medications, 9(7.9%)-H1-antagonists, 8(7%)-alpha-agonists, 6 (5.3%) patients-vitamin tablets, 42 (36.8%)-other drugs*.

By observing the 928 patients aged 1-7 years old we found out the following results:cardiac medications-243 (26.2%) patients, nonopioids-130 (14%), antipsychotic-127 (13.7%), antibiotics-67 (7.2%), 361 (38.9%)-other drugs. There were 5 suicide attempts.

The analysis of 93 patients aged 7-14 years old led to following results: nonopioids-26(28%) patients, antipsychotic drugs-18(19.4%), cardiac medications-14(15%), H1-antagonists-11 (11.8%), antiemetic drugs-9 (9.7%), 15 (16.1%)-other drugs. There were 22 suicide attempts.

The number of 14-18 years old patients with ADIs was 125, among them 53 (42.4%) patients were poisoned with nonopioids, 23(18.4%)-antipsychotic drugs, 19(15.2%)-H1-antagonists, 12 (9.6%)-cardiac medications, 18 (14.4%)-other drugs. There were 91 suicide attempts.

*hormone medications, antibiotics, antifungal drugs, PPIs, PG analogues, etc.

We found out that there are 4 most common reasons for ADIs in children: non-opioid analgesics, cardiac medications, antipsychotic drugs and H1-antagonists. The first two drug classes cause predominantly ADIs in 0-7 years old children. This phenomenon might be associated with extreme curiosity of kids as well as with parental negligence. In contrast to this, children aged 7-18 overuse mostly antipsychotic drugs and H1-antagonists and are inclined to suicide attempts.

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WHAT DRUGS CAUSE INTOXICATIONS IN CHILDREN?

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In this study we aimed to investigate the most common drugs that caused ADIs in 0-18 year old patients and to observe the prevalence of suicide attempts. A retrospective study was performed using medical charts up to 7 years (2012-2018) from 'Muratsan' University hospital complex(UHC) Intensive care unit (ICU) and toxicology. We have separated the patients in four age groups (0-1;1-7;7-14;14-18 years old). The overall number of patients who had ADIs and were admitted to resuscitation unit was 1260. Mean age of patients was 4.7 years. We have included the most common drug intoxications typical for each age group.

114 patients under 1 year old have been diagnosed with ADI: 34 (29.8%)-non-opioid analgesics, 15 (13.2%)-cardiac medications, 9 (7.9%)-H1-antagonists, 8 (7%)-alpha-agonists, 6 (5.3%) patients-vitamin tablets, 42 (36.8%)-other drugs*. By observing the 928 patients aged 1-7 years old we found out the following results: cardiac medications-243 (26.2%) patients, nonopioids-130 (14%), antipsychotic-127 (13.7%), antibiotics-67 (7.2%), 361 (38.9%)-other drugs. There were 5 suicide attempts.

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We found out that there are 4 most common reasons for ADIs in children: non-opioid analgesics, cardiac medications, antipsychotic drugs and H1-antagonists. The first two drug classes cause predominantly ADIs in 0-7 years old children. This phenomenon might be associated with extreme curiosity of kids as well as with parental negligence. In contrast to this, children aged 7-18 overuse mostly antipsychotic drugs and H1-antagonists and are inclined to suicide attempts.

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ABNORMAL TSH LEVELS AND PEDIATRIC OBESITY

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To determine the prevalence of elevated thyroid-stimulating hormone (TSH) levels in obese children and adolescents referred to pediatric endocrinology clinics and its association with positive Anti Thyroid Peroxidase Antibodies. (Anti TPO) A retrospective review of medical records of 100 obese children referred for abnormal thyroid function test was performed. Children were younger than 18 years of age with BMI above 95th percentile.

Data about age, sex, body mass index, TSH, thyroid functions, thyroid antibodies, were collected.

All patients were referred for abnormal thyroid function tests and got repeated tests along with Anti TPO levels. Interpretation of TSH results showed normal level for age in 65% and slightly elevated TSH but below 10 uIU/ml in 32% Only three obese patients (3%) had Hashimoto disease (positive Anti TPO) and elevated TSH requiring therapy.

Obese children are often screened and referred to pediatric endocrinology for abnormal thyroid function test. It is well known that TSH levels are mildly increased in obese children but there are no evidence-based data that treating this elevation can change the outcome of obesity.

Mild elevation of TSH values in the absence of autoimmune thyroid disease is common in obese children and adolescents. This elevation is often a result of obesity rather than a cause. High Leptin level in obese children has been postulated as an etiology.

Many primary care providers and even parents are looking for 'an easy fix' of obesity by making the diagnosis of hypothyroidism and treating it.

Screening for thyroid dysfunction in obese children should be done based on symptoms and family history rather than dealing with obesity alone.

