RMN ill-defined hyperintense areas in pons, cerebellum, basal ganglia, right parietal subcortical white matter. suspected encephalitis retrovirus by areas of parenchymal signal alteration above and infratentorial level.

Three days later reduction in the number and extent of intraxial lesions above and infratentorial.

**Results** The clinical and resonancia were doing suspect herpes virus encephalopathy, so income at the start of treatment with intravenous acyclovir. When we receive negative results and the improvement of symptoms, treatment it was suspended treatment with acyclovir on the fifteenth day and start treating autoimmune encephalitis with five boluses of methylprednisolone one gram every 24 hours.

**Conclusions** The day of discharge was treated with 60 mg of prednisolone daily. the fever subsides completely within three days before discharge, and intention tremor persists discrete gait instability.

**565** **REFLECTION ON A CASE OF DOPAMINE-RESPONSIVE DYSTONIA**

doi:10.1136/archdischild-2012-302724.0565

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**Background** Characteristic symptoms of Dopamine-responsive dystonia (DRD) are increased muscle tone and Parkinsonian features. Children with DRD are often misdiagnosed. The disorder responds well to treatment with Levodopa.

**Aim** To reflect on a case of DRD.

**Method** Case report of a 13 years old girl misdiagnosed with tetany.

**Results** The girl was hospitalized for opisthotonus, positive Trouseau and Chvostek signs, diagnosed as tetany. The laboratory analyses have shown: normal serum of calcium (2.28 mmol/l), normal serum of magnesium (0.80 mmol/l), normal serum of phosphor (1.26 mmol/l), normal alkaline phosphatase (261 u/l) and normal FTH (27.9 pg/ml). Although the initial evolution was favorable (with intravenous calcium gluconate), the hypoparathyroidism diagnosis requiring reconsideration. The final diagnosis was DRD with long good evolution after Levodopa treatment. Referring to family history we learned that the patient have a cousin with the same symptoms.

**Conclusions** The misdiagnosis results from the following similarities: increased muscle tone with opisthotonus, writer’s cramp with Trouseau sign, facial dystonia with Chvostek sign and difficult speech (due to facial dystonia) with patient illiteracy. All these similarities delayed the DRD diagnosis.

**566** **KLIPPEL TREUNANAY SYNDROME IN DIFFERENTIAL DIAGNOSIS OF CEREBRAL PALSY**

doi:10.1136/archdischild-2012-302724.0566

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In cerebral palsy (CP) atrophy of the paretic body half results in disturbed growth. Disturbed growth is also a feature of a rare disorder, Klippel Treunay syndrome (KTS). Here we report a child with an initial diagnosis of CP because of limping and thinning of the extremities on the right side who had a final diagnosis of KTS. Five year old male was admitted to our department of Pediatric Neurology. He had been followed up with the diagnosis of CP since he started walking because of limping and thinning of the extremities on the right side of his body. His prenatal and natal period was uneventful. Developmental milestones were normal. On physical examination hypertrophy of the left upper and lower extremities