PINK CITY
PEDIA MEDIA
JAIPUR | June 2025 | VOL 01

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From the Chief Editors' Desk


Dr. Alok Gupta


Dr. Sanjiv Hooja

Dear
Jaipur IAPians & Readers

With immense pride and déjà vu, we are elated to bring out 'Pink City Pedia Media' - the newsletter of IAP Jaipur after a long hiatus. This is an initiative to deliver a resource with evidence -based insights, practical tools and innovative strategies that both enlighten and empower the pediatric fraternity to address daily professional challenges.

This edition features some interesting cases, a section on pediatric cardiology that throws light on common cardiac emergencies and cardiac medication in PICU /NICU. 'Lest We Forget' is a homage to a set of trailblazing pediatricians are no longer with us but have left a lasting imprint with their incredible work. Also highlighted are the activities undertaken since April by Team IAP 2025, Jaipur and the events and initiatives planned.

This newsletter is more than a publication -it's a collaborative space. We therefore invite everyone to contribute with their input. Your ideas will nurture and drive the content for future issues. We welcome your feedback to make this newsletter, a true reflection of our shared commitment.

Happy Reading!!

With warm regards

Dr Alok Gupta
Dr Sanjiv Hooja
Chief Editors

JAIPUR IAP INSTALLATION 2025

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President's Note


Dr. Atul Shanker

Dear Esteemed Members,

It is with great pride and pleasure that I present to you the inaugural edition of the Jaipur IAP Society Newsletter.

This initiative marks a significant step in strengthening communication and collaboration within our vibrant pediatric community. The newsletter is envisioned as a platform to highlight our academic activities, showcase the achievements of our members, and keep everyone informed about upcoming events, workshops, and initiatives undertaken by the Jaipur IAP.

As we embark on this new journey, I sincerely thank all contributors and the editorial team whose dedication and effort have made this launch possible. I am confident that this publication will evolve into an engaging and informative forum that reflects the energy, intellect, and compassion of our pediatric fraternity.

Let us continue to work together towards excellence in child health, medical education, and professional development. I encourage all members to actively contribute and provide feedback to make this endeavor a resounding success.

Warm regards,

Dr. Atul Shanker
President, Jaipur IAP 2025

Secretary's Note & Vision


Dr. Mohit Vohra

Respected seniors, dear colleagues and friends,

It gives me immense joy to be part of this landmark moment—the launch of the newsletter of the Jaipur IAP Society after years. This newsletter is not just a publication; it is a reflection of our collective commitment to knowledge sharing, professional growth, and community building within the field of pediatrics.

Our vision for this newsletter is to create a vibrant and dynamic channel that connects every member of our society—academicians, clinicians, postgraduate students, and senior mentors alike. Through regular updates on academic programs, CME events, clinical pearls, research highlights, and member achievements, we hope to foster a culture of collaboration and continuous learning.

As Secretary, I envision this platform as a medium that not only celebrates our accomplishments but also inspires dialogue, innovation, and active participation. It will serve as a chronicle of our journey and a showcase of Jaipur's contribution to child health at the regional and national level.

I invite all members to share your ideas, insights, and feedback. Your engagement will be the driving force behind the growth and success of this initiative.

With best wishes,

Dr. Mohit Vohra
Honorary Secretary Jaipur 2025-27

A Child with Recurrent Vomiting

– A Case Report

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Surya Hospital, Jaipur, Rajasthan

Dr. Natwar Parwal
Consultant Pediatric
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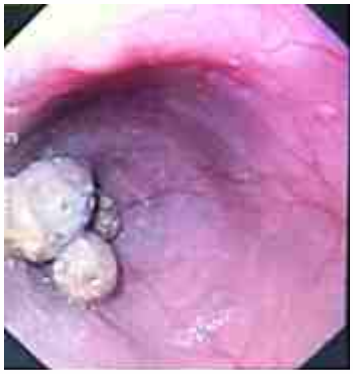
Dr. Deepak Shivpuri
Head of Department of Pediatrics
Surya Hospital

