

as well, as was shown in the longitudinal follow-up of a birth cohort in Delhi(2). These comments by no means underestimate the remarkable impact that has been made on mortality in the Pondicherry study.

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## REFERENCES

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### Intestinal Parasites Among Children at Bharatpur, Nepal

Intestinal parasitic infections are still responsible for malnutrition and morbidity in underdeveloped countries. We evaluated the magnitude of intestinal parasites among children at Bharatpur, Nepal Stool samples were collected from 211 children attending the OPD of our hospital during the period April, 1996 to February, 1997. Presenting complaints included pain abdomen, respiratory infections, fever, loss of appetite, diarrhea, dysentery, fullness of abdomen, *etc.* Both saline and iodine smears were made and microscopic examination was done for cysts and ova of various parasites.

The various parasites isolated are shown in *Table I*. The maximum isolation was of *Ascaris lumbricoides* followed by *Giardia lamblia*. Mixed infections were also noted in a few children. The prevalence of *Enterobius vermicularis* was low in our study. A contributory factor may be the fact that the perianal swabs from these children were not collected.

Amongst the intervention measures, it is important to take up sustained health education, provision of safe drinking water, improvement in environmental sanitation and provision of septic lavatories for these communities. It would also be useful to teach them about personal hygiene and conduct health education at schools through school health projects. During the school health checkups, periodic screening

TABLE I—Isolation of Specific Parasites

Parasite	<i>Ascaris lumbricoides</i>	<i>Giardia lamblia</i>	<i>Entamoeba histolytica</i>	<i>H. nana</i>	Hook worm	<i>Trichuris trichuri</i>	<i>Enterobius vermicularis</i>	Total no. of positive cases
No. of +ve cases	46	39	27	15	13	11	06	157
%	21.8	18.5	12.8	7.1	6.2	5.2	2.8	74.4

for intestinal parasites can be undertaken and deworming considered for those belonging to the poor communities.

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### Adult Contacts in children with Tuberculosis

The most important issue concerned with control of childhood tuberculosis is the detection of infectious adults. This can only be done by investigating and treating the adult contacts of tubercular children (ascending survey) and *vice versa*, *i.e.*, investigating and treating the children who are in contact with sputum positive cases (descending survey)(1). The recent article(2) on this subject was thus relevant and timely(2). Simultaneously, it was interesting to note that 61% of all children (diagnosed to be suffering from various forms of tuberculosis) had tubercular adult contacts. Of these, 9.3% were newly detected parents by means of ascending survey. In this connection, I seek a clarification on the following aspects:

1. As per the report, adult contacts were defined as those who had received antitubercular therapy in recent past (upto 2 years). Conventionally an infectious case is defined by presence of acid-fast bacilli (AFB) either in sputum or in bronchial aspirate. Were all cases (diagnosed as adult contacts study) sputum positive? Can we label any

adult as contact, in case he/she is being treated for tuberculosis on high index of suspicion without smear positivity; *i.e.*, those with long history of fever and cough, raised ESR, non response to antibiotics, receiving therapeutic trial with antitubercular therapy?

2. Authors considered both intrafamilial contacts (IFC) and extrafamilial contacts (EFC) where positive history of contacts was obtained. They found significant role of EFC (33% and 38.1% contribution in intrathoracic and extrathoracic childhood tuberculosis, respectively). However, they scrutinised only parents (IFC) where such positive history was denied. In such cases had EFC been investigated for tuberculosis, could it have resulted into better detection rate of adult contacts?
3. As per discussion, multiple adult sources were detected in 4 children. Did authors screen other asymptomatic adult contacts residing in same family where already one parent or grandparent was receiving antitubercular therapy? Such screening assumes great importance because 50% of these apparently non infectious infected adults would break down and become infectious(3).

Lastly, the message is very clear-Pedia-