strains of infant botulism. This form of botulism has become more prevalent than any other form. Many cases of infant botulism occur in breastfed infants who are being introduced to nonhuman milk substances (American Academy of Pediatrics, Committee on Infectious Diseases, and Pickering, 2012). There appears to be no common food or drug source of the organisms; however, the *C. botulinum* organisms have been found in honey. Botulism may occur in infants as young as 1 week old up to 12 months old with peak incidence between 2 and 4 months old.

The severity of the disease varies widely, from mild constipation to progressive sequential loss of neurologic function and respiratory failure (see Box 30-12). The affected infant is usually well before the onset of symptoms. Constipation is a common presenting symptom, and almost all infants exhibit generalized weakness and a decrease in spontaneous movements. Deep tendon reflexes are usually diminished or absent. Cranial nerve deficits are common, as evidenced by loss of head control, difficulty in feeding, weak cry, and reduced gag reflex. SMA type 1 and metabolic disorders are often mistaken for infant botulism in the initial diagnostic phase because of the similarities in clinical manifestations of hypotonia, lethargy, and poor feeding (Arnon, 2016b). Presenting clinical signs also often mimic those of sepsis in young infants. Botulism toxin exerts its effect by inhibiting the release of acetylcholine at the myoneural junction, thereby impairing motor activity of muscles innervated by affected nerves.

Diagnosis is made on the basis of the clinical history, physical examination, and laboratory detection of the organism in the patient's stool and, less commonly, blood. However, isolation of the organism may take several days; therefore, suspicion of botulism by clinical presentation should require emergent treatment (Arnon, 2016b). EMG may be helpful in establishing the diagnosis; however, results may be normal early in the course of the illness.

Treatment consists of immediate administration of botulism immune globulin intravenously (BIG-IV) (Arnon, 2016b) without delaying for laboratory diagnosis. Early administration of BIG-IV neutralizes the toxin and stops the progression of the disease. The human-derived botulism antitoxin (BIG-IV) has been evaluated and is now available nationwide for use only in infant botulism. Infants treated with BIG-IV usually have a shortened hospital stay from