



Letters to the Editor

Promoting Research- Writing a Letter to the Editor

Corresponding Author:

Dr. Mehrdad Jalalian,
Research Center of Iranian Blood Transfusion
Organization, Khorasan-e Razavi Blood
Center, Mashhad, Iran
Email: mehrdad.medic@gmail.com

Dear Editor,

I was pleased to see the introduction of a letter to the editor in the AMJ. This short review explores the importance of "Letter To the Editor" (LTE) and its impact on research. In the field of academic writing the term LTE is broadly used to refer to a group of articles where the author usually comments on a previously published work. Some journals publish these articles in the "Correspondence" section or tend to use the term "Letter" for these common format of papers; however, an LTE is treated as a real paper. The peer review process of LTEs is almost the same to the other types of manuscripts and they all go under the standard review procedure. Some journals employ a section editor known as "Editor of Letters" who may decide to judge on such manuscripts or send them to others for reviewing; but, the process of accepting the LTEs is faster than other types of manuscripts.

IMPACT OF LTE ON SCIENCE

A letter to the editor can focus on a current issue of the science but it is mostly consisted of comments of a reader on a newly published work (usually the last six month) in the target journal; however, there is no fixed time limit and the journals govern their own rules of publishing every kind of articles including LTEs. The content of an LTE can be either a critique or a comment on the cited paper; moreover, some editors even accept short communications in the condition that the author makes it more brief and re-written in the format of LTE. When the LTE consists of comment(s) on other works it may conclude with development of a new hypothesis. In this case, the cited paper works as a trigger for the

development of such idea in the mind of the reader (i.e. the author of the LTE). This idea in turn shed the light on a direction of future research and the proposed hypothesis can be examined by the author of LTE him/herself or anyone else. Moreover, in the case that the idea includes the regional comparison or needs to assess the effect of sociodemographic, genetic or environmental differences on the variable of interest, this article expresses the start point of a multicenter research in which both the authors of LTE and the cited paper will work in a team.

DOES IT COST TO BE PUBLISHED?

It should not be forgotten that the LTEs are rarely accepted for publication unless they are well written and the author proposes a new method or idea the conclusion of the letter. In the world that cost-effectiveness is the basis of development of market strategies in publishing scientific materials, only the eye catching LTEs have the chance of getting more citations and are guaranteed to help increase the Impact Factor of the target journal.

Sincerely,

Dr. Mehrdad Jalalian,

website: <http://www.drmehrdad.com>

Healthcare challenges in South Asia

Corresponding Author:

Dr. P. Ravi Shankar
KIST Medical College
P.O. Box 14142, Kathmandu, Nepal.
Email: ravi.dr.shankar@gmail.com

Dear Editor,

We read with great interest the article titled 'Health care in India' by BM Hegde (1). The author raises a number of issues regarding health care in India which may also be applicable to other developing countries. We agree with the author that a myth has been created about modern medicines, doctors and hi-tech hospitals being the cause



of rapid improvements in healthcare of the population. Good food, clean air, safe drinking water, good housing are the major reasons behind the dramatic improvement in health in the twentieth century.

The influence of drug companies on medical education and medical research is acknowledged in many countries. An article in the New England Journal of Medicine states that the relationships between doctors and the pharmaceutical industry starts in medical school, continues during post graduation (residency) and persists throughout the doctor's career (2). In developed nations continuing medical education is a common way in which drug companies interact with doctors. Distribution of resources is lopsided in many countries with hospital and doctors being concentrated in urban areas. In Nepal, a developing country to the north of India doctors and hospitals are mainly concentrated in the capital Kathmandu and other cities and rural populations have huge problems in accessing health and other resources. In the Kathmandu valley the population per doctor is around 1300 while in mountain and hill areas a doctor may cater to a population anywhere between twenty to thirty thousand (3). In the context of non-availability of doctors and modern medical care the term 'health expectancy' used by the author is interesting.

