

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

**Ravi Goyal,**  
246, Shopping Centre, Kota  
324 007, Rajasthan.

**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.

**N. Somu,**  
*Professor,*  
*Pediatric Respiratory Diseases,*  
*F-49, 1st Main Road,*  
*Anna Nagar, Madras 600 012.*

**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.