then spread to the entire body including limbs. It was itchy. The family are originally from Quebec and had been residing in Ireland for the past 2 years in relation to the father's occupation. Contact with infectious disease and recent travel were denied. He had never been hospitalised and had no medical diagnoses. His mother was adamant that all vaccinations were up to date and included the Varicella vaccine at one year of age in Canada. He had no known allergies and was not taking any medications.

On examination he had multiple vesicular and pustular lesions with an erythematous base. Some lesion had necrotic centres. There were some vesicles on his lower lip, buccal mucosa and also on the throat.

His WCC was 2.08, Neutrophils 0.73, Lymphocytes 0.73, CRP 20. Influenza, RSV and Monospot were negative.

He was initially treated with IV Augmentin and Flucloxacillin for a presumed diagnosis of Impetigo. More lesions appeared over his trunk and abdomen over the subsequent 24 hours although he was not systemically unwell. The Dermatologist made a clinical diagnosis of 'Chicken Pox'. He was discharged home on an immunocompetent dose of oral acyclovir pending results of skin swab, throat swabs and Varicella titre.

At follow up one week later he was clinically well with multiple healing lesions. His Varicella titres were high confirming a diagnosis of Varicella Zoster infection. His mother brought with her his vaccination records from Canada which showed that he had received only one dose of the Varicella vaccine and had missed the booster. This is in contrast to his siblings who were fully vaccinated and did not develop Varicella despite close contact.

Conclusion Common conditions are common. Vaccines can fail. Parents should be encouraged to keep detailed records of all vaccinations including boosters and to follow through with booster vaccines when indicated.

P224 THE HAZARDS OF AN IRISH HEATWAVE; ECTHYMA

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Background and aims Ecthyma is a pyogenic, deep skin infection caused by Group A Streptococcus usually combined with Staphylococcus aureus and sometimes pseudomonas in the context of warm, moist weather and overcrowding, most commonly seen in extremes of age and immunocompromised patients resulting in healing in a few weeks with scarring.

Our aim is to report a case of this very rare dermatological condition in a three year old boy.

Methods The clinical presentation, examination findings with clinical photographs, laboratory investigations, natural history, treatment and outcome are described.

A review of the current available literature was undertaken.

Results A previously well and neurodevelopmentally normal three year old boy presented to the Paediatric Emergency Department (PED) during the summer months with a rash for 6 days and high grade fever for 2 days. The rash started as vesicular lesions on the abdomen before spreading to the

limbs. On examination, lesions were 1.5x1 cm in size, pustular with hard crust of dried exudate and erythematous base mostly on abdomen, genitals and lower limbs. Systemic examination was normal. His full blood count was normal. CRP was raised. After review by the Dermatologist a clinical diagnosis of ecthyma was made. Skin swab grew Staphylococcus Aureus sensitive to Flucloxacillin with which he was treated intravenously for 5 days. He was discharged home on oral erythromycin for 10 days, fucidin cream for one week, hydromel baths and paraffin gel for 3 weeks. At Follow up 2 weeks later he was found to be well with healing of residual lesions.

Conclusion Our case raises awareness of this extremely rare dermatological condition in a Paediatric and an Irish context. To our knowledge it is the first case of its kind ever seen by either the Paediatric or Dermatology services in our institution but may not be the last if our good summers continue

P225 CONGENITAL HYALINE FIBROMATOSIS SYNDROME: A CASE REPORT OF HETEROZYGOUS ANTXR2 AND LITERATURE REVIEW

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Introduction Juvenile hyaline fibromatosis is a rare hereditary disease characterized by deposits of a clear substance (hyaline) in the skin and other body tissues, it becomes apparent at birth or in infancy presenting with severe pain with movement, skin lesions & bumps, gingival hyperplasia, progressive joint contractures, and bone lesions.¹ Complications can be life threatening. The inheritance follows autosomal recessive pattern, Causing mutations in the ANTXR2 gene. Treatment is supportive and aims to alleviate pain and other symptoms of the condition. The prevalence is unknown; about 84 people with this disorder have been reported in 2018.²

Case We report a 23 month old boy, born at 38 weeks gestation, no neonatal complications. He was referred to paediatric clinic at 3 month old with excessive crying, feeding difficulty and failure to thrive crossing down on centiles from 9th to <0.4th centile. At 8 months noted to have limited movement of both shoulders. He then started to have gingivitis and gum swelling which progressed to gingival hyperplasia. Developmentally he sat unsupported at 8 months, not crawling or standing no concerns about hearing or vision, plays and interacts well with siblings.

Parents are non consanguineous of Syrian origin, He has two sisters and one brother all well. They had no skin lesions or joint problems. There was no history of similarly affected relatives.

Physical examination He appears symmetrically small, generally bright visually alert to his surroundings. Visible nodules over left ear and left nostril, gum hypertrophy. Decreased muscle bulk in his deltoids with limited passive movement of both shoulders and extreme pain on any shoulder movement. Cannot stand or walk independently.

Laboratory investigations Biochemical and metabolic work up was all normal DNA PCR: Heterozygous ANTXR2 gene detected.