old girl who presented to the Emergency Department with non-traumatic right calf pain and swelling.

Case Summary A 4 year old girl presented to Emergency Department (A&E) with a 3 week history of right calf swelling after her usual, non-traumatic dancing. The swelling had worsened over 48 hours. On examination, her weight was 20 kg, just above the 75th centile with a BMI of 17.9. She was unable to fully extend her right leg or weight bear due to her calf swelling. Her right calf measured 28.6 cm compared to the left calf of 26.4 cm. She had been afebrile with no erythema of the joint. There was no demonstrable joint effusion and no issues with joints above and below. There was no family history of clotting disorder or joint arthropathy.

Ultrasound Scan showed a fluid collection in her right gastrocnemius. MRI confirmed a ruptured Baker's Cyst with inflammatory arthropathy alongside an extensive synovial proliferation throughout the knee joint with large joint effusions and associated soft tissue oedema tracking superiorly and inferiorly along the medial head of gastrocnemius and anteriorly along the tibia. Her was ESR of 26 mm, CRP <4 and a normal white cell count. clotting screen and auto-immune panel was negative. investigations revealed bilateral uveitis consistent with a diagnosis of JIA. resolution of joint pain and swelling only occurred after initiation of a short course of oral steroids and steroid injection to the right knee joint.

Clinical Implication This case highlights the atypical presentation of JIA and the clinical manifestations are highly variable in the presence of a ruptured Baker's Cyst. Although, Baker's cysts rare in children. Majority of them are managed conservatively with no other associated comorbidity. To our knowledge, this is the first case of JIA presenting with calf swelling in a toddler

Conclusion We suggest clinicians consider a possible joint inflammatory arthropathy in children presenting with a ruptured Baker's Cyst as early diagnosis and treatment could reduce morbidity associated with this inflammatory arthropathy.

G313 SHOULD RHEUMATIC FEVER AND POST-STREPTOCOCCAL REACTIVE ARTHRITIS BE MANAGED IN THE SAME WAY? A LITERATURE REVIEW

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Aims Although the incidence of rheumatic fever (RF) in the world is declining, the incidence of post-streptococcal reactive arthritis (PSRA) is on the rise. It remains unclear whether both diseases are separate entities or if PSRA is a form of RF. The management of PSRA varies. This review investigates and evaluates the similarities and differences between RF and PSRA, with a specific emphasis on the evidence base for current management guidelines for PSRA in literature.

Methods In this literature review, a focused and methodical search was done on PubMed, Cochrane Library, Google Search, using the words rheumatic fever and post-streptococcal reactive arthritis. Studies which were published between 1999 and 2019 were reviewed with regard to definition, aetiology, epidemiology, clinical presentation, diagnosis and treatment, with the intention of establishing if there is an

evidence-based definitive management for post-streptococcal reactive arthritis.

Results In terms of clinical presentation, RF and PSRA present differently. The age at which paediatric patients are affected by both RF and PSRA is similar, although PSRA has a second peak in adulthood. Additionally, the arthritic presentation in RF is more prolonged (2–3 weeks), whereas in PSRA lasts for 7–10 days. In terms of response to treatment, RF responds better than PSRA, which further indicates the need and importance for defining clear management guidelines for PSRA. There is limited evidence to support antibiotic prophylaxis in PSRA.

Conclusion Current literature supports rheumatic fever and post-streptococcal reactive arthritis as separate entities. However, the management for post-streptococcal reactive arthritis remains unclear. The lack of evidence supporting commonly used management guidelines in PSRA demonstrates the need for further research in this area.

G314(P) A SCOPING REVIEW TO SUPPORT THE DEVELOPMENT OF PGALSPLUS: A MULTI-PROFESSIONAL TOOL AND EDUCATIONAL RESOURCE

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Background Musculoskeletal (MSK) problems in children and young people (CYP) are common. The majority present to healthcare professionals in the community, but it can be challenging to identify those with serious disease. pGALS (paediatric Gait, Arms, Legs and Spine) was developed as a simple MSK clinical assessment to discern abnormal joints, initially within paediatric rheumatology and general paediatrics; pGALS can detect joint and functional problems in CYP with other serious conditions but alone is unlikely to be specific enough to diagnose definitive conditions or signpost referrals to orthopaedics, rheumatology, neurology or general paediatrics. Our aim was to scope the literature about MSK assessments applicable to CYP used in practice, focusing on evidence of validity in the context of diagnosis and assessment of Juvenile Idiopathic Arthritis (JIA), Mucopolysaccharidoses (MPS), Muscular Dystrophy (MD) and Developmental Coordination Disorder (DCD) as exemplar MSK conditions.

Methods Scoping review using a Library search tool (including several databases), Google Scholar, and consulting NICE guidance/pathways. Search terms included dyspraxia, paediatric MSK assessment, screening tools, balance, rheumatology, assessment tools for MD, MPS, JIA. Studies cited within relevant articles were also checked.