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TELEMEDICINE AS A METHOD OF PROVIDING PHYSICIAN COVERAGE A PILOT EXPERIENCE IN A PEDIATRIC ENDOCRINOLOGY CLINIC

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Telemedicine (TM) has been a rapidly growing method of providing health care in different medical settings. Using technology to provide healthcare at a distance can be very helpful in improving access to health care in rural areas, providing immediate medical care when needed and reducing the cost of delivering medical care. Telemedicine patients often report positive experiences, given the speed of access, time saved, and the ability to stay in contact with healthcare providers. These virtual visits may help improve compliance with follow-up consultations by reducing the barriers of distance and transportation.

Telemedicine may also be used in providing service coverage when the medical provider becomes suddenly unavailable due to any kind of emergency (medical, social).

We present our experience in using TM as a tool for provider coverage in an immediate need situation as an alternative to rescheduling patient appointments.

We evaluated families' choice in accepting a TM visit in a pediatric endocrinology clinic as an alternative to rescheduling appointments with the provider who suddenly became unavailable due to a medical emergency. The families were educated about the TM visit and were given the option to participate. The TM visits were conducted between two medical practices. Fourteen families were offered a TM visit when their physician was not available to conduct the visit. Six families (42%) agreed to participate in the TM visits, four families (66%) showed up. All cases of TM visits were follow-up visits to review the medical condition, growth parameters, laboratory test results and discuss the management plan.

Satisfaction rate regarding the TM visit was obtained at the end of the visit, this TM visit was the first experience for all families, all of the participating families (100%) expressed satisfaction with the visit and stated that they would participate in TM visits in the future, if offered.

Families who declined the TM visit were rescheduled for traditional physician visits with the same provider or another provider within the same group.

Telemedicine can offer a fast and practical solution to provide coverage for physicians when there is a sudden immediate need. Rescheduling may not be well received from some patients so having the TM option is a futuristic way of covering health care delivery. Patients should be informed about the TM visit structure prior to their participation. Conducting TM visit when patients are at home may increase acceptance and participation.

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A CASE OF INTENTIONAL VIRILIZATION OF A YOUNG FEMALE TODDLER. THE MEDICAL AND LEGAL CONSEQUENCES

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A five-month-old female, born with normal female genitalia, developed clitoromegaly. Physical examination showed a 3 cm length x 0.8 cm width clitoris and Tanner 2 pubic hair/1 breasts.

She lived with her biological grandmother and step grandfather. The grandmother worked, while step grandfather was the primary caregiver, during the day.

Laboratory testing showed very elevated levels of both total and free testosterone (above 1500 ng/dL: 52 nmol/L) (402.5 pg/mL), respectively LH and FSH levels were pre-pubertal, 17-hydroxyprogesterone, 11 Deoxycorticosterone, DHEA, ACTH, cortisol, anti-müllerian hormone (AMH), and tumor markers (HCG, AFP) levels were normal.

Karyotype was 46XX with FISH negative for SRY. Pelvic MRI showed a uterus with no pelvic masses.

When asked about possible exposure to hormones, the step grandfather, aged

52 years, stated that he was on testosterone creams and that he was probably accidentally exposed her by holding her after rubbing the cream on his shoulder. Education as to how to avoid exposure was provided. Testosterone levels dropped to 158 ng/dL (5.4 nmol/L) by 3 months after the first visit but went up few months later to 975 ng/dL (33.8 nmol/L) with growth acceleration, clitoral growth of 4.5 cm in length and labial fusion, muscular appearance and acne.

At this time, she was hospitalized for 6 weeks and Children's Protective Services were contacted. The step grandfather was not allowed to see her.

The testosterone dropped to a normal level of 3.8 ng/dL (0.13 nmol/L). The child was later adopted by extended family members.

The child's testosterone level remained undetectable after discharge but her voice remained very deep. She went through clitoroplasty. Her clitoral size was reduced surgically to 2.5 cm length. Her acne has resolved and her mood was pleasant.

Law enforcement investigation of the step-grandfather revealed several containers of testosterone products in the home, as well as pornography and multiple used condoms. He was arrested and convicted of committing serious bodily injury to a child, and was sentenced to 20 years in prison.

Discussion Virilization of pre-pubertal girls should prompt a detailed medical work-up to rule out a virilization form of Congenital Adrenal Hyperplasia (CAH) or androgen-producing tumors. If medical pathologies are ruled out, environmental exposure to testosterone should be suspected.

While all of the reported pediatric virilization cases due to hormonal exposure were accidental, this case is the first report of intentional and criminal exposure.

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CENTRAL PRECOCIOUS PUBERTY IN DIZYGOTIC TWIN SISTERS CAUSED BY MUTATION IN THE MAKORIN RING FINGER PROTEIN 3 GENE

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Background Central precocious puberty (CPP) is defined by gonadotrophin-dependent development of secondary sex characteristics before the age of 8 in girls and 9 years in boys. Approximately 25% of CPP cases are familial, but its genetic cause often remains unknown. Mutations in makorin RING finger protein 3 gene (MKRN) are a common cause of familial CPP, being identified in 33-46 % of familial cases. We describe dizygotic twin sisters diagnosed with CPP and treated with gonadotrophin-releasing hormone agonists analog (GnRHa), in whom genetic analysis revealed the cause for CPP.