Methods
neck.
drowsiness, the day before admission diplopia and pain associated
ing, no diarrhea, the next day associated dizziness, headache,
azithromycin. three days before entering a high fever, bilious vomit-
geal syndrome. six days ago began with fever being treated with
area.
Amplitude delta, acute, which are located in anterior and temporal
isolsone, yet this case was only solved after plasmapheresis cycle.
the treatment is immunoglobulin and pulse therapy with methylpred-
tations such as transverse myelitis. In most of tranverse myelitis cases
Conclusion
 Subsequently, a 5-day plasmapheresis cycle was iniciated, solving
the clinical case with an increasing recovering of motor and ventilation
function after 1 week of treatment.
Conclusion
 Enterovirus infections can cause several clinical manifestations
such as transverse myelitis. In most of transverse myelitis cases
the treatment is immunoglobulin and pulse therapy with methylpred-
nisolone, yet this case was only solved after plasmapheresis cycle.

Results
First treatment was initiated with 2 immunoglobulin’s cycles and pulse therapy with methylprednisolone not getting satis-
factory motor response. The patient developed with respiratory
and hypoventilation (PCO2 max - 90mmHg) becoming necessary to introduce a course of 5 days of non invasive ventilation. Subsequently, a 5-day plasmapheresis cycle was iniciated, solving the clinical case with an increasing recovering of motor and ventilation function after 1 week of treatment.

Conclusion
 Enterovirus infections can cause several clinical manifestations such as transverse myelitis. In most of transverse myelitis cases the treatment is immunoglobulin and pulse therapy with methylprednisolone, yet this case was only solved after plasmapheresis cycle.

Background and Aims
Nine year old boy admitted with menin-

Strikes disease, no rashes or petechiae.

Methods
 Hemogram: 13.24 leukocytes, neutrophils 87.4%
 Cerebrospinal fluid red blood cells 160/mmc 30/mmc polynu-
clear leukocytes 5%, lymphocytes 98%, Gram negative, PCR Herpes simplex I and II negative, negative enterovirus, varicella zoster negative. Negative blood cultures, Mantoux negative.
 Abnormal EEG tracing during wakefulness slow waves of high amplitude delta, acute, which are located in anterior and temporal area.

Conclusions
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 analysis 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 KLIPEL 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 disor-
der; Klippel Treunanay 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 extremi-
ties on the right side of his body. His perinatal and natal period was uneventful. Developmental milestones were normal. On physical examination hypertrophy of the left upper and lower extremities
with widespread port wine stain on his face, lower lip, arms, legs and trunk were noted. Brain magnetic resonance imaging revealed vascular malformations located periventricularly and adjacent to the corpus callosum. On brain magnetic resonance angiography ectatic, varicose deep veins (venous malformations) were detected. Lower extremity MRI showed hypertrophy of bones and soft tissues on the left side. As the child has capillary malformations (port wine stain), soft tissue and bone hypertrophy and vascular malformations a diagnosis of KTS was made. KTS consists of two major features; congenital vascular malformations and disturbed growth. For diagnosis presence of either capillary or venous malformations with disturbed growth of the bone or soft tissues is required. Children with the diagnosis of CP should be carefully examined for any finding suggesting a genetic disease.

**Background and Aims** Infants contribute about 5.25% of total poisoning exposures in humans. We report first case of infant to have survived Amlodipine intoxication.

**Methods** 11 month old infant received 12.5 times the maximum therapeutic dose of amlodipine as a result of a medication error. He presented with vomiting, lethargy, breathlessness, muffled heart sounds and progressed to hypotensive shock within hours of admission. He received mechanical ventilation, fluid therapy with normal saline and inotropes. Peripheral pulses remained feeble and blood pressure was 70/40 mm of Hg. High dose insulin infusion at 0.5 u/kg/hr was started simultaneously. To manage prerenal failure, oliguria and congestive cardiac failure calcium gluconate at 0.5 mEq/kg/hr was started simultaneously. The tumor was classified reduced to 448ms prior to discharge. QT c interval before surgery was 532ms and evidence of Horner’s syndrome post surgery. The patient was discharged 72 hours later. LQTS was also found to have LQTS. He had LQTS. He has had Long QT syndrome (LQTS) is a relatively common disease, however, it is rarely described in Black African patients. We would like to present a case of a heart patient who was treated with thoracoscopic left sympathectomy and 1/3 lower stellactomy.

**Methods** An 11-year old boy with sickle cell anemia (Hb 7.2g/dl) was also found to have LQTS. He had had >15 defibrillations in 5 years. He was on high dose beta-blockers but required a number of shocks despite it. Implantable defibrillator was rule out due to his home country lack of cardiac surgical expertise in case of complications. He was considered to be a suitable candidate for sympathectomy. This was done through a 3 trocar approach to the left upper chest. Sympathetic chain including stellate ganglion was exposed. 20mls of 0.5% lignoaine was sprayed over the ganglions. Prior to excision of sympathetic chain, all visible nerves traveling medially (to the heart) was excised with hook diathermy. Lower 1/3 of stellate ganglion as well as T2–T4 ganglia was resected en-bloc and submitted for histology.

**Results** There were no per- or post-operative complications and no evidence of Horner’s syndrome post surgery. The patient was discharged 72 hours later. LQTS interval before surgery was 532ms and reduced to 448ms prior to discharge.

**Conclusion** Sympathectomy including lower portion of stellate ganglion is a viable alternative for patient with LQTS.

**Background and Aim** Long QT syndrome (LQTS) is a relatively common disease, however, it is rarely described in Black African patients. We would like to present a case of a heart patient who was treated with thoracoscopic left sympathectomy and 1/3 lower stellactomy.

**Methods** An 11-year old boy with sickle cell anemia (Hb 7.2g/dl) was also found to have LQTS. He had had >15 defibrillations in 5 years. He was on high dose beta-blockers but required a number of shocks despite it. Implantable defibrillator was rule out due to his home country lack of cardiac surgical expertise in case of complications. He was considered to be a suitable candidate for sympathectomy. This was done through a 3 trocar approach to the left upper chest. Sympathetic chain including stellate ganglion was exposed. 20mls of 0.5% lignoaine was sprayed over the ganglions. Prior to excision of sympathetic chain, all visible nerves traveling medially (to the heart) was excised with hook diathermy. Lower 1/3 of stellate ganglion as well as T2–T4 ganglia was resected en-bloc and submitted for histology.

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