Turkish National Pediatric Society
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68th Turkish National Pediatric Congress

1st International Turkish National Pediatric Society (TNPS) Congress

23rd National Pediatric Nursing Congress

20-24 November 2024
Titanic Deluxe Belek-Antalya

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On behalf of the Local Organization and the International Scientific Committees, it gives us great pleasure to invite you to the **68th Turkish National Pediatrics Congress and 1st International Turkish National Pediatrics Society (TNPS) Congress**, scheduled to take place at Titanic Deluxe in Belek, Antalya from November 20 - 24, 2024.

We are proud to inform you that this year we are organizing the very 1st International Turkish National Pediatrics Society Congress in, which scientific content will include lectures by world-known clinical experts and researchers. Topics of discussion will span the entire pediatric field. The congress will bring together scholars from Italy, Croatia, Romania, Azerbaijan, the Turkish Republic of Northern Cyprus, Uzbekistan, Egypt, Jordan, Russia, Cyprus, Iraq, and the Republic of North Macedonia. The official languages of the Congress are Turkish and English, and simultaneous translations will be provided.

The congress will feature conferences, panels, expert consultations, as well as oral and poster presentations, along with courses covering fundamental topics and issues concerning pediatric health. It is our belief that by providing a platform for exchange and debate, we can inspire future pediatricians.

In addition to the acquisition of cutting-edge pediatric knowledge, we anticipate that you will also create long-lasting professional connections at our congress. We believe our program, set in the captivating Belek region, will also be one that you will not soon forget.

We extend our heartfelt regards and we look forward to welcoming you to Antalya in November.

Prof. Dr. Enver Hasanoğlu
President of the Congress

Prof. Dr. Yıldız Camcıoğlu
President of the Turkish National Pediatrics Society

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** Listed alphabetically by last name.*

POSTER PRESENTATION

PP-004

A Rare Case of Tuberculous Appendicitis Presenting with Perforated Appendicitis

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Introduction: Tuberculosis is a major global health issue, impacting 10.6 million people worldwide. In Turkey, there were 12,000 new and relapsed cases reported in 2022, resulting in an incidence rate of 14 cases per 100,000 individuals. Extrapulmonary tuberculosis occurs in 20–30% of patients, with bone, genitourinary tract, and perihilar lymph nodes being common sites of involvement. Tuberculous appendicitis is a very rare extrapulmonary manifestation of tuberculosis. In this work, we present a child with acute isolated tuberculous appendicitis presenting with perforated appendicitis

Material and Method: none

Results: none
Conclusion: A 14-year-old male presented with acute abdominal pain and fever. His medical history was unremarkable, and he had no symptoms of gastrointestinal or pulmonary issues. Physical examination revealed weakness, right lower quadrant tenderness, and rebound tenderness. Blood tests revealed leukocytosis with a count of 16.360/uL with neutrophilia (12.597/ uL). C-reactive protein was elevated to 12.7 mg/L, Abdominal ultrasound identified a swollen appendix with wall thickening and an abscess-like area. An appendectomy revealed a ruptured appendix with a mass-like formation inside and several mesenteric lymph nodes. The patient was initiated postoperatively with intravenous metronidazole and sulbactam-ampicillin. Pathological analysis showed granulomas and mucosal lymphoid tissue hyperplasia. Sputum tests confirmed the presence of acid-resistant, isoniazid-resistant Mycobacterium tuberculosis. Thoracic tomography, abdominal MRI, and colonoscopy results were normal. The patient was diagnosed with isolated tuberculous appendicitis and started on a 6-month antituberculosis treatment course. Follow-up showed no active tuberculosis signs and a stable clinical condition. This case highlights that appendicitis can be an initial sign of tuberculosis without pulmonary symptoms and underscores the importance of histopathological evaluation for diagnosis.
Histopathological view

Keywords: fever, perforated, tuberculosis, appendicitis

PP-005

The New Problem of Clinicians in the Globalizing World: Fever Etiology; Different Geographies, Different Factors

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Introduction: Malaria, caused by Plasmodium species and transmitted by Anopheles mosquitoes, is characterized by periodic fever. The World Health Organization (WHO) reported 247 million new malaria cases and 619,000 deaths in 2023 [1]. In Turkey, malaria is one of the most frequently imported infectious diseases, with 200-250 cases annually [2]. Despite decreasing incidence due to eradication efforts, the potential for malaria transmission exists in non-endemic regions, particularly through travel and immigration. The purpose of this case is to highlight the necessity of obtaining travel history in patients presenting with fever.

