We think that more needs to be done to avoid such situations in the future. To discourage authors from not responding to a pertinent query the authors should be informed that the query has been considered as pertinent and that it would be published, even if they choose not to respond. To decide whether the query is pertinent the journal can have an expert committee or seek the help of the reviewers of the article. Also, the journal website should be constructed in such a manner that the query once published is linked to the article and the fact regarding authors' non-response should be mentioned at the end of the article itself. This would alert the readers who read the article from the website and they would be then able to draw their own conclusions about the quality of the article. The editors should also consider if it is possible to publish authors' reply requiring detailed response under a new title so that it could be listed on PubMed as a separate publication.

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Abscess of the Nasal Septum with Staphylococcal Scalded Skin Syndrome

A 10-year-old boy from a Tsunami rescue camp was brought to our hospital with history of high grade intermittent fever for one week. At admission, he was looking depressed, not talking but obeying commands. He was febrile and there was marked peeling of his palms and soles. His respiratory rate was normal and his lungs were clear on auscultation. The other systems were also normal on examination. A diagnosis of staphylococcal scalded skin syndrome was considered based on the extensive exfoliation. However, there was no obvious focus of infection, except for a slightly abnormal broad nose. Examination of the nose revealed a tense bulging nasal septum and a diagnostic aspirate yielded thick pus from which *Staphylococcus aureus* was later isolated. The septal abscess was drained under general anesthesia. Intra operative examination revealed a near total necrosis of his membranous septum. He was adequately treated with intravenous cloxacillin for two weeks and discharged home in a healthy condition. Appropriate psychotherapy and antidepressants were also provided. The final diagnosis was abscess of the nasal septum with staphylococcal scalded skin syndrome and post traumatic stress disorder. Probably he had sustained a hematoma of the nasal septum during the tsunami which subsequently got infected with staphylococcus. As he was depressed, he never revealed the pain in his nose and the septal abscess was missed early.

Nasal septal abscess (NSA) is uncommon among children. Nasal obstruction, throbbing

nose pain, general malaise, fever, headache, and tenderness over the perinasal area are the common symptoms and *Staphylococcus aureus* is the most common organism cultured from NSA. Infection of a septal hematoma, direct extension along the tissue planes as seen with sinusitis, infections of dental etiology and venous spread from the orbits or cavernous sinus may result in the development of a NSA. There is usually an inciting traumatic event causing rupture of the small vessels that supply the nasal septum. The hematoma formed separates the mucoperichondrium from the septal cartilage. Cartilage destruction follows as a result of ischemic and pressure necrosis. The static blood forms an adequate medium for bacterial growth and subsequent abscess formation(1). The drainage and immediate reconstruction of the nasal septum are the golden standard in the treatment of NSA(2). The complications of a NSA include meningitis, saddle nose deformities, sepsis, bacteremia, and in younger patients maxillary hypoplasia. Staphylococcal scalded skin associated with NSA as noted in this boy is also rare.

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Prognostic Value of Early vs Late Steroid Resistance in Idiopathic Nephrotic Syndrome

We read with interest the editorial by Arvind Bagga on Steroid Resistant nephrotic syndrome (SRNS) in the January issue of Indian Pediatrics(1). The same issue also featured our experience with 136 biopsy proven cases SRNS over the last 12 years published as a "brief report"(2). We agree with the observation that the outcome of early steroid resistance (initial nonresponders - INR) is better than children who have late steroid resistnace (secondary nonresponders - SNR). In our study we had compared children with Minimal Change disease with non-MCD subtypes. We had observed that the distribution of the number of children who were INR and SNR was similar in the 2 groups. Hence we had commented that the better outcome in MCD was accounted for by the underlying histopathology, rather than the type of steroid resistance. We did not imply that the type of steroid resistance has no effect on the outcome and our results seem to have been misinterpreted. To further clarify this point we are reporting here a subgroup analysis of children with SRNS who were INR as compared to those with those who were SNR.

In our study of the 136 children with SRNS, 94 had early steroid resistance while 42 had late steroid resistance. They were treated with a variety of immunosuppressive protocols (intravenous cyclophosphamide, cyclo-sporine, dexamethasone). The mean age of onset of symptoms in INR was significantly greater than in SNR (9.4 + 5.05 vs 6.7 + 4.99 yrs, P = 0.004). The clinical and biochemical features at onset