PEDIATRIC DEATHS DUE TO H1N1

As of August 8, 2009, there were 477 total and 36 pediatric (<18 y) deaths reported in the USA related to H1N1 infection. Risk factors documented in children were age <5 years in 19% and chronic medical illness in 67%. Of the high risk medical illnesses, 92% had neurodevelopmental disorders (*e.g.* cerebral palsy or developmental delay). Eight (22%) of the 36 children were aged >5 years with no reported high-risk conditions. Two of these were obese, and 6 had a laboratory confirmed invasive bacterial co-infection. The mean duration of illness prior to death was 6 days (range 1-28 d). This interim analysis suggests that age <5 years, pre-existing neurodevelopmental disorder, and invasive bacterial co-infections add to the mortality in children having H1N1 infection.

(*MMWR September 4, 2009; 58: 941-947*)

THE BOOM IN CLINICAL TRIALS

Since 2005, there has been a steady rise in the number of clinical trials in India. In October 2008, the Drug Controller of India had registered 752 trials of which 72% were being conducted by pharmaceutical companies. A fair medical infrastructure, English speaking doctors, a large treatment naïve patient pool, genetic diversity with 6 of 7 genetic varieties of the human race, increasing number of patients with lifestyle disorders and the highest recruitment rates internationally- are all potent reasons for pharmaceutical companies to make a beeline for India. Drug Controller General of India (DCGI) has proposed several steps to promote clinical trials in India including single window clearance and fast track approval in 6-12 weeks. The DCGI also plans to register all contract research organizations (CRO), train clinical site inspectors and has lifted import duty on clinical trial supplies. Clinical trials are also exempt from sales tax. The government is aggressively promoting India as a destination for clinical trials despite large lacunae. An ICMR survey found that only 40 of 179 institutional ethical committees follow the prescribed legal provisions and function as per various ethical guidelines. There is no central register of Ethical Review Committee (ERC) decisions and if a protocol is rejected by one local ERC it may be submitted elsewhere.

(*Economic & Political Weekly, August 29, 2009*)

DAVID MORLEY – END OF A LEGEND

David Morley, the man who introduced the "road to health growth" charts and one of the few doctors who have been nominated for the Nobel Peace Prize, died recently. He trained in Cambridge but the left the UK to work in Nigeria. He showed that infant mortality could be cut by 80% not by the introduction of modern medicine or building hospitals but by education and the use of locally available resources. He constantly searched for low cost solutions to the daily problems he encountered. An interesting innovation was the ORS spoon which had 2 scoops on either end – one to measure sugar and one for salt. His passionate appeal to balance the skewed distribution of health resources are best heard in his original words "Although three-quarters of the population in most developing countries live in rural areas, three-quarters of the spending on medical care is in urban areas, where three-quarters of the doctors live. Three-quarters of the deaths are caused by conditions that can be prevented at low cost, but three-quarters of the medical budget is spent on curative services, many of them provided for the elite at high cost."

(*J Trop Pediatr, August 2009*)

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