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Reply

We agree entirely with Dr. Banerjee that multitransfused patients of beta thalassemia are susceptible to multiple endocrine dysfunctions of clinical import and hence need comprehensive evaluation. Cost considerations largely dictate the extent of evaluation especially in a country like ours. Regarding serum ACTH levels for diagnosis of secondary adrenal insufficiency, we beg to differ from Dr. Banerjee. A large overlap of ACTH levels, between normal and proven secondary adrenal insufficiency, has been documented in literature(1) and hence the test has limited value. The more discriminant CRH stimulation test is not routinely used in

clinical practice because of cost and non-availability. We concur with the views on pituitary MR imaging as an index of iron overload. In addition to T2 relaxation rate, the pituitary to fat signal intensity ratio (P/F) has been used as another marker of iron overload. The degree of reduction of P/F ratio correlates well with presence of hypogonadotropic hypogonadism, with a sensitivity of 90%, specificity of 89% and an overall accuracy of 89%(2).

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Fluid Resuscitation in Septic Shock

In reference to recent article(1) on this subject, we have the following comments to offer:

- In the study, authors have compared the efficacy of saline with degraded gelatin in saline. So they have compared the crystalloid with colloid in crystalloid. The study would have been more authenticated if comparison would have been made between crystalloid and pure colloid as 5% albumin, fresh frozen plasma, synthetic

colloid solutions (heta starch, dextran 40, dextran 60).

- Authors have used fluid boluses even after 6 hours up to 24 hours of fluid resuscitation. Ideally, if the administration of 60mL/kg of crystalloid results in no improvement in septic shock, myocardial dysfunction should be considered. That needs the inotropic support in the form of dopamine or epinephrine(2).

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