Abstract PO-0228 Figure 1

Abstract PO-0228 Figure 2

Conclusions There should be higher access to information about RVGE and vaccination against it. Breastfeeding till age of 2 years may facilitate severity of RVGE.

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PO-0228 ATYPICAL PRESENTATION OF TUBERCULOSIS IN A PATIENT WITHOUT BCG VACCINE

¹J. Correa de Lacerda, ¹PLF Perinei, ¹AGN Reis, ¹DAG Ribeiro, ¹CHS Vasques, ²ACC Frota, ³CC Sant’Anna, ⁴ES Goudouris, ⁵RM Maron. ¹Unidade de Pacientes Internos, Instituto de Puericultura E Pediatria Martagão Gesteira Da Universidade Federal Do Rio de Janeiro, Rio de Janeiro, Brazil; ²Infectologia Pediátrica, Instituto de Puericultura E Pediatria Martagão Gesteira Da Universidade Federal Do Rio de Janeiro, Rio de Janeiro, Brazil; ³Pneumologia Pediátrica, Instituto de Puericultura E Pediatria Martagão Gesteira Da

Universidade Federal Do Rio de Janeiro, Rio de Janeiro, Brazil; ⁴Alergia e Imunologia Pediátrica, Instituto de Puericultura E Pediatria Martagão Gesteira Da Universidade Federal Do Rio de Janeiro, Rio de Janeiro, Brazil; ⁵Neurocirurgia Pediátrica, Instituto de Puericultura E Pediatria Martagão Gesteira Da Universidade Federal Do Rio de Janeiro, Rio de Janeiro, Brazil

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Background and aim Tuberculosis is a highly prevalent disease in Brazil, but cranial bone presentation are extremely rare. We describe a case report of atypical cranial bone tuberculosis in a tertiary care teaching hospital in Rio de Janeiro, Brazil.

Methods PHGR, 4 years age, male, caucasian, born and raised in Saquarema, RJ, Brazil. The patient was admitted in September 2013 with back pain, fever, spleen and liver nodular lesions. Multiple osteolytic lesions were also found, more importantly in C6, C7 and cranial bone. A hepatic biopsy showed granulomatous hepatitis. Due to the cervical severity lesions, an empiric treatment for tuberculosis with RIP (Rifampicine, Isoniaside and Pirazinamide) began. Sixty days after treatment progressive improvement of all osteolytic lesions except on the cranial bone and calcified spleen and liver granulomas were observed. A cranial bone biopsy showed new granulomas and BAAR were visualised. After 5 months of RIP treatment the cranial bone lesions began to fade. He had not received the BCG vaccine (Calmet-Guerrin Bacillus) despite of this being part of the official brazilian immunisation schedule. The child has also been evaluated for Mendelian susceptibility to mycobacterial diseases.

Results We present a case of multisystemic tuberculosis in a boy with cranial bone compromising.

Conclusions Widespread tuberculosis can be seen in children that do not receive the BCG vaccine.

PO-0229 CONGENITAL TOXOPLASMOSIS (CT) IN INFANTS FOLLOWING IN VITRO FERTILISATION WITH IMMUNOSUPPRESSION IN EARLY PREGNANCY, TWO CASE REPORTS

¹AM Deasy, ¹SMC Slattery, ²W Ferguson, ¹P Gavin, ¹KM Butler. ¹Paediatric Infectious Diseases, Our Ladies Childrens Hospital Crumlin, Dublin, Ireland; ²Infectious Diseases, The Rotunda Hospital, Dublin, Ireland

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Introduction In Ireland, 75% of pregnant women are seronegative for toxoplasma, making them susceptible to primary infection during pregnancy.

First case: A female infant was conceived by IVF. Her mother received high dose steroids, humira and intravenous immunoglobulin at the initiation of, and during early pregnancy. The infant was neurologically abnormal at birth, had marked ventricular dilatation, intracranial calcification and bilateral retinal detachments. CT was confirmed with infant toxoplasma IgG and IgM positive. Maternal serology was consistent with primary maternal infection during pregnancy. Despite anti-toxoplasma therapy, the infant succumbed at six months of age.

Second Case: A one-year-old girl was investigated for a convergent strabismus. Conceived by IVF, her mother received high dose steroids for the first four months of pregnancy. Developmentally normal, at nine months of age she developed a right strabismus. Dilated funduscopy revealed an extensive right macular scar. Neuroimaging showed intracranial calcification. Although toxoplasma IgM was negative, CT was diagnosed based on strongly persistent Toxoplasma IgG Ab, without evidence of

decline over time. Developmental progress has been reassuringly appropriate. The macular scar is currently inactive.

Discussion The recognition of these two cases, one lethal infection in the setting of primary infection and one possible reactivation disease in women receiving immunosuppressive therapy to facilitate assisted reproduction raises a number of issues. Neither women were aware of toxoplasmosis, their toxoplasmosis status or measure to prevent its acquisition in pregnancy. Women under going immunosuppression in pregnancy should be aware of their status and advised regarding preventative measures.

PO-0230 MANAGEMENT OF SEVERE MALARIA IN CHILDREN, AN AUDIT OF CLINICAL PRACTISE IN A RURAL HOSPITAL IN ZAMBIA

¹AM Deasy, ¹V Luneta, ²KM Butler. ¹Paediatrics, Monze Mission Hospital, Monze, Zambia; ²Paediatric Infectious Diseases, Our Ladies Childrens Hospital Crumlin, Dublin, Ireland

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Introduction The malarial mortality rate remains highest in African infants and children. The purpose of this audit was to review our clinical practice and to assess our compliance with the WHO guideline for the management of severe malaria.

