Introduction Inflammation of the intervertebral disc and vertebral bodies is uncommon in children. The diagnosis can be challenging due to non-specific signs and symptoms.

Case Report A 12 month-old previously healthy female child presented with pain in the right hip, refusal to walk, and fever (up to 38.6°C) for five days. There was no history of trauma. On admission, the infant was febrile and had a limping gait. The remainder of the physical examination was normal. She was hospitalized for further investigation. A complete blood count revealed

10880 white blood cells/ μ L (52% neutrophils, 34% lymphocytes, 2% eosinophils and 10% monocytes), a haemoglobin level of 10.2g/dL, and a platelet count of 452000/ μ L. The erythrocyte sedimentation rate (ESR) was 73mm/hour and the C-reactive protein was 2.74 mg/dL. Radiography of the lower limbs and pelvis was normal. The following day, the child was unable to sit. Magnetic resonance imaging (MRI) of the spine showed an abnormal signal in the vertebral bodies and intervertebral disc at L4-L5, with a high signal on the STIR image, compatible with spondylodiscitis. Bed rest and empirical treatment with intravenous ceftriaxone and flucloxacillin was started.

Diagnostic tests performed to detect an infectious cause were negative, including blood and stool cultures, Wright's and Widal's tests, a Mantoux test, an Interferon-Gamma Release Assays blood test, a Polymerase Chain Reaction test for *Mycobacterium tuberculosis* from gastric washings, staining for acid-fast bacilli, and cultures for mycobacteria.

One week later, the levels of inflammatory markers decreased and the child improved clinically. An additional MRI study performed in the second week showed a reduction in signal alterations. After four weeks, the infant was sitting and walking again without difficulty or pain. The inflammatory markers returned to normal. Intravenous therapy was switched to oral treatment with cefuroxime and flucloxacillin for another four weeks.

At a follow-up visit, an MRI study showed complete resolution of spondylodiscitis. There were residual abnormalities of the disc space and

L4/L5 vertebrae, with no functional significance. The child was asymptomatic and behaving normally.

Conclusion Suspicion of spondylodiscitis is important when a child presents with walking difficulties. The vascular nature of the intervertebral disc in children explains the predisposition to this rare condition. Magnetic resonance imaging of the spine is the gold standard for diagnosis. Early diagnosis is important to ensure a favourable outcome.

55

REGRESSION OF MILESTONES IN AN INFANT AS PRESENTING FEATURE OF MATERNAL PERNICIOUS ANAEMIA

Abhidhamma Kaninde*, M Katre, K Papadopoulou, R Ramaswamy. *Leicester Royal Infirmary*

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Background Children presenting with regression of milestones is not uncommon in the Paediatric population. One should be aware of wide range of differential diagnosis including neuro metabolic causes. In our case, methylmalonic aciduria as a part was metabolic screening was noted leading to diagnosis of

vitamin B12 deficiency in the infant and pernicious anaemia in mother.

Case Presentation We report the case of a 6-month-old female patient presenting with a history of suspected seizures in the form of abnormal upper limb movements, staring episodes with background history of developmental delay and regression of milestones over last few months.

There were no infection concerns. Birth history was normal and she was exclusively breastfed. She was well until four months of age when she presented with what sounded like shuddering episodes but had a normal examination that time.

On examination, she was hypo-reflexic and had poor grasp. Her tone was normal. She did not have any neurocutaneous markers. Our initial impression was of afebrile seizure likely infantile spasms.

Investigation Blood investigation revealed macrocytic anaemia. Her renal, liver and thyroid function were normal. Serum ammonia and lactate were normal.

An EEG and MRI brain were normal. Although we could not get Serum Amino acids results due to sampling error, her urine organic acid analysis revealed excessive excretion of Methyl malonic acid prompting further evaluation. Her B12 levels were noted to be significantly low, i.e. <101 pg/ml (197-771) with normal folate levels. With a history of exclusive breastfeeding, her mother was also investigated and found to have anti-parietal cell antibodies confirming underlying pernicious anaemia.

Patient had good recovery with normalisation of urine organic acid profile after treatment with injectable hydroxocobalamin.

Discussion Developmental delay is a common presentation in paediatric setting. Choo et al mentions prevalence up-to 15% amongst preschool children. One should take through history and undertake comprehensive examination for narrowing down wide spectrum of differential diagnosis. Global developmental delay, regression of milestone, presence of abnormal neurological examination are some of the red alarm signs which mandates further evaluation including neuroimaging and baseline metabolic work up.

In our case, methylmalonic aciduria lead us to diagnosis of nutritional vitamin B12 deficiency reemphasising importance of metabolic work up in these clinical presentations. Some studies like Hoznik et al mentions methylmalonic aciduria as most sensitive marker for Vitamin B12 deficiency.

Conclusion Vitamin B12 deficiency should be considered as an important differential while evaluating infants with developmental delay

56

ACQUIRED TORTICOLLIS IN A TODDLER- A RARE DIAGNOSIS

Abhidhamma Kaninde*, S Rasheed, M Aslam. *Peterborough City Hospital*

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Introduction Acquired torticollis although uncommon but is an important presentation in paediatric setting. One should be very thorough and suspicious while evaluating these patients. If the torticollis is non-traumatic it suggests more serious pathology. In our case, neck swelling with fever was pointing towards infective etiology but persistent symptoms made us