

Listen to Mother First : Reply

It was indeed a serious lapse on the part of the consulting pediatrician. Mother's views/concerns should never be taken lightly more so in case of vaccination. Proper communication with parents becomes much more important considering that vaccines are given to healthy children and no vaccine is either 100% safe or 100% effective.

In the above instance, three vaccines were inadvertently re-administered within a week, which is against the established principles of vaccination in most instances. While only a single dose of BCG is indicated as per the vaccination schedule, more than one dose is required for OPV and Hepatitis-B. The birth dose of OPV and hepatitis-B serve only as 'priming' dose for the subsequent doses. For multi-dose vaccines, the minimum interval between 2 doses of the same vaccine is usually 4 weeks. This minimal interval of 4 weeks between primary doses allows development of successive waves of antigen-specific primary responses without interference [1].

While no untoward reaction should have occurred with the administered doses of OPV and Hepatitis-B, there may

be some interference theoretically with the induction of 'priming' with previous doses. However, the clinical significance is extremely difficult to judge. These extra doses should not be counted and subsequent doses of both the vaccines should be administered on the scheduled dates as indicated by the vaccination timetable.

In case of BCG, which acts mainly through induction of T-cell mediated immunity, any interference with primary induction of immune responses may or may not occur. Also, some heightened local reactions like ulceration at vaccination site or marked regional adenitis may be anticipated few weeks/months later in few instances. There is no need of administration of extra dose of BCG to this child also.

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The Peshawar Peril

Hardly few weeks past the award ceremony of Nobel peace prize for a child in Pakistan and peace is in pieces by the Peshawar peril. The horrifying incidents involving school children in Peshawar, Pakistan and Beslan, Russia are quite disturbing and shaking the entire core of humanity. Children form a vulnerable population at any given point of time and during these man-made disasters, they are the worst affected [1,2]. Why should these innocent children lose their lives for no fault of theirs? Waging war against bacteria and viruses has no meaning when massacres are the order of the day. Exploring mars is pointless when these barbaric acts turn your backyards into graveyards. Terrorism is nothing but a novel way to relive the Stone Age or even darker ages earlier. Terrorism in any form against children is not acceptable and there should be a global awakening in this context.

The story of an act of terror does not end on the same day. The ripples of these events in the community and

world as a whole are long-lasting and may generate untoward side effects. Post-traumatic stress disorders (PTSD) and disrupted family lives are usually severe and difficult for management. Just like basic life support, disaster preparedness should be made universal and should not be the headache of the affected nation alone [3]. The terrorists, and the culprits who sold them the weapons should be brought to book and penalized. Media also has a moral responsibility towards the mental wellbeing of children, and hence pictures and videos which may affect their normal milieu should not be broadcast. According to a recent meta-analysis, PTSD outcomes among children and adolescent survivors of natural and man-made disasters receiving psychological interventions were better when compared to those who did not receive any intervention [4]. Strong social support from families, teachers, and community coupled with economic resources to facilitate the family's adaptation should be part of the psychosocial rehabilitation [5]. A social change or revolution is the need of the hour for providing children a safe environment, irrespective of nationality and religion. All children have the right to live and this should not remain in paper alone, but ensured in

day to day practice. Roses should neither be nipped as buds nor soaked in blood.

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Treatment Guidelines for Seasonal Influenza: Need for a Rethink

This year again, H1N1 influenza has arrived in several States of India, and public is likely to get panicky if the number of cases or mortality due to the virus rises. For appropriate disease management, H1N1 wards have been activated in various hospitals in Delhi and a document titled ‘National Treatment Guidelines for Treatment of Seasonal Influenza’ has been circulated among the hospitals by Directorate of Health Services, Delhi [1]. The new guidelines are not yet available on the website of Delhi Government which still displays the 2012 recommendations [2]. Salient features of the new guidelines are as follows:

H1N1 mostly presents like other seasonal influenza cases but may have severe manifestations in certain situations. Children mostly have influenza like illness (ILI), and are to be managed with home isolation and cough hygiene, along with immediate reporting to health facility if they present with warning signs (persistent high fever beyond 3-4 days, hemoptysis, breathing difficulty, chest pain, altered sensorium, worsening of associated comorbidity, inability to feed, vomiting, tachypnea, seizure in a young child). Mild or moderate complications include otitis media, bronchiolitis, croup, or reactive airway disease. Severe complications include diarrhea, dehydration, sepsis, exacerbation of chronic illness, or febrile seizure. Complications are more in ‘high-risk group’ that includes all children <5 y age, and those with chronic underlying pulmonary (e.g. asthma), cardiovascular (e.g. congenital heart disease), neurological (e.g. cerebral palsy), metabolic (e.g. diabetes), renal, hematologic (e.g.

thalassemia), or immunological (e.g. primary or secondary immunodeficiency) conditions. Severe cases include those with clinical and radiological signs of lower respiratory tract disease, shock and multi-organ failure, exacerbation of underlying illness, progressive disease with respiratory compromise, central nervous system complications, or invasive bacterial infection. Nasopharyngeal swabs for real-time polymerase-chain-reaction for influenza should be sent if the patient has severe, complicated, or progressive disease; cluster of cases; and in high risk cases with ILIs. Antivirals are indicated only in confirmed cases of H1N1. Need of hospitalization is determined on individual basis. There is no role of chemoprophylaxis for the contacts.

These guidelines appear evasive on certain issues. Previous guidelines [3] included categories A, B and C, but in present guidelines the categorization has been done away with. According to the present guidelines, nasopharyngeal sampling is advised for all under-five children with ILIs. In a typical Governmental set-up, under-five children comprise almost two-thirds of the total daily pediatric outpatient attendance in this season. Approximately half of these children have symptoms of ILIs which amounts to approximate case load of 150 per day in our hospital. As per the new guidelines, these children constitute the high-risk group, and need to be sampled, which is neither practical nor feasible. Lack of clear-cut categories may amount to delayed treatment of cases and continuation of the virus in circulation by ignoring the contacts for treatment. Children with suspected H1N1 infection need to be classified in four distinct categories *viz.* A: where no intervention is required; B: where we test, but do not treat; C: where we test and treat, but hospitalization is not required; and D: where testing is followed by in-hospital treatment. The new guidelines have also done away with chemoprophylaxis of con-