inheritance and co-existence of renal ectopia with radial dysplasia suggests some malformation syndrome with autosomal dominant inheritance.

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REFERENCES

1. Waters PM. The upper limb. *In:* Morrisy RT, Weinstein SL (eds). Lovell & Winters Pediatric Orthopedics, 5th edition. Philadelphia: Lippincott Williams & Wilkins, USA, 2001; p. 842-903.
2. Czeizel AE, Vitez M, Kodaj I, Lenz W. A family study on isolated congenital radial and tibial deficiencies in Hungary, 1975-1984. Clin Genet 1993; 44: 32-36.

Plasmapheresis in Acute Disseminated Encephalomyelitis

I read with interest the recent report of plasmapheresis in childhood acute disseminated encephalomyelitis (ADEM) resulting in remarkable recovery(1). However, I would like to make certain observations.

Though the indication mentioned for resorting to plasmapheresis in the report is the unaffordability of intravenous immunoglobulin (IVIG) therapy, I wish to highlight other important reasons for preferring plasmapheresis over IVIG. Firstly, IVIG is known to exert its immunomodulatory effects for a prolonged period of time. The mean duration of action of IVIG is 53 days and the half life of immunoglobulin in the serum is 3-4 weeks(2). Therefore, employing plasmapheresis immediately after IVIG therapy would result in removal of circulating IVIG, thereby giving little time for IVIG to show its efficacy. This removal could be avoided by opting for IVIG therapy only after plasmapheresis has failed. Secondly, there are published reports of plasmapheresis succeeding even in IVIG-refractory cases of ADEM(3,4).

The probable reasons, IVIG is preferred over plasmapheresis in ADEM, are its ease of administration, the lack of plasmapheresis facilities in many centers and a fear of treatment-related complications with plasmapheresis. However, low-volume (manual) plasma exchanges have been shown to be efficacious in ADEM and can be performed with little training even in smaller centers(5). At the same time, low-volume exchanges are relatively safe too. However, I agree with the authors that randomized controlled trials are required to decide the most effective volume of plasmapheresis required in ADEM.

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REFERENCES

1. Nair RR, Rafeequ M, Girija AS. Plasma-

pheresis in childhood acute disseminated encephalomyelitis. Indian Pediatr 2005; 42: 479-482.

2. Ellis CM, Leary S, Payan J, Shaw C, Hu M, O'Brien M, *et al*. Use of human intravenous immunoglobulin in lower motor neuron syndromes. J Neurol Neurosurg Psychiatry 1999; 67: 15-19.

3. Balestri P, Grosso S, Acquaviva A, Bernini M. Plasmapheresis in a child affected by acute disseminated encephalomyelitis. Brain Dev 2000; 22: 123-126.

4. Miyazawa R, Hikima A, Takano Y, Arakawa H, Tomomasa T, Morikawa A. Plasmapheresis in fulminant acute disseminated encephalomyelitis. Brain Dev 2001; 23: 424-426.

5. Kumar S. Manual (low-volume) plasmapheresis: An effective and safe therapeutic procedure in acute neurological illnesses. Ann Ind Acad Neurol 2004; 7: 439-440.

Lipoblastoma in Infancy

An eight months old child presented with a painless swelling on the dorsum of the left foot for the last 3 months (*Fig, 1*). It had been gradually increasing in size and rapidly so for the last one month. There was no other similar swelling elsewhere in the body. Regional lymphnodes were not enlarged. Fine needle aspiration cytology was suggestive of lipoma. Plain radiograph of the foot did not reveal any calcification or bony involvement. At surgery, a well circumscribed lipomatous lesion of the foot encasing the tendons was found. Histopathology was suggestive of lipoblastoma.

Lipoblastoma is a relatively rare tumor that occurs in infancy and early childhood and arises from embryonic white fat. The most common symptom is a painless mass with or without increasing size. The trunk, extremities, head and neck, retroperitoneum, inguinal canal, peritoneal cavity, and lung are the common tumor sites. Histopathologic examination shows a cellular neoplasm composed of immature adipocytes with relatively well-defined septa, frequent lipoblasts and a fine vascular network.

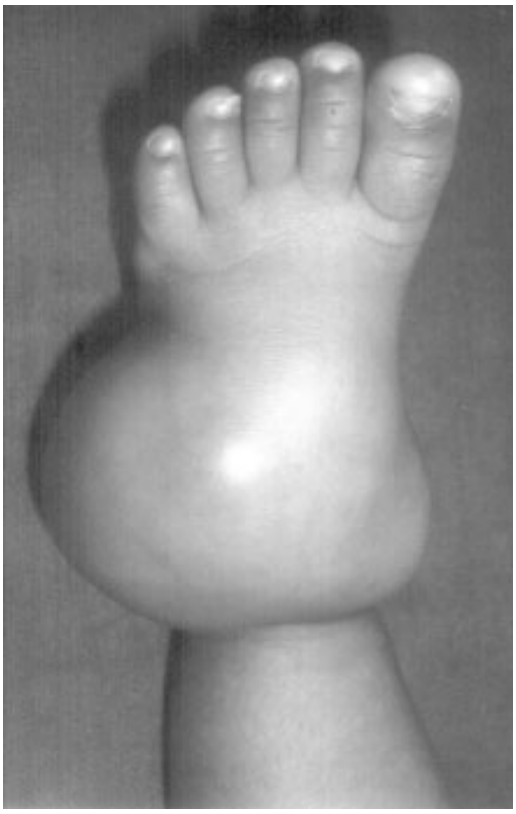

Fig. 1.Clinical photograph showing lipoblastoma of the left foot.