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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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.

GP69

CEREBRAL VASCULAR ACCIDENT ASSOCIATION POST PRIMARY VARICELLA INFECTION

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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

local guidelines. He attained his normal milestones with no delay, he crawled at one year and walked at 14 months, and he has 20 words with understanding of 3 steps command and respond appropriately. The delivery was full term vaginal delivery with no complications. On initial clinical examination he had no facial asymmetry or any other cranial nerve palsies. There was slight movement against gravity in the right upper limb compared to the left one and his right hand was in continuous fist. Tone in the right upper limb increased compared to the left upper limb with normal reflexes. His gait was normal with no tendency to fall to either side. Extensive laboratory investigations were done, full blood count initially showed leucocytosis with high eosinophilia. CT scan was done and it showed subtle low attenuation in the left globus pallidus. In addition, MRI under general anaesthesia demonstrated a small area of diffusion restriction in the left globus pallidus which indicated ischemia. MR angiography revealed narrowing of anterior cerebral artery and middle cerebral artery compared to the right side. Lumbar puncture was done and it was negative for varicella zoster PCR.

Discussion Cerebral complications post varicella infection is a cause of stroke in children. Detailed history of previous infection is essential in making a clinical diagnosis. One literature review states that 44% of cerebrovascular event in children is a consequence/associated with varicella cerebral complications.

GP70

PULMONARY MILIARY TUBERCULOSIS IN A TODDLER AFTER INITIAL PRESENTATION WITH TUBERCULOUS MENINGITIS

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Introduction Even though tuberculosis is considered to be a rare disease in developed countries, Romania is facing an important public health problem despite the fact that every newborn receives a BCG vaccine in maternity.

Case report We report a case of a 1 year and 9 months age female toddler from the roma community, otherwise previously healthy, born outside of Romania therefore she was not immunized against tuberculosis who presented with fever, choreiform movements, malaise, fatigue, anorexia, vomiting and generalized seizure. Clinical assessment showed positive signs of meningeal irritation and a Glasgow Coma Score of 8–9/15. CSF studies showed lymphocytosis and decreased glucose suggesting TB etiology. Thoracic radiography revealed the presence of a right hilar adenopathy and confluent right pericardial lesions. Head CT showed internal hydrocephalus and right maxillary sinusitis confirmed by MRI which also revealed areas of infarction and multiple inflammatory lesions suggestive of meningeal inflammation. *M. tuberculosis* was not detected in CSF PCR and cultures were negative. Considering close household contact with uncle and grandmother with active TB disease, the diagnosis of TB meningoencephalitis was made. Treatment with tetra conjugated tuberculo-statics, corticosteroids and anticonvulsants was started. The patient continued to deteriorate so she had a temporary

external CSF drainage placed. In evolution she developed cerebral venous and arterial thrombosis and she was started on anticoagulants. Consequently, she developed cortical blindness. Despite all this her state gradually improved and she was discharged after 70 days to follow anticonvulsant and tuberculostatic treatment at home but she was lost to follow up. After 9 months the mother interrupted treatment by her own will and she returned to the hospital a year after the first admission with high fever and presenting generalized seizures. Neurologic assessment showed a delay in language and mental retardation, normal sight. Thoracic radiography revealed hilar adenopathy and miliary aspect. Etiologic treatment was initiated and she was discharged to continue anti-tuberculous treatment being closely monitored by a pneumologist, with favorable outcome.

Discussion The case has an emotional and social impact, the patient coming from the roma community, without social security number thus impossibility of receiving treatment on the national programme, unimmunized, raising the question of BCG vaccination of certain ethnic groups regardless of the country of birth.

GP71

CASE SERIES: DIFFERENT AETIOLOGIES OF CHILDHOOD PERICARDITIS

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Aim This is a study of case series to find out the underlying causes of pericarditis in children presenting to the paediatric ward of a District General Hospital in Ireland.

Methods We encountered 4 patients who were diagnosed to have pericarditis in the Department of Paediatrics of Wexford General Hospital between the months of March to July 2018. Their medical records were studied to look for signs and symptoms at initial presentation, investigations carried out in our hospital as well as at the tertiary centre, the management done and outcome.

Results The study of medical records of these four patients showed that one of the patients had Non Hodgkin Lymphoma as an underlying cause; in the second patient pericarditis was the presenting feature of systemic onset juvenile rheumatoid arthritis. Rest of the two patients' cause was unknown and were classified as idiopathic.

All four patients had their ECG and echocardiogram done which confirmed the diagnosis of pericarditis. The patients were referred to the tertiary cardiac unit for further management. 2 cases with idiopathic pericarditis did improve with few weeks of treatment with ibuprofen and the other two cases received treatment for the underlying conditions which resulted in the improvement of the symptoms and signs related to pericarditis and the underlying illnesses.

Discussion This showed that the most common cause of pericarditis in paediatric age group is idiopathic which is in accordance with the published literature. The other causes found were secondary to malignancy and rheumatological condition. The symptoms and signs of pericarditis did improve with ibuprofen and commencement of treatment of the underlying causes.

Conclusion The most common cause of pericarditis in paediatric population is idiopathic. The outcome is dependent upon the underlying causes and is generally favourable.