Conclusions Although recommendations are being followed, there is still place for antibiotic therapy in RSV infection. The need for antibiotic cannot be easily predicted upon traditionally used inflammatory markers. Due to prolonged hospital stay, there is strong need for minimizing antibiotic use, and more precise clinical tools to assess the risk of antibiotic.

**GP196**  
THE USE OF A RAPID ANTIGEN DETECTION TEST FOR BETA HAEMOLYTIC GROUP A STREPTOCOCCUS TO AID THE MANAGEMENT OF PHARYNGITIS AND TONSILLITIS IN AN IRISH TERTIARY PAEDIATRIC EMERGENCY DEPARTMENT  
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**Introduction** Rates of community acquired methicillin resistant staphylococcus aureus (MRSA) in Israel is quite low and estimated at the range of 3% out of staphylococcus aureus isolates. This survey has been undertaken due to clinical impression of significant rise at the rates of MRSA isolates during the last few years in a closed community in Israel.

**Methods** All community acquired staphylococcus aureus isolates from children referred to Mayenei Hayeshuah Hospital in Bnei Brak Israel during the years 2015–2018 were analyzed. This hospital serves a closed ultraorthodox Jewish community characterized by crowdedness.

**Results** A total of 201 isolates were reviewed. Most isolates (163) were from skin and soft tissue specimens and the rest were from normally sterile fluids, urine and ear specimens.

The rates of MRSA isolates out of all staphylococcal isolates were 14%.

Most MRSA isolated were from the skin and soft tissue while none of the isolated from normally sterile fluid fluids grew out MRSA.

During the study years there was a dramatic rise at the rates of MRSA from 4% in 2015 to 23% in 2018.

Children with MRSA infections were younger than those with methicillin sensitive staphylococcus aureus (MSSA) infection (mean ages were 2.9 years and 5.9 years in MRSA vs. MSSA infected children respectively, p<0.001).

Clindamycin inducible resistance was detected in 44% of MSSA isolates and in 7% of MRSA isolates.

Trimethoprim/sulfamethoxazole resistant was observed in 2% of MSSA and in 7% of MRSA isolates.

**Conclusions** These findings demonstrates the ability of MRSA clones to spread rapidly especially in a closed and crowded community.

Our findings also indicate that clindamycin is not an appropriate antibiotic for empiric treatment of staphylococcal infection unless administered with another anti staphylococcal agent.

In addition, the increased rate of trimethoprim/sulfamethoxazole resistant is worrisome and should be closely monitored.
ability to cause acute flaccid myelitis. Acute flaccid myelitis (AFM) refers to acute flaccid limb weakness with predominantly gray matter spinal cord lesions on imaging or evidence of anterior horn cell damage on electrodiagnostic studies. In 2014, in the midst of a large outbreak of EV D68-associated respiratory disease in the United States, clusters of AFM were noted in children. Enhanced nationwide surveillance ultimately identified 120 cases of AFM. Enterovirus D68 was the most common virus detected in these patients. Full recovery was rare (5%). More recently, a 2019 report describes 29-cases of EV D68-associated AFM diagnosed in 12 European countries in 2016. We present the first cases of EV D68-associated AFM in Ireland to date.

**Clinical cases** In June 2016, a previously well 2-year 9 month old girl presented with a one-week history of cough, fever and vomiting. Thirty-six hours later, respiratory status worsened and she developed AFM and bulbar palsy necessitating intubation and ventilation. CSF analysis demonstrated a lymphocytic pleocytosis. In October 2018, a 4-year old boy, with a background of acute lymphoblastic leukaemia diagnosed 17-months previously, presented with fever, worsening cough and pancytopenia. Three-days later, he required intubation and ventilation after a respiratory arrest. On weaning sedation, eight-days later, he displayed clinical signs of AFM. Both children had nasopharyngeal aspirates (NPA) PCR positive for rhinovirus/enterovirus, and stool/rectal swabs PCR positive for rotavirus/adenovirus and rotavirus. MRI showed extensive abnormal signal predominantly of white matter in the cervico-thoracic cord. Electromyography was indicative of anterior horn cell involvement. Both children required prolonged ICU and hospital stays, have severe residual neurologic deficits with flaccid quadriaparesis, tracheostomy and require ongoing ventilatory support.

**Results** Subsequent subtyping of EV isolates from both children was positive for EV D68. Additional testing of 800 rhinovirus/enterovirus and stool/rectal swabs PCR positive for EV. CSF was PCR negative for EV, HPE, HSV, HHV-6, VZV and adenovirus. MRI showed extensive abnormal signal predominantly of white matter in the cervico-thoracic cord. Electromyography was indicative of anterior horn cell involvement. Both children required prolonged ICU and hospital stays, have severe residual neurologic deficits with flaccid quadriaparesis, tracheostomy and require ongoing ventilatory support.

**Conclusion** This report of two-children with rapidly progressive AFM following prodromal febrile respiratory or gastrointestinal illness in association with EV D68 infection and recent results of enhanced European and local surveillance suggests that EV D68 AFM has arrived in Ireland.

**GP200** **IS THE INFLUENZA IN NEONATES A DANGEROUS INFECTION? – OWN OBSERVATIONS**

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**Background** Influenza is a viral infectious disease affecting every age group, including neonates and infants.

**Aim** To analyze the frequency, clinical signs and course of influenza in neonates hospitalized during three influenza epidemic seasons.

**Material and Methods** 12 neonates were hospitalized due to influenza in Department of Pediatrics in three influenza epidemic seasons. Rapid Influenza Diagnostic Tests (RIDTs) and/or Real Time-Polymerase Chains Reaction Tests (RT-PCR) were performed in patients with a clinical suspicion of influenza.

**Results** From September 2015 to August 2018 we hospitalized 294 patients with influenza. The youngest patient was 12 days old, the oldest – 17 years 3 months. 4.1% (12/294) were neonates. The most common reason for hospital referral was fever (58.3%; 7/12). Other observe symptoms were: coryza (58.3%; 7/12), change of behavior (58.3%; 7/12), cough (50%; 6/12), dyspnea (40%; 5/12) and apneas (8.3%; 1/12). RIDTs were performed in seven (58.3%) of neonates, but positive results were only in 2 cases (16%). The final diagnosis was made using RT-PCR tests. 83.3% (10/12) of neonates were diagnosed with influenza A and 1.7% (2/12) influenza B. Complications occurred in eight neonates. 75% (9/12) patients had contact with the infection at home. None of the families were influenza-vaccinated before the season. The average time of hospitalization was 10.2 days (from 6 to 15 days).

**Conclusion** The course of influenza in neonates can be severe. RIDTs seem not very useful in diagnose.

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