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TOXIC EPIDERMAL NECROLYSIS IN A 4 YEAR OLD GIRL IN THE UAEAlyazia Al Hallami*, Najla Al Kuwaiti, Omer Yousef. *Tawam hospital, Abu Dhabi/Alain, UAE*

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Learning objectives Present a case of toxic epidermal necrolysis in the UAE who was found to have *mycoplasma pneumoniae* respiratory infection.

Case summary A 4-year-old girl, previously healthy, presented with fever of 3 days with a rash for 1 day. The rash was erythematous, sand paper like involving her chest, back, upper and lower extremities. She was found to have streptococcal pharyngitis, treated as a case of scarlet fever and discharged home on Amoxicillin-Clavulanate acid and ibuprofen.

The next day, she presented again with fever and increasing rash that is now involving the eyes and mouth (lips an oral mucosa). The rash was evolving to erosions and sloughing of the skin on the chest and back.

Considering that her skin involvement was tremendous (> 30%), she was diagnosed as toxic epidermal necrolysis (TEN). She was admitted to the pediatrics intensive care unit (PICU).

When looking for the underlying cause, the triggering factor was suspected to be either drug related or infection related. She was tested for mycoplasma infection that turned out to be positive, and she was managed with azithromycin.

Throughout her illness she was hemodynamically stable, on the 4th day of illness she started to improve in sense of settling fever and tachycardia, Her inflammatory markers were decreasing as well.

She continued her medical care in the hospital for 20 days and discharged home with follow-ups.

Methods Case report and literature review

Discussion We believe as clinicians that in the UAE we rarely encounter such critical cases that warrant a multidisciplinary approach, aiming to deliver the best care and maintain the well being of the patient. In reviewing the literature there was no reported case in the UAE. Moreover, etiological underlying factors are clearly known in the medical history. We believe that three factors were implied in this case; Amoxicillin use, *mycoplasma pneumoniae* respiratory infection and the possibility of genetic predisposition.

Conclusion SJS/TEN is a challenging diagnosis, that merits prompt recognition and management hoping to prevent its sequelae. Many factors contribute to the development of these unpleasant and eventful diagnoses. Pediatricians need to be alerted regarding this diagnosis and the available management modalities.

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CONSTRICTIVE PERICARDITIS: A RARE AND CHALLENGING DIAGNOSIS

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Constrictive pericarditis is a rare condition in children and often presents with clinical features unrelated to the heart making diagnosis challenging. It results from scarring leading to inelasticity of the pericardial sac which produces an inability to adapt to volume changes due to a restriction in diastolic

filling. The most common causes in the developed world are idiopathic, prior cardiac surgery and chest radiotherapy. In the developing world tuberculosis remains the commonest cause.

We herein report an eleven year old boy of Indian ethnicity who attended a Dublin Paediatric Emergency with chest pain and shortness of breath.

He was living in Ireland but spent the first five years of his life in India. His vaccinations including BCG were up-to-date. There was no history of contact with Tuberculosis.

He was afebrile and had a normal respiratory rate, heart rate and heart sounds. Examination revealed dullness on percussion in the left lower lobe of the lung with tender hepatomegaly. Chest radiograph reported dense consolidation in the left lower lobe with a parapneumonic effusion.

He had a low serum albumin and total protein at 22 g/L and 46 g/L respectively and elevated gamma-glutamyl transferase of 80U/L.

The patient was treated with intravenous Cefotaxime and oral Azithromycin for possible pneumonia. He remained systemically well but a repeat radiograph taken five days later showed no improvement.

Analysis of pleural fluid by thoracentesis indicated a transudative type. He was seen by the Infectious Disease team and all investigations including inflammatory markers were normal. An eye exam was also normal.

Chest computed tomography (CT) scan reported mild pericardial thickening with hepatic enlargement. A large left-sided pleural effusion with minor basal atelectasis and a small contralateral pleural effusion was noted. There was small mediastinal lymphadenopathy.

Electrocardiogram (ECG) showed flattening of the T-waves and was generally low voltage.

Echocardiogram revealed dilated inferior vena cava and hepatic veins with thickened pericardium and intra-atrial septum deviating towards the Left Atrium suggesting elevated Right Atrial pressure.

Cardiac catheterisation demonstrated elevated pressures consistent with constrictive pericarditis. The patient has been taken over by the cardiology team for ongoing management.

Discussion Constrictive Pericarditis is a rare condition in children but this case highlights the importance of a meticulous and multidisciplinary approach to look at other causes when a patient is not responding to treatment as expected.

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'STRIDOR' THE PRESENTING SYMPTOM OF SCIMITAR SYNDROME WITH TRACHEAL RING – A CASE REPORTWajida Mazher*, John Twomey. *University Hospital Limerick, Limerick, Ireland*

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We report a very interesting case of Scimitar syndrome with tracheal ring in a 5 month old thriving baby with chronic stridor.

Stridor is caused by upper airway obstruction and laryngomalacia being the most common cause of chronic stridor in children, followed by croup, which is an acute presentation.

Scimitar syndrome on the other hand is a rare congenital cardiopulmonary anomaly with incidence of 2 per 100,000 live births with 2:1 female predominance, consists of partial anomalous pulmonary venous connection of right lung to inferior vena cava, right lung hypoplasia, dextrocardia and anomalous systemic arterial supply to right lung.