

sample values. The patient had recurrent problems with social functioning, which manifested as intermittent palpitations, precordial sensations, and a prolonged episode of large amplitude uncontrollable tremor for which he was hospitalized once again after the second episode of pancreatitis.

Conclusion The presented cases show the possible extent of extrapulmonary illness caused by *Mycoplasma pneumoniae* in children. Judging by these cases, autoimmune mechanisms and also genetic factors seem to play an important role in the infection of a specific organ by *M. pneumoniae*.

255 REFEEDING SYNDROME IN HOSPITALIZED CHILDREN AND ADOLESCENTS WITH EATING DISORDERS- EXPERIENCE OF TERTIARY CENTER

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Refeeding syndrome (RFS) describes potentially fatal shift in electrolytes in severe malnourished patients receiving rapid and excessive food re-introduction. It is a result of hormonal and metabolic disturbances.

There are various clinical and laboratory features with hypophosphatemia being the most common one. Elevation in liver function tests is also frequently seen. Patients with anorexia are a high-risk group for developing RFS. The aim of the study was to investigate the incidence and clinical features of RFS among hospitalized patients, as well as severity of malnutrition (Z-score, BMI).

This study is a retrospective analysis of medical documentation of patients diagnosed with anorexia nervosa (restricting (ANRT) and binge eating/purging

(ANBP) subtype), eating disorder NOS (EDNOS) and avoidant/restrictive food intake disorder (ARFID) who were admitted to our Centre for eating disorders in children and adolescents during a 5 year period (2014-2018). We analyzed the age, gender, duration of the disease before admittance, anthropometric data (BMI and Z-score), average weight loss, the need for nasogastric (NG) tube feeding and phosphate supplementation. For statistical analysis we used t-test.

256 patients (232 female) aged 6-20 years (median 15 +/- 2.06) of which 43% were diagnosed with ANRT, 10% ANBP, 8% ARFID, 39% with EDNOS were included in the study. The average duration of the disease at the time of admittance was 13.25 +/- 13.43 months. Average BMI Z-score was -1.97 +/- 1.63 average weight loss was 20 +/- 9.76% initial body weight (IBW).

Hypophosphatemia was found in 15.6% patients, of which 65% received phosphate supplements by oral or intravenous route depending of phosphate serum concentration. Elevated liver enzymes due to RFS were found in 9.3% of patients. In total RFS in some form developed in 23% patients.

Average BMI Z-score of patients that developed RFS was -2.6 +/- 1.89, average weight loss was 23.9 +/- 9.85% of IBW. Both variables were significantly different ($p < 0.05$) in comparison with non-RFS group which had BMI Z-score of

-1.76 +/- 1.47 and average weight loss of 18.7 +/- 9.3% of IBW. The average duration of the disease was similar in both groups (13 months) ($p = 0.84$).

NG tube feeding was needed in 27% of all patients, 24% patients in non-RFS group and 37% in patients with RFS.

Our study reported that even in controlled hospital conditions and with careful realimentation RFS has a high incidence. We found statistically significant difference when it comes to BMI Z-score and average weight loss between two groups of patients.

256 HEMOPHAGOCYTIC LYMPHOHISTIOCYTOSIS IN A 13-YEAR OLD GIRL WITH CROHN'S DISEASE

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Hemophagocytic lymphohistiocytosis (HLH) is a severe, life-threatening disorder of uncontrolled immune activation and inflammation which, if left untreated, can lead to organ failure and death. Mortality is high, so prompt recognition and treatment are crucial. However, clinical presentation is unspecific, condition is rare, so in some cases the diagnosis and treatment can be delayed, which further impairs chances of recovery. In recent years, the number of reported cases of HLH in inflammatory bowel disease (IBD) patients has increased, probably due to higher awareness than real rise in incidence, although this condition is still often overlooked.

We describe a 13-year-old girl with Crohn's disease (CD) on azathioprine therapy, who developed HLH as a complication of primary CMV infection and EBV reactivation.

13-year-old girl was diagnosed with CD two years prior and was in stable remission with standard pediatric therapy, enteral therapy, followed by azathioprine maintenance therapy, which she was currently taking. The function of TPMT was normal.

Two months after last follow up she was admitted in poor clinical condition with a prolonged period of high-grade fever, fatigue, poor appetite, weight loss, few episodes of vomiting associated with peaks of fever and slight abdominal tenderness. No other symptoms suggestive of CD relapse were present which was later confirmed by normal ileocolonoscopy and MR enterography. According to history she was in contact with infectious mononucleosis patient two months prior. Azathioprine was discontinued. After obtaining specimens for microbiological analysis empirical broad-spectrum antibiotics were initiated. During next few days her clinical state started to deteriorate. At this point, additional tests confirmed our suspicion of

HLH: persistent fever, bicytopenia, hyperferritinemia, hypofibrinogenemia, hypertriglyceridemia, low NK activity, splenomegaly, and CD68 and ANA positive phagocytes in bone marrow smear. All bacterial cultures came back negative. Serology and PCR results revealed that HLH was a complication of primary CMV infection with EBV reactivation.

Treatment with systemic corticosteroids was initiated with excellent response, lithic drop of fever, improvement in general condition and normalization of biochemical markers. The dose of corticosteroids was tapered gradually and her clinical state was monitored closely. She had no signs of relapses of HLH, primary disease, nor no signs of malignant disease during one year of follow-up period.

The clinicians should be aware of this complication with high mortality especially in pediatric patients. In CD HLH is probably developing as combination of several factors: primary disease, immunomodulation and infection (primary or reactivation).

