

A Novel Approach to Correct Retracted Nipples

Retracted nipples is a very common problem with a reported prevalence of 9.8% in pregnant mothers [1]. It is also a very important cause of lactation failure due to inability of baby to suckle at breast. Usual methods to treat retracted nipples include manual eversion of nipples by fingers (Hoffman technique), using syringe pump, and breast shield [2]. Breast shield is no more recommended because of fear of creating nipple confusion and infection. Use of manual eversion and syringe pump singly or in combination are mostly successful in treating retracted nipples. A few more non surgical methods like suction pump fitted bra and breast jewellery to maintain protectility of the nipples have been described. In resistant cases, surgical correction can be done but it is possible only before pregnancy.

Recently, in a primiparous mother, who presented to us with grade 2 retracted nipples (Han and Hong classification) [3], these methods failed to correct the condition. Baby was given expressed breastmilk by spoon. However, the parents were very keen to establish breastfeeding. As the conventional methods to correct the retracted nipples had failed, we requested the father to suck at nipples of his wife

frequently to correct the retracted nipples. The first concern of the father was that while sucking at breast, milk will go in his mouth. We reassured him that this human milk will not cause any untoward effects even if swallowed. Father agreed and over next one week the problem had improved.

When other conventional methods fails to correct retracted nipples, often due to insufficient mechanical suction, husband can be used as a good suction machine. The natural relations between husband and wife should overcome any inhibitions for some thing which will go a long way for their baby. Vigorous sucking by husband will not only help in correcting retracted nipples but will also improve lactation by stimulation of prolactin and oxytocin reflexes.

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REFERENCES

1. Alexander J, Campbell M. Prevalence of inverted and non-protractile nipples in antenatal women who intend to breastfeed. *Breast*. 1997;6:72-8.
2. Singh M. *Care of the Newborn*, 6th ed. New Delhi: Sagar Publication. 2004;170.
3. Han S, Hong YG. The inverted nipple: its grading and surgical correction. *Plast Reconstr Surg*. 1999;104:389-95.

First Dose of Measles Vaccine after 12 Months of Age

When measles vaccine was included in our national Universal Immunization Program in 1985, the schedule was to give one dose between 9 and 12 months of age. With the emphasis on immunization coverage assessment at the end of the first year of life, 9-12 months was interpreted by health workers as the exclusive age window for the vaccine and children who missed it within that window were not

given it at a later age. This was recognized and corrected by the National Technical Advisory Group on Immunization (NTAGI), resulting in a Government Order to ensure that a dose of measles vaccine should be given to all children up to age 5 (personal communication, John TJ, co-chair, NTAGI). Despite these guidelines, many health workers still believe that by 12 months the window for the vaccine is over. We illustrate this with a case report to highlight the need for wider publicity to ensure that the vaccine is not denied to any child on the basis of age.

An 18 month old child, not vaccinated against measles was hospitalized with severe measles in February 2010. The child was treated appropriately and recovered. Measles IgM antibody was detected according to standard methodology, confirming the clinical diagnosis. Colleagues in the Department of Child Health corroborated the occurrence of an outbreak of measles in at least one periurban village during January/February. The child's mother reported that she had taken the child on completion of 9 months for the measles vaccine on 3 occasions, to the closest urban health center. Twice the health worker declined to vaccinate as the child had a mild cough and cold and the third time the mother was told that the child was too old to receive the measles vaccine, having passed the first birthday. The child had received all the other UIP vaccines including 3 doses of Hepatitis B vaccine, currently included in UIP in Tamil Nadu.

The refusal to offer measles vaccine after 12 months of age is a matter of serious concern. The

Immunization Handbook for Medical Officers states that while the ideal target age to administer measles vaccine is 9 to 12 months, it is to be administered up to 5 years of age under the UIP [1]. We spoke with 2 staff members of 2 urban health posts; one said that measles vaccine should be given beyond 12 months up to 5 years but the second said she would not give the vaccine beyond 12 months of age. We reiterate the importance of informing all staff of the current guidelines to use every opportunity to vaccinate all children aged 10 months to 5 years against measles.

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REFERENCES

1. Immunization Handbook for Medical Officers. Ministry of Health and Family Welfare. New Delhi: Govt. of India; 2008. p 19.

Relevance of Continuation of Universal Vitamin A Supplementation Program in India

The prevalence of clinical vitamin A deficiency (VAD) has declined considerably in India, as compared to previous years. However, this decline was not uniform throughout India. The prevalence of clinical VAD (tip of the iceberg of VAD), in terms of Bitot's spot, an objective sign of VAD among rural pre-school children ranged from nil in Kerala to 1.4% in the state of Madhya Pradesh. The national level prevalence (0.8%) was still higher than the figures recommended by the WHO ($\geq 0.5\%$), indicating the public health significance in rural pre-school children of India [1]. While in case of blood vitamin A deficiency ($< 20\mu\text{g/dL}$), the prevalence (61%) was a public health problem ($\geq 20\%$) [2] in all NNMB states, ranging from 52% in Maharashtra to 88% in

Madhya Pradesh. The proportion of severe blood VAD ($< 10\mu\text{g/dL}$) was (21.5%) also $\geq 5\%$ indicating severe public health problem [2] in all the NNMB states [3]. Though the Indian Council of Medical Research multicentre study [4] carried out during 1997-2000 in 16 districts of 11 states reported low prevalence of clinical VAD, the prevalence was significantly higher in districts of Gaya (4.7%), Patna (3.1%) and Bikaner (1.1%), where the consumption of vegetarian diet is predominant (NFHS-3) as compared to other districts from north and northeast states. The sub-clinical vitamin A status of these children would have given true status VAD, because the clinical VAD may be nil as reported in children of Kerala, while the prevalence of sub-clinical VAD was very high (79.4%) among the same children [3].

The consumption of foods rich in vitamin A was very poor among rural pre-school children in India. The mean intake of leafy vegetables and milk & milk products, the rich sources of vitamin A were deficit by 80-85% and 71-75%, respectively as against the RDI, while the intakes of fruits and flesh foods were still