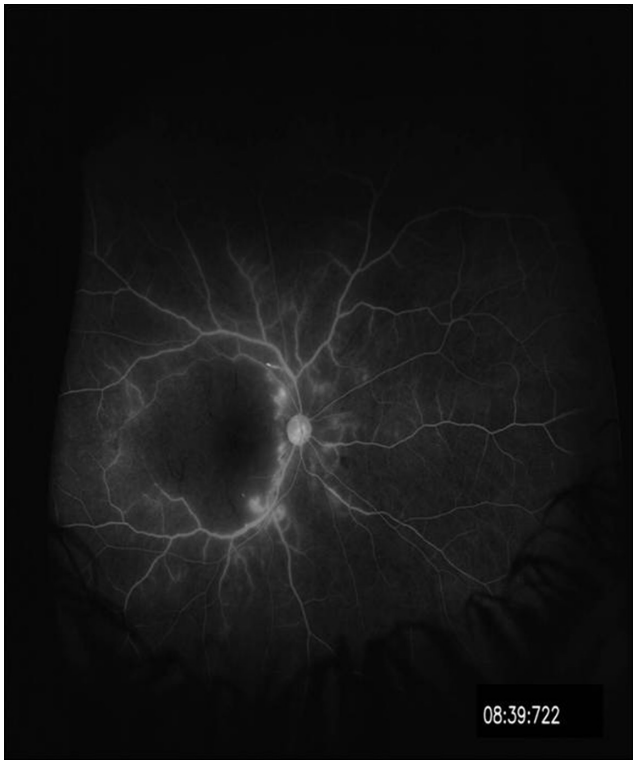

Abstract 134 Figure 1

done that revealed capillary 'drop-out', vessel wall staining and leakage of dye. (Figure 1) He had antinuclear antibodies (4+ speckled pattern). A diagnosis of SLE with isolated retinal involvement (vasculopathy) was considered. In view of severely impaired visual acuity, he was managed with injection cyclophosphamide (followed by maintenance mycophenolate mofetil) and pulse methylprednisolone (followed by oral prednsiolone). One year on follow up, his visual acuity has improved to 6/60 in both eyes. Repeat FFA revealed significant decrease in the non perfused areas of retina.

Conclusions Eye involvement in paediatric lupus is underecognized entity and may need aggressive therapy.

135 SKIN PEELING AND IRRITABILITY IN A YOUNG BOY WITH SYSTEMIC LUPUS ERYTHEMATOSUS- IS THERE AN OVERLAP WITH KAWASAKI DISEASE?

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Background and Aims Juvenile systemic lupus erythematosus (SLE) and Kawasaki disease can have several overlapping clinical and laboratory manifestations. But the co-occurrence of both disorders is extremely uncommon.

Methods To report the case of a young boy who had features of both SLE and KD

Results A 5 year old boy presented with fever for 2 months associated with photosensitive malar rash, oral ulcers and myalgias.On examination, he was irritable, had malar rash, a generalised erythematosus macular rash, oral ulcers, red and vertically cracked lips, redness of bulbar conjunctiva, cervical lymphadenopathy and hepatomegaly. Laboratory investigations are summarised in Table 1. All infectious disease workup was normal. He had hypocomplementemia, positive ANA, anti dsDNA and anti-nucleosome antibody. He was diagnosed as SLE and initiated on oral prednisolone. Fever subsided, transaminitis and leucopenia showed gradual recovery. One week later developed periungual skin peeling and he remained irritable. Laboratory investigations showed anaemia, thrombocytosis, persistently elevated ESR and high CRP (Table 1) A diagnosis of incomplete KD was proffered. He was given intravenous immunoglobulin (IVIG) (2 gm/kg), which led to prompt improvement in his irritability. He was initiated on aspirin (3 mg/kg/day) and continued on oral prednisolone. Aspirin was discontinued 6 weeks later after confirmation of normal coronary findings on echocardiography. Beau's lines were noticed in the finger nails at this time. At 3 months follow-up, he continues to remain well. Serum transaminases, platelet counts, ESR and CRP have normalised. (Table 1)

Conclusions Overlap of KD and SLE is extremely uncommon. (Table 2)

Abstract 135 Table 1 Laboratory investigations

Investigation / Day of Admission	Hemoglobin (gm/L)	White blood cell count ($\times 10^9$ cells/L)	Differential counts (P/L/M/E)	Platelet counts ($\times 10^9$/L)	ESR (mm in 1st hr)	CRP (mg/L)	AST/ ALT (U/L)
Day 1	76	3.3	30/60/8/2	292	52	82	182/73
Day 5	70	4.1	21/69/9/1	269	83	-	816/287
Day 9	76	7.3	54/38/6/2	225	-	-	456/286
Day 21*	83	14.9	45/35/9	510	61	16	88/139
Day 60	100	13.6	49/41/9/1	400	40	4	36/45

*IVIg was administered on day 21

Abstract 135 Table 2

Sr. no.	Author and year	Age/Sex	Interval between diagnosis of KD and SLE
1	Laxer et al (1988)[4]	5 years/F	3.5 years (KD diagnosed before SLE)
2	Diniz et al (2012)[3]	4 years/F	1 year (KD diagnosed before SLE)
3	Diniz et al (2012)[3]	13 years/F	Simultaneous
4	Present case (2016)	5 years/M	Simultaneous

Abbreviations- KD- Kawasaki disease; SLE- systemic lupus erythematosus

136 NEUROPSYCHIATRIC LUPUS WITH HEPATITIS IN A CHILD WITH CMV CO-INFECTION: IS CMV A SIMPLE BY-STANDER?

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Background and Aims Cytomegalovirus (CMV) infection at first presentation in paediatric SLE (pSLE) is a rare phenomenon.

Aim- To report an adolescent girl with SLE presenting with neurological and hepatic manifestations and CMV co-infection.

Methods A 12 year old girl presented with history of fever, maculopapular rash over the trunk, malar rash and jaundice.

Abstract 136 Table 1 Laboratory investigations

Investigation	Result
Hemoglobin (g/L)	87
Leucocyte counts (x 109/L)	6
Platelet counts (X 109/L)	20
Urea/creatinine	15/0.6
Serum protein/albumin	5.8/2.8
Total bilirubin/ direct	13/12
AST/ALT/ALP	1650/120/45 5
PTI	50%
aPTT	57 (<28)
ANA	3+ (homogenous)
Anti-dsDNA	733 IU/ml (<40)
C3 C4	68 (50-150) 6 (20-50)
DCT	Anti-IgG +, C3d -
APL work up	negative
Serologies for HAV, HCV, HEV, HIV, EBV	negative
CMV PCR	8160 copies/ml
Anti-LKM/ SMA/ PCA	negative
MRI Brain	Cerebral atrophy
CSF examination	No evidence of meningitis HSV DNA PCR, CMV PCR - negative

(DCT – Direct Coombs test, APL- anti-phospholipid, HAV- Hepatitis A, HCV- Hepatitis C, HEV- Hepatitis E, HIV- Human Immunodeficiency Virus, EBV – Epstein Barr Virus)