and without contrast showed subdural collections over both convexities. *Hemophilus influenzae* type b was isolated from blood and cerebrospinal fluid cultures.

On hospital day (HD) 8 and HD 26, the patient underwent transfontanel subdural taps for the persistence of the subdural collections. On HD 44, a magnetic resonance imaging (Fig. 1) revealed a loculated subdural empyema with a markedly worsened midline shift. The patient underwent a craniotomy with the removal of the pyogenic membrane and drainage of the fluid.

Before the availability of vaccinations, *H. influenzae* type b was the leading cause of bacterial meningitis in the United States. Following widespread vaccination, the disease virtually disappeared with the annual incidence of Hib decreasing to an estimated annual incidence of 0.27 cases per 100,000 children <5 years of age since 2001.¹

Risk factors for invasive Hib disease in our patient included her age and, most important, lack of Hib vaccination. Routine immunization services faced stark challenges in 2020, with the coronavirus disease 2019 (COVID-19) pandemic causing the most widespread and most significant global disruption in recent history. Supply and facility constraints, fear of severe acute respiratory syndrome coronavirus 2 exposure in healthcare settings, as was the case in our patient, might explain why routine immunization was among the most affected health services. Globally, estimated coverage in 2020 fell to 76.7% for third-dose diphtheria-tetanus-pertussis vaccine while first-dose measles-containing vaccine dropped to 78.9%.² A recent study suggests a potential 10% increase in mortality from vaccine-preventable diseases due to pandemic-related disruptions to routine immunization.³ The second half of 2020 showed signs of recovery; nevertheless, recovery efforts were far from complete. While COVID-19 remains a formidable threat in 2021, even when the pandemic ends gaps in vaccine coverage increase, the risk of vaccine-preventable disease outbreaks.

Many current US trainees have likely never seen or managed Hib meningitis. Due to failing vaccination rates related to COVID-19, providers should be alert to the presence of vaccine-preventable infections and their management. In addition, strengthening routine immunization data systems and efforts to target resources and outreach, reaching children who missed regular vaccine doses during the pandemic will be essential to minimize the risk of vaccine-preventable disease outbreaks; otherwise the world’s fragile progress could easily give way to vaccine-preventable disease outbreaks in 2021 and beyond.

**Do not Miss the Diagnosis of Bacterial Sepsis in Infants With COVID-19**

> **To the Editors:**
>
> A 34-day-old male infant presented with a 2-day-history of cough, poor feeding and vomiting after feeding. His severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) polymerase chain reaction test was positive, and he was admitted to the hospital for intravenous hydration. Physical examination revealed no specific finding of...
coronavirus Disease 2019 (COVID-2019) or bacterial infections. His biochemical, hematological parameters and acute phase reactants at admission were in the normal reference range. On the 3rd day of admission, he developed tachycardia and became restless and inconstantol. His laboratory results revealed elevated C-reactive protein level [8.75 mg/dl–(0–0.5 mg/dl)]. Empirical antimicrobial treatment (ampicillin and cefotaxime) was initiated after sepsis workup was performed. Enterobacter cloacae was isolated from the 2 consecutive blood cultures.

COVID-19 seems to have a favorable clinical course in children; however, knowledge about the course of disease in symptomatic infants is scarce.1 A study of pediatric SARS-CoV-2 cases in China reported that 11% of infants had a severe or critical illness.2 In infants, findings such as fever, lethargy, poor feeding, vomiting, tachypnea and tachycardia attributed to the SARS-CoV-23 can be also seen in bacterial sepsis. Laboratory parameters may not always help distinguish between COVID-19 and bacterial sepsis. Bacterial coinfection has been previously reported in SARS-CoV-2-positive infants.4 A preterm neonate was reported to develop sepsis caused by Enterobacter species as in our case.5 It is important that clinicians be aware of the development of bacterial sepsis during SARS-CoV-2 infection, especially in infants.

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MIS-C and Identical Twins: A Case Series

To the Editor:
Multisystem inflammatory syndrome in children (MIS-C) caused after coronavirus disease 2019 (COVID-19) was first reported in patients presenting with shock in Europe and North America in mid-April 2020.1,2 Here, we present 3 pediatric cases with MIS-C who had identical twins (Fig. 1). In all 3 cases, while the twin was infected, they did not develop MIS-C.