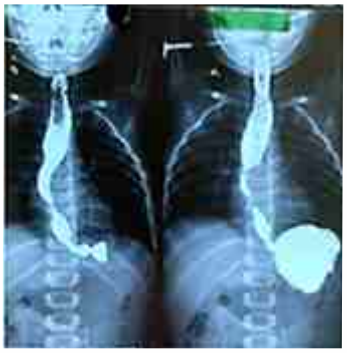
Esophageal stricture caused by tracheo-esophageal fistula and accidental corrosive ingestion is common in the pediatric age group. Other causes are disk battery ingestion, iatrogenic, congenital, and anatomical. Most cases are seen in the under 5 years age group. Endoscopic stricture dilatation is a very effective procedure to save these children from surgery.

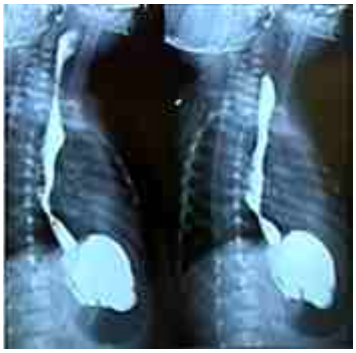
We present a 2-year-old male child who came with complaints of recurrent vomiting since the age of 6 months, 2–4 times a day, occurring a few minutes to hours after ingestion. Vomiting was non-bilious, non-projectile, with no blood in vomits, and mainly occurred with solid foods. On examination, weight and height were below the 10th centile. Blood reports including CBC, LFT, RFT, TTG, and TSH showed no significant findings. Multiple abdominal ultrasounds showed normal results. Other possible etiologies of vomiting were ruled out through various investigations. The child visited multiple clinics and hospitals at local and district levels and received PPIs, antiemetics, and antibiotics. He was also put on laxatives multiple times for constipation, possibly due to a milk-based diet.

UGI endoscopy showed a classical stricture in the mid-esophagus, likely congenital. Three small seeds were seen (Fig-1) and retrieved by Rothnet from the stricture site.



Barium swallow (Fig-1) was done after endoscopy to confirm the stricture.





Dilatation was done twice in the last 3 months by Savary Gillard Dilator . The patient tolerated semisolid diet well and had no vomiting in the last couple of months. His weight, height, and general well-being showed significant improvement.

Discussion

Sometimes common food items may get stuck in the esophagus due to esophageal stricture, such as tamarind seed, maize, pomegranate seed, lemon seed, orange seed, wheat, bone piece, etc.

Common causes of esophageal stricture are

1. Corrosive ingestion – alkali or acids (after a few days to weeks)
2. Postoperative cases of tracheo-esophageal fistula
3. Accidental foreign body/disk battery stuck in the esophagus causing ulcers and later on stricture
4. Congenital

Due to stricture, food or non-food items like stones or glass balls that may get stuck at the stricture site, causing nausea, vomiting, and dysphagia, which do not respond to PPI and antiemetics.

Treatment by UGI endoscopy

1. By Savary Gilliard Dilator
2. By Balloon dilatation – especially for long, complicated, and tortuous strictures

Children usually get relief in 3–4 procedure sittings and start eating semisolid or solid diets. If above procedures do not succeed than surgery may be needed.

Prevention: The most common and preventable cause is corrosive ingestion. Keep acids and alkalis used in households (like battery water, soda, toilet cleaner, stain remover, floor cleaner, coloring agents, etc.) out of children's reach.

Conclusion

Esophageal stricture is one of the less common causes of persistent or recurrent vomiting. Dilation by Savary Gilliard Dilator or balloon is safe and effective for esophageal strictures. Most patients benefit after 3–4 dilatation procedures. We can prevent children from undergoing multiple procedures by avoiding seeds or thick food items in the initial period.

