Abstract IDDF2019-ABS-0015 Figure 1 Amino acid profile

Samples were drawn for hemoglobin, Ferritin, Proteins, Albumin, lipid and amino acid profile at enrollment. GFD was introduced with diet charts and counselling sessions. Children were followed up at 1,3 and 6 months. Change in biochemistry at the end of 6 months was analyzed

Results In our study the mean age of presentation was 74 months, youngest being 19 months old. 50.9% of the patients had classic malabsorptive symptoms, 25% had refractory anemia, 13% short stature and 11% were diagnosed on sibling screen. Notable associations included Autism spectrum disorder, enamel hypoplasia and atopy. At presentation, 84% of patients were anemic, 9.85% were severely anemic. After 6 months of treatment none had severe anemia (<8g/dl), though 74% remained anemic with a significant change ($p=0.045$). Significant improvement in ferritin ($p=0.0001$), protein ($p=0.002$) and HDL levels ($p=0.02$) was observed. We observed significant ($p=0.006$) increase in citrulline, fall in alanine ($p<0.0005$), valine ($p<0.0005$), proline ($p=0.0005$) and lysine ($p=0.004$) levels during follow up as shown in figure 1 (figure.1).

Conclusions Significant Improvement in anemia and ferritin levels on the basis of dietary modification alone emphasizes the role of intestinal malabsorption in children with CD. Change in Protein and HDL levels signify cardioprotective role of GFD in celiacs with deranged lipid profile. Marginal though a significant rise in plasma citrulline levels strongly supports citrulline's role as a marker of enterocyte mass recovery in CD. We conclude that it takes at least 6 months of GFD to show significant improvement in nutritional parameters in children with celiac disease and follow up should be planned accordingly.

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ENTERIC FEVER IN TWO SIBLINGS WITH MANIFESTATIONS OF SEVERE HEMORRHAGE AND SHOCK

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Background Enteric fever is an infectious disease caused by *Salmonella typhi*, seen more common in developing countries. It can affect almost any organ systems of the body, and there are occasional reports in the literature of patients presenting with severe hemorrhage & very rarely of both hemorrhage and shock. Here we are presenting cases of two siblings, both of them suffering from enteric fever simultaneously, presenting with severe multiple site hemorrhage, shock and with severe thrombocytopenia

Methods Two siblings admitted were observed for signs and symptoms with investigations.

Results Sibling 1- An 11-year-old boy was admitted with complaints of fever for 8 days, decreased oral acceptance for 5 days, abdominal pain, vomiting and skin rashes for last 3 days. His HR was 100/min, RR 24/min, BP was 60/40. There were multiple petechial rashes over face and extremities. On per abdominal examination, he had Hepatosplenomegaly. The patient was given IVF, Ionotropes and Antibiotics. Hb was 9.4 gm/dl, TLC- 5600 and platelet count 2.5 lacs. PT/APTT was normal. On day 4 child developed melena and hematuria with a platelet count fallen to 40,000 and Hb 9 gm/dl so platelet and PRBC transfusion given in view of hemorrhage. Meanwhile, blood culture found positive for salmonella typhi sensitive to ceftriaxone, azithromycin and ciprofloxacin. On day 5, tab azithromycin added in v/o persistence of fever with ceftriaxone. On day 7 child became afebrile.

Sibling 2- A 8-year-old younger sibling of the above case admitted with complaints of fever, pain in the abdomen, petechiae over face for 15 days. Her HR was 108/min, RR 28/min, and BP was 70/54. Multiple petechial rashes present. Hepatosplenomegaly was present. Hb 9.5 gm/dl, TLC- 5100 and platelet count 1.65 lakh. S. Widal was positive, patient managed similarly and discharged on day 9.

Conclusions We kept the diagnosis of viral hemorrhagic fever in these cases with suspicion of enteric fever and by starting treatment for the same, we were able to salvage our patients. Thus in patients presenting with manifestations like shock and hemorrhage, a possibility of enteric fever should always be kept.