C-reactive protein and procalcitonin were normal). Instead, somewhat surprisingly, the nasopharyngeal swab tested positive for SARS-CoV-2. Local EMS headquarter was immediately warned to sanitize the ambulance for possible SARS-CoV-2 contamination, as well as to inform all rescue members, in order to start their surveillance for COVID-19 symptoms. A few hours later, the patient underwent pediatric neurological examination and video-EEG recording, showing the recurrence of slow spikes-slow waves complex on a normal background activity, both at wake and during sleep. Considering the absence of neurological deficits, age of seizure onset, its occurrence during sleep, interictal EEG findings, the possible diagnosis of early onset self-limited childhood occipital epilepsy was done.[5] As clinical conditions quickly improved, the child was discharged home, scheduling further neurological investigations once the swab was negative for SARS-CoV-2. Local surveillance system for COVID-19 was alerted whilst the family was recommended to keep on quarantine.

Our case emphasizes that keeping a high suspicion for SARS-CoV-2 infection is pivotal in hot spots, regardless of the absence of typical COVID-19 symptoms, especially in the pediatric population. Indeed, a non-negligible proportion of SARS-CoV-2 PCR positive children may be truly asymptomatic or pre-symptomatic at presentation.

As for the seizures episode, we know that infections and fever are leading seizure-precipitating factors in children. However, to our knowledge, this is the first case of self-limited seizures in an afebrile child with SARS-CoV-2. Whether this was a pure coincidence or how much SARS-CoV-2 infection may have facilitated the seizure in a subject genetically predisposed to a self-limited focal epilepsy remains an open question. In any case, our report confirms the possible occurrence of epileptic de novo seizure in a child with SARS-CoV-2, stressing the need for immediate and accurate clinical and EEG investigations.

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Can we rely on digital thermometer at home for kids going to school during COVID-19 outbreak?

In these weeks, most students are returning to school for face-to-face lessons after remote learning replaced normal activities during SARS-CoV-2 outbreak at the beginning of 2020. Although the clinical findings in children with COVID-19 are diverse, fever and cough are the most common reported symptoms (>60%).[1]

While some countries require temperature checks at school entry,[2] in others (including Italy and UK) the governments rely on parents to monitor their children's health and keep kids home if their temperature rises

above 37.5 °C or if they show any signs of respiratory illness.[3]

The most commonly used thermometer in the home is the digital thermometer (DT). However, it has been shown that measurement of fever is not entirely reliable when a DT is used: in a study on 284 children and adolescent in a pediatric emergency triage, three out of ten individuals were falsely negative with DT when fever was defined as an axillary temperature higher than 37.5 °C, and six out of ten when the limit was set to higher than 39 °C.[4]

Indications should be given to families not to rely on digital thermometer, but to use more trustworthy instruments (*e.g.* galinstan thermometer) to screen for fever, especially during this extraordinary time, in order to contain the diffusion of SARS-CoV-2.

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Unilateral Lisch nodules in a pediatric patient: a sign for genetic mosaicism?

A 10-year-old girl was referred for multiple Lisch nodules (LN) in the right eye observed during the routine ophthalmologic visit. At the examination, she had one *cafè-au-lait* spot on the left wrist and one *cafè- au-lait* spot on the back, both with a maximum diameter >0.5 cm. The remaining physical exam was unremarkable. In particular, she had no axillary/inguinal freckles nor evident plexiform neurofibromas. Pubertal development was normal for age. Neurological examination was normal. Head circumference was on the 50-75° centile. She had normal cognitive development and normal growth. Her personal and family history was unremarkable. Ophthalmological examination revealed unilateral LN, which were confirmed at biomicroscopic examination (Figure 1, 2). Visual acuity was 20/20 bilaterally. The anatomical component was normal. Fundus oculi were normal. Magnetic resonance imaging was normal.

The patient underwent genetic testing with Next-Generation Sequencing (NGS) for NF1 (58 exons, 8661 bp; RefSeq NM_000267.3) and SPRED1 (7 exons, 7780 bp; RefSeq NM_152594.2); the coverage depth for the first gene was 178.2X, whereas for the latter was 171.9X. The target region with coverage ≥20X was 99.6% for NF1 and 100% for SPRED1. Allele-fraction cut-off was 5%, with Forward/Reverse

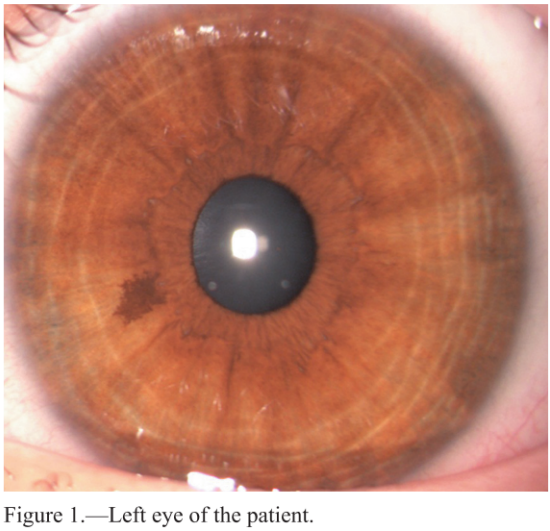

Figure 1.—Left eye of the patient.