negative. Liver function tests were normal. Persisting fever 48 hours after parenteral antibiotics (ceftriaxone, 75 mg/kg/day), leukocytosis and elevated CRP coupled with thrombocytosis (platelet count 750×109/L) led to diagnosis of 'incomplete' Kawasaki disease. Administration of intravenous immunoglobulin (2 g/kg over 12 hours) and aspirin (80 mg/kg/day) subsequently lead to normalization of body temperature in 24h and normalization of inflammatory markers (ESR 12 and CRP 10 mg/dL) in the next 48h. Echocardiography done on day–10 and during later follow-up revealed no coronary artery abnormalities.

Infectious etiology of Kawasaki disease (KD) has been long debated. Putatively, at least 1 in 3 cases of KD have concomitant infection which could be systemic or focal [1,2]. In tropical countries where uncommon presentation of common infections is very common, one needs to be vigilant not to miss KD which may follow recovery from infections such as dengue [3]. In fact, apart from rotavirus and dengue, KD is reportedly associated with more than 20 bacterial and viral infections, and also observed post-vaccination [4,5]. Also, seasonal clustering of cases suggests existence of an environmental trigger. However, such temporal associations have not so far been proven to be causal.

Failure to identify a single etiological agent despite 40 years of research implies that KD might represent an aberrant yet predictable immunological phenomenon triggered by exposure to a variety of environmental factors in a genetically predisposed host. The learning point in this case is the clinician's prudence in the diagnosis and treatment of incomplete KD as a syndrome based on clinical criteria irrespective of other underlying specific and non-specific infectious conditions.

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Pediatric Multiple Sclerosis

An 11-year-old girl presented to us with history of sudden diminution of vision in the right eye. There was no associated history of altered sensorium, fever, headache, vomiting, rashes or head injury. She also had a history of feeling of decreased sensation in left arm 4 weeks ago, which recovered completely and spontaneously within 2 weeks. There was decreased visual acuity in the right eye, with evidence of optic atrophy on fundoscopy. The Visual Evoked Potential (VEP) test revealed increased latency and decreased amplitude in the right eye.

Magnetic resonance imaging (MRI) of the brain showed multiple lesions involving white matter in bilateral periventricular, bilateral fronto-parietal subcortical and right temporal subcortical regions. On contrast enhanced cerebral MRI, few enhancing lesions were located in the corpus callosum, periventricular and bilateral frontal regions (***Fig.* 1**). MRI spinal cord showed T2 hyperintense lesions in cord at C2, C4 and D12 vertebral levels. The cerebrospinal fluid analysis revealed normal cytology and biochemistry, with no oligoclonal band. Anti NMO antibodies were negative. According to Polman (2010 revised Mcdonald criteria) [1], diagnosis of multiple sclerosis (MS) was made and pulse corticosteroid therapy with methylprednisolone was started with strict monitoring of vital and laboratory parameters. The vision improved within 24 hours of initiation of therapy and the girl was discharged on oral steroids, after 3 days of intravenous therapy.

Multiple sclerosis (MS) is a chronic demyelinating disorder of brain, spinal cord and optic nerves characterized by a relapsing-remitting course of neurologic events, separated in time and space, without encephalopathy, thus distinguishing it from acute disseminated encephalomyelitis [2]. Oligoclonal band in cerebrospinal fluid is considered to be a useful aid in diagnosis, but may be absent in up to 60% of confirmed

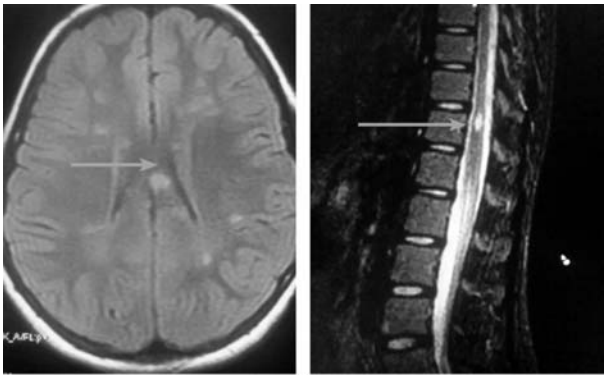

FIG.1 *MRI Brain and MRI Spinal cord showing lesions consistent with multiple sclerosis.*

pediatric cases. Its incidence is reported to be about 5.68/100000 per year, and the pediatric population accounts for about 2% to 5% of all MS cases [3]. Intravenous methyl prednisone is the preferred therapy in freshly diagnosed cases. Currently available first-line disease modifying therapies for adults, including interferon â and glatiramer acetate, have not been approved by the US FDA for the treatment of children with MS.

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Faculty Promotion Guidelines: Authorship and Indexing Issues Need More Deliberations

The recent editorial in Indian Pediatrics [1] is very timely, and attracted the attention of medical professionals across the globe, particularly from India. Very rarely such a vast circulation of any editorial in various online medical professionals groups and social media has been observed in recent times. All the five criteria notified by Medical Council of India (MCI) for faculty promotion were critically commented upon by the authors. Although the concerns listed in the editorial in question seems to be raised logically and are rational, but in our opinion concerns raised about indexing and authorship criteria needs further deliberations.

As far as indexing issue is concerned, indeed the suggestions by the authors in editorial are worth consideration and as suggested by them Science Citation Index and IndMEd should replace Index Copernicus. We would like to add further that list of indexing agencies should be increased from the current six to about ten, and it should be made mandatory that any publication must have at least two out of the ten indexing. This will definitely help in curtailing the wings of predatory journals that now run their business mostly by listing themselves on "Index Corpernicus" or by obtaining a single indexing as per MCI requirements. The introduction of a minimum requirement of any two indexings for promotion purpose will force them to raise their publication standard, and side-by-side this step will automatically take care of quality of research by faculty.

There is no doubt that the contribution of all authors is equally important and cannot be ignored, but the motive behind MCI guideline cannot be brushed aside. Gift authorship is a reality, and should be tackled. And there are more reasons to defend the MCI guideline in this regard. In a study based on international assessment of authorship position, significant differences existed between the understandings of appropriate roles for first versus last listed authors. First-listed authors were at least seven times more likely to be involved in study conception and conduct, manuscript writing, had a major study contribution and performed the majority of the work involved. Lastly listed authors were at least seven times more likely to be viewed as having a minor or no contribution to the study, provide funding, be a laboratory head/mentor, hold a senior position, and supervise/oversee the study [2]. Moreover, the way of referencing reduces the visibility of all authors apart from the first few [3]. According to a recent study [4], only 15.6% clearly declared contributions from all three International Committee of Medical Journal Editors (ICMJE) categories and the responses of 166 (13.0%) authors