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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REFERENCES

1. Jacobs SE, Lamson DM, George KS, Walsh TJ. Human rhinoviruses. Clin Microbiol Rev. 2013;26:135-62.
2. Mandell GL, Bennett JE, Dolin R. Rhinovirus. *In:* Mandell GL, Bennett JE, Dolin R, editors. Mandell, Douglas, and Bennett's Principles and Practice of Infectious Diseases. 7th ed. New York: Churchill Livingstone; 2010. p.2389-98.
3. Henquell C, Mirand A, Deusebis AL, Regagnon C, Archimbaud C, Chambon M, *et al*. Prospective genotyping of human rhinoviruses in children and adults during the winter of 2009-2010. J Clin Virol. 2012;53:280-4.
4. Spodick DW. Pericardial diseases. *In:* Braunwald E, Zipes D, Libby P, editors. Heart Disease: A Textbook of Cardiovascular Medicine. 6th ed. Philadelphia: WB Saunders; 2001.p.1823-76.

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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REFERENCES

1. Shinde S, Kabra NS, Sharma SR, Avasthi BS, Ahmed J. Glycerin suppository for promoting feeding tolerance in preterm very low birthweight neonates: a randomized controlled trial. Indian Pediatr. 2014;51:367-70.
2. Khadr SN, Ibhanesebhor SE, Rennix C, Fisher HE, Manjunatha CM, Young D, *et al.* Randomized controlled trial: Impact of glycerin suppositories on time to full feed in preterm infants. Neonatology. 2011;100:169-76.

3. Emil S, Nguyen T, Sills J, Padilla G. Meconium obstruction in extremely low-birth weight neonates: Guidelines for diagnosis and management. J Pediatr Surg. 2004;39:731-7.

AUTHOR'S REPLY

1. Interventions were performed by study nurse (two) behind the disguise of curtain. In glycerin group, suppository was administered. In control group, study nurse went behind the curtain, opened baby's diaper and put it again. No rectal stimulation or lubricant was administered in control group.
2. We had just speculated that more frequent administration of glycerin suppository (Like 12 hourly) may be more effective. We did not find any reference recommending standard of glycerin suppository for prophylactic use in preterm neonates.
3. Individual neonates may reach full feeds at different ages. Therefore, to keep uniformity of intervention in participants we chose to continue it till day 14 and not until full enteral feeds was achieved.

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Paracetamol – High Strength Formulations and Toxicity

In India, paracetamol is available in many formulations such as liquid suspension, drops, tablets, injection, rectal suppositories with varying concentrations (120/125/150/250/500 mg/5 mL). The usual cause of paracetamol overdose is frequent administration of the drug round the clock by an anxious parent who regards fever as a potential dangerous event and as a trigger for febrile seizures. Unfortunately, therapeutic misadventure (wrong prescription by a doctor) is also an important cause of paracetamol toxicity in our set-up. In an earlier study, paracetamol syrup (250mg/5 mL) was common reason of accidental single over dose (46%) and 'drops' was the common formulation causing toxicity due to multiple dose ingestion (63%) [1]. Even if the medical practitioner prescribes paracetamol in the right dosage, caregivers inadvertently administer a high strength formulation, resulting in over-dosage. The American Academy of Paediatrics has recently recommended the use of a single strength liquid preparation and the pharma industry in USA has been adhering to this recommendation. As an initiative, our hospital, administration has implemented a policy of use of only a single strength preparation of 125mg/5 mL to prevent over-dosage. This initiative needs to be propagated all over India through the Indian Academy of Paediatrics. There is a need to counsel parents that antipyretic agents do not prevent febrile convulsions and should not be used specifically for this purpose [2]. Antipyretic agents with the sole aim of reducing body temperature in children with fever is not recommended and should only be considered for children with fever-related discomfort [3]. Pediatricians should also promote patient safety by advocating for simplified formulations, dosing instructions, and dosing devices [4].

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REFERENCES

1. Lakshmi M, Radhika R. Analysis of acetaminophen toxicity in children in a tertiary care setting, Indian J Trauma Emerg Pediatr. 2013;5:5-8.
2. Steering Committee on Quality Improvement and Management, Subcommittee on Febrile Seizures American Academy of Pediatrics. Febrile seizures: Clinical practice guideline for the long-term management of the child with simple febrile seizures. Pediatrics. 2008;121:1281-6.
3. Fields E, Chard J, Murphy MS, Richardson M; Guideline Development Group and Technical Team. Assessment and initial management of feverish illness in children younger than 5 years: Summary of updated NICE guidance. BMJ. 2013;346:f2866.
4. Section on Clinical Pharmacology and Therapeutics; Committee on Drugs, Sullivan JE, Farrar HC. Fever and antipyretic use in children. Pediatrics. 2011; 127:580-7.