P652 AN UNUSUAL CASE OF RECURRING DEMYELINATING NEUROLOGICAL DISORDER IN A 3 YEAR OLD

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Background Multiple sclerosis (MS) is an increasingly recognised acquired demyelinating neurological disorder in the paediatric population. Although 3 to 7 per cent of cases of multiple sclerosis experience their first attack during childhood and adolescence, onset before 10 years of age is extremely uncommon and its incidence is reported as 0.2 to 0.7 percent. Youngest age of presentation reported in literature is 2 years.

Case summary A 3 year old female child presented with a four week history of ataxia, lethargy, intermittent headache, a 2 week history of right sided torticollis and new right convergent strabismus for 5 days. Of note she had recovered from an upper respiratory tract infection two months previously. She had low grade pyrexia. The neurological examination confirmed impaired cerebellar function. Ophthalmological examination confirmed a right sided optic neuritis, decreased vision and concomitant esotropia. Magnetic resonance imaging (MRI) of the brain showed increased T2 signal intensities bilaterally in the brainstem and cerebral hemispheres. Spinal cord cervical and thoracic lesions were also noted.

CSF analysis was normal, including routine viral PCR and culture, as well as oligoclonal bands. She received a three day course of methylprednisolone. Clinically isolated syndrome of demyelination was considered and she was discharged on a decreasing dose of prednisolone. Her initial symptoms resolved completely and follow-up ophthalmological examination was normal.

Two years and 9 months later, she represented with recently increasing lethargies, poor balance, dizziness, vomiting and irritability. She complained of difficulty seeing the whiteboard at school and headaches for a few weeks. On examination Romberg's sign was positive and she also had a right sided divergent strabismus.

A repeat MRI showed multiple T2 hyper intensities bilaterally, some old, some new, involving basal ganglia, cerebral hemispheres and brainstem.

MRI and spectroscopy were both normal. CSF oligoclonal bands were positive on this occasion. Results of lysosomal enzyme panel, metabolic screening, CSF ACE levels, and molecular genetic testing for the MELAS mutation were normal. She responded to a five day course of methylprednisolone. Third MRI done three months later revealed significant resolution of the previous changes globally. She is clinically well 6 years post her diagnosis and is currently on immunotherapy.

Conclusion Early consideration of multiple sclerosis is necessary in young children presenting with remitting/relapsing unifocal or multifocal neurological features with recurring MRI changes in brain and spinal cord. Early diagnosis of MS is particularly important, given the current immunotherapy treatments available.

P653 SWALLOWING DISORDER REVEALING LEIGH'S SYNDROME

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Introduction Leigh's syndrome is a sub-acute necrotizing encephalomyopathy involving brainstem involvement and basal ganglia. The symptoms are variable. The prognosis is rather unfortunate.

Case report An infant aged 1 year 2 months consulted for acute dyspnea as part of a penetration syndrome. He has no background and his parents are first cousins.

The history back to 2 hours before admission marked by the ingestion of a piece of meat bone and the installation of progressive worsening dyspnea.

On examination, he was eutrophic. Its temperature was 38.5°C. He has respiratory distress. The chest radio showed a bronchial syndrome. Fibroscopy completed with esophagoscopy was without abnormalities. Neurologically, the infant was irritable and whiny. A lumbar puncture was negative. Brain imaging was without abnormalities. The evolution was marked by the installation of a hypotonia and an alteration of consciousness. The metabolic balance showed metabolic acidosis with hyperlactataemia, hyperammonemia and increased lactate/pyruvate ratio. The electroencephalogram showed paroxysmal discharges. The MR spectroscopy showed an involvement of brainstem, gray nuclei, cerebellum and marrow with a lactate peak confirming the diagnosis of Leigh's syndrome. The evolution was quickly fatal due to a neurological distress chart.

Conclusion There is currently no therapy for Leigh's syndrome. The treatment is symptomatic and does not significantly alter the course of the disease.

P654 A RARE CAUSE FOR ACUTE HYDROCEPHALUS IN CHILDREN

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Colloid cysts are congenital benign lesions constituting 1% of CNS tumors. Pediatric colloid cysts are rare lesions compared with adults. These are more common in the third and fifth decade. Their occurrence in the pediatric age group is less commonly seen. These pediatric colloid cysts have aggressive and varied behavior than in adults. They are non-neoplastic true epithelium lined cysts of the central neuraxis.

They may be totally asymptomatic or may manifest with symptoms of raised intracranial pressure. The symptoms may be intermittent, self-limiting, and nonspecifically apparent when the foramen of Monro is blocked temporarily by pendulous movement of the cyst or may be acute and severe presenting with acute hydrocephalus, brain herniation, and sudden death.

Pediatric colloid cysts have rarely been reported. We report A 4-year-old boy with the history of headache, anorexia, over