and older. Hence, we are left with the blanket statement that children are spared from severe COVID-19, an argument that is currently being used in many European countries, including the UK and Germany, to not vaccinate adolescents. Although few children become severely ill from SARS-CoV-2 infection compared with adults, the increasing number of delta variant infections will most likely result in preventable morbidity and mortality in this age group. Therefore, we call not only for pediatric clinical trials of antiviral drugs but, more importantly, for universal access to COVID-19 immunization for children and adolescents as safe and effective vaccines become licensed and available.1

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Sustaining Early Infant Diagnosis of HIV During Coronavirus Disease 2019 Pandemic

Experience Collecting Dry Blood Spots Samples at Home From HIV-exposed Infants in Nigeria

To the Editors:

Despite advances in prevention of mother to child transmission (PMTCT) of HIV, 160,000 new pediatric HIV infections were reported in 2020.1 Vertical transmission of HIV in Nigeria remains high at 22%, with 37,000 new infections among children 0–14 years annually.2 In Nigeria, access to early infant diagnosis (EID) has improved significantly; however, only 27% of HIV-exposed infants received an HIV test by 2 months of age in 2019.3 EID programs require mothers to bring their infants to the health facility for testing. However, the global coronavirus disease 2019 (COVID-19) pandemic movement restrictions necessitated changes to the PMTCT service delivery model for infant follow-up to ensure uninterrupted service delivery.

Nigeria reported its first COVID-19 case on February 27, 2020.4 By March, a mandatory lock down with subsequent movement restrictions limited access to health facilities for nonemergency presen-

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Prelock down (October 2019 to March 2020), RISE collected 690 samples of which 57% (397/690) were collected within 2 months of birth with average turnaround time of 30 days. Postlock down (April to September 2020), 634 samples were collected of which 60% (379/634) were within 2 months of birth while maintaining an average turnaround time of 34 days. Regarding actual tests done, prelock down tests were done for 75% of samples for infants <2 months (n = 295) with 1.0 % positivity rate, while postlock down, 77% (n = 291) were tested with 0.3% positivity.

Early results from the RISE program have shown that DBS specimens for HIV diagnosis in infants can be safely collected at home while maintaining specimen integrity and delivery of results back to caregiv-

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Multisystem Inflammatory Syndrome in Children Presenting as Cardiac Tamponade

To the Editors:

Multisystem inflammatory syndrome in children (MIS-C) is a new disease entity seen 3–4 weeks post-severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2) exposure (symptomatic or asymptomatic) and has predominant cardiac and gastrointestinal system involvement.1 Ventricular dysfunction, coronary dilatation, valvulitis and pericardial effusion have been reported as prominent cardiac findings in MIS-C.2,3 We describe a teenager with MIS-C, who presented with myopericarditis and acute pericardial tamponade, requiring urgent surgical pericardiostomy and drainage.

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A 13-year-old girl came with a history of intermittent high-grade fever for 1 week, nausea and vomiting for 3 days and swelling of hands and feet for 2 days. She had a history of SARS-CoV-2 exposure 1 month back but was asymptomatic then. On admission, she was febrile, tachypneic, tachycardic with a regular pulse that varied in intensity with the respiratory cycle, concerning for pulsus paradoxus, had hypotension, engorged neck veins, facial puffiness and edema over hands and feet. On auscultation, air entry was decreased bilaterally in both lower zones and heart sounds were distant. There was no murmur. Liver was palpable, and the umbilicus was everted. Her reverse transcriptase polymerase chain reaction test for SARS-CoV-2 was negative on admission, and anti–SARS-CoV-2 IgG antibodies were positive. Blood investigations showed increased inflammatory markers (Fig. 1). Chest radiogram showed cardiomegaly and blunted costophrenic angles bilaterally (Fig. 1A).

Echocardiography showed a structurally normal heart but massive pericardial effusion with right atrial and ventricular free wall collapse in diastole, normal biventricular function and bilateral pleural effusion (Fig. 1B and C). In view of both pleural and pericardial effusions, the patient underwent urgent surgical “wide anterior pericardiectomy” with bilateral intercostal tube drainage, and 650 mL of transudative pericardial fluid was drained. Epicardium and pericardium were intense red colored, and pericardial biopsy confirmed acute inflammation (Fig. 1D and E). She received intravenous immunoglobulin and high-dose intravenous steroids and showed clinical and hemodynamic improvement within 48 hours. She was discharged after 1 week of drain removal, on tapering doses of oral steroids and aspirin. At 1-month follow-up, she was asymptomatic and there was no pericardial collection on echocardiography evaluation.

Pericardial involvement in the acute coronavirus disease 2019 may not always be associated myocardial involvement and can rarely present as tamponade requiring drainage.4 Pericardial involvement in MIS-C has also been known; however, in a recent study, only 20% of children presenting with acute cardiovascular manifestations had associated mild-to-moderate pericardial effusion on echocardiogram, and none had severe effusion.2 MIS-C presenting with pericardial tamponade requiring emergency pericardiocentesis has not been reported. Our case not only shows a rare presentation of MIS-C but also highlights the possibility of surgical intervention in the management of MIS-C. Shock in MIS-C can have multiple reasons, of which, although rare, pericardial tamponade should also be considered.

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