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.

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 deimpactation. Orthopedic surgeons observed the patient and hip examination was normal. Lumbar sacral 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 deimpactation. Then, he performed double-contrast opaque clister showing a radiological aspect of Hirschspung’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.