

the ganglioneuroma is surgically removed. The child was discharged with low weight heparine.

**Conclusion** Von Recklinghausen disease generally has a good prognosis. Major risks for morbidity and mortality are vascular complications. In case of pulmonary hypertension in these patients early diagnosis and sufficient therapy is essential to avoid major complications. Pulmonary embolism and NF as a cause for pulmonary hypertension has not been described before.

#### 571 MALIGNANT PERTUSSIS IN THE YOUNG INFANT: A CASE REPORT

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Infections by bordetella pertussis, has resurged in many countries around the world including developed regions. Where as new vaccination strategies for adolescents, pregnant women and adults have been recommended, mortality affecting young infants is still significant. Patients with severe cases present with extreme leukocytosis and develop refractory hypoxemia and pulmonary hypertension that is unresponsive to maximal intensive care.

**Objective** To report a case of malignant pertussis in a 4 weeks old infant.

**Design** a descriptive case report.

**Patient** a 4 weeks old boy was admitted to the intensive Care Unit with respiratory distress and a diagnosis of bronchiolitis. Both parents and a 19 months old sibling had upper respiratory infection symptoms. Four days before admission he started with coryza and cough. The cough was not paroxysmal and cyanosis and whooping were never present. He presented a marked leucocytosis with lymphocytosis. Respiratory failure occurred rapidly from the fourth day with subsequent deterioration due to the development of severe pulmonary hypertension and multiorgan failure which caused the infant's death after 4 days of intensive care therapy.

Although Bordetella Pertussis was not confirmed by PCR, culture or serology the findings on the autopsy were suggestive of malignant pertussis.

**Comments** mortality due to malignant pertussis remains superior to 75% regardless life support measures. Adults are the main source of contamination of non-immunized infants, thus immunization of older adolescents and adults who will have close contact with infants aged < 12 months is the most effective preventive measure.

#### 572 INTRACTABLE DIARRHEA FROM CYTOMEGALOVIRUS COLITIS IN AN IMMUNOCOMPETENT ADOLESCENT

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**Introduction** We reported CMV colitis in an immunocompetent adolescent who was critically ill with septicaemia and significant intractable diarrhea that responded to specific CMV treatment.

**Case** A 15-year-old boy who previously known hereditary spherocytosis was referred to our hospital because of anemia, increased transaminase level, and massive cholestasis. The abdominal ultrasonography was detected cholelithiasis, choledoch stones, and dilated proximally bile ducts. External biliary drainage tube was placed into the choledoch. On the following days, splenic rupture and sepsis developed. Therefore, the patient was underwent splenectomy and cholecystectomy. After closed of external biliary drainage tube, patient was developed severe dehydration and malnutrition due to watery stool. The colonoscopy and colonic biopsies was performed. It was shown macroscopic colitis and CMV intranuclear inclusion

bodies in rectosigmoid colon. Moreover, PCR for CMV DNA in blood (6142 copy/mL) and colonic biopsy specimens was positive. The immunologic screen tests were normal. Parenteral gancyclovir for 21 days and oral gancyclovir therapy was continued two weeks. The patient resolved completely, serum PCR for CMV DNA was detected negative after two months.

**Conclusion** CMV colitis, although rare in immunocompetent adolescent, should be considered in the differential diagnosis of severe colitis when other causes fail to explain the course of disease.

#### 573 UNCOMMON PRESENTATION OF UMBILICAL SEPSIS IN NEWBORN CAUSED BY HERPES INFECTION

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Herpes simplex virus (HSV) is a widespread pathogen. Comparatively neonatal HSV infections are rare but frequently severe with high mortality and morbidity. Early detection and treatment, has been shown to decrease the mortality significantly.

We present a rare presentation of neonatal herpes in an 8 day old neonate who presented with fever and pustules around the umbilicus. Baby was treated with intravenous benzylpenicillin and flucloxacillin. However, baby was still febrile after 48 hours of treatment with vesicular lesions now appearing around the umbilicus. There was no history of genital herpes or cold sores in family. Viral swab was taken and acyclovir started. Wound swab and blood PCR was positive for HSV 2. Lumbar puncture done at day 14 was clear. Baby was treated with two weeks of intravenous acyclovir. There were problems with intravenous access with difficult access and later central line causing thrombosis.

Baby represented at 5 weeks age with vesicular umbilical lesions and was treated with 2 weeks course of oral acyclovir.

Many issues were highlighted in this case.

Lumbar puncture was not done early on as umbilical sepsis was thought to be focus of infection. It was difficult to establish whether this neonate had CNS herpes.

Long term intravenous treatment is easily said than can be given. This neonate had difficult access; central line was not without complication. What is the best way forward?

The lesions recurred within 2 weeks of the baby going home. Suppressing Acyclovir therapy - Would it be beneficial for him?

#### 574 VARICELLA ZOSTER INFECTION COMPLICATED BY MENINGOCOCCAL MENINGITIS, SEPSIS AND SUBDURAL EMPYEMA IN AN INFANT, A CASE REPORT

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**Aims** To highlight possible and may be fatal complications of Varicella Zoster virus (VZV) infection.

**Method** We report a case of an infant with VZV infection who developed meningococcal sepsis, meningococcal meningitis, VZV encephalitis and subdural empyema.

**Results** A 3 month, previously well and developmentally normal male child was admitted with skin rash. He had contact with varicella zoster infection. His initial inflammatory markers were high. He was treated as Chicken pox. His blood culture grew *Nisseria Meningitidis*, treated with intravenous antibiotics. He remained unwell with poor response to antibiotics. A lumbar puncture was then performed. This revealed a picture consistent with bacterial meningitis. CSF PCR was positive for *N. Meningitidis* as well as for VZV. A week after admission he started to have seizures. This required intubation and PICU admission. A brain CT showed to