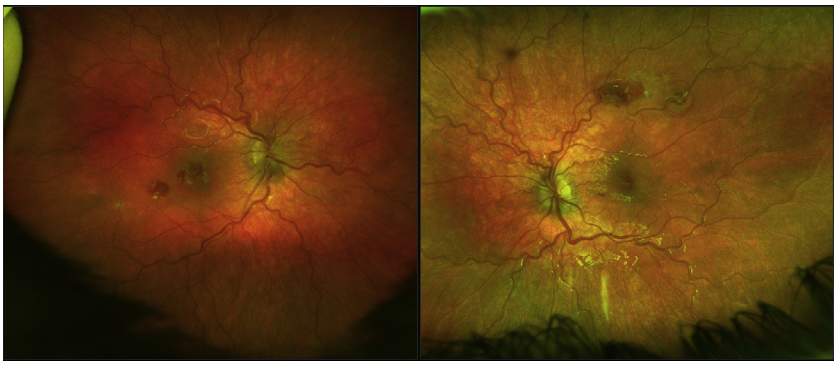

Figure. Widefield fundus photography showed multiple white-centered hemorrhages bilaterally, with tortuous retinal vessels.

blood tests should include complete blood count, erythrocyte sedimentation rate, C-reactive protein, and blood culture. An echocardiogram should also be arranged to look for vegetation. Complete blood count would also be helpful in identifying anemia and leukemia, as in this case. Lastly, HIV antibody testing should be performed in suspected cases. ■

Data Statement

Data sharing statement available at www.jpeds.com.

Derek K.-H. Ho, FRCOphth
Department of Ophthalmology

Sami Khan, MRCPCH
Department of Pediatrics

Raina Goyal, FRCS
Department of Ophthalmology
Royal Glamorgan Hospital
Ynysmaerdy, Llantrisant, United Kingdom

References

1. Ling R, James B. White-centred retinal haemorrhages (Roth spots). Postgrad Med J 1998;74:581-2.
2. Kanski. 2010, Signs in ophthalmology: causes and differential diagnosis. 1st ed. St Louis (MO): Mosby; 2010.

Peritonsillar Abscess in an Infant

An 8-month-old girl presented to the emergency department (ED) with a 3-day history of fever, decreased oral intake, and limited neck and jaw movement. Her examination was notable for right-sided palatal edema, a left-shifted uvula, and an obstructed view of the oropharynx. A computed tomography (CT) scan of the neck demonstrated a 4-cm right peritonsillar abscess with significant mass effect on the airway (**Figure 1**). She was managed with noninvasive airway support and intravenous steroids plus intravenous ampicillin/sulbactam. She was taken to the operating room by the otolaryngology service, who drained 12 mL of purulent fluid from the abscess. She rapidly improved and was discharged from the hospital on day 4 with a course of oral amoxicillin/clavulanic acid.

Peritonsillar abscess is a suppurative tissue infection that occurs in the palatine tonsils. The presentation includes fever, dysphagia, drooling, and trismus. It is a rare condition in children younger than 5 years of age, with a mean age of onset of 12 years and two-thirds of the cases occurring in children aged >10 years.[1] Sepsis, jugular vein thrombosis, and airway obstruction are potential serious complications.[2] Smaller infant airways may be more susceptible to compromise, as evidenced in this patient, and thus more difficult to support (noninvasively or invasively) in critical scenarios.

As in this case, fever and decreased oral intake may be the only initial complaints in an infant with a peritonsillar abscess. These common pediatric symptoms are nonspecific, making a peritonsillar abscess difficult to diagnose, especially if clear visualization of the oropharynx is not performed or if these symptoms are attributed to another more common infectious etiology in this age group, such as Coxsackievirus or primary herpetic gingivostomatitis. Careful physical examination, including good visualization of the oropharynx, is key to suspecting the diagnosis of a peritonsillar abscess in an infant. Recognizing the vulnerability of the infant airway in the setting of a deep space neck infection is paramount to supporting the airway and

J Pediatr 2020;227:320-1.

