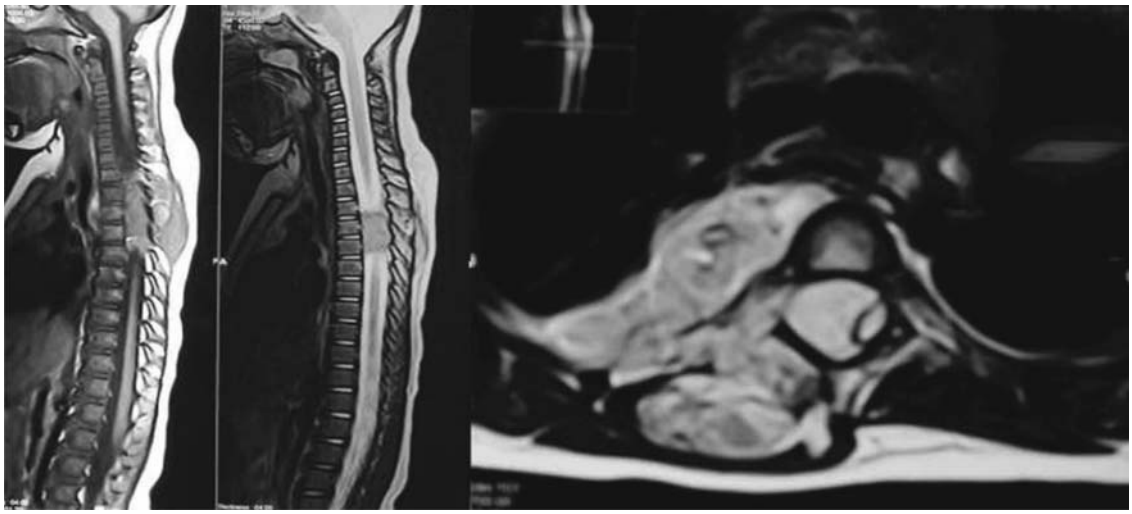

(*a*) (*b*) (*c*)

FIG. 1 *(a) Sagittal T1WI MRI showing isointense epidural and paraspinal mass at D3-D5 level; (b) Sagittal T2WI MRI showing hyperintense mass; (c) Axial T2WI showed T2 hyperintense dumbell-shaped epidural mass involving adjoining chest wall with severely compressed cord displaced to the left.*

radiotherapy. Positron Emission Tomography scan in the follow up period revealed no recurrence of the tumor and patient is symptom-free for the last three years.

Primary spinal epidural rhabdomyosarcoma is an extremely rare tumor and only few cases have been reported [1-4]. Treatment includes combination of surgery, chemotherapy and radiotherapy. Prognosis depends upon the age of patient, extent of the tumor, tumor histology, and presence of metastasis. When an epidural spinal mass with nonspecific imaging findings is found, rhabdomyo-sarcoma should be included in the differential diagnosis. Follow-up imaging is important to monitor tumor regression during or after completion of chemotherapy and radiotherapy, and to detect tumor recurrence or metastasis.

***SUSHIL KUMAR AND #AMIT GARG**

*Departments of *Neurosurgery and #Radiology, St. Stephens Hospital, New Delhi, India.*
**sushilneuro@rediffmail.com*

REFERENCES

1. Khalatbari MR, Jalaeikhoo H, Hamidi M, Moharamzad Y. Primary spinal epidural rhabdomyosarcoma: A case report and review of the literature. Childs Nerv Syst. 2012; 28:1977-80.
2. Rumboldt Z, Jednacak H, Talan-Hraniloviæ J, Kalousek V. Spinal epidural rhabdomyosarcoma. Acta Neurochir (Wien). 2004;146:195-7.
3. Salam S, Ganiou K, Idrissi A, Karkouri M, Aksim M, Ouzidane L. Paravertebral rhabdomyosarcoma: Rare etiology of spinal cord compression. African J Neurol Sci. 2010;29:77-82.
4. Yadav P, Gujrati· A, Buch A. Paravertebral and epidural sarcoma with spinal cord compression in a child: Case report and review of the literature. Medical Journal of DY Patil University. 2015;8:520-4.

Non-availability of Pediatric Formulations of Antiretroviral Drugs

In September 2015, World Health Organization (WHO) released a guideline whereby it was recommended that all HIV-infected children should be put on life-long anti-retroviral therapy (ART) irrespective of age, clinical manifestations and CD4 counts [1]. Tenofovir (TDF) is now recommended for use in children, and older molecules like stavudine are being phased out [1]. As part of Prevention of mother-to-child transmission (PMTCT) of HIV, pregnant women are now put on life-long triple drug ART and their babies after birth are started on daily nevirapine (NVP) or zidovudine (AZT) for 4-6 weeks while their mothers breastfeed them. This was labelled as option B+ [2].

