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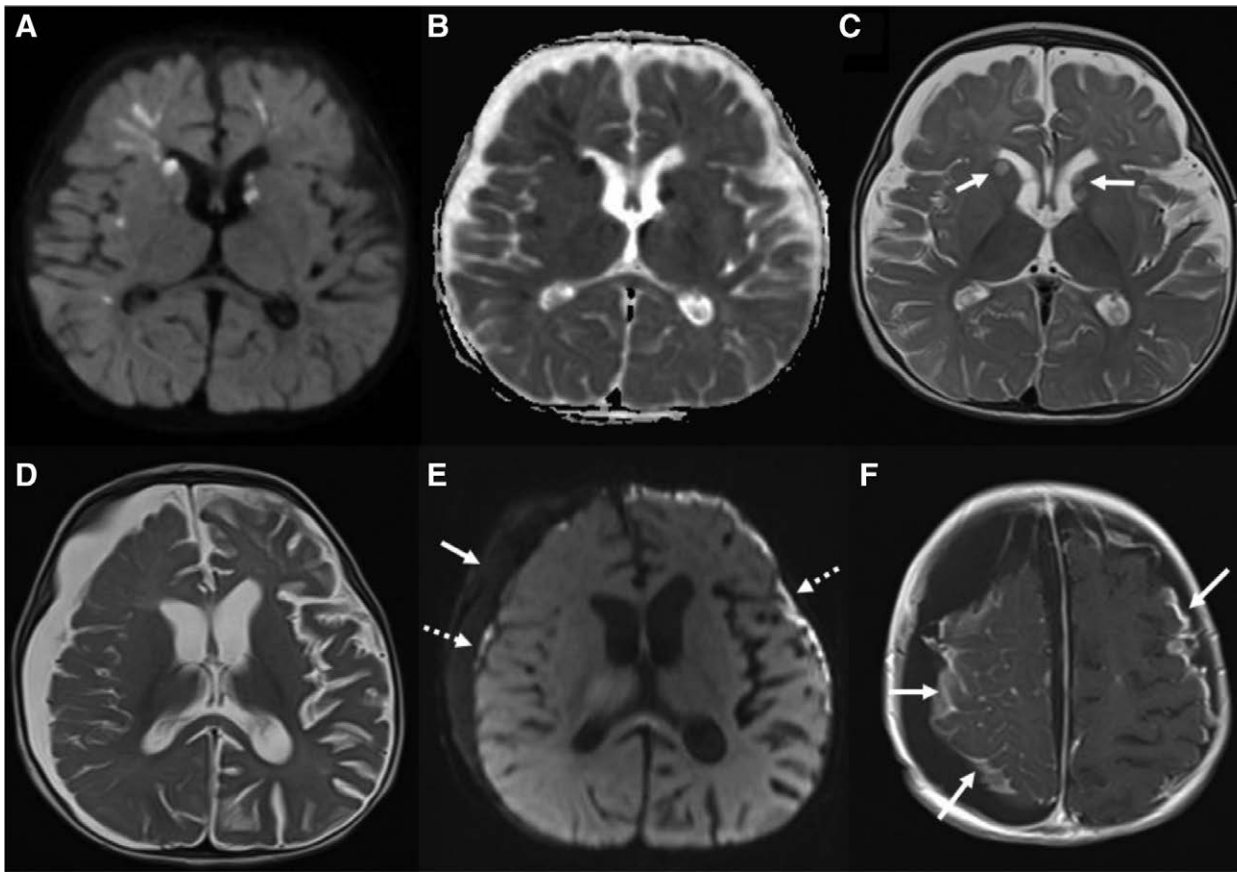


FIGURE 1. Initial MRI: (A) axial diffusion-weighted image and (B) ADC map show multiple small infarcts in the white matter and basal ganglia. C: Axial T2-weighted image shows T2 hyperintensity of the infarcts (arrows). MRI after 2 weeks: (D) axial T2-weighted image demonstrates interval development of right subdural collection with mass effect and hydrocephalus. E: Axial diffusion-weighted image reveals coexisting extra-axial effusion (solid arrow) that shows no diffusion restriction and empyema with diffusion restriction (dashed arrows). F: Contrast-enhanced axial T1-weighted image shows significant leptomeningeal enhancement.

