Bee Sting in Mother and Urticarial Rash in Her Baby

A 12-day-old female infant was admitted with complaints of redness covering the whole body. In history, the mother had been stung on the lip by a bee 4 hours earlier. Swelling and pain subsequently developed in the mother's upper lip and cheek. No treatment other than ice compression was applied. The area on the lip stung by the bee could be seen, but the sting itself could not be identified. Approximately 1 hour afterward, the infant was breastfed by the mother, following which a widespread urticarial rash was observed over the whole body of the infant. Mother and baby had consumed no allergenic food or medications and had not been exposed to any allergens. It proved technically impossible to test the breast milk for IgE against wasp venom. Subsequently, 1/5 saline solution of 150 mL/kg (dextrose monohydrate + sodium chloride) and single dose dexamethasone (1 mg/kg) was administered intravenously. The rash started to disappear within the first 30 minutes and had completely resolved 2 hours later. Formula food was recommended instead of breastfeeding for the next 12 hours. The infant was discharged with full recovery.

Breastmilk contains dietary antigens [1]. Maternal antigen exposure affects antigen presence in breast milk [2]. This can be important for neonates as antigen handling in the infant gut may be impaired due to their higher gastric pH and lower secretion of pancreatic enzymes [3]. Various levels of antigen can be found in breastmilk, depending on maternal antigen exposure and mammary gland permeability [4].

Our 12-day-old patient was breastfeed after her mother was stung by a bee. After breastfeeding, urticarial rash developed over her whole body. We think that the mother was sensitized to wasp venom and that the specific IgE may have been transferred to the child during birth. The rashes resolved following the administration of dexamethasone. In the case of allergic reactions in children of breastfeeding mothers, we recommend that food intake, medications taken and exposure to any allergens in the mother be enquired into.

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Tachycardia-Induced Cardiomyopathy Presenting with Cardiogenic Shock

We describe a 6 year-old boy who was admitted in the pediatric intensive care unit in cardiogenic shock due to incessant supraventricular tachycardia (SVT) (***Fig.* 1**) Examination revealed poor skin perfusion in a pale, lethargic boy with elevated heart rate of 180 beats per minute with a 3-day history of palpitations, fatigue and poor feeding. His past medical history included an episode of paroxysmal SVT after a viral infection at 3 years of age which was successfully managed with amiodarone, propaphenone and propranolol. Initial resuscitation required rapid fluid administration, inotropic support and mechanical ventilation. Initial chest radiography showed cardiomegaly and pulmonary venous congestion. Troponin levels were elevated at 0,76 ngD L. Transthoracic echocardiography revealed a dilated left ventricle with hypokinesia, markedly reduced left ventricular ejection fraction (LVEF) around 26% without any congenital cardiac defects. The patient rapidly developed multiorgan failure. Acute myocarditis was excluded due to absence of abnormal T wave