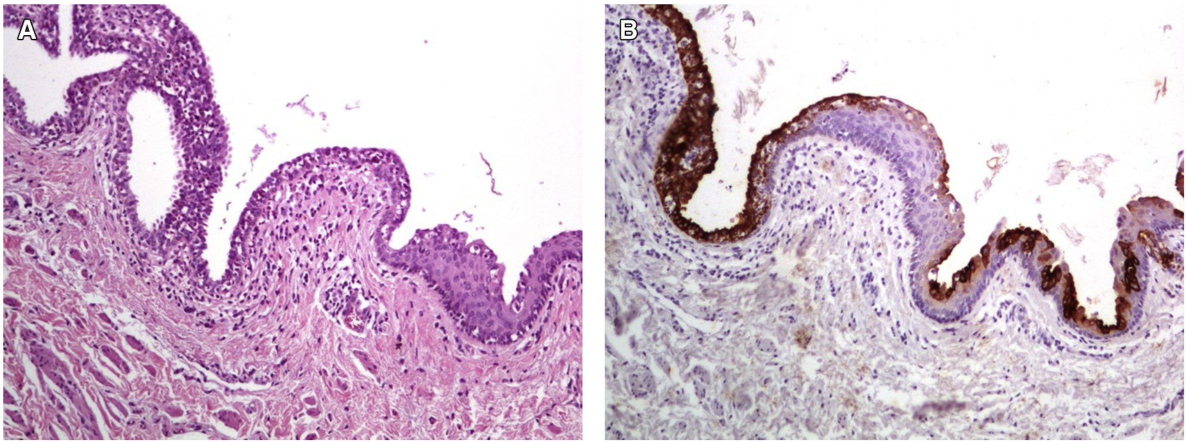

Figure 3. **A,** Columnar epithelium (left) in transition to non-keratinizing stratified squamous epithelium (right). **B,** Immunohistochemical stain for cytokeratin-7 of the area shown in **A**, displaying diffuse antigen positivity in the columnar epithelium (left), and only residual surface columnar cells in the metaplastic squamous epithelium (right).

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https://doi.org/10.1016/j.jpeds.2021.04.072

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Reply

To the Editor:

The authors show histologic images from an excised median raphe cyst in a young boy. To even a humble pediatric urologist, the representative histology shows a cystic space lined with epithelium. This arrangement explains why this embryologic fusion abnormality is unlikely to spontaneous resolve with time. As such, these histology images represent a contribution to the literature. Surgical excision is curative so long as it is complete. Pediatricians should be aware this lesion may span the entire median raphe, from the ventral penile shaft to the anus. Surgeons should be sure to examine the entire perineum for satellite cysts to prevent recurrence. The lesion is benign but can become infected and, understandably, may cause psychological distress in older children.

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https://doi.org/10.1016/j.jpeds.2021.04.070

The author declares no conflicts of interest.

Final Outcomes of a Pediatric Surge-in-Place Model during the Coronavirus Disease 2019 Pandemic

To the Editor:

We reported our hospital's approach to "surge-in-place," where pediatric providers and nurses cared for adults with coronavirus disease 2019 (COVID-19) in a 40-bed unit within a children's hospital.[1] We leveraged our existent quality and safety infrastructure to rapidly create and run this unit within our integrated healthcare system. Final outcomes of our first 100 patients were unavailable at article submission. Reporting these outcomes is important to understand whether our strategy resulted in similar outcomes as adults treated in traditional clinical settings.

Ninety patients were discharged: 83 (92%) to home and 7 (8%) to long-term care facilities. Ten patients died in the hospital. The total cohort's median length of stay (LOS) was 5 days (IQR 2-9). Of the surviving patients, 8 (8.9%) had a 30-day emergency department visit, 4 (4.4%) had a 30-day readmission, and 1 (1.1%) had a 30-day mortality.

Compared with a large New York City cohort,[2] of whom 46% had available outcome data, we had a greater overall discharge rate (90% vs 79%), lower in-hospital mortality (10% vs 21%), and similar LOS (5 [IQR 2-9] vs 4 [IQR 2-7]). Our mortality rate was substantially less than nationally reported data (20.3%).[3] Compared with patients in our own healthcare system, we had a lower mortality rate (10% vs 15.5%) and similar LOS.[4] These disparate mortality rates are not surprising, as we intended to admit younger, healthier patients. With readmission rates ranging from 2.2%[2] to 4.5%,[5] our rate of 4.4% is not markedly different.

Patients hospitalized with COVID-19 on our unique unit experienced similar outcomes to what the literature reports. For healthcare systems deciding how to allocate pediatric resources to meet the care demands of adult patients during a healthcare crisis, these data support a "surge-in-place" model.

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https://doi.org/10.1016/j.jpeds.2021.04.068

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Automated oxygen saturation targeting strategy in neonates

To the Editor:

Srivatsa et al showed improvement in neonatal mortality and morbidity following implementation of the automated oxygen saturation targeting (OST) strategy.[1] The authors showed a reduction in any stage retinopathy of prematurity (ROP) and bronchopulmonary dysplasia (BPD) from epoch 1 to epoch 2, without any significant change in mortality. If we ignore the overall secular trend of improving neonatal outcomes, this reduction can be attributed to change in the lower range of saturation targets (from 85% to 89%). This finding is contrary (but reassuring) to a recent meta-analysis.[2] We ask for clarification on the following points. (1) The authors showed significant improvement in adverse outcomes during epoch 3 (compared with epoch 1). During these 2 phases, there were major differences in saturation targets, use of automated OST strategy, and other neonatal practices.[3] Therefore, it is difficult to say that the improvement was solely due to the implementation of the OST strategy. Though the authors showed a significant downtrend, a head-to-head comparison of epoch 2 and 3 can better assess whether the improvement was solely due to an automated OST strategy. (2) There was a significant difference in the mode of delivery and multiple gestations (higher in epoch 1) across the epochs. Both parameters can have a direct impact on studied outcomes and warrant their inclusion in adjusted analysis.[3-5] (3) The discrepancy in the denominator of ROP outcomes requires clarification. (4) A recent meta-analysis has shown that despite the use of automated control of oxygenation, the meantime spent within the target saturation range is 55.8 %.[6] In this study, though the data on time spent in saturation range during the first epoch is missing, the authors should compare second and third epochs (the authors have histograms for the second epoch) to see whether implementation of automated OST led to improvement in time spent in desired saturation range. If the authors find significantly higher compliance rates in the third epoch, the conclusion of this study will be further strengthened.

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https://doi.org/10.1016/j.jpeds.2021.04.055

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