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FIGURE 1. Erythematous dry ulcerated skin lesion on the right arm.

The patient presented several risk factors for DP as reported in the literature: administration of diphtheria anti-toxin after day 2, incomplete primary vaccination, and severe form with systemic dispersion of the toxin.[1,3,4] A study by Kanwal et al[3] involving 48 children admitted to pediatric intensive care unit for DP reported that 75% were boys and 60.5% were less than 5 years old. The initial improvement in bulbar symptoms and the recovery period of respiratory muscle function corresponded to the median duration of recovery reported in the studies by Gowda et al[4] and Kanwal et al.[3] Kanwal et al[3] reported that limb symptoms recovered by day 72 (range: 40–120 days), with a muscle power grading of 3/5 (Medical Research Council scale).[3] This recovery period was shorter for our patient compared to the durations reported in the literature. Given the anamnestic, clinical, biologic (CSF), nerve conduction and even anatomopathological similarities between GBS and DP, we were unable to definitively exclude either diagnosis. To our knowledge, there is only one reported case that was treated as a GBS but did not received diphtheria anti-toxin.[5] There are no randomized controlled studies evaluating immunoglobulin in DP. However, considering the similarities and potential overlap between GBS and DP, immunoglobulin therapy could be an interesting approach to explore in the management of DP.

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Tania Van Goethem, MD*
Hugo Kerambrun, MD†
Yvonnick Boue, MD†
Abdourahim Chamouine, MD‡
Sylvain Brisse PhD§¶
Julie Toubiana, MD§¶
Justine Franco, MD‡

*Department of Pediatrics, Cliniques St-Jean, Brussels, Belgium
†Department of Intensive Care Unit, Mayotte Hospital, Mamoudzou, France
‡Department of Paediatrics, Mayotte Hospital, Mamoudzou, France
§Institut Pasteur, Centre National de Reference des Corynebacteries du complexe diphtherae, Paris, France
¶Department of General Pediatrics and Pediatric Infectious Diseases, Universite Paris Cite, Hopital Necker-Enfants Malades, APHP, Paris, France

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A Rare Cause of Preseptal Cellulitis

Neisseria meningitidis

To the Editors:

Inflammation of the eyelids and periorbital tissues without signs of orbital involvement is termed periorbital or preseptal cellulitis.[1] It is a common condition, usually in young children under 5 years of age. Data on microorganisms causing preseptal cellulitis are limited. Herein, a case of *Neisseria meningitidis*, which is often overlooked as a possible cause of preseptal cellulitis, is presented.

A 6-month-old female patient presented with erythematous edema of the upper and lower eyelids with purulent discharge in the right eye for 1 day without a history of trauma, upper respiratory tract infection or sinusitis. There were no distinctive features in her medical history. Her vaccination history was compatible with her age. Systemic examination was normal; there was no sign of meningeal irritation.

The ophthalmologic evaluation of the right eye revealed erythematous edema and warmth of the upper and lower eyelid and conjunctival hyperemia with purulent discharge (Fig. 1). Proptosis was absent, and the pupillary reactions were normal with normal ocular movements. The examination of the left eye was normal.

In laboratory tests, white blood cell count was 13.200/mm^3 (39.9% neutrophil), hemoglobin was 13 g/dL, platelet count was 415.000/mm^3 and C-reactive protein was 1.8 mg/L. Blood electrolytes, liver and kidney functions were normal. The conjunctival culture was performed. The patient was hospitalized and ampicillin-sulbactam was initiated with the diagnosis of preseptal cellulitis. *N. meningitidis* serogroup B grew in the conjunctival culture (Gram stain: Gram-negative diplococci,

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Address for correspondence: Nursel Atay Ünal, MD, Department of Pediatric Infectious Disease, Gazi University Faculty of Medicine, 06560, Yenimahalle, Ankara, Turkey. E-mail: nur.sel@hotmail.com; nurselatay@gazi.edu.tr
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FIGURE 1. Erythematous edema of the upper and lower eyelid and conjunctival hyperemia with purulent discharge.

4–5 neutrophil). The susceptibility test showed that the microorganism was sensitive to ceftriaxone. Peripheral blood culture was negative. The patient's symptoms improved quickly after treatment was revised to ceftriaxone, and he was discharged after 7 days of treatment.

