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E-Gastropedia

**Pediatric Gastroenterology
Issues in office practice**

Online Webinar

25th-26th March 2021

Organized by
Indian Academy of Pediatrics Delhi

Earnest request to all
DIAP Members
to become



CIAP Members
at the earliest,
if not already done.



Dr Lalit Mendiratta
President
IAP Delhi



Dr Manish Gupta
Secretary
IAP Delhi



Dr Pankaj Garg
Editor
Treasurer, IAP Delhi

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IAP Delhi Editor's Pen



Dr Pankaj Garg

Treasurer cum Secretary Elect.
IAP Delhi

Dear IAP Delhi Members & Friends,

I thank you all for appreciating the First Issue of E-Journal of Delhi Pediatrics. So many Members in Person and in Group applauded the vision of current Leadership of Delhi IAP under the able guidance of Dr Lalit Mendiratta for bringing monthly E-Journal of Delhi Pediatrics. to you.

Team Delhi IAP and the Editorial Board hereby present to you the February Edition of the E-Journal of Delhi and we have tried to do some innovations and maintained some important features as were in the previous edition.

The foremost purpose of the journal is to keep you updated about the new developments in the field of academics with minimum efforts. Keeping this in mind, we have articles which deal with the PALS Update and Vaccine hesitancy. We have started a new feature "Tip of the month" and in this issue this includes disorders of sexual differentiation. We will be "Peeping into heart" by focusing one congenital heart defect and this issue highlights ventricular septal defect. We have kept the articles short and in crisp format for easy reading. We have also continued with Journal Clippings in this issue. We have added one photo and Xray quiz and Crossword is there again. I request you to send the answers on the e mail of the Delhi Secretariat and we will be publishing names of all sending the correct answers of the quiz and the crossword in the next issue. We have also started a parent teaching oriented article on "Childhood Cancers" which solves the common questions frequently asked by the parents. Another new feature is "Prescription Writing" in which we wish to keep much focused prescription skill in a common disease and or infection and in this edition we have included enteric fever. We hope the readers enjoy these new features.

We have also included the calendar of events proposed for the year 2021 along with the activities done in the month of February along with the future planned events.

Life is not only academics but definitely much more than that. We have included a "Sport's Page" in which the activities done by the branch in the last month has been included. Another page has been dedicated to the creative writing by the members in form of poems or short stories. We have received lots of poems and short stories and Dr Deepak Gautam has reviewed them. We are including four in the current edition and the rest will be included in next edition. I hereby request all of you to send your articles for publication as well.

We have made many changes in the current edition and the editorial board is eagerly looking forward to get feedback from you all.

Happy reading,

Long Live IAP.

Jai Hind.

Dr Pankaj Garg

Treasurer cum Secretary Elect.,
IAP Delhi

IAP Delhi President's Pen



Dr Lalit Mendiratta

President
IAP Delhi

It gives me immense pleasure in writing a message for our second monthly issue of E journal of Delhi Pediatrics. It has been an eventful and busy journey since last month. We had a wonderful picnic organized for all IAP Delhi members. I always believe IAP is an Association first than an academy and all of us are part of one family. It was a great get together when around 150 family members met each other and has become historical as being first time in the history of IAP Delhi.

We also had wonderful academic sessions on Pneumonia and Typhoid fever apart from monthly clinical meeting held virtually.

We all are very excited about “Cyclathon” event being organized on 28th February which is again a first time in the history of IAP Delhi. The theme is cycling for Health and Happiness.

As per our commitment to society, we organized a health camp on 31st January at Children of the World and all children were examined by multiple specialists. Not only that but we are also doing our best for their other needs as requested by them.

I sincerely thank my team Dr Manish Gupta, Dr Pankaj Garg, Dr Deepak Gautam, Dr Anil Vaishnavi and all my CIAP executives, city branches executives and my office staff and all dear IAP members for the kind support and encouragement for doing all these activities.

Lastly my thanks to IAP Delhi team and city branches members who have helped so many of us for COVID-19 vaccination registration. I sincerely pray almighty for everyone for a good health.

Thanks

IAP Delhi Secretary's Pen



Dr Manish Gupta

Secretary
IAP Delhi

Hello Friends,

We congratulate you all the IAP Delhi Family for receiving the Best Branch State award in 1100-2000 category at Mumbai CIAP Pedicon on 6th February for 2020 activities of IAP Delhi. It is all due to efforts of Present and Past Office Bearers, Executive Board members and all IAP Delhi members that IAP Delhi could get recognition for the work done. Dr R K Nabh President, Dr Smita Mishra Secretary and Dr Manish Gupta Treasurer IAP Delhi 2020 could do full year activities which were well appreciated all over India.

This Second Digital Edition of Delhi Pediatrics E-Journal 2021 is now expanding the articles, IAP Delhi Past & Forthcoming activity reports do give all the happenings at IAP Delhi. I congratulate Dr Pankaj Garg Editor for his excellent works.

I request all the members to participate in all the IAP Delhi activities and enjoy the full benefits of the entire academic and non Academic activities of IAP Delhi.

I thank all my Office bearers and Executive Board members and all city branch OBs and EBs for their full co operation to all IAP Delhi activities

Do join us for E Dermapedia 2021 conference & CYCLATHON 2021.

Happy learnings to all

Thanks and Regards

Dr Manish Gupta

General Secretary, IAP Delhi

Section I : Academic

PALS 2020 Update



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The 2020 Guidelines are a comprehensive revision of the AHA's guidelines for pediatric and neonatal resuscitation based on new evidences. Recommendations for pediatric basic life support (PBLs) and CPR in infants, children, and adolescents have been combined with recommendations for pediatric advanced life support (PALS) in a single document in the 2020 guidelines. Following table summarises the key changes.

New Recommendations	2020	2010 / 2015	Reason for change
Changes to the Assisted Ventilation Rate: Rescue Breathing	PBLs-If palpable pulse present but absent or inadequate respiratory effort then give 1 breath every 2-3 sec (20-30 breaths/min)	PBLs- Rescue breaths at a rate of about 12 to 20/ min (1 breath every 3-5 sec) until spontaneous breathing resumes	
Changes to the Assisted Ventilation Rate: Ventilation Rate During CPR With an Advanced Airway	PALS-When performing CPR in infants and children with an advanced airway, it may be reasonable to target a respiratory rate range of 1 breath every 2-3 seconds (20-30/min), accounting for age and clinical condition. Rates exceeding these recommendations may compromise hemodynamics	PALS- If the infant or child is intubated, ventilate at a rate of about 1 breath every 6 seconds (10/min) without interrupting chest compressions	Higher ventilation rates (at least 30/min in infants younger than 1 year and at least 25/min in children) are associated with improved rates of ROSC and survival in pediatric IHCA

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Section I : Academic

Section I : Academic: *PALS 2020 Update* Continued...

Cuffed ETTs	It is reasonable to choose cuffed ETTs for intubating infants and children with due attention to ETT size, position, and cuff inflation pressure (usually <20-25cmH20)	Both cuffed and uncuffed ETTs are acceptable but in certain conditions (eg, poor lung compliance, high airway resistance) a cuffed ETT may be preferable	Cuffed ETTs reduce the need for reintubation with reduced risk of aspiration. Subglottic stenosis is also rare if careful technique is followed
Cricoid Pressure During Intubation	Routine use of cricoid pressure is not recommended during endotracheal intubation	There is insufficient evidence to recommend routine application of cricoid pressure	Studies have not shown any benefit of using cricoid pressure. It also interferes with ventilation and the speed of intubation
Emphasis on Early Epinephrine Administration	In pediatric cardiac arrest, epinephrine should be given within 5 minutes from the start of chest compressions.	It is reasonable to administer epinephrine in pediatric cardiac arrest	Both IHCA and OHCA have shown better outcomes when epinephrine was administered early within 5 min particularly when the rhythm is non-shockable
Invasive Blood Pressure Monitoring to Assess CPR Quality	For patients with continuous invasive arterial blood pressure monitoring in place at the time of cardiac arrest, it is reasonable for providers to use diastolic blood pressure to assess CPR quality	For patients with invasive hemodynamic monitoring in place at the time of cardiac arrest, it may be reasonable for rescuers to use blood pressure to guide CPR quality.	Good neurologic outcome was seen when diastolic blood pressure was at least 25 mm Hg in infants and at least 30 mm Hg in children
Detecting and Treating Seizures After ROSC	When resources are available, continuous EEG monitoring is recommended for the detection of seizures following cardiac arrest in patients with persistent encephalopathy. Clinical seizures and nonconvulsive status epilepticus (NCSE) need to be treated	An EEG should be promptly performed, interpreted and monitored frequently or continuously in comatose patients after ROSC	Both convulsive and non-convulsive status epilepticus are associated with poor outcome, and treatment of status epilepticus is beneficial in general
Evaluation and Support for Cardiac Arrest Survivors	It is recommended that pediatric cardiac arrest survivors be evaluated for rehabilitation services and referred for neurologic evaluation for at least the first year after cardiac arrest	No recommendation	The recovery from cardiac arrest continues long after the initial hospitalization and the survivors require integrated medical, rehabilitative care with community support to achieve the best possible long-term outcome

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Section I : Academic: *PALS 2020 Update* Continued...

