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## Present Status of Hemoglobinopathies in India

The recent editorial(1) on this subject was very informative but the table showing the distribution of abnormal hemoglobins in India has left out Karnataka completely. I can not give an exact figure in this context as I don't think a survey of the disease has been conducted but we do have a large number of cases of  $\beta$ -thalassemia major as well as sickle cell anemia in Karnataka. The Billigiri Ranga Hills in the Malnad area of Karnataka is one of the pockets of sickle cell anemia.

In St John's Medical College Hospital we are following about 20 cases of  $\beta$ -thalassemia major and about 10 cases of sickle cell anemia and every year about 3-5 new cases are added on. The other hospitals in Bangalore and other major cities in Karnataka must be having a similar number of cases.

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## Propranolol in Supraventricular Tachycardia

With reference to the article on the "Management of Supraventricular Tachycardia (SVT) in Infancy and Childhood"(1), we would like to add other pharmacotherapy used for SVT by

presenting our experience of treating a newborn with SVT who required propranolol in addition to cardioversion and digoxin.

A 10 day old baby boy was admitted with a history of poor feeding, lethargy, rapid respiration and grunting since age of 5 days. It was a full term infant born to a primigravida mother by spontaneous vaginal delivery. His birth weight

was 2.5 kg. Physical examination of the baby revealed a respiratory rate of 80/minute, there was an expiratory grunt and subcostal recessions. He had marked tachycardia with heart rate of 300/minute and the peripheral pulsations showed low volume. His capillary refilling time was 6 seconds. There was central and peripheral cyanosis. Neonatal reflexes were poorly elicitable. X-ray film of the chest was normal and electrocardiogram suggested paroxysmal supraventricular tachycardia (PSVT). Since the child was hemodynamically unstable, DC cardioversion was done (1 Joule/kg) successfully followed by *rapid digitalization*. He was put on maintenance digoxin. Two days later he again had PSVT. It was reverted back to normal rhythm with ice pack application over the face. Next day he again had PSVT which was reverted back only transiently initially, later on it did not respond to ice packs application over face. Oral propranolol in doses of 2.5 mg/kg/day in two divided doses was added. PSVT reverted back to normal rhythm after 6 hours and subsequently there is no recurrence till age of 2<sup>1/2</sup> months. The child is on maintenance digoxin and propranolol. His ECG and echocardiogram are normal.

Propranolol has been recognized for the last two decades as a useful pharmacological agent for treatment of digitalis resistant PSVT in childhood. The usual recommended doses are 1-4 mg/kg/day(2). A high dose up to 16 mg/kg/day has been used in refractory cases

with satisfactory results(3). Empiric therapy with digoxin and propranolol is effective in 64% of children with supraventricular tachycardia(4). Another nonselective beta adrenoreceptor blocking agent, nadolol has also shown similar results with an added advantage of once a day doses regimen(5).

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