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CACNA1A Mutation Presenting as Stroke in a Young Child

Dr. Meenal Garg
Pediatric Neurologist
Children's Neurosciences Centre, Neoclinic Children Hospital

A 9-month-old-child with developmental delay (not evaluated previously) presented acutely with atypical focal febrile status epilepticus. Neurological assessment showed roving eye movements, right facial paralysis and hemiparesis with hypotonia. MRI brain showed an acute infarct in left basal ganglia with normal angiography (Figure 1a) He was managed as a case of acute ischemic stroke. While in the hospital, he had deterioration of sensorium and suffered a second stroke on the opposite side a few days later. As the neuroimaging showed bilateral basal ganglia involvement (Figure 1b), extensive work up for vascular, hematological, metabolic and genetic causes was started which was inconclusive.

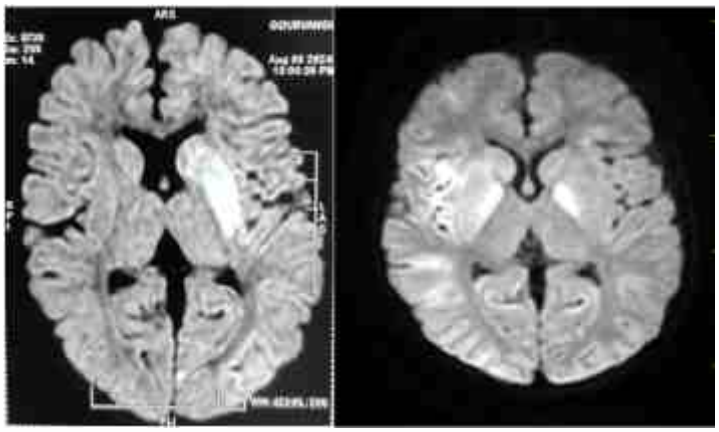


Figure 1. a) Left basal ganglia infarct b) Bilateral basal ganglia infarct

Targeted genetic testing (rapid exome sequencing) revealed a de novo, heterozygous missense mutation in exon 5 of the CACNA1A gene; OMIM#617106). The variant, p.Leu232Pro, affects a Leucine residue that is highly conserved across species. In view of the correlation with clinical findings, the variant was considered to be causative.

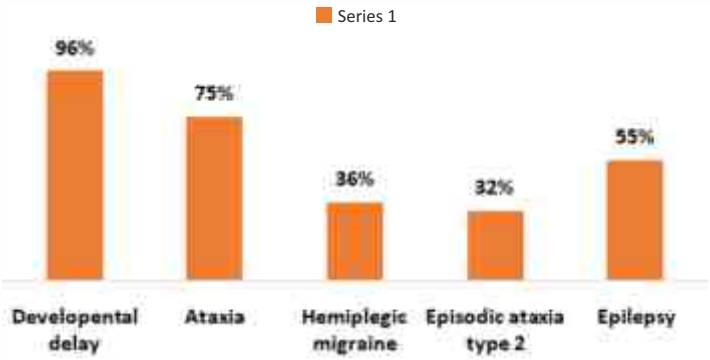
Gene (Transcript)	Location	Variant	Zygosity	Disease (OMIM)	Inheritance
CACNA1A (-) (ENST00000360228.11)	Exon 5	c.695T>C (p.Leu232Pro)	heterozygous	Developmental and epileptic encephalopathy 42 (OMIM#617106)	Autosomal dominant

Following the genetic testing, the child was started on verapamil, as a few reports have commented on the efficacy of this drug in reducing the likelihood of stroke caused by the mutation. Verapamil is a non-dihydropyridine calcium channel blocker that works by inhibiting the influx of calcium ions via voltage-sensitive calcium channels in the vascular smooth muscle and myocardium. On 3 months of follow up, the child did not suffer another stroke, although he had frequent recurrent transient ischemic attacks (TIAs), along with significant developmental delay and movement disorder. He was then started on acetazolamide, which has been frequently used in CACNA1A mutations, after which the frequency of TIAs has significantly reduced.

