**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/µL (52% neutrophils, 34% lymphocytes, 2% eosinophils and 10% monocytes), a haemoglobin level of 10.2g/dL, and a platelet count of 452000/µL. 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, 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 fluclouacinil 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.

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

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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 hydroxocobalmin.

**Discussion** Developmental delay is a common presentation in paediatric setting. Choo et al mentions prevalence up to 15% amongst preschool children. One should take thorough 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 el 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.

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**ACQUIRED TORTICULLIS IN A TODDLER- A RARE DIAGNOSIS**

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**Introduction** Acquired torticollis although uncommon but is an important presentation in paediatric setting. One should be thoroughly 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...
INTUSSUSCEPTION ENCEPHALOPATHY: A CLINICALLY DECEPTIVE PRESENTATION

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A 7-month-old presented with reduced responsiveness and non-bilious vomiting. On presentation, he was encephalopathic, apyrexial with normal vital signs. Pupils were intermittently miotic and initial abdominal examination was normal. Investigations including blood gas, biochemistry, inflammatory markers, metabolic and toxicology panels were normal. A CT brain scan showed no abnormality.

Abdominal examination 24 hours later elicited a possibility of tenderness.

Therefore we proceeded with abdominal ultrasound which revealed an evidence of ileocolic intussusception. Initial standard management of ileocolic intussusception was attempted by radiological pneumatic reduction (air enema) which was unsuccessful. Subsequent definitive surgical management achieved by laparotomy and manual reduction successfully released the obstruction.

He recovered uneventfully and underwent usual post-surgical care.

Discussion A recent study showed about 4% of children diagnosed with intussusception had one or more neurological symptoms recorded at presentation. Lethargy was the most frequent, followed by hypotonia, generalised weakness, paroxysmal events, and fluctuating consciousness. One study reported a series of 13 cases of children whom impairment of the mental state preceded the appearance of common gastrointestinal symptoms. Another distinctive feature is the presence of miosis. The aetiology is unclear but there has been hypotheses that this could be caused by the production of endogenous opioid in response to stress and pain.

Conclusion This case illustrates a rare occasion of intussusception presenting as an acute encephalopathy in the absence of typical signs of bowel obstruction.

Although uncommon, the recognition of this possibility should be entertained, particularly in an unexplained encephalopathy.

COMPARATIVE CHARACTERISTICS OF THE ETIOLOGICAL SPECTRUM OF ACUTE VIRAL RESPIRATORY INFECTIONS IN PEDIATRIC PATIENTS IN UKRAINE DURING 2018–2020

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Background Acute respiratory viral infections (ARVI) continue to be the main reason for seeking pediatric care in Ukraine. Comparative characteristics of etiological spectrum of ARVI in Ukraine has not been sufficiently studied.


Methods The study was conducted in the Eurolab clinic (Kyiv, Ukraine) during the period 2018–2020. Nasopharyngeal swabs, collected from ARVI children aged 2 months to 16 years old, were analyzed by multiplex real time polymerase chain reaction for 7 viruses – Respiratory Syncytial virus (RSV), Parainfluenza virus (PIV), Adenovirus (AdV), human Metapneumovirus (hMPV), Rhinovirus (RV), human Bocavirus (hBoV), and Coronavirus (CoV). Rapid influenza diagnostic testing was used.

Results 147 samples were collected during the period from October 2018 until February 2019; 125 (85.0%) were positive: hMPV – 33 (26.3%), IVA – 28 (22.4%), RV – 21 (16.8%), RSV – 10 (8.0%), hBoV – 7 (5.6%), AdV – 5 (4.0%), PIV – 4 (3.4%). Diagnosis of pneumonia was established in 18% of children infected by hMPV and 21% of children with IVA infection. Other clinical manifestations of hMPV infection were: tracheobronchitis, obstructive bronchiolitis, broncholithiasis, rhinopharyngitis, laryngitis. 12 of the children with RV infection had symptoms of rhinopharyngitis,