

Fluoride Dentifrices - The Right Age to Start!!!

I have read in "*Indian Pediatrics*" November 2002 issue that "Fluoridated toothpaste can be safely recommended to children above 6 years old." But, "*Indian Pediatrics*, April 2010 recommended that "toothbrushing of all dentate children should be performed with a fluoridated toothpaste." I want to know the exact time to start a fluoridated toothpaste in a child.

Tushar Kanti Ghosh

26, RBC Road, Kolkata 700 028,

West Bengal, India.

drtkghosh@yahoo.co.in

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REPLY

Use of fluoridated toothpastes is the most common method of reducing dental caries. Use of fluoridated toothpaste and toothbrush serves two important roles- (i) to deliver fluoride on the tooth surface (ii) mechanical action of toothbrush bristles clean the tooth surface.

Fluoridated toothpaste can be introduced at 3 years of age. Although fluoride ingestion is a concern

for this age group, during this time, most children develop the skills to expectorate toothpaste adequately. In children less than 3 years old, the fluoride ingested is upto 50% applied on the toothbrush, which is a cause of concern(1). Until the child learns to expectorate efficiently, it is important for parents to supervise their child's brushing. Other advocate the use of a smear of fluoridated toothpaste for children less than two years and a pea size amount for children 2-5 years(2). Few studies have documented the use of fluoride toothpastes in the form of smear in children less than 3 years old. But wide consensus for fluoride toothpastes use in this age group has not been achieved(2-4).

Preetika Chandna and Vivek K Adlakha

Subharti Dental College,

Meerut, UP, India.

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Transient Hyperglycemia in a H1N1 Positive Child on Oseltamivir

Complications of H1N1 infection include severe pneumonia, empyema, ARDS, seizures, encephalitis and myocarditis(1). We report a 11 year old female, diagnosed to have H1N1 infection by RT-PCR, in

whom a routine random blood sugar showed hyperglycemia (240 mg/dL). Child had high fasting (149,109,172 mg/dL) and postprandial blood sugar (258,160,192 mg/dL), respectively on day 1, 2 and 3 of testing. However, 4th day onwards, for three consecutive days, child had normal fasting and postprandial sugar. HbA1C was normal (6.3%) suggesting this was a transient hyperglycemia. Urine and serum ketones were negative on all 6 days. Urine Sugar was 1+ positive for the first 3 days when blood

sugar was high and negative once blood sugar normalized. Child was receiving oseltamivir only during the illness.

It is thought that influenza causes an increase in IL-6 levels which may lead to increased cortisol levels, followed by a pronounced dose-dependent increase in blood glucose. It is also postulated that systemic hypercytokinemia in influenza causes hyperglycemia and that the glucose levels reflect the degree of pathogenicity(2). Literature search revealed hyperglycemia as a complication associated with higher mortality in H5N1 cases(2) and in few critically ill children with influenza encephalopathy(3). Another speculation was whether the hyperglycemia was related to administration of oseltamivir, a complication of this drug, hitherto undescribed. However, only rare aggravation of pre-existing diabetes has been described with oseltamivir(4), and not transient hyperglycemia.

Rajesh Kulkarni and Aarti Kinikar,

*From Department of Pediatrics,
B J Medical College, Pune 411 001,
Maharashtra, India.
docrajesh75@yahoo.com*

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Antisnake Venom in a Neonate with Snake bite

We read with interest the case report by Jindal, *et al.*(1) describing the management of a 27 day old neonate with snakebite envenomation. Surprisingly, there is no mention of ptosis in this case report of severe neurotoxic ophitoxemia. The dose of 50 vials (500 mL) of ASV used will neutralize 300mg of cobra venom and 225mg of krait venom which is well beyond the capability of each snake to achieve in a bite. This is a clear case of unnecessary overuse of ASV. The endpoint of ASV administration is where the dose is sufficient to neutralize any unbound venom. Keeping the reversal of respiratory and neuromuscular paralysis as the end point and pumping in ASV to achieve it as done in this case is definitely not rational. Twenty vials is the maximum that can be given to a patient with neurotoxic snakebite envenomation. Larger doses of ASV over prolonged duration have no benefit in reversing envenomation(2,3). ASV dose has nothing to do with body size but only the amount of venom injected. There is no good evidence to suggest children should

receive either more ASV because of body mass or less in order to avoid adverse reactions(4). In summary, this case study can mislead peripheral doctors on the dose of ASV.

B Adhisivam,

*Department of Pediatrics, JIPM, Education and
Research (JIPMER), Pondicherry 605 006.
adhisivam1975@yahoo.co.uk*

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REPLY

The dose of ASV to be used in a neonatal snake bite