individuals. Although the gastrointestinal tract is the target of autoimmune insult, celiac disease is also associated with extra-intestinal problems: autoimmune disorders, malignancies, dermatologic conditions, rheumatologist conditions, neurologic and psychiatric disorders. The psychological symptoms are one of the most interesting and unexpected presentations, which may be the result of nutrient malabsorption or increased levels of proinflammatory cytokines.

Case report We present the case of a 15 year old adolescent girl with a history of autoimmune thyroiditis on replacement therapy with levothyroxine, who was hospitalised because of behaviour disorders and oligobradimenorrhea. On clinical examination the patient presented drowsiness, sudden behavioural changes, learning problems, bradylalia and a tendency to isolate herself. Blood tests showed positive anti-TG2 antibodies ($>10\times$ normal) and EMA antibodies. HLA typing was also performed and was positive for HLA-DQ2 cis: DQA1*05 - DQB1*02 - DRB1*03. On the psychiatric consult she was diagnosed with a minor depressive syndrome. She was immediately started on a gluten free diet. Although she showed low compliance to the diet on the follow-up examinations, removing gluten resulted in positive effects on the psychiatric symptomatology. We would also like to add that the patient refused the oesophagogastrroduodenoscopy and psychological counselling.

Conclusion Recent studies have shown an association between celiac disease and psychiatric conditions, especially depression. Medical personnel should be aware of this atypical presentation of the disease in order to correctly diagnose and treat celiac disease. Also, psychiatric patients who are resistant to traditional therapy should be investigated for celiac disease in case they also present symptoms of CD or if a positive family history exists.

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MATERNAL PERNICIOUS ANAEMIA ASSOCIATED WITH ANOREXIA AND KETOTIC HYPOGLYCAEMIA IN A CHILD WITH METHYLMALONIC ACID AND OROTIC ACID EXCRETION IN THE URINE – A CASE REPORT

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Case report A 13 month-old baby girl presented with vomiting and refusal to feed; she was mostly breast feeding. On examination, she appeared off form, underweight, hypotonic and pale. Bedside testing revealed a low blood glucose level of 1.7 mmol/l with a normal lactate. She was also noted to have mild electrolyte disturbances and a slightly acidotic venous blood gas analysis. Further investigations, including urinary organic acids, revealed marked ketonuria with increased methylmalonic acid (MMA) (1014 $\mu\text{M}/\text{mmol creat.}$, ref. <8) and orotic acid excretion. She was found to be severely deficient in vitamin B12 (<125 ng/l) which explained her macrocytic anaemia and raised plasma

homocysteine (62 microM/l, ref. <8) and urinary MMA. Her initial plasma amino acids showed relatively increased glutamine, low citrulline and arginine with other amino acids relatively low. Plasma ammonia levels were essentially normal.

Interventions/Results The patient was initially commenced on intravenous fluids with dextrose and electrolytes. She was also treated with parenteral vitamin B12 injections, along with folate supplements, which caused a marked improvement in mood, tone, and appetite. MMA excretion, homocysteine and blood film normalized although excretion of orotic acid persisted. Further investigations revealed that her mother had low vitamin B12 levels and was positive for parietal cell antibodies, indicative of maternal pernicious anaemia. Metabolic work-up also included an Allopurinol load test which was abnormal. Ornithine transcarbamylase (OTC) gene mutation analysis did not detect any pathogenic variants. Although orotic aciduria has a recognized association with megaloblastic anemia, it would not be explained by low serum B12 levels. The family was instructed that their child could still become unwell and would need monitoring and/or dietetic intervention and an emergency regime during periods with increased metabolic stress, such as infections. The girl made a full recovery with no active issues identifiable at 2 y of age.

Conclusion This case report highlights the following points 1) the importance of glucose and ketone measurements along with a full hypoglycemia work up at the point of care, if glucose low, in a child who presents acutely unwell e.g. with poor feeding and vomiting, 2) one should be vigilant for potential maternal causes in an infant especially those who are breastfed, and 3) the potential relevance and diagnostic dilemma caused by incidental findings of yet uncertain significance for this individual.

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ARTERIAL ISCHAEMIC STROKE SECONDARY TO VARICELLA VASCULITIS

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A 5 year old boy presented to the Emergency Department with a 1 day history of evolving right sided hemiparesis and drooling on a background of primary varicella infection 3 months previously. No other significant medical history. No significant family history.

On examination GSC 15/15, vitals were stable. Cardiovascular, respiratory, gastrointestinal, ENT examinations were unremarkable. Neurological examination; speech was normal, on mobilizing his right leg dragged along floor. No ataxia or foot drop were noted. Cranial nerves II – XII grossly intact. Muscle bulk, tone and reflexes all normal. Reduced power 3/5 in the right upper and lower limbs.

Investigations FBC, U+E, LFT, Coagulation all normal. CSF VZA DNA detected, VZV IgG >100 mIU/ml.

CT and MRA brain

No abnormality identified. MRI Brain: Acute Left sided ischemic stroke – affecting the left subinsular region and the posterior limb of the left internal capsule.

Diagnosis Arterial ischaemic stroke secondary to varicella vasculitis