The CACNA1A gene, located on chromosome 19p13, encodes the pore-forming α1A subunit of the voltage-gated CaV2.1 (P/Q-type) Ca2+ channel, which mediates the intracellular entry of Ca2+ ions. Mutations in the CACNA1A gene result in great clinical heterogeneity, and presents with chronic progressive symptoms or paroxysmal events, or both. Missense mutations removing such proline residues have been shown to alter Cav2.1 channel function in a gain-of-function manner.

Mutations in the CACNA1A gene can lead to multiple phenotypic presentations, some of which have yet to be fully elucidated. Perhaps best characterized is episodic ataxia type 2 caused by loss-of-function mutations in the CACNA1A gene. Gain-of-function mutations in the CACNA1A gene are associated with Familial Hemiplegic Migraine Type 1, Other associated phenotypes include Developmental and Epileptic Encephalopathy 42, as well as Idiopathic Generalized Epilepsy (IGE). To date, only six cases of a pathogenic CACNA1A variant associated with strokes in pediatric populations have been described in the literature.

Graph 1. CACNA1A related disorders



This patient shows that genetic testing is an invaluable tool in our arsenal for the evaluation of children with stroke and can potentially alter the line of management in such patients. The rarity of CACNA1A-associated stroke also needs to be highlighted, as clinical diagnosis in difficult and potential disease-modifying treatment can be offered. While a gain-of-function mechanism for this Cav2.1 voltage-gated Ca2+ channel in likely in causing stroke in our patient, further studies are needed to understand the basis of stroke.The elucidation of the gene function and the expansion of the clinical profile is important for accurate diagnosis and targeted treatment strategies

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Pediatric Cardiac Emergencies

Dr Kanupriya Chaturvedi
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Cardiac emergencies in children are not uncommon and need timely recognition and intervention as delay in diagnosis and/or treatment can lead to increased morbidity and mortality.

The common conditions presenting as cardiac emergencies in the pediatric and neonatal age group are:

- Neonates with duct dependent circulation
  1. Duct dependent pulmonary circulation
  2. Duct dependent systemic circulation
- Transposition of great arteries
- Obstructed total anomalous pulmonary venous connection
- Cyanotic spells
- Tachyarrhythmia and bradyarrhythmia
- Heart failure
- Pericardial tamponade

Since all these lesions individually require an extensive discussion, in this review, we shall stick to the emergencies secondary to structural heart defects.

Duct dependent lesions:

The duct dependent lesions are those in which the ductus arteriosus (commonly PDA) is an absolute requirement for survival. These lesions can be classified as those with 1.) Duct dependent pulmonary circulation and those with 2.) Duct dependent systemic circulation.

Common examples of lesions with duct dependent systemic circulation :

Hypoplastic left heart syndrome, critical coarctation of aorta or interrupted aortic arch and critical aortic stenosis.

Common examples of lesions with duct dependent pulmonary circulation :

Tricuspid atresia with severe pulmonary stenosis, pulmonary atresia, critical pulmonary stenosis, and some cases of Ebstein anomaly with functional pulmonary atresia.

Why an emergency?

In duct dependent systemic circulation, once the duct starts closing, forward flow into the descending and sometimes ascending aorta is compromised and patients present with signs of circulatory collapse. If not reversed promptly, it can lead to death due to severely decreased cardiac output.

In duct dependent pulmonary circulation, as the duct starts constricting pulmonary blood flow is severely compromised leading to severe cyanosis and poor venous return to left atrium causing low cardiac output and eventual death.

What can be done?

