

to reason to believe that this spontaneous recovery can be hastened even by an inappropriate drug like furazolidone. Whether to use furazolidone or not in properly selected patients is for the individual consultant to decide but it should be based on scientific reasoning.

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Reply

It is an established fact that if the infected strains of *S. typhi* are not multi-drug resistant, chloramphenicol, trimethoprim-sulphamethoxazole or ampicillin are the recommended drugs for typhoid fever. However, resistance of *S. typhi* strains to these drugs is approaching an unacceptably high level world wide(1,2). Currently, multi-drug resistant *S. typhi* are being encountered with increasing frequency in India(3-6) and the treatment of typhoid fever particularly in children has become a therapeutic challenge. Emergence of multi-drug

resistant strains of *S. typhi* has also necessitated use of ciprofloxacin to treat typhoid fever in children(7) despite controversy over its use in individuals in this age group(8). Few studies showed the usefulness of third generation cephalosporin(9,10) but these drugs are expensive and are available only for parenteral administration.

In contrast, *in vitro* studies of *S. typhi* strains isolated in Calcutta and elsewhere show that the isolates are susceptible to furazolidone(3,6,11). Several clinical alternatives to chloramphenicol in the treatment of typhoid fever(12,13) even if it is caused by multi-drug resistant strains of *S.*

typhi(14). Furazolidone therapy has also been incorporated in an Internationally reputed textbook(15). Still clinicians have the misconception that furazolidone is not well absorbed from the gastrointestinal tract and does not attain substantial serum concentration and it is not expected to be effective for the treatment of systemic illness such as typhoid fever. However, recent pharmacokinetic studies showed that furazolidone is well absorbed and achieves good level in blood and a significant level in bile and urine(16-18). Furthermore, furazolidone has many other favorable characteristics: it is cheap, can be administered orally, is appropriate to use in all age groups, free from severe side effects And does not change the intestinal microflora.

Overall, patients should be treated according to the clinical judgement of the physicians. The treatment schedule mentioned in the text of our article(19) does not have any clinicopharmacological basis. Simply clinically suspected, uncomplicated typhoid fever cases received furazolidone even who had fever for 3 weeks and the drug was changed to next superior drug if needed. Ciprofloxacin was initiated to these patients who had fever for more than 3 weeks for fear of intestinal and extra intestinal complications.

According to the recommendation of standard text book(15), the dose of furazolidone (7.5 mg/kg/day) was used in our study population for the treatment of multi-drug resistant typhoid fever.

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Examination Reform: Not Only OSCE But Reform Selection of Teachers Also

I read with interest the "Viewpoint" on examination reforms highlighting the role of teacher to help students to learn medicine in a better way(1). Although this article is focused on changes in undergraduate (UG) examination system, the same teachers are involved in Postgraduate (PG) examinations also, so similar deficiencies exist in these examinations also.

Identical concerns have also been raised by Gupta(2). In both articles(1,2), the remedy for shortcomings of present examination system is said to be OSCE (Objective Structured Clinical Examination) approach. It is true that poor assessment of students

by teachers is *one* of the major factors in making "Compromised" quality of Pediatricians (as well as other specialists). In this context Mehta suggested two important rectifications during Postgraduate training programme(3): (i) Thesis writing can be replaced by writing of articles in medical Journals; and (ii) Utilization of teachers for teaching by pruning their unproductive activities. This suggestion specifically deserves discussion amongst policy makers and administrators so as to arrive at a consensus regarding use of medical teachers as "teachers" rather than busy practitioners.

The crucial issue is to improve the falling standards of medical education at UG as well as PG level. In my opinion, the root cause for this problem is poorly defined selection process to choose medical teachers, *i.e.*, lecturers. The selection process abso-