

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 automatism [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

advocacy. Even when confusion prevails among counsellors on this topic, in absence of proper guidance, the documented figures would help us to keep away scepticism about additional psychological burden [2].

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Competency-based Medical Education: The Next Steps

Modi, *et al.* should be congratulated for an excellent account of competency-based medical education, and for discussing its contextualisation within healthcare professional education in India [1]. Although their account is high quality, there are additional features of competency-based medical education that need to be discussed. There is a need to have teachers and tutors who can deliver competency-based medical education, and also assessors who can reliably judge when learners have reached the requisite competence. These teachers-cum-assessors will need to develop new educational skills to make these judgements. In the past, assessors might have judged a trainee by looking at the time they have spent in training, or their completion of various modules, their passing of certain exams; however, these achievements will no longer work in the new world of competency-based medical education [2,3].

First and foremost, when introducing this new concept of medical education in India, considerable planning will need to be given to win the hearts and minds of the assessors. Another challenge will be making the somewhat theoretical concept of competency-based medical education understandable and practical for all stakeholders – including both trainees and trainers. In this regard another model of medical education touched on by the authors will need to come to the

foreground – that of entrustable professional activities (EPA) [4]. The attractiveness of EPA is that they convert the high-minded hypotheses of competence back to the grassroot level of clinical medicine. All clinicians understand what it is to trust a trainee to carry out a procedure, or to do a consultation with a certain type of patient, or indeed to go “on-call” without resident supervision. So an important first step in the journey that medical education in India must take is that of converting competences into EPA which are very much context-specific; only that those relevant in the specific clinical and learning environment of India will work. Doing this work will be challenging and time-consuming, but the potential reward is great: a new generation of trainees who have been trained to the highest possible international standards.

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