decreased oral intake. The child was referred to a tertiary centre for review. On physical examination the child was alert but lethargic with tachycardia to 164 and a fever of 38.9 degrees. She had no drooling, increased work of breathing or stridor. Auscultation revealed equal air entry, normal heart and bowel sounds. Abdomen was soft, non tender without distension. She was treated with antipyretics and chest and abdominal imaging was arranged.

AP chest radiograph and plain abdominal images revealed a circular 2 cm radiopaque object located in the stomach. On review by radiology the object appeared to have a ‘halo sign’, a feature consistent with button batteries. Given the uncertain origin of the object and potential for complications associated with button battery ingestion our patient was fasted for an endoscopy.

Endoscopy revealed two 10 cent coins sitting in the gastric antrum with localized erosions and erythema. These were successfully removed with a Roth net and the patient was discharged the same day.

Foreign body (FB) ingestion/inhalation most commonly occurs in children aged between six months and three years. The most common objects are coins, reported in up to 88% of cases. (1) FB ingestion usually only requires imaging followed by clinical observation. Coins are unlikely to cause complications, whereas button batteries pose a risk of metal poisoning, burns, oesophageal strictures, perforation, tracheoesophageal fistula and haemorrhage. (2)

One study revealed that 14% of children with oesophageal FBs were asymptomatic on presentation, highlighting the need for imaging. Recommended investigations include AP and lateral neck, AP and lateral chest and abdominal radiographs. (4)

The sensitivity of plan films in detecting a battery was 80.4%, specificity 79.1% with an overall accuracy of 79.8%. The same study demonstrated that stacking two coins on top of each other lead to high rates of misidentification as batteries with an overall accuracy below 60%. (1) Importantly this study used artificially produced images which therefore did not include soft tissues and bony structures which could prevent accurate identification.

This case highlights the importance of accurate identification of foreign objects and the need for high clinical suspicion of FB.

**Results**

In 52/117 (44.4%) cases a viral agent was identified. Among them 11/52 (21.1%) had isolated thrombocytopenia, 32/52 (61.5%) had neutropenia/leukopenia and 9 (17.3%) had thrombocytopenia with neutro/leukopenia or anemia.

The patients with viral infection had a mean (±SD) age: 3.3 ± 3.9 years. The mean ±SD duration of fever was 3.4 ± 2.8 days.

The highest prevalence of cytopenia was observed during spring (27/52) (51.9%) and the lowest during fall (13.5%).

Among the cases with thrombocytopenia, a viral agent was identified in 38.5% and a bacterial agent in 38.5%.

In children with thrombocytopenia, the most frequently detected viruses were Epstein-Barr virus (10.2%), followed by a herpesvirus (6.1%). In cases with severe thrombocytopenia, mycoplasma infection was most frequent (4.1%). Finally, in cases with bilineage cytopenia, influenza type A and B were more frequently detected among viruses, and Pseudomonas, Brucella and Rickettsia cororii among bacteria.

In cases of viral infections, thrombocytopenia was transient and lasted for 31.3 ± 65.5 days, while in those with 2 cell lines involvement (thrombocytopenia with neutropenia/leukopenia) it lasted for 26.8 ± 38.9 days.

In 13 cases with a bacterial infection 2/13 (15.4%) had thrombocytopenia and 3/13 (23.1%) thrombocytopenia with neutro/leukopenia.

Among the 21 cases with chronic cytopenia (11 girls and 10 boys), thrombocytopenia was present at 7/21 (33.3%). Among them an infectious agent was identified in 2/7 (28.6%) cases. One child with chronic thrombocytopenia was diagnosed having SLE.

In three children (two with thrombocytopenia and anemia and one with neutropenia/leukopenia and anemia), malignancy was finally diagnosed in a time-period of 4–7 months after the initial assessment. (2 with ALL and 1 with MDS).

**Conclusion**

Postinfectious thrombocytopenia in childhood is usually transient with benign course, it resolves spontaneously and is usually associated with common viral or bacterial infections. However, in cases of chronic thrombocytopenia, especially if more than one cell lines are affected, close follow-up is necessary for the early detection of chronic hematologic or autoimmune disease.