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IAP Drug Formulary 2004

A comprehensive pediatric drug formulary as CDROM which is updated regularly every year and containing a listing of all pediatric drugs under generic name with every available brand names; with recommended dosages for every possible pediatric illness with its toxicity and drug interactions – a much felt need as there is growing evidence that tools for computer based prescribing help pediatricians to make better and cheaper prescribing decisions - has become a reality with the launch of this prestigious project of IAP CMEG at Kolkata in January this year. It is already being used by around 2000 pediatricians all over India and has been accepted as an official publication of IAP and finds pride of place on the cover of Academy Today and the website of IAP – www.iapindia.org with link to its own website www.iapdrugformulary.com. This IAP Drug Formulary 2004 is more than just a formulary. It has IAP recommendations on every pediatric illness in the book presented system-wise and formulated by respective sub chapters of IAP. Therefore, this becomes a handy desk-top reference in the clinic, during hospital rounds and for teaching purposes.

Tools for computer based prescribing range from computerised drug formulary to decision support tools that extract data from

the patients records and suggest a ranged list of suitable drugs. These more sophisticated decision support tools can improve the accuracy, appropriateness, speed and cost of prescribing. Evidence from three randomised studies showed that use of decision support tools improved the accuracy of drug dosing (1) while ward pharmacists who used decision support tools in an American hospital made better choices of which antibiotic to prescribe(2). Computer tools is associated with more legible and complete prescriptions, compared to written prescription. Access to advanced decision support tools to general practitioners make their prescribing behaviour closer to that of expert doctors because they are able to select a higher proportion of appropriate, generic and cost effective drugs.

Several new developments are taking place such as full integration with electronic patient records and providing patients with tailored leaflets to improve compliance. Once electronic signatures become legal, doctors will be able to send prescriptions electronically to a pharmacy eliminating signed print outs and speeding up follow up enquiries by pharmacists. Automated pill counters able to dispense some drugs directly could also see the light of day in the not-too-distant future(3).

The unique feature of the IAP Drug Formulary 2004 is that once the user buys a

copy of the book and CDROM, he would be having a life long companion as updates of the IAP recommendations for drug therapy for pediatric illnesses and monographs of new drugs available for pediatric use would be available for downloading on to the users hard disc at least once every year for ever! The first time this is to happen is by early November 2005 and if this facility functions as planned, the formulary would have achieved every bit of what it had been intended for.

Jeerson C. Unni,
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DOTS in Pediatric Tuberculosis

Questions have been raised regarding category IV (*i.e.*, DOTSPLUS MDR treatment) for Pediatric patients and there is no specific indication or benefit. Ours is a 200 bedded male TB hospital out of which 18 beds are kept apart in three separate rooms for MDR TB treatment and they are always full. We have, during the past 6 years, treated 4 pediatric patients successfully with second line drugs. DOTSPLUS by RNTCP has not been launched in West Bengal. We feel that MDR treatment should be given on a daily basis, to admitted patients only, to observe and tackle side effects of the drugs.

In Prof. P.M. Udani's Text book of Pediatrics 1998: vol 2; p. 1084, the subcarinal lymph nodes, mediastinal lymph node tuberculosis is quite common in BCG vaccinated young children below 4 years of

age. There is no such group in the AIIMS study. This type of tuberculosis is very difficult to diagnose by plain CXR alone. It is not possible to advise a CT scan as it is very expensive and the massive radiation will be harmful to the children. How should they be diagnosed in busy pediatric OPD? Here the scoring system advocated by P.M. Udani and Keith Edwards in Crofton's Textbook of Clinical Tuberculosis should be of great help. In fact the very first point in the draft minutes of the workshop, under the heading Research Issues: Diagnosis: Development of and a multi-centric field evaluation of a Pediatric Scoring System. IAP guidelines in management of Pediatrics TB also has a scoring system. There may be over-diagnosis by the scoring system, but then, we will not get children coming back to us with severe and multi-system disease later. These are the children who attend OPD repeatedly for LRTI with negative CXR. We have had such cases.