

above cut-off for repeat sample to be considered screen positive if first sample is an early sample [2].

With the study methodology, every 5th baby had to be called for repeat evaluation resulting into higher costs as well as unnecessary parental anxiety. This could have been easily avoided with first screen sample after 72 hours followed by recall of screen positives for confirmation. In case of premature babies, repeat sampling could have been done later (may be at 2 weeks) in view of delayed maturation of hypothalamus-pituitary-thyroid axis [2,3]. Authors also have not mentioned whether the hypothyroid newborn with cord blood thyroxine of 18 mU/L was preterm or the mother had thyrotoxicosis. Authors also should have stated whether the two hypothyroid babies picked up at 2 weeks had prematurity or any accompanying maternal condition.

The findings of this study once again stress the importance of sampling after the TSH surge is over and having a proper cut-off to minimize false positive rate. Sampling at 4 or 5 days followed by recall of screen positives for confirmatory test will involve sampling only twice as against 3 or 4 times as in this study. As cord blood TSH is known to have higher false positive rate, this strategy may increase the cost and parental anxiety [4,5].

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## Effective Strategy for Newborn Screening for Congenital Hypothyroidism: Author's Reply

We are extremely grateful to the authors for their valuable comments:

1. The total number of samples were 1950. The error in the article is regretted.
2. We have presented the sex distribution as obtained in the study sample. This need not be representative of general population.
3. We do not believe and claim that our screening strategy was fool-proof. We started cord blood screening at a time when universal thyroid screening was not mandatory through the state. Even now, its not being done in many centers. Our main aim was to find out the general pattern and to find out the incidence. We do agree with the authors that a better screening strategy can be employed.
4. Cord blood TSH of 18 mU/L was observed in a term baby; mother had no known thyroid morbidities.
5. Cases diagnosed at 2 weeks of age were late preterm babies without any maternal thyroid illness.

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## Temporal Lobe Epilepsy Masquerading as Tetany

A 7-year-old female child presented in the Pediatric Neurology clinic of our hospital with history of three episodes of tetanic carpopedal spasms in past one month.

The first episode occurred when she was studying and suddenly felt numbness and tingling of both lower extremities followed by of upper extremities. She then developed spasm of both wrists and posturing suggestive of carpopedal spasm. She was taken to the nearest Emergency room where she was given injection calcium gluconate after which she improved and was discharged on oral calcium. Serum calcium was not done because of

non-availability of the same at this facility. Two days later, she again had similar posturing of both hands. She was taken to another hospital where she improved within a few minutes. After 12 hour of this admission, she started complaining of pain in abdomen, both hands and both feet along with fisting (posture as carpedal spasms) of both hands. The posturing improved within 20-30 minutes of the admission. Serum calcium, Random blood sugar, Serum sodium, Potassium and electrocardiogram at the time of admission were within normal limits. Her arterial blood gas analysis was also within normal ranges. After this event, she was evaluated in the Pediatric Neurology clinic, and a review history revealed that prior to the start of every event she always had a strange feeling in her lower extremity described as discomfort or numbness. This feeling was followed by a typical posturing of her both hands. Moreover, she continued to feel the strange feeling in her both lower extremities, especially distal leg and feet, for around 10-30 minutes. This history prompted us to keep seizure originating from the somatosensory area and then progressing to motor area as one of the possibilities. EEG revealed presence of focal interictal epileptiform discharges in the form of 50-200 microvolt spike-slow wave complexes originating from left temporal area. MRI brain revealed mild loss of volume and thinning of grey matter involving left hippocampal formation with prominence of adjacent temporal horn; however, no significant T2/FLAIR hyperintense signals are noted from either of the

hippocampus suggestive of mesial temporal sclerosis.

Focal seizures presenting as tetany is a very rare manifestation of temporal lobe epilepsy. Tetany may indicate enhanced neuromuscular activity and associated sensory disturbance [1]. Somatosensory aura occurs very rarely as a part of temporal lobe seizure semiology. Tonic and dystonic posturing in temporal lobe epilepsy may also be a part of automatisms [2]. In the current patient, the dystonic posturing of hands mimicked tetany and therefore prompted the treating clinician to think of commoner etiologies of tetany.

The case is reported to increase awareness amongst the pediatricians regarding carpedal spasm as one of the rare manifestation of temporal lobe epilepsy.

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## Disclosure of HIV Status to Children

Dwivedi and colleagues put up a great report on disclosure of HIV status to children [1]. A time when hesitation generally takes the upper hand over need for disclosure, the article deserves appreciation for its bold effect on the unsung stories of HIV-affected families. However, I would like to add few more points:

1. The issue has multiple effects on the future health of the family. Parents need to wait till appearance of symptoms in child for making the decision [2]. This gives rise to a double-edged problem. Explaining transmission of disease and its link to behavior is one of the toughest challenges the parents face. For fear of disclosing their HIV status to peer group or others,

mothers may withhold children from HIV treatment [3]. The psychological burden of disclosure on the growing child adds to the gradual discovery of sexuality, leading to complex and potential consequences [4].

2. There are possibilities of social isolation, severe emotional distress and perturbed self-image in children when disclosure is withheld over prolonged periods [5]. Even, uninfected infants will continue to be exposed to the risk of long-term adverse effects of antiretroviral drugs. In addition, AIDS orphans were found engaged in less positive activities and were more likely to experience higher rates of depression, crime and difficulties with friend circle compared to children orphaned by other causes [6].
3. Though the authors did not scale the effect of disclosure on adherence, I think it is good parameter to measure the success of the program, and for further