Method A retrospective chart review of malaria cases over 14 weeks was undertaken. 43 cases of malaria in paediatric inpatients were identified.

Data extraction included duration and nature of presenting symptoms, clinical signs recorded, time to diagnosis, time to anti-malarial treatment and fluid management.

Results There were 43 cases of malaria, 20 males, 23 females, median age 3 years (3 mths - 12 years), median length of stay 4.3 days (1–11 days). 35/40 (80%) of these cases were classified severe malaria by WHO criteria. The overall mortality rate was 16.3%. 29/40 (73%) were diagnosed prior to admission: only 22 (55%) received a first dose of anti malarial drug within 4 h of presentation. 12% experienced significant diagnostic delays. No child received either normal saline or albumin bolus. 12% received a bolus of dextrose. 10 patients (25%) received blood transfusions. 30 patients (75%) received intravenous quinine, as artesunate, the WHO recommended first line for the treatment of severe malaria, is not currently available in our hospital.

Discussion Children hospitalised with malaria in rural Zambia continue to have unacceptably high mortality. This audit highlights the importance of urgent medical review, need for earlier diagnosis and prompt initiation of better antimalarial agents. Late diagnosis and lack of availability of artesunate were identified as potential significant contributors to the high mortality rates in this audit.

PO-0231 CARDIAC INVOLVEMENT, MAJOR PROBLEM IN HUMAN IMMUNODEFICIENCY VIRUS INFECTION IN CHILDREN

¹L Dimitriu, ²C Jitareanu, ³AG Dimitriu. ¹Pediatric Cardiology, Medex Medical Center, Iasi, Romania; ²Pediatric Cardiology, Children's Hospital, Iasi, Romania; ³Pediatric Cardiology, University of Medicine and Pharmacy, Iasi, Romania

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Objectives The present the main clinical aspects and diagnostic of cardiac involvement induced by human immunodeficiency virus infection in children.

Methods Patients: 51 children (2–16 years) with HIV infection/AIDS in various stages of evolution, with diverse symptoms affecting many organs. Evaluation of patients: clinical, ECG, Chest X ray, echocardiography (echo).

Results 60% of patients were included in group P2f clinical staging by clinical exam and CD4 lymphocytes values. Signs of cardiac involvement: heart failure (11 cases), tachycardia (20 cases), deafness of the heart sounds ± gallop rhythm ± systolic murmur of mitral regurgitation (12), dyspnea (14 cases), other non-symptomatic (14) or with signs of others diseases. ECG : disturbances of ventricular repolarisation. Rx. CT: cardiomegaly (30% cases) ± aspects of pulmonary infections. Echo exam: cardiac involvement (66% cases): dilated cardiomyopathy, the most severe changes (14 cases), pericarditis (10), isolated dilation of the left and right ventricle (6), LV diastolic dysfunctional (14 cases), pulmonary hypertension (6). The severity and incidence of cardiac disease was associated with significant reduction of CD4 value < 400/mm³. Histological exam (28 patients died by pulmonary infections): myocarditis, pericardial and myocardial inflammatory infiltration, necrotic lesions.

Conclusion By the high incidence (66% of cases) and severity of clinical manifestations, cardiac suffering during HIV infection/AIDS is one of the most important problems of these patients. Cardiological evaluation of patients is necessary in all the stages of the infection, even non-symptomatic, for the diagnosis and follow-up of evolution. Echocardiography is the most sensitive noninvasive method for highlighting cardiac damage in these patients.

PO-0232 WITHDRAWN

PO-0233 EVALUATION OF HOSPITAL MANAGEMENT FOR PARAPNEUMONIC EFFUSION IN CHILDREN

F Dubos¹, A Le Mee², C Mordacq², M Lagree¹, A Deschildre², A Deschildre², ¹A Martinot. ¹Pediatric Emergency Unit and Infectious Diseases R. Salengro Hospital CHRU Lille and University Lille Nord-de-France UDSL, Lille, France; ²Pediatric Pulmonology Unit Jeanne de Flandre Hospital, CHRU Lille and University Lille Nord-de-France UDSL, Lille, France

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Aim To evaluate the initial management of children with parapneumonic effusion admitted to all French university hospitals.

Methods A nationwide survey of all university hospitals (n = 35) took place in 2011 to assess practices for children with parapneumonic effusion, through a hypothetical clinical vignette and a standardized questionnaire. Two to four paediatricians per hospital were interviewed and asked about their initial management, probabilistic antibiotic therapy and its adaptation to microbiological results, additional treatment, and action in the absence of improvement. Answers of paediatricians working in emergency departments, intensive care units, and conventional paediatric units were compared.

Results Of the 100 paediatricians contacted, 95 responded: 98% would order an initial blood test, and 70% diagnostic thoracentesis. All would start immediate antibiotic therapy: 31% with a single drug, 67% with 2 drugs, and 2% with 3 drugs. The most frequent initial choices were third-generation cephalosporin alone (17%) or combined with rifampicin (33%) or vancomycin (24%). Adaptation varied according to drug used, dose, and duration, especially when the microorganism was not *S.*