Septic Shock	It is reasonable to administer fluid in 10 mL/kg or 20 mL/kg aliquots with frequent reassessment	Initial fluid bolus of 20 mL/kg to infants and children with shock is reasonable, including those with conditions such as severe sepsis, severe malaria, and dengue.	Unwarranted and liberal fluid bolus can cause fluid overload which has been shown to increase mortality in septic shock patients, so the current recommendations are for conservative fluid use with frequent reassessment and monitoring for fluid overload.
Corticosteroid Administration	For septic shock unresponsive to fluids and requiring vasoactive support, it may be reasonable to consider stress-dose corticosteroids.	No recommendation	Corticosteroid administration shows some benefit in some patients with refractory septic shock.
Hemorrhagic Shock	In hypotensive hemorrhagic shock following trauma, it is reasonable to administer blood products, when available, instead of crystalloid for ongoing volume resuscitation.	Previous versions of the guidelines did not differentiate the treatment of hemorrhagic shock from other causes of hypovolemic shock	Balanced blood component resuscitation using PRBC, FFP and platelets (1:1:1) has shown benefits in trauma patients
Opioid Overdose	For patients in respiratory arrest, rescue breathing or bag-mask ventilation should be maintained until spontaneous breathing returns, and administer intramuscular or intranasal naloxone if spontaneous breathing does not reappear	Empiric administration of intramuscular or intranasal naloxone to all unresponsive opioid-associated life-threatening respiratory depression and supporting respiration with bag-mask till spontaneous breathing returns. No recommendation of naloxone in opioid-associated cardiac arrest.	Naloxone can be administered by trained providers, laypersons with focused training, and untrained laypersons
Myocarditis	For children with myocarditis or cardiomyopathy and refractory low cardiac output, prearrest use of ECLS or mechanical circulatory support can be beneficial to provide end-organ support and prevent cardiac arrest. Early post arrest extracorporeal CPR should be considered	No recommendation	Myocarditis causes significant pediatric mortality hence new recommendations have focussed on its management

Section I : Academic

Section I : Academic: *PALS 2020 Update* Continued...

Pulmonary Hypertension	Inhaled nitric oxide or prostacyclin should be used as the initial therapy to treat pulmonary hypertensive crises or acute right-sided heart failure. Provide adequate analgesics, sedatives, and neuromuscular blocking agents. Oxygen and induction of alkalosis through hyperventilation or alkali administration is useful. ECLS to be considered who are refractory to above measures	Consider administering inhaled nitric oxide or aerosolized prostacyclin or analogue to reduce pulmonary vascular resistance.	Previous PALS guidelines did not provide recommendations for managing pulmonary hypertension in infants and children. These new recommendations are consistent with guidelines on pediatric pulmonary hypertension published by the AHA and the American Thoracic Society in 2015
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Additional Updates in 2020 PALS

- 1 A separate OHCA Chain of Survival has been created to distinguish the differences between OHCA and IHCA.
- 2 In both the OHCA and IHCA chains, a sixth link has been added to stress the importance of recovery, which focuses on short- and long-term treatment evaluation, and support for survivors and their families.
3. The Pediatric Cardiac Arrest Algorithm, Pediatric Bradycardia with a pulse algorithm and the Pediatric Tachycardia with a pulse algorithm have been updated.
4. Two new Opioid-Associated Emergency algorithms have been added for lay rescuers and trained rescuers.
- 5 A new checklist is provided for pediatric post-cardiac arrest.

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Section I : Academic

Vaccine Hesitancy



Dr Vipul Jain

MD Pediatrics,
Fellow Afro-ADVAC

Even though the term “**Vaccine Hesitancy**” was coined in 2012 by the **WHO Strategic Advisory Group of Experts (SAGE)**, this behavior trait is as old as vaccine itself!

Vaccine Hesitancy refers to delay in acceptance or refusal of a vaccine despite being widely available. It is a common, but complex behavior. Vaccine hesitancy is context-specific and varies from place to place, different at different times, and different with different vaccines. That’s why it is more of vaccine hesitancy and not vaccination hesitancy, though the behavior broadly affects the complete vaccination.

Trust in Vaccines

Lack of trust or confidence in a vaccine is the major reason behind vaccine hesitancy. It includes concerns about the safety of the vaccine, trust in the health care delivery system, and trust in approval authorities. Alexandre de Figueiredo et al mapped the vaccine confidence across 149 countries from 2015-19 and quoted that confidence in the importance of vaccines (rather than in their safety or effectiveness) had the strongest univariate association with vaccine uptake.

Refusal of Vaccines

Universally, acceptance of vaccines is the norm in the majority of the populations, barring a small number who refuse all over the world. The most common cause of refusal of a vaccine is lack of information or miss information (**myths**) about the vaccine or the disease it prevents with the second important cause being religious reasons.

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Section I : Academic: *Vaccine Hesitancy* Continued...

Disease prevalence, vaccine availability and hesitancy

Though there is no direct correlation between vaccine availability or disease prevalence with vaccine hesitancy, they do affect vaccine acceptance.

The Covid-19 epidemic provides us a classic example of vaccine hesitancy. When the disease was spreading like wild-fire everyone wanted to know when the vaccine would be available. The much anticipated roll-out of the vaccine though was met with a lot of doubt and skepticism as the Covid numbers had started dwindling rapidly! From its status of being “most sought after” to “take with caution” and “is it really required?” took just a couple of weeks. As the perceived risk of infection is low people tend to hesitate in taking the vaccine.

On the other hand, we have an example of demand-driven vaccination from none other than Uttar Pradesh, where vaccine acceptance, in general, is not great. The community demanded through the courts using public interest litigation, access to the Japanese encephalitis vaccine and succeeded.

Three “C” model of vaccine hesitancy

Vaccine hesitancy is complex and it is difficult to understand its determinants.

The WHO EURO vaccine communication working group has highlighted three determinants of vaccine hesitancy:

1. Confidence

- a. The effectiveness and safety of the vaccine.
- b. The system to deliver the vaccine, including health services and professionals.
- c. The motivation of policymakers, or political will to administer the vaccine.

2. Complacency

- a. Where disease prevalence is low, vaccination is not supposed to be necessary.
- b. Timing of carrying out vaccination drives.
- c. Perception and ability of individuals to understand the need for vaccines.

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Section I : Academic: *Vaccine Hesitancy* Continued...

3. Convenience

- a. Physical availability.
- b. Affordability and willingness to pay if vaccines are paid.
- c. The geographical location of vaccination centers.
- d. Language and literature used to promote the vaccine.
- e. Time and place in relation to cultural context. Vaccination drives during festivals have poor acceptance.

Role of media and communication in vaccine acceptance

In this media-driven era, it becomes very important to monitor and regulate how the media takes up the news on vaccine development and distribution to the public. The slightest of doubts created by the media, whether real or imagined, may create a fallacious impression in the public and become a very important factor leading to rejection or acceptance of a vaccine.

Myths leading to Covid vaccine hesitancy

1 Vaccines cause infertility.

There is no evidence of infertility or any affect on the reproductive system. There is no vaccine to date that can cause infertility.

2 Vaccines can change DNA.

This rumor has been doing the rounds ever since two mRNA vaccines have been developed for Covid-19. There is no way that vaccine mRNA can change the DNA of our human cells. mRNA is the instruction to the body to make a protein. Conventionally, most vaccines are developed by actually giving a protein or giving a small, tiny component of the germ that we're trying to vaccinate against. This is a new approach where instead of giving that tiny little part, we just give the instruction to our own bodies via mRNA, to make that tiny little part, and then our natural immune system takes care of the rest.

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Section I : Academic: *Vaccine Hesitancy* Continued...

3 Vaccines contain unsafe toxins.

All the components that go into vaccines are extensively tested to make sure that everything that is in there, at the dose that is in there, is safe for humans. But one can be hypersensitive to any specific component of a vaccine. The risk of being hypersensitive to any component cannot be generalized and cannot be predicted.

4 The Covid-19 vaccines aren't safe because they were developed quickly

COVID-19 is similar to other coronaviruses we've seen in humans in the past, like MERS and SARS, so there was previous research that could be used to speed up the process. Safety was not compromised in any way. What happened quickly was formulating the vaccine to test and the approvals required for such testing. Safety was not compromised in any way.

5 I've already had COVID-19, so I don't need to get vaccinated

There is preliminary evidence that the vaccine offers better, more robust, and longer-lasting protection than the natural infection with the virus.

6 People with underlying conditions shouldn't get vaccinated

People who have underlying conditions like diabetes and heart disease are at higher risk of getting complications from COVID-19, so it is even more important they get vaccinated. The risk of being hypersensitive or allergic to any of the components is the same in these underlying conditions as in the general population.

7 People with suppressed immune systems shouldn't get vaccinated.

People with suppressed immune systems (like from cancer treatments or autoimmune diseases) should definitely get vaccinated as they are more affected by the disease in general. Immunosuppressed individuals need not worry as the vaccine will not hurt them as it does not contain a live virus. On the other hand, it is possible that immunosuppressed

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individuals might not get as much protection as those with healthy immune systems. But that should not deter them from taking the vaccine. The risk of being hypersensitive or allergic to any of the components in immunosuppressed individuals is the same as the general population.

8 Those individuals on blood thinners should not take the vaccine

Being on a blood thinner or having thrombocytopenia is not a contraindication to take the vaccine. The 0.5 ml or 0.3 ml deep intramuscular vaccine usually does not lead to bleeding in subjects who are on blood thinners. Nevertheless, slight compression of the vaccine site for a few minutes would suffice if one has a bleeding tendency.

Conclusion

Several factors contribute to modern vaccine hesitancy, including the layperson's self-discovery of information via social media. It is difficult for them to balance risks and benefits of the vaccine rationally when it comes to finding information on the internet. It is the duty of medical professionals and policymakers to adopt a variety of practices to combat prevalent vaccine hesitancy, including measures to educate patients, fellow clinicians, and the public. Helpful strategies may include using every visit to educate about the benefits of vaccination; the formulation of clear standing orders or nursing protocols to prevent vaccination errors; drafting and adopting clear, evidence based, unambiguous recommendations.

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Section I : Academic

PRESCRIPTION WRITING FOR CHILDREN WITH ENTERIC FEVER



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Suspicion:

1. Persistent fever in a child beyond 4th to 7th day and increasingly high grade progressively instead of subsiding. Antipyretics are partially effective.
2. Pain abdomen, vomiting with diarrhea or constipation may also be present

Investigations:

1. Hemoglobin, Total leucocyte count, Differential count: leucocyte counts are likely to be normal or lower part of the range.
2. Blood culture with sensitivity of 40 to 60 % in first week must be done in all
3. Typhi dot IgM may be done in first week as it is positive from 3rd day onwards and the positivity decreases day 8 onwards. There are false positive cases and should be interpreted accordingly.
4. Serum Widal test: not a very reliable test. May be of help if done by tube method in week 2. Titer of O antigen 1:100 or more and H antigen 1: 200 or more are considered suggestive. Paired samples at a gap of 1-2 weeks showing fourfold rise is considered more reliable.

