REPLY

In response to letter from Sahu, we wish to inform that: (*a*) the group extensively deliberated about appropriate doses for anti-TB drugs to be recommended for our country based on available evidence and concluded that the earlier recommended dosages needed revision. The current dosages were arrived after looking into various available pharmacokinetic data and evidence within and outside the country (published and unpublished data from studies at AIIMS and NIRT). The group arrived at these recommendations as a consensus, while keeping in mind the absolute need for adequate serum levels and also the possible risk of cumulative hepatotoxicity; (*b*) the group recommends the total duration of ATT in intracranial TB including TB Meningitis should be 9-12 months depending upon the clinical progress on treatment. This is in consonance with available evidence and experience; and (*c*) among retreatment cases, the INH resistance is significant but not absolute, hence a third drug ethambutol, is added to in the continuation phase (RHE). There is no scientific basis or evidence for including pyrazinamide instead of ethambutol in the continuation phase. Pyrazinamide works best when there is active inflammation and in acidic pH, hence its benefit may not be seen during the continuation phase [1]. Furthermore, addition of Ethambutol not only helps in preventing emergence of drug resistance [2] but also would minimize the potential risk of hepato-toxicity with prolonged use of the suggested three hepatotoxic drugs (RHZ).

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REFERENCE

1. Snider DE Jr. Controlled clinical trial of four 6-month regimens of chemotherapy for pulmonary tuberculosis. Second East Africal/British Medical Research Council Study. Am Rev Respir Dis. 1976; 114:471-75.
2. Wallace F. The chemotherapy of pulmonary tuberculosis: a review. Chest. 1979;76:785-96.

Updated National Guidelines for Pediatric Tuberculosis in India, 2012: Some Unresolved Issues

With respect to the recently published updated national guidelines for pediatric tuberculosis in India [1], we feel that the following issues need to be clarified for the benefit of practicing pediatricians.

1. Management algorithm (***Fig*.1a**) describes that sputum positive cases need not undergo a chest *X*-ray. While *X*-ray chest may not be necessary for diagnosis and initiation of treatment, it is vital for follow up and determination of duration of intensive phase treatment.
2. The guideline says that "There is no role for inaccurate/inconsistent diagnostics like serology (IgM, IgG, IgA antibodies against MTB antigens), various in-house or non-validated commercial PCR tests and BCG test." PCR is a very useful and promising diagnostic test for tuberculosis [2-4], though the existing commercial PCRs are non-validated. Since the PCRs for TB are likely to be validated in near future, it should have been mentioned separately rather than clubbing it with serological and BCG tests.
3. Management of childhood tuberculosis through DOTS centre is programmatically logical, but if a child has to attend DOTS centre three days a week, then his/her academic performance, self-esteem and mainstreaming is likely to be compromised. Therefore we need to find a practical solution to address this very important issue. DOTS providers are not highly skilled workers, hence one of the viable solutions could be to train school teachers assigned to 'medical room' in most of the schools and give them the responsibility of DOTS providers after initial registration at DOTS center. This could significantly minimize visits to DOTS centre.
4. The guidelines recommend INH prophylaxis to "All asymptomatic contacts (under 6 years of age) of a smear positive case, after ruling out active disease and irrespective of their BCG, TST or nutritional status." This appears to be an overstatement which arbitrarily puts the whole family under a cloud with consequent social stigma and even partial failure in compliance by those who really need to take it. Secondly, are we justified to give single drug chemoprophylaxis with INH which has a resistance rate of >5% in our community? What would be the overall impact on INH resistance?
5. INH chemoprophylaxis in all TST positive cases has been recommended for 6 months. What is the evidence to support this conclusion? Duration of