REFERENCES

1 Snvastava RN Painful Pricks Indian Pediatr 1997; 34: 1140.

2 Schechter NL, Blankson V, Pachter LM, Sullivan CM, Costa L The ouchless place No pain, children's gain Pediatrics 1997; 99: 890-894:

3. Norman I, Jones PL Complications of the use of EMLA Br J Anaesth 1990; 64: 403.

4. French GM, Painter EC, Coury DL Blowing away shot pain A technique for pain management during immunization Pediatrics 1994;93: 384-388.

Reply

Dr. Yash Paul makes some very interesting observations. I agree with his view that in our medical set up (where doctors act as masters and nursing staff as those who take orders) any criticism by the nurses would not be appreciated by the doctors. One or both parents should be allowed to be present while procedures are being carried out. The home remedy that he suggests for neonates and infants certainly needs to be tried. Distraction techniques may work if one has time and patience. Most of us are short on both. In final analysis it is a matter of attitudes and concern. It is so much simpler to give a prick quickly and get it over with! However, pricks and pain must be minimized for hospitalized children who often undergo prolonged treatment and are subjected to multiple injections, venesections and other procedures.

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Tobacco Use in Rural Indian Children

I read with interest the recent publication on this subject(l). The statement "Data on tobacco use by rural children or youth in India are few and only recently available" is surprising. In 1987 in Indian Pediatrics a paper on "Smoking behavior of rural school boys" was published by us(2). Other papers on the subject in urban school boys were published in 1978 and 1980(3,4). These studies have specifically addressed the reasons for smoking among the school boys.

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REFERENCES

1. Krishnamurthy S, Ramaswamy R, Trivedi U, Zachariah V. Tobacco use in rural Indian Children. Indian Pediatr 1997; 34: 923-927.

2. Singhi S, Broca JS, Mathur GM. Smoking behaviour of rural school boys. Indian Pediatr 1987; 24: 655-659.

3. Babu DS, Chuttani CS, Murthy NS. Some epidemiological factors related to smoking among school children of Delhi Urban area. Int J Epidemiol 1978; 7:178-179.

4. Lai KB, Singhi S, Gurnani M, Chowdhary BR, Garg OP. An epidemiological study on smoking among Ajmer urban school boys. Indian J Pediatr 1980; 47: 403-408.

Acute Bacterial Meningitis

I read with interest the recent article on Acute Bacterial Meningistis (ABM)(1). However, the following aspects require further clarification:

1. The authors have mentioned CSF CRP as nonspecific marker of CNS inflammation. However, other workers have opined that CSF CRP is a valuable test for diagnosis of ABM. In an earlier study(2) CSF CRP showed 100% sensitivity and 96-100% specificity for diagnosis of ABM. They also mentioned that negative CSF CRP excludes pyogenic meningistis and concluded that patients with CRP detected in CSF should be considered to be having pyogenic men ingitis unless proved otherwise. CSF CRP being a simple, reliable and inex pensive test is recommended as a first step of investigation for rapid differen tiation of the type of meningitis. Further, serial determinations of serum CRP has also been employed to monitor the course of ABM(3). Thus CSF CRP and serial serum CRP levels may be routinely recommended for rapid diag nosis and predicting the complications of ABM respectively.
2. The foot note of *Table 11* in their publica tion^) states "All drugs should be given intravenously". But Rifampicin (indicated in ABM due to penicillin resistant *S. pneumoniae)* is available only in oral formulation so it has to be used either by Ryle's tube or orally if the patient is accepting.
3. Regarding use of dexamethasone in meningitis due to Hib, it is to be remembered that timing of the first steroid dose is quite critical. In experimental studies(4) it has been observed that if dexamethosone was given 1 hour after ceftriaxone then inflammation was reduced only moderately 'thereby failing to prevent sequelae. The dose and duration of dexamethasone use in ABM requires further clarification since one author(5) has suggested IV dexamethasone 0.5 mg/kg - first dose prior to antibiotics and subsequently just a dose or two doses more at the intervals of 6-8 hours (maximum of three doses) while they(l) have advised 0.15 mg/kg every 6 hours for 2-4 days.

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REFERENCES

1. Aneja S, Aggarwal A. Acute bacterial meningitis. Indian Pediatr 1997; 34: 1097-1109.
2. Pemde HK, Harish K, Thurani YP, Srivastava S, Belapurkar KM. C-reactive Protein in childhood meningitis. Indian J Pediatr 1996; 63: 73-77.
3. Singh UK, Sinha RK, Suman S, Singh VK. C-reactive Protein as an indicator of com-