Treatment:

1. Once diagnosis of enteric fever is confirmed most patients can be managed well on OPD treatment.

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Section I : Academic: *Prescription Writing For Children With Enteric Fever* Continued...

2. Drug of choice will be Cefixime at 8 mg/kg/dose 12 hourly with maximum dose of 400 mg for 14 days or 5 to 7 days post defervescence.
3. Alternative option is to use Azithromycin at a dose of 5 to 10 mg/kg/dose 12 hrly with maximum dose of 500 mg for 14 days or 5 to 7 days post defervescence.
4. Indications of Hospitalization: Patients with persistent vomiting, inability to take oral feed, severe diarrhea and abdominal distension will require parenteral antibiotic therapy preferably in a hospital. Drug of choice will be Ceftriaxone 50-75 mg/kg/day preferably divided in two doses for 14 days with maximum single dose of 1.5 gm-2 gm. Once child stabilises, is afebrile and starts taking orally, we can complete the treatment with oral cefixime as above.

Supportive Measures:

General supportive measures like use of antipyretics, maintenance of hydration, appropriate nutrition and prompt recognition and treatment of complications are extremely important for a favourable outcome. The child should continue to have normal diet and no food should be restricted.

Adjunctive Corticosteroids for Severe Infection:

with suspected or known enteric fever & severe systemic illness (delirium, obtundation, stupor, coma or shock), dexamethasone (3 mg/kg followed by 1 mg/kg every 6 hours for a total of 48 hours).

Surgical Intervention for Ileal Perforation:

Prompt surgical intervention is usually indicated, as is broader antimicrobial coverage to cover peritonitis and potential secondary bacteremia with enteric organisms. The extent of surgical intervention remains controversial; the best surgical procedure appears to be segmental resection of the involved intestine, when possible.

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Section I : Academic: *Prescription Writing For Children With Enteric Fever* Continued...

Follow Up:

Successful treatment in uncomplicated cases usually results in clinical improvement within three to five days. In most clinical trials, the mean time to defervescence is four to six days, so persistent fever of this duration following treatment initiation do not imply therapeutic failure. Patients should be subsequently monitored for or instructed to report recurrent symptoms, which could reflect relapse.

Relapse:

Relapse of enteric fever after clinical cure can occur in immunocompetent individuals; in such cases, it typically occurs two to three weeks after resolution of fever.

Prognosis:

Effective antibiotic therapy has dramatically impacted the outcomes of enteric fever. In the pre-antibiotic era, mortality rates were 15 percent or greater and survivors experienced a prolonged illness lasting weeks, with months of subsequent debilitation. Approximately 10 percent of untreated patients relapsed and up to 4 percent become chronic carriers of the organism.

Among those receiving medical care in the post-antibiotic era, the average mortality rate from enteric fever is estimated to be less than 1 percent.

Prevention of Enteric Fever:

The disease does not give a good lasting immunity and all children post recovery after 2 to 3 weeks of completing antibiotic therapy must be given conjugated typhoid vaccines to prevent future episodes.

Section I : Academic

PEEPING INTO HEART: VENTRICULAR SEPTAL DEFECT



Dr Neeraj Aggarwal



Dr Mridul Aggarwal



Dr Reena Joshi



Dr Raja Joshi

Department of Pediatric Cardiac Sciences
Sir Ganga Ram Hospital, New Delhi

DIAGNOSIS OF VSD

Clinical features
Small VSD:
asymptomatic, systolic thrill, PSM at LLSB
Large VSD:
FTT, CHF, precordial bulge, hyperdynamic precordium, ESM at LUSB, MDM at apex

CXR
Small VSD: normal
Moderate - large VSD: cardiomegaly, ↑pulmonary vascularity
Large VSD with ↑PVR: absence of cardiomegaly, prominent PA segment, dilated central PAs, and ↓pulmonary vascularity

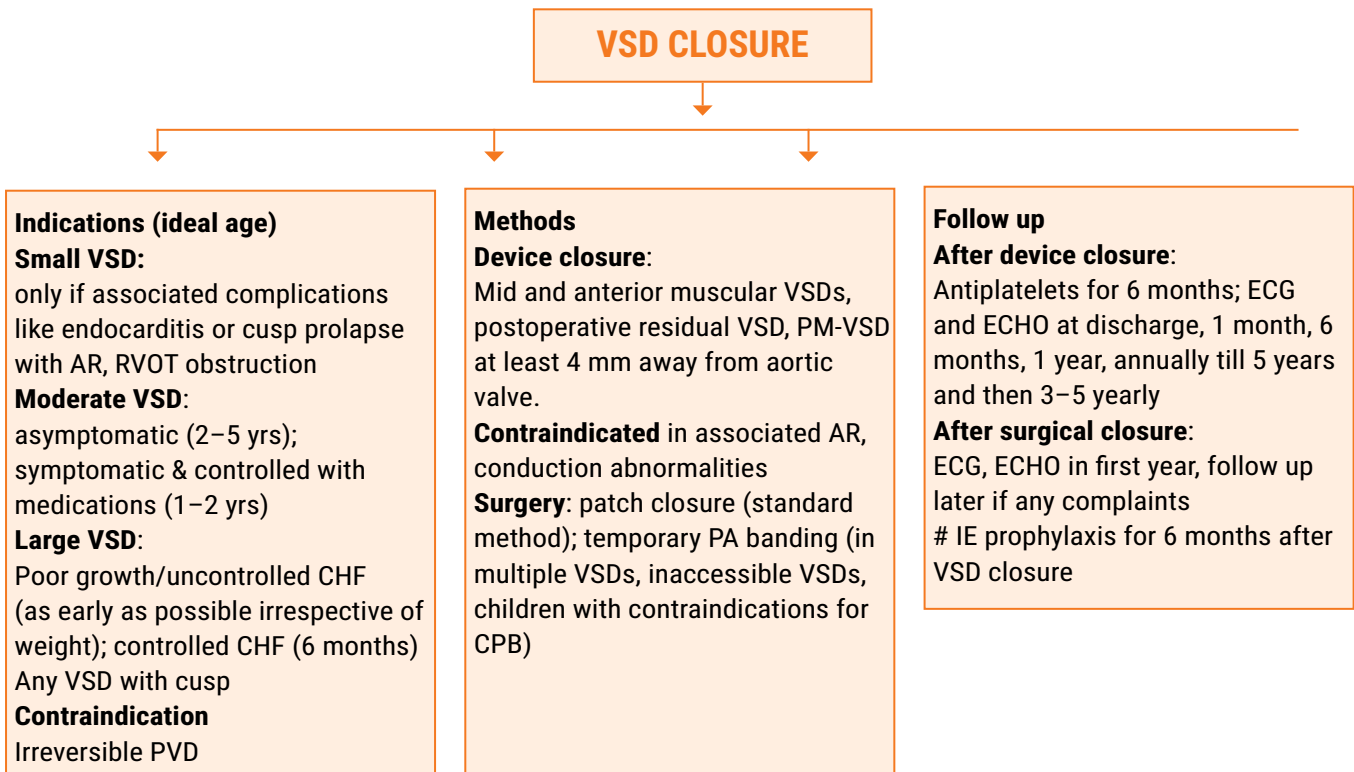
ECG
Small VSD: normal
Moderate VSD: LVH^a and LAE^b
Large VSD: BVH^c
Large VSD with ↑PVR: RVH with RAD

ECHO
To assess:
Size, number
Location
Relation to valves,
PA pressure,
Associated lesions

Cardiac catheteri-zation
Only In cases of suspected PVD

Section I : Academic

Section I : Academic: *Prescription Writing For Children With Enteric Fever* Continued...



(AR-aortic regurgitation, BVH-biventricular hypertrophy, CPB-cardiopulmonary bypass, CHF-congestive heart failure, ESM-ejection systolic murmur, FTT-failure to thrive, IE-infective endocarditis, LAE-left atrial enlargement, LLSB-lower left sternal border, LUSB-left upper sternal border, LVH-left ventricular hypertrophy, MDM-mid diastolic murmur, PA-pulmonary artery, PM-VSD-perimembranous VSD, PSM-pansystolic murmur, PVD-pulmonary vascular disease, PVR-pulmonary vascular resistance, RAD-right axis deviation, RVH-right ventricular hypertrophy, RVOT-right ventricular outflow tract)

^atall R waves and tall peaked T waves in inferior (II, III, aVF) and lateral leads (V5–V6) with prominent q waves in V5–V6

^bbroad notched P waves in leads I and II, with a broad deep P terminal force in lead V1

^clarge equidiphasic RS complexes (Katz-Wachtel pattern) in mid-precordial leads

Section I : Academic

TIP OF THE MONTH



Dr Ravindra Kumar

I/C Pediatric &
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Hindu Rao Hospital, Delhi

- The “Idealized” male infant defined as one with a penile size between 2.5 and 4.5 cm in length, normal position of the urethral meatus, testes in the scrotum and an XY karyotype.
- The “Idealized” female infant had a clitoris ranging in size 0.2–0.85 cm, a normal female reproductive tract and an XX karyotype.
- **Micropenis**-- Stretched phallic length < 1.9 cm
- **Clitoromegaly**-- > 1cm clitoris length

*Brook C, Clayton P, Brown R, Brook's Clinical

*Pediatric Endocrinology, 7th edition
west sussex, Blackwell Publishing; 2020

- Newborn problems that merit disorders of sex development (DSD) investigation.
 - 1 **Ambiguous genitalia**
 - 2 **Apparent female genitalia with:**
 - a Enlarged clitoris
 - b Posterior labial fusion
 - c Inguinal/labial mass
 - 3 **Apparent male genitalia with:**
 - a A Penis with B/L Non-palpable testes
 - b Isolated perineoscrotal hypospadias
 - c Severe hypospadias, undescended testes, micropenis
 - 4 Genital anomalies associated with **syndromes**
 - 5 **Family history of DSD, such as complete androgen insensitivity syndrome (CAIS)**
 - 6 **Discordance between genital appearance and prenatal karyotype**

Parents Guide on Childhood Cancer



Dr Manas Kalra

Pediatric Hematologist
Oncologist & BMT Physician
Sir Ganga Ram Hospital
New Delhi

The prevalence of cancer is increasing by the day. The common man exclaims- Is it even possible for a child to develop cancer? Yes it is!! Whereas the need for creating awareness is increasing by the day, so is the need to improve quality care and rehabilitation of these children in society. WHO has announced a Global Initiative in 2018 to spread awareness and achieve at least a 60% survival rate for children with cancer by 2030.