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ANOTHER FACE OF EPSTEIN-BARR VIRAL INFECTION: ACUTE ACALCULOUS CHOLECYSTITIS AND SEVERE LIVER LESION IN PREVIOUSLY HEALTHY FIVE-YEAR-OLD GIRL WITH PRIMAINFECTION

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Acute acalculous cholecystitis (AAC) is a rare disease, particularly in children. It is mostly observed in critically ill or post-surgical patients due to dehydration, increased bile viscosity, decreased oral intake and gallbladder dysmotility. Most AACs in children are caused by infectious agents and are characterized by favorable clinical course and conservative treatment. Also, AAC is an atypical and rare complication of Epstein-Barr virus (EBV) infection. The occurrence of AAC has been described in some chronic disorders and systemic autoimmune diseases. The clinical and laboratory presentation of AAC is variable. The diagnosis is based on radiological criteria. Abdominal ultrasound typically shows distended gallbladder with thickened wall, pericholecystic fluid or edema and absence of gallstones or dilatation/obstruction of bile ducts.

We present a girl with AAC and acute severe liver lesion due to the EBV primoinfection.

Previously healthy 5-year-old-girl was admitted to the Pediatric Department (April 2020) due to jaundice, severe liver lesion and cholestasis. She was inappetent for a week; had pruritus, pale and yellowish skin, occasional abdominal pain and one hypocholeic stool. No fever, nausea or vomiting was reported. At admittance, icterus, an enlarged liver (3 cm in the medioclavicular line) and a negative Murphy's sign were noticed. She was afebrile, HR 132/min, BP 80/50 mmHg; body height 116.3 cm (88th centile), BMI 18 kg/m² (93rd centile). She had no lymphadenopathy or pharyngitis.

Laboratory tests revealed severe hepatitis and conjugated hyperbilirubinemia (AST 1908 U/L, ALT 3222 U/L, GGT 51 U/L, bilirubin total 83.6 μmol/L, conjugated 68.5 μmol/L, total serum bile acids 61.2 μmol/L) with preserved synthetic and metabolic liver function and normal values of inflammatory markers. Ultrasonography revealed mild hepatosplenomegaly, hyperechogenic liver parenchyma, normal bile ducts and slightly dilated gallbladder with thickened and layered wall, significant pericholecystic edema and the absence of gallstones. The following assessment found no elements of malignancy, autoimmune etiology, chronic primary and secondary liver diseases, dyslipidemia, bacterial or parasitic infection. Serological analysis confirmed EBV primoinfection and significant viremia (28 000 copies/ml at PCR test). Conservative treatment was followed by spontaneous clinical, laboratory and radiological regression.

We presented a rare hepato-biliary manifestation of EBV infection in children. Our aim was to highlight the importance

of recognizing AAC as a differential diagnosis in children with abdominal pain and/or acute cholestasis. Radiological evaluation and monitoring as well as collaboration of gastroenterologists and radiologists are essential in management of these patients.

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A RARE CASE OF ACUTE PANCREATITIS AND REACTIVE ARTHRITIS IN ROTAVIRUS GASTROENTERITIS

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Pancreatitis in children is an acute inflammation of the pancreas that manifests itself with abdominal pain localized in the epigastrium and elevated levels of enzymes secreted by the pancreas and is a significant cause of mortality and morbidity. Hyperamylasemia and hyperlipasemia occur relatively frequently in acute gastroenteritis, but pancreatitis itself is relatively rare. Reactive arthritis can also often be associated with acute viral infections although it is extremely rarely described with rotavirus infection.

We present a rare case of pancreatitis and reactive arthritis associated with rotavirus gastroenteritis.

A 5-year-old, 9-month-old girl presented with severe epigastric pain, vomiting, and sub febrile condition that lasted for 24 hours.

Family and personal anamnesis were without peculiarities. At admission, severe pain in the epigastrium, sub febrile and increased peristalsis without other deviations were noted. Leukocytosis (19.3×10^9 , 86% of segmented leukocytes), elevated CRP (19.9 mg/L) and markedly elevated lipase (4025 U/L), serum amylase present in laboratory findings

U/L) and urine (13439 U/L). Rotavirus antigen was isolated in stool by negative other microbiological analysis. No pathology of the hepatobiliary tree, with minimal changes of the pancreas, in terms of hypo echogenicity without effusion was detected by ultrasound. She did not develop cystic lesions.

Upon admission, oral intake was discontinued and parenteral hydration was initiated.

Intensive monitoring shows a favourable trend of rapid decline in amylase and lipase values. After 72 hours, oral administration was started with gradual discontinuation of the intravenous infusion, which was well tolerated. The diet continued with the accelerated introduction of protein and fat without relapse. She was febrile for 3 days with rapid clinical recovery. On the seventh day of the stay, complains of pain and swelling of the dorsum of the left foot with a renewed increase in inflammatory parameters (CRP 27.4 mg/L, SE 52 mm/ 3.6 hp). Through clinical evaluation and ultrasound findings, arthritis was suspected (in the projection of the navicular and cuneiform bone, synovitis and enhanced power – doppler signal). Given the rapid clinical recovery over the next 2 days, without the need for further diagnostic or therapeutic interventions, it was concluded that this was transient reactive arthritis.

Rotavirus is a common cause of severe diarrhoea in children worldwide and it is a significant cause of morbidity in developed countries and mortality in developing countries. Although extremely rare, associated pancreatitis is a serious and potentially fatal extra intestinal complication and further