

imbalance in the dietary ratio of protein to energy that has been implicated in the pathogenesis of kwashiorkor(2). The families involved do not fit the stereotypic profile in which malnutrition would be anticipated. The parents were well-educated, seemed knowledgeable and responsible, and had at least average family income. Diagnoses were delayed by a low index of suspicion as the skin changes of kwashiorkar were thought to be an exacerbation of the primary skin problem. In addition, kwashiorkar is uncommon in Kerala, and as a result, physicians may be unfamiliar with their clinical features. With resumption of a proper diet, the edema subsided in two weeks and skin changes were reversed, though the primary skin lesions persisted.

We were unable to find previous reports of kwashiorkor caused by dietary restriction as a part of treatment in alternative medicine, but cases may have occurred and may have not been reported. A heightened level of vigilance is required so that

nutritional deficiency, which may result in severe life-threatening complications, is not overlooked.

ACKNOWLEDGMENT

We gratefully acknowledge the help and guidance given by Dr V K Parvathy, Head and Professor of Pediatrics and Dr S Criton, Head and Professor of Dermatology, Amala Institute of Medical Sciences, Thrissur, Kerala.

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Homicide by Neglect? Uncontrolled Pediatric Infectious Diseases

Aiding or abetting someone's death is criminal act in jurisprudence. If diagnosis or treatment is faulty for a child with serious illness, the medical attendant is guilty of negligence – attracting punitive consequences and payment of compensation to the afflicted. Is not the agency supplying water contaminated with *Vibrio cholerae* or *Salmonella typhi* guilty of criminal negligence?

The choice of the named pathogens is with reason. Both are notoriously water-borne. The April issue of *Indian Pediatrics* has two papers on therapy of cholera and diagnosis of typhoid fever, both bacteriologically proven(1,2). One counted 180 children with cholera in one hospital in Delhi, during March 2006 to February 2007(1). The other counted 41 children with typhoid fever in one hospital in

Mysore(2). The nation-wide magnitude of cholera and typhoid fever are unimaginably enormous. Yet India has no systematic control plan against water-borne infectious diseases (IDs).

Another paper reported overall prevalence of 3.5% clinical tuberculosis (TB) among children attending one hospital in Agra(3). The reason for continued high burden of pediatric TB in spite of routine BCG vaccination remains uninvestigated by the National TB Control Programme. Falciparum malaria is widely prevalent in most States, malaria control programme notwithstanding. I recently found that 2-5% of pediatric admissions are for bacterial meningitis (unpublished), the common causes of which are *Haemophilus influenzae* type b (Hib) and *Streptococcus pneumoniae*. For bacterial meningitis, there is no control program.

The national average coverage of children with the cheapest of vaccines (against diphtheria, whooping cough, tetanus, measles and polio) is <50%(4). Since in some States it is >80%, in others it must be dismally low - and vaccine-preventable

'killers', except polio, are obviously prevalent. India does not practice public health surveillance and no reliable data exist on burdens or spectrum of IDs. This is like closing eyes to miss the obvious.

Why does India's health system neglect to prevent IDs? Lack of intervention tools cannot be blamed. Is lack of systematic intervention by national policy(5)? If lack of public demand is an excuse not to spend funds on public health, Indian Academy of Pediatrics ought to make that explicit demand. Whatever the reasons, the Government is not justified in passively promoting morbidity, mortality and family-level poverty by not controlling IDs.

The manifesto of Indian National Congress (INC) for 2009 parliamentary elections promised 'health security for all'(6). After winning the elections INC remains silent on it. The Party President and Prime Minister are accountable to people on the promise. Health security subsumes ID-control, for which responsibility with accountability should be assigned to the Minister and Secretary, Department of Health and to Directors of Health Services and National Centre for Disease Prevention and Control.

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Declaration. I declare no conflict of interests. The opinions are personal and do not necessarily reflect those of any organization/committee of which I am a member.

NTAGI Recommendations Overlooked Crucial ICMR Data

We thank the NTAGI for publishing its recommendation on Hib vaccine in *Indian Pediatrics*(1) as this journal allows 'extended peer review' in its correspondence columns. We are concerned that the technical advisory body has overlooked crucial evidence gathered in studies done by the ICMR while making its recommendations.

In 2002, one of the members of this subcommittee, Professor Thomas Cherian wrote in this journal quite categorically, that based on the data available Hib vaccine could not be recommended for routine use in the EPI in India(2). He recommended more studies be done to establish the need for vaccination. Press reports in 2005(3) suggest that one such study was indeed undertaken by the ICMR in Anaicut block, Vellore. We did not find the results of the study published in an indexed journal in spite of an extensive search of the literature. We presume the data must have been made available to the NTAGI.

The first part of the ICMR study was supposed to look at the incidence of pneumonia (regardless of