of measles has shifted upwards, we will be able to schedule the first dose at 12 months rather than 9 months, to reduce the frequency of vaccine-failure. However this should come as a recommendation from the national program. When unvaccinated children and those who failed to respond to vaccination accumulate to large numbers, measles will break out. To prevent it, high coverage with first dose and a second opportunity are necessary.

When the first dose is given at 9 months (or later) a second dose may be given in the second year of life, such as at the time of the DPT booster. Delaying the second dose to 5 years is not ideal since some children may remain susceptible up to that time.

Three doses of measles vaccine are not necessary. If a child got measles vaccine at 9 months and one MMR dose in the second year of life, another dose MMR is not necessary for the sake of *measles protection*. However, if better protection from mumps is desired with a second dose, then the second MMR will serve that purpose – not essential, but harmless and useful against mumps. Rubella vaccine's purpose is slightly different from that of measles and mumps components. Individual protection of children from rubella is of not of much value – rubella *per se* being a mild disease, but reduced circulation of rubella virus in the community (to prevent maternal rubella infection leading to congenital rubella syndrome) is the goal of rubella vaccination program.

With these principles, one can tailor-make measles-containing vaccination to fit the individual child's circumstances; IAP guidelines will help. As for national immunization program, the second dose may be scheduled for convenience as routine (in second year of life) or as campaign with a broader age range – the upper age will determine the interval for the next campaign.

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Prevalence of Childhood Tuberculosis at Secondary Hospitals in Uttar Pradesh

I read with great interest the recent communication by Vashishtha and John(1). They have documented the annual rate of *Mycobacterium tuberculosis* (Mtb) infection in children attending an outpatient department of a secondary level hospital in Western Uttar Pradesh. The prevalence rate of Mtb infection in different age groups are much higher than community surveys in rural Uttar Pradesh by Indian Council of Medical Research. Although findings from the study do not indicate the exact community prevalence, the implications are that a significant proportion of outpatient workload for practicing pediatricians in Western Uttar Pradesh (UP) would be children with tuberculosis. I have documented the overall prevalence of childhood (1month-18 years) tuberculosis (not infection) in out-patients at Shanti-Mangalick hospital (Agra, UP) using IAP guidelines to be 3.5% (95% CI 2.5% -4.0%)(2, 3). This concurs with the high prevalence rates of infection documented by Vashishtha and John and the natural history of tuberculosis disease in children.

The challenges noted while managing children with tuberculosis as outpatients were difficulties in demonstrating acid-fast bacilli, inability to link the children with the RNTCP program due to guidelines and logistic issues, an extremely high prevalence of extra-pulmonary tuberculosis (~ 50%), long delays in diagnosis considering the duration of symptoms at presentation (median 4.5 months, IQR 1-6.5 months), inability to do contact tracing in all children and follow up and affordability issues.

The observations made by me in 2004 and by Vashistha in 2008 indicate that little progress has happened in the control of tuberculosis in Western UP. The effectiveness of the RNTCP program in controlling tuberculosis in adults and children in this region is questionable. The role of practicing pediatricians must be appreciated for the control and management of tuberculosis in children in the region. Only with their active involvement it might be feasible to develop an integrated computerized system with a district hospital or medical school taking the lead to ensure compulsory follow up of each child with tuberculosis and attempt contact tracing using available community resources.

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Score for Neonatal Acute Physiology II

We read with interest the article by Sundaram, *et al*.(1). One of the main objective of this paper was to evaluate the ability of SNAP score II for the prediction of death in septicemic neonates. In the study subjects, the mortality was 62.5% (25 of the 40 enrolled subjects died). What clinical use would be any predictive score when the population itself is at such a high risk of mortality? As in the study, by applying the SNAP II score the predictive ability went up by 15.5% (i.e. from baseline 62.5% to 88%). How will a patient benefit if the clinician says the risk of death is 2/3rd or 3/4th.

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In a recent article(1), the authors have cited their own primary study(2) as reference no 6, on "adapted criteria" for organ dysfunction adapted from article in reference no 10. I retrieved reference no 6(2) but could not find any adaptation criteria. Secondly, it is known that among low birth weight (LBW) babies , small for gestational age (SGA) babies have differing hormonal responses to stress(3) which can affect physiological response in return. In this study, 30% of enrolled babies were SGA. I wonder as to what was the impact of SGA status on SNAP II scores?

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