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G315(P) ABSTRACT WITHDRAWN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.