Prostaglandin E1 (PGE1) has been a revolutionary, lifesaving discovery for management of duct dependent lesions. It should be started in any neonate diagnosed with a duct dependent lesion until definitive management can be undertaken. Surgical management includes a mBTT (modified Blalock-Thomas-Taussig) shunt or a Norwood procedure and in recent times, stenting of the ductus, a catheter-based procedure is gradually becoming the treatment of choice for these lesions.

Critical aortic stenosis and critical coarctation can also be dealt with by catheter interventions namely, balloon aortic valvuloplasty and balloon coarcto-plasty.

Transposition of great arteries :

Transposition of great arteries (in this context, dextro or D-TGA) truly becomes a medical emergency if it is accompanied with an intact ventricular septum (IVS) or a very small VSD, behaving almost like an intact septum. It most commonly presents as severe cyanosis in an otherwise well appearing newborn.

Why an emergency?

TGA-IVS leads to severe hypoxemia shortly after birth which can further cause metabolic acidosis, respiratory distress and multi organ failure.

What can be done?

The definitive treatment of TGA is surgical, ideally an arterial switch operation. Surgery is often performed within a week of life and no more than a month. If the critical time lapses, patient can become unfit for a switch surgery. For stabilization, a balloon atrial septostomy, which is a catheter-based procedure, can be done which increases the size of the patent foramen ovale (PFO) and allows for better mixing of blood until surgery is undertaken.

Obstructed total anomalous pulmonary venous connection (TAPVC):

TAPVC per se is not an emergency, however when associated with obstruction to pulmonary venous return, it needs urgent referral and treatment. It is one of the few true cardiac surgical emergencies.

Why an emergency?

Obstruction to pulmonary venous return causes congestion in the lungs leading to pulmonary edema, respiratory distress and eventually respiratory failure.

What can be done?

Obstructed TAPVC requires urgent surgery, however, there have been a few case reports of stenting of the vertical vein of TAPVC to tide over acute crisis and prepare the patient for corrective surgery. There is no role of PGE1 in management of TAPVC.

Cyanotic spells:

Classically seen in patients with Tetralogy of Fallot. It is marked with paroxysmal episodes of increased cyanosis, dyspnea, and decreasing intensity of murmur, usually precipitated by events that increase sympathetic activity, like crying.

Why an emergency?

Prolonged cyanotic spells can cause seizures, cardiac arrest, or death. Immediate intervention is crucial to prevent hypoxic brain damage and metabolic acidosis.

A single episode of cyanotic spell is sufficient to warrant consideration for surgical repair

What can be done?

Acute management includes knee chest position, oxygen, IV fluids, acidosis correction, sedation and beta- blockers. Definitive treatment is surgical correction. Palliative measures can be undertaken for patient who are not good candidates immediate for surgery (sepsis, very low weight etc.) and include an m-BTT shuntor aductal stent/ RVOT stent which is a catheter-based intervention.

Lest We Forget

A Homage to doyens of Pediatrics, no longer with us

Compiled by Dr. Sanjiv Hooja

Dr. SHAKUNTLA SAXENA

One of the most prominent and revered paediatricians of her time, Dr. Shakuntala Saxena was widely regarded as the First Lady of Paediatrics in Rajasthan. Born in London in 1929, she did her MBBS from Agra Medical College and MD from Mumbai under the renowned Dr. P.M. Udani. She was the Founder Chairperson of Rajasthan State Board of Paediatrics . She had more than 125 papers to her name published in various national and international journals. Known for her punctuality,she was an excellent teacher, a strict disciplinarian, a hard taskmaster yet popular among students . A distinguished academician, she was actively involved in undergraduate and postgraduate teaching . The legion of students who trained under her are scattered throughout the globe and are a living testimony to her legacy. Post -retirement she dedicated herself to community service and was actively associated with the Rama Krishna Mission in JaipurShe passed away in 2021 at ripe age of 92.

