Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

ichthyosis, Netherton syndrome), infections, benign skin diseases (ie, infantile psoriasis, atopic dermatitis, or seborrheic dermatitis), immune disorders, metabolic diseases, and drug-related erythroderma. Failure to thrive, severe infections, neurologic symptoms, or signs of metabolic imbalance are red flags for urgent diagnostic and therapeutic interventions.[4]

Erythroderma with alopecia, failure to thrive, diarrhea, hepatosplenomegaly, and lymphadenopathy are suggestive of PID, a complex of signs and symptoms called Omenn syndrome. In this case, the severe and extensive skin phenotype was due to autoreactive T cells responsible for a graft-versus-host disease-like phenotype.

The correct management of erythrodermic neonates is a multistep procedure and always requires the knowledge of family and medical history and a physical examination; a dermatologic visit is recommended. Because benign erythematous disorders are rare in neonates, further analyses, such as complete blood count, serum electrolytes, blood gas analyses, and serum IgE levels, are often necessary.[4] Immunologic phenotype and genetic tests are crucial in case a PID is suspected. In desquamative erythroderma, a skin biopsy is also important.[7] Performing an early diagnosis is a key element, as its delay, in most cases of neonatal erythroderma, may lead to fatal consequences. ■

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Giant Urticaria and Acral Peeling in a Child with Coronavirus Disease 2019

A healthy 6-year-old girl presented with pruritic skin eruptions. The child was on the sixth day of isolation, with her mother suffering from a mild form of coronavirus disease 2019 (COVID-19) with ageusia and a single febrile episode.

The next day, the child developed fever and pharyngodynia. In the emergency department, a nasal swab for severe acute respiratory syndrome coronavirus 2 (both molecular and antigen tests) was positive, and she was admitted to the COVID-19 unit of our institute.

J Pediatr 2021;230:261-5.

https://doi.org/10.1016/j.jpeds.2020.10.039

Skin examination revealed fleeting urticarial lesions lasting <24 hours and migrant appearance with polycyclic contours consistent with the diagnosis of acute viral giant urticaria (**Figure**, A-C). Two days after the onset of the skin lesions, a desquamation of the distal phalanges of the hands and feet appeared with cyanosis of the apical portion of the nail bed (**Figure**, D).

The remaining physical examination and blood tests were unremarkable. No cardiac or respiratory abnormalities or signs suggestive of Kawasaki disease were evident. An oropharyngeal swab permitted us to rule out a streptococcal infection.

The patient's fever disappeared quickly, lasting only 24 hours. Antihistamine therapy was given for symptomatic

