

months (using DASII) was 84. There was no recurrence of seizures, or developmental delay on follow-up over next 13 months. The final diagnosis made was Benign infantile seizures with mild gastroenteritis.

This syndrome – recognized only in the last decade – is still not accepted by the International League Against Epilepsy [6]. Rotavirus has been reported as the most common etiological agent in this condition in different studies [4,5]. However, other organisms have also been reported [3], and it has not been possible to attribute the convulsions to any organism, as yet [2]. The clinical symptoms are reported to precede the convulsions by an average of 2 days [4], similar to that in our case.

The importance of recognition of this condition is that it helps in avoiding unnecessary long term anti-epileptic therapy, and favorably counsel the parents about the low risk of recurrence of seizures.

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## Management of Patent Ductus Arteriosus

I read the recent review article [1] on management of patent ductus arteriosus (PDA) in very low birth weight (VLBW) infants with interest. I wish to seek clarifications regarding authors' conclusion about birth weight <800 g (without any reference to gestational age) being a deciding factor for treatment when babies with PDA are symptomatic or require positive pressure ventilator support. The reference quoted [2] reports significant effect on mortality and morbidity in the presence of persistent PDA only with gestational age <25 weeks. Moreover, there is evidence that the rate of spontaneous closure in babies weighing >1000g at birth is significantly high [3], and hence interventions for ductal closure may be relevant only in those having birth weight ≤1000g. Furthermore, neither individual randomized controlled trials nor meta-analyses of those trials have been able to demonstrate any long term benefits of interventions for ductal closure in babies with PDA, irrespective of the gestational age and birth weight [4,5]. In this context, should management of these infants be guided only by clinical judgement on an individual basis, irrespective of gestational age or birth weight?

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#### AUTHOR'S REPLY

We thank the reader for his comments and providing us the opportunity to further discuss the controversies in the management of PDA in VLBW infants. We agree with the reader that spontaneous closure of PDA is significantly high in VLBW infants with birth weight >1000g [1-2],

and the presence of PDA is associated with significant morbidity and mortality in infants of gestational age <25 weeks [3]. However, it is not clear from the literature where to draw the demarcation line as far as the birth weight is concerned. An unpublished audit done in our department revealed that birth weight was a better predictor than gestational age with regard to PDA-related morbidities. We found that morbidities such as massive pulmonary hemorrhage and severe intra-ventricular hemorrhage were significantly higher in babies with birth weight less than 800g with untreated PDA, regardless of gestational age. Hypothermia, peri-natal asphyxia, lack of antenatal steroids and intrauterine growth retardation were additional risk factors.

If treatment for the PDA is based on clinical judgment alone, we might end up in over treating it, and exposing the neonates to treatment - related morbidities. Hence we

recommend that the treatment strategies should be based on birth weight as well, in addition to hemodynamic significance of PDA and need for assisted ventilation.

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## Management of Children with Severe Acute Malnutrition

We read the two recent publications [1,2] related to Severe acute malnutrition (SAM), and wish to highlight certain issues. The prevalence of bilateral pitting edema was found to be 8.1% [1] and 27% [2]. These proportions are very high. Recent National Nutrition Monitoring Survey Report [3] has reported the time trends in prevalence of Kwashiorkor as 1.2% (1975-79), 0.2% (1988-1990), 0.8% (1996-1997) and 0% (2011-2012) [3]. The reasons for high prevalence of bilateral pitting edema found in Uttar Pradesh and Madhya Pradesh need to be elaborated.

The study that was conducted in twelve Nutrition Rehabilitation Centers (NRCs) in Uttar Pradesh [1] documented high defaulter rates (49% and 46%) amongst SAM children with complications admitted to NRCs and uncomplicated SAM children, respectively. With such a high defaulter rate, the results documenting mortality of 1.2% amongst SAM children admitted to NRCs are not valid. What were the reasons for high defaulter rate amongst complicated and uncomplicated SAM children? This information could help immensely in improving the functioning of NRCs in other states for efficient management of children with SAM.

The discharge and recovery rates were 17.8% (complicated SAM) and 28.7% (uncomplicated SAM), which reflect that inadequate services were provided to SAM children who were admitted to NRCs in Uttar Pradesh.

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#### AUTHOR'S REPLY

The 8.1% prevalence of bilateral pitting edema among children with SAM admitted in the 12 NRCs in Uttar Pradesh should not be confused with the prevalence of Kwashiorkor as found in the nutrition surveys in the community. The proportion of patients admitted in a health facility with a certain health condition may not correlate with its prevalence in the community. It would also be important to note that the frontline workers during their training on identification and referral of children with