Rotavirus and enteric adenovirus were well established medically important pathogens causing infantile diarrhea. However, coronavirus and small round featureless viruses were identified in the present study though their role of causation of diarrhea is still unknown(4).

P. Dutta, A.N. Ghosh, S.S. Bhattacharya, U. Mitra, R. Rasaily, M.K. Bhattacharya, S. Chakraborty, M. Lahiri,
Division of Clinical Medicine and Electron Microscopy, National Institute of Cholera and Enteric Diseases, P-33, CIT Road, Scheme-XM, Beliaghata, Calcutta 700 010
and
Dr. B.C. Roy Memorial Hospital for Children, 111, Narkeldanga Main Road, Calcutta 700 054.

REFERENCES

1. Middleton PJ. Role of viruses in pediatric gastrointestinal disease and epidemiological factors. *In:* Virus Infections of the Gastrointestinal Tract. Eds Tyrrell DA, Kapikian AZ. New York, Marcel Dekker Inc, 1982, pp 211-225.
2. Davis HA. Electron microscopy and immune electron microscopy for detection of gastroenteritis viruses. *In:* Virus Infections of Gastrointestinal Tract. Eds Tyrrell DA, Kapikian AZ. New York, Marcel Dekker Inc, 1982, pp 37-87.
3. Sen D, Saha MR, Nair GB, Das P, *et al.* Etiological spectrum of acute diarrhea in hospitalized patients in Calcutta. Indian J Med Res 1985, 82: 286-291.
4. Blacklow NR, Grenberg HB. Viral gastroenteritis. New Eng J Med 1991, 325: 252-264.

Adverse Drug Reaction Monitoring of Ciprofloxacin

With reference to the article entitled "Adverse Drug monitoring of Ciprofloxacin in Pediatrics Practice" by Karande *et al.*(1) I would like to include another unusual side effect of Ciprofloxacin.

A ten-years-old female child was admitted at Yashwantrao Chavan Memorial Hospital at Pimpri, with history of fever for seven days. On examination the child was febrile and toxic. Spleen was palpable 1 cm below the left costal line. Rest of the findings were normal. Investigations revealed a hemoglobin of 10 g/dl, total leucocyte count of 8,800/cu mm with 64% polymorphs, 28% lymphocytes, 4% eosinophils and 4% monocytes. ESR was 9 mm of Hg. Urine and stool examination and Chest *X*-rays were normal. Blood Widal was positive with O and H titres in dilution of 1 in 240. Child was started on intravenous chloramphenicol 100 mg/kg/day every six hours and supportive treatment. Child did not respond and hence on 5th day was started on oral Ciprofloxacin (15 mg/kg/day) in two divided dosages. On third day, the child developed a squint in left eye (10°). Rest of the neurological examination was normal. Fundoscopic examination and refraction were normal. Cerebrospinal fluid was examined which was normal. The child became afebrile on fourth day and was discharged on seventh day. Till discharge the squint was same without abnormal neurological finding. The child was lost for follow up.

As there is no other cause for development of squint, we assumed it as unusual

side effect of Ciprofloxacin. It is mentioned as unusual side effect of another quinolone Nalidixic acid(2) but not of Ciprofloxacin.

N.S. Deshpande,
Yashwantrao Chavan Memorial Hospital, Pimpri Chinchwad Municipal Corporation, Pimpri, Pune 411 018.

REFERENCES

1. Karande SC, Kshirsagar NA. Adverse drug reaction monitoring of Ciprofloxacin in Pediatric Practice. Indian Pediatr 1992, 29: 181-188.
2. Illingworth RS. Common Symptoms of Disease in Children, 5th edn. Singapore, Blackwell Scientific Publications, 1975, pp 180-181.

Unusual Foreign Body (Stone) in the Esophagus of a Neonate Mimicking Tracheoesophageal Fistula

Foreign body (FB) in the esophagus during neonatal life is a very rare occurrence(1,2). Elder sibs in the family put FB in the oral cavity of infants without realizing the consequences. Suddenly, the FB get swallowed in and obstruct the esophagus. We managed a 45-day-old infant with a foreign body stone in the esophagus, put in the oral cavity by elder sib at the age of 13 days of life. He had respiratory distress and dysphagia mimicking tracheo-esophageal fistula.

A 45-day-old male infant was hospitalized with history of cough, chocking, hematemesis and excessive froth in the mouth since the 13th day of life. He was born to primigravida mother at term by normal vaginal delivery in a hospital without any adverse perinatal factors and was breast fed. On 13th day of life, the mother noticed sudden chocking, cough, respiratory distress and froth in the mouth while the baby was in the lap of elder sib. The baby had hematemesis and malena subsequently. He was put on breast feeds. He tried sucking initially but was tired and could not swallow the milk as it came out by the angle of the mouth. His condition deteriorated and he was admitted in local medical college with the diagnosis of bronchopneumonia. He was kept nil orally and was given intravenous fluids (IV) and antibiotics. He received one blood transfusion. On showing a little improvement, breast feeding was retried. However, again he could not swallow and had excessive frothing and a bout of severe cough. Subsequently, he was given Ryle's tube feeding but his respiratory distress did not improve. Meanwhile, he had two more episodes of hematemesis and malena. On the 37th day of life, he was referred to PGIMER, Chandigarh with a diagnosis of tracheoesophageal fistula (TOF). He remained in the Pediatric emergency ward for 7 days and was managed as aspiration pneumonia but when oral feeding was started he again had severe choking followed by respiratory distress. All the investigations including barium meal done by instilling thin barium through Ryle's tube were reported normal. Pediatric Gastroenterology consultation was called for exclusion of TOF. The whole history was reviewed and possibility of foreign body was kept in mind. At 45th day of life, on review of the *X*-rays of chest, a foreign body in upper one third of esophagus was suspected (*Fig. 1*) and subsequently was confirmed under fluoroscopy. On the same day, upper gastrointestinal