

## Non-availability of Vaccines and Program Ownership

Raoot, *et al.* [1], in the recent issue of *Indian Pediatrics*, reported the success of Delhi in introducing newer vaccines. Given the fact that health is a state subject, the proactive role of Delhi is noteworthy. It is encouraging that individual state/ Union Territory takes lead for providing extra vaccines to its children. However, typhoid vaccine being out of stock in Delhi since November 2016 and MMR vaccine since December 2016 (till April, 2017), we would like to point out the other side of 'walking the extra mile'.

As expected, policy makers and doctors know the difference between National Immunization Schedule and the schedule followed by individual states. From their point of view, this newer initiative is remarkable. On the other hand, for common parents attending immunization sessions for their children, stock-out means a breach of trust. After returning without getting vaccine twice/thrice over a period of six months, we really do not know what

trust on vaccination program they are left with. When a vaccine scheduled for their children is not available and health worker is not able say any probable date for the next availability of that particular vaccine, the whole immunization program suffers a setback.

With such examples of failure in supply chain management, we need to introspect the reasons of such discontinuity in vaccine availability. An exploratory study on this is probably the need of the hour. Nevertheless, if we consider the fact that even with irregular supply, we protected a number of children (as evident from reduced case load) in a way better than other states, we should take pride and look forward to consolidate the gain we have achieved so far.

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### REFERENCE

1. Raoot A, Dewan DK, Dubey AP, Seth S. Introduction of newer vaccines in State Immunization Schedule. *Indian Pediatr.* 2017;54:271-4.

## Optimizing Antibiotic Therapy for Necrotizing Enterocolitis – Need of the Hour

In last three decades, our understanding about pathophysiology of Necrotizing enterocolitis (NEC) has improved. There is a high degree of variability in the antibiotic regimen for the treatment of NEC, even within a single treating unit, with no regimen appearing superior over another. A recent study by Blackwood, *et al.* [1] documented that 22 different pre-operative antibiotic regimens were used with average duration of 10.6 d (mode 14 d). The 15 different post-operative antibiotic regimens had an average duration of 6.6 d (mode 2 d) [1].

An international survey done by Zani, *et al.* [2] on the

management of NEC documented that most (67%) surgeons use a combination of two (51%) or three (48%) antibiotics for more than 7 days, and keep patients nil-by-mouth for 7 (41%) or 10 (49%) days. Currently, there is no consensus in the literature about the antibiotic regimen for neonates with NEC [2].

The Cochrane review by Shah, *et al.* [3] concluded that there is insufficient evidence to recommend a particular antibiotic regimen for NEC. There has been no randomized trial in this area since late 1980s. As prolonged antibiotics usage is associated with dysbiosis and affects neonatal outcomes, there is urgent need to optimize antibiotic therapy.

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