Limited data is available on the qualitative distribution of undernutrition amongst children 6-9 years of age in National Capital Territory (NCT) of Delhi. We conducted a study to provide an answer.

Keeping in view the anticipated underweight prevalence of 50%, a confidence interval of 95%, relative precision of 10% and a design effect of two, a sample size of 768 children was calculated. Thirty schools/clusters were selected using ‘population proportionate to size’ cluster sampling methodology(1). In the identified schools, children were briefed about the objectives of the study and informed consent was taken. In each school (cluster), a minimum of 30 children were enrolled for the study. Anthropometric measurements of weight and height were recorded for each child using SECA electronic weighing scale and anthropometric height rod, respectively. The three indices of nutritional status i.e., weight for age, height for age and weight for height were expressed in standard deviation units (z scores) from the National Council of Health Statistics (NCHS) median as specified by World Health Organization using the anthropac software.

A total of 471 (48.7%) boys and 495 (51.2%) girls were included in the study. The percent of children underweight, stunted, and wasted were 52.5, 45.1 and 11.1%, respectively. It was observed that 9.7, 15.3, and 2.8% of the children were severely (< 3SD) underweight, stunted, and wasted, respectively. The prevalence of underweight and stunting was significantly higher in boys as compared to girls.

Prevalence of Undernutrition Amongst Children (6-9 Years) in Delhi

T.S. Raghu Raman, Daljit Singh, Command Hospital (Air Force), Bangalore 560 007, Karnataka, India.

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Earlier studies conducted in Mumbai and Punjab reported that 40.2% and 20.5% of children 5-14 years were underweight(2,3). Stunting was observed in 45.1% of the children. A comparatively lower proportions of children were wasted (13.1%) for their age indicating that acute (severe, but short term) undernutrition is less common in children. However, earlier studies conducted in Kerala on children (5-12 years) in 2000 and 2001 have reported the prevalence of wasting as 53.3% and 57.6% respectively(4,5). The results of the present study revealed that 52.5% of children were suffering from one or the other form of under nutrition, possibly due to inadequate diet and chronic infections. Strengthening of the school health services and creating awareness among parents about the nutritional requirements of their children is required.

Practical Approach to Neonatal Analgesia

We read with interest the article, “Practical approach to neonatal analgesia”(1). The authors have dealt with many aspects of neonatal analgesia. Surprisingly, there is no section on the assessment of pain in neonates.

Many validated pain measures are currently available to assess pain in both term and preterm infants. Behavioral and physiological alterations of neonatal pain are incorporated in these pain measures. Some of the well-validated pain scores include the Neonatal Facial Coding System, the Objective Pain Scale, CRIES (crying, requirement for oxygen, increase in heart rate, blood pressure, facial expression and sleeplessness), Premature Infant Pain Profile (PIPP) and the Neonatal Infant Pain Scale(2).

The approach to neonatal analgesia could have been better summarized. The authors have underplayed the role of fentanyl, alfentanil and sufentanil in neonatal analgesia by quoting various side effects. However, chest wall and glottic rigidity are most often seen with bolus doses; and fentanyl and its congeners can be safely used as small frequent doses (0.5 to 10 µg/kg) or as infusions (1-5 µg/kg/h)(2). EMLA is not an effective analgesic for heel lancing and the side effect of methemoglobinemia with repeated usage in preterms has not yet been adequately studied(3).

Umesh Kapil,
Vani Sethi,
Department of Human Nutrition,
All India Institute of Medical Sciences,
New Delhi 110 029, India.

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