Mauskar for permitting to publish and patient management, respectively.

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REFERENCES

1. Laks H, Marco JD, Willman VL. The Blalock-Taussig shunt in the first six months of life. J Thorac Cardiovas Surg 1975; 70: 687-691.
2. Rana JS, Ahmad KA, Shamim AS, Hassan SB, Ahmed MA. Blalock-Taussig Shunt: Experience from the Developing World. Heart Lung Circ 2002; 11: 152-156.
3. Pongprot Y, Silvilairat S, Woragidpoonpol S, Sittiwangkul R, Phornphutkul C. Pseudoaneurysm following modified Blalock-Taussig shunt: a rare complication mimicking pulmonary disease. J Med Assoc Thai 2003; 86:365-368.
4. Coren ME, Green C, Yates R, Bush A. Complications of modified Blalock- Taussig shunts mimicking pulmonary disease. Arch Dis Child 1998; 79: 361-362.
5. Tabaee SA, Rostami A, Givtaj N, Mali S, Pourabasi SM, Arefi S. Modified Blalock-Taussig Shunt and Giant Perigraft Reaction. J Teh Univ Heart Ctr 2007; 3: 173-176.

Cross System Practice and Prescription

Bonnisan liquid and Liv-52 preparations are being prescribed by some doctors. Can practitioners of modern medicine i.e. allopathic practitioners prescribe ayurvedic medicines? I seek clarification from the medico legal cell of IAP on this issue.

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Reply

The National Law School Banglore, has interpreted the two judgments of Supreme Court of India on this issue two judgments and came to the conclusion that there is no bar on cross system practice. The apex court has only laid down that every practitioner must discharge "a duty of care" to every patient he accepts to treat and "the practitioner must bring to his task reasonable degree of skill and knowledge, and must exercise a reasonable degree of care." The onus is on practitioner to demonstrate that he has the requisite knowledge and skill to prescribe that medicine and to treat the patient in a particular system.

We know that the modern medicine is usually a peer-reviewed, research oriented and evidence based practice. The same may not be applicable to the other system of traditional Indian medicine or Homeopathy. According to essentials or prerequisites for negligence there must be damage to the patient which should be as a direct result of deficiency in duty or care(1). The Apex Court, in the Poonam Varma v. Ashwin Patel case has ruled that if you are practicing any other system it is *Negligence per se*. The other side of this issue is that in many developing countries where rural health is important and qualified practitioners are not available the authorities are appointing community health workers (CHW)(2). These CHW are provided with some of the common medicines which can be used for domiciliary management of common illnesses. Do they have the deep and complete knowledge of these illnesses or medicines? If an unqualified CHW can prescribe or dispense medicines why a graduate in medical curriculum (traditional or homeopathic) cannot do so? This issue also needs a countrywide medical and legal debate.

Many recent editions of modern medicine books are coming with chapters and some references on traditional medicines(3). This indicates that some

studies have been conducted or are in progress at different centers. We feel that there is no harm in using such drugs/medicines which have been scientifically evaluated.

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REFERENCES

1. Tiwari S. Baldwa M. What is medical negligence; In: Baldwa M, Tiwari S, Shah N editors; Legal problems in day-to-day pediatrics practice: 1st edition, Hyderabad Paras Publishing 2005; 16-49.
2. Park K. Park's Text Book of Preventive and Social Medicine. 20th edition. Jabalpur: Banarsidas Bhanot; 2009. p. 791-815.
3. Kemper KJ, Gardiner P. Herbal medicines. *In*: Behrman RE, Kliegman RM, Jenson HB, editors *Nelson Textbook of Pediatrics*, 18th edition. Philadelphia: Saunders; 2007. p. 357-360.

Kawasaki Disease – Call for a National Registry for India

Congratulations on a "Kawasaki Disease (KD) enriched" issue (July 2009). Two key messages emerged from the article by Singh and Kawasaki(1). Firstly, that the problem of KD in India has grown exponentially in the last decade. Whether, as hypothesized by Kushner, *et al*.(2) India will follow the Western model (an old disease being diagnosed more frequently now) or the Japanese model (a new disease probably caused by the introduction of an agent in a susceptible population), the load of KD promises to be large in the near future. Secondly, treatment of KD is costly and the cost of sequelae (in the form of morbidity/mortality to a productive population) even larger. Not only is IVIG costlier than the per capita income of India, its usage is limited by non-uniform availability in time/place and that it is a biological product with finite resource.

It therefore behooves the Indian Academy of Pediatrics (IAP) to build their embankments before the tide rises any further. A multi pronged approach is needed:

(*a*) Setting up a national registry for the disease (at centers of excellence such as PGI, Chandigarh) would be a first step. Our experience with setting up a registry in Mumbai over 6 years ago(3) has shown that this has been a suitable way to create awareness about this entity, educate the primary pediatricians / parents and serve as a repository for cases.

(*b*) Liaising with researchers to identify lower cost treatment regimes is the next priority. Our reliance on imported knowledge is likely to be misplaced as has been seen in other diseases such as juvenile arthritis where patients who fail first line therapy often land up as therapeutic orphans for want of the costly biologicals.

(*c*) Working in tandem with cardiologists/echo cardiographers to standardize and diagnose coronary anomalies better and create a sense of involvement in them to transition these cases into adulthood.

(*d*) To appraise the health planners and political bodies about this entity which otherwise the lay person identifies better as a two wheeler of the same name.

I therefore earnestly appeal to the IAP to heed this clarion call.

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REFERENCES

1. Singh S, Kawasaki T. Kawasaki disease – An Indian perspective. Indian Pediatr 2009; 46: 563-572.
2. Kushner HI, Macnee R, Burns JC. Impressions of Kawasaki syndrome in India. Indian Pediatr 2006; 43: 939-942.
3. Khubchandani RP, Khemani C. Kawasaki disease registries reap results – experience in Mumbai. Indian J Pediatr 2006; 73: 545.