

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.

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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