Preseptal cellulitis is an infection of the subcutaneous tissues anterior to the orbital septum. It rarely leads to serious complications.[1] There are various causes of preseptal cellulitis: spread from adjacent structures which is common in the pediatric age group, direct inoculation after eyelid trauma or insect bites and hematogenous spread from an upper respiratory tract infection.[1]

Preseptal cellulitis is a rare presentation of Neisseria infection, with few cases reported in the literature.[2] The spectrum of skin and soft tissue involvement in meningococcal disease is quite wide. It includes a petechial or ecchymotic rash that can develop into palpable purpura, macular, papular and pustular lesions, necrotizing fasciitis and acute cellulitis.[3] Few cases of preseptal cellulitis caused by *N. meningitidis* have been reported in the pediatric literature.[2,4] One of these children was presented with meningococcal meningitis.[4]

Acute conjunctivitis caused by *N. meningitidis* is rare but it is potentially dangerous. It can be seen with systemic meningococcal infection or as primary meningococcal conjunctivitis. Cases of meningococcal conjunctivitis and preseptal cellulitis without invasive infection are even extremely infrequent. It is essential to perform conjunctival swab sampling in case of conjunctivitis associated with preseptal cellulitis before starting an empiric antibiotic treatment. *N. meningitidis* should be kept in mind as a possible causative agent in patients diagnosed with preseptal cellulitis and acute or hyperacute purulent conjunctivitis. Culture of purulent discharge is mandatory for diagnosis.

Nursel Atay Ünal, MD*
Tuğba Bedir Demirdağ, MD*
Bercın Tarlan, MD†
Meltem Polat, MD*
Anıl Tapısız, MD*
Hasan Tezer, MD*
*Department of Pediatric Infectious Diseases, Gazi University, Ankara, Turkey
†Department of Ophthalmology, Gazi University, Ankara, Turkey

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Prevention of RSV Bronchiolitis
An Ethical Issue

To the Editors:

Respiratory syncytial virus (RSV) is a major cause of acute lower respiratory infection among infants.[1]

In 2023, nirsevimab was finally approved by the European Medicine Agency,[2] but the universal immunization campaign was launched only in a few European countries, with Italy not being one of them.[3]

In March 2023, Galicia introduced universal prophylaxis with nirsevimab into the national immunization program. The campaign was structured around 3 groups[4]: (1) risk: children born with risk factors between October 2021 and March 2023 received nirsevimab in the first week of the campaign; (2) catch-up: children born between April and September 24, 2023, received a dose at the beginning of the season and (3) at birth: children born from September 25, 2023 to March 2024 received a dose in the hospital, in the first day of life.

Reported data[5] are extremely encouraging: immunization coverage ranges from 85.3% in the catch-up group to 100% of the risk group, with a total of 11,982 immunized children from September 25, 2023 to February 18, 2024. Reports show an 83% reduction in hospitalization rate for RSV in the cohort of catch-up children and 88% in the cohort of infants <6 months of age.

If we had introduced immunization with nirsevimab and achieved the same vaccination coverage as Galicia,[5] we estimated hospitalizations' reduction in our cohort (Fig. 1), comparing median values of admissions in previous seasons versus the season 2023–2024 in Galicia.[5] We applied Galicia's hospitalization reduction rates to our cohort by splitting patients into 3 groups: children <6 months at admission (group A), infants born between April 1, and September 24, 2023 and older than 6 months at admission (group B) and both eligible for immunization and patients born before April 1st 2023 (group C), eligible for immunization only with risk factors, according to actual Spanish indications.

From October 2023 to February 2024, 232 children were hospitalized with RSV bronchiolitis at the Pediatric Unit of Bambino Gesù Children's Hospital.

However, 209/232 infants were of group A, 12/232 patients belonged to group B and 11/232 patients were of group C, but none of them had risk factors, thus not eligible for nirsevimab.

If immunization with nirsevimab had been available, RSV's admissions in our cohort could have been reduced from 232 to 36 (23 group A, 2 group B and 11 group C).

Epidemiological data confirm that RSV bronchiolitis mostly affects healthy and young infants: in fact, more than 90% of children hospitalized in our cohort were <6 months old. Early nirsevimab administration appears to be

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The datasets used and analyzed during the current study are available from the corresponding author on reasonable request.
This study was conducted in accordance with the Helsinki Declaration. It was a purely observational retrospective study on routinely collected anonymous data. It was not possible to request informed consent for participation in the study, given the retrospective nature of the study. In any case, consent to completely anonymous use of clinical data for research/epidemiological purposes is routinely sought from all patients upon admission.
The study protocol was approved by the Institutional Review Board and Ethics Committee of our institution (protocol 2053-OPBG).
Address for correspondence: Livia Antilici, MD, Hospital University Pediatrics Clinical Area, Bambino Gesù Children's Hospital IRCCS, Piazza Sant'Onofrio 4-00165 Roma, Rome, Italy. E-mail: livia.antilici@opbg.net.
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