References


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Coxsackievirus type A16 infection in a neonate

Sir,

Coxsackievirus type A16, commonly associated with the characteristic syndrome of hand, foot, and mouth disease, is an unusual infective agent in children under one year of age, particularly in the neonatal period. A short nonspecific illness in a newborn baby was shown to be associated with hand, foot, and mouth disease in his mother, and Coxsackievirus type A16 was recovered from both.

Case report

A 3-week-old baby boy was admitted with a 24-hour history of drowsiness and refusing feeds. Delivery had been normal at 35 weeks’ gestation after premature rupture of membranes and intermittent labour pains for 10 days. Birthweight was 2.7 kg, and the baby had been nursed in the special care unit for 10 days because of a feeding problem associated with mild jaundice. Breast feeding had been maintained.

He was a well nourished but drowsy and slightly jaundiced infant; temperature 34.6°C; Dextrostix 25mg/100 ml. A full infection screen failed to show any focus of infection, and a provisional diagnosis of cold injury was made. It was found that his mother had been ill for 4 days previously, with a febrile ‘flu-like’ illness, associated with painful ulceration of her mouth, feet, and hands. Coincidentally with the infant’s illness, a sibling also had nonspecific malaise.

Coxsackievirus type A16 was grown in monkey-kidney tissue cultures from maternal throat swab and vesicle fluid, and from the infant’s throat swab; the infant’s CSF was acellular and sterile.

The infant initially required tube feeding, and was nursed in an incubator until his temperature rose to normal. He was discharged home clinically well 5 days later.

Coxsackievirus type A16 infections are most commonly associated with hand, foot, and mouth disease, but have also been found in encephalitis, meningitis, myocarditis, and pericarditis. The highest incidence is in the 1-3-year-old age group (Gamble, 1962), and the incubation period is short, between 3 and 6 days. The disease is highly contagious, primary cases occurring in children, and spreading horizontally from sibling to sibling, and to parent.

The present case is interesting with regard to the age of the patient and the symptoms, which were relatively mild and atypical. Previously, neonatal infection with this agent has been reported in association with fatal myocarditis (Wright et al., 1963; Golberg and McAdam, 1965), but neonatal infections are rare, probably because of protection by maternal antibody (Gear, 1958; D. R. Gamble, 1977, personal communication). There are no previous reports of this infection being acquired postnatally from the mother. In this instance breast milk was not examined virologically, which might have shown the route of transmission.

References


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Bronchodilator drugs and young children

Sir,

In their paper (Archives, 1978, 53, 532), Lenney and Milner concluded that wheezy children under age 18 months did not respond to treatment with nebulised salbutamol, as measured by respiratory resistance or thoracic gas volume. They also quoted two other studies (Radford, 1975; Rutter et al., 1975) which had similar conclusions. All these studies were performed in the recovery stage of an acute attack. In my experience, at the height of an attack, in the most severe stage, two-thirds of infants under one year show improvement in auscultatory findings when treated with nebulised salbutamol or isoetharine (König, 1978). Although no pulmonary function tests were done on infants of this age, there was a significant reduction in respiratory rate and dyspnoea score.
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