Dr. NIRMAL MIGLANI

Former Professor and Head of Department of Paediatrics, SMS Medical College and Medical Superintendent of the erstwhile SPMCHI, Dr. Nirmal Miglani was one of the most distinguished teaching faculty in Rajasthan . Born in 1935 in Waryam (now in Pakistan), she went on to do her graduation and post graduation from Medical College Indore. Thereafter she joined the state medical services of Rajasthan doing teaching stints in various medical colleges and hospitals. She headed SPMCHI from 1987 - 2003 till her retirement . A teacher and a clinician par excellence, she lay special emphasis on developing and honing clinical skills and inculcating a sense of dedication and devotion to the profession. Despite her eminence,she often choose to remain away from the limelight .She passed away in 2017. She lives on in the hearts of the multitude of students who trained under her and have been inspired by her erudition, dedication, simplicity and discipline.

Dr. PREM PRAKASH GUPTA

Dr. Prem Prakarsh Gupta was born in 1946, in Karauli Rajasthan. After doing his MD in 1973 from SMS Medical College, he joined the State Medical Education Services. He had teaching stints at various medical colleges before he became the Professor and Head of Department, as well as Medical Superintendent, Kota Medical College and attached Hospitals. He retired from government service in 2006 . After his superannuation he became the Professor and Head of Department ,Mahatma, Gandhi Medical College till his demise in 2021. He was Secretary, Rajasthan Medical Relief Society. He had a keen interest in teaching at undergraduate and postgraduate level. He published more than 50 papers and delivered more than 30 lectures at various conferences. He was also a recipient of the Commonwealth Fellowship in Neonatolgy. He is remembered for his meticulous approach towards patients and research work.

Dr. CHAMAN RAM VERMA

A visionary pioneer , Dr. Chaman Verma significantly contributed to the development of paediatrics and neonatology in Rajasthan. Born in 1956, he did his MD in 1983. He joined the state medical services in 1984, as an assistant professor. Subsequently, he worked in Saudi Arabia for five years .He returned to India in 1997 and joined the Department of Paediatrics, SMS Medical College. He rose to become the Professor and Head of the Department until he retired in 2014 .There after he joined as Dean, Faculty of Medicine and Allied Sciences, NIMS University, a post he held till his demise in 2024. He is remembered for his clinical acumen, great administrative skills and mentorship of numerous students.

Dr. RAJ KUMAR GUPTA

With more than 25 years of teaching experience, Dr. Rajkumar Gupta was Senior Professor and Medical Superintendent of Jaykay lon Hospital. One of the most brilliant students of his batch, (with five gold medals to his credit), he did his MD in 1993. He was instrumental in establishing the Division of Gastroenterology as a superspeciality at Jaykaylon Hospital and was a pioneer of GI endoscopy in Rajasthan. He was a very active IAP and got elected thrice as Central IAP Executive Board member. He was awarded with the Fellow of Indian Academy of Paediatrics (FIPA) in 2011 at a very young age. He had more than 50 publications in renowned journals and delivered more than 20 talks at national and international level. he had a keen interest in research and was the principal investigator in seven research projects at SMS medical College. He was very popular both among students and colleagues but inspite of his immense accomplishments, he came across as a person with deep humility .His untimely demise in 2022 has left a void that is hard to fill. He is remembered for his radiant smile, compassion, and rare quality to readily help everyone who came in touch with him.

Dr. MUNISH KAKKAR

Former Professor and Head, Department of Paediatrics as well as Additional Principal , MGUMST; Dr. Munish Kakkar was a deeply committed, hard-working academician. He did his MBBS from RNT Medical College Udaipur and MD from erstwhile SPMCHI in 1992. He was one of the handful of paediatricians in Rajasthan who also did MRCPCH in 2002 from the Royal College of Paediatrics and Child Health . After a stint at the Ministry of Health in Saudi Arabia, he joined Mahatma Gandhi Medical College as an Assistant Professor in 2002 . He quickly rose through the ranks and became the Head of the Department in 2005 , a post he held till he last. A keen clinician, he had a special interest in paediatric cardiology. He had several papers in his name that were published in various national and international journals. As a person he came across as an intelligent, jovial, extremely helpful,ever- smiling person with a rare ability to charm people with his words . A tennis player himself, he was fond of gardening, music and photography. Although his untimely departure has left a void, his legacy continues to endure.