Results 32 articles were deemed appropriate, describing specific assessment or screening tools in the context of diagnosis. Within DCD, motor co-ordination batteries aid diagnosis as part of specialist assessment, but are regarded as too lengthy for the purpose of screening; a questionnaire may be a useful first-step diagnostic tool, along with assessment of static balance (found to be significantly worse in children with DCD). In paediatric rheumatology, pGALS is the only validated screening tool to discern normal from abnormal. For

neuromuscular conditions the North Star Ambulatory Assessment is valid, reliable and practical as a functional assessment, and includes activities necessary to remain functionally ambulant. With regards to MPS, searches did not reveal specific MSK tests, but evidence suggests that skeletal malformations and joint problems are the most frequently presenting signs. pGALS performs well to identify abnormal joints with restriction within an MPS group.

Conclusion This review supports the development of a 'pGALSplus' toolkit to facilitate identification of CYP with potentially serious disease. pGALSplus will be targeted at community-based clinicians and will likely include physical examination, questionnaire(s) and appropriate adjuncts.

G315(P) ABSTRACT WITHDRAWN

G316(P) AUTISM AND CSLE (CHILDHOOD ONSET SYSTEMIC LUPUS ERYTHEMATOSUS) DIAGNOSTIC DILEMMA: A CASE OF RARE COMBINATIONS

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Case We present a case of a 7-year-old girl with severe autism presenting with facial swelling and bilateral cervical lymphadenopathy initially thought to be lymphoma but later diagnosed as systemic lupus with nephritis and neuro-lupus. Her initial course was stormy needing admission to intensive care unit and referral to oncology centre for work up of lymphoma.

This child had no significant hospitalisations in the past. Her initial blood results and CT (Computerised tomography) chest suggestive of lymphoma with tumor lysis. She was transferred to a local paediatric oncology centre for lymph node and bone marrow testing which were both negative. She developed focal seizure secondary to hypertension and PRES (Posterior reversible encephalopathy), needing intubation and transferred to intensive care unit for 48 hours. Magnetic resonance (MRI) imaging brain showed signs consisted with cerebral lupus. Autoimmune screen strongly positive for antibodies ANA (Antinuclear), ds DNA (double stranded deoxyribonucleic acid), Anti-Ro, Anti-Smith, RNP (Ribonucleoprotein), RNP70, low C3 (complement) and C4 in keeping with SLE.

Course She was treated with intravenous (IV) pulsed methylprednisolone for 3 days, followed by oral prednisolone, IV cyclophosphamide and later switched to Mycophenolate (MMF) therapy with which she made good recovery. Renal biopsy was not performed as the child remained hypertensive despite being on antihypertensive medications. Other complications included ascites, pleural effusion and pericardial effusion which was managed conservatively. She stayed in the hospital for 2 months with good neurological recovery back to her previous status.

At 3 months - She remains on immunosuppressive medication i.e. Mycophenolate and tapering doses of oral prednisolone with good clinical response. MRI head shows significant improvement in comparison to her previous images, complete resolution of the pericardial effusion and urine examination no evidence of proteinuria or haematuria.

Conclusion cSLE (Childhood Systemic Lupus Erythematosus) with multi-system involvement in an autistic child can be difficult to diagnose and manage. The case highlights that cSLE is a disease of thousand faces with varied clinical presentations and the need for high index of suspicion. This case also highlights the role of multidisciplinary teams in the management of such complex cases.

G317(P) ABSTRACT WITHDRAWN

G318(P) BRITISH SOCIETY OF PAEDIATRIC AND ADOLESCENT RHEUMATOLOGY (BSPAR) STANDARDS OF CARE FOR UVEITIS SCREENING IN CHILDREN WITH JUVENILE IDIOPATHIC ARTHRITIS (JIA) – COMPLIANCE IN A SINGLE CENTRE IN SOUTHERN IRELAND

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Background Uveitis is an extra-articular manifestation of Juvenile Idiopathic Arthritis (JIA) that affects up to 30% of patients. Presentation is classically insidious and may cause blindness. It is essential that regular slit-lamp examination is performed in all cases of JIA. BSPAR/Royal College of Ophthalmology (RCO) Uveitis Screening principles recommend following JIA diagnosis, slit-lamp examination should occur;

- Immediately and no later than 6 weeks from referral (recommendation 1)
- Every 2 months, from onset of arthritis, for 6 months (recommendation 2)
- Every 3–4 months thereafter (recommendation 3)

Aims To describe compliance with BSPAR/RCO guidelines in newly diagnosed cases of JIA.

Methodology A retrospective chart review of children with JIA attending our Centre was performed to ascertain compliance with BSPAR/RCO guidelines.

Results 28 children with a diagnosis of JIA attend our Centre (Female n=23, 82%). Nine patients were ANA positive (28%). Classification of patients identified 39% (n=11) had polyarticular JIA, 22% (n=6) had Oligoarticular JIA, 14% (n=4) had systemic onset JIA, 14% (n=4) had Psoriatic JIA and 11% (n=3) had enthesitis-related arthritis. Table 1 details results of compliance with BSPAR/RCO guidelines.

Abstract G318(P) Table 1

Compliance n (%)	Yes	No	Not documented	Not applicable*
Recommendation 1	9 (32%)	16 (57%)	3 (11%)	-
Recommendation 2	5 (18%)	18 (64%)	3 (11%)	2 (7%)
Recommendation 3	3–4 monthly 8 (29%)	>4 monthly 14 (50%)	3 (10.5%)	3 (10.5%)

*Not attending service for period to be assessed i.e. relatively new JIA diagnosis.