

Although predominant causes of painful, hyporeflexic weakness of bilateral lower limbs are GBS and viral myositis, often pseudoparalysis due to trauma, scurvy or referred pain from the loin, lower back or hip joint may mimic GBS, thereby causing diagnostic confusion [1]. The classic triad of psoas abscess (fever, flank pain, and limitation of hip joint movement) can be found only in 30% of patients [2].

The atypical presentation with bilateral painful gait instability in absence of fever, trauma or intramuscular injection in our case clinically resembled GBS or pathology localized to lumbosacral plexus or spinal cord. However, instead of performing costly and tedious investigations like MRI and nerve conduction study, simple ultrasonography may clinch the correct diagnosis easily. Pseudoparalysis in children under 15 may be caused due to various etiologies like skeletal trauma, lymphadenitis or muscle aches from a viral illness, transient synovitis, septic arthritis, osteomyelitis, pyomyositis, fasciitis, cellulitis, rheumatological diseases such as juvenile idiopathic arthritis, acute rheumatic fever and malignancies like sarcoma and leukemia [3,4]. Hence, atypical presentation of iliopsoas abscess requires a high index of suspicion on part of pediatricians, to establish a timely diagnosis.

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## What is the Determinant of 2019 Novel Coronavirus Prognosis in Children?

We read the article by Li, et al. [1] with interest and would like to offer some observations about the study based on the current literature.

In the pathogenesis of a standard viral infection, the pathogen's contact with the mucosa is initially followed by an innate immunity response (macrophage, antigen presenting and natural killer cell). Subsequently, adaptive immunity comes into play and is responsible for the elimination of infected cells, activation of the antibody response, and production of memory T-cells. T-cells are the primary decisive element in adaptive immunity capability. For this reason, the adaptive immune response mediated by the thymus is a process that regulates the immune response responsible for preventing invasive damage from a virus. Therefore, the thymus is the most influential organ in the transmission of viral disease [2].

The thymus generally decreases in function and anatomically shrinks with age. This function and size loss becomes specially prominent after the age of 50 [3]. Thymic involution and the gradual decrease in T-cell count and ability with age are together termed as immunosenescence [4]. The primary reason for morbidity and mortality in COVID-19 cases is due to lung manifestation. The primary reason for a frequently severe clinical presentation in patients of ages 50 and up is thought to be due to a deficient, irregular and uncontrollable antiviral response as a result of thymus

involution and immunosenescence. Important factors in achieving an adequate immune response are an increase in thymus activity and T-cell action along with immune system coordination.

When examining the critical COVID-19 cases in the literature, the male gender seems to be more common; this is speculated to be due to greater tobacco use and ACE-2 receptor expression. The literature also shows that thymic involution is more apparent in males compared to females. This difference in thymic involution indicates that males face a greater extent of immunosenescence. We believe this mechanism might be responsible for clinical worsening in males [5].

We believe that thymus regression and lung immunosenescence are the main deciding factors of lung involvement depth in adult COVID-19 patients. But, we do not know thymus activity in children cases with severe COVID-19. We feel that there is a need to examine the patients for thymus size, and look for association between thymus size and the severity of lung involvement.

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## Requesting National Guidelines for Screen Time in Indian Children from IAP

We read with great interest the research article by Meena, et al. [1] on screen time in children by 15-18 months of age. We wish to share our survey findings of 109 well children (12-36 months) at three hospitals in Bangalore between September, 2016 to April, 2017. We found that the mean (SD) screen time exposure was 120 (96.2) minutes (range 0-540 min) in this age group, similar to the study by Meena, et al. [1]. Television (69%), mobile phones (66%), tablet (27.5%) and laptop (22%) were the most common electronic media used in our study. We found rhymes (89%) commercial advertisements (62%), educational videos (36%), and cartoons (20%) constituted majority of the activities during screen time. Importantly, 73% of the parents used screen time to help the child in eating, 51% for entertainment, and 34.8% as a distraction to give the caregiver some free time. Contrary to their findings, we found that only 7% of the parents thought screen time was good for the child. We found that 26% of these children had delay in speech for their respective ages. An association with speech delay and screen time has also been reported earlier [2,3].

We agree with the authors that it is the need of the hour to not only provide Indian guidelines for screen time in toddlers to parents but also to make them aware of possible adverse effects it may cause in their toddler's speech development. We are eagerly waiting for guidelines of Indian Academy of Pediatrics on screen time for children to address this important issue, and to communicate these to parents in addition to practitioners.

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## The Need for Geographic Location Specific Optical Density Cut-offs for IgM ELISA Serology to Diagnose Scrub Typhus in Children

We read with interest the article on detection of immunoglobulin M and immunoglobulin G antibodies against *Orientia tsutsugamushi* for scrub typhus (ST) diagnosis by Gupte, et al. [1]. This study was done to estimate the regional cut-off of optical density (OD) values of serum IgM antibodies by ELISA for the diagnosis of ST. Authors had successfully determined regional cut off of OD value for IgM antibodies, which will be utilized in diagnosing ST in that area. This study has shed light into one of the most obvious pitfalls in

diagnosing ST by serology (IgM ELISA) i.e., using an inaccurate, arbitrary OD value cut off for diagnosis. This has serious implications that are applicable beyond the study population.

We would like to raise two pertinent points based on the study conclusions. Most studies conducted in pediatric ST using serology by IgM ELISA used 0.5 OD as an arbitrary cut off in accordance with the definition of 'probable case' by the IAP guidelines on rickettsial diseases in children [2]. Since OD of 0.5 is much lower than most of the cut offs reported from Southeast Asia, where ST is endemic in many parts, all these studies with OD cut off of 0.5 might have actually over diagnosed ST and hence the results have to be cautiously interpreted [3-5]. Since the OD cut off is going to be influenced by geographical location and degree of endemicity, it is imperative to use location specific OD cut off to diagnose ST [4]. Conducting epidemiological studies to identify the OD cut