condensation collection traps. It is pertinent here to point out that the latest Fisher and Paykel MR 810 (Aukland, New Zealand) humidifier we have bought does not even have a temperature read-out but it has 3 heat settings. One does not know when 37º C temperature is achieved. In contrast, the low cost humidifiers provided by Appropriate Technologies, Jan Swasthya Sahyoj (1626/33 First floor, Naiwala, Karol Bagh, New Delhi) has incorporated a temperature read-out for the heating chamber. We do not feel that heating wires for the tubing are crucial. The authors misunderstand the principle of primum-*non-nocere*. If the principle of do-no-harm were an absolute and overriding principle, one would never use antibiotics because we know there is a small chance of anaphylaxis and the possibility of death. The principle applies only to interventions where the chance of harm is more than the likelihood of benefit. *Primum-non-nocere* gives way *to primum succurrere*-'first hasten to help,' in most circumstances. In the context of using oxygen for a hypoxic child, to deny the child oxygen, just for want of a heating coil would be reprehensible.

Our correspondents write of the superiority of nasal prongs. This may well be true, but they are costly, not widely available, and the nasopharyngeal tube works well. There are two other points. Murki and colleague say that a FiO_2 monitor costing Rs. 15000 to 25000 must be used if an expensive blender is not utilized. We disagree. The FiO_2 monitor is not used in any CPAP system. It can be used to measure oxygen concentration in apparatus like the head box but not in-line, in ventilator tubings.

We hope that the simple, state-of-the-art apparatus we described can be used widely and that it will make a difference to the survival of babies.

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Guidelines on Acute Rheumatic Fever

Indian Pediatrics recently published Guidelines formulated by the IAP Cardiology Chapter for the management of Acute Rheumatic Fever(1). But it is very unfortunate that many of the recommendation of the committee can not be taken as the standard protocol due to various reasons.

A. Drugs for treatment of pharyngitis and secondary prophylaxis: Dose and interval of Benzathine Penicillin

1. Instead of keeping two intervals (15 days for <27kg and 21days for >27kg) it is better to take interval of 3 weeks(2) and cut off weight to 20 kg or give the adult dose irrespective of weight. (More variable parameters create more confusion).
2. Dose of oral cephalexin 15-20mg/kg bd is inadequate. Minimum of 50mg/kg per day in four-divided dose should be given for eradication of pharyngeal streptococci.
3. Time tested Sulpha used for prophylaxis is not mentioned at all.
4. Erythromycin frequency of dosing not mentioned.
5. Is there a need to mention the adult dosing of penicillin in the pediatric guidelines.

B. Diagnostic criteria

The following doubts regarding diagnostic criteria need further clarification

1. Rheumatic chorea: One should rule our chorea due to other causes.
2. Definition of recurrence: Manifestation after a period of 8 weeks "following stopping complete treatment". If it is an irregular treatment, clinical manifestations may not represent a recurrence.

3. Arthralgia and ECG changes should not be considered as minor criteria if arthritis or carditis is a major criteria.

4. Why age-dependent cutoffs are provided for only Anti DNase B and not for ASO?

5. Polymorphonuclear leucocytosis is very nonspecific criteria and not included now in minor criteria.

6. Criteria for mild, moderate and severe carditis is not mentioned.

7. Indication for other NSAIDS is very unclear.

8. There is yet no uniform consensus on use of methylprednisolone in severe carditis. Recommendations advice is for 3 days which is inadequate.

9. Atrial fibrillation in a child even with established valvular lesion should be taken as active carditis. Mere treatment of atrial fibrillation is not enough in a child. This we feel is a totally misleading message.

Overall, these recommendations should have been very clear. It should help practicing pediatrician and not confuse him. Hope that we will get right modification from concerned body.

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Reply

We are happy that the guidelines have drawn this level of interest and welcome the tradition of healthy criticism. To bring out a consensus statement on this subject was a tremendous job for the committee due to diversity in practical approach at the institutional and individual levels. First of all we are thankful for pointing out the fact that arthralgia and increase PR intervals are not included as minor criteria in presence of arthritis and carditis, respectively. We regret this inadvertent mistake. Regarding the ASLO/ Anti DNAs B levels, it must be clarified that laboratory value prevalent in the geographical area must be defined and used. We have mentioned values available in literature. Leukocytosis is still retained as a part of acute phase reactant in WHO 2001 update and in current IAP guidelines though ESR and ASLO are more important. Leukocytosis has a role when ESR values are not reliable.

Many of other concerns were discussed in detail during discussion, like weight cut-off in relation to doses of benzathine penicillin G injection and its dosing schedule, doses of cephalexin and use of sulfa drugs etc. Hopefully, Cardiology chapter of IAP would be able to address these issues in near future.

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