agreement with our assessment. Genetic testing was subsequently positive for congenital myotonic dystrophy. Parents finally consented to withdrawal of intensive care at day 64 of life and he died shortly after extubation.

Conclusion Critical care decision on withdrawal of intensive care can be a very traumatic experience for families. It is essential to follow the guidance available. As paediatricians we are advocates for the baby but at the same time we have to be empathetic and considerate to the sentiments of the family.

535 NECROTIZING ENTEROCOLITIS IN A NEWBORN FOLLOWING INTRAVENOUS IMMUNOMBREXIN TREATMENT FOR HEMOLYTIC DISEASE

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ABO iso-immunization is the most frequent hemolytic disease of the newborn. Treatment depends on the total serum bilirubin level, which may increase very rapidly in the first 48 h of life in cases of hemolytic disease of the newborn. Phototherapy and, in severe cases, exchange transfusion are used to prevent hyperbilirubinemia encephalopathy. Intravenous immunoglobulins are used to reduce exchange transfusion. Herein we present a female infant who was admitted to the our NICU because of ABO immune hemolytic disease and after two courses of 1gr/kg of IVIG infusion, she developed NEC. Administration of IVIG to newborns with significant hyperbilirubinemia due to ABO hemolytic disease should be cautiously employed and always administered under strict.

536 NEONATAL HSV ENCEPHALITIS: CONTROVERSIES OVER DIFFERENT THERAPEUTIC APPROACHES AND THEIR EFFECTS ON NEURO-DEVELOPMENTAL OUTCOMES

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Background and Aims Neonatal HSV encephalitis is well described and known to cause morbidity. However, there is no consensus regarding its optimal treatment, especially around using suppressive oral therapy after intravenous acyclovir. We aim to discuss treatment controversies and review possible neurodevelopmental outcomes in such cases.

Methods We report a case of vertically transmitted neonatal HSV-1 encephalitis and review existing literature on available treatment options (PubMed, EMBASE).

Results Our patient became pyrexial (39.0°C) and lethargic on day 7 of life. Investigations revealed a raised CRP (80mg/l) and CSF pleocytosis (WCC-26/mm3, 90% lymphocytes) with normal CSF biochemistry. IV antibiotics were empirically started. After developing encephalopathy and seizures on day 2 of illness, IV acyclovir was added. CSF PCR was positive for HSV-1. EEG showed multifo-}

300mg/m2/dose TDS regime. Its optimal duration (6months, 12months or longer) is unclear. Neurodevelopmental outcomes mostly depend on the severity of the initial insult; Evidence that different suppressive treatments influence outcomes is poor.

537 AN IMPORTANT CAUSE OF DYSKINESIA

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Kernicterus has been referred to a disease of the past. However, we report two cases of kernicterus presenting with a dyskinetic movement disorder. Both cases had neonatal jaundice and were well until the age of 3 years with normal intellect. On examination dystonia, dyskinesia and chorea were seen. Further examination revealed an upgaze palsy and auditory neuropathy.

Kernicterus describes a neurological syndrome resulting from deposition of unconjugated bilirubin in basal ganglia & brainstem nuclei.

With the recent NICE guidance for jaundice therapy these cases highlight the importance of rigorous treatment of hyperbilirubinemia. They also remind us to consider kernicterus as a diagnosis in a child presenting with a movement disorder and normal intellect.

538 THE VALUE OF NEAR-INFRARED SPECTROSCOPY (NIRS) IN PERINATAL ASPHYXIA-A CASE REPORT

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Background Perinatal asphyxia remains a challenging entity. NIRS offers a method to continuously monitor cerebral oxygen saturation.

Aim To obtain insight into haemodynamic changes during hypothermia and rewarming in perinatal asphyxia using NIRS.

Methods We report of an asphyxiated patient (57+6 weeks’, Apgar 6 and 8 at 1 and 5 minutes, first arterial blood gas pH of 6.67, base deficit –25%). NIRS was started during the first hour of life and continued for a total recording time of 125 hours. Simultaneously, we measured brain function using amplitude-integrated electroencephalography (aEEG). On day 7 magnetic resonance imaging (MRI) has been performed. After discharge, the patient was reassessed neurologically.

Results The initial cerebral rSO2 was 65%. When cooling was started FTOE was 0.28. At 33.5°C FTOE had decreased to 0.20, cerebral rSO2 increased to 70%. When cooling was ended to the sentiments of the family. It is essential to follow the guidance available. As paediatricians we are advocates for the baby but at the same time we have to be empathetic and considerate to the sentiments of the family.

severe form of congenital toxoplasmosis with extensive cerebral findings

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