

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-

tricians and Physicians have to play a key role in ascending surveys and descending surveys, respectively for tuberculosis control.

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REFERENCES

1. Udani PM. Tuberculosis in children: A

multisystem disease-Past, present and future. *Tuberculosis News Bull* 1996; 1: 3-8.

2. Somu N, Vijaysekran, Kannaki M, Balachandran A, Subramanyan L. Adult Contacts in children with tuberculosis. *Indian Pediatr* 1997; 34: 819-822.
3. Udani PM. Tuberculosis in children. Magnitude of problem and clinical classification. *Tuberculosis News Bull* 1997; 2: 6-8.

Reply

The diagnosis of tuberculosis in children is presumptive due to poor bacteriologic confirmation(1). The idea of identifying adult source of infection as an important clue in the diagnosis of TB in children is well supported by many authors(2).

In our study, adults who had received anti-tubercular therapy from recognized institutions (in the past 2 years) were considered as adult contacts which included both infectious tuberculosis and smear negative pulmonary tuberculosis; many adult contacts belonged to the latter category. Of course investigation of all the family members other than parents and close extra

family members definitely could have resulted in better adult contact detection.

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REFERENCES

1. Harries A, Maher D. Diagnosis and treatment in children: *In: Tuberculosis: A Clinical Manual for South East Asia*. Geneva, World Health Organization, 1997; pp 45-52.
2. Nemir RD, O Hare D. Tuberculosis in children 10 years of age and younger: Three decades of experience during chemotherapeutic era. *Pediatrics* 1991; 88: 236-241.