CLINICAL CASES

Spot diagnosis

Dr. Ram Gulati
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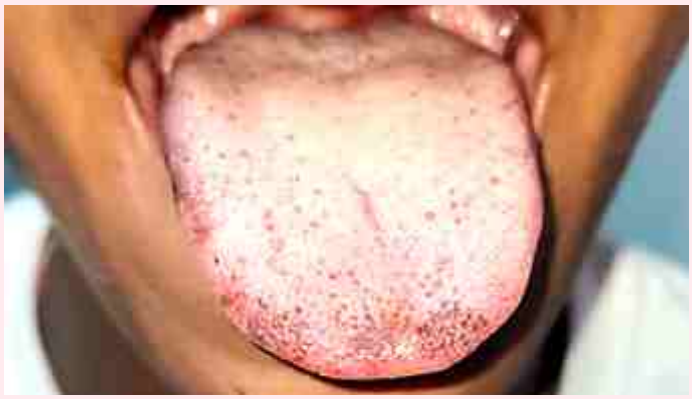

A 12-year-old boy presented to the Dermatology OPD with a one-month history of developing dark-coloured dots on the dorsum of the tongue, mostly on the distal part. The lesions werechild was asymptomatic.The lesions were non-progressive, but persisted and so the parents sought medical consultation.

The boy was in good health, with no significant past medical history, dental procedures or any drug intake. There was no similar family history.

The examination of the oral mucosa showed the presence of multiple pinhead-sized, well-demarcated, hyperpigmented papules on the tip and dorsolateral surface of the tongue. The rest of the oral mucosa appeared normal. Cutaneous examination did not reveal any abnormality.

The clinical picture was consistent with the diagnosis of pigmented fungiform papillae of the tongue, which is a benign idiopathic condition. In this condition, the fungiform papillae located on the tip and lateral portion of the tongue become hyperpigmented, appearing as mushroom-like structures bearing brown or dark colour. Etiology of the condition remains unknown. Management includes counselling regarding the benign nature of the lesions.

Pearls of Wisdom

(In appropriate clinical settings)

Dr. Rupesh Masand
Professor & Head, Department of Pediatrics MGMC

If

A. CRP increased + ESR increased..... suggestive of Juvenile idiopathic arthritis (D/d: infections / malignancy)

B. CRP normal or decreased + ESR increased..... suggestive of SLE flare-up (without infection)

C. CRP increased + ESR decreased.... suggestive of HLH / MAS

Spotter Table

Congenital Ichthyosiform Erythroderma

Dr. Shipra Khandelwal
MD (Pediatrics)
BJ Wadia & JEM Hospital Mumbai

Congenital Ichthyosiform Erythroderma (CIE)

Clinical Presentation

A 2-days-old-male came with complaints of diffuse erythema and peeling of skin soon after birth; thickening of palms and soles (palmoplantar hyperkeratosis), lethargy with refusal to feeds

