lower stage of disease, could be of sampling error and data collection from non-heterogeneous population (predominantly stage 1). As per National Mental Health Survey 2016, prevalence of mental disorders in general population from urban area (aged 13-17 years) is 13.5% [6]. Lower prevalence of mental illness in index study compared to general population may not be taken as prerequisite to recommend a larger study. Most (88.1%) of cohort group had acquired HIV via vertical transmission suggesting long term illness; this might not substantiate author’s explanation that adolescents were lacking in knowledge about their disease. Hence the low prevalence of the psychiatric illness cannot validate the above explanation. The index study is deducing partially informative data since the sample seems to be from very selected, population leading to questionable external validity. Hence, the study has doubtful implications, or minimal addition to existing knowledge.

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AUTHORS’ REPLY

The design and methodology of the study included the association of psychiatric problems in adolescents with various clinical factors including stage of the disease, which can be related to the CD4 count of the patients. The lower incidence of psychological problems in patients with high CD4 counts was also seen in various other studies [1]. Recently, a systematic review on prevalence of mental health problems in adolescent has also been published [2]. Since the study cohort was limited to tertiary-care center and most of the children were on HAART, it was difficult to reduce the skewing of the data. Also larger studies are needed to emphasize the need to integrate mental health in the care of adolescents living with HIV.

EXPERT COMMENTS

Pilania, et al. [1] have reported their observations on prevalence of psychiatric disorders in 101 consecutively enrolled adolescent patients with HIV. What this study brings out is, that prevalence of psychiatric disorders is similar to what is observed in apparently healthy urban Indian adolescents [2]. A possible explanation for this finding is that all their subjects were on anti-retroviral therapy (ART), nearly 3/4th of them for over 3 years. Thus, not surprisingly, 92% of them were in WHO stage 1 of the disease. Further information like their CD4 counts, viral load, nutritional status, are not given in the data, but most adolescents in this situation are expected to be having a good CD4 count, suppressed viral loads and body mass index in normal range, thus contributing to their overall wellbeing. A more appropriate conclusion from the study would have been that with early initiation and continued ART, adolescents with HIV do not have higher prevalence of psychiatric disorders as compared to age-matched peers. Any conclusion beyond this—trying to look for impact of factors like WHO clinical stage, age, socio-economic status, HIV status disclosure etc, on occurrence of psychiatric illness in these subjects is not possible from the data provided, which is primarily descriptive in nature. Calculation of odds ratios would have helped gain this information.

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Position Paper on Kawasaki Disease in India: Pertinent issues

We read with interest the recently published IAP position paper on Kawasaki Disease (KD) [1]. We would like to highlight the following issues that require further consideration.

Under laboratory investigations, it is noted that serum levels of NT-Pro-BNP (N-terminal Pro-brain natriuretic peptide)>225 pg/mL can assist in the diagnosis of KD (86.5% sensitivity and 94.8% specificity to suggest myocardial dysfunction). However, in the subsequent section, authors mention that cut off values for

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AUTHORS’ REPLY

We are in agreement with the author that NT Pro BNP is not a well established tool for the diagnosis of KD. As rightly pointed out, NT pro BNP varies with age and the values provided in the paper are from the study by Dahdah et al. [1]. It must be said that one should refer to age related upper limits of normal and it is also useful to keep in mind to avoid making diagnosis of Kawasaki disease just on the basis of NT Pro BNP alone. Moreover, data on KD in India is predominantly emerging from few centres and not representative of the scenario in the whole country. We did not intend to highlight or analyze Indian data. However, both this position paper and AHA statement define IVIG resistance as persistence or recurrence of fever 36 hours after the end of IVIG infusion. Several recent studies and the Japanese Society of Pediatric Cardiology and Cardiac Surgery guidelines suggest a 48-hour time frame for the same [5]. The 36-hour cut-off, when applied strictly, could potentially lead to over-diagnosis of IVIG resistance. This is a pertinent issue that needs further exploration, considering that the time taken for IVIG infusion itself can be variable (typically 12 hours in North America and 20-24 hours in Japan) [5]. AHA recommends IVIG infusion over 10-12 hours (as opposed to 12-24 hours recommended by authors).

There are certain variations in the definition of recurrence. Recurrent KD is defined as a repeat episode of KD after complete resolution of the first episode [1,2]. Acute illness in KD usually lasts for 4 to 6 weeks and several Japanese surveys have classified KD as recurrent if there is an interval of at least two months from the onset of the first illness to onset of the new episode [6]. In the paper, the available Indian data has not been critically evaluated. It is imperative to consider relevant local data to bring in the much needed Indian perspective. In the process, lack of good quality data on the disease epidemiology and the importance of a national registry could have been highlighted. Finally, a conflict of interest statement by the authors is missing.

GOWDA PARAMESHWARA PRASHANTH1* AND ANITA TANDON2

Departments of Pediatrics,
1College of Medicine and Health Sciences, National University of Science and Technology, Muscat; and 2Sohar Regional Teaching Hospital, Sohar; Sultanate of Oman.
*prashanth_lucknow@rediffmail.com