Material and Method: A 7-year-old male with no significant medical history was admitted to the pediatric emergency clinic with fever and vomiting lasting two days. His fever peaked at 39°C, occurring every 4-6 hours despite antipyretics. Vomiting recurred post-meals without diarrhea. Due to weakness, lack of oral intake, and persistent fever, he was referred to the infectious disease clinic. Physical examination revealed hepatosplenomegaly, and laboratory tests indicated leukopenia (3.3x10^9/L), thrombocytopenia (81x10^9/L), and elevated liver enzymes (AST 146 U/L, ALT 88 U/L). Notably, the patient had traveled to Africa two weeks prior, visiting Zanzibar, Tanzania, Burundi, and Rwanda. Despite receiving malaria prophylaxis advice, the family chose not to use it. Given the travel history and clinical findings, malaria was suspected. Blood samples were sent to the Turkish Public Health Agency, revealing banana-shaped gametocytes and young trophozoites, consistent with Plasmodium falciparum.

Results: Treatment with Artemether/lumefantrine (20mg/120mg) and primaquine was initiated. Fever resolution was noted within the first day of treatment. Daily peripheral smear examinations showed no parasites by the 72nd hour. The patient completed a three-day course of Artemether/lumefantrine and a 14-day course of primaquine. He was discharged on the eighth day, with a plan for an additional six days of oral primaquine.

Conclusion: In an increasingly globalized world, clinicians must consider non-endemic fever etiologies, particularly in Turkey. A thorough patient history, including travel details, prophylaxis adherence, animal contact, and dietary factors, is essential for accurate differential diagnosis.

Keywords: fever, Malaria

PP-006

Congenıtal Glucose-Galactose Malabsorptıon: Slc5a1 Mutatıon / Case Presentıng Wıth Hypernatremıc Dehydratıon

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Introduction: Glucose/galactose malabsorption is a rare autosomal recessive disorder caused by a defect in glucose and galactose transport.Patients with GGM present with neonatal onset of severe life-threatening watery diarrhea and dehydration.

Material and Method: A two-month-old male patient, born at term by C/S weighing 3625 grams and the first and only living child of the family, was admitted to our pediatric emergency department with suffered from restlessness, abdominal distension, fever, and decreased sucking. There was a consanguineous relationship between the parents. On physical examination, general condition was poor, turgor was decreased, tone was decreased and he appeared weak and pale. His consciousness was sleepy and he appeared severely dehydrated. Blood pressure: 87/50, SPO2: 96, pulse: 230, temperature: 39.5. Weight was -0.81 SDS. Other system examinations were normal. A severe hypernatremic dehydratyon was documented with lab tests.The patient was admitted to the pediatric intensive care unit due to hypernatremic dehydration. During follow-up, oral intake was stopped, and hydration was maintained based on sodium levels. The patient continued to have watery diarrhea, with 24 diapers per day, and acholic stool was observed. A watery stool discharge was observed during rectal examination. Stool was acidic with a pH of <6. Anti-endomysium and tissue transglutaminase antibodies were normal. Fractionated sodium and urinary osmolality were normal.Metabolic tests were interpreted as normal. Stool culture showed no growth. The following days, despite starting MCT-supported extensively hydrolyzed formula the patient's diarrhea and hypernatremia persisted. Lactose-free formula was trialed with a presumptive diagnosis of lactose intolerance. However, the patient's hypernatremia and diarrhea continued. Empirically, switched to fructose-based formula. After the introduction of the fructose-based formula, diarrhea attacks subsided, and sodium levels normalized. On day 20 of hospitalization, the patient's weight percentile was 24.51, with an SDS of -0.69. The patient was discharged. Genomic DNA was extracted from peripheral blood and sent for whole exome sequencing (WES). WES identified a likely pathogenic heterozygous c.583+2T>C variant (OMIM: 606824).WES also identified another heterozygous variant of

uncertain clinical significance in the SLC5A1 gene, c.899>A p.(Arg300His) (OMIM: 606824). The baby was started on a special formula (Galactomine® - fructose-based) with an appropriate diet plan. The baby is now thriving without diarrhea attacks.

Results: Nutritional therapy involved step-by-step trials of different enteral products.

Conclusion: Pediatricians should take into account unexpected congenital causes in while looking for common causes in infa nts who present with the chronic diarrhea.Genetic testing is highly encouraged as it helps in early recognition of those patients, preventing major complications.

Keywords: glucose-galactose malabsorption, SCL5A1, diarrhea

PP-008

A Rare Complication of Acute Otitis Media: Cerebellar Abscess

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Introduction: Cerebellar abscess is a very rare and fatal complication of acute otitis media (1). Today, with the increase in the use of antibiotics, the risk of developing complications related to otitis media has decreased (2). However, as in our case, acute otitis media can cause intracranial complications, albeit rarely.

