TABLE *H—Month-wise Distribution of Poliomyelitis Cases*

Month	1994	1995	1996
January	49	19	11
February	57	11	09
March	43	21	16
April	39	21	04
May	88	26	11
June	93	42	10
July	145	97	33
August	202	123	76
September	161	107	84
October	90	88	47
November	42	68	28
December	53	67	40
Total	1062	690	369

An increase has also been noted in the fully immunized cases from 22% in the year 1994 to 27% in 1996. Forty per cent children did not take even a single dose of routine OPV but 50% among them did take 2 doses of pulse polio because of the mass publicity of the programme. To conclude, PPIP has made a definite dent in the occurrence of polio cases as experienced at our center.

Bina Ahuja,
V.K. Gupta,
Supriya Arora,
Department of Physical Medicine and Rehabilitation,
Kalaivati Saran Childrens' Hospital,
New Delhi 110 001.

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Splenic Infarct in Falciparum Malaria

Splenic infarction is a rare finding in cases of falciparum malaria(1). We report here two cases of falciparum malaria, with splenic infarction, which were diagnosed by ultrasonography.

Two children (7 yr old girl and 3 yr old boy) were admitted with history of fever for more than ten days and pain in abdomen. Both children had received chloroquine, before coming to us but without any relief of fever. On examination they had high grade fever, anemia and tender splenomegaly with liver enlargement. Peripheral blood smear for falciparum malaria was positive in both of them. Ultrasonography (USG) of abdomen revealed splenic infarct in both. The girl had three to four splenic infarcts of size 10 to 14 mm. A dramatic response was seen in both after administration of oral quinine. There was subsidence of fever but the splenomegaly persisted in both the cases even after a month when they were last seen in the follow up clinic.

The possible factors contributing to splenic infarction in falciparum malaria are tissue avascularity following rapid splenomegaly and increased stickiness of the parasitized RBCs(2). USG is not performed routinely in cases of splenomegaly

with falciparum malaria. It is possible that there may be cases of splenic infarction which are missed and remain undiagnosed.

V.K. Agarwal,
Sanjiv Agarwal,
Tarun Pathak,
Agarwal Nursing Home,
19/8 Thorn Hill Road,
Allahabad 211 001.

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Consumer Protection Act and Medical Profession

I read the 'Viewpoint' on the above subject with interest(1). I wish to contest the assertions and conclusions made in the paragraph captioned "Medical cases are highly technical and judges cannot make fair decisions" (Para 2, page 323). The author, says "All over the world, even in the developed countries like USA and UK, medical negligence cases are decided by judges who have no medical expertise. Even before COPRA was enacted, cases of medical negligence were decided in civil and criminal courts where judges have no medical expertise." Very true indeed, and it should be noted that till date, no Doctor had objected to being tried by a non-medical fudge. Then, what is the difference today? The crucial difference, has been knowingly or unknowingly overlooked. The trial in the Consumer courts is not by a judge who does not have medical expertise, but does have unquestioned legal knowledge and training, but is by a panel of 'judges', where the final decision is by majority, and consisting of a legal personnel (for example, a retired judge) and two non-medical, and what is even more important, non-legal personnel, (for example, social worker). This is what the doctors find obnoxious, and defying the principles of scientific justice, and to the best of my knowledge, such provisions do not exist anywhere else in the world-developing or developed.

Anil Shukla,
Honorary Secretary,
Allahabad Branch of
Indian Medical Association,
B 227, Mehdauri Colony, Teliarganj,
Allahabad 211 004.

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