

statistically insignificant. PFOS exposure and birth weight were associated in some studies, while others found no association.

Conclusions The literature suggests no consistent association between in utero exposure to PFOS and birth weight. However, exposure to PFOA is associated with decreased average birth weight in populations with high exposure levels. Considering the global exposure to PFCs, this calls for careful interpretation within a public health perspective.

PO-0353 LICHEN STRIATUS – CASE REPORT

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Background Lichen striatus is a common dermatosis that follows the lines of Blaschko. Aetiology of this eruption is unknown, its features are less known to paediatricians.

Objective We attempted to characterise the clinical, pathologic features and evolution of one case presented to the paediatric department in our clinic.

Materials and methods A 2-year-old girl, atopic, presented with fever and upper respiratory tract infection.

Clinical examination: one month long dull-red papulo-squamous dermatosis arranged in a Blaschko line. The eruption appeared suddenly a month ago. The skin lesions were asymmetrically distributed linearly unilateral along the left arm, arranged in a Blaschko line pattern. Intense itching was present in this case.

Laboratory results: Hb = 12,6 g/dl, Ht = 35,2%, WBC = 9400/ μ L, S = 25%, Eo = 2,5%, Ba = 0,745%, Ly = 71,1%, RBC = $4,38 \times 10$ mil/ μ L, PLT = 336000 μ L, ALT = 23 U/L, AST = 31 U/L, CRP = 0,6 mg/dL; Creatinin, Immunogram, Glucose –normal; HIV 1 + 2, Ag HBs, Anti HCV-negative

Histopathology revealed features consistent with lichen striatus.

Treatment for itchy lichen striatus consisted in topical steroid application (mometasone furoate 1% cream once daily for two weeks).

Five months later, complete resolution of the skin lesions occurred without any other treatment, leaving only slightly hypopigmented macules on the left arm.

Conclusion

1. That lesions of lichen striatus may have a prolonged active phase, the differential diagnosis includes other inflammatory diseases that can assume a linear pattern, paediatrician and dermatologist must team up in these cases;

2. Post-inflammatory hypopigmentation can be a cause for concern for the parents and their children.

PO-0354 CHRONIC BULLOUS DISEASE OF CHILDHOOD (CBDC) OR LINEAR IGA DERMATOSIS

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Introduction Linear IgA dermatosis is an autoimmune bullous disease characterised by the presence of linear deposits of IgA in the dermoepidermal junction. Predominates in the first decade of life. It produces blisters that tend to be distributed in rings or cluster of jewels.

Case Report 4 year old boy with generalised bullous lesions on face, trunk and limbs, which are grouped in rings. No palmo-plantar involvement or mucous membranes with good condition. 10 days before diagnosed of chickenpox. He had also been treated with amoxicillin- clavulanic acid for otitis media.

On suspicion of bullous impetigo he was hospitalised. Paediatric dermatology oriented probable diagnosis, bullous disease linear IgA dermatosis type vs bullous pemphigoid and practiced skin biopsy. Initial treatment oral prednisone at doses of 1 mg/kg and topical mupirocin.

Results Direct immunofluorescence confirmed the linear IgA deposits at the dermoepidermal junction. Sulfone (1,3 mg/kg) was added to oral corticosteroid treatment, in order to remove corticosteroids at long-term. Three months later the child is in remission from his lesions. The evolution will determine whether it can be considered a case of primary or secondary CBDC, primary cases tend to recur in months or years

Conclusions We present a case of a child with typical lesions of CBDC, with good response to steroids and sulfone.

At the time of diagnosis he was treated with amoxicillin- clavulanic because of infectious process. There are reported cases of CBDC secondary to viral, bacterial processes and drugs, such like amoxicillin and clavulanic.

PO-0355 HENOCH-SCHÖNLEIN PURPURA: CLINICAL COURSE TO 6 MONTHS OF FOLLOW

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Background and aims The Henoch-Schönlein Purpura (HSP) is the most common of small-vessel vasculitis in children, with an annual incidence of 20.4/100.000 in <17 years. The pathogenesis is unknown, but exposure to various antigens (infectious agents, vaccines, drugs) is considered as a possible immune factor trigger.

Methods Retrospective descriptive study by review of medical records of patients diagnosed with HSP between 2002–2013, and followed in rheumatology consultations for at least 6 months.

Results 119 children with a mean age at diagnosis of 6.1 years (range 1–14 years) were controlled.

Symptoms, blood pressure and urine dipstick were recorded at baseline and monthly during six months.

A previous infectious process was observed in 43 cases (36%): 10 streptococcus, 1 EBV, 2 Mycoplasma, 2 adenovirus and one parvovirus.

Purple was the first clinical sign in 90%. Of extrarenal symptoms, arthralgia appeared in 40 (33.6%) patients during follow-up, affecting more frequently ankles and knees (84%). The scrotal oedema occurred in 4 children, 2 had oedema of scalp and one on the sacrum. The abdominal pain was present in 18 cases (15%), 6 with ultrasound suggestive of intestinal wall vasculitis. The isolated microscopic hematuria was seen in 18 cases (15%), presenting normal blood pressure, 3 of these patients developed nephropathy in the next 2 months.