

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.

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DOTS in Pediatric Tuberculosis

Questions have been raised regarding category IV (*i.e.*, DOTSPPLUS 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. DOTSPPLUS 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.

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Reply

1. Dr. Sumit Kumar is right in highlighting the need for category four in DOTS. We agree that with DOTS, resistant TB can be decreased significantly. However, it will not disappear completely. Drug resistant TB in children is reflection of drug resistant TB in adult patients. As long as there are adults with multi drug resistant tuberculosis, there will be cases of MDR tuberculosis in children and that justifies need for category 4 in the treatment strategies(1).

2. Possibility of increasing subcarinal adenopathy in intrathoracic tuberculosis has been suggested and increasing BCG coverage has been attributed to this phenomenon(2). There are not documented studies to support this hypothesis.

It is difficult to identify subcarinal adenopathy on plain CXR. Even hilar and paratracheal nodes may be missed on plain CXR in 15-20% of proven intrathoracic tuberculosis(3,4), There is definite radiation hazards and high cost involved with chest CT scan, hence it cannot be done in all suspected cases of tuberculosis. Therefore it is advisable to keep a high index of suspicion of tuberculosis and before asking for CT chest look for other

supporting evidence in form of recent contact with adult patients with tuberculosis, positive tuberculin test or suspicion of nodes on CXR.

3. In scoring systems more weightage is given to laboratory test *i.e.*, acid-fast bacilli, tubercles in biopsy suggestive radiology and tuberculin test >10 mm induration. These scoring systems need validation in individual countries. There is definite need for a scoring system based on clinical features for making a diagnosis of tuberculosis in children; however, feasibility of achieving the same remains doubtful.

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