Atypical Subacute Sclerosing Panencephalitis with Short Onset Latency

I read with great interest the case reported by the authors [1] describing the unusual latency period in subacute scerosing panencephalitis (SSPE). The usual latency period of SSPE is 6-10 years from its onset as it is a slow virus neurodegenerative disorder. The exact factors and influences that allow the measles infection to persist are unclear, but may include several immunological factors [2]. Numerous alterations in M protein have been described in SSPE because of extensive point mutations in viral genome, possibly resulting in persistent viral infection [3].

Since it is a slow progressive neurodegerative disorder a latency period of two month is very unusual. Authors have not described the pathogenesis behind this unusual occurrence. Moreover CSF analysis shows only raised IgG levels with normal IgM levels but looking at short latency period there is more possibility of raised IgM levels instead of IgG measles antibody. Therefore this case is looking more likely a case of SSPE from congenital measles and in that case this latency becomes irrelevant. Serology of the mother can be helpful in these cases.

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Cholera-like Illness Due to *Aeromonas caviae*

A 2-year-old girl presented with rice watery stools and vomiting for 12 hours. There was no blood in the stools. On examination she had some dehydration. Stool microscopy and hanging drop revealed darting motile bacilli morphologically resembling *Vibrio cholera*. Her blood count and renal function tests were normal. Dehydration was corrected with IV Ringer lactate and she was commenced on Azithromicin. Her HIV status was non-reactive. Stool culture grew *Aeromonas caviae*, which was sensitive to doxycycline, chloramphenicol, furazolidine and resistant to nalidixic acid, ceftraixone, co-trimaxazole and ampicillin. She was discharged after three days.

Aeromonas species are ubiquitous water borne medically important, Gram-negative, rod-shaped micro-organisms [1]. Today, they are regarded not only as disease-causing pathogen of fish but are also responsible for variety of complications in both immunocompetent and immunocompromised humans [2]. Aeromonas have gained importance as human pathogens causing gastrointestinal infections. They also cause extraintestinal infections such as cellulitis, wound infections, sepsis and urinary tract infections [1]. Deodhar, *et al*. [3] isolated Aeromonas from 45 (1.8%) of 2,480 patients with acute gastroenteritis. Out of 863 traveller's diarrhea patients returning from Asia, Africa, and Latin America, 2% of cases were caused by Aeromonas [4]. Studies have shown that three Aeromonas *(A. hydrophila, A. caviae* and *A. veronii* bv Sobria) are responsible for ≥85% of human infections [2]. Clinical spectrum of Aeromonas-induced diarrhoea varies from toxigenic diarrhea to colitis and in developing countries it is predominantly toxigenic [3]. The most common presentation for Aeromonas gastroenteritis is secretory(watery) enteritis suggesting the toxigenic nature of the organism [2]. Aeromonas strains are almost universally susceptible to fluoroquinolones and exhibited multidrug resistance [2]. Bhowmika, *et al*. [1] isolated potentially pathogenic and

multi-drug-resistant strains of *A. hydrophila* from natural surface waters, and showed its ability to produce virulence-associated factors similar to that in clinical isolates thereby indicating a significant risk to public health [1]. To conclude, *Aeromonas* associated gastroenteritis in children mimics cholera and the presence of this emerging organism should be kept in mind while treating acute gastroenteritis.

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Role of Zinc in Neonatal Sepsis: Emerging Data

The study conducted by Mehta, *et al*. [1] is indeed, one of its own kind and has a good internal validity, although following issues need attention

It is not mentioned on what basis a dose for zinc (1 mg/ kg/day) was decided; and how the exact dose of 1 mg/kg of zinc was administered in each infant by using a 10 mg dispersable tablet (almost all weighing less than 3 kg). The safety of administering zinc to an infant who needed to be nil per oral has also not been described. The breast feeding status of the infants in the two groups have not been mentioned. There is no mention of the average age at which the infants were enrolled in the study. The inclusion of other markers of infection like procalcitonin and blood culture (BACTEC) would have given more specificity in identifying sepsis patients. Some kind of sickness assessment score (PRISM / CRIB) to determine the severity of illness could help better understand the status of the given cohort. Duration of antibiotic treatment is not clear. The diagnosis of sepsis is described to be one of the three criteria. However, in the absence of first two criteria the presence of only third criteria is unlikely to warrant the need of antibiotics as *X*-ray findings could be non-specific for neonatal pneumonia.

Studies have shown that zinc supplementation is benificial in reducing the mortality of small for gestation age (SGA) infants [2]. It will be prudent to sub-group the cohort as appropriate for gestational age (AGA) and SGA and then analyse the results. Demographic, clinical, microbiological data of the infants who died need to be compared with the rest of the group.

In a recently published multicentric randomized controlled trial (RCT) by Bhatnagar, *et al*. [4] the authors reported that zinc reduced treatment failure (defined as a need to change antibiotics within 7 days of randomization, or a need for intensive care, or death at any time within 21 days) in infants younger than 120 days with probable serious bacterial infection by 40%. These promising results are contrary to that seen by the authors [1].

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REPLY

The dose of zinc as 1 mg/kg was chosen based on zinc dosing in neonates as in standard texts [1,2]. The 10 mg tablets were dissolved in expressed breastmilk made upto