ppm(unpublished data). Patro, *et al*. [2] have also shown 64.2 % household samples and 70.9% at the retail shops (*n*=55) in Jharkhand as optimally iodized samples.

JASBINDER KAUR AND SEEMA GUPTA
Department of Biochemistry, Govt. Medical College and Hospital, Chandigarh, India.
jasbinderkaur@yahoo.co.in

REFERENCES

1. Chudasama R, Patel UV, Ravikant R, Verma PH. Iodine deficiency disorders in 6-12 years - old rural primary school children in Kutch district, Gujarat. Indian Pediatr.2011;48:453-6.
2. Patro BK, Subodh P, Zodpey S, Shukla A, Karmakar MG, Pandav CS. Tracking progress toward elimination of iodine deficiency disorders in Jharkhand, India. Indian J Comm Med. 2008;33:182-5.

Migraine Variant

I read with interest the case reported by Chakravarty and Mukherjee labeled as a migraine variant [1]. They describe a 4 year old boy with delayed expressive language development and episodic focal motor and language deficits lasting 10 minutes to 3 days. Many inborn errors of metabolism can have such a presentation in childhood even in the absence of overt changes on brain magnetic resonance (MR) imaging including organic acidemias (methylmalonic, propionic and isovaleric), maple syrup urine disease, ornithine transcarbamylase (OTC) deficiency, and, hydroxyl-methyl-glutaryl CoA lyase deficiency [2]. Particularly in boys, OTC deficiency is an important consideration. Lack of appropriate metabolic investigations to screen for these disorders and MR spectroscopy, together with absence of headache in the child, makes the diagnosis doubtful, at best.

RAVINDRA ARYA
Division of Neurology, Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio
Ravindra.Arya@cchmc.org

REFERENCES

1. Chakravarty A, Mukherjee M. Sporadic hemiplegic migraine. Indian Pediatr. 2012;49:150.
2. Saudubray J-M, Charpentier C. Clinical Phenotypes: Diagnosis/ Algorithms *In*: Scriver CR, Sly WS, Childs B, Beaudet AL, Valle D, Kinzler KW, *et al*., editors. The Metabolic and Molecular Bases of Inherited Disease. 8th *ed*: McGraw-Hill Professional; 2000.

REPLY

The child is under review for several months now and is doing well. His speech has also improved. There has been no further episode of any focal neurological problem. These would exclude any underlying metabolic disorder.

AMBAR CHAKRAVARTY
saschakra@yahoo.com

Routine Immunization: Campaign or *Routine*?

Goel, *et al.* provide an information report on effectiveness of a campaign to strengthen routine immunization in Bihar [1]. The exercise involved massive organizational inputs in infrastructure, management and manpower. *Anganwadi* and ANM workers, ASHAs and vaccinators were mobilized and budgetary support and political commitment were forthcoming.

The chief reason for poor coverage of routine (and other) immunizations is ignorance of the parents and the family of the benefits of immunizations. If that were clearly understood there would be a demand for vaccinations. Literacy rates are high in Indian states with impressive immunization coverage. Whereas campaigns are useful to achieve short term benefits, they are very difficult to sustain. Communities need to be educated and informed of the value of immunizations *and* other aspects of health care, with the help of *Anganwadi* and ASHA workers, school teachers and panchayat bodies and others. Minor reactions following DPT vaccine administration, often responsible for dropouts, should be properly managed and the family reassured. Supply of vaccines, maintenance of cold chain and safe injection practices must be ensured. Completeness of immunizations can be monitored with the help of a health card for every child, which would have records of vaccines administered and other vital health parameters [2]. Local officials should be charged with the responsibility of immunization and other health interventions and made accountable.