

oral alendronate is an effective alternative to intravenous pamidronate in treating patients with PFD. However, they have not mentioned about the only paper comparing intravenous and oral bisphosphonates in PFD(2). In the above-mentioned article, no differences were found in the favorable response to either oral bisphosphonates alone or in combination with intravenous therapy regarding bone pain and fracture healing. Therefore, lower cost and ease of administration are not the only reasons favoring the use of oral over intravenous bisphosphonates, but there are published reports too.

Concern has been raised regarding the safety profile of bisphosphonates in children as most of the experience has been obtained from their use in osteoporosis and Paget's disease that predominantly occur in adults. However, no serious side effects were noted in a recent study(3) conducted on 18 children and adolescents using pamidronate treatment for 1.2-9.1 years (median 3.8 years).

In conclusion, bisphosphonates are safe and effective in reducing bone pain and incidence of fractures in children with PFD. Oral alendronate is an effective alternative to intravenous pamidronate in this setting.

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## Neonatal Necrotizing Fasciitis

We report two cases of necrotizing fasciitis in the newborn.

*Case 1:* A 25-day-old full term normally delivered neonate presented with redness and swelling of occipital skin for one day. There was no history of trauma. Local examination revealed an 8 × 7 cm reddish patch over the occipital region. Within 24 hours the scalp showed patches of necrotic skin, discharging fluid and ulcers with slough on its floor. Pus culture grew streptococcus pyogenes

while the blood culture was sterile. The infant was treated with parenteral antibiotics, debridement and subsequent skin grafting.

*Case 2:* An 11-day-old full term caesarean delivered neonate presented to us with necrosis over left occiput, right forearm and both legs. Local examination revealed two necrotic patches - over left occiput measuring 5 × 6 cm. Also a 5 × 4 cm lesion was present over the left dorsum of forearm with a well established line of demarcation (*Fig. 1*). The pus culture grew streptococcus pyogenes and the blood culture was sterile. The infant was treated with early debridement, intravenous



Fig. 1. Photograph showing two necrotic patches - over left occiput measuring 5×6 cms and a 5 × 4 cm lesion over the left dorsum of forearm.

antibiotics followed by skin grafting on a healthy granulation tissue bed three weeks later. Follow up showed secondary healing.

Necrotizing fasciitis is predominantly an adult disorder. It affects diverse parts of the body but involvement of head and neck is uncommon(1). Necrotizing fasciitis in neonate is attributable to omphalitis, mammitis, balanitis, postoperative complications and fetal monitoring(2). In children scalp lacerations, cervical adenitis and chicken pox can cause necrotizing fasciitis.

The predominant causative bacteria include group B streptococci, group D enterococcus, group A streptococci, *Staphylococcus aureus*, Enterobacteriae and anaerobic bacteria(3).

Initial presentation ranges from minimal rash to erythema, edema, induration or cellulitis. These later develop peau d'orange appearance, violaceous discoloration, bullae or necrosis(1,2). Blood cultures in 20% and skin lesions in 30% identify the bacteria(4).

High index of suspicion, prompt aggressive surgery (debridements, release incisions, excisions, fasciotomy, skin grafting), appropriate antibiotics and supportive care is the mainstay of management, especially in neonates. Survival with only fasciotomy, drainage and antibiotics is reported in few cases(5). Mortality from necrotizing fasciitis can be high(1). Survival is related to early diagnosis and adequate treatment.

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