afghani boy who presented with fever and jaundice for two days. There was no history of recent travel abroad. Investigations revealed a high DIRECT bilirubin level and elevated liver enzymes. Hepatitis A virus immunoglobulin M (HAV IgM) was detected. During the course of hepatitis A, the child developed clinically significant and symptomatic bilateral pleural effusion associated with ascites. The diagnosis was confirmed with chest x-ray and ultrasonography. Lowest Albumin level was 23 g/l. Both pleural effusion and ascites resolved spontaneously without intervention.

Conclusions In patients with jaundice and pleural effusion and/or ascites, Hepatitis A is an important differential diagnosis. Both conditions are self-limited. Pleural and/or peritoneal diagnostic tapping is not warranted. Research is required to explore the underlying pathogenesis of the association.

955 FIRST-EVER CASE OF CEREBRAL TOXOPLASMOSIS IN HYPER IGE SYNDROME WITH DOCK8 MUTATION

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Background and Aims A ten year-old girl with hyper IgE syndrome caused by DOCK8 mutation was admitted to our hospital due to neuropsychiatric symptoms. Cranial MRI revealed multifocal cerebral lesions. Our aim was to clarify the etiology of these lesions by extended microbiology tests and comprehensive search in the literature then provide her with proper treatment options.

Methods Multiple blood and cerebrospinal fluid samples and were examined for bacterial and fungal culture, Aspergillus and Cryptococcus antigen, HSV, CMV, Mycobacterium and Toxoplasma PCR, panfungal PCR and for Toxocara and E. histolytica serology. Brain biopsy was also done for histology, bacterial and fungal culture.

Results All diagnostic assays showed negative results therefore causative agents could not be identified. For treatment, ceftriaxone and metronidazole combination was initially used accompanied by slight clinical and neuroradiological progression. Considering the possible presence of vascular brain lesions, high dose parenteral steroid treatment was introduced together with preemptive parenteral voriconazole therapy. Further progression in the clinical and radiological status was observed. Although there is no report of cerebral toxoplasmosis in this disorder, empirical anti-toxoplasma treatment was initiated with significant clinical improvement and radiological regression after 6-week therapy. Retrospective tests of CSF for Toxoplasma serology showed IgG titer increment.

Conclusion To our knowledge this is the first paper on cerebral toxoplasmosis in hyper IgE syndrome to date. In case of cerebral lesions in these patients Toxoplasma reactivation should be considered inspite of negative Toxoplasma PCR and antitoxoplasma treatment should be introduced in the absence of other etiologic factor.

956 INFANT BOTULISM DUE TO HONEY INGESTATION

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Background and Aims Botulism is a neuroparalytic disease caused by neurotoxins produced by the bacteria *Clostridium botulinum*. This neurotoxin inhibits the normal release of acetylcholine in the synaptic cleft, inducing presynaptic neuromuscular blockade. Infant botulism results from the absorption of heat-labile neurotoxin produced in situ by ingested *Clostridium botulinum*. Honey and environmental exposure are the main sources of acquisition of the organism.

Patient The patient was a 6-month-old girl with bilateral ptosis, muscle weakness, constipation and history of honey consumption. Lumbar puncture (LP), electromyography (EMG), nerve conduction study (NVS) and brain magnetic resonance imaging (MRI) were performed that all were normal. Stool evaluation for botulinum toxin was positive for toxin-A. Due to delayed diagnosis and improvement of general condition with conservative management botulinum anti-toxins did not started for her. After several days symptoms gradually improved and she was discharged with good general condition.

Conclusion Botulinum should be considered in every patient with weakness and ptosis. Botulism evaluation and appropriate management should be done.

957 MULTIPLE HUGE HYDATID CYSTS OF LIVER

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