Material and Method: In this case report, we aimed to draw attention to cerebellar abscess, a rare and mortal complication that develops after acute otitis media in an eight-year-old female patient.

Results: An eight-year-old girl was admitted to the otolaryngology clinic fifteen days ago with complaints of pain and fever in both ears. The patient was diagnosed with acute otititis media and was started on amoxicillin clavulanic acid at the appropriate dose. As her existing complaints continued and she developed loss of balance, she applied to the pediatric outpatient clinic. On physical examination, the general condition was moderate, sluggish in appearance. The Trendelenburg and Romberg tests were positive. The finger-nose test was clumsy. Dysdiokinesia was present. In the patient's blood tests, CRP was found to be 70 mg/dl and sediment was 50 mm/s. In the brain computed tomography of the patient, "A hypodense heterogeneous space-occupying lesion with a lobule edge of 37x30 mm in size was observed in the axial plane in the left posterior fossa(Figure1a, 1b)". Brain magnetic resonance imaging revealed bilateral otomastoiditis, abscess in the left cerebellum(Figure2a, 2b). The patient was evaluated by neurosurgeon and otorhinolaryngology clinics and underwent surgery. The pathology result of the material taken from the field was "changes secondary to inflammation". The patient was started on vancomycin, meropenem and metranidazole treatments. As a result of the culture of the material taken from the surgical site, there was no growth and the treatment was completed in four weeks. The patient was discharged after clinical improvement was achieved and the acute phase reactants returned to normal in blood tests.

Conclusion: In cerebellum abscesses, cerebellar findings such as ataxia and nystagmus, as well as findings due to increased intracranial pressure and brainstem compression can be seen. Today, it is rare to encounter brain abscess thanks to antibiotics. However, morbidity and mortality are still high complications. For this reason, detailed neurological and vestibular system examinations should be performed in patients presenting with headache and dizziness. When acute intracranial problems occur in patients with these complaints, otitis media complications should always be kept in mind in the differential diagnosis.

Keywords: Cerebellar Abscess, Acute Otitis Media, İntracranial Complications

PP-009

Is Reversible Posterior Leukoencephalopathy Syndrome (RPLS) Always Reversible? A Case Report

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Aim: Reversible posterior leukoencephalopathy syndrome (RPLS), also known as posterior reversible encephalopathy syndrome (PRES), is a clinical and neuroradiological condition characterized by headache, altered consciousness, visual disturbances, and seizures. With prompt diagnosis and appropriate treatment, it is often fully reversible. However, delayed diagnosis or inadequate treatment can lead to non-reversible clinical and neuroimaging outcomes. This case report highlights a 13-year-old patient with RPLS, aiming to raise awareness about its inclusion in differential diagnoses during emergency department visits, especially in cases of severe hypertension.

Case: A 13-year-old female patient with a history of infantile nephropathic cystinosis, hypertension, and chronic kidney disease on peritoneal dialysis, presented with a two-day history of headache unresponsive to analgesics and agitation. On examination, her blood pressure was significantly elevated (177/123 mmHg), but her neurological and systemic examinations were otherwise normal. Despite medical management with metoprolol and amlodipine, her symptoms persisted, and she developed visual disturbances followed by generalized seizures. Neuroimaging was normal on CT, while MR showed characteristic findings of bilateral parieto-occipital cortical and subcortical hyperintense lesions consistent with RPLS. The patient was treated with anticonvulsants and antihypertensives. Following intensive care management, including EEG monitoring and midazolam infusion, her seizures resolved. However, follow-up brain MRI showed age-inappropriate atrophic changes, despite clinical improvement.

Conclusion: RPLS is a syndrome that presents with a combination of neurological symptoms and radiological findings. While it is usually reversible with early intervention, some cases may show non-reversible outcomes like the one presented. The case emphasizes the importance of early diagnosis and management, especially in pediatric patients with comorbid conditions like chronic kidney disease and hypertension. Additionally, neuroimaging, particularly MRI, plays a crucial role in diagnosis, as early neuroimaging findings may predict long-term outcomes.

Keywords: Reversible Posterior Leukoencephalopathy Syndrome, Hypertension, Pediatric, Emergency Care

P-015

Neurofibromatosis-Noonan Syndrome, A Rare Case Report in Monozygotic Twins

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Aim: Here we present data from a pair of monozygotic twins affected Neurofibromatosis-Noonan syndrome (NFNS)1 resulting from a heterozygous mutation. Neurofibromatosis-Noonan syndrome (NFNS) is a RASopathy and a variant of neurofibromatosis type 1 (NF1) characterized by the combination of features of NF1, such as café-au-lait spots, iris Lisch nodules, axillary and inguinal freckling, optic nerve glioma and multiple neurofibromas, and Noonan syndrome (NS), such as short stature, typical facial features (hypertelorism, ptosis, downslanting palpebral fissures, low-set posteriorly rotated ears with a thickened helix, and a broad forehead), congenital heart defects and unusual pectus deformity.

