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Comments

INH chemoprophylaxis is a beneficial and cost-effective tool for the control of tuberculosis. Lately there has been newer research in western world in this context primarily related to the duration of chemoprophylaxis and it's side, effects. The prolonged duration of six—nine months chemoprophylaxis makes compliance difficult. Therefore, alternate modalities like directly observed biweekly INH prophylaxis for six—nine months or using drugs like rifampicin alone or along with INH for three—four months are being evaluated. INH induced hepatotoxicity has further put it into defame. This, however, is not common in childhood and therefore, not a limiting factor in high prevalence countries like India where most of the persons requiring prophylaxis are in the younger age group(l).

In India, the rising trend of INH resistance has raised doubts about the INH prophylaxis. The initial resistance to INH has been reported between 10-12% (not 10 to 90% as mentioned by the authors) in our country(2). Recommending rifampicin with or without ethambutol for prophylactic therapy may not be prudent given the enormity of the problem, cost of the therapy and need to use these drugs for 6-9 months when resistance is suspected. In the situation, where there is confidence that the source case has INH resistant organisms, it appears reasonable to treat with rifampicin with or without ethambutol in standard dosages for nine months.

The childhood contacts of known cases of multidrug resistance (rifampicin and INH) may require diligent observation as no other drug has been evaluated for preventive therapy. However, in contacts at a high risk of tuberculosis *(e.g.,* immunocompro-mized), preventive therapy may be considered. If the organisms are known to be susceptible and active disease has been excluded, nine months of daily ethambutol and pyrazinamide may be considered. If the organisms are resistant to ethambutol as well, pyrazinamide along with quinolones may be used(3).

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Transmission of Salmonella

The mode of transmission for *S. typhi* is water, food borne *or* vertical transmission. It is surprising to have typhoid fever in an exclusively breast fed 4 months-old-infant(l). Will the authors give the likely explanation regarding mode of transmission in that particular case.

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Reply

We appreciate the comments on our article. The most common mode of transmission of *S. typhi* is through ingestion of contaminated water or food. Rarely, infection may be transmitted from mother to fetus by transplacental route. Since the infant reported was breastfed, food can be excluded as a source of infection. There was no history of typhoid fever in the mother but she was not investigated for the carrier state. We believe that the most likely source of infection in the present infant was the ingestion of contaminated water. The parents are in habit of giving small amount of water to infants, especially during summer months.

Probably the confusion has arisen over the use of the term "exclusive breastfeeding" in the article. We intended to mean that the infant was not given any other food item besides the breast milk, which could have served as a vehicle for transmission of *S. typhi.*

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