

asymptomatic but they don't usually receive well baby certificate for immediate puerperal sterilization.

2. *Comments upon the requirement for well-baby certificates:* Getting pediatrician certificate for neonatal well-being is an established age old practice in Tamilnadu both in government and private sectors. It is clearly mentioned in a recent WHO document that 'Because female sterilization is permanent careful counselling is important to make sure that woman will not regret her decision (to undergo puerperal sterilization)' [1]. As discussed in our paper and agreed in the comments on our paper, infant death is the important cause for regret in developing countries and so ensuring a well-baby certificate for the neonate by the paediatrician is entirely in order. Although this process is not explicitly mentioned in our Ministry of Health reference cited in the commentary, in page 11 of that reference it has been mentioned that 'A delay of upto 7 days (for doing postpartum sterilization) may be justified in situations which demand a more accurate assessment of the baby's chances of survival' [2]. Pediatrician's certificate of baby's well-being is thus included therein.

3. We fully agree with the authors' comment that informed consent be taken mentioning the drawbacks of one time physical examination and certification process of neonatal well-being. Our one year observational study was not designed for a further one year follow-up because of logistic problems. Even during our study period, two babies were brought back with ventricular septal defects that became evident after the certification process. It has to be noted that 65% of women using birth control measures in 2007-2008 preferred female sterilization, and states like Tamilnadu, Andhra Pradesh, Karnataka and Kerala have achieved replacement fertility levels by offering minilap tubectomy on a regular basis throughout the year [2].

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## The Real Need of the Hour

During a recent surge in the number of dengue cases in central and southern Tamil Nadu, we handled a number of referrals from the surrounding rural areas in our nursing home. While analyzing a total of 50 children with a diagnosis of dengue during the month of December 2012, we came across results which probably merit serious rethinking about our approach to early diagnosis and appropriate management of infectious diseases.

Of the 50 patients, 12% were below 1 year of age and 64% were above 5 years with a slight male predominance (60:40). Warning symptoms were present in 40% of cases and was usually vomiting or epigastric pain. Two children had petechial and purpuric spots and no child had significant mucosal or systemic bleeds. Only one child (2%) has evidence of significant plasma leakage and compensated shock requiring fluid resuscitation. 4 children (8%) showed evidence of fluid overload (2 children had ascites and 2 children had ascites with pleural effusion) but this did not cause respiratory embarrassment or warrant diuretic therapy in any case. 44

children (88%) were referred because of positive NS1 antigen and 6 children due to positive IgM antibodies to dengue. Significant pruritus was present in 16 cases (32%) and was noticed to herald recovery from the illness in these children. Thrombocytopenia (platelet count < 100,000/mm<sup>3</sup>) was present in 22 cases (44%). None of the patients required blood component therapy. Regression analysis showed that thrombocytopenia was a poor indicator of bleeding tendency and positive NS 1 did not show co-relation to thrombocytopenia, presence of warning signs or fluid overload.

While none of the findings are new or suggest any change in the existing management of the illness, we feel that many of the patients and the treating pediatricians were unnecessarily traumatized because of a positive antigen test. This made us recall a perspective on early diagnosis of febrile illness in the journal [1]. In that article, it was argued that as infectious diseases are a major cause of mortality in children and also placed tremendous economic burden on the country, early diagnosis of infectious disease is the need of the hour [1], and the case for NS 1 antigen in dengue was well made out. NS1 assays are very useful in the diagnosis of dengue with high sensitivity and specificity [2]. In our case, we noticed a reverse of the predictions with an increase in

economic and health care burden due to a rapid diagnostic test for dengue resulting in stress for parents and unnecessary paranoia. It should be remembered that the natural history of dengue and the pointers towards children who can develop severe dengue have been characterized [3]. The symptoms are easily recognizable by parents and they can be taught to identify the symptoms and bring the child to medical attention should the need arise. Hence, the real need of the hour in a country like ours, where there is a serious lacunae in high-quality primary care and referral services, is to improve the skills of the pediatricians in not just recognizing the symptoms and signs of specific illness but also to counsel and coach the parents about the appropriate management of their wards [4]. The role of rapid diagnostic tests, especially in dengue, should be probably be limited to serve epidemiological purposes.

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