many Negri bodies. The indirect immunofluorescence (IF) test(2) was also positive. When the specimen was inoculated intracerebrally into 3-day-old mice they became sick after 9 days. Rabies virus antigen could be demonstrated by IF test in the brains of sick mice and Rhabdoviruses could also be demonstrated in the mouse brain preparations by electron microscopy(3) (*Fig.*).

The incident described here is reminiscent of a similar situation that occurred in school precincts of the Jayakwadi irrigation project in Maharashtra(4) reported in 1975. These episodes illustrate that children are at risk of exposure to the rabid dog bite at school and emphasizes a need for vigilance by the school authorities.

The children bitten by the rabid dog could not afford the tissue culture vaccine, considered as ideal in such situations for post exposure prophylaxis(5). This further emphasizes the need for a cheap, safer and effective rabies vaccine. Fortunately, to date, none of the victims of rabid dog bite described here have developed rabies.

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Positioning of the Lower Limbs in Acute Paralytic Poliomyelitis

Acute paralytic poliomyelitis continues to plague the infants and young children of our country. It is estimated that every day 500-700 new cases of paralytic poliomyelitis occur and for every one paralytic case, there are 20 subclinical cases(1). Involvement of lower limbs is by far the commonest. The outcome of the disease depends on age(2), immunization status and severity of the initial paralysis(3).

Treatment includes proper positioning, physiotherapy and regular follow up once in 2 to 4 weeks either till recovery is complete or for a period of 2 years. Gravitational pull on the affected weak muscles is known to impede recovery(4). Hence, proper positioning of the limbs during the stage of acute paralysis is of paramount importance(4). This, however, is difficult in young children since the child changes its posture frequently even when asleep.

At the Department of Pediatrics, J.J.M. Medical College, Davangere, we are using a simple device for positioning the paralysed lower limbs during the acute stage. Tying of both legs together by using a handkerchief

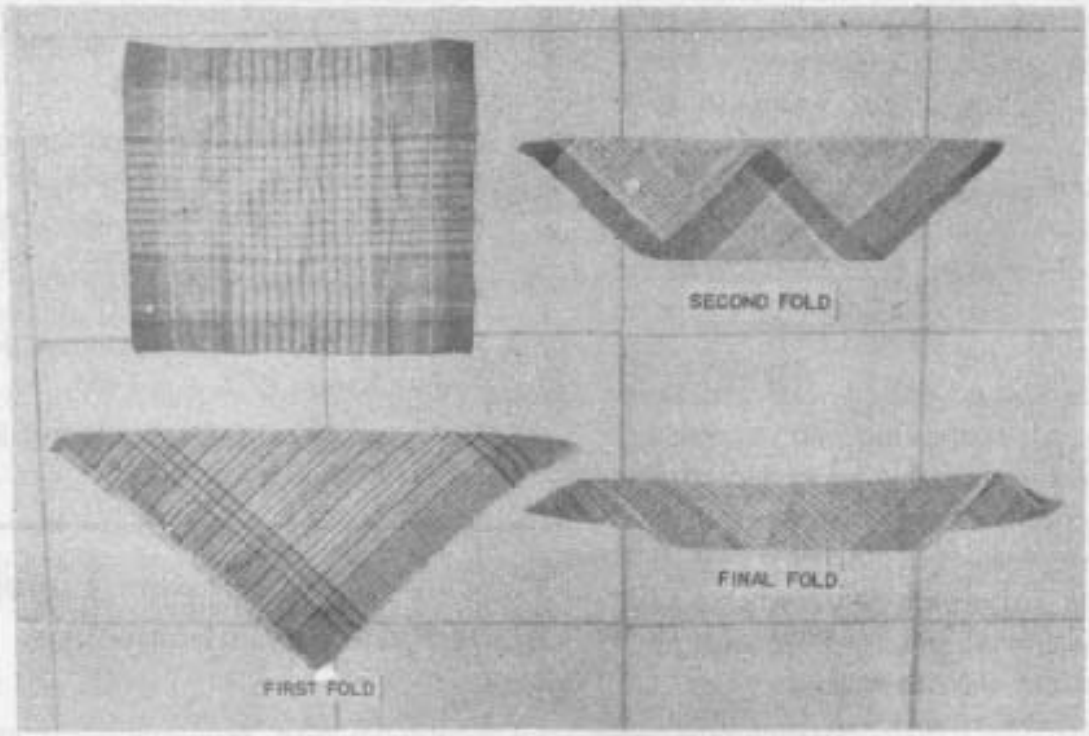

Fig. 1. A handkerchief 40 × 40 cm is folded as shown in the figure.

