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.

Part of the study “Clinical peculiarities of rotaviral infection, molecular epidemiology and health associated life quality for hospitalised children and their family members”, financially supported by Riga Stradins University.

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 PHGGR, 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 Baccilus) 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.

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 fundoscopy 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, 2V Luneta, 3KM Butler. 1Paediatrics, Monze Mission Hospital, Monze, Zambia; 2Paediatric Infectious Diseases, Our Ladies Childrens Hospital Crumlin, Dublin, Ireland

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 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

1A Dimitriu, 2C Ilieanu, 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

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

PO-0232 WITHDRAWN

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

F Dubé1, A Le Mesurier, 2C Mordaunt, 3M Lagare, 1A Deschildre, 2A Deschildre, 1A Martinot. 1Pediatric Emergency Unit and Infectious Diseases R. Salengro Hospital CHRU Lille and University Lille Nord-de-France USLD, Lille, France; 2Pediatric Cardiology Unit Jeanne de Flandre Hospital, CHRU Lille and University Lille Nord-de-France USLD, Lille, France

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.