

et al. Antibodies to HTLV-III/LAV in transfusion dependent thalassemia. Blood 1985, 65 (Suppl. 1): IIIa.

5. Novelli VM, Mostafavipour H, Abulaban M, *et al.* High prevalence of human immunodeficiency virus infection in children with thalassemia exposed to blood imported from the United States. *Pediatr Infect Dis J* 1987, 6: 765-766.

Comments

We read with interest the article by Surjeet Singh *et al.*(1) in which the authors couldn't find even a single case positive for HIV-I antibody at Chandigarh. Their results also indirectly reflect the absence of, or a very low HIV seropositivity in voluntary donors of the region. We all are aware that HIV is a potentially dangerous virus transmitted through blood and children receiving multiple blood transfusions are at a greater risk to get it, more so those cases who have received untested blood like some of the children reported in this study. In contrast to this, in a number of studies the seropositivity of HIV virus among multi-transfused patients was found to range from 4-24.6%(2-4). In a study at our institution in New Delhi, out of 75 multi-transfused children 7(9.3%) were positive for HIV-I antibody by ELISA method which was later on confirmed by Western-Blot technique(5). Out of these 75 cases, 64 were of thalassemia and 11 of other diseases requiring multiple blood transfusions. Similarly, in another study by Sen *et al.*(6), out of 203 cases, 18 children (8.9%) were positive for HIV-I antibodies by ELISA method and 6 children were diagnosed clinical AIDS as per the WHO

criteria. There are similar reports from Bombay, Calcutta and Vellore also(2-4). According to an ICMR report(7), the seropositivity in donated blood in India is estimated to be between 0.1-1.5%. Here we would also like to point out that AIDS virus is slowly spreading in India and therefore all efforts must be directed towards proper screening of blood and other blood products because it is the major route of transmission in children receiving multiple transfusions.

A.P. Dubey,
P. Choudhury,
R.K. Puri,

Department of Pediatrics,
Maulana Azad Medical College and
Associated LNJP Hospital,
New Delhi 110 002.

REFERENCES

1. Singh S, Gulati S, Marwaha RK, Garewal G, Kumar L, Sehgal S. HIV serosurveillance in multitransfused thalassemic children. *Indian Pediatr* 1993, 30: 104-105.
2. Bhushan V, Chandy M, Khanduri U, *et al.* Transfusion associated HIV infection in patients with hematologic disorders. Proceedings of 32nd Annual Conference of ISHBT. December 12-14, 1991, p 20.
3. Rao A, De M, Lahiri OP, *et al.* Sero-surveillance of early stages of HIV in hemophiliacs. Proceedings of 32nd Annual Conference of ISHBT. December 12-14, 1991, p 29.
4. Kaur J, Rao S, Manglani M, *et al.* Prevalence of plasma borne infections in multi-transfused thalassemic patients. Proceedings of 32nd Annual Conference of ISHBT, December 12-14, 1991, p 33.
5. Juneja M. Prevalence of AIDS and hepatitis markers in multitransfused pediatric patients. Thesis submitted for M.D. (Pediatrics), Delhi University, August 1991.

6. Sen S, Mishra NM, Giri T, *et al.* AIDS in multi-transfused children in thalassemia. *Indian Pediatr* 1992, 29.
7. Anonymous. HIV infection among blood donors in India. *CARC Calling* 1988, 1: 13.

Fixed Drug Eruption in Infancy

Fixed drug eruptions are uncommon in children(1) and extremely rare in infants(2,3). We report a child who developed a fixed eruption at the age of 6 months. Provocation tests were able to identify the causative drug in this case.

At the age of 6 months the infant first developed a circular, well-defined erythematous lesion on his right arm while he was being treated for regurgitation of feeds. No other details of the primary illness were available. Suspecting a drug to be the cause of the lesion, the mother stopped all therapy. This led to the subsidence of the erythema and the development of macular hyperpigmentation at the site. The lesion remained quiescent till he was 8 months old when erythema developed around the hyperpigmented macule during therapy for fever. The erythema subsided spontaneously when treatment was stopped. Subsequently, he had 15-20 such exacerbations of the original lesion, over the next 2 years while receiving treatment for various illnesses including diarrhea, fever and respiratory infections. These exacerbations led to an increase in the size and the intensity of hyperpigmentation of the original macule and when seen by us at the age of 2½ years, he had a 5 × 6 cm hyperpigmented macule on the right arm. He had also developed lesions on the shaft of the penis and the left arm at the age of 18 months and 26 months,

respectively. These macules too had flared up everytime there was an exacerbation of the lesion of the right arm. The child's parents were illiterate and did not know which drugs had been administered prior to the flare-ups. In view of the strong likelihood of recurrences (since a commonly prescribed drug appeared to be the cause), and the absence of a severe or life threatening reaction in the past, it was decided to subject the child to provocation tests to identify the causative drug. Informed consent was obtained from the mother, and the child was admitted to hospital. A single dose of the following drugs was administered orally, one every day: erythromycin, analgin, ampicillin, furoxone and co-trimoxazole and the skin lesions observed for a flare-up over the next 24 hours. While the first 5 drugs did not provoke any reaction, erythema, warmth and tenderness developed in the lesions 30 minutes after co-trimoxazole was administered. The reaction was controlled with topical flucinolone acetonide and the child discharged from hospital with instructions to the parents on avoidance of co-trimoxazole.

In view of well demarcated hyperpigmented lesions showing recurrence of inflammation with repeat exposure to the causative drug, a diagnosis of fixed drug eruptions was considered. Confirmation of the etiology was obtained by provocation testing. Fixed drug eruptions appear to be uncommon in children(1). As with other allergic drug reactions, the low incidence is probably due to the immaturity of the system in children(2) and absence of exposures to drugs required for sensitization to occur(3). Since co-trimoxazole is commonly prescribed for a variety of indications in our country, it is likely that our patient had developed sensitization during a