Sir Robert Hutchison is a famous British physician and author of the famous 'Clinical methods'. Sir Robert's petition to doctors starts with the words 'From inability to let well alone'. In the modern world as beautifully put by the author drugs are increasingly being promoted and used for improving normal functioning and for conditions which can be regarded as a part of normal life. Convincing healthy people they are sick or can use medicines to further improve their functioning will enormously increase the market for medicines (4). In Asia, drugs for conditions like erectile dysfunction, male pattern baldness, attention deficit hyperactivity disorder and irritable bowel syndrome are widely promoted. Fairness creams and traditional medicines are also widely used (5). A recent article in this journal had examined the widespread promotion of lifestyle drugs in India (6). The author has said correctly that defining what is 'normal' in medicine is often difficult. Also normality may be redefined by commercial interests for their own profit.

The author raises a point that increasing number of doctors and hospitals has nothing to do with life expectancy and mortality. A certain number of health personnel are needed to provide care. Medical colleges in South Asia justify their presence by citing the low number of doctors especially in rural areas. Most doctors educated in these schools mainly in the private sector are unlikely to serve the rural population. This issue needs more research and debate. Also a large population may have an adverse impact on quality of life and will make it difficult to provide health services. Most South Asian countries are facing a population explosion and unfortunately we believe in the brouhaha over faster and ever

accelerating economic growth and the advantages of a 'young' population ignoring the adverse effects of population growth. Market forces are increasingly shaping the economy in India and South Asia and hospitals and companies concentrate on medicines and services which are marketable and can give a good profit. This results in the situation that hi-tech services and medicines are available in South Asia while essential medicines and basic health services are often not available.

We would also like to congratulate the Australasian Medical Journal on a fair and efficient publishing process. The review process is quick and fair and papers have been published within one month after publication with most being online within two months. The template for submission of articles can play a role in quick publishing. Once the article is finalized it can easily be converted to a publication ready PDF. The online model and the dedication and energy of the editor-in-chief and the editorial board and quick decisions by the reviewers make for an enjoyable publishing process. Other journals could study the AMJ publishing model and reduce delays in the manuscript processing, peer review and publishing process.

Sincerely,

P. Ravi Shankar and Subish Palaian

References

1. Hegde BM. Healthcare in India. Australasian Medical Journal 2010; 1 (5):271-275.
2. Blumenthal D. Doctors and drug companies. New Engl J Med 2004; 351:1885-90.
3. Courneya CA, Dunne D. PAHS: a Nepali project with international implications. Clinical Governance: An International Journal 2009; 14:134-44. www.emeraldinsight.com/1477-7274.htm.
4. Shankar PR. Sir Robert Hutchison's petition and the medical humanities. International Journal of Medical Education 2010; 1:2-4.
5. Shankar PR, Subish P. Disease mongering. Singapore Med J 2007; 48:275-80.
6. Rahman SZ, Gupta V, Dang A, Suklecha A. Lifestyle drugs in India: Are we ready for them. Australasian Medical Journal 2010; 1 (3):186-189



Prevalence of Overweight and Obesity among the rural school children in Udupi taluk, South India

Corresponding Author:

Name: Dr.Veena Kamath
Email: venkamath@yahoo.com

Dear Editor,

Obesity is a global nutritional concern. The increasing prevalence of overweight, obesity and its consequences prompted the World Health Organization to designate obesity as global epidemic. Childhood obesity is not an immediately lethal disease itself, but has a significant risk factor associated with a range of serious non-communicable diseases in adulthood. Hypertension, hypercholesterolemia, type-2 Diabetes mellitus, gall bladder disease, asthma, mental health concerns and Orthopaedic disorders have been linked to obesity.¹ A school based cross sectional study was conducted in the rural schools of Udupi taluk, Karnataka.. Children aged 6-15 years were included in the study. The data was collected from 2262 students of which 1118 (49.4%) were girls and 1144 (50.6%) were boys. Consent of parents was obtained by the school authorities.

