

doses may be considered in a child with septic shock who has features suggestive of adrenal insufficiency (hypoglycemia, hyponatremia, hyperkalemia in combination). The guidelines do not recommend steroids for all children with septic shock.

Overall, there is little good quality published evidence for many aspects of management of severely malnourished child and there is need for more research in these areas.

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REFERENCES

1. Ashworth A, Khanum S, Jackson A, Schofield C.

Guidelines for the inpatient treatment of severely malnourished children. Geneva: World Health Organisation; 2003.

2. Dutta P, Mitra U, Manna B, Niyogi SK, Roy K, Mondal C, *et al.* Double blind, randomised controlled clinical trial of hypo-osmolar oral rehydration salt solution in dehydrating acute diarrhoea in severely malnourished (marasmic) children. *Arch Dis Child* 2001; 84: 237-240.
3. Bhatnagar S, Lodha R, Choudhury P, Sachdev HP, Shah N, Narayan S, *et al.* IAP guidelines 2006 on hospital based management of severely malnourished children (adapted from the WHO Guidelines). *Indian Pediatr* 2007; 44: 443-461.
4. Carcillo JA, Fields AI. American College of Critical Care Medicine Task Force Committee Members. Clinical practice parameters for hemodynamic support of pediatric and neonatal patients in septic shock. *Crit Care Med* 2002; 30: 1365- 1378.

Probiotics and Diarrhea

This refers to IAP Guidelines 2004 and 2006 on Management of Acute Diarrhea (1,2).

The stand of Task Force on Probiotics needs some clarification. The group stated that there is presently insufficient evidence to recommend probiotics in the treatment of acute diarrhea in our setting. As reasons for this stand four points from the 1st Consensus Statement are cited. Under new point 5 it is stated: There is an urgent need to study the following issues before probiotics may be considered for treatment of diarrhea.

My dilemma is: Should I prescribe probiotics or wait for some more years when IAP Task Force provides us guidelines after conducting a nation-wide study on probiotics, because, results obtained in one region may not be applicable to the children in the other regions.

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REFERENCES

1. Consensus Statement of IAP National Task Force: Status Report on Management of Acute Diarrhea. *Indian Pediatr* 2004; 41: 335 - 348.
2. IAP Guidelines 2006 on Management of Acute Diarrhea. *Indian Pediatr* 2007; 44: 380 - 389.

Reply

Regarding the use of probiotics, the available evidence did not support the routine use of probiotics in acute diarrhea; hence, the recommendation for need for more data was made. The authors will like to clarify that conducting a study for evaluating the role of probiotics is not the mandate for the Task force. The authors do not agree with the statement made by Dr Paul as it is for group of researchers to take up research questions and design and conduct studies for the same.

The issues of probiotic safety and efficacy are important. There is no reason to believe that the probiotics will cause significant adverse effects in Indian children. However, the efficacy needs to be

proven. We are sure that the author will agree that one will not like to use a product that is safe but has no therapeutic effect. Even after the review of recently published literature, there is no change in the position on probiotics. It has recently been shown in a trial that not all commercially available probiotic preparations are effective in children with acute diarrhea(1). In this trial duration of diarrhea was significantly shorter in children who received *L. rhamnosus* strain GG and the mix of four bacterial strains-*L. delbrueckii var bulgaricus*, *Streptococcus thermophilus*, *L. acidophilus*, and *Bifidobacterium bifidum* than in children who received oral rehydration solution alone. Most of the probiotics that are marketed in the country do not have these strains. In addition, the data on efficacy from the developed world cannot be extrapolated to our scenario in view of the differences in the gut microbiology and breast

feeding rates. Therefore, it is crucial that we have evidence to support the use of probiotics in acute diarrhea. While this issue is resolved, our fraternity should try to improve the implementation of the more agreed upon guidelines.

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REFERENCE

1. Canani RB, Cirillo P, Terrin G, Cesarano L, Spagnuolo MI, De Vincenzo A, *et al.* Probiotics for treatment of acute diarrhoea in children: randomised clinical trial of five different preparations. *BMJ* 2007; 335: 340. Epub 2007 Aug 9.

Hospital Management of Severely Malnourished Children

The IAP Guidelines 2006 on Hospital Based Management of Severely Malnourished Children(1) makes excellent practical reading and would serve as a brilliant ready reckoner for practising pediatricians. A few points need further clarification.

1. In Step 10: Prepare follow-up after recovery, adequate emphasis has not been placed on the edematous child with malnutrition which is easily the more tricky case to manage than the purely malnourished child without edema. During hospital rounds, our seniors always taught us to look for the Brian Wharton's tick sign. By that they implied the initial weight loss that is seen in the edematous malnourished child when he loses fluid weight in the initial stages of improvement. The uptick of the tick sign after the initial few days is the actual dry weight that the child begins to gain after losing the edematous weight initially. I still distinctly remember my days as a resident doctor when every morning and evening we used to check for weight loss. Infact, early weight gain was considered an ominous sign in

the presence of edema. Therefore, in this section, we need to incorporate this fact as a possible cause of poor weight gain!

2. Do we need to titrate the dose of vitamin A by weight too? We may have a 2 year old severely malnourished child with a weight of say 7 kg for whom a vitamin A dose of 2,00,000 I.U. may be an overdose. Would a cut-off of 8 or 10 kgs to decide whether to give 1,00,000 or 2,00,000 I.U. of vitamin A be useful?

3. No mention has been made about the mood of the child in the entire article. The malnourished child with edema is typically listless, anorexic and apathetic unlike the malnourished child without edema. Not only is it a diagnostic clue, it is also a useful indicator of the trend towards recovery as also one of the useful guides for "criteria for discharge" when the child starts smiling and becomes interested and curious about his surroundings.

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