# *Letters to the Editor*

## Cerebral Palsy

The recent article by Srivastava *et al.* highlights the multifaceted problems relating to cerebral palsy(1). While their recommendations regarding the need to reinforce the existing maternal and child health services are indeed justifiable, the authors' observation that natal factors were responsible for majority of the cases of cerebral palsy (43.8%) are at variance with other recently published reports(2-4). Perinatal factors of labor and delivery, *e.g.,* midforceps delivery, prolonged labor, breech delivery, nuchal cord, *etc.* were previously implicated but now have been proven beyond doubt not to correlate well with cerebral palsy, mental retardation or seizure(3,4). This view is further supported by observation of static incidence of neurological sequalae despite improvement in perinatal care. With regard to perinatal anoxia, it is noteworthy that the degree of asphyxia necessary to cause permanent brain damage in experimental animals is quite close to which causes death and it is true for humans too(5). Therefore, as in the animal models, death, on one had, or intact survival, on the other are most likely outcomes than survival with brain damage. Conversely, even when perinatal asphyxia is confirmed, most etiologies of such asphyxia are due not to preventable intrapartum events or interventions but to pre-existing, usually congenital, often subtle (cytoarchitectural) malformations and dysgenesis, neurologic or otherwise(3,4); which is rather responsible for the mental retardation or cerebral palsy detected later on follow up. Natal factors mentioned by the authors(1), thus, were mere associations and not responsible for cerebral palsy and associated handicaps in their patients.

**REFERENCES**


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## Reply

The etiopathogenesis of cerebral palsy is a complex one and the exact etiology remains unknown till to date. The recent changing trend in the etiology of cerebral palsy especially the controversial role of birth anoxia or perinatal asphyxia, which we

were fully aware while writing the article, has been highlighted in several studies particularly from developed countries, as rightly pointed out.

While we agree with these views, the question remains–should we, particularly in developing countries like ours, where, by and large, natal and perinatal events are not effectively managed due to lack of facilities, completely ignore the identified natal factors (43.8%) which could possibly be the cause of cerebral palsy. As such the natal factors can not probably be looked upon as mere associations.

In developing countries, more well controlled and prospective studies are required before fully endorsing the views originating from the developed countries.

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## HIV Infection in Multi Transfused Thalassemic Children

Prevalence of HIV-1 or HIV-2 infections is of interest to Hematologists/Pediatricians engaged in the management of thalassemia. Prevalence of HIV infection is on the rise in our country. Already, over 1 million people are estimated to be infected with HIV infection(1). Seropositivity of HIV infection in multitransfused patients has been reported to vary between 4 to 24.6% of children(2-4). Seropositivity for HIV-1 from other institutions of Delhi has been reported as 9.3 and 8.9%, respectively(5,6). In our study 91 patients of thalassemia between the ages of 7 months to 21 years (55 males, 26 females) on regular transfusion were screened for HIV-1 infection by ELISA. These children had received 2 to 203 (mean 44) blood transfusions prior to their screening. All these children were sero negative. Thus, in the city of Delhi prevalence of HIV-1 infection varied between 0 to 9.3 with overall prevalence in 25 of 369 thalassemia children (6.77%). Our data supports the studies of Singh *et al.*(7).

It is most likely that all these children got the infection through blood transfusion. However, the possibility of infection through contaminated needles and syringes cannot be ruled out, as none of the hospitals of Delhi can afford use of disposables. Since these children are at higher risk, it is suggested that in all these cases disposables should be used and the blood given should be free of HIV infection. Even blood testing by antibody detection method (ELISA) does not offer 100% safety, as blood may be infectious even in the absence of antibodies (window period). So far in our country sero-surveillance studies have only been conducted for HIV-1 infection. There is need to undertake such studies for HIV-2 infection as well. Seropositivity in donors has been reported as 1.03% by ICMR(8). Though HIV screening is mandatory in our country but by and large blood banks in small towns and cities do not do so. Since blood demand is far higher than its availability, especially in towns and small cities, it is possible that professional blood donors moved to smaller