be reinforced by the integration of BBI risk assessment to induction of new community trainees. We plan to implement this in March 2015, and we aim to maintain and reinforce those changes, by continuous monitoring and service evaluation.

**G432(P) INVESTIGATION INTO AN INCREASE IN PAEDIATRIC TUBERCULOSIS INCIDENCE IN GREATER MANCHESTER**

ER Willis, C Bell, C Murray, Freeman, S Farrow, Massarano, McMaster, Shankar, McCann, Petrovic. Paediatric Respiratory Medicine, Royal Manchester Children’s Hospital, Central Manchester University Hospitals NHS Foundation Trust, Manchester, UK; General Paediatrics, Bolton NHS Foundation Trust, Bolton, UK; General Paediatrics, Tameside Hospital NHS Foundation Trust, Manchester, UK; Paediatric Infectious Diseases, Pennine Acute Hospitals NHS Trust, Manchester, UK; Public Health, Public Health England, Manchester, UK; University of Manchester, Manchester, UK

Aims During the period 2003/4–2009 there was an almost 3-fold increase in the incidence of tuberculosis (TB) in children in Greater Manchester (GM). The aim of this investigation was to understand the factors driving this increase, with a view to improving prevention and reversing the increasing trend.

Methods Data were prospectively collected from paediatric TB cases diagnosed within GM between 1 January 2012 and 31 December 2013. Cases were GM residents <16 years at diagnosis. Information was collected from the parents/guardians of each case using a standardised proforma, where possible at the initial clinical consultation. At the end of the investigation period, teleconferences were held with each clinical service to assess the potential preventability in the UK setting of reported cases.

Results 60 TB cases were ascertained during the study period. Proforma were completed for 56/60. 57% were male. Age ranged from 0–15 years with 32% of cases under 5 years of age and 21% of the cases 15 years of age. Over half of the cases (31/56 (55%)) were UK-born, 9/56 (16%) were born in Pakistan and country of birth for the remainder was distributed across 11 different countries.

A total of 17 cases (30%) were judged to have been potentially preventable. Figure 1 shows the factors contributing to preventability by number of cases. 7/17 of the potentially preventable cases were UK-born.

Conclusion A third of cases for whom data collection was completed were judged to have been potentially preventable. The two main themes that emerged were failure of the new entrant screening process and failure to be vaccinated with BCG vaccine despite being eligible. In order to reduce the burden of paediatric TB, it is important to ensure effective mechanisms are in place to maximise ascertainment of eligible new entrants to the UK. With regards to BCG vaccination, a review of arrangements across GM is currently underway.

**G433(P) KIKUCHI DISEASE WITH MULTISYSTEM INVOLVEMENT: A CASE REPORT**

VK Sahu. Paediatric Medicine, KK Women’s and Children’s Hospital, Singapore

10.1136/archdischild-2015-308599.387
**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. \(^1\) Kikuchi disease affects a wide age range of patients (2–75 years) but typically affects young adults (mean age, 20–30 years). \(^2\) 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 (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 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 (septic meningitis, raised liver transaminases, DCT positive anaemia, and interface dermatitis). MRI/MRA brain was normal. CSF cultures were negative. Bone Marrow showed no evidence of malignancy. Lymph node biopsy was consistent with Kikuchi’s lymphadenitis.

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**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. \(^1\)

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 \(^1\). The prognosis for kikuchi is generally optimistic; however, a concurrent autoimmune disease or the risk of developing an autoimmune disease needs careful monitoring. \(^3\)

**REFERENCES**

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

5 Haves, A Koshy, S Lewis, E Bayles. Paediatrics, County Durham and Darlington NHS Foundation Trust, Darlington, UK

10.1136/archdischild-2015-308599.387

**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.

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