subjective, and hence inherently difficult to detect, acknowledge and control. They can exist anywhere in the chain of research, right from institutional review boards arbitrarily accepting/rejecting proposals based on personal relations to reviewers choosing to sit on papers of scientific competitors under the veil of blinded peer review. Often they can be as subtle as the religious [3] or moral beliefs of the reviewer or the 'academic self-interest' of the investigator [2]. In this connection, the instructions to authors [4] of Indian Pediatrics mention that, "conflicts can occur for other reasons, such as personal relationships, academic competition and intellectual passion." Interestingly; however, while there are regulatory guidelines for financial competing interests, non-financial conflicts of interests have remained a gray area, with utmost reliance placed on disclosure and subjective integrity of the authors, reviewers and editors. It is important to realize that such conflicts are intrinsic to research, and are mostly too subjective and arbitrary to be readily quantified by an objective measure. Hence the need of the hour is the acknowledgement of their existence and sensitization of all concerned stakeholders about voluntary self-reporting/disclosure of any such existing conflicts.

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Recurrent Hemarthrosis : An Unusual Cause

A 7-year-old boy was brought to us with swelling of the right knee since 1 year of age. The swelling used to appear suddenly once every two months, would last for a few days and then gradually subside on its own. During the episode, the patient used to have severe pain in the knee joint and was not able to walk. There were no aggravating or relieving factors. There was no history of fever, trauma, bleeding from any other site or swelling of any other joint.

Examination revealed a child with a fluctuating, tender swelling on the medial aspect of the right knee joint (***Fig.* 1**). Movements at the right knee joint were restricted. Further examination revealed a swelling on the medial aspect of the right foot, just in front of medial malleolus, fluctuant, non-tender, which used to decrease in size on raising the leg and used to blanch on pressure. The parents informed that this swelling was present since birth. Careful scrutiny also revealed that the affected limb was clearly hypertrophied and larger than the unaffected limb.

An MRI of the right lower limb was suggestive of a diffusely insinuating vascular malformation, haemo-lymphatic in nature, noted along the antero-medial aspect of the right leg with intra-articular extension and distension of the knee joint with mild joint effusion and evidence of intra-articular hemorrhage due to prior bleeds (***Fig.* 2**). Similar focal lesions were also noted on the dorsum and medial aspect of the foot. The vascular surgeon plans to thrombose the vascular supply of the intra-articular portion of the malformation to prevent the recurrent hemarthrosis which would otherwise eventually destroy the joint.

Klippel Trenaunay syndrome is a cutaneous vascular malformation that, in combination with bony and soft tissue hypertrophy and venous abnormalities, constitutes the triad of defects of this usually nonheritable disorder [1]. However, interestingly, scattered reports are available in world literature that it may occasionally be inherited [2,3].

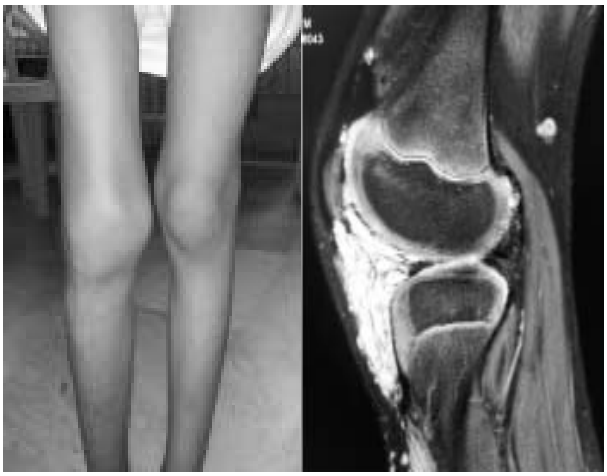

FIG.1. *Right-sided hemarthrosis* **FIG.**2. *Intra-articular bleed*

Our child had asymmetric limb hypertrophy, vascular malformations as well as a cutaneous vascular malformation on the lower foot. The lower limb is involved in 95% of the cases [4]. While bleeding from the vascular lesions are infrequent complications (hematuria from a vascular malformation of the urinary tract or rectal bleeding from a gut lesion) [4], intra-articular bleeds from such a lesion are extremely rare [5]. Screening of this child revealed no other associated features such as lymphatic obstruction, spina bifida, hypospadias, polydactyly, syndactyly, oligodactyly, orofacial abnormalities, hyperhidrosis, hypertrichosis, paresthesia, or decalcification of bones [4].