Height was taken with the help of a stadiometer after removing the footwear with the subject standing erect and heel and occiput touching the upright rod to the nearest 0.5cm. Weight was measured to nearest 100gms. Less than 5th percentile was taken as underweight, 5th to less than 85th percentile as normal, 85th to less than 95th percentile was taken as overweight and equal to or more than 95th percentile as obese. Data was analyzed using SPSS version 11.5. The WHO percentile criterion was used to assess the prevalence of obesity and overweight. About 81% of students were in the age group of 6 to 11 years. Overall the prevalence of obesity and overweight was 2.8%. Of which 1.5% were overweight & 1.3% were obese. It was found to be more among boys (2.8%) as compared to girls (2.6%). The prevalence of obesity was found to increase with increasing age and this difference was found with to be significant (p=0.032). There was no significant difference in nutritional status among males and females in the 6 to 8 year age group but the nutritional status was found to significantly differ among males and females of 9 to 11 and 12-15 years age group (p<0.05). A study in Delhi on

affluent school children showed the prevalence of obesity to be 7.4%.² Another study conducted by the nutrition foundation of India found among 5000 children aged 4-18 years in a Delhi private school 29% were overweight.³

Table 1: Distribution of the study subjects based on the nutritional status using WHO criteria

Nutritional status	Male	Female	Total
6-8 yrs			
Overweight	4 (0.9)	5(1.1)	9(1.0)
Obese	2(0.4)	5(1.1)	7(0.8)
Total	457	450	907
9-11 yrs			
Overweight	10(2.2)	7(1.5)	17(1.8)
Obese	5(1.1)	6(1.3)	11(1.2)
Total	460	464	924
12-15 yrs			
Overweight	7(3.1)	0	7(1.6)
Obese	5(2.2)	6(2.9)	11(2.6)
Total	227	204	431

To conclude our study shows that the prevalence of obesity and overweight in this part of the country is very low. This is thus an ideal situation where health education interventions could play a vital role to prevent further increase in obesity.

Sincerely,

Veena Kamath¹, Sanjay Pattanshetty², Prasanna Mithra³, Lena A⁴

¹Professor, ^{2,3}Assistant Professor, ⁴ Lecturer
Kasturba Medical College, Manipal University, Manipal
India

References

1. Kaur S, Kapil U, Singh P. Pattern of chronic diseases amongst adolescent obese children in developing countries. Current sciences 2005;88:1052-1056
2. Kapil, U., Singh, P., Pathak P, Dwivedi SN. Prevalence of obesity amongst affluent



adolescent school children. Indian Pediatr2001; **39**:449–452.

- Chatterjee, P., India sees parallel rise in malnutrition and obesity. Lancet 2002; **360**:1948

Hepatitis B vaccination coverage among Indian Medical Students

Corresponding Author:

Manjeet Singh,
Email: msbatrkt@yahoo.com

Dear Editor,

Medical course exposes the students to HBV (hepatitis B virus) infection. In a study performed on medical students, overall prevalence was found to be 11.0% for HBsAg and 65.9% for anti Hbc¹ whereas prevalence of hepatitis was found to be 15.9% among tribal populations and 2.4% among non-tribal population of India ². More clinical students were infected with HBV than preclinical which might be due to more exposure to HBV patients. Risk factors associated HBV infection included accidental needle stick injuries and unprotected exposure to patients' body fluids. HBV vaccination status was also found to be very low among medical students^{1,3,4}. Therefore it is obvious that when unimmunized first year medical students will go for clinical classes, they might be exposed to infected patients as well as patients can also get infected from students. Complete hepatitis B vaccination of medical students can prevent this. Therefore the present study was carried out to observe the vaccination status and attitude of medical students towards HBV.

After giving a brief introduction on the study, self-administered, questionnaires were distributed to 135 first year medical students of an Indian Medical college, with reference to hepatitis B vaccination history and reasons for not completing vaccination. Only 29 students had received three doses and a booster before admission. Fifty six students received 1, 2 or 3 doses. Sadly twenty students were not remembering how many doses they had taken. Also only 14 students out of 135 had record of immunization (table 1). Unfortunately 50 students were not immunized at all. These students were at risk of getting infected from patients. They can also act as a potential source of infection to patients.