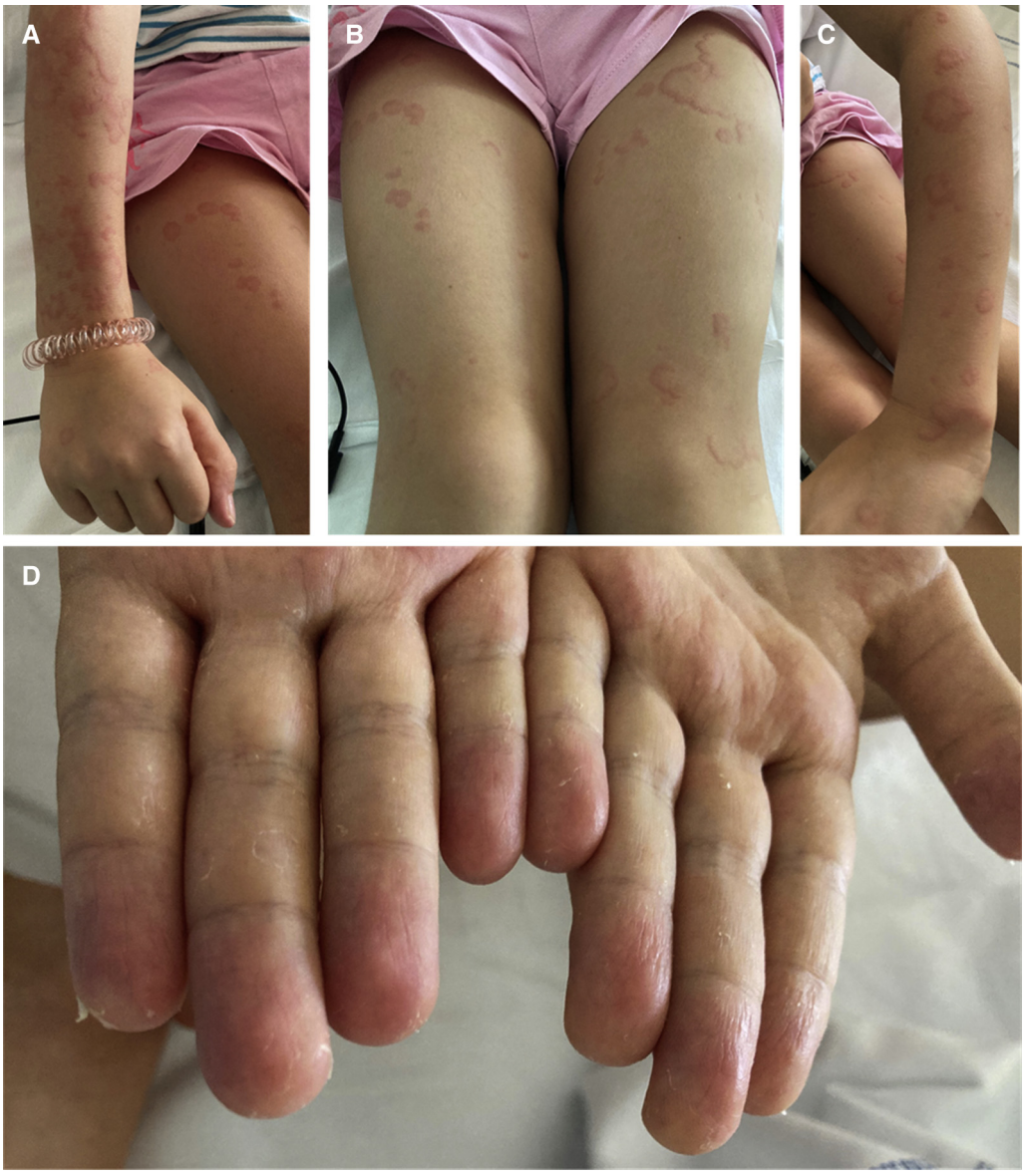

Figure. Giant urticaria. **A-C,** Fleeting orticarioid lesions with polycyclic contours. **D,** Desquamation of the distal phalanges of the hands.

relief, with resolution of skin symptoms within 4 days. Mother and child were discharged in good general condition and continued isolation at home.

Several clinical cases of suspected COVID-19 with skin involvement have been described in pediatric age, but most of them were unconfirmed cases.[1-4] The presence of acral peeling, not yet clearly described as a sign of COVID-19, in association with giant urticaria, should be emphasized in our confirmed pediatric case. Moreover, the skin manifestation was the first presenting sign of COVID-19, before the onset of fever. This must be taken into consideration to recognize a pediatric COVID-19 case early. ■

We thank Emilio Casalini, MD, and Stefania Santaniello, MD, for their support in this case as pediatricians in training.

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Paroxysmal Tonic Downgaze: A Pseudo Sunsetting Sign

A 30-day-old boy, born full-term, presented with a 1-day history of abnormal eye movements characterized by frequent, brief episodes of intermittent downgaze with vertical nystagmus that occurred while awake (**Video** [available at www.jpeds.com] and **Figure**). These episodes occurred both in supine and upright position without clear triggers. The neurologic examination was otherwise normal. Increased intracranial pressure was considered owing to the similarity to the sunsetting eye sign, although our patient had preserved upgaze, and his downgaze was intermittent but not persistent. Magnetic resonance imaging of the brain and spine were normal. Video electroencephalography was normal both between and during the eye movements. Urine homovanillic acid and vanillylmandelic acid were measured and found to be normal, excluding neuroblastoma and opsoclonus myoclonus syndrome, even though our patient's abnormal eye movements occurred only in the vertical plane.

These abnormal eye movements resolved spontaneously after 2 weeks, and his subsequent neurodevelopment has been normal. This child was thus diagnosed with paroxysmal tonic downgaze of infancy. These types of eye movements have been hypothesized to result from immature myelination of the corticomesencephalic vertical gaze pathways.[1,2] This benign self-limited disorder has similarities with paroxysmal tonic upgaze.[2] Both disorders are rarely associated with neurodevelopmental impairment, especially in children with preexisting neurologic dysfunction.[3,4] Transient, benign neonatal and infantile paroxysmal eye gaze disturbances

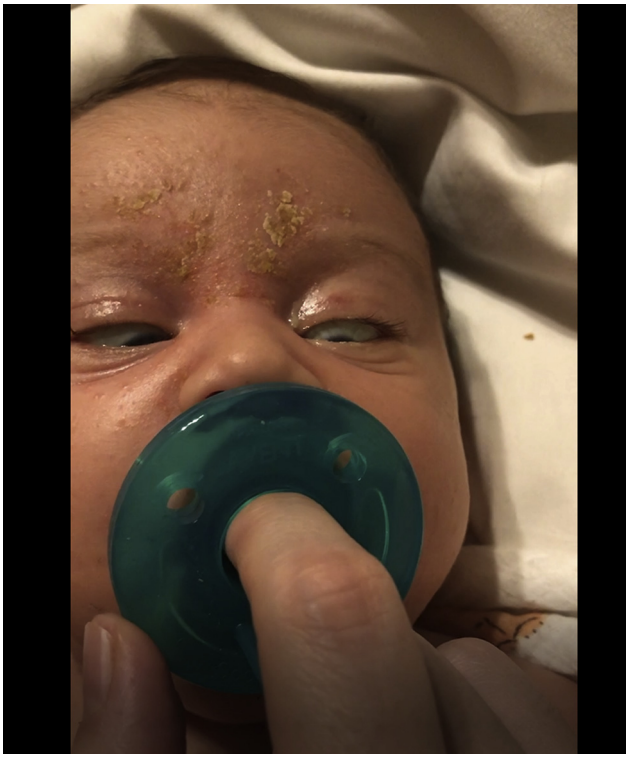

Figure. Episodes of downward eye deviation (resembling setting sun eye phenomenon) with vertical nystagmus lasting 10-15 seconds, occurring in both supine and upright positions with no clear triggers. The neurologic examination was normal.

The authors declare no conflicts of interest.

J Pediatr 2021;230:263-4.

https://doi.org/10.1016/j.jpeds.2020.12.009