

fever prior to referral were 8 and 6.5 days respectively in the two time frames. Unilateral cervical lymphadenopathy was seen in 92%; nonpurulent conjunctivitis and skin rash in 88%; oral mucosal changes in 85%. Of the 81% with desquamation, 71% developed periungual and perianal desquamation within 10 days of illness, similar to reported observations(1). Arthralgia was present in 42%. Cardiac complications were seen in 23% which included coronary artery dilatation in 3, coronary artery aneurysm in 2 all of which regressed in the follow-up, and congestive cardiac failure in 1 with unresolved mitral and tricuspid regurgitation in the five year follow-up. Elevated ESR and positive CRP were observed in 96% and 88% respectively. Thrombocytosis was seen within 10 days in 73%. Intravenous immunoglobulin given to 73% of children was well tolerated with one requiring two doses of 2 g/kg. All received high dose aspirin during the acute phase followed by low dose of 3-5 mg/kg/day for six weeks. There was no mortality.

On analysis of Indian case series totaling five or more(1,2), there seems to be a concentration of cases in coastal cities numbering to 206 (73%), against 75 from rest of India. The highest incidence of KS from United States is from Hawaii and within the continent from West Coast(3). Japan, Taiwan and Hong Kong account for most cases of KS in Asia. In contrast, Great Britain and Australia have very low incidence(4). A Washington study(5) in response to

three outbreaks of KS in close residential proximity to water bodies recommends further studies exploring the relation of Kawasaki disease occurring more in proximity to sea-shore!

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Tuberculosis Infection in BCG Vaccinated and Non-vaccinated Children

The paper on prevalence of tuberculosis (TB) infection according to BCG vaccination status by Pulickal and Fernandez is appreciated for the focus on childhood TB infection, especially in Kerala where it had not previously been explored(1). Several studies in other parts of India report lack of protection of TB infection by BCG vaccination(2). The protection reported in Kerala appears to be

artifact of analysis. Using 10 mm cut-off value for PPD response in non-vaccinated and 15 mm in vaccinated children deflates sensitivity of TB infection in the latter(2-5). Different cut-off values is inappropriate in school-age children in India(2-5). The recommendation is to ignore BCG status for assessing TB infection prevalence by PPD test(2,3,5).

The analysis should have started with determining the cut-off values appropriate for Palakkad region, by drawing superimposed graphs of frequency distributions of reaction sizes in both

groups(2, 4). Examples of this method may be found in several papers(2-5). If they are similar, the common antimode should be used as cut-off value. If they are dissimilar then the 2 antimodes give valid cut-off values for comparison. Clues in the table suggest that distributions are quite similar, as the proportions according to reaction sizes are similar. Thus, <5 mm reaction was 60.3% and 60.2% and >9 mm was 26% and 24% in the 2 groups, respectively(1). Neither difference is statistically significant(1).

A re-analysis and re-interpretation are requested so that we may know if BCG response is qualitatively better in Kerala than in neighbouring Tamil Nadu and other States in India(2-5).

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