

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.

**Shinjini Bhatnagar,
Rakesh Lodha,**

*Department of Pediatrics,
All India Institute of Medical Sciences,
New Delhi 110 029.*

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.

M. Sanklecha,

*Consultant Pediatrician,
Bombay Hospital,
Mumbai, India.*

E-mail : doctormukesh@gmail.com.

REFERENCE

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Reply

The authors thank Dr Sanklecha for the interest in the guidelines. We agree with the comments on the issue of weight gain in an edematous severely malnourished child and these will be included in the next

version.

There is possibly a need for titrating the dose of vitamin A by weight. However, there is no published evidence or guideline for the same.

We agree with the author regarding the importance of evaluation of mood of the child and his/ her interest in the surroundings.

**Rakesh Lodha,
Shinjini Bhatnagar,**
*Department of Pediatrics,
All India Institute of Medical Sciences,
New Delhi, India.*