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Polio Eradication: Let us Face the Facts and Accept the Reality

In the January 2004 issue of the Bulletin of Polio Eradication Committee of IAP Dr. Jacob John had stated: "it is still possible to see the last case of wild-virus polio in 2003 itself. If that does not happen then it should happen in the first quarter of 2004". The India Expert Advisory Group concluded at the 26-27 March, 2004 meeting that the transmission of wild polioviruses can be stopped in the country within months. The prophesy turned out to be incorrect as can be seen in *Table I*.

It would be relevant to state that many polio cases are being missed because of the following two reasons(1): (i) AFP cases where vaccine polioviruses are found in stools are discarded as non-polio. (ii) Wild polioviruses not detected in stool samples of AFP cases. Many such cases are discarded as non-polio even without 60 days follow up.

High incidence of vaccine failure: According to the official data polio incidence in children who had received four or more of doses of OPV was as follows: In year 2000: 58%, in

2001: 60%, in 2002: 44%, and in 2003: 51%. According to Kohler, *et al.* out of 181 VAPP cases during 1999, 78 children had received five or more doses of OPV before onset of paralysis(2).

High incidence of VAPP: The expected number of VAPP cases every year was 60-75. According to revised data made available by the NPSP the number of VAPP cases were as follows: 1998 : 124, 1999 : 206, 2000 : 151, 2001 : 120, 2002 : 203. According to my estimates about 300 cases occur every year(1).

It can be said that present eradication program ensures that polio is not eradicated. Polio cases will continue to occur because of vaccine failure and due to mutant vaccine polioviruses. Infected immunocompromised children will continue to spread for prolonged period in the community wild as well as mutant vaccine polioviruses.

It is suggested that following three measures be considered: (i) new guidelines for AFP classification be formulated so that no polio case is missed, (ii) IPV be made available for those children who are immunocompromised or have immunocompromised close contacts, and (iii) the reasons for vaccine failure be determined and appropriate

TABLE I—Number of polio cases in 2004.

As on	5.6.04	14.8.04	11.9.04
Representative period	First 3 months	First 6 months	First 7 months
Virologically confirmed	10	33	54
Compatible	45	95	121

remedial measures, if feasible be taken, otherwise some alternate strategy for polio eradication be formulated.

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Bilateral Communicating Intralobar Pulmonary Sequestration

A one-month-old female child presented with recurrent respiratory tract infections since birth. X-ray chest showed haziness of the right lower and middle zones and also of the left lower zone. Bronchoscopy revealed a normal tracheobronchial tree. Post bronchoscopy X-ray showed partial clearing of the opacities. Spiral CT scan showed intra lobar sequestration of right and left lower lobes. MRI angiogram showed aberrant arterial feeder from celiac trunk supplying both right and left sequestrations. Gastrograffin studies showed gastro-bronchial communication arising as a single trunk from lesser curvature of the stomach and dividing into two supplying both sequestrations (*Fig.1*).

Laparotomy and division of the gastro-bronchial communication was done. Vascular supply was inaccessible and so were not divided. Right thoracotomy showed right lower lobe and middle lobe sequestration. Both lobes were resected. Left lower lobe sequestration was left as such since resection of the left lower lobe along with right lower and middle lobes would have caused severe respiratory insufficiency. Vascular supply to the left side was identified and divided. Histopathological examination confirmed the diagnosis of intralobar sequestration. CT scan after 6 months showed that left lower lobe sequestration had disappeared.

This is a communicating type of sequestration where the sequestration communicates with the fore gut. Savic, *et al.*(1) reported that only 2.2% were in the middle or upper lobes. In our case both right and left lower lobes as well as middle lobe were involved making it an extremely rare presenta-