Prevalence of Vitamin A Deficiency in Isolated Geographical Pockets of India

We read with interest the recent paper on determinants of vitamin A deficiency (VAD) [1] and the accompanying editorial [2]. The exceedingly high prevalence of VAD documented in the survey needs detailed examination prior to drawing any operational inferences. Apart from the serious analytic flaws pointed out in the editorial, we have the following additional concerns and comments.

It is unclear whether the survey regions, namely 6 of 1212 Villages and 4 peri-urban areas of 70 municipal wards, were chosen through an unbiased randomization process accounting at least for the socio-economic status. Apparently, the data primarily pertains to the marginalized and lower socio-economic population. The survey was largely conducted during the non winter period, when VAD estimates are usually higher. The authors have also not provided cluster adjusted estimates and 95% confidence intervals. It would therefore be inappropriate to extrapolate the findings from this survey to the entire Aligarh District.

As the crucial data were primarily collected by postgraduate students, the reader would need reassurance regarding the validity of the measure through information on training imparted, quality control and quantification of inter and intra-observer variability.

The possibility of adopting an "invalid" operational definition for identification of corneal ulceration and corneal scar cannot be excluded. The investigators might have included "any corneal opacity" as a marker of Xerophthalmia. This criterion is fallacious, particularly in the current era, unless history of traumatic injury, use of tropical traditional medicines, and history of infections has been excluded. An earlier study documented history of previous corneal injury in 65.4% of such children [3]. The District Nutrition Profile Survey of 1,64,512 children conducted by ICMR in 16 districts of country in 2001, documented a prevalence of Bitot's spots above 0.5 % in only 3 districts (Bikaner, Gaya and Patna); none of these districts had children with corneal ulceration [4].

In order to provide meaningful programmatic input, receipt of mega-dose Vitamin A supplementation (VAS) should have been recorded. In Uttar Pradesh (including Aligarh), biannual rounds of VAS are being carried for 8 years with the help of UNICEF for the age group 6-60 months. Such a high prevalence of VAD despite these massive inputs needs a thorough introspection.

Nevertheless, we agree that VAD of public health magnitude does exist in isolated geographical pockets in the country. These regions are drought prone, flood prone and have issues related to food availability. There is an urgent need of identifying such pockets and institute appropriate remedial measures including interim VAS.

UMESH KAPIL AND HPS SACHDEV*

*Public Health Nutrition, Department of Gastroenterology and Human Nutrition Unit, All India Institute of Medical Sciences, New Delhi, and *Pediatrics and Clinical Epidemiology, Sitaram Bhartia Institute of Science and Research, B-16, Qutab Institutional Area, New Delhi, India.*
umeshkapil@gmail.com,

REFERENCES

1. Sachdeva S, Alam S, Beig FK, Khan Z, Khalique N. Determinants of vitamin A deficiency amongst children in Aligarh district, Uttar Pradesh. Indian Pediatr. 2011;48:861-6.
2. Arlappa N. Vitamin A deficiency is still a public health problem in India. Indian Pediatr. 2011;48:853-4.
3. Districts of Aligarh Mandal. http://aligarh,nic.in/web2009/aligarh_profile.htm. Accessed on 30 November 2011.
4. Srinivasan M, Christine AG, Celine G, Cevallos V, Mascarenhas JM ,Asokan B, *et al.* Epidemiology and aetiological diagnosis of corneal ulceration in Madurai, South India. Br J Ophthalmol. 1997;81:965-71.

Is Rituximab Approved in Pediatric Non Hodgkin Lymphoma?

This is in reference to the article on Drug Review – Rituximab [1]. The author had stated in the (***Table* I**) children with CD 20+ Non Hodgkin Lymphoma, Rituximab can be administered and Level of evidence as 1a. It is not clear whether to use rituximab in newly diagnosed or in relapsed setting. Level 1a represents Systematic review (in homogeneity) randomized control trial [2]. Attiasa and Weitzmanb reported review of case series in children with relapsed CD 20+ NHL adding rituximab as salvage monotherapy or with chemotherapy showing activity [3]. Children's Oncology Group (COG) added rituximab to chemotherapy in Pahse I/II study in relapsed and refractory setting, which showed good activity [4]. Children's Oncology Group presented a abstract at American Society of Hematology in newly

diagnosed CD 20+ NHL treated with chemotherapy + rituximab comparing with historic controls who received only chemotherapy, author had clearly concluded stating further randomized trials are required before adding rituximab to stanadard chemotherapy [5].The MabThera package information clearly states the safety and efficacy of MabThera (Rituximab) in children has not been established [6].

