

pubertal presentations. However, the SD of <3 in both the groups indicate that there were a substantial number of patients below the age of 10 years and a significant number of patients in the bipolar group presented with >1 episode, indicating an earlier onset of the illness. Although difficult to extend the findings to any epidemiological trends in the Indian population, it sheds some light on the clinical presentation of mood disorders in the clinic based population from an Indian context, adding to the emerging literature and greater understanding of the concept of mood disorders in childhood.

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The Ignominy of Low birth Weight in South Asia

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Although estimates vary, it is recognized that more than 20 million infants worldwide, representing 16% of all births in developing countries, are born with low birth weight (LBW). The vast majority, over 95%, of these births are in developing countries [1]. More than two thirds (68%) of all LBW infants are born with evidence of intrauterine growth retardation (IUGR), the majority in South-Central Asia, where more than a quarter (27%) of all infants weigh less than 2500 g at birth [2]. Such IUGR infants mostly include those born at term (about 9.6% of all newborns weigh between 2000 and 2499 g at birth). They may also include preterm infants (an estimated 1.3% infants born globally weighing between 1500-1999 g at birth) or those born with a combination of prematurity and IUGR. Term IUGR infants have much higher rates of morbidity and neonatal complications including a higher risk of mortality [2]. It is estimated that newborn infants weighing between 2000–2499 g (those representing the majority with term IUGR) are 2.8 (95% CI 1.8-4.4) times more likely to die during the neonatal period than those weighing more than 2499 g at birth. Despite limited data from community settings, it is also known that the corresponding relative risks of dying

from birth asphyxia and infectious diseases are 2.3 (95% CI 1.3-4.1) and 2.0 (95% CI 1.2-3.4) for those weighing 2000-2499g at birth [2]. More importantly, the well documented long term effects of LBW, coupled with post-natal factors also highlight important links with the growing epidemic of non-communicable diseases [3].

Recognized major risk factors associated with term LBW include maternal undernutrition, frequently reflected with low maternal body-mass index [4], as well as placental insufficiency associated with severe morbidity such as pre-eclampsia. The potential role of multiple micronutrient deficiencies in affecting birth weight is underscored by several studies from South Asia attributing the IUGR to specific deficiencies and corroborated by the recognized effect of multiple micronutrient supplementation in pregnancy on increasing the birth weight [5]. These distal determinants of LBW are manifestations of a number of proximal factors including poverty and marginalization. These social determinants of LBW were poignantly underscored by the classic enunciation of the “Asian enigma” by the late Professor Ramalingaswami, *et al*. [6], who highlighted the importance of gender

inequality, lack of female empowerment and the key role played by the environment and caring practices in determining maternal and childhood undernutrition. Over the last two decades, numerous scholars and nutrition scientists from the region have explored the risk factors associated with LBW and suggested solutions. In this issue of the journal, Mumbare, *et al.* [7] once again underscore the importance of maternal undernutrition, poor education and lack of antenatal care in a cohort of term LBW infants born in a hospital setting in Maharashtra. Notwithstanding the limitations of a hospital-based cohort and the large proportion of infants excluded from the analysis, these findings are a stark reminder that little has changed.

South Asia must stand out as one of the most unfortunate regions of the world. Despite enormous resources, steady economic growth and dividends of a young population, inequity remains a major issue and major pockets of poverty remain. The issues and solutions to the challenge of LBW were highlighted decades ago as falling within the domain of human rights rather than health alone. While economists and politicians argue over the definitions of poverty, many women remain underserved, frequently bereft of fundamental rights and access to health, education and adequate nutrition. While much progress has been made in initiating large scale public health programs aimed at service delivery through community health workers, unconditional poverty alleviation strategies and conditional cash transfers, the emphasis is still on quick fixes rather than fundamental societal change. In contrast to Latin America and much of Southeast Asia, progress in key interventions such as female education and empowerment, enhancement of age at marriage and first pregnancy and access to family

planning remain painfully slow. If South Asia is to make progress in human development, addressing maternal and fetal undernutrition through concerted multi-sector initiatives, community education and preconception care are key.

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Erratum

Figure 1 of the article entitled "Azathioprine Hypersensitivity Presenting as Sweet Syndrome in a Child with Ulcerative Colitis" published in Volume 48; December 2011 issue on page no. 971 should be replaced with the figure given below.



FIG. 1 Pustular and crust lesions surrounded by erythema appeared on face (a) and arm (b) 10 days after administration of azathioprine. (c) Skin biopsy of pustular lesion shows massive neutrophilic infiltration in entire dermis (H&E, x400).