14000/mm³ with lymphocytic predominance and numerous atypical lymphocytes in the smear. Her IMN monospot test was positive. Her alanine aminotransferase

(ALT) was 370 IU/L. She was discharged home with diagnosis of glandular fever on symptomatic treatment. A week later, she represented with jaundice, pruritus, nausea and anorexia. Her liver functions showed ALT: 1956 IU/L, aspartate aminotransferase (AST): 1007 IU/L, alkaline phosphatase (ALP): 162 IU/L, total bilirubin: 70 µmol/L, direct bilirubin: 47 µmol/L and albumin:

45 g/L. Her renal functions and clotting was normal.

Her viral markers (hepatitis B virus surface antigen, anti-hepatitis C virus, hepatitis A virus immunoglobulin IgM) were negative. Hepatitis E IgG antibody was positive whereas IgM was negative. Antinuclear, anti-mitochondrial and anti-smooth antibody profile was negative. Ultrasound abdomen showed mild splenomegaly (14cm). Her copper level was 35.8 µmol/L

(N: 11-22 µmol/L) and ceruloplasmin level was 0.52 g/L (0.16-0.45 g/L). EBV viral capsid antigen IgM and IgG were positive and EBV nuclear antigen IgG was negative. Cytomegalovirus IgM was negative and IgG were positive. Her IgA and IgM antibody levels were mildly elevated 3.36 g/L (N: 0.8-2.8 g/L) and 2.8 g/L (N: 0.5-1.9 g/L) respectively. She was treated with ursodeoxycholic acid and fat soluble vitamins. Her liver functions improved but were still deranged 4 weeks later.

Symptomatic hepatitis in IMN is rare, more so in paediatric population compared to elderly. The elevation in aminotransferases levels are usually less than fivefold and hyperbilirubinaemia is seen in up to 5% of patients.

In our patient ALT increased more than 30 times and she became clinically jaundiced and symptomatic. Fulminant hepatitis is very rare. Possible mechanisms are lymphocytic infiltration of hepatocytes, cholestasis and auto-immune hepatitis. Treatment is mainly symptomatic and supportive.

Conclusion Patients with IMN should be observed for jaundice and subsequently monitored for liver function in case of hepatitis. EBV should be considered in patients presenting with clinical jaundice.

47 AN UNLIKELY LIMP...

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Introduction Limp is a common complaint in childhood and could have many causes including traumatic, infectious, tumoral and inflammatory diseases. Beyond lower extremity pathology, limp can also be caused by abnormalities of the abdomen, urinary tract, back and nervous system.

Case-Report 13 years old boy, living in France since his 4 years old, but with a short term stay in Portugal of nine months, was admitted to the the hospital with abdominal, hip and thigh pain, with consequent limping gait.

He had these recurring complaints for over 1 year. For the abdominal pain, he had an x-ray that showed marked fecal impaction, with a megacolon, so he was admitted to our ward for deimpaction. Orthopedic surgeons observed the patient and hip examination was normal. Lumbosacral Magnetic Resonance (MRI) was also normal and blood tests showed a normal hemogram, renal function and immunologic study was

negative. After 1 month, he returned with the same symptoms. He had past history of constipation since he was a child, not valued by the family. At the objective examination, there was a palpable fecaloma in the ampulla and palpable stool at digital rectal examination, so he was hospitalized again for deimpaction. Then, he performed double-contrast opaque clister showing a radiological aspect of Hirschsprung's disease. A rheumatologist opinion was requested and a MRI of abdominal, pelvic and hip was performed, that revealed a sigmoid colon with a maximum caliber of 95 mm filled with feces, and consequent anterior bladder deviation and compression of the psoas iliacus muscle. After eating habit modification and regular treatment with laxatives, the symptoms disappeared. Rectal biopsy wasn't performed, because he was lost to follow up.

Discussion This may possibly be a result of an undiagnosed Hirschsprung in a male with recurrent episodes of constipation since infancy, but never followed by the same doctor. The first symptom – pain in the hip and thigh – was due to the compression of the psoas iliacus by the megacolon.

48 OUR ROSTER, OUR CHOICE: IMPACT OF A SHIFT WORK ROSTER'S LAYOUT ON EMOTIONAL WELL-BEING AND BURNOUT LEVELS

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To determine the impact of a change in the layout of a rolling shift work roster according to non-consultant hospital doctors (NCHDs) preferences on emotional well-being and burnout levels in a Paediatric Emergency Department (PED).

Our roster consists of 15 NCHDs. It contains two and a half cycles, spanning ten weeks each over six months.

An online survey was designed to analyse the first cycle of the roster.

Five factors of emotional well-being (happiness, motivation, tiredness, irritability and sleep quality) were highlighted and the survey was circulated to all NCHDs at the end of their shift each week for 10 weeks.

Answer options were framed using a Likert-scale ranging from 1-79. The results were then compiled into a multi-line graph.

The Maslach Burnout Inventory (MBI) was also distributed after the first cycle of to determine the level of burnout for physicians.

After analysing the results the roster was changed whilst taking into account physicians preferences and burnout for NCHDs was determined once again at the end of the next cycle.

The multi-line graph showed that NCHDs ended the week-day nights with mild-moderate negative emotions. After the annual leave break, positive emotions were at their peak where NCHDs felt very happy, energetic and motivated. Over the next few weeks, their emotions remained neutral as they still had enough breaks and shorter shifts. However, from the first twilight shift (Week 5), negative emotions dominated until NCHDs were emotionally drained at the end of the Week 9 shift. After the change in the roster, NCHDs emotions picked up during Weeks 5 – 9 moving towards neutral and slightly positive.