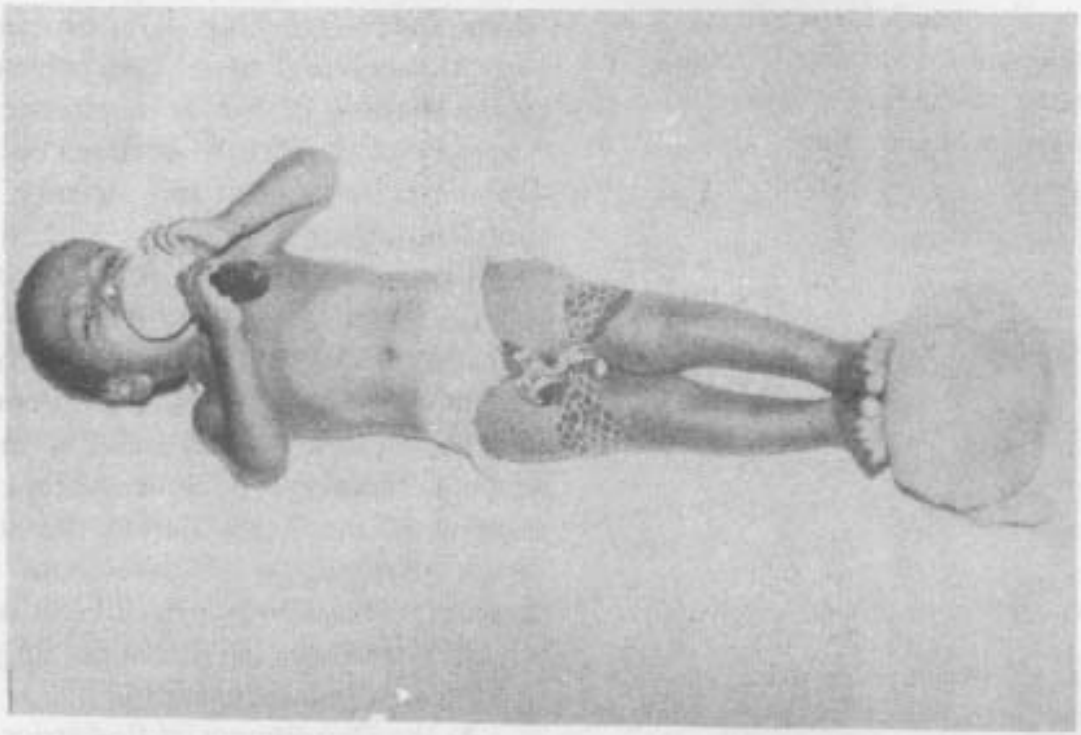

Fig. 2. The handkerchief is tied to both legs just above the knees to achieve neutral positioning. A sandbag at footend keeps the feet at 90 degrees.

carefully folded as shown in *Fig. 1* helps to bring about neutral positioning as shown in *Fig. 2*. Tying both the legs also prevents the mother from carrying the baby in her waist, which is a traditional practice of carrying babies by the Indian mother. This practice can produce undue stretching of the adductor muscles and lead to weakness in the muscles.

This method can be employed either when one lower limb or when both lower limbs are involved. The normal limb will act as a splint to anchor the weak limb thus preventing undue stretching. The duration of tying both the legs together is throughout the acute period of the disease (which is usually 4 to 8 weeks) and well into the convalescent period till the child has had good return of power (Grade III and above). The usual duration recommended will be for about 3 to 5 months in most cases. Tying both the legs also prevents early ambulation which is not desirable in acute paralytic poliomyelitis.

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Theophylline Infusion for Prevention of Apnea of Prematurity

Merchant *et al.* in their recent article(1) have suggested continuous theophylline infusion for prevention of apnea of prematurity. While such a concept is theoretically sound, certain practical aspects of their study call for further explanation.

The aims of the study were to determine the optimal dosage and factors adversely affecting serum theophylline levels –apart from studying the efficacy of theophylline in primary apnea. These would have been possible only if different dosage schedules were employed, while controlling for other variables, for determination of optimal dosage schedule and some dosage in different babies with the variables for studying factors affecting serum theophylline levels. In the absence of such attempts, meaningful conclusions cannot be drawn from the study. For example, comparison of *Figs. 1* and *2* reveals that a sizeable population of the infants in the study were small for dates. Serum levels of theophylline are higher in these infants than in appropriate for gestation infants(2) despite the elimination half lifes being similar in both(3). Optimal requirement of the drug for these infants would be much lower than for other infants. Similarly, hypoxia, acidosis, total parenteral nutrition and infection adversely affect the serum theophylline levels, and unless controlled for, would alter the results of the study.

The authors have used a wide range of infusion rate (0.2 mg/kg/h to 0.38 mg/kg/h) without offering any reason for the variation. Aranda *et al.*(4) have calculated that to achieve a serum level of 10 mg/L, the