National AIDS Control Organization (NACO) in India adopted the option B+ PMTCT guidelines recommended by WHO for public sector in India in 2013 [3]. However, India has the largest private healthcare system in the world with over 80-85% physicians practising in the private sector [4]. Thus, to achieve the goal of eliminating pediatric HIV, it is important that the private sector is also involved in management of HIV-infected women and children.

The antiretroviral drugs are currently are procured by NACO from the pharmaceutical companies based on the bid process [5]. However, physicians in private sector prescribe the medication that is then dispensed by the chemist. Unfortunately, in the last few months, the pharmaceutical companies have gradually stopped manufacturing the pediatric formulations. Initially, syrup formulations of AZT, lamivudine (3TC), nevirapine (NVP) and lopinavir/ritonavir (LPVr) were available in India and fixed drug combinations (FDC) of stavudine (d4T) and 3TC were available. However, currently, no liquid formulation of AZT, 3TC and NVP or the FDC are available in the private sector. The other NRTI like TDF and abacavir (ABC) are available only as adult formulations. Moreover, as part of PMTCT, if a baby has to be prescribed AZT or NVP, we are back to good old days of pulverising the adult tablet of NVP (200 mg) into 6 mg sachet and dispensing to the newborn. Thus, currently we are left with no pediatric formulation of antiretrovirals except for LPVr. This has created an immense problem in treating HIV-exposed and infected children. This had led to even delay in starting the NVP prophylaxis in HIV-exposed infants while the parents search for the pediatric formulation.

Thus, in order to achieve the goal of "Getting to zero", it is imperative that pediatric formulations are available for all. We seem to be heading towards the initial days of HIV epidemic – where drugs were just not available. With this grim scenario as the ground reality, it would not be unusual to expect a rise in pediatric HIV in the near future.

IRA SHAH
Pediatric HIV Clinic, BJ Wadia Hospital for Children, Mumbai, India.
irashah@pediatriconcall.com

REFERENCES

1. World Health Organization (WHO). Guideline on When to Start Antiretroviral Therapy and on Pre-exposure Prophylaxis for HIV. September 2015, Geneva. Available from: *http://apps.who.int/iris/bitstream/10665/186275/1/9789241509565_eng.pdf?ua=1*. Accessed June 2, 2016.
2. World Health Organization (WHO). Use of Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infection in Infants. April 2012, Geneva. Available from: *http://apps.who.int/iris/bitstream/10665/70892/2/WHO_HIV_2012.6_eng.pdf*. Accessed June 2, 2016.
3. National Aids Control Organization (NACO). Prevention of Parent to Child Transmission (PPTCT) of HIV using Multi Drug Anti-retroviral Regimen in India. December 2013, New Delhi. Available from: *http://naco.gov.in/upload/NACP%20-%20IV/18022014%20BSD/National_Guidelines_for_PPTCT.pdf*. Accessed June 2, 2016.
4. Loh LC, Ugarte-Gil C, Darko K. Private sector contributions and their effect on physician emigration in the developing world. Bull WHO. 2013;91:227-23.
5. National Aids Control Organization (NACO). Available from: *http://www.naco.gov.in/upload/2015%20MSLNS/Minutes_of_the_Pre-bid_meeting_ARV_Paediatric-08-2015.pdf*. Accessed June 2, 2016.

Bystander Cardio-Pulmonary Resuscitation Saves Life in a Patient with Short QT Syndrome

The short QT syndrome (SQTS) is a primary cardiac electrical disease characterized by abnormally short QT intervals and an increased propensity to develop arrhythmias. It is a relatively recent addition to the list of inherited channelopathies responsible for sudden cardiac death (SCD). Gussak, *et al*. [1] first described SQTS in 2000, and about 70 cases are reported till now.

A 10-year-old boy, resident of Delhi, suddenly fell unconscious, was not responding, not breathing and quickly turned blue and cold at home. His uncle, an officer with city police, was trained to carry out cardio-pulmonary resuscitation (CPR). He immediately started CPR, and approximately after 7 cycles of CPR, child was revived. At arrival to our hospital, he was stable with normal vital signs and consciousness. ECG done revealed QT/QTc interval of 280ms/305ms. His electrolytes, magnetic resonance imaging brain, electro-encephalography and thyroid profile were normal. Repeat ECG at heart rate of 60 revealed QT interval 280ms and J point to T-wave peak interval of 200ms (***Fig.* 1**). Family history was negative for SCD. We placed an implantable Cardio-defibrillator (ICD).

A short QT interval is usually considered if QTc is <340ms. However, there is an overlapping range of QT