

woody thickening of the skin with tethering of the underlying fascia are commonly noted in Melorheostosis. Growth disorders of the limbs are often the first signs in the affected children(3). It is usually associated with pain in adults, but not in children. In contrast to the typical extra-osseous sclerosis flowing like molten wax in adults, endosteal sclerosis is noted in children(2). The clinico-radiological features in this girl were consistent with Melorheostosis and the polyostotic involvement with symmetric radiological findings makes this case interesting. The simian crease as noted in this child has not been reported with Melorheostosis but could be just coincidental. The differential diagnoses include Scleroderma, Post Poliomyelitis paralysis, Rheumatic fever, Enchondromatosis, Diaphyseal dysplasia, Osteopathia striata, Osteopoikilosis and osteopetrosis. It may co-exist with osteopoikilosis, osteopathia striata and malformations of blood vessels or lymphatics(4). Bone scintigraphy is invariably positive in Melorheostosis revealing increased uptake of tracer predominantly in the cortex. Surgical procedures such as tendon lengthening, excision of fibrous and osseous tissue, fasciotomy, capsulotomy and amputation of severely affected and painful limbs have been described. However, recurrences are common(5).

Acknowledgement

We thank Dr. Deonath Mahto and Dr. Renitha for their contribution to the case management and imaging respectively.

**Adhisivam B.,
Mahadevan S.,**

*Department of Pediatrics,
Jawaharlal Institute of Postgraduate Medical
Education and Research (JIPMER),
Pondicherry 605 006, India.*

REFERENCES

1. Hellemans J, Preobrazhenska O, Willaert A, Debeer P, Verdonk P, Costa T, *et al.* Loss-of-function mutations in LEMD3 result in osteo-poikilosis, Buschke-Ollendorff syndrome and melorheostosis. *Nature Genet* 2004; 36: 1213-1218.
2. Younge D, Drummond D, Herring J, Cruess RL. Melorheostosis in children: Clinical features and natural history. *J Bone Joint Surg* 1979; 61: 415-418.
3. Beauvais P, Faure C, Montagne JP, Chigot PL, Maroteaux P. Leri's melorheostosis: Three pediatric cases and a review of the literature. *Pediatr Radiol* 1977; 6: 153-159.
4. Greenspan A, Azouz EM. Bone dysplasia series. Melorheostosis: Review and update. *Can Assoc Radiol J* 1999; 50:324-330.
5. Freyschmidt J. Melorheostosis: A review of 23 cases. *Eur Radiol* 2001; 11:474- 479.

Tips to Treat Asthma

I read with interest the article titled "Adherence issues in Asthma" published in the December issue of Indian Pediatrics and would like to share our experiences over the past one and half decade at our Asthma clinic at Bangalore.

1. The successful adherence to inhaled medications by the parents and the child will mainly depend upon the time spent by the physician during the first visit to explain, convince and support them.

2. The concept of Blue (reliever) and Brown (controller) and their differing yet contributory effects on Asthma control needs to be explained clearly during the first visit itself. Otherwise, as the Blue inhalers are less expensive and the Brown inhalers relatively 4 times the cost, and the effect of the Blue inhalations being evident within fifteen minutes in contrast to the brown inhalers which take weeks to perceive their effects, most often the Blue inhalers replace the Brown ones very shortly after initiation.
3. At each followup visit, the physician should always check, reinforce the technique of

inhalation as well as encourage the child if he is compliant. Parents should carry the inhalers and the spacers and facemasks with them during followup visits. Serial peakflow recordings help in this regard.

4. Spacers should be an integral part of inhalation therapy along with metered dose inhalers . Face masks should be used when appropriate.
5. The success story of a child and his family with proper inhalation therapy should be shared with other parents during parent education sessions so as to motivate them to continue enthusiastically.
6. The time of consultation for children with asthma should be separate from the usual consultation hours in order to provide sufficient time to the child and his family.

7. Defaulting parents are receptive when they bring their child with acute exacerbations. This situation should be utilized optimally to bring home the concept that regular controller medications do prevent /bring down acute exacerbations.

8. To write the date of purchase on the inhaler will be useful to assess compliance to some extent.

Last but not least, a knowledgeable and compassionate physician who spends time and understands the child and his family dynamics and not merely the disease process is the key to successful adherence.

S. Nagabhushana,

Professor of Pediatrics,

M.V.J. Medical College,

Hoskote, Bangalore, India.

E-mail: nagabhusana_s@rediffmail.com

‘Cling Film’ to Wrap Herniated Loops

Recently, I read with interest the article on, ‘A technique for transporting neonates with gastroschisis(1).

We at the University College London Hospital use the commercially available ‘cling film’ to wrap and suspend the loops of bowel. It is cheap and very easily available at any of the supermarkets; additionally, the loops of bowel being already exposed to the vaginal flora very strict asepsis does not have a major role to play. Hence, the ordinary

film suffices the needs. And lastly, the film being transparent the bowels can be visualized directly for any color changes.

This technique ensures that there is no major fluid loss or ischemia and then when the baby is cardiovascularly stable mortality does not remain a big issue.

We appreciate any such local adaptations to the internationally standardized techniques.

Sunil S. Bhide,

Darent Valley Hospital,

Dartford DA2 8DA, UK.

E-mail: dr_sunil@hotmail.com