CASE 1
A 2-year-old previously healthy boy presented with a 4-day fever, diffuse rash, nausea-vomiting, and diarrhea. Vital signs at the time of examination included a temperature of 39.6°C, heart rate of 146 beats/min, blood pressure of 95/60 mm Hg, respiratory rate of 33 breaths/min, and oxygen saturation of 94% on room air. On admission, physical examination showed a diffuse urticarial rash that localized face and lower extremities, bilateral conjunctivitis, and papillitis of the tongue, lip cracking, and fissuring. He was tachycardic with 3/6 systolic murmurs and had clear lungs to auscultation bilaterally. He was admitted to pediatric intensive care unit (PICU) with a diagnosis of MIS-C. His identical twin was asymptomatic, his physical examination was normal. Clinical and laboratory findings were shown in Table 1. Nasopharyngeal swab for SARS-CoV-2 by RT-PCR was negative, but SARS-CoV-2 antibodies were positive. Also, his identical twin and his parents were antibody positive. An echocardiogram revealed ventricular systolic dysfunction and LVEF 45% with mitral insufficiency. Treatment was initiated with fluid replacement therapy, milrinone (0.5 μg/kg/min) and noradrenaline (0.1 µg/kg/min) infusion, enoxaparin (low molecular weight heparin) 6000 U, IVIG 1 g/kg for 2 days, and methylprednisolone 30 mg/kg/day for 3 days followed by a prednisone taper. The patient experienced a near resolution of symptoms and normalization of vital signs within 4 days. Inflammatory markers improved rapidly over 9 days. On day 10, the patient was discharged home on prednisone and aspirin 100 mg. Although the identical twin was antibody positive, he developed no symptoms and laboratory values were normal.

CASE 2
A 12-year-old previously healthy boy presented with a 7-day history of fever, vomiting, diarrhea, and abdominal pain. One month ago, our patient, his identical twin, and parents were PCR positive for SARS-CoV-2 from nasopharyngeal swabs. Vital signs at the time of examination included a temperature of 39.1°C, heart rate of 149 beats/min, blood pressure of 88/42 mm Hg, respiratory rate of 36 breaths/min, and oxygen saturation of 92% on room air. On admission, physical examination showed a diffuse erythematous rash that localized on bilateral axillary and inguinal regions, bilateral conjunctivitis, and papillitis of the tongue, lip cracking, and fissuring. He had signs of meningeal irritation, decreased breath sounds at the lung bases. He was tachycardic with 3/6 systolic murmurs and hypotensive, so he was admitted to PICU with a diagnosis of MIS-C. His identical twin was asymptomatic, his physical examination was normal. Clinical and laboratory findings were shown in Table 1. An echocardiogram revealed ventricular systolic dysfunction and LVEF 40% with mitral insufficiency. Brain magnetic resonance imaging (MRI) showed hyperintensity on T2-weighted images in the splenium of the corpus callosum with restricted diffusion. Treatment was initiated with fluid replacement therapy, milrinone (0.5 μg/kg/min) and noradrenaline (0.1 μg/kg/min) infusion, enoxaparin (low molecular weight heparin) 6000 U, IVIG 1 g/kg for 2 days, and methylprednisolone 1 g/day for 5 days followed by a prednisone taper. The patient experienced a near resolution of symptoms and normalization of vital signs within 5 days. Inflammatory markers improved rapidly over 7 days. Repeated brain MRI on day 7 was normal, indicating the resolution of the lesion in the splenium of the corpus callosum. On day 10, the patient was discharged home on prednisone and aspirin 100 mg. Although the identical twin had COVID-19 infection 1 month ago and was positive for antibodies, he developed no symptoms and laboratory values were normal.

CASE 3
A 10-year-old previously healthy boy presented with a 4-day history of fever, vomiting, diarrhea, abdominal pain, and rash. On admission, physical examination showed a diffuse erythematous rash that localized on bilateral axillary and inguinal regions, bilateral conjunctivitis, and papillitis of the tongue, lip cracking, and fissuring. He had signs of meningeal irritation, decreased breath sounds at the lung bases. He was tachycardic with 3/6 systolic murmurs and hypotensive, so he was admitted to PICU with a diagnosis of MIS-C. His identical twin was asymptomatic, his physical examination was normal. Clinical and laboratory findings were shown in Table 1. An echocardiogram revealed ventricular systolic dysfunction and LVEF 45% with mitral insufficiency. Treatment was initiated with fluid replacement therapy, milrinone (0.5 μg/kg/min) and noradrenaline (0.1 μg/kg/min) infusion, enoxaparin (low molecular weight heparin) 6000 U, IVIG 1 g/kg for 2 days, and methylprednisolone 1 g/day for 5 days followed by a prednisone taper. The patient experienced a near resolution of symptoms and normalization of vital signs within 5 days. Inflammatory markers improved rapidly over 7 days. Repeated brain MRI on day 7 was normal, indicating the resolution of the lesion in the splenium of the corpus callosum. On day 10, the patient was discharged home on prednisone and aspirin 100 mg. Although the identical twin had COVID-19 infection 1 month ago and was positive for antibodies, he developed no symptoms and laboratory values were normal.