Here we will highlight some of the common questions asked by parents and their answers:

1 What is cancer and how does a patient get it?

Cancer is an uncontrolled growth of cells. These cells grow very fast and can spread from one part of body to the other. There is no specific cause for cancer. It usually happens due to aberration in cell machinery which can not check the uncontrolled division of cells. Sometimes cancer occurs because of infection (hepatitis B, C or HIV), environmental factors (pollution or chemicals), genetic reasons or habits like smoking, chewing tobacco or alcohol.

2 Do children get cancers? How many children in India suffer from cancer every year?

Approximately 50,000 children suffer from cancer every year in India. Unfortunately not even half of these are able to access cancer care. Many are not even diagnosed to have cancer before they succumb to their illnesses. There are many barriers to getting quality cancer care in India - delay in access of primary care, lack of knowledge of common childhood cancers among primary care physicians, referral pathways, distance from home to

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Section I : Academic

Section I : Academic: *Parents Guide on Childhood Cancer* Continued...

cancer centre, financial burden, lack of cancer care centres and trained personnel managing childhood cancer. After the diagnosis is made, lack of expert cancer care physicians, pathologists and hematologists, surgeons and radiation/ blood bank/ ICU facility further hinder the care of these patients especially in tier 2 cities. Most metropolitan cities in India are now well equipped with doctors, nurses and physicians to manage children with cancer.

3 What are the common cancers in children and what are their symptoms?

Common childhood cancers are blood cancers, lymphomas and brain tumors. Solid tumors include wilm's tumor, neuroblastoma, bone tumors and retinoblastoma constitute the other major chunk of childhood cancers.

One should suspect cancer if fever persists beyond 1-2 weeks and after all the basic tests for infections and common illnesses have come out to be negative. Often these children are treated for typhoid or TB without adequate evidence. Other common symptoms are bone pains and lump felt anywhere in the body - commonly in the belly, neck or bones. These lumps are generally painless and keep growing in size. Some children present with back pain, paleness of skin, bruises, unexplained weight loss, recent onset of squint, white reflex in the pupil or protrusion of eyes. Brain tumors can present with recurrent headaches, vomiting or disturbance in balance and gait.

4 How is the outcome of childhood cancer?

Most childhood cancers are curable. Those children who present very late often have advanced and metastatic disease and it is difficult to cure them. Blood cancer- Acute lymphoblastic leukemia- the commonest cancer in children can be cured in 80% of the cases with modern chemotherapy which lasts a period of 2-2.5 years. Some cancers like Hodgkin lymphoma and wilms' tumor can be cured in 90% of the cases if the disease is picked early. Isn't this even better than diabetes and hypertension for which there is no cure yet?

Some children relapse during or after completion of therapy. Most don't. Those who do, are managed with either very aggressive therapy or best supportive care.

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Section I : Academic

Section I : Academic: *Parents Guide on Childhood Cancer* Continued...

5 What are the side effects of treatment? What do you mean by chemotherapy? Is it painful?

Drugs that kill cancer are called chemotherapy. While killing cancer cells they kill a few normal cells also. Normal cells have the ability to recover. Nausea- vomiting, hair loss, mouth ulcers, skin and nail changes, fever, drop in hemoglobin or platelets are common side effects. Most of these side effects are temporary. Chemotherapy is not painful. Most often, it is given as an intravenous drip mixed in saline or as an oral medication. Treatment for childhood cancer is challenging but children are very resilient and recover quite soon. Most childhood cancers are cured and many children live an almost normal life after completion of therapy. Late effects of cancer treatment are more common after treatment of brain and bone tumors. With newer technologies of radiation, non-mutilating surgeries and advances such as targeted therapy/ immunotherapy, even these late effects are being minimised.

6 What are the common restrictions for children undergoing cancer care?

They should avoid crowded places like cinema halls and malls. They are not allowed to eat food from outside of home. Hygiene is of paramount importance. They should avoid contact with people suffering from infections like cold, diarrhoea, rash etc. Vaccination is withheld during chemotherapy and restarted after completion of therapy. They are advised to take healthy home cooked food and do gentle exercises. Children are encouraged to indulge in indoor activities and continuation of studies once intensive phase of therapy is complete.

7 What is your message to parents who are going through cancer treatment for their children?

Parents, siblings, extended family, friends, doctors and nurses- the child is dependent on all of us for his/her survival. We need to work cohesively with positivity and determination, and hope for the best. Cure of cancer is possible. Despite all odds, you will surely find a way. Once you choose hope, anything's possible. I always tell my patients that- there surely is light at the end of the tunnel!

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Section I : Academic

Use of Oxygen as a Drug in Pediatric Practice



Dr Richa Singh

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Sr Consultant- Pediatrics



Dr Sankalp Dudeja

Consultant Neonatologist &
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Oxygen is one of the most commonly used therapeutic agents. It is an effective, essential and often a life-saving drug for newborn and children. However, recent research has demonstrated that even short exposures to oxygen can lead to oxidant stress and may adversely affect short and long term outcomes. The use of oxygen, thus, has a risk-to-benefit equation just as for any other drug. Therefore, a balanced perspective of the scientific and clinical aspects of oxygen use in pediatric practice is needed, especially for those who have a poor antioxidant reserve like a preterm newborn.

Physiological & Pathological effects of Oxygen Therapy

- **Effects on Ventilation**

The most common indication of giving oxygen therapy is hypoxia. The supplemental oxygen reaches the alveoli and blood and causes increase in the arterial paO_2 . Oxygen therapy causes dilation of pulmonary arterioles and capillaries which further increases the delivered oxygen and thereby, paO_2 and spO_2 .

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Section I : Academic

Section I : Academic: *Use of Oxygen as a Drug in Pediatric Practice*1 Continued...

- **Hemodynamic Effects**

Oxygen therapy causes causes systemic peripheral vasoconstriction, thereby causing a temporary increase in blood pressure. This transient change is rapidly counter-balanced by reduction in heart rate and cardiac output. The unique combination of hyperoxia-induced vasoconstriction and high blood oxygen tension caused by oxygen therapy, affords an advantage by decreasing the vasogenic component of tissue edema and is, therefore, considered beneficial in sepsis, crush injury and compartment syndrome as well as cerebral edema.

- **Oxygen Toxicity, Reactive Oxygen Species(ROS) and CNS insult**

The major limitation in a liberal clinical use of oxygen therapy is its potential toxicity and the relatively narrow margin of safety that exists between its effective and toxic doses. Excessive oxygen exposure causes production of ROS, which can cause insult to almost every body organ. Among the affected organs, the brain has been the most extensively studied. In newborns and children, the control of cerebral perfusion is less tightly regulated, increasing their vulnerability to oxidative stress. Exposure to ROS leads to neuronal excitotoxicity via effects on calcium flux. It has been seen that exposure to hyperoxia induces apoptosis in the oligodendroglial cells of the brain.

Oxygen use in various clinical scenarios

- **Oxygen use in Bronchiolitis**

Bronchiolitis in infants is generally managed conservatively. Oxygen is generally administered when there is cyanosis, moderate or severe respiratory distress, or hypoxemia as indicated by pulse oximetry. Most guidelines suggest giving supplemental oxygen when the spO₂ is 92% or below. Giving oxygen through Heated humidified high flow nasal cannula (HHHFNC) is often beneficial for infants with moderate/ severe respiratory distress as it reduces work of breathing by causing dead space wash-out. It has been seen that among infants with bronchiolitis, those who receive oxygen therapy through HHHFNC have significantly lower rates of escalation of care due to treatment failure than those who receive standard oxygen therapy.

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Section I : Academic: *Use of Oxygen as a Drug in Pediatric Practice*1 Continued...

- **Childhood Pneumonia and Oxygen Treatment**

Childhood pneumonia is a leading cause of morbidity and mortality in under-five children, especially in developing countries. It is a major cause of hospital admission and death being responsible for approximately one out of every five deaths among under-five children globally. One major contributor of mortality in pneumonia is hypoxemia. Airflow obstruction from respiratory tract secretions, respiratory muscle fatigue as well as reduced central respiratory centre response to hypoxia and hypercarbia contributes to the hypoxemia in pneumonia. Most guidelines suggest that lower limits of acceptable spO_2 in children with pneumonia is 92%, similar to bronchiolitis. However, all children admitted for pneumonia who are cyanosed and/or have grunting respiration should in addition to antibiotics be promptly commenced on oxygen therapy, if there are no means of confirming hypoxemia.

- **Oxygen Therapy in Newborns**

Respiratory distress at birth is a very common problem in both term and preterm newborns. The common causes are Hyaline membrane disease, transient tachypnea of newborn, pneumonia and meconium aspiration syndrome. Newborns with respiratory distress often need a respiratory support- Supplemental oxygen through head box & nasal prongs, HHHFNC, CPAP or mechanical ventilation- based on their degree of prematurity and severity of respiratory distress. In newborns with respiratory distress, oxygen is often life-saving. However, exposure to oxygen is associated with increased risk of many diseases particularly retinopathy of prematurity (ROP) and bronchopulmonary dysplasia (BPD).

