



**Abstract G432(P) Figure 1** Factors contributing to preventability of TB infection by number of cases and country of birth (UK/Non UK-born)

**Introduction** Kikuchi disease (histiocytic necrotizing lymphadenitis) first described in Japan (1972) is a self-limited disorder of unknown aetiology, characterised by focal painful lymphadenitis, fever, malaise and weight loss.<sup>1</sup> Kikuchi disease affects a wide age range of patients (2–75 years) but typically affects young adults (mean age, 20–30 years).<sup>2</sup> It has been reported predominantly in Asian population and occurs sporadically outside Asia.

We report a case of Kikuchi disease with multisystem involvement in a 14-year-old Chinese boy.

**Case report** Child was admitted to our hospital with 3 weeks of fever (daily spikes > 39°C), intermittent frontal headaches, rash, weight loss (2 kg) and oral ulcers for one week. No travel history.

**Clinical examination:** Febrile child with left cervical and left submandibular lymphadenopathy, hepatomegaly and maculopapular rash. Rest of the examination was unremarkable.

Child was investigated for fever of unknown origin and treated with intravenous antibiotics (ceftriaxone and clindamycin).

**Investigations:** Blood, stool, urine cultures, Rickettsia, Toxoplasmosis, EBV, CMV, Salmonella serology, HSV PCR, TB (T – spot test), ANA and anti dsDNA negative. Raised ASOT (800 units), LDH 524 (170–283 U/L), ESR (170 mm/hr) and CRP (46 mg/l). Bone Marrow showed no evidence of malignancy. Lymph node biopsy was consistent with Kikuchi's lymphadenitis.

Child was discharged after 12 days with oral prednisolone but readmitted 4 days later with seizures requiring anticonvulsants and ventilation. Child was diagnosed with Kikuchi's disease with multisystem involvement (aseptic meningitis, raised liver transaminases, DCT positive anaemia, and interface dermatitis). MRI/MRA brain was normal. CSF cultures were negative. Child was treated with intravenous antibiotics and methylprednisolone followed by oral steroids and antibiotics on discharge. Child has remained well on follow up clinic visits.

**Conclusions** Clinical differential diagnosis for Kikuchi disease includes infectious mononucleosis, bacterial lymphadenitis, cat scratch disease, mycobacterium tuberculosis, CMV disease,

toxoplasmosis, systemic lupus erythematosus (SLE), malignancy and kawasaki disease.<sup>1</sup>

Diagnosis of Kikuchi's disease is confirmed by lymph node biopsy showing histiocytic necrotizing lymphadenitis (similar to SLE); however, association of Kikuchi disease with SLE remains unclear. Corticosteroid therapy may speed up recovery in patients with kikuchi disease<sup>1</sup>. The prognosis for kikuchi is generally optimistic; however, a concurrent autoimmune disease or the risk of developing an autoimmune disease needs careful monitoring.<sup>3</sup>

#### REFERENCES

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#### G434(P) PRESCRIBING PRACTICES FOR BUCCAL MIDAZOLAM AND ITS USE IN THE COMMUNITY

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**Background** NICE Clinical Guideline 137 recommends prescribing buccal midazolam to children who have prolonged (lasting 5 min or more) or repeated (3 or more in an hour) convulsive seizures in the community. Treatment should be administered by trained clinical personnel or, if specified by an individually agreed protocol drawn up with the specialist, by family members or carers with appropriate training.

**Aims** We aimed to audit Buccal Midazolam prescriptions and to review if: 1) Prescribers are following the NICE guideline. 2) Correct dose (according to BNF) is prescribed. 3) These are part of the written epilepsy plan.

**Methods** 24 children registered with General Practitioners and who had buccal midazolam on their repeat prescription records were identified.

**Results** Of the 24 children included in the study, 12 were in mainstream school and 12 were in special needs school. 15 children were on antiepileptic drugs. 10 children had generalised tonic-clonic seizures with or without absences, 7 had focal or multifocal seizures plus generalised tonic-clonic seizures (secondary generalised), 4 had focal seizures, 2 had multifocal seizures, and 1 child had absence seizures occurring in clusters. 1 child had focal seizures lasting less than 5 min (but was prescribed buccal midazolam due to parental anxiety). 23 children had seizures lasting more than 5 min. 22 children were under the care of a hospital consultant. 2 children had been discharged and GPs were asked to stop midazolam; but continued to be on repeat prescriptions. 21 children were on the appropriate dose according to BNF. 23 children had reference to a written management plan with 19 having a copy in the notes. 17 children had documented evidence of training delivered to parents. 19 children had an emergency plan at school. 10 children had used buccal midazolam in the community.