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Active Tuberculosis with Takayasu Arteritis

A 14-year-old girl presented with the chief complaints of low grade, intermittent fever and persistent cough for 4 months. She had calf pain and exertional dyspnea for 1 month. Her heart rate was 114/minute. Lower limb pulses were not palpable. She had a systolic murmur over the pulmonary area and a bruit over epigastrium. Blood pressure in her upper limb (186/118 mm of Hg) was considerably higher than in lower limb (160/86 mm of Hg). Her blood pressure had never been recorded previously. She had no family history of hypertension. The blood counts were normal but ESR was 114 mm/1st hr. Chest *X*-ray showed haziness of middle and lower zones of bilateral lung fields, with an enlarged cardiac shadow. Echocardiography suggested mild mitral regurgitation with tricuspid regurgitation and mild pulmonary arterial hypertension. Ophthalmoscopy showed bilateral papilledema. Mantoux induration was 32x28 mm. Sputum was positive for acid fast bacilli (2+). Magnetic resonance angiography showed narrowing of abdominal aorta from the point of origin of renal arteries along with absence of collaterals in left femoral region (***Fig.* 1**). There was narrowing of both renal arteries. A diagnosis of tuberculosis in a patient of Takayasu arteritis was made as per 1990 ACR (American College of Rheumatology) criteria for Takayasu arteritis [1].

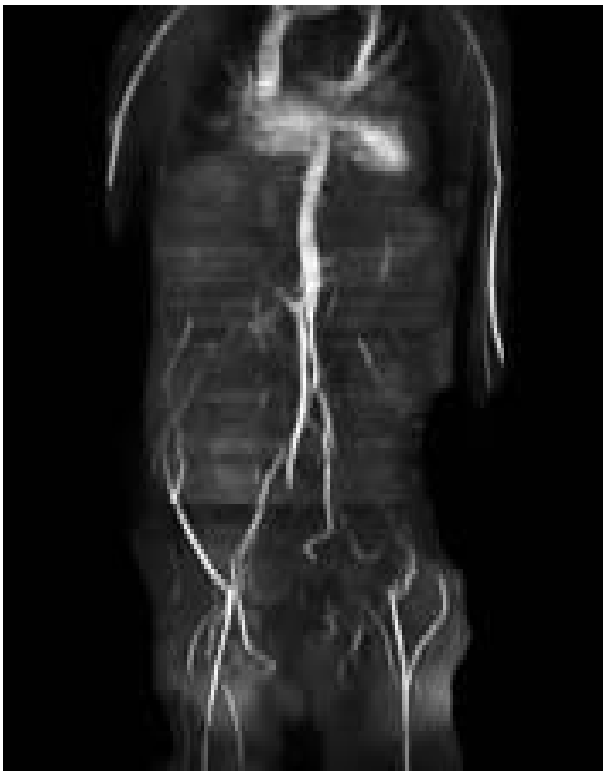

FIG.1. *MR angiography showing narrowing of abdominal aorta and absence of collaterals in left femoral region.*

We started treatment for tuberculosis with isoniazid, rifampicin, ethambutol and pyrazinamide. Prednisolone, methotrexate and folic acid were added following consultation with rheumatologist. Amlodipine was also added. Thereafter because of persistence of hypertension we added atenolol, spironolactone and prazosin sequentially. Gradually her fever subsided and blood pressure stabilized at 132/88 mm Hg. She has been discharged and is under regular follow up.