

## 'Charms' in Childrearing

Traditional or cultural practices are time honored rituals and beliefs which are prevalent in the community and they may pertain to a wide range of activities. A charm is defined as something worn about the person to ward off evil or ensure good fortune. Commonest purpose for use of a charm is for general wellbeing, and is found to be higher among people living in rural areas in joint family with poor socioeconomic status, or with advanced age of parents and poor literacy status of parents.

The traditional practices are so ingrained in the society that it is difficult to change them even when they are identified to be useless or harmful [1]. Though harmless, their presence can be a source of infection due to frequent contamination [2]. Moreover, they often result in delay in health-seeking with resultant deterioration of the child [3].

This study was done between October 2011 and September 2012 in the Department of Pediatrics, JJM Medical College, Davanagere. We studied 1000 children (500 cases with charms and 500 controls without charms) attending the hospital for the presence of Charms, and factors related to their usage; using a structured form, followed by interview with a single researcher (ANR). The case and control groups were comparable in terms of age, gender composition and religion. More than two-third cases (77.2%) and controls (71.2%) were younger than 5 years. There were no differences between cases and controls with respected to sex distribution (62.2% and 64.4% males) and religion (91% and 87.6% Hindus). 64% and 36% were from rural and urban areas. The various types of charms in the study were: *Tayatha* 41.2%, *Ele* (thread) and *Anthra* 26.1%, *Drishtimani* (string of beads) 10.6% and *Cheeti* 10.6% . Other types

constituted around 12%. Similar observations have been reported by other studies [4,5]. Most of the charms used are harmless. Each charm is usually related to particular symptoms or a disease, but most are non-specific. It can be suggested that culture and health beliefs should be taken into account when training programs are prepared to change traditional child care practices and to promote health behavior. A pediatrician should understand the local tradition and charms, which can guide in the clinical practice. Nursing education curriculums should also train nurses to assess traditional practices, to reinforce positive cultural practices, and to discourage potentially harmful ones.

Almost all the charms in the study were harmless. The results of this study can help health professionals to recognize the role of traditions in child health.

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## REFERENCES

1. Singh M. Care of the Newborn: 7<sup>th</sup>ed. New Delhi: Sagar Publications; 2010.
2. Taneja DK, Singhal PK, Dhawan S. Superstitions in pediatric illness among rural mothers. *Indian Pediatr.* 1988;25:447-52.
3. Kushwaha KP, Mathur GP, Mathur S, Singh YD, Sati TR. Superstitious therapy during illnesses of pre-school children. *Indian Pediatr.* 1986;23:163-8.
4. Shukla RS, Bhambal SS, Bhandari NR. Study of superstitions and practices in under five. *Indian Pediatr.* 1979;16:403-8.
5. Krishnamurthy, Rajgopal T. Folk lore and child rearing practices in South India. *In: Current Topics in Pediatrics.* New Delhi, Interprint, Mehta House, 1977. p. 507.

## Autoimmunity in Immunodeficiency

A 1-year-old boy presented with recurrent attacks of severe life threatening infections since 5 months of age, along with persistent diarrhea for last 3 months. He was visibly malnourished and had generalized erythroderma with scaling. Immunophenotyping from peripheral blood showed very low CD4+ and CD8+ count (9/ $\mu$ L and 94/ $\mu$ L,

respectively); CD4/CD8 ratio was 0.09. Immunoglobulin (IgM: 6 mg/100 mL, IgA: 6 mg/100 mL, IgG: 110 mg/100 mL, IgE: 5.71.U/mL) levels were below normal suggesting a diagnosis of Severe combined immunodeficiency (SCID). This patient developed high fever, hepatosplenomegaly and pancytopenia (total leukocyte count  $0.3 \times 10^3/\mu$ L, neutrophil 12%, platelet count  $78 \times 10^3/\mu$ L, hemoglobin 6.8 g/dL). Fasting triglycerides (342 mg/dL) and serum ferritin (9240 ng/mL) were raised, and bone marrow showed hemophagocytosis. Intravenous immunoglobulins were started along with

antibiotics. General condition of the patient deteriorated and the patient expired in next few days.