Retinopathy of Prematurity

In 1954, Ashton and Cook were the first to establish that oxygen is important in disrupting retinal blood vessel development. The relation between hyperoxia, low-gestational age, growth retardation, oxygen dependent growth factors, and oxidative stress are now being understood more clearly. We know that in the first phase of retinopathy of prematurity, hyperoxia inhibits vascular endothelial growth factor. In the second phase, there is a rebound increase in vascular endothelial growth factor and when it reaches a threshold around 32 to 34 weeks postconceptional age, uncontrolled neovascularization may occur. It is known that by strictly avoiding hyperoxia, that is, $SaO_2 > 94-95\%$ & avoiding fluctuations in SaO_2 , it is possible to control and prevent severe retinopathy of prematurity in most cases.

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Section I : Academic: *Use of Oxygen as a Drug in Pediatric Practice*1 Continued...

Bronchopulmonary Dysplasia

Bronchopulmonary dysplasia (BPD) is the major cause of pulmonary disease in newborns. The pathophysiology and management of BPD has changed with the improvement of neonatal intensive care unit (NICU) management and with the increase of survival rates. Despite the improvements made, BPD is still a major problem, resulting in frequent hospital admissions, impaired weight and height growth and neurodevelopmental disorders. BPD is a result of lung injury due to multiple etiologic factors – genetic, metabolic, nutritional, mechanical and infectious – which act in a cumulative and synergic way. Exposure to ROS is largely recognized as one of the major causes of lung damage. ROS is the final common endpoint for a complex convergence of events, some genetically determined and some triggered by infection and other stressors. Individualized interventions to support ventilation, minimize oxygen exposure and encourage growth decreases both the frequency and severity of BPD. Future perspectives suggest supplementation with enzymatic and/or non-enzymatic antioxidants. The use of antioxidants in preterm newborns particularly exposed to ROS and at risk for BPD represents a logical strategy to ameliorate ROS injury, but further studies are needed to support this hypothesis.

Conclusion

Undoubtedly, oxygen therapy is an important tool and has saved many lives and improved others. However, oxygen therapy risk, cost, and benefits should be considered in the same way as other drugs and titrated to a measured end point to avoid excessive or inadequate dosing. Withholding oxygen can have a detrimental effect, yet continuing to provide oxygen therapy when it is no longer indicated can cause oxidative damage with long term implication, prolong hospitalization and increase the cost of care.

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Editor-In-Chief (Indian Pediatrics)



Dr Devendra Mishra

Section III : Activity

IAP Delhi Event Calender 2021

IAP Delhi Team 2021

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Dr Deepak Gautam
President Elect., IAP Delhi

Dr Pankaj Garg
Treasurer, IAP Delhi

Dr Anil Vaishnavi
Vice President, IAP Delhi

Date	Academics	Cocurricular Activity
14 th -15 th January	E-Rheumatpedia	Academics Activity
Sunday, 24 th January	Raag-n-Sur	Cocurricular Activity
Thursday, 18 th February	IAP Delhi Monthly Clinical Meeting	Academics Activity
25 th -26 th February	E-Dermapedia	Academics Activity
Sunday, 28 th February	Cyclathon	Cocurricular Activity
Thursday, 18 ^v March	IAP Delhi Monthly Clinical Meeting	Academics Activity
20 th -21 st March 2021	ResRCHcon 2021	Academics Activity
Sunday, 21 st March	Downs Syndrome Day	Cocurricular Activity
25 th -26 ^v March	Gastropedia	Academics Activity
Thursday, 15 th April	IAP Delhi Monthly Clinical Meeting	Academics Activity
29 th -30 th April	Neuropedia	Academics Activity
Sunday, 25 th April	Geet aur Niratya	Cocurricular Activity
13 th -14 th May	Carcon	Academics Activity
Saturday, 15 th May	Iap Delhi Sports Meet	Cocurricular Activity
Thursday, 20 th May	IAP Delhi Monthly Clinical Meeting	Academics Activity
Monday, 31 st May	Case Based Cme	Cocurricular Activity
Saturday, 5 th June	World Environment Day (Plantation by Members)	Cocurricular Activity

Section III : Activity

Section III : Activity: *IAP Delhi Event Calendar 2021* Continued...

Date	Academics	Cocurricular Activity
Thursday, 17 th June	IAP Delhi Monthly Clinical Meeting	Academics Activity
Sunday, 20 th June	Delhi Respicon	Academics Activity
Monday, 21 st June	Yoga Day	Cocurricular Activity
Saturday, 26 th June	International Day against substance abuse (Book Release)	Cocurricular Activity
Thursday, 15 th July	IAP Delhi Monthly Clinical Meeting	Academics Activity
Sunday, 18 th July	Hematopedia	Academics Activity
Thursday, 29 th July	Ors Day (Book Release on Diarrhea)	Cocurricular Activity
Thursday, 12 th August	Nephropedia	Academics Activity
Sunday, 1 st August	Breastfeeding Week	Cocurricular Activity
Thursday, 19 th August	IAP Delhi Monthly Clinical Meeting	Academics Activity
Sunday, 29 th August	Iap Charity Day	Cocurricular Activity
11 th -12 th September	Pcni 2021	Academics Activity
Thursday, 16 th Sept	IAP Delhi Monthly Clinical Meeting	Academics Activity
Saturday, 25 th September	National Daughter Day	Cocurricular Activity
14 th -15 th October	Adolescon	Academics Activity
Thursday, 21 st October	IAP Delhi Monthly Clinical Meeting	Academics Activity
Sunday, 14 th November	Children's Day	Cocurricular Activity
Thursday, 18 th November	IAP Delhi Monthly Clinical Meeting	Academics Activity
Sunday, 21 st November	Immunization Update	Cocurricular Activity
Sunday, 28 th November	IAP Als Program	Cocurricular Activity
Sunday, 12 th December	IAP Delhi Annual Day	Academics Activity

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Section III : Activity

IAP Delhi January 2021 Activity Report

- 1 IAP Delhi members conducted **Health check up camp** at “**Children of World School**” for **Orphan Children at Dwarka**. 80 children were checked and screened by various specialties of Pediatrics. Thanks to **Dr Vipul Jain for helping we organize this activity. Dr Smita Mishra, Dr Richa Arora , Dr Swati Kanodia, Dr Pravin Kumar, Dr Ashish Sahni, Dr Lalit Mendiratta, Dr Manish Gupta and Dr Vipul Jain contributed their time for the camp**. The financial help for building the boundary wall of the premises is also being looked into.
- 2 **Team IAP Delhi 2020 (Dr RK Nabh, President, Dr Smita Mishra, Secretary, Dr Manish Gupta Treasurer, Dr Lalit Mendiaratta, President Elect)** received the **Best Branch award** in 1100-2000 members category at Mumbai CIAP PEDICON on 6th February. **East Delhi Branch of IAP Delhi received 8 prizes in various categories and IAP North Delhi Branch received third Best Branch award** in its respective category.
- 3 **PNEUMONIAS - Online CME 2.00-6.00 pm** on 9th February 2021 for IAP Delhi Members on DDAP was conducted. We thank our Faculties for the **CME Dr Rakesh Dogra, Dr Vineet Sehgal, Dr Shalini Tyagi, Dr Manish Gupta and Dr Dhiren Gupta**. 75 participants appreciated the latest science of LRTI in children
- 4 Talk on **Enteric Fever** on 16th February 2021, Diagnosis and Prevention was given by **Dr Lalit Mendiratta & Dr Arun Wadhwa** and Session was **Moderated by Dr Manish Gupta**.
- 5 **JOSH 2021-IAP Delhi Fun Day Picnic** was organized on **14th February by Dr Lalit Mendiratta, Dr Manish Gupta Secretary, Dr Pankaj Garg Treasurer at Deva Farms**. It was well supported by Dr Navin Rana, Dr Shekhar Biswas, Dr Vipul Jain, Dr MS Tomar, Dr Ravindra Gupta and all the branches. The Picnic included family members of IAP Delhi members. There were around 150 attendees and it was partially funded by IAP Delhi. Picnic celebrated brotherhood on Valentine Day and Birthday of Shaheed Bhagat Singh. It also created awareness among members of IAP Delhi for Fitness by organizing sports activities for children and the members. All winners were given medals by North Delhi IAP branch.
- 6 IAP Delhi Monthly Clinical meeting was conducted on DDAP on 18th Feb 21. Three sessions were well attended by all IAP Delhi members. President elect CIAP Dr Ramesh spoke on Yummy Allergens. RML Hosp presented a case of Encephalitis. Dr Manish Malhotra discussed Common eye problems in Office Pediatrics.

Section III : Activity

Section III : Activity: IAP Delhi January 2021 Activity Report Continued...

- 7 **WAR - Writing Antibiotics Responsibly Module of CIAP** was conducted on dIAP for IAP Delhi members 02.00-05.00 pm on 20th & 21st February 2021, by **Dr Ajay Kumar Gupta**. It was attended well and emphasized the importance of Rational Antibiotics Use.
- 8 **Book Released** on Immunisation Authored by **Dr. Arun Wadhwa**.
- 9 **Book "APPROACHING TEENS"** Authored by **President Dr. Lalit Mendiratta and Shivi Mendiratta** was released in Pedicon 2021 and **Won the Appreciation award from CIAP**.
- 10 Meeting of task force on **Immunisation DTF** attended on 4th February and 8th February. STF meeting attended in which IMI program (Intensified Mission Indradhanush) was launched.
- 11 IAP Delhi **OB facilitated the process of COVID vaccination registration** in all the parts of Delhi along with all city branches.
- 12 **Vaccination Awareness Campaign** was supported by all IAP OB by spreading message in social media. The **President himself broadcast a message on RADIO MIRCHI** encouraging all health workers and community to go ahead for vaccination.
- 13 **IAP Delhi supported the IMA** in their **efforts against mixopathy by supporting hunger strike** in various parts of Delhi & also received the letter of thanks & appreciation from IMA.
- 14 **Post Graduate Clinics In Pediatrics: IAP Delhi, Association of National Board Accredited Institutes (ANBAI) and Institute of Child Health, Sir Ganga Ram Hospital** has started weekly post graduate clinics. These are being organised to teach the DNB students and to help them prepare for the final practice examinations. First such session was organized on 24th Feb 2021 at 8PM. Case was presented by Dr Ravi Teja and was moderated by Dr Dinesh Kaul.