Birth History	Term baby(38 weeks), birth weight 2.8 kg, third by birth order; born to G3P1L1A1 mother
Family History	Third-degree consanguineous marriage
Investigations	Sepsis screen positive Based on phenotypic features Congenital Ichthyosiform Erythroderma suspected hence whole-exome sequencing done which revealed deletion of ALOX12B gene
Management	- Intravenous fluids and antibiotics - Topical emollients - Oral Acitretin
Complications	Severe sepsis, Disseminated Intravascular Coagulation (DIC)
Important Points	**Prevalence-**1/ 2,00,000 to 1 /10,00,000 **Etiology-** Autosomal recessive caused by mutation in known ARCI-related genes (ABCA12 , ALOX12B, ALOXE3 , TGM1) **Diagnosis-** whole-exome sequencing **Treatment-** use of emollients and oral retinoids and vitamin A for hyperkeratosis. Topical steroids and calcineurin inhibitors are less effective
Preventive Strategies	Prenatal diagnosis by amniocentesis or chorionic villus sampling and counselling in affected families - Early diagnosis and multidisciplinary management
Key Learning	CIE requires early supportive care; sepsis is a major cause of neonatal mortality in these patients

Cardiac Medications in PICU/NICU

Dr Prashant Mitharwal
(Pediatric Intensivist, HOPE Hospitals, Jaipur)

There are many cardiac drugs which are used in ICU, but we will discuss most commonly drugs here.

Inotropes and vasopressors : Inotrope increase cardiac contractility and vasopressor increases vasomotor tone by vasoconstriction.

Inotropes : Dopamine, adrenaline (adrenaline also acts as vasopressor at more than 0.3 mcg/kg/min dose)

Vasopressor : noradrenaline, vasopressin

Inodilator : which increase contractility and reduce afterload too by vasodilation (helpful in cardiac failure), eg dobutamine and milrinone.

Mechanism of action :

Dobutamine : A β_1-adrenergic agonist that enhances myocardial contractility, commonly used in heart failure and low cardiac output states.

Milrinone : A phosphodiesterase inhibitor that increases intracellular cAMP, leading to improved contractility and vasodilation. It is particularly useful in patients with elevated systemic vascular resistance.

Epinephrine : A mixed α and β-adrenergic agonist, utilized in cardiac arrest and severe hypotension.

Norepinephrine: Primarily an α-adrenergic agonist, it increases systemic vascular resistance and is used in septic shock and other hypotensive emergencies.

Vasopressin : An antidiuretic hormone analog that acts on V_1 receptors to cause vasoconstriction, aiding in blood pressure support.

Dose :

Epinephrine and Norepinephrine :

Preparation : 0.3 mg/kg in 50 ml NS/D5%, at 1 ml/hr = 0.1 mcg/kg/min

Dose : 0.05 mcg/kg/min to 0.5 mcg/kg/min

Dopamine and dobutamine :

Preparation: 30 mg/kg in 50 ml NS/D5, at 1 ml/hr = 10 mcg/kg/min
Dose: 5-20 mcg/kg/min

Vasopressin :

Preparation: 20 units in 50 ml NS/D5%, at 0.045ml/kh/hr = 0.0003 units/kg/min

Dose: 0.0003 – 0.002 units/kg/min

Milrinone :

Preparation: <10 kg, 10 mg in 50 ml, 0.15 ml/kg/hr = 0.5 mcg/kg/min >10 kg, 20 mg in 50 ml, 0.075 ml/kg/hr = 0.5 mcg/kg/min

Dose : 0.25 – 0.75 mcg/kg/min

The selection of these agents is guided by hemodynamic monitoring and clinical judgment.

Septic shock (mostly cold shock in children) : epinephrine

CHF : Dobutamine/milrinone/low dose epinephrine

Warm shock : norepinephrine/vasopressin.

IAP ACTIVITIES APRIL-MAY 2025

THALCON 2025 9-10 MAY 2025

JAIPUR IAP CME -HEMATOLOGY .PEDIATRIC IMMUNODEFICIENCY DISORDERS..SPEAKER DR SATYEN KATEWA 8.05.2025

JAIPUR IAP IMMUNISATION DIALOGUE..28.05.2025

RTI.GEMS 3.0 18.05.2025

Jaipur IAP Activities April-May 2025

Autism Awareness Activities

Celebration of Birthdays of Senior Paediatricians

Dr. B. K. Jain

Dr. Ashok Kasliwal

Upcoming Events