phenytoin. Due to ongoing seizure activity was loaded with IV levetiracetam. Did not respond to pyridoxine challenge.

Investigations included bloods and CSF sent for metabolic work up, Serum glycine was 1905, with raised CSF:plasma glycine levels EEG (showed burst suppressive pattern) MRI-normal.

Child transferred to tertiary centre for ongoing management. Needed 7 days of intensive care, managed by metabolic and neurology teams. Regular follow-up at local centre.

Is currently on phenobarbitone, levetiracetam, sodium benzoate and folinic acid

Conclusion To date, no effective treatment exists for NKH. The standard treatment strategies for NKH include sodium benzoate (to reduce plasma concentration of glycine) and NMDA receptor antagonists (ketamine, dextromethorphan, felbamate, and topiramate). Both sodium benzoate and dextromethorphan may improve alertness and decrease seizure frequency if prescribed during the newborn period.

P102 AN ADOLESCENT GIRL WITH ULCUS VULVAE ACUTUM

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Background Ulcus vulvae acutum (UVA) is a disease characterized by primary aphthous ulcer or reactive nonsexually related acute genital ulcer. The etiology is unknown. The diagnosis is made by excluding other infectious and noninfectious causes which can be responsible for vulvar ulcer.

Case report A 12-year-old girl had a pustule-like lesion which appeared on her genital region 4 days ago and grew rapidly with a swelling and tenderness. Before the admission, she did not take any medication except the analgesics. On the physical examination, no pathological findings were observed other than a very painful ulceronecrotic lesion with purulent discharge which was on the entrance of the vagina, at 6 o'clock position. The whole blood count showed a hemoglobin level of 12.6 g/dL, a white blood count of 4210/mm³, and a platelet count of 187000/mm³. ESH was 14 mm/h and CRP was 26 mg/L. The serum biochemistry analysis and complete urinalysis were normal. Discharge culture was performed and intravenous piperacillin-tazobactam and fluconazole were administered empirically. Beside the antimicrobial agents oral paracetamol, ibuprofen and topical lidocaine were added to the treatment. Uveitis was not observed and Patch test and HLA B51 were negative. The vaginal and urine cultures were negative. The serological tests for EBV, CMV, herpes simplex virus (HSV) type 1 and 2, *Toxoplasma gondii*, parvovirus B19, hepatitis B virus (HBV), hepatitis C virus (HCV), hepatitis A virus (HAV), human immunodeficiency virus (HIV), and VDRL were found to be negative. The patient was started on intravenous methylprednisolone (2 mg/kg/day) with the preliminary diagnosis of UVA. Application of topical steroid and anesthetic on the lesions was continued. After the methylprednisolone treatment, the ulcer rapidly shrank and the pain markedly relieved. On the 6th day of hospitalization, the dosage of methylprednisolone was reduced to 1 mg/kg/day and she was discharged. No new lesions were evident in the follow-up and the methylprednisolone was stopped gradually within 3 weeks. During the 9-month follow-up, there were no new lesions and complaints.

Conclusion The most prevalent cause of genital ulcers is HSV and it is related to sexual activity. When vulvar ulcer is observed in children, the history of sexual activity and sexual abuse should be carefully questioned. If there is no history of sexual activity, after excluding all the other possible causes, UVA should be considered first for the differential diagnosis.

P103 IMPROVEMENT ON PERSISTENT VOMITING AFTER ADMINISTRATION OF AMITRIPTYLINE: CASE REPORT FROM LIMITED RESOURCES SETTING IN EAST NUSA TENGGARA, INDONESIA

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Background Cyclic vomiting syndrome (CVS) is a functional gastrointestinal disorder (FGID), characterised by recurring episodes of intense vomiting accompanied by nausea and headache followed by asymptomatic period between the episodes. It remains recognised despite its known prevalence, which is 1.9% in school-age children worldwide. In Indonesia, neither the prevalence nor the incidence of cyclic vomiting syndrome has been reported. A number of published studies reported that CVS is more common among Caucasians, which explains its obscurity in our country. The lack of awareness of this disorder along with low-resource setting highlights the challenge of this case.

Case presentation This is a case report of paediatric cyclic vomiting syndrome in a local, limited resource private hospital in Manggarai Regency, East Nusa Tenggara, Indonesia. A 10-year-old girl was admitted due to her sixth episode of vomiting over the past six weeks. She was hospitalised a few times due to her episodes of vomiting and was diagnosed with gastro-oesophageal reflux disease (GORD) earlier. Her episodes were characterised by vomiting every 30–60 minutes at first, gradually declining over 3–4 days, and recurring in about 6–7 days. All the available test results were unremarkable. The diagnosis was established based on the criteria of The International Classification of Headache Disorder 2004 (ICHD-II), excluding possible aetiologies using the only available resources in our location, and resolution of symptoms after administration of amitriptyline. She was discharged with continuous amitriptyline for 2 weeks and went into remission.

Conclusion CVS should always be considered in repeated vomiting in children. When recurrent vomiting is suspected as CVS in limited resources settings, diagnostic therapy should immediately be performed. Recognition of this disorder is important to establish prompt diagnosis and convenient intervention, thus improving the quality of life of the children.

