specific in children, with Erythema Migrans being the commonest presenting feature which is often missed as a heralding sign. Two children presented with LMN FP who we treated empirically for LD with Amoxicillin with subsequent results confirming the diagnosis. One was a holiday maker from an area not reported to have Lyme disease and the second child was on holiday in Republic of Ireland with known prevalence of Lyme disease. Both children presented to medical services in the preceding days with a rash and one with unilateral facial swelling (with development of LMN FP on same side). It is thought that up to fifty percent of facial Palsy in Children may be as a result of LD.

Conclusion Our findings confirm that LD is increasingly more common in the UK and should be considered as the most common cause of LMN FP. Symptomatic LD is potentially progressive with long term consequences. We propose empiric treatment of all cases of LMN FP with Amoxicillin or Doxy-cycline whilst awaiting serological confirmation of LD. In addition, clinicians should be considering LD much earlier in the differential of children presenting with a LMN FP.

**REFERENCE**


**G325(P)** AN EVALUATION OF OUR LOCAL PAEDIATRIC EPILEPSY SERVICES

LB Patel, M El Gamal, D Murray, P Nair. General Paediatrics, East Lancashire Hospitals NHS Trust, Blackburn, UK

10.1136/archdischild-2018-rcpch.315

**G324(P)** CHILDHOOD STROKE DUE TO CEREBRAL ARTERIOPATHY; A PANDORA’S BOX?

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**Aim** Stroke is an acute neurologic deficit that results from an ischaemic or haemorrhagic cerebral vascular event, persists for at least 24 hours, and results from a disturbance of the cerebral circulation. Childhood stroke is not common, but leads to significant morbidity and mortality. It is among the top ten causes of death in childhood. Stroke mimics are much commoner which make the diagnosis more challenging. We describe an intriguing case for which a wide array of tests has not revealed the precise aetiology.

**Methods** The clinical, laboratory and radiological data were reviewed. 

**Results** A 3-year-old girl, only child of non-consanguineous Polish parents presented with marked altered level of consciousness preceded by upper respiratory tract infection. Examination revealed non-reactive pupils without focal neurological signs. Electroencephalography demonstrated diffuse encephalopathy. She was managed for probable encephalitis. There was clinical deterioration evident by headaches, an episode of focal seizure with subsequent right sided hemiparesis. Serial magnetic resonance image (MRI) and angiography (MRA) of the brain revealed diffuse abnormality of intracranial vessels with attenuated calibre of intracranial vessels and bilateral watershed infarcts. There was visual loss without evidence of optic neuritis. Metabolic, coagulation, autoimmune, infection, extracranial imaging and available genetic screen have been normal so far. Fluctuating blood pressure has remained a challenge in her management. She is being managed on immunosuppressive, antiepileptic, antihypertensive and antithrombotic agents. Multidisciplinary team follow-up is ongoing. Follow-up brain MRI and MRA (at five months) confirmed stable bilateral infarcts and vessels appearance.

**Conclusion** Cerebral arteriopathy has been recognised as a major risk factor for arterial ischaemic stroke in children. It may develop in a previously healthy child without any known risk factors. However, recent upper respiratory tract infection has been shown to be a significant predictor of underlying arteriopathy. The risk of recurrence in this case remains uncertain.