

Kerosene Free Delhi: Safer for Children

With the successful implementation of 'Delhi: A Kerosene-Free City Scheme, 2012', Delhi was declared the first 'kerosene-free city' in the country on June 17, 2014. The step is intended to "improve environment conservation as no toxic fumes would emanate from burning the oil, lesser possibility of adulteration in petrol, beneficial impact on air pollution and improvement in the quality of life of people benefited under the scheme besides lesser fire accidents and burn injuries" [1]. We, the pediatricians welcome this step by the Delhi government the most. Despite being a polluting fuel, use of kerosene oil continued for household cooking purposes and children kept on ingesting it out of curiosity, resulting in a significant morbidity and number of hospitalization in this age group.

While conducting a study among 1663 children aged 6 mo-5 y admitted to a tertiary care hospital catering to urban slum population, to find the relation between mid-upper arm circumference and mortality, between March 2012 and February 2013; our attention was drawn to 91 children admitted with poisoning. Of these, kerosene oil ingestion was the single most common accidental poisoning, observed in 34 (37.4%) children. More than two decades back, in this same population, we reported 70 cases of kerosene oil poisoning in children during a 3 year period. These cases constituted 46.4% of total admissions due to accidental poisoning in children between 1988 to 1990 when there was shortage of electricity and cooking gas [2]. It appears that the scenario has hardly changed over a quarter of a century.

Similar reports are available from other parts of the

country. Rathore, *et al.* [3] observed that kerosene oil ingestion was commonest accidental poisoning seen in 31% children in a tertiary care hospital in Lucknow. Bhat, *et al.* [4] reported 22 children with kerosene oil poisoning (18.8% of accidental poisoning cases) in 2011. Vasavada, *et al.* [5] from Ahmedabad, Gujarat documented 83 children with kerosene oil poisoning, constituting 47.1% of the total cases with accidental poisoning.

We hope that following Kerosene-free Delhi Scheme, the menace of kerosene poisoning will ultimately cease and bring relief to the affected children and their families, and the treating doctors. A laudable initiative indeed, the kerosene-free scheme needs to be extended to the entire nation to eliminate kerosene oil poisoning, the most common cause of accidental poisoning in children.

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Pericardial Effusion Associated with Rhinovirus Infection in an Immunocompetent Infant

Human rhinovirus (HRV) is one of the most frequent causes of respiratory tract infections (RTIs) [1]. Most HRV infections are self-limited, but sometimes are

associated with complications such as severe lower RTIs, bacterial sinusitis and otitis media [2]. Two 4-month-old twin girls, were hospitalized with us in view of hypoxia due to bronchiolitis. On examination, temperature was 37.7°C, oxygen saturation was 90%, heart and respiratory rates were 128 bpm and 60 per min, respectively. Respiratory system examination revealed rhonchi and chest retraction; cardiac examination was normal. White blood cell and platelet counts were normal; hemoglobin

was 9.8 g/dL with hypochromic microcytic anemia. C-reactive protein and blood biochemistry were normal. On chest radiography, bilateral hyperinflation was present without evidence of consolidation. Multiplex viral PCR (Fast Track Diagnostics/ Respiratuar Pathogen 21, Luxemburg) test from nasopharyngeal aspirate was positive for rhinovirus in both the patient and her twin. On fifth day, detailed cardiac examination was planned because of insufficient improvement in hypoxia despite symptomatic treatment. On echocardiography, 9 mm pericardial effusion (PE) was detected on rear wall of interventricular septum with normal cardiac function and anatomy. On repeated echocardiographies, complete disappearance of PE was observed. Hypoxia and bronchospasm improved within ten days, and patient was discharged after normal test results for immune deficiencies. Recurrence was not detected on follow-ups.

In this child, PE could not be attributed to any another cause, and was attributed to HRV infection. To the best of our knowledge, HRV is not reported as a cause of PE. Few cases of pericarditis associated with HRV-C besides most common causes include Coxsackie virus, infectious mononucleosis, Adenovirus, Echo virus, hepatitis viruses

and HIV [3,4]. The limitation of diagnosis in our patient was that we could not directly test HRV in pericardial fluid.

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Glycerin Suppository in Preterm Neonates

I appreciate the efforts of the authors for undertaking and publishing a good quality randomized controlled trial on glycerine suppositories for promoting feed tolerance in preterm babies [1]. Through this communication, I wish to seek certain clarifications:

1. Infants assigned to control group were not given any suppository and only a sham procedure was performed. However, the details of the sham procedure is not given and I wonder whether that has got any lubricant or rectal stimulant action promoting rectal evacuation in control group as well.
2. The dose of suppository used was one gram once a day and authors have mentioned that a more frequent application (*e.g.* 12 hourly) or higher dose may be more effective in accelerating meconium evacuation. However, the reference quoted [2] does not recommend the use of glycerine suppository for

meconium obstruction in extremely low-birth-weight neonates. Moreover, Khadr, *et al.* [3] had used 500 mg dose for similar group of infants in a similar study. Is there a recommended dose for glycerine suppository in preterm babies for prophylactic purpose?

3. The intervention in the control arm was continued till day 14; is there any reason why daily suppositories were not continued until full enteral feeds were achieved?

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