VIJAY GANDHI LINGA AND RAGHUNADHARAO DIGUMATI
Assistant Professor, Department of Medical Oncology, Nizams Institute of Medical Sciences, Hyderabad, Andhra Pradesh; vijaygandhilinga@yahoo.com

REFERENCE

1. Borker A, Choudhary N. Rituximab. Indian Pediatr. 2011; 48:627-32.
2. Phillips B, Ball C, Sackett D, Badenoch D, Straus S, Haynes B, *et al*. Levels of evidence and grades of recommendation. Available from: URL: http://www.cebm.net/index.aspx?o=1025. Accessed on November 22nd, 2011.
3. Attiasa D, Weitzmanb S. The efficacy of rituximab in high-grade pediatric B-cell lymphoma/leukemia: a review of available evidence. Curr Opin Pediatr. 2008;20:17-22.
4. Griffin TC, Weitzman S, Weinstein H, Chang M, Cairo M, Hutchison R, *et al*. A study of rituximab and ifosfamide, carboplatin, and etoposide chemotherapy in children with recurrent/refractory B-cell (CD20+) non-Hodgkin lymphoma and mature B-cell acute lymphoblastic leukemia: report from the Children's Oncology Group. Pediatr Blood Cancer. 2009;52:177-81.
5. Cairo MS, Lynch J, Harrison L, Van de ven C, Gross T, Shiramizu B, *et al*. Safety, efficacy and rituximab levels following chemoimmunotherapy (rituximab + FAB chemotherapy) in children and adolescents with mature B-cell Non-Hodgkin lymphoma (B-NHL): a Children's Oncology Group report. Blood (ASH Meeting Abstracts). 2008;112:838.
6. European Medicines Agency. MabThera Product Information. Available from: URL: http://www.ema.europa.eu/docs/en_GB/document_library/EPAR_-_Product_Information/human/000165/WC500025821.pdf. Accessed November 22nd, 2011.

Diagnosis of Ventilator-associated Pneumonia: Safety First

The article entitled 'Clinical Pulmonary Infection Score to diagnose ventilator-associated pneumonia in children' makes interesting reading [1].

A variety of sampling techniques can be used to obtain a bronchial sample for culture and it is not always necessary to use a bronchoscopic BAL to confirm the diagnosis [2,3,4]. This assumes greater significance in infants ventilated with smaller endotracheal tubes (ETTs) as it is not possible to pass the bronchoscope through these ETTs. In the study mentioned above, the authors have used an LMA to pass the bronchoscope in such infants to obtain a BAL. Such a procedure of replacing an ETT in a child requiring mechanical ventilation with an LMA for a diagnostic procedure is fraught with danger and cannot be universally recommended. In fact, the LMA is relatively contraindicated for bronchoscopy in patients in whom endotracheal intubation and intermittent positive pressure ventilation offers a safer alternative [5]. The absence of complications in this particular study cannot justify this practice.

Alternative methods of obtaining uncontaminated lower airway samples for culture such as a mini-BAL, blind bronchoscopic sampling and non-bronchoscopic BAL are acceptable for routine clinical practice [3,4] and can be used safely in ventilated infants.

BANANI PODDAR
Department of Critical Care Medicine, Sanjay Gandhi Postgraduate Institute of Medical Sciences, Lucknow 226 014, India.
bananip@sgpgi.ac.in

REFERENCES

1. Sachdev A, Chugh K, Sethi M, Gupta D, Wattal C, Menon G. Clinical pulmonary imfection score to diagnose ventilator-associated pneumonia in children. Indian Pediatr. 2011;48:949-53.
2. Lodha R, Kabra SK. Diagnosis of ventilator associated pneumonia: is there a simple solution. Indian Pediatr. 2011;48:939-40.
3. Venkatachalam V, Hendley JO, Willson DF. The diagnostic dilemma of ventilator-associated pneumonia in critically ill children. Pediatr Crit Care Med. 2011;12:286-96.
4. Foglia E, Meier MD, Elward A. Ventilator-associated pneumonia in neonatal and pediatric intensive care unit patients. Clin Microbiol Rev. 2007;20:409-25.
5. Slonim AD, Ognibene FD. Enhancing patient safety for pediatric bronchoscopy. Alternatives to conscious sedation. Chest. 2001;120:341-2.