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REPLY

We thank Dr Puliyel for showing keen interest in the recommendation of Polio Eradication Committee of IAP(1, 2).

The word "now" does not necessarily imply "immediately". It only means that as of "now"("presently"), we have to start thinking of and developing the process of stockpiling the vaccine in India. This process would be as per the norms and practices followed internationally, including consideration of shelf life of the vaccine. Furthermore, this is in concurrence of the guideline issued by WHO to individual countries for the 'endgame' and for 'post-eradication phase' of polio eradication(3).

The committee has concluded that poor RI rates in key states like UP and Bihar is one of the main reasons why PE initiative has failed to succeed in these areas. Bolstering of poor RI, particularly in endemic areas must be done urgently to avoid re-introduction of the wild virus from outside, hence the recommendation of aiming to achieve the target at the earliest possible deadline i.e. by the end of the current year. This recommendation reflects how much significance PEC attaches to improved RI rates in context of achieving and maintaining polio eradication goal. The 38% fully immunized rate was reported for the year 2001, the more recent estimate based on NFHS-3 is 43.5%(2).

We agree with Dr Puliyel that original objective of GPEI, i.e. "absence of need to immunize children perpetually after achieving global polio eradication" can not be met. This is mainly due to certain unforeseen events like phenomenon of cVDPV, iVDPV, etc that encountered during the implementation of GPEI strategy that leads WHO to redraft their objective and goals (3). Regarding the issue of blaming GOI, Dr Puliyel must know that technically it is the GOI which is officially in charge of entire program run by international agencie, even though the agencies are running and calling the shots. NPSP is officially looking after the 'surveillance' part of the entire exercise; it is the GOI who is in charge of entire proceedings. Hence, it is quite appropriate to direct all our recommendations to GOI and not to any other organization.

It is therefore clear that the inference drawn by Dr Puliyel "It is unfortunate that the IAP should participate in this game plan to lay blame on the GOI" and also the heading given to his letter "Setting the scene to blame the GOI for failure of Polio Eradication" are based on Dr. Puliyel's misreading/misinterpretation of the recommendations. In this regard, we would only reiterate what was written in an earlier issue of Indian Pediatrics(4) that the IAP believes in lending a supporting hand to the Government and all agencies engaged in PE, in spite of differences which it expresses through its publications, meetings, conferences etc. It believes in adopting an attitude of persuasion, not cynicism and acrimony. Thus, imputing the motive that IAP is into the game plan of shifting the scene to blame the GOI is, in itself, unfortunate.

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Paraplegia : A Rare Manifestation of Vitamin K Deficiency

Late onset Vitamin K Deficiency Bleeding (VKDB) is a syndrome defined as unexpected bleeding attributable to severe vitamin K deficiency in infants 2 to 12 weeks of age, occuring primarily in exclusively breastfed infants who have received no or inadequate neonatal vitamin K prophylaxis. The incidence ranges from 4.4 to 7.2 per 100000 births(1). It tends to be more severe than early onset or classical disease. 50-80% of VKDB patients present with serious intracranial hemorrhage. Other manifestations are ecchymosis, nodular purpura and bleeding from GI tract/mucus membranes/skin punctures or surgical incisions(1-5). We describe a rare case of VKDB with spinal hemorrhage.

A 9 month old boy presented with ecchymotic patches for 7 days, bleeding from both ear and pallor for 2 days with paucity of spontaneous movements in both legs and urinary retention for 1 day. There was no icterus, lymphadenopathy or hepatosplenomegaly. Higher mental functions were normal. Tone was decreased with power of 0/5 across all joints in lower limbs. Knee and ankle jerk were not elicitable at admission but became brisk after 6 days. Abdominal, cremasteric and anal reflexes were absent. Babinski response was positive bilaterally. There was no evidence of any liver disease/ drug intake or chronic diarrhea. There was no history of similar illness and family history was negative. The child was born at term and did not receive vitamin K injection at birth. He was on exclusive breast feeding since birth.

Both PT and APTT were deranged (PT 96.0 s against 27s, PTTK >120s against 12s, PT index=3.55) with a normal platelet count (480×10^3/μL). Peripheral smear showed microcytic hypochromic RBCs and normal platelet morphology. Liver function tests including serum bilirubin, SGPT, ALP and albumin were normal.

Child was given intravenous vitamin K (5 mg) and packed red cells (in view of Hb 2.9 g/dL). Bleeding stopped after vitamin K administration and PT/PTTK normalised within 24 hours. MRI spine revealed posterior epidural hemorrhage in lower thoracic and lumbar region at and below T11/T12 level. At discharge (after 10 days), power at both hips, both knees and both ankles improved to 3/5, 2/5 and 1/5, respectively. On follow up after 1 month, power at both hips, both knees and both ankles was 4/5, 3/5, and 2/5, respectively and urinary complaints had subsided.

We conclude that paraplegia should be considered as one of the important cause of spinal hemorrhage, especially in infancy.

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