Background and Aims  In September 2011 results of an audit on the acute management of SE in referring hospitals highlighting safety and feasibility of extubation in some children avoiding transfer to PICU were presented. We re-audited practice to determine whether education had an effect on local extubation rates.

Methods  Audit of referral forms with a diagnosis of “seizures”, “SE”, “fit/fitting,” “convulsion” and “epilepsy” from 1 September 2011 till 1 April 2012. Review of discharge summaries and notes of patients transferred to PICU.

Results  56 referrals for seizures (48 patients) in the 7 month period. At referral, 49 patients were intubated. 30 of 49 intubated patients were transferred to PICU, 19 extubated locally. 15 of 30 retrieved and 6 of 15 extubated patients had epilepsy.

Reasons for not attempting extubation included: ongoing seizures (2), Pectechial rash (2), transfer for expert opinion (1), previous failed extubation (2) and refusal to assess (2).

All patients managed locally extubated within 6 hours. Extubation in PICU was after < 6 (4), < 12 (7), < 24 (11) or >24 hours (3), data unavailable in 4.

1 patient was re-intubated locally because of further seizures.

Conclusions We found an increase in safe extubations: 18.9% prior and 38.7% after. This re-audit indicates that outreach education by PICU retrieval teams can achieve change in practice. It reconfirms that patients with SE transferred to PICU have a short duration of intubation. Refusal to assess feasibility of extubation by the local hospital can no longer be considered good medical practice.

The signal-to-noise ratio, i.e., $\Delta \text{rStO}_2 / S_w$, was 17.6, 14.5, and 12.5 for FORE-SIGHT, INVOS and NONIN, respectively.

Conclusion The different absolute values and dynamic ranges will make comparison of data collected with different devices difficult.

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<th>Table 2. Dynamic range of the NIRS devices</th>
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<td>INVOS</td>
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976 CYCLOSPORINE-ASSOCIATED THROMBOTIC MICROANGIOPATHY AND THROMBOCYTOPENIA-ASSOCIATED MULTIPLE ORGAN FAILURE: A CASE SUCCESSFULLY TREATED WITH THERAPEUTIC PLASMA EXCHANGE

Introduction  Thrombotic microangiopathy (TMA) is characterized by microvascular thrombosis, thrombocytopenia, and microangiopathic hemolytic anemia. Thrombotic thrombocytopenic purpura (TTP), hemolytic-uremic syndrome (HUS), and disseminated intravascular coagulation (DIC) are responsible from most of these cases. Secondary TMA syndromes are associated with sepsis/infection, cancer, transplantation, autoimmune diseases, and drugs. Studies showed that cyclosporine (CSA) is associated with TMA but the number of reported cases are very small.

Case Report  A 13-year-old girl was admitted to the pediatric intensive care unit (PICU) with multiple organ failure. She was diagnosed with polyglucan deficiency syndrome at an outside facility and had a history of celiac disease, autoimmune thyroiditis, and diabetes mellitus type I. CSA was started seven months before our PICU admission for persistent diarrhea. In PICU admission the patient was thrombocytopenic, anemic and she had multiple organ failure (renal, cardiovascular, hepatic, respiratory, and hemato logic). Laboratory and clinical findings were consistent with TMA and TAMOF. TTP, HUS, DIC, and sepsis ruled out. We thought that CSA was the cause of TMA and TAMOF CSA was stopped and five days of therapeutic plasma exchange (TPE) procedure performed. With TPE the patient improved clinically. Laboratory findings were normalized and after five days of TPE, TMA and MOF dissolved.

Conclusion  CSA can be associated with TMA and TAMOF. The most commonly used strategy in treatment is the discontinuation of CSA. The experience in this case indicates that TPE may be effective in treatment of CSA-associated TMA and TAMOF especially in the presence of systemic TMA and MOF.