Author's Reply

Sir,

We appreciate Prof Sarin's query. Doing urodynamic studies in small children is a difficult undertaking and requiring a lot of patience and time but is feasible.

1. Double lumen (8F, Albyn Medical) urethral catheter wa first inserted using all antiseptic precautions and secured with adhesive plaster. The rectal probe (4.5F, MED 5400, UK) was then inserted into the distal stoma of children awaiting PSARP and into the neonaus of children who already had undergone PSARP and was also secured in the same way. About an hour before the examination they were given Trichlorfos syrup (50 mg/kg) single dose. All this was done on the urodynamic couch in the urodynamic room and after trichlorphos had been administered the child was left undisturbed till the beginning of the study.

In a quiet sleeping child, the first wincing or movement of legs was taken as first sensation. It is difficult to differentiate between volume fill for urgency and pain in children of smaller age group. We kept vigorous movement as the point of urgency and crying as a marker of volume for pain. Leak point was documented with observed leak.

Sometimes in a very agitated child the study had to be deferred or redone on a different date.

2. Two patients had radiological absence of only the last piece of sacrum with no external evidence of any marking sign and were fairly continent for age hence were included in the study.

3. Voiding cystourethrogram was not performed in the present study and findings of the same were not included in the protocol.

4. The possible reasons for deterioration of Neurovesical dysfunction in patients having undergone posterior sagittal anorectoplasty (PSARP) can only be hypothesized. The study was not intended to look at these factors but just to document objectively if at all there is any change following PSARP. (a) During PSARP sometimes the lower most portions of rectum (the region of the rectourinary fistula) is sacrificed which may ultimately have an effect on the mucosal receptors at the level of internal sphincter. These have been shown to play a part in the final continence mechanism and may have a modulatory role in the ultimate vesical function.[1,2,3]

(b) Other reports have also documented that cutting the sphincter muscle in the midline is associated with decrease in mean amplitude on EMG of external anal sphincter.[4]

5. The compliance rates of the parents diagnosed to have NVD was not assessed in the study.

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Note: The Editor regrets for the inordinate delay in publishing this Letter to the Editor.

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Correspondence

Antithymocyte Globulin and Cyclosporin in Children with Acquired Aplastic Anemia

Sir,

We read with interest the paper by Jagdish Chandra *et al*[1] as we have been using a combination of anti thymocyte globulin and cyclosporin in the treatment of acquired aplastic anemia at our centre. We have the following questions and comments about the paper:

1. The authors have used three different preparations of immunosuppressants in the study but have not

mentioned how many patients received each type of the drug. It is possible that more responders were in the groups which received Lymphoglobuline (Merieux, Lyon, France) or Atgam (Upjohn, USA) as compared to Thymogam group (Bharat Serum, India).

We have used Thymogam at a dose of 15 mg/kg/day for 5 days in 12 patients with either severe (7) or very severe aplastic anemia (5), of which only 2 (16%) have shown a partial response at 6 months. Both were in the severe aplastic anemia group.

2. Chromosomal breakage study was not carried out in 17 patients. It is known that mere absence of physical signs and absence of consanguinity does not rule out Fanconi anemia and the test should be carried out in all cases of aplastic anemia presenting in pediatric age group[2]. The treatment also differs in the two conditions.
3. It appears that methyl prednisolone was not given to all the children as the text mentions that "some children received methylprednisolone". The number of children who received methyl-prednisolone should have been mentioned.
4. What was the duration of cyclosporin therapy. It has been mentioned that "cyclosporin was continued at least until day 180". Was it less than 180 days in some patients.
5. Paroxysmal nocturnal hemoglobinuria has been reported in pediatric population with aplastic anemia and the patients should be screened for the same[3].
6. We feel that giving platelet transfusion at platelet count less than 5000/mm^3 was a very low level, as there is risk of severe bleeding manifestations especially in patients with aplastic anemia. The recommendations are to give prophylactic platelet transfusion when platelet count is < 10,000/mm^3 or <20,000/mm^3 in the presence of fever[4].

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Author's Reply

Sir,

We appreciate the interest shown in the article[1] . Inresponse to the comments we have following to offer:

1. Different response rates were observed with different preparation of ATG used. Nine children were treated with Lymphoglobuline, which we used in initial phase of study of which 2 achieved CR and 3 PR. Both children who received Atgam achieved partial remission . Only 2 of 9 children receiving Thymogam acheived PR. The only ATG preparation available in india at present are Atgam and Thymogam with huge cost difference. It is possible that different preparations have different biological equivalents. However, due to small numbers, it will be difficult to draw a definite conclusion.

2. It is well recognised that mere absence of physical findings dos not rule out Fanconi's anemia. We sgree that the treatment does differ in 2 Conditions. We already mentioned that it was done in later 6 patients of this cohort and it is now routinely done in all patients.

3. Six children were given methylprednisolonee. Addition of methylprednisolone did not give any advantage.

4. As mentioned in material and methods section cyclosporine was started on day 1 and continued at least until day 180[1] . None of the children receivedit for less than 6 months.

5. PNH is indeed very rare in children despite occasional case reports and thus children were not screened. Presence of PNH clone in aplastic aneamia suggests an improved outcome to immunosuppressive therapy in adults. The treatment, however, remains the same.

6. We are well aware of the cited guidelines. The cut off 5,000/mm^3 was used only for chronic clinically stable patients who did not have any bleeding