Hence, medical students should be advised to have HBV vaccination before coming to clinical side. Important reasons for noncompliance were forgetfulness, no reminder, lack of knowledge on hepatitis B infection and lack of compulsion. These hurdles can be easily overcome by educating students and their family members who come on the day of admission on HBV infection and motivated for successful and effective vaccination. Students should be emphasized on record maintenance also.

Our data highlight the need of a national policy in India as HBV vaccination to health care personnel is not mandatory. Limitations of this study include non-availability of vaccination record in many and recall bias in addition to non-screening for HBV markers.

Table 1: Status of immunization among students

Vaccination status	Complete vaccination (3 doses and a booster)	
	Number of students	students with record
Male (n= 76)	16	6
Female (n = 59)	13	4
Total (n=135)	29	10

Incomplete vaccination (1/2/3 doses)					
Number of students	students with record	1 dose	2 doses	3 doses	Don't know
33	2	6	6	10	11
23	2	3	5	6	9
56	4	9	11	16	20

No vaccination
Number of students
27
23
50



Sincerely,

Manjeet Singh^{1*}; Sushma Sood^{2*}; Naresh Kumar^{1*} and Hitesh Kumar^{3*}

¹Assistant Professor; ²Senior Professor & Head; ³Senior Resident;
* Department of Physiology; † Department of Medicine, Pt. B. D. Sharma PGIMS, Rohtak, Haryana

References

1. Pido B, Kagimu M. Prevalence of hepatitis B virus (HBV) infection among Makerere University medical students. *African Health Sciences* 2005; 5(2): 92 -8.
2. Batham A, Narula D, Toteja T, Sreenivas V, Jacob MP. Systematic Review and Meta-analysis of Prevalence of Hepatitis B in India. *Indian pediatrics* 2207; 663 (44):663-74.
3. Verma M, Mehat G. Needle stick injuries among medical students. *J Indian Med Assoc* 2000; 98(8):436-8.
4. Okeke EN, Ladep NG, Agaba EI, Malu AO. Hepatitis B vaccination status and needle stick injuries among medical students in a Nigerian university. *Niger J Med* 2008; 17(3): 330-2.

Applying new education and leadership concepts in two Nepalese Medical Schools

Corresponding Author:

Dr. P. Ravi Shankar
KIST Medical College
P.O. Box 14142
Kathmandu, Nepal.
Email: ravi.dr.shankar@gmail.com

Dear Editor,

Problem: Newer concepts in health professions education, educational leadership, educational research and educational innovation are not common in South Asian health professions education schools.

A possible solution: The two-year part-time Foundation for International Medical Education and Research (FAIMER) fellowship in health professions education and educational leadership offers an opportunity to learn new concepts in education and equips fellows with skills necessary to implement Education Innovation Projects (EIPs) in their home institution and tries to address this problem.

Lessons learned: I was a fellow of the inaugural 2007 batch of PSGFAIMER Regional Institute in Coimbatore, India. I tried to implement various concepts and skills learnt in Coimbatore at two Nepalese medical schools – Manipal College of Medical Sciences (MCOMS), Pokhara and KIST Medical College (KISTMC), Lalitpur

Introduction of fellows & small group dynamics:

At the beginning of session I of the FAIMER fellowship each fellow interviews three others over a fifteen minute period and introduces one to the large group. I and my colleagues have used this method during the pharmacology practical session for first year undergraduate medical (MBBS) students at KISTMC. I found this method useful in introducing students to each other, and encouraging them to work as a team.

Open house and the listserv:

At the 'open house' during session I fellows share their concerns and problems with faculty and organizers in a free and frank atmosphere. I held 'open house' sessions during the Medical Humanities (MH) module for first year KISTMC students. Students enjoyed voicing their concerns in a free and frank atmosphere. The fellowship has two off-site sessions (II and IV) where fellows and faculty stay in touch through the listserv. Different topics are moderated each month by two first year fellows with the support of second years and faculty. I was not very successful in creating an online discussion forum for MBBS students. We had created an online Google group for the MH module but only a few students participated.

