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REFERENCES

- 1 **Dagan R**, Powell K, Hall C, et al. Identification of infants unlikely to have serious bacterial infection although hospitalized for suspected sepsis. *J Pediatr* 1985;**107**:855–60.
- 2 **Dagan R**, Sofer S, Phillip M, et al. Ambulatory care of febrile infants younger than two months of age classified as being at low risk for serious bacterial infections. *J Pediatr* 1988;**112**:355–60.
- 3 **McCarthy CA**, Powell KR, Jaskiewicz JA, et al. Outpatient management of selected infants younger than two months of age evaluated for possible sepsis. *Pediatr Infect Dis J* 1990;**9**:385–9.
- 4 **Baskin M**, O'Rourke EJ, Fleisher GR. Outpatient treatment of febrile infants 28 to 89 days of age with intramuscular administration of ceftriaxone. *J Pediatr* 1992;**120**:22–7.
- 5 **ACEP Clinical Policies Committee, Clinical Policies Committee, Clinical Policies Subcommittee on Pediatric Fever**. Clinical policy for children younger than three years presenting to the emergency department with fever. *Ann Emerg Med* 2003;**42**:530–45.
- 6 **Miron D**, Shkenievski F, Horowitz Y. *Simple low risk factors for severe infection in febrile young infants*. Heraklion, Crete: European Society of Pediatric Infectious Diseases, 1999.
- 7 **Gorelick MH**, Shaw KN. Screening tests for urinary tract infection in children: a meta-analysis. *Pediatrics* 1999;**104**:e54.
- 8 **McIntosh K**. Community-acquired pneumonia in children. *N Engl J Med* 2002;**346**:429–37.
- 9 **Sadow KB**, Chamberlain JM. Blood cultures in the evaluation of children with cellulitis. *Pediatrics* 1998;**101**:e4.
- 10 **Chie CH**, Lin TY, Bullard MJ. Application of criteria identifying febrile outpatient neonates at low risk for bacterial infections. *Pediatr Infect Dis J* 1994;**13**:946–9.
- 11 **Chie CH**, Lin TY, Bullard MJ. Identification of febrile neonates unlikely to have bacterial infections. *Pediatr Infect Dis J* 1997;**16**:59–63.
- 12 **Baker MD**, Bell LM. Unpredictability of serious bacterial illness in febrile infants from birth to 1 month of age. *Arch Pediatr Adolesc Med* 1999;**153**:508–11.
- 13 **Kadish HA**, Loveridge B, Tobey J, et al. Applying outpatient protocols in febrile infants 1–28 days of age: can the threshold be lowered? *Clin Pediatr (Phila)* 2000;**39**:81–8.
- 14 **Turner D**, Leibovitz E, Aran A, et al. Acute otitis media in infants younger than two months of age: microbiology, clinical presentation and therapeutic approach. *Pediatr Infect Dis J* 2002;**21**:669–74.
- 15 **Herr SM**, Wald ER, Pitetti RD, et al. Enhanced UA improves identification of febrile infants ages 60 days and younger at low risk for serious bacterial illness. *Pediatrics* 2001;**108**:866–71.
- 16 **Crain EF**, Gershel JC. Urinary tract infections in febrile infants younger than 8 weeks of age. *Pediatrics* 1990;**86**:363–7.
- 17 **Chie CH**, Lin TY. Application of the Rochester Criteria in febrile neonates. *Pediatr Infect Dis J* 1998;**17**:267–9.

IMAGES IN NEONATAL MEDICINE.....

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Nasal trauma due to nasal continuous positive airway pressure in newborns

We would like to report a preterm baby, who sustained a major nasal injury secondary to nasal continuous positive airway pressure (nCPAP). The baby was extremely low birth weight and needed CPAP for 3 weeks. The baby developed laceration of the alae nasi within a week (fig 1). The laceration was 1 cm in size, causing division of the alae nasi on the medial side. The tear took 4 weeks to heal after nCPAP. This baby had recovered well from the nasal injuries at the time of discharge.

nCPAP is a common mode of respiratory support used in neonatal intensive care units. Elective use of nCPAP has helped to reduce the incidence of failed extubation. The nasal trauma was caused by nasal prongs and has been reported as 20%.¹ A recent randomised control study by Yong *et al*² found a higher incidence of nasal trauma due to CPAP and also found that there was no significant difference in nasal trauma between prongs and mask. The nasal injuries reported in the literature range from redness, erythema, crusting and excoriation to scaling. The common sites for injuries are the base of the septum, where it meets the philtrum, caused by the mask, and the medial aspect of the septum, caused by the prongs. Duration of nCPAP is a definite risk factor for nasal trauma. Birth weight, gestation and type of nasal device are not significant.

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Figure 1 Baby with laceration of alae nasi. Informed parental consent was obtained for publication of this figure.

REFERENCES

- 1 **Robertson NJ**, McCarthy LS, Hamilton PA, et al. Nasal deformities resulting from flow driver continuous positive airway pressure. *Arch Dis Child Fetal Neonatal Ed* 1996;**75**:F209–12.
- 2 **Yong S-C**, Chen S-J, Boo N-Y, et al. Nasal trauma associated with nasal prong versus nasal mask during continuous positive airway pressure treatment in very low birth infants. *Arch Dis Child Fetal Neonatal Ed* 2005;**90**:F480–3.