

after meal with the fasting stage, the differences were insignificant.

On the basis of our results we may conclude that the time honored practice of taking blood sample for ESR in "fasting state" only may be abandoned and can be done irrespective of whether the patient is in fasting state or not.

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**A.K. Agarwal,
J. Singh,
S.P. Sudrania,**

*Department of Pediatrics,
Sir Padampat Mother
and Child Health Institute,
SMS Medical College, Jaipur.*

Extrapyramidal Syndrome Following Ciprofloxacin Treatment

Ciprofloxacin is a commonly used antibiotic in enteric fever these days due to prevalence of multi drug resistant *S. typhi*(l). Extra pyramidal syndrome (EPS) following ciprofloxacin administration has not been reported in literature till date. We report here one such case.

A five-year-old male child was admitted with history of fever for 8 days. On examination, the child was febrile, liver was palpable 3 cm below the right costal margin and spleen 2 cm below the left costal margin. There were no other abnormal findings. Investigations revealed a hemoglobin of 8 g/dl, total leucocyte count of 4,400/cu mm with 61% polymorphs, 35% lymphocytes and 4% monocytes. Chest

X-ray, urine and stool examination were normal. Widal test was positive with O and H titre in dilution of 1 in 480. The child was started on oral ciprofloxacin (15 mg/kg/day) in two divided doses and oral paracetamol (15 mg/kg) when required. On third day the child developed uprolling of eyes with torticollis and increase in tone of all four limbs with abnormal posturing. The patient was given parenteral (IV) diazepam (0.4 mg/kg) stat following which he had an uneventful recovery from this episode. Neurological examination (including fundus) was normal. Repeat complete blood counts and cerebrospinal fluid was examined, which were also normal. Ciprofloxacin was stopped and the child was started on parenteral (IV) ceftriaxaone(2) (100 mg/kg/day) in two divided doses. He became afebrile on fifth day and was discharged on the tenth day.

As there was no other cause for development of extrapyramidal syndrome, we assumed it to be an unusual side effect of ciprofloxacin therapy.

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**J. Singh,
A.K. Agarwal,
S.P. Sudrania,**

*Department of Pediatrics, Sir Padampat
Mother and Child Health Institute,
SMS Medical College, Jaipur 302 004.*

Post-Polio Residual Paralysis in Rural Areas—Place of Physical Therapy

Millions of children with paralytic poliomyelitis in India are deprived of proper care for want of adequate number of specialists. Children in the underprivileged communities have limited access to hospital care due to monetary reasons. Of those who have access to the hospital, only a few get appliances, very often without proper training. Incorrect selection of patient for surgery and over prescribing of appliances are also common. However, the single important factor needed for a regular follow-up of these unfortunate children is the family's motivation and participation in the treatment.

The above observations prompted us to co-ordinate with a voluntary organization, Handicap International to explore methods for rehabilitation of children with Post-polio Residual Paralysis (PRP). The most important aspect was to diffuse the practice of physical therapy to the community

level where the cases can be treated locally. This called for the development of low cost orthoses, made of PVC polypropylene calipers and training the technicians.

Twenty seven volunteers from three local organizations were trained at Handicap International, Pondicherry since 1990. These Multipurpose Rehabilitation Technicians (MRT) are the key persons in the community oriented physical therapy program and they are helped by trained local helpers.

MRT training involves one year of continuous intensive training at Pondicherry followed by continuing training for 2 years lasting for 15 days every four months. Volunteers having completed Higher Secondary Schooling, are recruited for training. Once the training is over, MRT evaluates the patient's needs in the field-choosing and making the appliances, preparing the child to walk and above all motivate the parents to participate in treatment and teach them to do exercise at home.

For better understanding by the parents and family members, the most useful exercises are described in sheet with drawings and explained to them in local