Pancreatitis as a Complication of Crimean-Congo Hemorrhagic Fever in a Child

To the Editors:

Crimean-Congo hemorrhagic fever (CCHF) is a zoonotic disease transmitted mainly by ticks and characterized by fever and hemorrhage, varying from asymptomatic to a 10%–80% mortality rate.[1,2] Atypical complications or presentations such as epididymo-orchitis,[3] acute renal failure, appendicitis, parotitis[4] and peritoneal effusion may also occur. We present a 17-year-old girl—the first case of acute pancreatitis seen as a complication of CCHF in the pediatric population.

A 17-year-old previously healthy girl was referred to our hospital from an endemic area. She had a history of tick bites 3 days before. She was suffering from headaches, dizziness, nausea, vomiting and fever. Upon hospital admission, she had a high fever (38.6 °C) and a tick bite mark (0.5 × 0.5 cm) on the extensor side of her right wrist. Laboratory findings are shown in Figure 1. Polymerase chain reaction (PCR) of blood for CCHF was positive. Ribavirin, fresh frozen plasma and thrombocyte suspension were given. Alanine aminotransferase and aspartate aminotransferase increased to a maximum of 1232 U/L and 1435 U/L, respectively. Ursodeoxycholic acid and intravenous *N*-acetylcysteine therapy were administered.

On the fifth day, the patient was diagnosed with secondary hemophagocytosis due to elevated ferritin (11051 μg/L), triglycerides (258 mg/dL), fever, thrombocytopenia (34×10^9/L) and neutropenia (370×10^6/L). She underwent plasmapheresis and received intravenous immunoglobulin (2 g/kg) and pulse steroid therapy (3 days) in the intensive care unit. After 2 days of treatment, her hemophagocytosis-related symptoms improved.

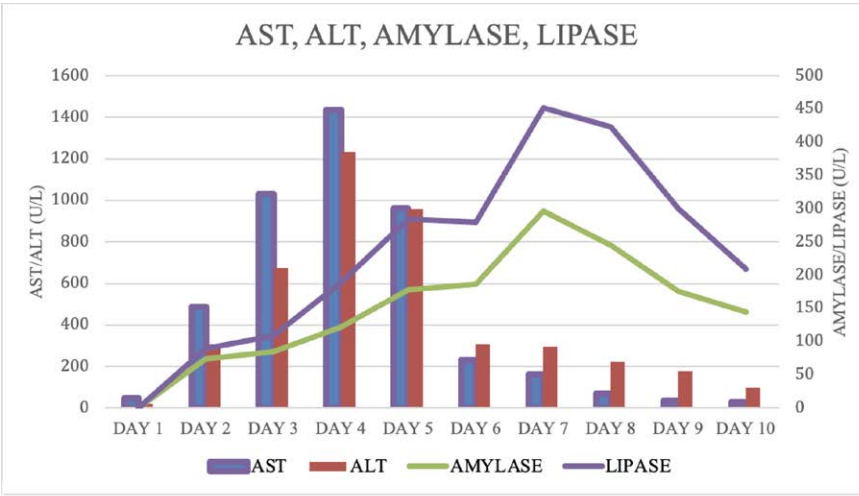
Upon admission, the patient's amylase level was 74 U/L (normal range: 0–94 U/L), and the lipase value was 89 U/L (normal range: 0–194 U/L). However, by the fourth day of hospitalization, the amylase level surged to 296 U/L, 3 times the upper limit of normal, and the lipase value rose to 451 U/L, twice the upper limit of the normal range. These findings, coupled with the patient's complaint of mild abdominal pain in the upper left and epigastric regions, led to the diagnosis of acute pancreatitis. Adequate hydration and antibiotic therapy were administered. Subsequent follow-up revealed normalized amylase and lipase levels, along with a resolved physical

