Findings: Of the 76 cases, 70 infants fully cooperated with researchers. The number of male and female patients in case and control groups was, 19 versus 16 and 18 versus 17 respectively. The results revealed significant difference between two groups in lowering fever at 4, 5, 7 and 8 hours after treatment was initiated, but there is no significant difference at 2 hours after drug was administrated..

Conclusion: An alternating treatment of acetaminophen (15mg/kg) and ibuprofen (10mg/kg) 4 hours later is more effective than acetaminophen in lowering fever in infants 9 to 24 months old.

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IN INFANTS WITH AN INITIAL DIAGNOSIS OF TRANSIENT HYPOGAMMAGLOBULINEMIA OF INFANCY (THI), IS THE USE OF IV IMMUNOGLOBULIN WARRANTED?

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Introduction: THI is a defect in a child's endogenous immunoglobulin production. It presents early following the physiological catabolism of the remnants of maternal immunoglobulin, transferred trans-placentally during the course of pregnancy. Physiological hypogammaglobulinemia normalises by 2-4 months. However during prolonged THI; the infant is rendered susceptible to a range of bacterial infections. In severe cases intravenous immunoglobulin-G (IV-IgG) replacement therapy has been proposed as treatment.

Objectives: To analyse current experimental literature in order to assess the suitability of IV-IgG therapy for patients diagnosed with suspected THI. Assessment of therapeutic use of IV-IgG from retrospective case controls. Further qualification of when to use IV-IgG by assessment of additional factors: symptomatology, time to normalisation of immunoglobulins and comparison with other immunodeficiency syndromes.

Methods: *PubMed* - searched with MeSH term "hypogammaglobulinemia"; "transient hypogammaglobulinemia infancy", "hypogammaglobulinemia IVIg", "paediatric hypogammaglobulinaemia".

Results: Antibiotics are first-line treatment for recurrent infections. IV-IgG replacement therapy is not routinely warranted for symptomatic THI. Cases where infections are severe/resistant to conventional management, IV-IgG therapy can be considered.

Other primary immunodeficiencies requiring IVIG therapy present similarly to THI as recurrent infections. In contrast THI is self-resolving with a benign clinical progression if managed appropriately;

Conclusion: Most children with THI do not require IV-IgG, with the exception of severe life-threatening infections or ongoing bacterial respiratory infection despite prophylactic antibiotic therapy. In these circumstances trials of IV-IgG for 6-12 months are indicated.

There are no published studies that comprehensively assess the cost-effectiveness of IV-IgG replacement in any healthcare setting for THI.

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DISCREPANCY BETWEEN INTERFERON GAMMA RELEASE ASSAY AND TUBERCULIN SKIN TEST FOR DIAGNOSIS OF LATENT TUBERCULOSIS INFECTION IN BCG VACCINATED CHILDREN

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Background and aims: Tuberculosis is one of the major health problems in the world. Interferon gamma release assay (IGRA) is a novel tool for Mycobacterium tuberculosis infection diagnosis. The aim of our study was comparing the TST and human PPD based IGRA for diagnosing Latent tuberculosis infection (LTBI) in BCG vaccinated children.

Methods: Between august 2006 and may 2007 a total of 242 children aged 1month to 168 months (mean 21 months)whom admitted to different wards of Mofid children hospital and met the inclusion criteria were enrolled in a cross sectional study with sequential manner. Each patient was tested with both TST and human PPD based IGRA.

Results: 28 (11.6%) had indeterminant, 123 (50.8%) had positive and 91 (37.6%) had negative results with IGRA. 12 (5%) had positive and 130 (95%) had negative results With TST. The overall agreement between TST and Quantiferon was %43.5 ($\kappa=0.004$, $P.V.=0.87$, $SE=0.03$). With increasing age, the probability of TST positivity decreased but was not statistically significant ($P_v: 0.25$, $Beta:-0.012$). Also with increasing age, the probability of IGRA positivity was increased but was not statistically significant ($P_v:0.54$, $beta:0.002$).

Conclusions: There may be discrepancy between human PPD based IGRA and TST results in BCG vaccinated children.

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CONSIDERATIONS ON FIVE CASES OF NEWBORNS FROM A/H1N1 INFECTED MOTHERS

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Introduction: A/H1N1 virus influenza represents a global health issue, causing more than 17000 deaths so far. The purpose of this paper is to present five cases of newborns from A/H1N1 infected women and the evolution of clinical aspects in mother-child couples.

Material and methods: The authors analyzed the evolution of clinical, biological, inflammatory parameters and the A/H1N1 viral detection tests of the mothers' nasal secretions.

Results: There have been five cases of newborns from A/H1N1 infected women between November 2009 - February 2010 in our Centre.

Mothers' disease had the clinical aspect of viral infection. In all cases, the virological tests detected A/H1N1 virus in nasal secretions. Two women presented influenza symptoms which started 2 and 3 weeks, respectively, before the extraction of the foetus. Despite prolonged mechanical ventilation, they died shortly after surgery. Three women needed CPAP, with favourable outcome.

The newborns' mean gestational age was 35 weeks. All newborns (3 males, 2 females) were extracted by caesarean section. Apgar scores were 5-8 in 4 cases and 2 for one newborn which needed complex resuscitation at birth. Two newborns developed congenital pneumonia-like clinical and radiological

signs. The virological tests did not detect A/H1N1 virus in the nasal secretions of the newborns. The outcome of the newborns was favourable in all cases.

Conclusions: A/H1N1 virus infection caused the early extraction of the foetus. The delay of the caesarean section caused a poor outcome for the mother. The newborns had negative viral detection tests and a slowly favourable outcome.

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FEVER IN PEDIATRIC LIVER TRANSPLANT RECIPIENTS: WHAT DO YOU DO?

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Background: Fever in the pediatric after a liver transplant indicates a variety of things. There is no doubt this is an important and frequent occurrence. In our experience, it takes place more frequently in younger children at the time of the transplant and even more within the first year of the transplant. The immunosuppressive therapy has been massively used in this timeframe. Family members receive education to immediately report to the Center of reference these symptoms.

Goals: To create a team and nursing protocol for an appropriate approach when children after liver transplant report fever to identify the etiology and set the right therapy- to prevent mayor complication and assure a best quality of life for the patient

Interventions: The paediatric patient contact us reporting fever for more than 24 hours undergoes a number of blood tests and consults, after a global and thorough nursing assessment at the time of admission at the hospital. After the general assessment following the indication of the protocol. The process ends with a meeting with all the clinical team members.

Outcomes: We identify how to treat them, to guarantee to the patient the best level of care based on the needs of the children. Up until now we have established this approach for 40 children: 32 of them required a hospital admission. 34 had an infection as etiology of the fever symptom and 6 a rejection. The etiology diagnosis took place within the 72 hours, this guarantees a timely, specific therapy.