occur in febrile children even without signs of respiratory failure. By merging WHO/ECDC and Chinese epidemiology, we have developed an algorithm as decision-making matrix to decide on the patients’ disposition (Fig. 1).1–4

In conclusion, the pediatric emergency is more logistic than clinical. So, we urge you to plan local advice and follow your institutional and national guidelines.

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It is interesting to take inspiration from telemedicine, which uses a lot of audio-video technologies to improve patient health by facilitating interactions between patients and clinicians or between 2 or more clinicians.1 Our hospital tried to adapt to COVID-19 health emergency in a short time. So, some dedicated rooms to lockdown infected children, without an interphone or telemetry system, were set up, cameras were positioned inside, and handheld transceivers (HTs) were given to the parents for communication with the HCWs. HTs let these interactions be synchronous, wherein parties engage in real-time, 2-way communication, without any delay of time.

In this way, we significantly reduced the number of clinical evaluations carried out on the patient and therefore the use of PPE, reducing exposure to potential infectious sources. We believe that HT can be a useful tool both to save PPE and also to protect HCWs during COVID-19 outbreak.

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Febrile Infant: COVID-19 in Addition to the Usual Suspects

To the Editors:

SARS-CoV-2, the RNA coronavirus etiologic agent of pneumonias that appeared in December 2019 was sequenced and confirmed in January 2020 by the Chinese Center for Disease Control and Prevention.1 The World Health Organization on March 11 officially designated COVID-19 a pandemic as it spread rapidly to 196 countries with over 54,000 confirmed cases in the United States alone.2

While reports about the virus have focused on the adult population, the largest study on children to date has been reported from China by Dong et al. Their clinical severity analysis, which included both COVID-19-positive patients and those with a high index of suspicion, revealed that severe (ie, respiratory distress) and critical (ie, ARDS or shock) occurred in 5.9% of children compared with 18.5% in adults, with infants below age one comprising the highest proportion.3

We report a previously healthy, fully vaccinated, late preterm, 58-day-old male who presented with fever. On the day of admission, he was sleeping longer than normal, had watery eye discharge with periorbital erythema and a rectal temperature of 101.2°F. Stools were softer and greener for the past 2 days. There was no respiratory distress, cough, decreased intake, decreased frequency of wet diapers, sick contacts, or travel. Physical examination revealed T 100.8°F (rectal), HR 176 beats per minute, slight fussiness, glassy eyes with mild surrounding erythema, soft anterior fontanelle, normal tympanic membranes bilaterally, and mild nasal congestion. The rest of his examination was normal. Laboratory assessment showed complete blood count: white blood cells (WBC) 5.44 k/μL (normal: 4.0–19.5 k/μL) with 43% neutrophils (ANC 2497/μL; normal: 1000–12,500/μL), 34% lymphocytes (ALC 1.86 k/μL; normal: 1.0–3.5 k/μL), 10% monocytes, 10% eosinophils, 2.5% reactive lymphocytes. Platelets 278 k/μL (normal: 150–350 k/μL) and a mildly anemic hemoglobin at 9.2 g/dL (normal: 9.4–12 g/dL). Comprehensive metabolic panel was normal except for a mildly elevated alkaline

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