**Conclusion** Majority of the prescriptions were in accordance with the NICE guidelines and on the appropriate dose. All but 1 had a written management plan but only 19 were available in notes. The fact that 2 children were still on the list of repeat prescription by the GP even after discharge was worrying and would not have come to attention if it was not for the audit.

#### G435(P) EVOLUTION OF "LOOKED AFTER CHILDREN'S" (LAC) REGIONAL NETWORK – JOINT MEDICAL AND NURSING INPUT – A NOVEL CONCEPT

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**Aims** This work details the rejuvenation of LAC network in a region reflecting on the factors that had resulted in the network moving towards dissolution.

**Methods** NICE guidelines in 2010 clearly mentioned strong leadership, effective partnership and multiagency working for all professionals working with LAC. Need for redevelopment of network which previously existed had been long felt due to new guidance and to improve cross border working. The original network comprised of doctors only and gradually declined due to falling attendance. In 2012 Looked after intercollegiate guidance was published by RCPCH, wherein the role of all LAC professionals was defined. A baseline benchmarking survey was undertaken in 2012 to do a needs analysis with aim to develop an understanding for medical and nursing network along with requirement by strategic clinical network, British adoption and fostering agency. Subsequently a strategy was drawn and resources were identified. Plan was discussed with all stake holders (Strategic Clinical Network (SCN), British Association for Adoption and Fostering (BAAF) and LAC nursing leads. Network was formed in June 2012, using combined medical and nursing network as a novel concept. Local BAAF provided administrative input and the feedback to central BAAF which links with RCPCH.

**Results** We have a very successful joint nursing and medical network which is well attended and has had a very positive response. Network meets up twice a year and is supported both

by SCN and BAAF. The agenda covers peer review and good practice including audits are shared to improve outcome. The meeting day is split part, so that nursing and medical network can learn from cases relevant to their practice. Guest speakers from local authority and CAMHS too have been a part to improve education and it has been highly appreciated. Numbers of designated professionals joining network has grown.

**Conclusion** To develop a network it is important to be clear with aims and available resources; ours is a good example. It is a valuable source for peer review for designated LAC professionals.

#### G436(P) A RETROSPECTIVE AUDIT OF MELATONIN PRESCRIBING AMONGST THE COMMUNITY PAEDIATRICIANS IN A HERTFORDSHIRE CHILD DEVELOPMENT CENTRE AND COST IMPLICATIONS

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**Aims** In 2012–2013 melatonin prescriptions cost our Paediatric department over £45,000 per year. An audit was carried out to explore the practice of prescribing melatonin among clinicians, compare it with current evidence for melatonin prescribing and find cost effective ways of reducing the annual melatonin spend.

**Methods** Families of children with neurodevelopmental disorders issued with melatonin from hospital or community pharmacies from January to June 2013 were included in the audit. Cases were randomly selected and case-notes and doctor's reports audited retrospectively. Children on melatonin for less than 6 months were excluded from the study.

**Results** A total of 17 case-notes were audited. A detailed sleep history was documented in merely 1 case. Only 12% of cases were given verbal advice on sleep hygiene, prior to starting melatonin, and received sleep support whilst on melatonin. Paediatricians requested sleep hygiene support from Primary care in 6% of children. A sleep-diary was never used to monitor sleep at any stage of management. Children taking melatonin ranged from 1 to 8 years, with one child on melatonin for 12 years. Paediatricians did not suggest breaks from therapy in all cases. Given dosages of melatonin were ranged from 2 mg to 12 mg.

**Conclusion** This audit highlighted the need for the development and implementation of evidence-based melatonin guidelines for Paediatricians, a sleep tool-kit for health professionals to help conduct a more effective sleep interview and sleep information to help support families establish good sleep hygiene in their children. So far, a melatonin guideline and sleep support tool-kit has been developed and circulated to relevant stakeholders. This has resulted in better prescribing practice, sleep support for families and a reduction in melatonin prescribing. Following the introduction of the guidelines, the preliminary results on the melatonin expenditure concluded a cost saving amount of £5651 over a period of 5 months, April to August 2014, compared to the same time period in 2013. These initial results are quite promising in predicting a larger saving in the future.

#### G437(P) A CASE OF CONGENITAL GLAUCOMA IN MOSAIC DOWN'S SYNDROME (TRISOMY 21)

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