

antibody generation is better when DPT vaccine is administered at 8, 16 and 24 weeks as compared to 6, 10 and 14 weeks.

Thus DPT vaccine administration at 8, 16 and 24 weeks should be considered. Similarly, if a mother is not a case of hepatitis B virus infection, administration of hepatitis B vaccine to her child should be deferred to the latter part of infancy or even later.

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Reply

WHO has shelved the controversy on the use of thiomersal as preservative in multi dose vaccine formulation vials. Being an ethyl mercury, it does not produce any neurotoxicity unlike methyl mercury. With 25 mcg for each vaccine administration (much less in combination formulation multi dose vials), the cumulative effect on neuro-toxicity, once feared is no more a concern. Therefore, many countries in the world use thiomersal preserved vaccine formulation in their routine National Immunization Program.

Without going into the pros and cons of 6,10,14 weeks and 8,16,24 weeks, it is worth while following the latest WHO schedule for DTwP and HB Vaccine which is highly immunogenic and has established high field efficacy since 1975 and 2000 respectively. No doubt, increasing interval between the 3 doses of the same vaccine, enhances the immunogenicity, GMT, *etc.* However, the minimum protective antibody level achieved through wider coverage at short interval with excellent field efficacy, have resulted in successful elimination/eradication of the

targeted diseases in countries world over using the WHO schedule.

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Study of Drugs in Indian Children

Regarding the use of probiotics in acute diarrhea in children, the National Task Force had stated: "Almost all the studies till now were done in developed countries except for one very small study from Pakistan. It may not be possible to extrapolate the findings of these studies to our setting where the breast feeding rates are high and the microbial colonization of the gut is different"(1). It is a logical argument. Which drugs have been introduced in the Indian market during the last five years only after evaluation on Indian children?

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REFERENCE

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Reply

There are some drugs for which the formulation used is global. In such situations evidence of limited efficacy is traditionally acceptable. In case of probiotics the effect on patients is dependent on the formulation used.

Some have desired effect while others do not. One of the formulations marketed in our setting was sensitive to all antibiotics tested. Information on product strain is very poorly described in the inserts of the marketed formulations. Probiotics do not offer additional benefit in infants who are breast fed. Additionally, the bacterial flora in Indians is very different. Because the efficacy of probiotics is dependent on the formulation and host factors it is rationale to invest in randomized controlled trials to gather evidence of benefit. We have to be clear in our messages to pharma companies because they generate the drugs. These companies are

also aware that not all information required to make judgment is readily available when they market the drugs. Physicians have great responsibility in preserving this balance to ensure that medical practice is based on evidence. If this is not the case with many other formulations we have not been sufficiently alert. With all humility this should not be the argument for greater laxity.

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