Case: Seven year-old female monozygotic twins with typical clinical features of NF1 were referred to our clinic due to ptosis. Both cases had, broad forehead, sparse eyebrows, depressed nasal bridge, hypertelorism, low set ears, deeply grooved philtrum, kyphoscoliosis, sacral hypertrichosis, multiple cafe-au-lait spots and axillary and inguinal freckling. Due to clinical features including macrocephaly, short stature, facial dysmorphism, webbed and short neck and pectus excavatum in addition to the typical findings of NF1, a clinical diagnosis of NFNS was considered in these patients. The family history was unremarkable, and careful examination of other family members did not show evidence of the condition. Genetic analyses were performed and molecular analysis of both cases revealed a heterozygous c3721 C>T p.R1241 variant in the NF1 gene. This variant has been predicted as pathogenic. No mutation was found in the PTPN11 gene.

Conclusion: If a patient presents with the clinical features of both NS and NF1, NFNS should be considered. NF1 and NS are both related to abnormalities in the RASMAPK signaling pathway, but have distinct differences at the genetic level. In patients with NF1, neurofibromin, encoded by the NF1 gene and acting as a negative regulator in the Ras-MAPK pathway, can inactivate or deregulate Ras-GTPase. However, NS is genetically heterogeneous. PTPN11 gene has been implicated in the etiology of more than 50% of NS cases. In NS patients, SHP2 protein, encoded by the PTPN11 gene and acting as a positive regulator of Ras-mediated signaling transduction, can activate Ras signaling pathway. Investigations have been performed to determine whether NFNS represents a variable manifestation of either NS or NF1, or is an independent disease. These investigations have found that NFNS, a variant form of NF1, is caused by heterozygous mutations in the NF1 gene. NF1 was also the only pathogenic variant gene causing NFNS in the presented case.

Keywords: Neurofibromatosis, Noonan Syndrome, Monozygotic Twins, NFNS

PP-019

A Diabetic Ketoacidosis Case That Accompanying Peripheral Facial Nerve Palsy After Ear Piercing

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Introduction: Diabetic ketoacidosis (DKA) is the leading cause of morbidity and mortality in children with type 1 diabetes mellitus. One of the common precipitating factors for DKA is infections. Herein, we present a patient who got diagnosis of diabetic ketoacidosis with peripheral facial nerve palsy due to acute otitis externa as a consequence of ear piercing.

Material and Method: A 14 year old female patient , diagnosed type 1 diabetes mellitus 6 years ago and using subcutaneous insulin presented to the our emergency department with right earache. She had her right tragus pierced 2 weeks ago. After 3 days she got right earache. She had a history of swimming in the pool after piercing. On her physcial examination; swelling on the posterior of right parotid gland (lymphadenopathy), right tragus hyperemia and tenderness, and right peripheral facial palsy (figure 1 and 2). Other systems on physical examination were normal. Laboratory findings revealed metabolic acidosis (pH 7.31, pCO2 31.1 mmHg, cHCO3 16,6 mEq/l), hyperglycemia (glucose 665 mg/dL), and ketonemia (ketone 5.7 mmol/L.Urinalysis was significant for ketonuria and glucosuria. The patient was transferred to the pediatric intensive care unit (PICU). Methylprednisolone treatment for peripheral facial palsy and ciprofloxacin ear drops and intravenous sulbactam-ampicillin for acute otitis externa started.After 10 day antibiotics and 7 day methylprednisolone treatment, her peripheral facial palsy and the findings on her ear and face resolved, with policlinic control recommendation she was discharged.

Results: While peripheral facial paralysis and DKA can be seen separately in childhood, their coexistence is very rare.Through this case, we wanted to present to you a case whose peripheral facial paralysis and DKA were cured with successful treatment.

Conclusion: The use of earrings and piercings in the adolescent age group has become widespread recently. In literature, there are not many pediatric cases about patients with DKA and peripheral facial nerve palsy together after ear piercing. When an adolescent patient with DKA and peripheral facial nerve palsy presents, the use of earrings and piercings should be kept in mind.

Keywords: Diabetic Ketoacidosis, Ear Piercing, Acute Otitis Externa, Peripheral Facial Nerve Palsy

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