Dr Manish Gupta

General Secretary

IAP Delhi 2021

Section III : Activity

IAP Delhi Upcoming Events

IAP Delhi Team 2021

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Treasurer, IAP Delhi

Dr Anil Vaishnavi
Vice President, IAP Delhi

- **E DERMAPEDIA**

25th & 26th February 2021

Virtual Pediatric conference will be organized with registration charges Rs 250/- for IAP Delhi Members & Rs 350/- for non IAP Delhi Members.

More than 150 participants have already registered.

Pan India Pediatric Dermatology experts have confirmed their sessions in the conference as Faculty.

- **CYCLATHON**

28th February 2021

Cycling for Health & Happiness, Cycling event to inspire fitness awareness among IAP Delhi Members has been planned at Nehru Park in 2 categories of 6 km & 12 km. All permissions have been taken. T Shirts for CYCLATHON 2021 were launched at JOSH 2021, the IAP Delhi Picnic where 30 Pediatricians registered for the event.

- **Congenital Urological Disorders**

12th March 2021

has been planned at DDAP

- **IAP Delhi Monthly Clinical meeting**

21st March 2021

Section III : Activity

Journal clippings

1. **Association between rotavirus gastroenteritis and intussusception: suggested evidence from a retrospective study in claims databases in the United States**

(Human Vaccines and Immunotherapeutics, January 2021)

The etiology of intussusception (IS) remains unclear although there is some evidence to suggest a role for viral infection. Williams et al investigated role of rotavirus gastroenteritis (RVGE) in first year of life as a risk factor for IS. They did a retrospective, self-controlled case series (SCCS) using data from United States administrative claims databases. Incidence rate ratios (IRR) of IS were calculated for the 7- and 21-day risk periods after RVGE (main analysis) or after fracture (sensitivity analysis). A total of 290,912,068 subjects were screened; 42 presented claims for RVGE and IS, and 66 for fracture and IS. The IRRs of IS after RVGE were 79.6 (95% confidence interval, CI: 38.6–164.4) and 25.5 (95% CI: 13.2–49.2) in the 7- and 21-day risk periods. The sensitivity analysis showed an association between IS and fracture for both periods, suggesting potential confounding. Post-hoc analyses did not confirm the association between fracture and IS but suggested a potential association between RVGE and IS.

Courtesy: ...tandfonline.com **Read the full article.**

<https://doi.org/10.1080/21645515.2020.1770514>

2. **Evaluation of Rooming-in Practice for Neonates Born to Mothers with Severe Acute Respiratory Syndrome Coronavirus 2 Infection in Italy**

(JAMA Pediatrics, December, 2020) &

Neonatal management and outcomes during the COVID-19 pandemic: an observation cohort study. (Lancet Child Adolescent Health, October 2020)

&

Assessment of Maternal and Neonatal Cord Blood SARS-CoV-2 Antibodies and Placental Transfer Ratios (JAMA Pediatrics, January, 2021)

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Section III : Activity

Journal clippings

Ronchi et al evaluated safety of rooming-in and breastfeeding safe for neonates born to mothers infected with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) in this multicenter cohort study involving 62 neonates born to 61 mothers with COVID-19 infection in Italy. They found that no neonate tested positive for SARS-CoV-2 on nasopharyngeal swab at birth, and only 1 neonate was diagnosed as having SARS-CoV-2 infection in 3 weeks follow-up, despite the fact that 95% of them were breastfed and roomed in with mothers with adequate droplet and contact precautions. This was similar to another observational cohort study by Salvatore et al published in October involving 120 babies in a single hospital in New York. Mothers were allowed to practice skin-to-skin care and breastfeed if they wore a surgical mask when near their newborn and practiced proper hand hygiene before skin-to-skin contact, breastfeeding, and routine care. Infants were kept in a closed incubator in the same room as their mothers. Infants were tested for SARS-CoV-2 by RT-PCR using nasopharyngeal swabs taken at 24 hours, 5 to 7 days, and 14 days after birth, and were clinically evaluated by telemedicine at 1 month after birth. Test results were negative in all of these infants at 24 hours, and none of 82 of the 120 infants who underwent testing at 5 to 7 days had positive results. Close to 80% of the infants were breastfed the first week of life. In January 2021, Flannery et al demonstrated that SARS-CoV-2 IgG antibodies were transferred across the placenta in 72 of 83 pregnant women who were seropositive, and cord blood IgG concentrations were directly associated with maternal antibody concentrations...which supports the potential for maternally derived antibodies to provide neonatal protection from SARS-CoV-2 infection.

Courtesy: ...jamanetwork.com **Read the full article.**

🔗 https://jamanetwork.com/journals/jamapediatrics/fullarticle/2773311?utm_source=twitter&utm_medium=social_jamaped&utm_campaign=article_alert&utm_content=automated_rss

🔗 https://jamanetwork.com/journals/jamapediatrics/fullarticle/2775945?guestAccessKey=2b9cd473-27cd-4fb7-bee8-8015b92dd229&utm_source=twitter&utm_medium=social_jamapeds&utm_term=4447066898&utm_campaign=article_alert&linkId=110236903

Courtesy: ...pubmed.ncbi.nlm.nih.gov. **Read the full article.**

🔗 <https://pubmed.ncbi.nlm.nih.gov/z/32711687/>

Section III : Activity

Journal clippings

3. **Effect of Enteral Lipid Supplement on Severe Retinopathy of Prematurity. A Randomized Clinical Trial**

(*JAMA Pediatrics*, February, 2021)

This RCT by Hellstom et al was published this month. It was done to know whether enteral supplementation with fatty acids reduces ROP in extremely preterm infants. It was a multicenter study performed at 3 university hospitals in Sweden involving 206 infants born at less than 27 weeks' gestation. They were randomized to either supplementation [enteral oil providing AA (100 mg/kg/d) and DHA (50 mg/kg/d) (AA:DHA group)] within 3 days after birth until 40 weeks' postmenstrual age or no supplementation. Treatment with AA and DHA reduced severe ROP compared with the standard of care (16 of 101 [15.8%] in the AA: DHA group vs 35 of 105 [33.3%] in the control group; adjusted relative risk, 0.50 [95% CI, 0.28-0.91]; $P = .02$). The AA:DHA group had significantly higher fractions of AA and DHA in serum phospholipids compared with controls (overall mean difference in AA:DHA group, 0.82 mol% [95% CI, 0.46-1.18 mol%]; $P < .001$; overall mean difference in control group, 0.13 mol% [95% CI, 0.01-0.24 mol%]; $P = .03$). There were no significant differences between the AA:DHA group and the control group in the rates of bronchopulmonary dysplasia (48 of 101 [47.5%] vs 48 of 105 [45.7%]) and of any grade of intraventricular hemorrhage (43 of 101 [42.6%] vs 42 of 105 [40.0%]). In the AA: DHA group and control group, respectively, sepsis occurred in 42 of 101 infants (41.6%) and 53 of 105 infants (50.5%), serious adverse events occurred in 26 of 101 infants (25.7%) and 26 of 105 infants (24.8%), and 16 of 101 infants (15.8%) and 13 of 106 infants (12.3%) died.

Courtesy: ...jamanetwork.com **Read the full article.**

https://jamanetwork.com/journals/jamapediatrics/fullarticle/2775874?utm_source=twitter&utm_medium=social_jamaped&utm_term=4454393405&utm_campaign=amplification&linkId=110434537

Section III : Activity

Journal clippings

4. **Predictors of serious bacterial infections using serum biomarkers in an infant population aged 0 to 90 days: a prospective cohort study**

(BMJ Paediatrics Open, January 2021)

Young febrile infants are at risk for serious bacterial infections (SBI). Chang et al conducted this prospective cohort study to evaluate the diagnostic accuracy of components of the complete blood count in comparison with C-reactive protein (CRP) to predict SBI among febrile infants. They included 187 febrile infants ≤ 3 months old and analyzed their white blood cell count (WBC), absolute neutrophil ratio (ANC), neutrophil to lymphocyte ratio (NLR), platelet to lymphocyte ratio, mean platelet volume to platelet count ratio, and compared these to the performance of CRP. Of the 187 infants analyzed, 54 (28.9%) were diagnosed with SBI. Median values of WBC, ANC, NLR and CRP were significantly higher in infants with SBI: WBC (13.8 vs 11.4 $\times 10^9$ /L, $p=0.004$), ANC (6.7 vs 4.1 $\times 10^9$ /L, $p<0.001$), NLR (1.3 vs 0.9, $p=0.001$) and CRP (21.0 vs 2.3 mg/L, $p<0.001$), compared with those without. CRP had the best discriminatory values for SBI, with area under the curve (AUC) of 0.815 (95% CI 0.747 to 0.883), compared with WBC, ANC and NLR. A predictive model consisting of WBC, ANC and NLR in combination with clinical parameters had an AUC of 0.814 (95% CI 0.746 to 0.883). There was increased discriminative performance when this predictive model was combined with CRP, (AUC of 0.844, 95% CI 0.782 to 0.906).

