The present study is limited by the fact that it includes only Indian journals which are currently indexed for MEDLINE. The present study highlights that a majority of the journals are yet to adapt their editorial policies with regard to the issue of clinical trial registration.

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SOUMYADEEP BHAUMIK AND TAMOGHNA BISWAS
2, Amalangshu Sen Road,
Kolkata 700 048, West Bengal, India.
soumyadeepbhaumik@rediffmail.com

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Clinical Response to Antibiotics Among Children with Bloody Diarrhea

WHO recommends ciprofloxacin as the drug of choice for bloody diarrhea. We retrospectively analyzed antibiotic response in 100 children with bloody diarrhea admitted between 2006-2010. Cotrimoxazole (*n*=55) had higher chance of attaining improved appetite and normal activity in 48h, hospitalization of <3d, blood disappearance in ≤5d and not requiring a second antibiotic compared to others (*n*=45). Older antimicrobials should be tried in all possible situations.

Key words: *Antibiotic response, Bloody diarrhea, Children, Dysentry, India.*

WHO recommends ciprofloxacin as the drug of choice for treatment of bloody diarrhea [1]. In this context, we recorded clinical response to antibiotics in 127 children from case records, admitted with a clinical diagnosis of bloody diarrhea to Government Medical College, Thrissur between 2006-2010. Inclusion criteria were children 1 mo-12 y with visible red blood in loose stools at admission / during ward stay. Those with melena, blood streaks over formed stools, chronic hepatic / renal / bleeding disorders, surgical abdomen, those who left our hospital before satisfactory completion of treatment, and blood detected only on microscopy were excluded. We finally analyzed 100 patients. Data on demography, presentation, complications, risk factors, co-morbidities and antibiotics used were collected. Clinical response to therapy was based on 6 WHO parameters - disappearance of fever, fewer stools, less blood, less pain, improved appetite and attainment of normal activity [1]. Each parameter if achieved within 48 h was scored 1. Outcome measures were total score, duration of hospitalization, time taken for blood disappearance, and need for a second antibiotic from our ward.

89% had risk factors- infancy (20), non-breastfed (19), unconsciousness (6), hyperthermia (37) and malnutrition (48). 59% had complications- dehydration (43), metabolic derangement (11), seizures (19) and rectal prolapse (3). Presence of complications had 2.8 times higher chance of need for second antibiotic from our wards (P= 0.019, 95% CI=1.165- 6.730). 34% had co-morbidities. Two children who died had co-morbidities. Absence of co-morbidities had 3.5 times higher chance of attaining total scores 5 or 6

(*P*=0.007, 95% CI=1.366- 8.969) and 2.78 times higher chance of a lesser hospital stay of < 5d (*P*=0.028, 95% CI=1.096-7.079). Guidelines should stress the need to look for co-morbidities.

We gave co-trimoxazole in 55 subjects as first line; 44 responded within 48 h (table I). Co-trimoxazole as our first line had higher chance of attaining normal activity (*P*=0.027, OR 2.82, 95%CI=1.102-7.216) and improved appetite (*P*=0.044, OR 2.768, 95% CI=1.003-7.740) within 48 h, blood disappearance in 5d (*P*=0.004, OR5.180, 95% CI=1.553-17.278), hospital stay of <3d (*P*=0.008, OR3, 95% CI=1.319-6.823) and not requiring a second antibiotic from our ward (*P*=0.000, OR 9.24, 95% CI=3.62-23.706) when compared to those who were initially given antibiotics other than co-trimoxazole. 59% who responded to co-trimoxazole had more than one risk factor. Reasons for not starting co-trimoxazole in 45 subjects included altered sensorium/ seizures (18), severe dehydration (8), co-morbidities (4), unresponsive to two antibiotics (4), good response to prior antibiotic (3), persistent vomiting (2), severe malnutrition (2), recent inter-state travel (2), infancy (1) and parental anxiety (1). One study from Bangalore (2002-07) showed decreased co-trimoxazole and chloramphenicol resistance, and another from Vietnam (2009) showed significant ampicillin and chloramphenicol sensitivity in bloody diarrheas [3,4].

Co-trimoxazole still works well in our setting as first line antibiotic even in children with multiple risk factors. Older antimicrobials should be tried in outpatients without risk factors, complications/serious co-morbidities. If inadequate clinical response occurs in 48h, newer antibiotics may be started. The latter may be kept in reserve as resistance to these including ciprofloxacin, and cephalosporins has occurred in India [4,5]. Those with risk factors, complications / serious co-morbidities should be admitted, started on older drugs if possible. Early switch to newer antibiotics should be done if needed.

PRIYA SREENIVASAN, *ZINIA T NUJUM AND KK PURUSHOTHAMAN

*Department of Pediatrics, Government Medical College, Thrissur; and *Department of Community Medicine, Government Medical College, Thiruvananthapuram; Kerala.*
priyavineed@yahoo.co.in

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