were absent in both lower extremities. Babinski’s signs were not noted. The Romberg sign was present. Magnetic resonans imaging (MRI) of the spinal cord revealed enhancing T2 hyperintensity within the spinal cord, from T10-L1. (Figure 1). Cerebrospinal fluid (CSF) showed no pleocytosis and normal protein and glucose concentrations. The CSF did not show oligoclonal banding and immunoglobulin (Ig)G index was normal. Serum serologic evaluation of Borrelia burgdorferi was positive for IgM but negative for IgG. CSF serologic evaluation was negative (both ELISA and Western blot). The patient was diagnosed as manifesting acute transverse myelitis. He was treated with intravenous methylprednisolone pulse therapy (1000 mg/day for 5 consecutive days), followed by oral prednisolone (1 mg/kg per day for 14 days for burrellosis).

**Conclusion** This case serves as a reminder that acute transverse myelitis can be a rare clinical manifestation of Lyme disease.

**Results** In the group receiving probiotics, mostly colonizing the stool cultures bacteria were Klebsiella spp, Escherichia coli, Enterococcus spp., Enterobacteriaceae spp., Staphylococcus spp. respectively, and in the group not receiving probiotic mostly colonizing the stool cultures bacteria were Klebsiella spp, Enterococcus spp., Staphylococcus spp., Escherichia coli, Enterobacteriaceae spp. respectively. When probiotic receiving group compared was with not receiving group, proliferation rate of stool cultures was higher in probiotic group. In the groups receiving and not receiving probiotic, proliferation of the nose cultures were similar. Increase in the proliferation rates of weekly stool cultures in probiotic receiving group was statistically significant but there was no statistically difference in the proliferation rates of nose and other cultures that were taken weekly. There was no statistical difference in both groups in the development of resistant organisms.

**Conclusions** The use of probiotics in neonatal intensive care unit for premature infants who received treatment with antibiotics, did not prevent the colonization of pathogenic microorganisms.

**Background** The empirical use of antibiotics in children with suspected meningitis is a common clinical practice worldwide that often leads to drug resistance. It is difficult to clinically differentiate bacterial when compared to viral meningitis until a culture study of cerebral spinal fluid (CSF) or CSF viral PCR study is performed. A ‘wait and see’ approach may lead to undesirable outcome. Bacterial Meningitis Score (BMS) is a tool that was developed to help physicians to differentiate between viral versus bacterial meningitis.

**Aim** To determine the usefulness if any of BMS for discriminating between bacterial or viral meningitis is young children.

**Methodology** We retrospectively reviewed the charts of all children (from birth till 14 years old) who were admitted with the diagnosis of meningitis to Hamad general hospital in last 2 years period. A total 120 patients (68% boys) with confirmed meningitis were reviewed during the study period. The mean age was (6.3±2.7) year. The majority of patients 112 (93.3%) had viral type meningitis while the remaining had bacterial meningitis (Strep Pneumia, Neisseria meningitis and H. Influenza). The sensitivity of BMS tool revealed a sensitivity of 100% (95% CI: 75.1 to 100.0) and a specificity of 60.9% (95% CI:50.1–69.7).

**Conclusion** Our study shows that BMS is a simple, easy and highly sensitive tool that can differentiate bacterial from viral meningitis and it is use may limit the use of unnecessary antibiotic s and hospitalizations.