complex seems to be unreasonable. Further studies in children with primary complex need to be done before such guidelines are laid down.

As regards treatment, the present algorithm rightly lays emphasis that there is no role for empirical trial of antitubercular therapy. However, in "probable cases" which includes all symptomatic children/children with history of contact with radiology suggestive of tuberculosis, positive skin test, but with bacteriology negative for AFB, the guidelines of treatment have not been specified. With the AFB positivity rate being actually low in primary complex (as mentioned above), and with not enough Indian data available, this would not be a good suggestion in a community set up in an endemic nation like ours were under-treatment of tuberculosis would be more hazardous than overtreatment.

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**REPLY**

1. It is true that there is scanty literature in India on bacteriological confirmation of childhood tuberculosis and specifically related to primary complex. Both studies quoted do show bacteriological positivity to an extent of 30% though separate data on primary complex is not available in one of the studies while the other study quoted 15% positivity in primary complex. Thus it was not possible to draw definite conclusion with studies involving small number of children. We intended to give a strong message that we must attempt bacteriological diagnosis in every case of childhood tuberculosis including primary complex irrespective of success, and I am sure more we try more we will find AFB.
2. As regards to "probable" case of childhood tuberculosis, decision of treating would depend upon individual physician's analysis of probability. In case of doubt, one should consider another opinion and then take a decision. There cannot be structured protocol for such cases. It is not correct to presume that overtreatment is safer than undertreatment. In fact mistakes on both sides are hazardous and that is the reason we hope that our members follow the protocol to minimize both undertreatment and overtreatment. That is also the reason that we have stressed on bacteriological diagnosis.

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# Consensus Statement on Childhood Tuberculosis

We read with interest consensus statement on childhood tuberculosis (1). This statement is not only important for private practitioner but also for those working in the Government/ Public sector. However, we would like to share our experience with childhood tuberculosis.

The Group has rightly recommended the dose of tuberculin unit for Monteux test (MT) that it should not exceed 5TU. In developing country, such as