Seema Kapoor,
Nitin Kapur,
Division of Genetics,
Department of Pediatrics,
Maulana Azad Medical College,
New Delhi 110 002, India.

Correspondence:
Dr. Seema Kapoor,
M-439, Guru Harkrishan Nagar,
Paschim Vihar,
New Delhi 110 087, India.
E-mail: seemam@vsnl.com

REFERENCES

1. Lin AE, Gorlin RJ, Lurie IW, Brunner HG, vander Burgt I, Naumchick IV *et al*. Further delineation of the Branchio-oculo-facial syndromes. Am J Med Genet 1995; 56: 42-59.
2. Bennacceur S, Buisson T, Bertolus C, Couly G. Branchio-oculo-facial syndrome with cleft lip and bilateral dermal thymus. Cleft Palate Craniofac J 1998; 35: 454-459.
3. Raveh E, Papsin BC, Forte V. Branchio-oculo-facial syndrome. Int J Pediatr Otorhinolaryngol 2000; 53: 149-156.
4. Fujimoto A, Lipson M, LacroRV, Sheno NW, Boetler WD, Jones KL, *et al*. New Autosomal domonant branchio-oculo-facial syndrome. Am J Med Genet 1987; 27: 943-951.
5. Correa-Cerro LS, Kennerknecht I, Just W, Vogel W, Muller D. The gene for branchio-oculo-facial syndrome does not colocalize to the EYA 1-4 genes. J Med Genet 2000; 37: 620-623.

Mumps-Need for Urgent Action

The epidemiology of mumps in India and the magnitude of the problem are still not fully appreciated, as pointed out by Dr. Jacob John(l). Mumps continues to occur in epidemic proportions, despite the availability of an effective vaccine. We present the data on mumps cases admitted to the Institute of Maternal and Child Health, Calicut, (North Kerala) during the five-year period from 1999 to 2003. Compilation of data was done as part of monitoring of epidemic and infectious diseases. Data sheets were filled every week and records maintained. This was done as part of the Prevention of Epidemic and Infectious Disease initiative. Children with mumps are usually admitted only when complications occur. Although the data does not give exact estimate of the disease burden in the community, it is a reflection of the magnitude of the problem. The diagnosis of mumps was made clinically on the basis of the presence of acute parotitis, unilateral or bilateral(l) .

There were 301 children admitted with mumps between 1999 and 2003. After a declining trend from 1999 to 2001 the number of cases increased. There were 92 admissions in 1999, 79 in 2000, 20 in 2001 and 55 in both 2002 and 2003.

The male female ratio was 2.2:1, with 208 boys (69%) and 93 (31%) girls. Majority of cases (58%) were in the 5-9 year age group. 85 children (28%) were in the 1-4 year age group and 39 (13%) were in the 10-12 year age group. There were two children below the age

of one year. Cases occurred throughout the year, though there was a significant decline every year from May to July.

The age profile of our subjects is similar to that from the epidemic reported from Thiruvananthapuram in South Kerala(l). The male preponderance can be explained by the fact that complications due to mumps occur more frequently in boys(2).

The data presented highlights the fact that mumps contributes significantly to morbidity in children. MMR vaccine is not included in the routine immunization schedule in Kerala and so majority of children do not receive MMR vaccine. The IAP has recommended inclusion of MMR vaccine in the immunization schedule(3). Our data suggests that this needs to be complied with urgently.

M.G. Geeta,
P. Krishna Kumar,
Department of Pediatrics,
Institute of Maternal and Child Health,
Medical College, Calicut,
North Kerala, India.
E-mail: krshnakumar@sancharnet.in

REFERENCES

1. John TJ. An outbreak of Mumps in Thiruvananthapuram District. Indian Pediatr 2004; 41: 298-300.
2. Maldonado Y. Mumps. *In:* Behrman RE, Kliegman RM, Jenson HB. Eds. Nelson Text Book of Pediatrics, 17th Ed. Philadelpha, Saunders 2004; pp l035 -1036.
3. Committee on Immunization, Indian Academy of Pediatrics. Update on immunization policies, guidelines and recommendations. Indian Pediatr 2004; 41: 239-244.

Indomethacin Prophylaxis for Intraventricular Hemorrhage in Very Low Birth Weight Babies

The article on indomethacin prophylaxis for intraventricular hemorrhage by Nair, *et al.* in the June 2004 issue of Indian Pediatrics has some serious statistical and methodological errors that need clarification(1).

The calculated sample size with the assumptions of the authors (15% to 5% reduction, alpha error 5% and beta error 85%) using Epi Info 6 yields a requirement of 180 subjects per limb, rather than 154 as stated.

The authors' calculation of post hoc power of the study after the interim analysis is also erroneous. The authors have to explain how they arrived, post hoc, at a figure of "70% power". Epi Info 6 program shows that to detect a 15% to 5% reduction in the key outcome, the interim sample size (n = 115) had a power of only 30%. To detect the difference in major IVH that was actually present in the study (10.7% vs 6.7%), as being significant with a 5% error, the interim sample size had a power as low as 6%. For the sub-group analyses where p value was <0.05, post hoc power calculation was anyway meaningless.

The relative risk calculation of IVH grade III and IV in the birth weight category of 750-999 g is faulty. Since RR is defined as the incidence among exposed divided by incidence among the unexposed, it works out to be 6/24 divided by 1/26 (*Table II*). This