Sessions on change and conflict management:

The session on change management is conducted with a primary focus on the fellow's EIP. Fellows learn to deal with forces against change in their home institution. The session on conflict management is introduced through role-plays dealing with a conflict situation in a medical school. The 'HEAL IT' model of resolving conflicts is practical and applicable in many situations. H stands for Have an attitude of curiosity, not of judgment; E for Evaluate facts, ideas and principles, A for Appreciate other person's point of view, L for Listen, I for the I perspective and T for Take time and space to have a conversation.

Sessions on abstract writing:

Second year fellows convert their EIP into an abstract ready for publication. Having published extensively and submitted abstracts to many conferences I shared my experience and expertise with fellows. I was able to help first year medical students of KISTMC with preparing



abstracts for an international medical student conference in India which were accepted.

Problem-based learning and interactive teaching:

The FAIMER sessions are mainly based on small group work and discussions. Fellows assign themselves roles of group leader, time keeper, recorder and presenter. I use this concept during the Pharmacology small group practical sessions. Students develop leadership skills and find the method democratic.

Fellowship sessions make extensive use of flip charts for presenting group work, concepts and ideas and stimulating discussions. I have been using flip charts in the Pharmacology laboratory for two years. Low cost, ease of use and flexibility are major advantages.

KISTMC conducts regular faculty training sessions. Recently we have introduced sessions on adult learning and small group dynamics. Faculty gains experience in facilitating small group sessions.

Microteaching and giving feedback:

Microteaching sessions are conducted during session III. Second year fellows prepare and deliver a short seven minute presentation to small groups of other fellows and faculty. After the presentation fellows do a self-reflection followed by feedback from others.

Microteaching sessions are conducted during KISTMC faculty training workshops. Faculty self-reflect on their performance. A structured format for giving feedback to presenters is used during fellowship sessions and the same has been adopted in our institution.

Self-reflection:

Self reflection plays an important role in the fellowship. During on-site sessions fellows are required to self-reflect on various aspects and also submit a self-reflection on the Mentor-Learner (ML) web session.

The FAIMER fellowship offers South Asian health profession educators a unique opportunity to learn new concepts and skills and apply them in their home institution. Health professions educators from under-represented institutions, regions and countries should take advantage of the program.

Sincerely,

P. Ravi Shankar

Nocturnal Enuresis in Sudan

Corresponding Author:

Magdi A.H Mahgoub
Email: mahibashi@hotmail.com

Dear Editor,

When we were kids there were things that we liked to talk about with our friends like when having new computer games, going to the toy store or our plans for the weekend. In the mean time there were things we probably didn't like to talk about or let someone to know about; like how many times we cried when going to the dentist, but the most embarrassing one for me at least was how we wet the bed when we sleep at night.

Millions of kids and teenagers from every part of the world wet the bed every night. Bedwetting could not be that serious as malaria or tuberculosis in our African countries or at least not having the priority among the killing diseases. But it's not an excuse to ignore a condition that can be like crises for that little child's world. Most kids don't tell anyone even their parents so it's easy to feel kind of alone.

We aimed in a study that was conducted in Khartoum, the capital of Sudan. To determine the prevalence of nocturnal enuresis (bedwetting) in children aged 5-14 years measuring association factors such as gender and positive family history. based on the fact that each morning an estimated 5-7 million children in the United States wake up in a wet bed due to nocturnal enuresis according to a study from the American Psychiatric Association. Not only had that but around 25% of them are unfortunately punished for a problem beyond them¹. We also aimed in this study to determine the parental knowledge and attitudes toward children with bedwetting. Children are not the only ones who are involved in this issue. Parents of those who suffer play a major role and are strongly involved. Actually they are charged with finding a cure for their children situation. An epidemiological cross-sectional study was carried out with a questionnaire completed by the parents of children attending primary school and aged from 5 to 14 years old. The study was conducted in Khartoum schools by selecting randomly 280 child from 7 different schools and sending home the questionnaire along with the consent form to their parents .218 questionnaires were collected from the total 280 questionnaires giving a responding rate of 77.8% and were considered valid for statistical significance.