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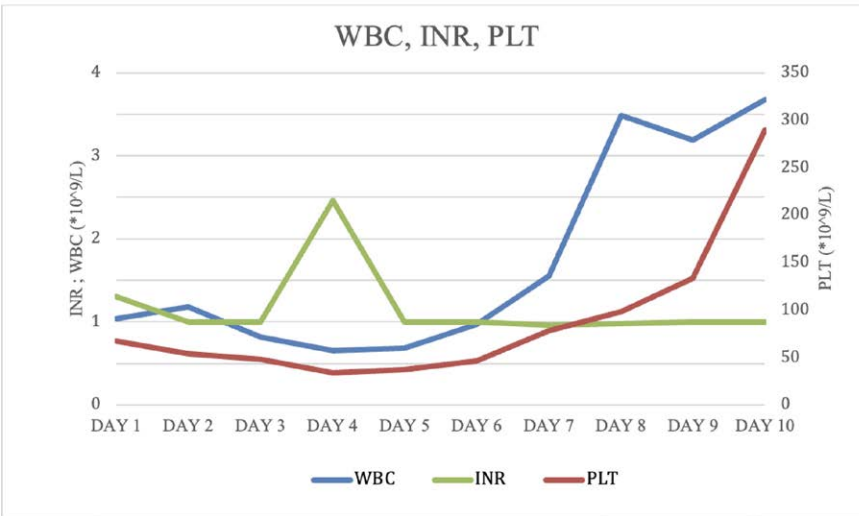


FIGURE 1. Biochemical and hematologic laboratory findings of patient.

examination, prompting the patient's discharge on the 11th day, considered cured.

Not only does CCHF pose risks on its own, but its serious complications, such as acute pancreatitis in our patient, elevate morbidity and mortality.[2] Given its potential severity, prompt recognition of pancreatitis in CCHF cases is crucial. Diagnostic criteria include abdominal pain, elevated amylase or lipase levels and imaging findings consistent with acute pancreatitis.[5] In our case, imaging was unnecessary due to clear clinical and laboratory indicators, and a high risk of CCHF contamination. While viral infections account for a fraction of pediatric pancreatitis cases, their role in CCHF-related pancreatitis remains unclear.[5] Our patient tested negative for other viral pathogens. Although pancreatitis in CCHF patients has been reported in older adults,[6] ours marks the first pediatric case. This highlights the importance of early aggressive fluid replacement to mitigate pancreatitis complications in CCHF.

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Significance of Procalcitonin in Hospitalized Children With Respiratory Syncytial Virus

To the Editor:

Lower airway infections are the most common cause of hospitalization in young children within the United States, and respiratory syncytial virus (RSV) is thought to be to most common causative organism.[1,2] With patients hospitalized for community-acquired pneumonia (CAP), there is no definitive diagnostic test to determine whether the causative pathogen is viral or bacterial in origin, and treatment is determined by clinical findings in association with radiographic and serologic markers.[1]

During 2022, we reviewed all pediatric patients who were admitted, had a procalcitonin (PCT) drawn and tested positive for RSV on PCR testing. Patients were stratified into a high PCT or low PCT group based on the cutoff of >0.25 ng/mL[3]. Patients were further stratified into definite, probable or possible bacterial pneumonia or likely viral lower airway infection based on chest x-ray reports and microbiologic data. Definite bacterial pneumonia was defined as a positive blood culture with a CAP pathogen and radiographic imaging consistent with CAP. Probable pneumonia was defined as a positive respiratory culture for a CAP pathogen and radiographic imaging consistent with CAP. Possible pneumonia was defined as any positive culture for a CAP pathogen or radiographic imaging consistent with CAP (Table 1)[4].

In our cohort, patients who had elevated PCT on admission were more likely to receive empiric therapy and, in

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