Although it sounds paradoxical, an autoimmune phenomenon can complicate a pre-existing primary immunodeficiency disorder, thereby creating a diagnostic and therapeutic challenge for the physician. Cases like Autoimmune thrombocytopenia and Autoimmune hemolytic anemia in Common variable immuno-deficiency [1], and Omen syndrome and Autoimmune thrombocytopenia in SCID [2] have been reported. Impairment of both central and peripheral tolerance is responsible for autoimmunity observed in SCID [3]. Treatment with immunosuppressive agents such as corticosteroids can exacerbate the infections associated with immunodeficiency disorders. So non-immunosuppressive agents such as intravenous immunoglobulins and targeted monoclonal antibodies are likely to be preferable [4].

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#### REFERENCES

1. Ramyar A, Aghamohammadi A, Moazzami K, Rezaei N, Yeganeh M, Cheraghi T, *et al.* Presence of idiopathic thrombocytopenic purpura and autoimmune hemolytic anemia in the patients with common variable immunodeficiency. *Iran J Allergy Asthma Immunol.* 2008;7:169-75.
2. Elhasid R, Bergman R, Etzioni A. Autoimmunity in severe combined immunodeficiency. *Blood.* 2002;100:2676-7.
3. Milner JD, Fasth A, Etzioni A. Autoimmunity in severe combined immunodeficiency (SCID): lessons from patients and experimental models. *J Clin Immunol.* 2008;28:29-33.
4. Goyal R, Bulua AC, Nikolov NP, Schwartzberg PL, Siegel RM. *Curr Opin Rheumatol.* 2009;21:78-84.

## Pentavalent vaccines and operational difficulties

The Puducherry Government had been providing BCG, OPV, DPT, Hepatitis B, Measles and MMR vaccines to all government hospitals, medical colleges and primary health centers. Now, the Government of Puducherry launched the pentavalent vaccine is program in January 2013 [1]. The pentavalent vaccine is given in three doses at 6, 10 and 14 weeks along with oral polio vaccine (OPV). IAPCOI timetable 2013 recommends HiB vaccine at 6, 10, 14 weeks, and a booster dose between 15-18 months [2]. Some want to follow the older regimen instead of pentavalent vaccines as they feel the safety of vaccines is more important than the number of injections. With the non-availability of HiB vaccine in the government supply, parents are advised to buy it from outside.

When the Government of India and Indian Academy of Pediatrics are sure of implementation of pentavalent vaccine program, why it is not incorporated in the National immunization programme and IAPCOI Recommendations 2013? Is it not wiser to expand the National immunization program first, and more importantly, make it uniform throughout the country, and,

then go for the combined vaccines? Is it not wiser to expand the spectrum of vaccine preventable diseases rather than focus on combination vaccines? No doubt the combined vaccines are there to stay, but the policy makers cannot ignore the pitfalls. The most important objective is effective and safe vaccines, and to achieve the goal of 100% immunization coverage in the country.

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#### REFERENCES

1. Pentavalent vaccines for all children soon. *The Hindu* 2013 Jan 12; Tamilnadu: pg 2(col 1).
2. Indian Academy of Pediatrics, Advisory Committee on Vaccines and Immunization Practices (ACVIP), Vashishtha VM, Kalra A, Bose A, Choudhury P, Yewale VN, Bansal CP, *et al.* Indian Academy of Pediatrics recommended immunization schedule for children aged 0 through 18 years, India, 2013 and updates on immunization. *Indian Pediatr.* 2013;50:1095-108.

#### REPLY

Apropos of the query regarding Hib vaccination schedule, this is to clarify herewith that IAP ACVIP recommendations are mainly for individual protection of a particular child in an office-practice setting. They are the most appropriate way of using available licensed vaccines