pigmented naevus were irregularly shape macule, papules, and plaques of various colours.

Multiple pigmented satellite lesions of size 4–5 cm were present over the body, head, face and extremities. Tufts of coarse hair were present over the satellite lesions, with finer hair covering the abdominal areas of pigmentation. Three nodular lesions were present in the perianal region. Areas of excoriation were noted on the flank areas. No other physical abnormalities were present. Neurological examination was unremarkable.

MRI examination revealed extensive intracranial melanocytic infiltrate, confirming a diagnosis of CGMN with NCM.

Discussion CGMN is an extremely rare condition with incidence estimated at 1/500000 births. Lesions are caused by genetic mutations which lead to defective proliferation, differentiation and migration of melanoblasts. Risk of transformation of GCMN to malignant melanoma varies between 0 and 3.8%, with 80% of this number symptomatic by the age of seven.

CNN originates between the 5th–24th week of gestation and arises from gain of function mutations in either BRAF or NRAS. The protooncogenes c-met and c-kit have also been demonstrated to play a role in the formation of CMN. CMN are predominantly caused by sporadic de novo mutations.

Neurocutaneous melanosis is a rare complication of CMN with just over 100 cases reported. Most patients with NCM are asymptomatic at birth with sequelae appearing later in development.

Treatment of GCMN is both symptomatic and palliative, with surgical techniques including serial resection, excision and grafting and the use of tissue expanders. Non-excisional techniques include dermabrasion, laser ablation and curettage.

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GP68

MORE THAN A FEVER: A CASE SERIES OF ATYPICAL KAWASAKI DISEASE

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10.1136/archdischild-2019-epa.134

Introduction Kawasaki Disease is a vasculitis which tends to occur in children between the ages of 1 and 8 years. It is characterized by prolonged fever ($>38.5^{\circ}\text{C}$, >5 days), exanthem, non-exudative conjunctivitis, inflammation of mucous membranes and cervical lymphadenopathy. Coronary artery aneurysms may develop and rupture or cause myocardial infarction.

Diagnosis is by clinical criteria and treatment includes aspirin and IV immunoglobulin. Diagnostic criteria for Kawasaki disease are fever and at least four of five additional clinical signs.

Atypical (Incomplete) Kawasaki disease should be considered in all children with unexplained fever for more than 5 days, associated with 2 or 3 of the main clinical findings of

Kawasaki disease. Diagnosis of Atypical Kawasaki disease is based on echocardiographic findings indicating the involvement of the coronary arteries.

Case Series From February 2016 to October 2018, four patients presented to Sligo University Hospital with Atypical Kawasaki's Disease. The patients varied in age from seven months to four years old.

The classical signs of Kawasaki disease include persistent high grade pyrexia bilateral non-exudative conjunctivitis, bright red ('strawberry') tongue, cervical lymphadenopathy and skin desquamation. Less specific signs include rash and irritability.

All four patients developed persistent high-grade pyrexia ($>38.5^{\circ}\text{C}$, >5 days) and lymphadenopathy. None had all the typical signs of Kawasaki disease. Three were observed to have a widespread maculopapular rash. Two had bilateral exudative conjunctivitis, or irritability. One had a 'strawberry tongue' appearance. None had skin desquamation.

Only 50% of patients had Kawasaki disease in their initial differential diagnosis. Other differentials included upper respiratory tract infection, tonsillitis, scarlet fever, transient synovitis, cervical lymphadenitis and retropharyngeal abscess.

Management All four patients were treated with IVIG and aspirin. The mean duration of pyrexia prior to commencement of treatment was 7.5 days. The mean duration from hospital presentation to commencement of treatment was 3.5 days.

Outcome 50% of patients made a complete recovery. Despite treatment, 25% developed a mild fusiform dilatation of the left coronary artery. A further 25% developed a saccular aneurysm of the left circumflex coronary artery.

Discussion It is imperative to include Kawasaki and Atypical (Incomplete) Kawasaki disease in the differential diagnosis of a child with persistent high-grade pyrexia. Delays in treatment may lead to a greater risk of coronary aneurysm and mortality.

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CEREBRAL VASCULAR ACCIDENT ASSOCIATION POST PRIMARY VARICELLA INFECTION

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10.1136/archdischild-2019-epa.135

Summary An 18 month old boy presented with right monoplegia and intermittent ataxia. This occurred five months post primary varicella infection. His CT brain revealed low dense lesion in the basal ganglia, a region associated with vasculopathy post varicella infection. The child showed motor recovery with physiotherapy, antiviral, steroid and aspirin. He developed chorea, a manifestation of basal ganglion dysfunction.

Case description An 18 month male presented to the emergency department, with inability to use his right hand since the morning and they noticed that he had difficulty crawling without history of trauma or fever. He had primary varicella infection five months earlier, and parents noticed intermittent unsteady gait for the preceding couple of weeks. He had measles mumps and rubella vaccination four months prior to his presentation and had hand foot and mouth disease a month later. He had a simple febrile convulsion four weeks beforehand and was treated as an outpatient in accordance with