Our patient presented with worsening stridor over time and required intubation due to respiratory failure. Echocardiogram, CT angiogram and MRI revealed Scimitar syndrome with PAPVD (Partial anomalous pulmonary venous drainage) and tracheal ring. MAPCAs (Major aortopulmonary collateral arteries) ligation, PAPVD repair, laryngeal repair and slide tracheoplasty was successfully done and baby showed significant clinical improvement.

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EPIDIDYMITIS IN HENOC-SCHONLEIN PURPURA, AN UNUSUAL PRESENTATION OF A COMMON VASCULITIC CONDITION IN CHILDREN

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10.1136/archdischild-2019-epa.447

Background Henoch-Schonlein purpura is a common vasculitic condition in paediatric age group. The hallmark of this syndrome is vasculitic skin rash, arthralgia and abdominal pain. Acute scrotal pain and swelling is not a common presentation of this disease. We would like to present a six and half year-old boy who presented with pain and left testicular swelling. We suspected epididymitis and torsion of testes clinically. Torsion was ruled out by doing doppler ultrasound. He was successfully managed conservatively by oral steroids and analgesia. Epididymitis is more common than torsion in HSP. Aim of this case presentation is to improve awareness of this unusual morbidity of this common vasculitic condition in children.

Case report A six and half year-old Irish, Caucasian boy presented to our emergency room with one day history of abdominal pain, rash on legs and followed by scrotal pain and swelling. There was no preceding history of any illness prior to his presentation. According to his parents he developed rash on his lower legs a day prior to hospital visit. He started complaining of pain in this mid abdomen followed by pain in his left scrotum. There was no history of vomiting, diarrhoea or bleeding from any site of his body. They denied history of sick contact before this illness. There were no previous medical complaints.

His examinations revealed normal vital signs. He had non-blanching purpuric rash on his lower limbs and feet. His abdominal examination showed soft non-tender abdomen with no guarding. He had scrotal swelling and was complaining of left scrotal pain. Routine blood investigations performed including FBC, coagulation profile, U & E, blood culture. The results turned out to be normal. A diagnosis of Henoch-Schonlein purpura was made. Urgent surgical review was requested. He was seen by surgical team and was diagnosed epididymitis clinically. An US doppler of scrotum requested as part of clinical workup reported normal results.

As his condition failed to improve, we started him a short course of oral steroids along with analgesia. He showed significant improvement and was discharged after 2 days to complete treatment at home.

Conclusion Henoch-Schonlein purpura can cause immune mediated epididymitis and painful scrotum. Patient can be managed conservatively if US scrotal region is normal and surgical exploration can be avoided.

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THE MEDICAL AND SURGICAL MANAGEMENT OF RAISED INTRAOCULAR PRESSURE (IOP) IN CHILDREN: A CHALLENGING OPHTHALMOLOGY CASE

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10.1136/archdischild-2019-epa.448

Background Glaucoma is one of the most common causes of blindness in adults. In children, while it is much less common it is even more challenging to diagnose, monitor and treat.

Case 7 year old SA presented with headache on a background of Eczema and Vernal Keratoconjunctivitis. Full work up was normal, including Lumbar Puncture and CT Brain. He was poorly compliant with topical steroids prescribed for a Keratoconjunctivitis flare. On examination during Ophthalmology review, SA had conjunctival injection with corneal punctate erosions consistent with ocular surface disease. Exam was otherwise normal but difficult to perform due to photosensitivity. Symptoms improved with topical steroids, which were tapered with close monitoring as an outpatient. At two months IOPs were elevated. Steroids were discontinued and pressure reducing drops commenced. Mild hypertension was measured on subsequent visits.

SA re-presented with acute photophobia and left frontal headache. IOPs were elevated at 60 mmHg (left) and 45 mmHg (right). Acetazolamide and Mannitol were administered intravenously. During examination under anaesthetic (EUA), pressure in left eye measured 34 mmHg and normal in right. The sclerae were extremely hardened. Pigment and fibrin were noted in the left anterior chamber. Left cup:disc ratio was 0.3, significantly greater than 0.1 in the right, with normal fundi. He was diagnosed with scleritis and anterior uveitis. Investigations for causes of uveitis were all negative; including Anterior Chamber Paracentesis (Herpes Simplex), MRI Brain (Vasculitis), Quantiferon Gold (Tuberculosis), Syphilis, Lyme and Bartonella serology, ANCA, serum ACE, Chest XRay. Treatment comprised oral Prednisolone, topical steroids, Acetazolamide, Latanoprost, Timolol and Dorzolamide. Inflammation resolved, pressure was reasonably controlled. Glaucoma surgery is likely to fail in the presence of active or recent inflammation, so surgical management was postponed.

Despite maximum medical management SA presented a third time with raised IOP. He was brought to theatre urgently. Ahmed Valve was inserted into his left eye. Bilateral scleral calcification led to difficult valve insertion. His formal diagnosis is Idiopathic Nodular Scleritis, Intraocular Inflammation and Left Uveitic Glaucoma.

Conclusion Management of childhood glaucoma and uveitis is challenging especially in rare conditions such as this. SA's IOP is controlled, although accurate monitoring remains challenging. Rigid thickened corneas lead to falsely elevated pressures. SA developed astigmatism due to nodular scleritis involving the peripheral cornea. No progression of optic disc cupping was noted at further EUA. Despite a difficult clinical course, SA is currently asymptomatic on tapering doses of steroids and Adalimumab, enjoying an improved quality of life.