Courtesy: ...[bmjpaedsopen](#) *Read the full article.*

<https://bmjpaedsopen.bmj.com/content/5/1/e000861>

Compiled by Dr Puneet Kumar

Section III : Activity

Crossword Answer January 2021

¹ S	A	I	¹¹ L					
² O	R	S	E				¹² S	
³ P	E	¹³ N	U	M	B	⁴ R	¹⁴ A	¹⁵ P
		O	K			⁵ I	L	I
	⁶ P	C	O	D	⁷ L	C	¹⁶ T	L
	⁸ V	A	C	C	I	N	E	E
	A	R	O	O	⁹ S	S	S	S
	T	D	R	¹⁰ I	A	P	L	
	S	I	I	N	L		A	
		A	A		K			

Vertical

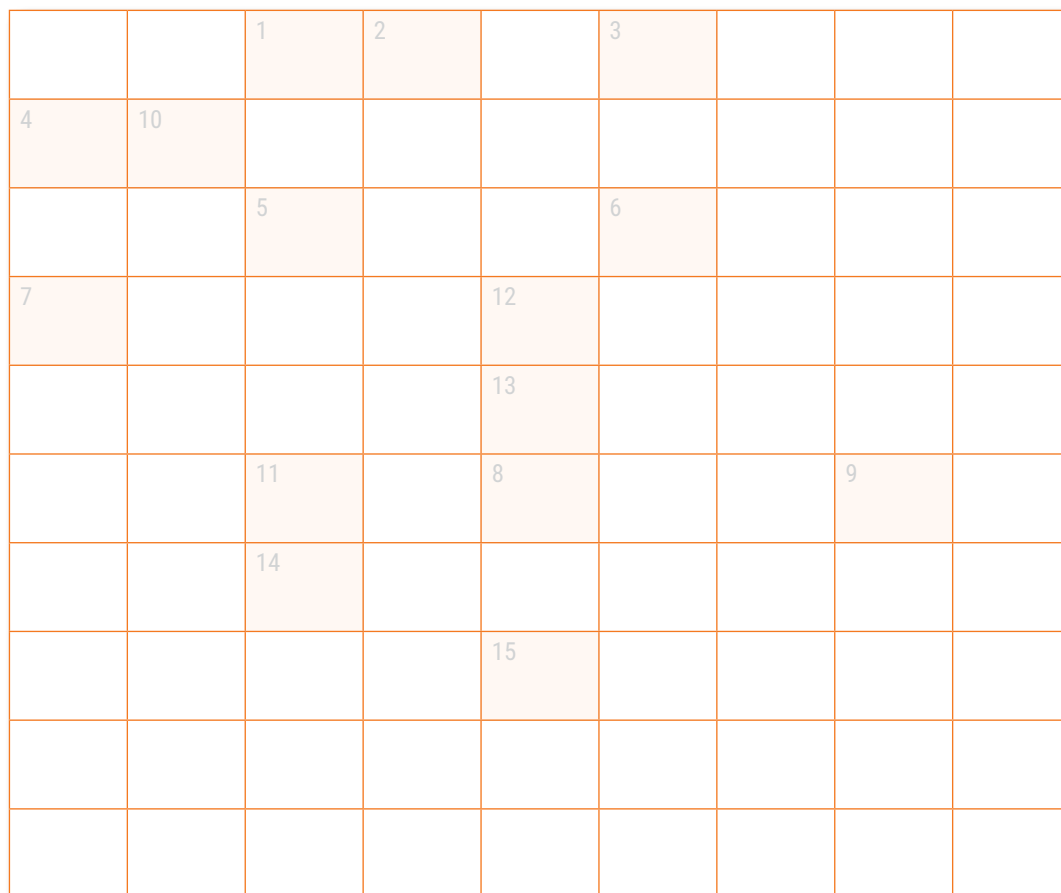
- 1 You need this for proper functioning ⁽³⁾
- 7 It prevents CLD ⁽⁴⁾
- 8 Technique to peep into the chest ⁽⁴⁾
- 11 This reflex named after an animal can indicate a tumor ⁽¹⁰⁾
- 12 Fortified food with brain advantage ⁽⁴⁾
- 13 Opportunistic ⁽⁸⁾
- 14 Almost dead ⁽⁴⁾
- 15 Painless bleed ⁽⁵⁾
- 16 Resolution power of an imaging technique ⁽⁵⁾

Across

- 1 This sign indicates the organ of immunity ⁽⁴⁾
- 2 This simple therapeutic strategy has saved millions of children in the world ⁽³⁾
- 3 In this territory, you are almost dead ⁽⁹⁾
- 4 Constipation is a common cause of this ⁽³⁾
- 5 Viruses do this to lungs ⁽³⁾
- 6 Overweight adolescents have this ⁽⁴⁾
- 7 This gives you most calories with brain factor ⁽³⁾
- 8 All were waiting for this in year 2020 ⁽⁷⁾
- 9 Serious infection with bullae ⁽⁴⁾
- 10 We all belong to this organization ⁽³⁾

Section III : Activity

Crossword February 2021



Vertical

- 1 Found in liver, muscles and rbcs⁽³⁾
- 2 Absence of part of eye⁽⁷⁾
- 3 A powerful weapon with govt against medicos⁽⁴⁾
- 4 India specific liver disease which vanished⁽³⁾
- 5 Abnormal form of walking:
rule out neurological problems if bilateral⁽³⁾
- 6 Govt stamped mother's affection with this program
in aug 2016⁽³⁾
- 7 Distressed term neonate with scaphoid abdomen⁽³⁾
- 8 Doesn't figure out whether bone is at fault or liver⁽³⁾
- 9 Feeding related morbidity of prematures⁽³⁾

Across

- 5 It neutralizes acid⁽⁴⁾
- 7 Normal for frogs abnormal for humans⁽⁶⁾
- 10 Name changed to antibody related vasculitis⁽³⁾
- 11 Common deficiency happen if child is on mostly
maize diet⁽⁶⁾
- 12 This covid related technology won the noble prize⁽⁶⁾
- 13 Nick name of the female scientist ... woman who
first isolated corona virus⁽³⁾
- 14 Our president⁽⁵⁾
- 15 We eradicated it⁽³⁾

Contributed by Dr Pankaj Garg

Please send correct answers photoshot with your name on IAP Delhi eMail. We will be publishing names as well as correct answers in next e Journal (XXXVIII No. 3)

Return to Index

Section III : Activity

Photo Quiz 2021



13 Years Old Male Muslim Child born of Consanguineous Marriage came with symptoms suggestive of intestinal obstruction with mucocutaneous lesions on Cheek, Lips & Gingiva. On investigating child was found to have multiple polyps in intestine area with intussusception like features.

Kindly Make the Diagnosis.

X-ray Quiz 2021



New born, outside delivery came to causality in respiratory distress which needed intubation at admission. X-ray done at admission shows below picture

Identify Complete

Contributed by Dr Anil Vaishnavi

Section III : Activity

Sport's Page

“An organizational effectiveness is proportionate to the vision and strength of its leadership”

This is what we are learning from new team's president vision to make DELHI IAP as a more fitter and friendly organization. In the same league many programs are being organized by Delhi IAP

- 1 IAP DELHI fitness and cultural group was created and is very popular among all fitness conscious pediatricians.
- 2 Sport meet and family picnic To promote the physical, mental and social well being.

Date 14th feb 2021

Place: Camp Deva Farm, Alipur Delhi

Attended by all five city branches. Total 150 members and their family members attended.

Children's and family of members were awarded with medals by NORTH DELHI IAP branch.

- 3 **Cyclathon 2021** on 28 th Feb at Nehru park with theme cycling for health and happiness.

IAP DELHI is not only organizing different sport activity but is also coordinating and promoting city branches for social and sport activity. Few activities of city branches need to be mentioned. IAP EAST Delhi branch organized MORNING WALK to promote good life style and healthy habits among members on 26th January 2021. IAP west Delhi. Members are doing cycling and running on regular basis. IAP North Delhi is fantastically running its sports club with 70 members and doing weekly cycling activity, IAP NORTH DELHI also organized “**VIRTUAL RUNNING**” on 24th Feb where 30 members participated in 5km, 10km, 15km and 21km categories.

CHANGING TREND: IAP DELHI is trying to replace momentos with sapling for better environment. Birthday celebrations are being done at nearby parks so as to promote fitness and good social norm. All social and sports activities are being spread in society through Facebook, WhatsApp and other platforms.

Look for Upcoming events to participate and lose some weight and gain some happiness.

Compiled by Dr MS Tomar

EB Member IAP Delhi & Vice President IAP North Delhi

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Section III : Activity

Cultural Page

Tranquility

*The Road to Tranquility
Gives me an insight to my Destiny
As I stare into Infinity
I have a feeling of Serenity
In the road to Tranquility
The tall trees line up in all divinity
I look around the Vicinity
Admiring the mountains Magnanimity
I question Lord's Creativity
Urging to ponder over my Stupidity
The starry night in all its Grandeur
Snaps me out of my stupor
The Moon & starry night lightening my
way
Telling me not to go astray
I spend the night all awake
Rising up and putting everything at stake
I question my existence
Working hard for my sustenance
In this road to Tranquility
I stare into Infinity!*



Dr Deepa Passi

में सच हूँ।

हारा नहीं हूँ मैं हैरान हूँ मगर,
ज़मीर की तरह अभी ज़िंदा हूँ।
मेरे लबों पर ताला है खामोश हूँ,
मगर ज़िन्दा हूँ आज़ाद परिंदा हूँ।
ये वक्त की नज़ाकत है कि मैं चुप हूँ,
ये कतई न समझना कि मैं शर्मिन्दा हूँ।
मैं कल भी आफताब महताब था,
आज भी रब का बेखौफ़ बाशिन्दा हूँ।
हो सकता है तुम जीत गए मगर,
मैं हारा नहीं, जब तक ज़िन्दा हूँ।
मैं सच हूँ, परेशान हूँ मगर हारा नहीं,
सामने आऊंगा, ज़िन्दा था मैं ज़िन्दा हूँ।



Dr Anil Arora

Section III : Activity

Cultural Page

Ants

*Ants always fascinated me,
Be it red or black
It was nice to see them moving around
harmlessly...
Sitting all alone,
My eyes always feasted on them leisurely
Resting only after travelling several miles
with them
They were always my teachers...
Teaching me the lesson of unity,
Impacting how tiny ones can do something
big...
Enthralling to see their castle rise...
In front of my eyes,
With undiminished bias...
Last week,
I saw them near the window...
But were gone today!!
To begin a new world...
Deserting the castle behind,
In the pool of their sweat
Regardless of any regret!*



