Helping the Child with Dyslexia

Nearly 10-15% of school children have some difficulty in reading(l). The management of dyslexia is quite unsatisfactory. A simple step that should help a child with dyslexia who is studying in an English medium school would be to transfer him to a school where the medium of instruction is his mother tongue. This will be beneficial because:

(i) The child with dyslexia has a better command over his mother tongue than English. He thinks in his mother tongue. When he learns something in school he has to read in English, translate this mentally into his mother tongue, understand it, and then memorize the information in English. This applies until he becomes very fluent in English. The child with dyslexia already has significant comprehension difficulties, and the above process will multiply his defect.

(ii) In All Indian languages there is a clear and specific correlation between the spelling of a word and its pronounciation. Thus it is easy to associate a letter with its sound, which is the first step in learning the art of reading. English, however, offers multiple obstacles at this step. "Put" and "Cut" are spelt similarly and pronounced differently. The word grouping "gh" is pronounced differently in "rough" and "though", and in neither word is it pronounced similar to the letters "g" or "h".

(iii) Excepting the most severely affected children, most children with dyslexia will show significant improvement if they receive personalized attention from an individual who has plenty of time and patience. This can only be a dedicated parent. (a home tutor is a costly alternative). As a general rule, parents would find it easier to teach their children in the mother tongue.

This is not to imply that a child with dyslexia should receive an inferior education, it is a plea to lessen the language burden of the child, thus enabling him to develop his overall potential.

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Myasthenia Gravis Masquerading As Ocular Injury

Myasthenia gravis in children is rare and its presentation could vary. However, presentation as an ocular injury is unusual. General practitioners and Pediatricians should consider Myasthenia gravis in any child who presents with symptoms of ptosis. We report a child who presented to us with unilateral ptosis secondary to history of ocular injury.

A 7-year-old girl presented with dropping of left eyelid secondary to injury near, the eye. She had inguinal hernias for which she had undergone surgical correction in the past. The Casualty Officer found no

evidence of injury to the eyes with both pupils being equal and reactive and discharged the child with a referral letter to the Ophthalmologist if the problem persisted. The Ophthalmologist and the Pediatrician later found ptosis which was more marked on the left than on the right and no sign of eye injury. She also had left internuclear ophthalmoplegia. She had marked fatiguability of ptosis, especially on sustained upward gaze. Myasthenia gravis was confirmed by tensilon test. Her chest X-ray did not reveal an enlarged thymus and anti-acetylcholine antibody levels were within normal limits. Currently her symptoms are well controlled on 2 to 3 hourly pyridostigmine for the last 9 months.

Myasthenia gravis in children is rare(l) and does not have an autoimmune origin unlike adults(l) and hence may not be associated with other systemic disorders. Young children may hold open their eyes with their fingers or thumbs if the ptosis is severe enough to obstruct vision. Such symptoms should arouse the possibility of Myasthenia gravis. In our case, the history of eye injury was coincidental and the ocular signs were suggestive of Myasthenia gravis.

It is important to establish the diagnosis at an early stage. One of the major reason for this is that, if these children need to be anesthetised, it is vital to avoid drugs like scopolamine(2) which can potentiate the weakness. Also, it is vital to avoid certain drugs in such patients like aminoglycosides, doxycycline and chloroquine which can potentiate weakness of the affected muscles.

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