A CASE OF SHINGLES WITH NO HISTORY OF CHICKEN POX

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Introduction Herpes Zoster Ophthalmicus (HZO) is a specific form of shingles that affects the dermatome of the ophthalmic nerve. It can have serious sequelae including permanent visual loss if there is ocular involvement.

Case report A 20-month-old child presented to the Paediatric Assessment Unit with a vesicular rash on his left forehead, with swelling around the left eye. He had been treated with Flucloxacillin for impetigo, however this had failed to resolve the rash. He was afebrile, passing urine and stool normally but had decreased oral intake. On examination the rash was restricted to the territory of the left ophthalmic nerve. The left eye was swollen with a yellow discharge and could not be opened. Swabs from the eye, and of the vesicular fluid were sent for bacterial culture and viral PCR. Initial bloods, including FBC and CRP, were normal, with no evidence of systemic infection. A diagnosis of HZO was made, based on the clinical findings, and the child was commenced on IV Aciclovir, IV Co-Amoxiclav, and Chloramphenicol eye drops. The following day the child had developed a fever and was tachycardic and tachypnoeic; the antibiotics were continued. Varicella zoster IgG was found to be positive suggesting past infection. Ophthalmological opinion was sought to rule out ocular involvement. They found the child to be Hutchinson’s sign negative and agreed with the diagnosis of HZO without ocular involvement. The child received 7 days of Aciclovir, 7 days of antibiotics and 14 days of Chloramphenicol eye drops. The bacterial culture later isolated Moraxella catarrhalis, and the viral PCR confirmed Varicella zoster DNA.

Learning points Asymptomatic chickenpox is uncommon, although mild cases may be missed. Chickenpox infection can occur in utero and can cause scarring, neurological and ophthalmic complications, or the baby can be asymptomatic and present in early life with shingles. Accurate diagnosis is important to prompt early management. Examination of the eye with Ophthalmological input is important to rule out or manage ocular involvement. Hutchison’s sign indicates nasociliary branch involvement increasing the likelihood of ocular sequelae.

CHILDHOOD STROKE DUE TO CEREBRAL ARTERIOPATHY; A PANDORA’S BOX?

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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 Doxycycline 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.
IMPACT OF COMPLEX REHABILITATION USING ROBOTIC KINESIOThERAPY AND BOTULINUM THERAPY ON THE LEVEL OF SOCIAL ADAPTATION OF CHILDREN WITH CEREBRAL PALSY

Aims
34,000 Children and Young People (CYP) in England have a diagnosis of epilepsy and receive anti-epileptic drugs. NICE have described high-priority areas for quality improvement; The Epilepsy in CYP, Quality Standard (QS27). Our local service aims to provide an excellent multidisciplinary service to serve its patients and their families in a holistic manner. It is delivered by consultants, a specialist nurse, rotating junior doctors and the nursing team.

Methods
To evaluate our current local service standard against national guidance and identify areas of possible improvement, we developed a Caregiver and Patient Reported Survey (CPRS). It covered both quality standards and expectations from patients and their parents and caregivers. Anonymous CPRS were disseminated in the waiting areas of our multi-site outpatient paediatric epilepsy clinics over a 3 month period (n=44). Observational analyses were completed on all the returned CPRS and the results were mapped against national guidance.

Results
Observational analyses revealed 70.5% of CPRS were completed by caregiver/parent and 22.7% by CYP (6.8% no return). 84.1% stated that they were satisfied-very satisfied with our services, 90.9% were happy-very happy with their clinical experience, 82.7% were happy-very happy with the support they received outside of the clinic environment (34.0% no return) and 77.8% were happy-very happy with the support received whilst inpatients (38.6% no return).

Our patients had experienced problems in the educational, social and home lives due to epilepsy; 31.8% at school, 18.2% attending out of school clubs and 31.8% socialising. 18.2% of patients experienced problems with other areas including; side effects of medication, communication with services and behavioural issues. 90.2% were content with the information they received following diagnosis and 95.2% between appointments. 86% were happy to very happy with the verbal information and 81.4% with written information. 14% identified areas of change including; information on the effects of epilepsy on learning and education, more streamlined information and flexibility around access to services.

Conclusion
Communication and information delivery were identified as key areas of possible improvement. We are now developing an electronic, locally tailored Paediatric Epilepsy Information Pack to be disseminated to patients and their families.

CHARACTERISTICS AND OUTCOME OF HEADACHES IN CHILDREN FROM A TERTIARY CARE HEADACHE CLINIC

Aim
Headache is a common cause for referral to paediatric outpatients. Whilst there is clear guidance on recognition of patients intracranial causes of headache, the management and outcome of idiopathic headaches is variable.

Method
We reviewed the characteristics of 28 patients from a tertiary headache clinic between 2013 and 2015. Demographics, diagnosis, indication for MRI, management and outcome of the patients was reviewed.

Result
There was a female predominance of 61% with mean age of 12.8 years at initial appointment. 53% of patients were felt to have a chronic headache at presentation, 46% of which improved with treatment. The most frequent diagnosis was migraine without aura (57%) and migraine with aura (25%). Three patients were diagnosed with medication overuse headache, two with cluster headache, two with chronic paroxysmal hemicranias and one patient with each tension headache and idiopathic intracranial hypertension.

The majority of patients underwent MRI scan (89%) of which 72% were reported as normal, 20% had small white matter changes that are often seen in patients with migraine and 8% had no change in previously known abnormalities.