Sleep Rituals

Many of the sleep rituals described in the communication [1] do not apply to pediatric age group. We do not expect most children, except adolescents, to indulge in consumption of alcohol, sleeping pills, and nicotine products. Presuming that most children would be expected to go to bed by 10 PM in night, not indulging in heavy exercise for six hours prior to sleep is not practical because that is the time when they are expected to be out in the play grounds after doing their homework. It is necessary to suggest age specific sleep rituals applicable to our culture and social life.

ANUP MOHTA
mohtaanup@hotmail.com

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Rickettsial Diseases in Central India

The paper by Rathi *et al.* [1] is an interesting attempt to develop a clinical score to diagnose spotted fever. However I am intrigued to note that the authors have taken Ethics approval from the Institutional Review Committee at Cooper University Hospital at Camden, USA.

It is pertinent to note that for a study conducted on patients from India in India, ethics approval should be sought from Ethics Committee based in India. If the hospital where the study was conducted does not have an Institutional Ethics Committee, an external Ethics committee based in India should have been approached for the same. Even if there are two co-authors are from Camden, according to Clinical Trials Registry -India (Personal communication), Review Committee at Camden is in no position to give ethical clearance to a study done on patients in India.

ANUP MOHTA
mohtaanup@hotmail.com

REFERENCE

1. Rathi NB, Rathi AN, Goodman MH, Aghai ZH. Rickettsial Diseases in Central India: Proposed Clinical Scoring System for Early Detection of Spotted Fever. Indian Pediatr. 2011;48:867-72.

AUTHOR REPLY

We agree that any clinical trial or prospective study should be approved by a local ethics committee. However, this report is not a clinical trial or a prospective study. Since there was no ethics committee in Akola to review this study, we approached Institutional Review Board (IRB) at Cooper University Hospital in Camden, NJ. The IRB at Cooper University Hospital was willing to review and approve this study as two of the investigators were from their institution, this was a retrospective review of the cases and the only concern in a retrospective study is loss of privacy for the subjects. Every effort was made to protect the privacy of the subjects in this study. The investigators at Cooper University Hospital received only de-identified data.

NARENDRA B RATHI
drnbrathi@hotmail.com

REFERENCE

1. Rathi NB, Rathi AN, Goodman MH, Aghai ZH. Rickettsial Diseases in Central India: Proposed Clinical Scoring System for Early Detection of Spotted Fever. Indian Pediatr. 2011;48:867-72.

EXPERT REPLY

In normal circumstances the Institutional Ethics Committee (IEC) should be involved because it is not only the ethical issues in the protocol but also during the conduct of the study IEC has responsibilities to the enrolled subjects. All serious adverse events are reported to IEC and also there is role in deciding compensation as well as prevention of injuries to the patient from conduct of study. In the absence of IEC an independent ethics committee may be approached. However, it should be in a position to take up the responsibilities of Ethics Committee during the conduct of study, which may not be possible for an overseas ethics committee. Even for multi centric trials with same protocol which have ethical clearance from other Ethics Committees the clearance of IEC is required.

In present case however the study involves only analysis of retrospective data. No patients are being enrolled and there is no ongoing trial/study. Only important ethical issue is that the identity of study subjects is not revealed. It is possible to accept the

argument that in the absence of IEC the ethical clearance was sought from the Ethics Committee of institution to which two of the investigators belonged. This is an exception and should not be used as an easy way out.

GR Sethi
Professor of Pediatrics, and Ethical Advisor,
Indian Pediatrics,
grsethi56@gmail.com

Perspective on Challenges in Scaling up of Special Care Newborn Units

We read with great interest the Perspective "Challenges in Scaling up of Special Care Newborn Units- Lessons from India" by Neogi, *et al*. in December issue of Indian Pediatrics. As neonatologist working in one of the SCNUs, we would like to make the following comments.

1. The reason for persistence of deaths due to asphyxia has not been mentioned. We have observed that the mothers arrive in hospital late, when the fetus is compromised already and a severely asphyxiated baby is born. Early referral of mothers will definitely help. Also, in many hospitals there is lack of dedicated anesthesiologist for Caesarean section OT, resulting in a delay of 2 or even more hours, that can be detrimental for an asphyxiated newborn. Further, all deliveries are not attended by a health personnel trained in neonatal resuscitation.

2. It is not clear whether, while calculating neonatal mortality rate only SCNU deaths are included or deaths in the labour room, and post-natal ward are also included. Also, the denominator *i.e.* the live births would be different for inborn and out born babies. We feel that an appropriate calculation would be to calculate percentage of death amongst admitted patients, rather than calculating NMR.

3. Although a good sum of money has been allotted each year for maintenance of SCNU by the government, in our experience, we found that to get the fund released locally and utilise this finally for maintenance of SCNU, it took nearly nine months due to lengthy official formalities needed to be maintained by the NRHM officials.

4. Simply reducing neonatal mortality in SCNUs probably will not help in long run unless the babies discharged from these SCNUs are provided follow up and parents are further provided help regarding feeding and nutrition, immunization, hygiene etc. Hence personnel in each SCNU who can be trained to counsel parents during their hospital stay and follow up them at home probably will help a lot in addressing this problem, reducing NMR, IMR and achieving MDG. This facility for home follow up is not available at present in the SCNUs.

REETA BORA,
Associate Professor of Neonatology,
Department of Pediatrics,
Assam Medical College, Dibrugarh.
rbora_amc@yahoo.co.in

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Cutaneous Manifestations of Chikungunya Fever: Significance?

The recent publication on cutaneous manifestations of Chikungunya fever is very interesting [1]. I have some concerns on this report. First, I agree with the finding of Seetharam, *et al*. that there are many cutaneous disorder in their case series. However, the question is whether these manifestations are real clinical manifestation of Chikungunya fever or they are only accidental co-incidences. There was no exclusion for other causes of the identified cutaneous lesions. Indeed, some manifestations such as psoriasis should not be the direct lesions. In addition, I would like to discuss on the use of the patient' picture in the journal. The blinded of picture face and eyes might be applied (such as in ***Fig*. 1** a in this report).

VIROJ WIWANITKIT,
Wiwanitkit House, Bangkhae, Bangkok, Thailand.
Wviroj@yahoo.com

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