Out of the final sample (i.e. 218 children), 73 children were reported by their parents as suffering from nocturnal enuresis which give a prevalence of 33.5% compared with 21.3% in Nigeria² and 17.5% in Iran³. And it is obvious that it's much higher than the literature review which could be due to socio-cultural variations and attitude and behavioural differences. The frequency of enuresis was significantly higher among girls 57.6% (42) girls than boys 39.7% (29) boys. Unlike the global prevalence the girls here outnumber the boys. As found in other international studies, our study shows that prevalence of bedwetting decrease as the age of the child increased from 13.3% at 5-7 years to 2.3% at 12-14 years.

Decrease with age is thought to be mostly due to spontaneous improvement. 71.2% of these children wet their bed more than once in a week. 75% of the parents stated that their enuretic children don't have urinary diseases as far as they know. Also, 68.5%, 72.6% was stated for not having a GIT problems related to the nocturnal enuresis and not having any other medical disorders, respectively. Which support that most of the time bedwetting is not related to organic disorder. Besides other factors, role of hereditary was found to be important in aetiology of nocturnal enuresis in previous studies. Although a significance test was not performed for testing the role of family history in nocturnal enuresis, in our study (positive 49.3%) and consistent with the literature, NE was found to be more in children with family history. However further studies are needed to further substantiate that.

Nocturnal enuresis can take a toll on a child's self-esteem and is a frustrating problem to parents. Responses on the questionnaire of our study indicates that 76.7% of the respondents felt that bed-wetting had no effect on their child's self-esteem, while just 12.3% felt that their child was emotional, shy, embarrassed and/or hesitant to deal with his sibling and friends.

Feelings of the parents may range from worried to frustrated, sad to angry, and even tired. Children may be able to sense these feelings in parents. Study findings showed that knowledge of the nocturnal enuresis literature among parents was good and depend on the level of education. Survey addressed the age group of the parents. The largest age group in the sample is of 33 – 42 years range, which might indicate that their social life was traditional which would have a negative effect on their behaviours towards their children's bedwetting. Those who were highly educated were more supportive to their children.

Regarding treatment modalities used for stopping the bedwetting it was shown that 32.2% of the parents force their children to go to the bathroom before going to bed. 22.3% prevent them from drinking lots of liquids before going to bed. 25.7% wake their children up at night to go to the bathroom. And finally only 11.4% warn and scorn their children for not repeating it. It also depended on the level of education although it was not strongly correlated.

In conclusion, as can be expected by conventional wisdom and seen by literature, nocturnal enuresis (NE) is prevalent in Sudan among children 5-14 years of age. Parents should not become overwhelmed with feelings of frustration or failure due to their child's bed-wetting. Although there are no easy answers or quick fixes for the issue of bedwetting it's important to take positive steps together as a team (parents and child) in getting through nocturnal enuresis and especially its effect on our children. Support and praise will help a child. Shame and punishment will not.

Sincerely,

Magdi A.H Mahgoub¹, Shima Kamal²

¹MBBS University of Khartoum

The Author has awarded the APSI Certificate (Association for the Promotion of Scientific Innovation) in reference to the recommendation of the 2nd International Conference of Medical Students in Sudan for best second place research presented.

² MBBS University of Khartoum, MSc. Witwatersrand Johannesburg, Lecturer department of paediatrics and child health university of Khartoum

References

- 1- American Psychiatric Association .Diagnostic and statistical manual of mental disorders (4th ed.), Washington DC.
- 2- MO Ibadin, NJ Iduoriyekemwen, PO Abiodun; Survey of Childhood Enuresis in the Ehor Community, the EDO State, Nigeria; Saudi journal of kidney disease and transplantation. Year : 2006 | Volume : 17 | Issue : 2 | Page : 177-182
- 3- M.gharamani, Mahdi Basiry Moghadam, AmirAli Gharamani, In: Nocturnal Enuresis and its Impact on Growth; Iran J Pediatr, Jun 2008; Vol 18 (No 2), Pp: 167-170