Standard Treatment Guidelines for Pediatrics under Clinical Establishment Act 2010

The Clinical Establishment (Registration and Regulation) Act was enacted by the Union government to ensure that uniform and acceptable standard of health care is meted to the citizens in the private sector [1]. Till date, only 5 States and 4 Union territories have implemented it. As a part of providing standard treatment by private hospitals, treatment guidelines have been formulated for most broad specialties and super specialties. The standard treatment policy is intended to provide a ring of protection for both patients and doctors [2]. For the patients, it assures the delivery of a rational, safe, standard and uniform treatment. For the doctors who follow standard guidelines, it offers protection against medico-legal issues arising out of non-standard treatment. For Pediatrics and Pediatric surgery, the standard treatment guidelines (published at *www.clinicalestablishments.nic.in*) cover only a limited number of conditions [3]. There is no mention of management of common ailments like respiratory infection, diarrhea, malaria, typhoid, hepatitis, HIV, tuberculosis, envenomations and chronic diseases like asthma, diabetes and epilepsy. Similarly, developmental disorders like cerebral palsy, attention deficit hyperactivity disorder and autism have not found a place. Delivery room management of perinatal asphyxia, neonatal sepsis and screening for metabolic diseases have also been ignored.

We assume that the standard guidelines available through the website are only a sample and not an exhaustive list of common pediatric and pediatric surgical conditions. There is a haste in implementing the above program in various states. Standard guidelines need to be elaborate, focusing on common clinical conditions, and conditions associated with serious morbidity and mortality if not identified or treated appropriately. We urge the Academy to share the common pediatric protocols, that are already in place, with the appropriate authorities, so that the same can also be incorporated in the website.

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Benign Infantile Seizures with Mild Gastroenteritis

Benign infantile seizures with mild gastroenteritis, first described from Japan in 1982 [1], have been commonly reported from Asia [1-3]. More recently, many cases are also being reported from non-Asian countries, albeit infrequently [4,5]. Typically, previously healthy infants aged 6 months to 3 years, present with generalized, afebrile, isolated or cluster seizures. The laboratory examination, including blood glucose, serum electrolytes, and CSF, as well as the interictal EEG and neuroimaging are normal [4,5]. Subsequent recovery from the episode is complete [4].

An 11-month-old girl presented with a 15-minute generalized tonic seizure, associated with mild gastroenteritis of 2 days duration. There was no dehydration, and seizures subsided without any anti-convulsant treatment. Her serum glucose, electrolytes and ionic calcium, and hemogram were within normal range. The stool microscopy did not show pus cells, and bacterial culture did not reveal any organisms. Studies for Rotavirus were not done. Interictal EEG and MRI were non-contributory. Development quotient done after three

months (using DASII) was 84. There was no recurrence of seizures, or developmental delay on follow-up over next 13 months. The final diagnosis made was Benign infantile seizures with mild gastroenteritis.

This syndrome – recognized only in the last decade – is still not accepted by the International League Against Epilepsy [6]. Rotavirus has been reported as the most common etiological agent in this condition in different studies [4,5]. However, other organisms have also been reported [3], and it has not been possible to attribute the convulsions to any organism, as yet [2]. The clinical symptoms are reported to precede the convulsions by an average of 2 days [4], similar to that in our case.

The importance of recognition of this condition is that it helps in avoiding unnecessary long term anti-epileptic therapy, and favorably counsel the parents about the low risk of recurrence of seizures.

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Management of Patent Ductus Arteriosus

I read the recent review article [1] on management of patent ductus arteriosis (PDA) in very low birth weight (VLBW) infants with interest. I wish to seek clarifications regarding authors' conclusion about birth weight <800 g (without any reference to gestational age) being a deciding factor for treatment when babies with PDA are symptomatic or require positive pressure ventilator support. The reference quoted [2] reports significant effect on mortality and morbidity in the presence of persistent PDA only with gestational age <25 weeks. Moreover, there is evidence that the rate of spontaneous closure in babies weighing >1000g at birth is significantly high [3], and hence interventions for ductal closure may be relevant only in those having birth weight ≤1000g. Furthermore, neither individual randomized controlled trials nor meta-analyses of those trials have been able to demonstrate any long term benefits of interventions for ductal closure in babies with PDA, irrespective of the gestational age and birth weight [4,5]. In this context, should management of these infants be guided only by clinical judgement on an individual basis, irrespective of gestational age or birth weight?

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AUTHOR'S REPLY

We thank the reader for his comments and providing us the opportunity to further discuss the controversies in the management of PDA in VLBW infants. We agree with the reader that spontaneous closure of PDA is significantly high in VLBW infants with birth weight >1000g [1-2],