P104 A 9-WEEK BABY WITH PH OF 7.62 AND BICARBONATE OF 66.6

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Introduction Infantile hypertrophic pyloric stenosis (HPS) is a condition where hypertrophy of the pyloric sphincter results in narrowing of the pyloric canal. It is the most common

cause of gastric outlet obstruction in the 2- to 12-week-old age group. Pyloric stenosis leads to progressive and projectile vomiting.

It affects 2–3 per 1000 infants in Northern Europe but less common elsewhere in the world. Males (especially first borns) are affected approximately 4–6 times as often as females. The offspring of a mother, and, to a lesser extent the father who had pyloric stenosis are at higher risk for pyloric stenosis (Nelson Textbook of Paediatrics, 20th ed, Elsevier Saunders, 2016).

Impetus

- To stimulate discussion and further research on extreme electrolyte
- imbalances babies can tolerate.
- To demonstrate importance of slow correction of electrolyte imbalance over
- 72 hours.
- To consider Pyloric Stenosis as one of the differential diagnosis for
- constipation in early infancy.

Case Report We present a 9-week baby boy presenting with constipation and worsening vomiting for a week. He had very severe metabolic alkalosis (Ph-7.67), hypokalaemia (2.5 mmol/L) and hypochloreaemia (60 mmol/L). He was amazingly still breathing spontaneously with no apnoea. His electrolyte imbalance was slowly reversed over 72 hrs and later he was transferred to a tertiary surgical care unit for corrective pyloromyotomy. He recovery was uneventful post surgery. We would like to share baby's severe electrolyte imbalances and stimulate research on how much extremes of metabolic alkalosis infants can tolerate.

Abdominal ultrasound Pylorus appears moderately thickened measuring to 2.1 cm in length (normally up to 1.5–1.7 cm). Pyloric transverse diameter measures to 1.7 cm (normally up to 1.3 cm) and pyloric muscle thickness was 8.9 mm

Learning Points

- Slow correction of electrolyte imbalance is critical in treatment of pyloric stenosis.
- Observe very closely for apnoes in babies with severe metabolic alkalosis
- Always think of Pyloric Stenosis in infants presenting with constipation. Pyloromyotomy is performed only after baby's metabolic alkalosis is normalized.

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P105 FLOPPY INFANT: FORGOTTEN OR NEGLECTED SYMPTOM OF CELIAC DISEASE

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Introduction Celiac disease (CD) or gluten-sensitive enteropathy is an autoimmune disease of the small intestine precipitated by the ingestion of gluten in genetically susceptible individuals. The prevalence is 1 of every 120 to 300 persons. The association between neurological symptoms and celiac

disease was first described by Cooke and Smith in 1966. Initiation of a gluten-free diet reverses the mucosal lesion and corrects malabsorption with symptomatic improvement.

Case report A 16-months old girl presented to the University children hospital with acute hypotonia and suspected Guillain-Barre syndrome. Two months before admission, she developed vomiting and watery diarrhea, which lasted for few days. Two weeks afterwards, acute symmetrical weakness of upper and lower limbs was occurred, so the patient was admitted to regional hospital. Her past medical history was irrelevant. She had normal growth and normal milestones development. She was able to walk before her first birthday. There was no history of honey and canned food use. She had negative family history of a similar condition. Her physical examination showed a floppy, irritable and afebrile child with body weight of 9900 g (25–50th percentile). Both upper and lower limbs were very weak with no reflexes. After her laboratory tests, abdominal ultrasound and brain CT, the diagnosis of GB was established and the treatment with IVIG was initiated. Her neurological symptoms improved slightly, but after five doses her neurological condition deteriorated with appearance of pretibial and dorsal pedal edema, and then she was sent to our hospital. On admission, she was 16-month old girl, body stature 82 cm (90th percentile), body weight 8450 g (10th percentile), BMI 13.7 kg/m². Subcutaneous fatty tissue was significantly reduced, she also had severe generalised edema. Her abdomen was distended without signs of hepatosplenomegaly. Neurological examination revealed severe general hypotonia of limbs with reduced reflexes, without axial weakness. Routine laboratory revealed normal CBC, hypoproteinemia, hypoalbuminemia with normal kidney and liver function. Inflammatory parameters, the biochemistry and cytology of cerebrospinal fluid, and MR of lumbosacral region were normal. The electro-neuromyography was not performed. Clinical aspect and laboratory results indicated celiac disease. Very high anti-endomysial and anti-transglutaminase antibodies and positive genetic test (HLA DQ2) confirmed clinical suspicion. No duodenal biopsy was performed. During investigation, the therapy with corticosteroids, albumin and furosemide were started. After celiac disease was diagnosed, gluten free diet (GFD), vitamin B complex and folic acid were started with gradually decreasing of corticosteroid therapy. Neurological improvement appeared after five days. After 3 weeks, she improved in her nutritional and psychological aspects.

Conclusion We should think about CD, since many patients have atypical disease.

P106

DIAGNOSIS OF ACUTE MYOSITIS VS DUCHENNE MUSCULAR DYSTROPHY BY TIMING OF BLOOD'S ENZYME PROFILE

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Introduction Elevated Alanine Aminotransferase (ALT) and Aspartate Aminotransferase (AST) enzymes would sway a doctor toward thinking there's a liver problem; a high CK with high ALT and AST levels suggests that something's going on in the muscle. A correct diagnosis may prevent extensive investigations or procedures. In boys one of the worst case scenarios is Duchenne Muscular Dystrophy (DMD) a severe