Infant Feeding in HIV and Gatroesophageal Reflux

We read with interest the IYCF Guidelines 2016 [1] published recently in Indian Pediatrics. We would like to bring to the attention of the readers and policy makers the following issues:

1. Regarding "HIV and infant feeding", point "h" needs attention inlight of WHO recommen-dations and recent literature [2,3]. In its guiding practice statement, WHO clearly states that in mothers living with HIV, mixed feeding is better than "no breastfeeding at all."
2. Mothers living with HIV who plan to return to work/ school (increasing trend seen in young Indians), a shorter duration of breastfeeding is better than not initiating breastfeeding at all [2].
3. Regarding "HIV and infant feeding", point "m" dealing with exclusive replacement feeding (ERF), WHO is more emphatic regarding avoidance of animal milk in first six months of life. However, animal milk is a valid option for ERF in children above six months [2].
4. Regarding "Infant feeding in various conditions related to the infant", point (iv) deserves attention as recent literature shows that "upright positioning for 30 minutes after feeds" does not hold true in reducing gastroesophageal reflux (GER) [4]. The prone position was superior to the supine or upright positions while patients were awake or asleep. However, prone position cannot be recommended due to its association with sudden infant death syndrome (SIDS). The policy statement on task force on SIDS recommends supine position for infants including infants with GER [4].

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REFERENCES

1. Tiwari S, Bharadva K, Yadav B, Malik S, Gangal P, Banapurmath CR, *et al*, for the IYCF Chapter of IAP. Infant and Young Child Feeding Guidelines, 2016. Indian Pediatr. 2016;53:703-13.
2. WHO. Updates on HIV and Infant Feeding. Available from: *http://www.who.int/maternal_child_adolescent/documents/hiv-infant-feeding-2016/en/* . Accessed September 5, 2016.
3. Victora CG, Bahl R, Barros AJD, França GVA, Horton S, Krasevec A, *et al*. Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. Lancet. 2016;387:475-90.
4. Task Force on Sudden Infant Death Syndrome, Moon RY. SIDS and other sleep-related infant deaths: expansion of recommendations for a safe infant sleeping environment. Pediatrics. 2011;128:1030-9.

Editor's note: *The corresponding author of the guidelines in question did not provide a point-by-point response to these queries, and stated that these issues will be addressed at the time of next revision of guidelines.*

Need for Revision of Guidelines for Management of DR-TB in Children

Overall prevalence of drug resistant tuberculosis (DR-TB) in pediatric patient is increasing [1]. The Directly Observed Treatment, Short Course (DOTS) strategy has emerged as a possible solution to the rising number of tuberculosis (TB) cases and has been incorporated in India's Revised National Tuberculosis Control Programme (RNTCP) as well. RNTCP multidrug resistant (MDR) TB treatment regimen consist of 6 drugs [kanamycin (km), levofloxacin (lvx), ethionamide (eto), pyrazinamide (Z), ethambutol (E) and cycloserine (cs) during 6-9 months of an intensive phase and 4 drugs (lvx, eto, E and cs) during the 18 months of the continuation phase [2]. In recent studies it has been found that there is increasing fluoroquinolone and ethionamide resistance [1].

At our institute, we had a 10-year-old boy who was diagnosed with rifampicin-resistant (RR) miliary tuberculosis with pneumothorax by GenXpert on sputum sample. We started the child on second-line anti-tubercular therapy (ATT) consisting of moxifloxacin, amikacin, PAS, cs and clofazimine along with prednisolone, based on our previous experience with prevailing DR-TB in Mumbai and the sensitivity pattern [1]. Child improved on above regimen and was discharged with advice to follow-up with drug sensitivity testing (DST) report. After 15 days of above regimen, during a visit to a DOTS center for the medicines, drug regimen was changed to lvx, eto, Z, E, cs and km. After one week of above regime, child's condition deteriorated, and he