https://doi.org/10.1016/j.jpeds.2020.08.053

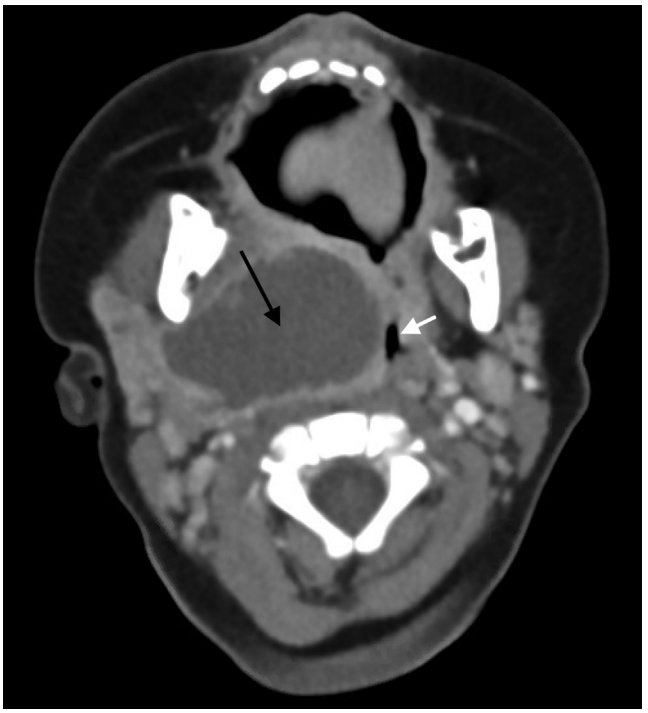

Figure 1. Axial computed tomography of the neck showing a 4-cm right peritonsillar abscess (black arrow) with significant mass effect and compression of the airway (white arrow)

preparing for possible decompensation. Neck imaging and subsequent medical and surgical management are crucial to the prompt and effective treatment of this uncommon but potentially life-threatening infection in infancy. ■

Bruna B.C. Olson, MD
Department of Pediatrics

Mark R. Zonfrillo, MD, MSCE
Department of Pediatrics
Department of Emergency Medicine

Lauren M. Allister, MD
Department of Pediatrics
Department of Emergency Medicine
Alpert Medical School
Brown University
Providence, RI

References

1. Hsiao H, Huang Y, Hsia S, Wu C, Lin J. Clinical features of peritonsillar abscess in children. Pediatr Neonatol 2012;53:366-70.
2. Bochner R, Gangar M, Belamarich P. A clinical approach to tonsillitis, tonsillar hypertrophy, and peritonsillar and retropharyngeal abscesses. Pediatr Rev 2017;38:81-92.

Bedside Airway Ultrasound in the Evaluation of Neonatal Stridor

A female infant was born at term after an uneventful gestation. Immediately after birth, she exhibited inspiratory stridor and cyanosis, necessitating respiratory support with continuous positive airway pressure and oxygen supplementation. Once stabilized, she was admitted to the neonatal unit. The physical examination was unremarkable. Stridor worsened with vigorous breathing, crying was dysphonic, and severe episodes of airway obstruction occurred during oral feedings. The differential diagnosis included laryngomalacia, congenital vocal cord palsy, tracheoesophageal fistula, and a vascular ring.

A gastric tube was inserted, and chest radiography confirmed passage of the tube to the stomach. Bedside airway ultrasound showed normal bilateral vocal cord movement and a near-total collapse of arytenoids during vigorous crying (**Figure** and **Video 1**; available at www.jpeds.com). Airway obstruction was mild on quiet breathing and disappeared during sleep (**Video 2**; available at www.jpeds.com). These finding were highly suggestive of laryngomalacia.

The infant was sedated with dexmedetomidine (0.7 μg/kg) and midazolam (0.05 mg/kg) and airway endoscopy was performed. Laryngomalacia was confirmed (**Video 3**; available at www.jpeds.com). The subglottic area, trachea, and main bronchus were normal. Evolution was favorable, with improvement in stridor and dysphonia over the succeeding months.

Laryngomalacia in the most common cause of stridor and airway obstruction in neonates and small infants.[1] A clinical diagnosis suffices in most cases; however, severe or atypical (eg, biphasic stridor, dysphonia, choking) presentations require confirmation by direct visualization of the larynx during spontaneous breathing using airway endoscopy, which also serves to evaluate the inferior airway for additional or alternative diagnosis. However, the airway endoscopy procedure requires specialized equipment and staff and is not always readily available. Moreover, this technique is somewhat invasive and disturbing to the child and often requires sedation, which may obscure the precise evaluation of dynamic airway obstruction. Finally, the procedure itself or the use of

J Pediatr 2020;227:321-23.

https://doi.org/10.1016/j.jpeds.2020.08.011