Childhood arterial ischaemic stroke is rare, with an incidence of 1.6 per 100,000.¹ As demonstrated in our patient, early recognition is key for thrombolysis to be effective. The publication of the Stroke in Childhood: Clinical guideline for diagnosis, management and rehabilitation (2017)² advocates the importance FAST (Face, Arms, Legs and Time) which has already proved to be successful for early diagnosis in adult patients. Effective collaboration with our adult counterparts is vital to share resources and implement guidance locally.

REFERENCES

1. Mallick AA, Ganesan V, Kirkham FJ, *et al.* Childhood arterial ischaemic stroke incidence, presenting features, and risk factors: A prospective population-based study. *The Lancet Neurology* 2014;**13**(1):35–43.
2. Stroke in childhood: Clinical guideline for diagnosis, management and rehabilitation. *Royal College of Paediatrics and Child Health* 2017.

G314(P) A RARE NEUROLOGICAL CAUSE OF LIMPING AND HIP DYSPLASIA

A Butt, G Sinha. *Paediatric, Walsall Manor Hospital, Walsall, UK*

10.1136/archdischild-2018-rcpch.305

Introduction Limping is a common presentation in children. It has many aetiologies, from trauma, infection, haematological conditions and malignancies. We would like to present a rare cause of limping. Syringomyelia describes a longitudinal fluid cavity of the spinal cord, whether a dilatation of the central canal or cavitation of the grey matter. There is a paucity of data, particularly of paediatric cases. Clinical manifestations depend on the location and size of the syrinx. They typically involve segmental signs, with wasting of the small muscles of the hand, sensory deficits and absence of tendon reflexes. It can also cause lower limb spasticity, and a loss of pain and temperature sensation.

Case report A previously fit and well 18 month girl was referred with a 3 month history of dragging the left foot and limping. The mother's pregnancy and child's neonatal period was uneventful. Her growth was between the 9th-25th centile, and developmental milestones were appropriate. She was passing urine normally, and was constipated for 4 months. On initial assessment she was noted to have birth marks on her lumbar spine. She had normal tone, power and reflexes in both lower and upper limbs. She had no wasting of the small muscles of the hands. Her left foot appeared to be larger than the right, and when walking she was dragging her left foot. At this point the parents were advised how to manage the constipation and the child was sent for physiotherapy, hip X-rays and MRI of the brain and spine. The hip X-ray showed mild loss of coverage of the left femoral head. The cranial MRI was normal. MRI without contrast showed a cystic abnormality in the conus medullaris most likely due to Syringomyelia; MRI contrast excluded spinal tumour. The radiologist felt the abnormal development of the left hip could be secondary to the syrinx, or evolution of developmental dysplasia.

Learning points/conclusion This case highlights the need for full examination, and appropriate investigation of the spine, hips, abdomen and lower limb from a musculoskeletal and neurological perspective.

G315(P) TREATMENT OF ANTICARDIOLIPIN ANTIBODY MEDIATED CHOREA IN AN ADOLESCENT MALE

¹R Odedun, ¹R Kumar, ²L McCann. ¹Paediatric Neurology, Alder Hey Children's Hospital, Liverpool, UK; ²Paediatric Rheumatology, Alder Hey Children's Hospital, Liverpool, UK

10.1136/archdischild-2018-rcpch.306

Background Anti-phospholipid antibody associated chorea is a rare cause of this movement disorder, with a higher incidence in females and children. Other causes include Wilson's disease, Sydenham's chorea and ataxia-telangiectasia. Aetiology is uncertain, but may involve anti-phospholipid mediated dysfunction of the basal ganglia. We report an unusual case of anticardiolipin antibody related chorea in an adolescent male presenting to secondary care services.

Case report Our patient is a 14 year old male who became unwell in December 2016 with gradual onset of uncontrolled movements in his arms, and behavioural changes. There was a notable history of minor head injury, preceding sore throat and recurrent tonsillitis. Over the next six months, he reported worsening of choreoathetoid movements affecting his gait and upper limb function.

He presented in April 2017 with acute slurring of speech three weeks after starting baclofen. He was then referred to tertiary paediatric neurology services. No features of Lupus were present on examination. His functioning was monitored after baclofen was stopped, and he progressed to treatment with high dose steroids, penicillin V and sodium valproate. He improved following significant rehabilitation with multidisciplinary involvement from occupational therapy, physiotherapy and the school team. His final diagnosis was revised to anticardiolipin antibody related chorea following results of immunological tests and consideration of the chronic progressive history. He was treated successfully with aspirin and mycophenolate mofetil, and has been discharged home with ongoing clinic review.

Results 12 lead ECG, echocardiogram and MRI brain normal.

ASO Titre: 400 units/ml (50–200)

Anti-DNAse B: 100 units/ml (<240 units/ml)

Anti-Mitochondrial Ab: positive

Anti-Nuclear Ab titre: 1:320 (Positive)

Anti-cardiolipin IgG Ab 1184.2 units/ml (0–19.9)

Anti-B2-GP-1 IgG 4269.7 units/ml (<20)

Conclusion As a patient's disease continues to evolve, so should our diagnostic approach. Atypical progression of disease should prompt review. Generally, treatment of anticardiolipin related chorea falls into 2 pathways; anticoagulation and immunosuppression, with evidence limited to case reports and small case series.

Acknowledgements to the local medical illustration team for performing serial videos showing improvement in function.

G316(P) COPY NUMBER VARIATION (CNV) IN A PATIENT WITH EPILEPSY AND HYPOTHYROIDISM: A RARE ASSOCIATION WITH RBFOX1 MICRODELETION

S Kapoor, S Kumar, N Hussain, S Ganesan. *Department of Paediatrics, University Hospitals of Leicester, Leicester*

10.1136/archdischild-2018-rcpch.307