

Tuberculosis Infection in Children: Need to Strengthen and Intensify Control Efforts

Yadav, et al. [1] reported the annual risk of tuberculosis infection (ARTI) of 1.2-1.6% and infection prevalence of 6.3-8.2% in tribal children <10 years in Madhya Pradesh. These metrics are similar to those in other tribal populations and in general populations throughout India [1]. They conclude stating: “there is need to strengthen and further intensify TB control measures in the area,” implying that current measures are failing. Other recent papers also have illustrated the failure of TB control in spite of long-standing efforts of the Ministry of Health [2,3]. National TB Control Programme (NTCP), started in 1962, was evaluated in 1990-92 and found to have failed [4,5]. The Revised NTCP (RNTCP) was launched in 1992-93 [4,5]. Control status requires reduction of cumulative infection prevalence to <1 in children by 14 years of age and ARTI of ~ 0.07% [3-5]. However, ARTI remains >1% over decades; infection prevalence in orders of magnitude higher than desired [1-4]. Nationally, there is no decline in incidence or prevalence of TB in adults [5].

Why has TB not come under control? Treatment of the infectious form of TB has not been validated sufficient for control [2-4]. Treatment can be given only to persons captured in the diagnostic net, but it does not capture all infectious cases, allowing many to seek private healthcare, wherein non-standard treatment is rampant, and follow up poor, contributing to development of drug resistance. The sensitivity of TB diagnosis is inadequate without micro-biological diagnostic support. Even those captured in RNTCP become non-infectious only after they have shed the bacilli for several weeks. Thus chains of infection continue unabated and ARTI remains high in all studies [1-4].

RNTCP must be revamped, deficiencies covered, interfaced effectively with healthcare (public and private sectors), and supported adequately with laboratory facilities [2-4]. Infection incidence must be regularly monitored in all districts by systematic surveys of ARTI [2-4]. Pediatric TB infection and disease must be given high priority for detection and treatment [2-4]. Such strengthening and intensification of RNTCP will be essential to control TB and convincingly document it.

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REFERENCES


Neonatal Adrenal Hemorrhage Presenting as Intestinal Obstruction

Due to its large volume and vascularity, neonatal adrenal hemorrhage (NAH) is not uncommon. However, there is only one case report of intestinal obstruction due to NAH [1]. A 3-day-old male neonate presented with bilious vomiting, distension of abdomen, lethargy and non-passage of stools for last 24 hours. He weighed 2700 g. The clinical examination revealed mass in the right lumbar region with generalized abdominal distension and absent bowel sounds. There was no pallor or icterus. No birth asphyxia was reported at birth. Hemogram and sepsis work up was normal. X-ray abdomen erect showed multiple air fluid levels. The ultrasonography (USG) abdomen revealed right adrenal hemorrhage measuring 65×55×30 mm in dimensions, displacing the right kidney downwards. The left adrenal gland was normal. CT scan of abdomen confirmed right adrenal hemorrhage displacing the right kidney downwards with extrinsic compression of the right hemicolon due to mass effect. Urinary VMA levels were normal. The baby had no hypotension, pallor or signs of adrenal insufficiency. He was treated