have convulsions even with serum lignocaine concentrations within the therapeutic range of 1-5 microgram/mL [2]. However, we could not estimate the serum concentration of lignocaine in our child. The maximum safe dose of lignocaine is 3 mg/kg [1]. On questioning, we got information that about 1mL of 2% lignocaine (20mg) had been used as local anesthetic for circumcision. Our baby weight was 5.2 kg and the maximum safe dose was 15.6 mg, but he had received 20 mg. Using Naranjo scale to ascribe the side-effect of lignocaine, it was Probable adverse drug reaction.

The treatment of local anesthetic toxicity is essentially supportive. The symptoms of toxicity persist as long as the plasma concentration remains above the therapeutic index [1]. Despite apparent safety of lignocaine, extra care should be taken in young children as it is easy to overestimate the dose-to-weight ratio [1].

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Wire-aided Reintubation following Rigid Bronchoscopy: A Safe Technique?

We read with interest the case report on wire-aided reintubation following rigid bronchoscopy: a safe technique [1]. Although it is an innovative technique but not necessarily safe one, especially in neonates.Isolated experience doesn't make it safe in all the hands.Secondly, it was totally wrong and unnesessary on behalf of authors to mention that multiple traumatic attempts were done by a senior pediatrician to intubate the baby.Thirdly, authors also mention failure of steroid administration at the referring hospital but actually there was no need for giving iv steroids as child was still intubated. Only when extubation is planned, should steroids be used [2].

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Takayasu Arteritis with Hashimoto's Thyroiditis

A 12-year-old Chinese girl was admitted to our hospital with a history of fatigue and hypertension lasting for about 9 months. She also had blood pressure (right arm) of 160/90 mmHg. Free thyroxine (FT4), free triiodothyronine (FT3), and thyroid stimulating hormone (TSH) were 40.5 pmol/L (ref range 12-22 pmol/L), 12.4 pmol/L (ref range 3.1-6.8 pmol/L), and 0.20 uIU/mL (ref range 0.27-4.2 uIU/mL), respectively. The titer of thyroid peroxidase antibodies (TPOAb) and thyroglobulin antibodies (TgAb) were 68 IU/mL (negative ≤34 IU/mL) and 142 IU/mL (negative ≤115IU/mL), respectively. Thyroid ultrasonography revealed increased thyroid volume, with diffuse hypoechogenicity. ECG revealed sinus tachycardia. A diagnosis of Hashimoto's thyroiditis was made. With treatment of thiamazole, L-thyroxine and propranolol hydrochloride, her FT4, FT3, TSH were detected at 17.5 pmol/L, 4.2 pmol/L, and 3.5 uIU/mL, respectively. Subsequently, she was given levothyroxine replacement treatment to maintain thyrotropin within range; however, her blood pressure was still high.

The blood pressure was 200/90 mmHg in right upper limb and 130/90 mmHg in the left upper limb. It was 145/90 mmHg in right lower limb and 140/80 mm Hg in the left lower limb. The radial artery pulse volume was low on the left side. Neck examination revealed a tender and mobile enlarged thyroid. Heart sounds were normal and bruits were detected over the left subclavian artery and abdominal aorta. She had grade II hypertensive retinopathy. ESR and CRP were 18 mm/h, and 10.5 mg/dL, respectively. Serum creatinine, electrolytes, transaminases and the urinalysis were in normal limits. Human immunodeficiency virus (HIV), hepatitis B virus, and hepatitis C virus were negative. Antinuclear antibody titer was 1:320 in a speckled pattern (low positive), extractable nuclear antigens (ENA) and C-antineutrophilic cytoplasmic antibodies (ANCA) were in normal range. Child was negative for HLA B27 and rheumatoid factor. Tuberculin test was negative. Thyroid scan indicated diffuse hyperplasia. Chest CT scan was normal, ECG showed sinus tachycardia, and an echocardiogram showed mild aortic regurgitation. Digital subtraction angiography (DSA) revealed occlusion of left axillary artery, narrowing of left subclavian artery and right external iliac artery, and proximal stenosis of the left renal arteries. She was diagnosed with Takayasu arteritis type V according to the American College of Rheumatology (ACR) criteria [1], and updated angiographic classification[2]. Prednisolone and antihypertensive agents were added to the aforementioned treatment.

This was an unusual association of Takayasu arteritis with Hashiomoto thyroiditis. The pathophysiological mechanism underscoring the association between these two diseases remains unclear. Cell-mediated immunological mechanisms play an important role in both diseases. Pro-inflammatory cytokines such as tumor necrosis factor (TNF)-α, interleukin (IL)-6, IL-8, IL-12 and IL-18, are common to both, amplifying the inflammatory process [3,4]. In view of the autoimmune features common to TA and HT, it is reasonable to consider the possibility of a pathophysiological association between them.

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Dengue Arthritis in a Child

A 28-months-old boy was admitted with fever of five days and passing black colored stools one day prior to admission. The child was conscious, irritable, with petechial lesions over trunk and abdomen. Palms and soles were erythematous. He was febrile and had tachycardia, wide pulse pressure (50 mm Hg), and hepatomegaly. The child was diagnosed as a case of severe dengue based on a positive NS1 antigen, and positive dengue IgM, and clinical profile. The child was treated as per standard WHO protocol; he improved and was discharged home.

The child was readmitted on fifth day, with a diffusely swollen right knee. Movements were restricted. There was anemia (Hb 8.2 g/dL), thrombocytosis (7,00,000 platelets/mm^3), and elevated ESR (120 mm). Plain radiograph of right knee revealed widened joint space with normal surrounding structures. Serological examination was negative for anti-nuclear antibodies and Chikungunya IgM antibodies. Arthrocentesis of right knee revealed turbid fluid, with only five lymphocytes per mm^3 without any organism on Gram stain and culture studies. Mantoux test was negative. The diagnosis of dengue arthritis was considered, against the post, viral reactive arthritis which usually involves hip joint. The child was treated with oral acetaminophen. At follow up after 2 weeks, the child was afebrile and playful without any pain or swelling in the right knee.

Dengue affects tendons, muscles, joints and bones. Polyarthralgia in dengue fever is known, but arthritis is rare [1,2]. Dengue and Chikungunya are arboviral infections transmitted by *Aedes aegypti*. They can be transmitted together in areas where both viruses co-circulate [3]. Most of the clinical and laboratory features of patients with chikungunya and dengue fever are similar. Arthritis is the predominant manifestation in