be considered in obese children with low or undetectable leptin levels.

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REFERENCES

1. Dubey S, Kabra M, Bajpai A, Pandey RM, Hasan M, Gautam RK, *et al*. Serum leptin levels in obese Indian children relation to clinical and biochemical parameters. Indian Pediatr 2007; 44: 257-262.
2. Garcia-mayor RV, Andrade M, Rios M, Lage M, Dieguez C, Casanueva FF. Serum leptin levels in normal children: Relationship to age, gender, body mass index, pituitary-gonadal hormones and pubertal stage. J Clin Endocrinol Metab 1997; 82: 2849-2855.
3. Hassink SG, Sheslow DV, de Lancey E, Opentanova I, Considine RV, Caro JF. Serum leptin in children with obesity: relationship to gender and development. Pediatrics 1996; 98:201-203.

IPV - Doubts Persist

Despite sustained efforts by the entire medical community, elimination of wild polio virus from India remains an enigma. The introduction of injectable polio vaccine[IPV] in the fray leads to a number of doubts and altered approaches on our part.

The Policy Update [1] on IPV does not come a day too soon and would be of immense benefit as a guide to the practicing pediatrician. However certain lacunae still remain.

The committee mentions "the risk of Vaccine associated paralytic polio (VAPP)" associated with OPV is lower in India. The committee fails to quantify what "lower" implies. It needs to be carefully noted that the risk is lower and not non-existent. Furthermore even if the risk is lower per dose of OPV given, is the risk really lower per patient vaccinated. We should not just calculate the risk per dose of OPV but the risk per child, each of whom may receive a large number of OPV doses in his first few years of life. In that case the risk rises exponentially. Are we ethically justified in exposing any child to OPV before adequate coverage with IPV is achieved (minimum of two doses of IPV)?

It would be ideal to avoid any dose of OPV till the child has completed his primary IPV schedule and achieved adequate antibody titers and only then allow OPV administration. Would we as pediatricians be able to defend ourselves medicolegally if a child develops VAPP due to OPV when IPV is commercially available? Also, why does the booster at 18 months and 5 years continue to remain OPV. It should be replaced by IPV which is a superior vaccine.

Another query; as exposure to the wild virus reduces, is there a risk to the population over five years and and is there any role for an additional IPV dose at ten years of age?

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REFERENCES

1. Singhal T, Amdekar YK, Thacker N. IAP Committee on Immunization. Indian Pediatr 2007; 44: 390-392.
2. John TJ. Vaccine associated paralytic polio in India. Bull World Health Organ 2002; 80 : 917.