

responsible for the misdiagnosis and continuation of antiparasitic chemotherapy. Thus, making quantitative serology the only dependable test, as antigen detection kit in pus is not available and detection rate of trophozoites in cases with mixed amebic and parasitic infection is poor(3,4).

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### **Allogeneic Peripheral Blood Stem Cell Transplantation in Aplastic Anemia**

Allogeneic hematopoietic stem cell transplantation (HSCT) is the definitive therapy for severe aplastic anemia (SAA)(1,2). The major factors that limit the success of HSCT are graft rejection and graft-versus-host diseases (GVHD)(3,4). Engraftment depends on the conditioning regimen, GVHD prophylaxis, number of donor marrow cells infused and alloimmunization of the patient(3,4). Taking an aplastic anemia with septicemia for transplant is a very high-risk proposition.

A 11-year-old boy was diagnosed to have aplastic anemia and treated with ATG followed by Cyclosporin for 6 months. He was admitted at our center with high-grade fever of one week's duration with pancytopenia. Blood culture grew *E. coli* on two occasions and

*Klebsiella* on one occasion. *Staphylococcus aureus* was grown from central line tip on two occasions. He was started on meropenem and teicoplanin for 3 weeks, when he developed maxillary sinusitis, for which he was started on amphotericin B. He continued to have intermittent fever. He was also given granulocyte infusions for one week. Blood culture was sterile after 3 weeks when a Hickman catheter insertion was done. During this time HLA typing of his 3-year-old sister was done and found to be 6 antigens matched. During the afebrile period patient was started on conditioning with fludarabine (30 mg/m<sup>2</sup> IV daily on day 2-4 busulfan (4 mg/kg/d q6h on day 5,6) and cyclophosphamide. 350 mg/m<sup>2</sup> IV daily on day 2-4. A peripheral blood stem cell (PBSC) harvest was done from the donor after 5 days of G-CSF at 10 mcg/kg/d. A volume of 110 mL was collected with an MNC of 3.65 × 10<sup>8</sup> cells/kg. The CD 34 cell dose was 1.34 × 10<sup>6</sup> cells/kg. GVHD prophylaxis was IV cyclosporin (CsA) at a dose of 3.0 mg/kg/d. G-CSF was started from

Day +7 at 5 mcg/kg/d. CsA was changed to the oral route on Day + 13. An absolute neutrophil count  $>500/\text{mm}^3$  was attained on day +9 and an unsupported platelet count  $>20000/\text{mm}^3$  was achieved on day +30. Chimerism analysis on day +24 by XY analysis revealed 100% donor cells. Patient was discharged on day +31. Patient is well at last follow up on day +140.

Taking a patient with aplastic anemia with sepsis for bone marrow transplant has a mortality close to 100%. Our patient was successfully transplanted using a conditioning regimen, which was not very highly immunosuppressive but enough to achieve engraftment. PBSC was preferred to bone marrow for faster engraftment. Busulfan along with Cyclophosphamide has been used for conditioning in SAA(5). Busulfan is cheaper than TBI and ATG. Hence, we recommend this conditioning as one option in patients with aplastic anemia especially with infection.

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## Dyslexia: Association with Attention Deficit Hyperactivity Disorder

The February 2005 issue of the Indian pediatrics reported the first study on the genetic polymorphisms of Attention Deficit Hyperactivity Disorder (ADHD) in the Indian subcontinent(1). ADHD is a childhood

disorder which has been inadequately studied in the region. There is a dearth of baseline literature and as a result many children remain undiagnosed and fall to the injustices of the illiterate majority. Bhaduri, *et al.* have made a great contribution by opening new avenues in the study of ADHD in the Asian region. This area definitely needs more exploration.

We would like to make some suggestions. It was interesting to observe the differences in