crises requiring intensive care which are stressful to them and their families. The palliative care team provides additional support during emergencies and health crises, while also helping to address the challenges of daily living. Therefore, an integrated palliative care program ideally consists of out-patient, in-patient, hospice and home care to maintain continuum of services. However, there are many successful PPC models across the world which have a different combination of these services.

A study published in 2017 estimated the global need for PPC to be 21.6 million, with 8.2 million children needing access to specialist palliative care service provision [3]. In India, these authors estimate that there are 1.6 million children in need of specialized pediatric palliative care [3]. Presently, there are very few trained PPC specialist doctors in India, which is both due to the lack of awareness about the existence of such a specialty, and limited provisions for training in this specialty. As some centers are now providing training in this speciality, we feel that more young pediatricians need to take-up this specialty by utilizing available training facilities, so that the quality of life of children with life-threatening conditions can be improved.

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Melioidosis Presenting with Membranous Tonsillitis and Erythema Nodosum

A 12-year-old boy presented with fever and cough of 12 days and painful skin lesions on legs for two days. He did not have any pre-existing medical illness, history of contact with soil, or groundwater. He presented in July, which is monsoon season in coastal Karnataka. On examination, his weight was 30 kg (75th percentile), height was 130 cm (50th to 75th centile), and vitals were stable. Oral examination revealed red and swollen tonsils with an exudative membrane on the medial surface. He had multiple erythematous, tender, nodular lesions of 10-20 mm size on bilateral lower limbs consistent with erythema nodosum. Systemic examination was unremarkable. Baseline blood tests showed hemoglobin of 10.5 g/dL, total leukocyte count of 11.8×10^9/L (P 80%, L 16%), platelet count of 241×10^9/L, erythrocyte sedimentation rate of 42 mm/h and C-reactive protein of 96 mg/dL. Throat swab and blood culture were sent, and he was prescribed intravenous amoxicillin/clavulanic acid and amikacin. His throat swab isolated *Burkholderia pesudomallei*, hence antibiotics were changed to intravenous ceftazidime (120 mg/kg/day). The child improved with resolution of symptoms over the next four days. He received ceftazidime for 10 days and was discharged on oral trimethoprim-sulfamethaxazole (6mg/kg of trimethoprim) for three months. The child is well at six month follow-up.

Melioidosis, caused by soil saprophyte *B. pseudomallei*, is an endemic infection in India [1]. Due to diverse clinical manifestation and lack of routine bacteriological detection methods, melioidosis stays under-diagnosed and under-reported [2]. Typical clinical

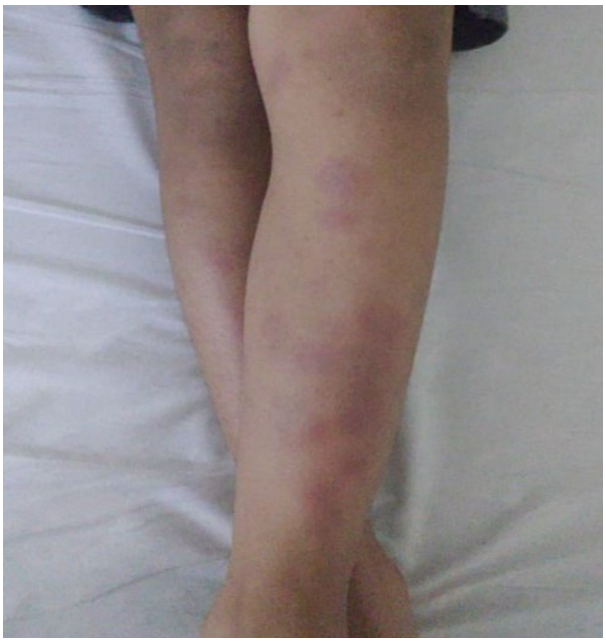

Fig. 1 *Erythematous nodular lesions seen on the lower limbs.*

presentation of melioidosis includes suppurative lesions in head and neck, soft tissue infection, pneumonia, and septicemia [3,4]. Our patient presented with membranous tonsillitis and erythema nodosum, common entities in pediatric practice, but *B. pseudomallei* as the etiologic agent for the same has not been previously reported. Two patients with pharyngitis with pharyngeal culture-positive, and a single patient with urticarial rash and blood culture positive for *B. peusdomallei* has been reported by Lumbiganon, *et al*. [4]. A study by Wuthiekanun, *et al*. [5] reported 100% specificity and 36% sensitivity of throat swab culture for melioidosis. Due to low sensitivity, throat swab warrants the need for adjunctive tests.

A high index of suspicion is required to diagnose melioidosis due to its varied presentation, especially in the presence of predisposing conditions like exposure to soil, water, rainy season, or an immunocompromised state.

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Sedation in Pediatric Bronchoscopy: Propofol *versus* Fentanyl

We read with interest the article by Gunathilaka, *et al.* [1] reporting on comparison of propofol and fentanyl for sedation in pediatric bronchoscopy. We wish to raise the following issues related to the article:

(*i*) The authors state that the allocated assignment was not disclosed to the bronchoscopist and the patient. However, the independent observer who also decided the cough score, secretion score and physician satisfaction score was not blinded to the assignment and this could have caused assessment bias in the study. Additionally, the primary investigator was not blinded to the study arm. However, the stop watch reading to document the time of achievement of Ramsay score 3 (primary outcome) was done by the primary investigator himself, which may have increased the chances of assessment bias in the study. It would have been better that a third person not involved in the study and blinded to the intervention was given the responsibility of assessing primary outcome (time to achieve Ramsay score 3).

(*ii*) The baseline characteristics table shows that mean (SD) oxygen saturation was 99.1 (1.5) and 99.1 (1.4) in propofol and fentanyl groups, respectively. This implies that upper limit of oxygen saturation was more than 100% in both the groups, which is not possible.

(*iii*) The results show that the mean (SD) time to achieve Ramsay score 3 (primary outcome) was 15.7 (4.4) seconds in propofol group. However, in secondary outcomes, the additional midazolam doses needed in propofol group was 11. But midazolam could only be used if the child was not sedated within 180 seconds. So the use of midazolam needs more clarification.

(*iv*) The article mentions that intravenous midazolam was repeated every 1 minute if Ramsay score of 3 was not achieved. The onset of effect for midazolam is 1 to 2.5 minutes, the peak effect is at 3 to 4 minutes, and the duration of effect is 15 to 80 minutes [2]. In a meta-analysis done for the comparison of propofol and midazolam for bronchoscopy [3], in all the four included randomized controlled trials, midazolam