

intravenous immune globulin (IVIG) (single dose) and aspirin, in order to prevent development of coronary artery aneurysms. Fever persists in 10–15% of the patients and KD is considered refractory then.

Case Report A 15 months old boy, with unremarkable medical history, was admitted with manifestations and laboratory findings of KD. Initially, IVIG (2g/kg) and aspirin (80mg/kg/24h) were given. Fever insisted and there was a further increase of the PLTs and hemolytic anemia was added. A second dose IVIG (2g/kg) was repeated. As fever remained, pulse IV solu-medrol (30/mg/kg/24h) was given in 3 days. There was a new recur of the fever and of the laboratory findings, thus a third dose of IVIG (2mg/kg) was administered, with complete recession of all manifestations. The extended laboratory investigation revealed positive IgM antibodies for *Mycoplasma pneumoniae*. During the boy's hospitalization, cardiologic echograms were normal.

Conclusions

1. Refractory KD cases might respond to 2 or 3 doses of IVIG (2g/kg), with the addition of pulse IV solu-medrol or other immunoregulator agents (e.g. infliximab). Since the disease is very rare, there are few controlled available data about the benefits of treatment.
2. *Mycoplasma pneumoniae* is considered as a trigger factor for KD, by producing superantigens, and can also trigger hemolytic anemia.
3. Though refractory KD is considered as high risk for development of coronary aneurysms, in the case herein, coronary arteries remained intact during all follow up visits.

844 REYE'S SYNDROME AND DISSEMINATED INTRAVASCULAR COAGULATION PRESENTED BY ROTAVIRUS INFECTION

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Z Yalaki, FI Arikan, G Buyukyilmaz, B Altan, H Demir, Y Dallar Bilge. *Pediatrics Clinic, Ankara Training and Research Hospital, Ankara, Turkey*

Rotavirus is one of the leading causes of severe gastroenteritis in childhood, which is an infection known to be limited to the gastrointestinal system. However, a case of extra-intestinal complication developed during rotavirus gastroenteritis is presented here.

Case A five years old patient with febrile convulsion, also having complaints of vomiting, diarrhea, and fever was brought to our hospital. General condition of the patient was bad; she was unconscious and severely dehydrated. Her laboratory findings showed acidosis and renal failure; coagulation tests showed impairment. During her monitoring, gastrointestinal bleeding, increase in liver function test values, hyperammonemia, neutropenia, and hypoglycemia were developed. Rotavirus antigen was found to be positive in the gaita test. Patient's general condition was improved by giving antibiotics, liquids, fresh frozen plasma, and thrombocytes in the early stages after which she was discharged.

Close monitoring of patients with rotavirus gastroenteritis in terms of extra-intestinal complications and applying appropriate treatment in the early stages may save lives.

845 IMPACT OF THREE YEARS INFECTION WITH INFLUENZA A (H1N1) VIRUS IN CHILDREN

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E Blevrakis, T Tavladaki, AM Spanaki, MD Fitrolaki, S Iliia, E Vasilaki, E Geromarkaki, G Briassoulis. *PICU, University Hospital of Heraklion, Heraklion, Greece*

Background and Aim Influenza A virus infection involved the public Health System worldwide so much that on June 2009 WHO announced the disease from epidemic as pandemic. Our purpose was to investigate the incidence, clinical characteristics, treatment

and outcome of H1N1 in children with respiratory tract infection required hospitalization in PICU.

Material and Methods Influenza A in children hospitalized in our unit with respiratory infection during the period April 2009–March 2012 was confirmed by special pharyngeal sample.

Results During this period, 58 out of 322 children were admitted in our Unit with respiratory infection. Seven patients (12%) (4 girls and 3 boys, age 2^{1/2}, 4^{1/2}, 5, 6^{1/2}, 8, 9 and 10 years), all unvaccinated for H1N1, were influenza A infected. Their initial symptoms were:

- Fever > 38° C (5 cases)
- Respiratory infection (2 cases of pneumonitis)
- Bronchial asthma and pneumomediastinum
- Febrile + status epilepticus
- Cardiac arrest, multiorgan failure

Five children needed intubation and mechanical ventilation. Five had underlying disease -two had asthma, one had bronchopulmonary dysplasia and heart disease, and two had cerebral palsy.

Oseltamivir was administered immediately and for 5 days in all cases and in one case, with persistent infection, for 15 days.

The outcome was good in 6 cases and only the child with bronchopulmonary dysplasia and heart disease developed multiorgan failure and eventually died.

Conclusion 12% of patients with respiratory infection in our PICU was H1N1 positive. One patient with severe underlying disease died. 71% need mechanical ventilation and the majority of them had co-morbidities.

846 RESPIRATORY SYNCYTIAL VIRUS AS CAUSE OF LOWER RESPIRATORY TRACT INFECTION IN YOUNG CHILDREN IN CENTRAL AND EASTERN EUROPE

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¹O Van de Steen, ²M Gunjaca, ³V Klepac, ⁴B Gross, ⁵G Notario, ⁶F Miri. ¹Abbott SA/NV, Brussel, Belgium; ²Abbott Laboratories d.o.o, Zagreb, Croatia; ³Abbott GmbH & Co. KG, Wiesbaden, Germany; ⁴Abbott Laboratories, Abbott Park, IL, USA

Background Respiratory Syncytial virus (RSV) infection can cause severe morbidity leading to hospitalization and admission to paediatric intensive care unit (ICU). Limited epidemiological data exist about RSV as cause of lower respiratory tract infection (LRTI) requiring hospitalization in Central and Eastern Europe (CEE).

Methods This is a prospective cross-sectional observational multi-country epidemiological study. Children younger than 1 year hospitalized for LRTI between October 2009–April 2010 and/or October 2010–April 2011 are included (two consecutive RSV seasons). We present data on differences in LRTI disease severity comparing RSV positive premature infants (gestational age ≤ 36weeks) with RSV positive infants without risk factors (gestational age > 36weeks, no congenital heart disease, no bronchopulmonary dysplasia and no neuromuscular disease).

Results 3,474 evaluable subjects were included from 12 CEE countries. In 3,354 cases (96.5%) a RSV rapid test was performed: 1,423 cases (42.4%) were tested RSV positive. Among the RSV positive group, 266 infants were prematurely born (RSVppos); 1,034 presented without risk factors (RSVnorf). Mean hospitalization duration were 17 and 8 days respectively for RSVppos group and RSVnorf group (p<0.001). 41.4% of RSVppos required ICU hospitalization versus 12.6% RSVnorf (p<0.001). RSVppos exhibited a longer mean duration in ICU stay versus RSVnorf (13 days vs 6 days, p<0.001). 2.6% of RSVppos died during hospitalization versus 0.3% RSVnorf (p<0.001).

Conclusions Premature infants hospitalized for RSV LRTI exhibit a longer stay in hospital, more frequent and longer stay in ICU and a higher mortality compared with infants without risk factors.