Dr Suchitra Sharma

मेरा जीवन
जिन्दगी तेरे संग चलता रहा,
गिरा पर संभलता रहा।
राह में मिली मुश्किलें,
पर हौंसलो से भरता रहा॥
लगता था कही रह न जाऊं,
लोट के वापिस आ न पाऊं,
छाया था अंधेरा घना।
जिन्दगी तेरे संग चलता रहा,
गिरा पर संभलता रहा।
जीवन में आई परीक्षाएं कई,
और आती ही रहेंगी।
जब भी डगमगाया,
उम्मीद की किरण पकड़े रहा॥
जिन्दगी तेरे संग चलता रहा,
गिरा पर संभलता रहा।
जब समय था क्रूर,
और मैं फिसल गया।
मुझे हमसफर ऐसा मिला,
मेरा जीवन निखर गया॥
जिन्दगी तेरे संग चलता रहा,
गिरा पर संभलता रहा।
राह में मिली मुश्किलें,
पर हौंसलो से भरता रहा ॥



Dr Vikram Bansal

IAP Delhi Membership Form

Name of the Applicant					
Designation				Date of Birth	
Email Id				Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Postal Address for Communications					
Tel Residence		Office		Mob.	
Name of Zonal Branch you would like to join <input type="checkbox"/> Central <input type="checkbox"/> East <input type="checkbox"/> West <input type="checkbox"/> North <input type="checkbox"/> South: Whether Central IAP member, if so Membership No:					
No	Educational Qualification	Name of the University	Qualifying Year		
1					
2					
3					
4					
Medical Council Reg. No		Reg. Authority (e.g. MCI/State Medical Council)			
Name & Address of the Proposer					
Membership No. of the Proposer				Signature	
Name & Address of the Seconder					
Membership No. of the Seconder				Signature	
Declaration : I hereby declare that I have never been arrested/prosecuted and convicted by a criminal court or involved in any case registered by the police.					
Place & Date			Signature of the Applicant		
Membership Category	Fee	Category	Total Amount Payable		
Life	₹ 2000/-	₹ 2000/-	₹ 2000/-		
Associate Life	₹ 2000/-	₹ 2000/-	₹ 2000/-		
Cash/Local Cheque/may be drawn in favor of "Indian Academy of Pediatrics Delhi" payable at New Delhi.					
For office use only					
Payment Details Received		Rupees			
by Cash/Local Cheque/DD No		Date		Bank	
Receipt No		Date		General Secretary/ Treasurer	
Note: Please submit self-attested photocopies of Qualification & Registration Certificate & One Passport size photograph.					

Central IAP Membership Form

Personal Details											
Name of the Applicant											
		(Surname)			(First Name)			(Middle Name)			
Date of Birth								Sex: Male / Female			
Complete Postal Address for Communications											
City		Postal Pin			State			Nationality			
Registered Mobile No					Alternate Mobile						
Registered Email					Alternate Email						
IAP State Branch					IAP Dist./City/Local Branch						
Qualification											
Medical / Pediatric Qualification		Name of the University			Qualifying Year			Registration with State Medical Council or Medical Council of India			
Other Details											
IAP membership no. and name of the Proposer											
							Signature				
IAP membership no. and Name of the Seconder											
							Signature				
Place											
Date					(Signature of the Applicant) (Use black ink pen)						
Please provide following information for IAP Photo Identity Card. Please attach a stamp size photograph (3x2.5 cms) with this application.											
Doctor's Name					Mobile No				Blood Group		
Allergies					Emergency Medications						

Central IAP Membership Form

The Society provides-

- Facilities to Students, Scholars and Institutions for the study of or Research in Pediatrics in any of its aspects by way of scholarships, fellowships, grants, endowments, etc.
- Either through itself or in cooperation with other bodies or persons fellowships, prizes, certificates, diplomas of proficiency in the science of Pediatrics and conduct such tests, examinations or other scrutiny as may be prescribed from time to time.
- Free of cost or at subsidized cost its official journals, books, periodicals or publications on pediatrics and allied subjects which the society thinks is desirable for the promotion of its objects.
- Opportunity to its member to participate in Conferences, Lectures, Meetings, Seminars, Symposia, Workshops, Continuing Medical Education Programs, etc.
- Opportunity to become members of its Branches / Subspecialty Chapters / Groups / Cells / Committees.

Affiliations / Collaboration-

The Society is affiliated to:

- i International Pediatric Association (IPA)
- ii International Society of Tropical Pediatrics (ISTP)
- iii American Academy of Pediatrics (AAP)
- iv Asian Pacific Pediatric Association (APPA)
- v Asian Society for Pediatric Infectious Disease (ASPID)
- vi South Asia Pediatric Association (SAPA)
- vii Royal College of Pediatrics and Child Health (RCPCH)

Categories of Membership-

- 1 **Life Member:** Life Membership is granted to any person who is a residential Indian citizen possessing MBBS or equivalent degree in Modern Medicine recognized by Medical Council of India (MCI) and is holding a diploma/degree in pediatrics (such as MD Ped., DNB Ped., DCH) recognized by Medical Council of India (MCI) or any equivalent Nation Statutory Body formed by Government of India.
- 2 **Associate Life Member** is granted to any person possessing MBBS or equivalent degree recognized by Medical Council of India (MCI) or any equivalent National Statutory Body formed by Government of India.

How to Apply for Membership-

Application should be made in the prescribed form. Along with the application for membership of IAP, photo copies of the following documents should be submitted-

- Photo copies of the M.B.B.S. & Post Graduation Certificates as (as per degrees listed in your application).
- Photo copies of the degrees registration certificates with State Medical Council OR Medical Council of India (as the case may be).
- ID Proof with Photo : Aadhar Card / Passport / Voter ID / PAN Card

Membership Fee-

The Membership Fee Structure is as follows:

Category of Membership	Admission Fee	Membership Fee	Total Amount Payable
Life	₹ 500/-	₹ 9,500/-	₹ 10,000/-
Associate Life	₹ 500/-	₹ 9,500/-	₹ 10,000/-

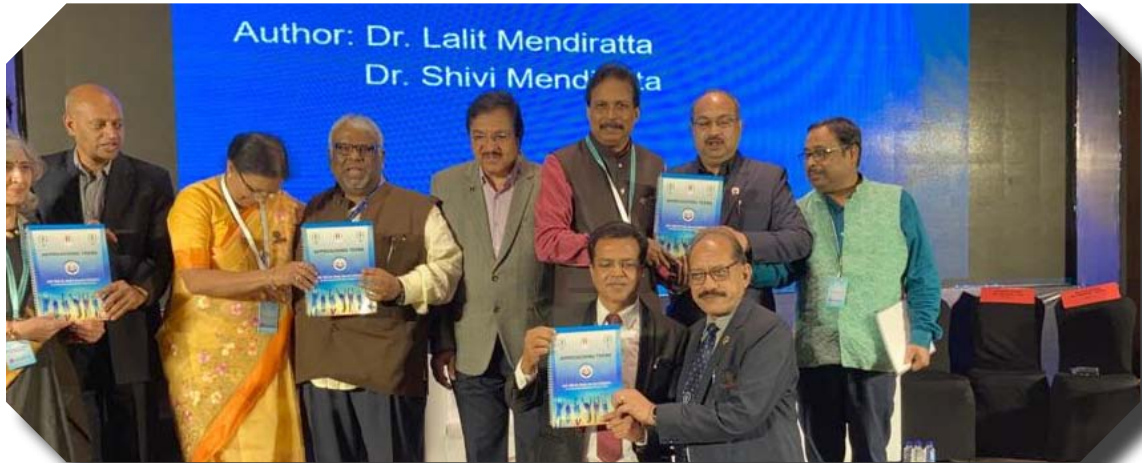
The Membership Fee should be paid by a crossed bank draft / at par cheque drawn in favor of "INDIAN ACADEMY OF PEDIATRICS" payable at Mumbai or NEFT.

Bank details: **BANK OF BARODA**, Branch-Juinagar, Navi Mumbai

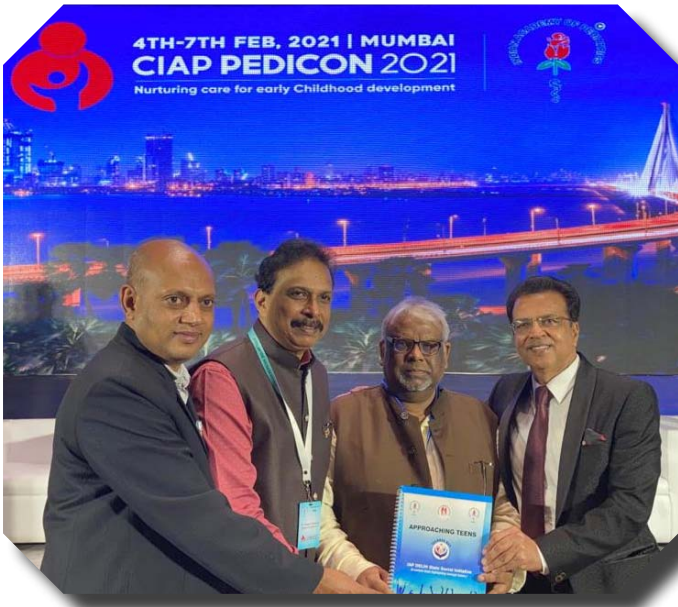
IFSC Code: **BARBOJUNAG** (Fifth character is Zero) ‘

Current A/c No.42080200000253.

Gallery



Approaching Teen book edited by Shivi Mendiratta & Dr Lalit Mendiratta



Approaching Teen Book launch at Pedicon 2021



Best Branch Prize During Pedicon 2021



IAP Delhi Gets Best Branch Prize During Pedicon 2021

Gallery



War Module 20th and 21st February 2021



*Dr Amurag Aggarwal getting
Coronal Warrior Award*



IAP East Delhi Members With Saplings

Gallery



Picnic Photograph at Camp Deva Farm, Alipur, Delhi