myalgia/neurodevelopmental delay/torticollis/facial palsy/sensory defects/flaccidity were eloquently featured.

Anatomical complexities/overlapping effects of BPs rendered classifications oversimplistic, however, an adducted arm /an internally rotated shoulder/a pronated fore arm/a decreased elbow flexion/the presence of a grasp but not a biceps reflex/normal hand (ROM) but no Moro reflex/ nosologically consistent with EDBP(n=34), whereas normal shoulder/elbow use, but hand/fingers palsy/ Horner's syndrome consistent with DKBP (n=4)/ overlapping features(n=10),Predominantly,rapid recovery suggested prognostically excellent neuropraxic sequences, whereas, occasional fibrosing, neuromatous compressive phenomena portended delayed recovery. For other subsets, accidental unbalanced differential traction during infant minding, misguided child's play or motoring related ATI (n=16)were significantly implicated precedents suggestive of a disruptive-avulsive

pattern, auguring delayed residual resolutions. Intractable defects despite specific evaluations/ physico-stimulatory interventions implied progression to advanced electrophysiology/imaging, neurolysis, explorative/ reparative interventions or electromyoneurography/novel therapeutic modalities.

Conclusions/importance: The analytic epidemiology of BP is dynamically variable. Experientially, dystocias are important antecedents. Characterizing estimates/patterns of BPs proffers apposite figures for research directions/specific deterrent interventions.

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AN OVERVIEW OF THE HETEROGENEITY AND COMPLEXITIES IN THE PATHOBIOLOGY,MOLECULAR MECHANISMS, NATURAL HISTORY AND INTERVENTIONS IN PAEDIATRIC MYASTHENIA GRAVIS(MG).

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Background/purpose: Originally described by Thomas Willis (1621-1675) (MG) results from a postsynaptic impairment of neuromuscular transmission resulting in abnormal muscle fatigability following repeated stimulations due to immune mediated deficiency of AchRs/ectopic

thymic elaboration of (CXCL13).Anecdotally, JMGs were autoimmune related, CMGs were genomically determined, hence elevated AchRantibodies were non/universal. Recognised MG subtypes include/ Neonatal/AcquiredMGs/Congenital Achdeficiency ArthrogrypticMGs/Familial Fast/slow Channelopathies/Congenital OcularMGs / Ocular MGs/ latent general MGs (LGMGs) of / Limbgirdle MGs. Ongoing concerns suggests that its childhood incidence is considerably higher than was previously reported. This paper, proffers a single referral centres experience with ChildhoodMGs Methods,Cases/Interventions:

A prospective observational case series study.

Results: 24 Cases overall, Females(n=19)Ocular MGs (n=7) Juvenile MGs, (n=4), Congenital MGs (CMG), (n= 6), CMG with arthrogryposis (n=3) Ocular autoimmune with thyrotoxicosis (n=4), generalized autoimmune MGs with thyrotoxicosis (n =3) Lateralised ocular involvement in MG previously thought to be an unusual phenomenon were commonly featured in all subsets. All cases achieved the primary outcome measure of correction of blepharoptosis with a functionally/cosmetically acceptable increase in the interpalpebral fissure height precluding progressions to invasive interventions / thymectomy /single fibreEMGs/ immunomodulation/plasmapheresis. In older children progressive muscle weakness on repetitive muscle action improved. Steroid responsiveness were uniformly satisfactory/a rapidly regular phenomenon in the non-autoimmune subsets, whereas, it was previously considered an unusual phenomena /made case reports. There were no Myasthenic/Cholinergic crisis.

Conclusion/importance: Against previous inferences,age/steroid responsiveness may not be very robust supportive criteria for differentiating JMG/ CMG/other subsets.

These results may provide further insights into pathogenesis /clinical evaluations /

Future specific research directions/ interventions.