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Original Article

Exploration of the Lived- in Experience of Mothers of Infants with Oral Facial Clefts

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Abstract

The present study was conducted to explore the lived- in experience of mothers of infants with oral facial clefts in selected Hospital, Thrissur. Objectives of the study were to elicit the lived- in experience of mothers of infants with oral facial clefts and to prepare a coping module for those mothers. Qualitative research approach with phenomenological design was used. Ten samples were selected by using convenient sampling technique. Content validity of the tool was done with the help of experts and the reliability was based on trust worthiness of the data. The data were collected with a semi structured interview and analyzed using thematic analysis. Five themes were derived from exploring the lived- in experience of mothers of infants with OFC. The themes were divided into physical dimensions, psychological dimensions, social dimensions, spiritual dimensions and economical dimensions. Various subthemes were derived from these themes. The results of the phenomena studied have helped to develop a conceptual frame work. The study concluded that the mothers of infants with oral facial clefts had both positive as well as negative experiences.

Keywords: Lived-in Experiences; Mother; Infant; OFC; Coping Module.

Introduction

Birth of the child is a greatest moment in a mother's life. But after the child's birth, if it becomes apparent that something is wrong with the child, the beautiful moment is replaced with shock and disappointment. When children are born with oral facial clefts (OFC), the stigma of OFC affects not only the individual but also the family and society. No congenital anomaly has more complexity and diverse than cleft lip and palate. When child born with OFC mother is under shock and distress [1].

It is estimated that overall global prevalence of oral facial clefts is one individual in every 600 new born babies. Assuming 15,000 births per hour worldwide, a child is born with cleft somewhere in the world in every 2 minutes. The Indian subcontinent remains one of the most populous areas of the world with an estimated population of 1.1 billion, in India alone. This yields an estimated 24.5 million births per year and birth prevalence of clefts is somewhere between 27,000 and 33,000. Cleft lip and palate occur in about 1-2 per 1000 births in the developed world [2].

Statement of the Problem

A study to explore the lived- in experience of mothers of infants with oral facial clefts in selected Hospital, Thrissur

Objectives

- To elicit the lived- in experience of mothers of infants with oral facial clefts.
- To prepare a module on coping strategy for the mothers of infants with oral Facial clefts

Operational Definitions

- *Lived- in experience:* Refers to the expressed experiences of mothers while taking care of infants with oral facial clefts.
- *Oral facial clefts (OFC):* It is the congenital anomalies of the face which includes cleft lip and palate.
- *Mothers:* Refers to mothers of infants affected with oral facial clefts (OFC).
- *Infants*: Refers to the age group of children between 1 month to 1 year, who is affected with cleft lip and palate.

Assumptions

Mothers of infants with oral facial clefts may have both positive experience and negative experience.

Methodology

Design

Qualitative design with phenomenological approach.

Setting

Charles Pinto Center at Jubilee Mission Medical College, Thrissur.

Sample and sampling technique

Convenient sample of 10 mothers of infants with OFC who is admitted in Charles pinto Centre for surgery.

Sampling Criteria

Inclusion criteria

- Mothers who are able to speak and understand Malayalam.
- Mothers who are willing to participate in the study.
- Mothers who are available during data collection period.

Exclusion criteria

- Mothers with hearing problem.
- Mothers who are not willing to participate in the study.
- Mothers of infants with both cleft lip and palate.

Instruments

Section A: Demographic profile of mother

Demographic profile of infant

Clinical profile of infant

Section B: Semi structured interview schedule regarding the experience of mother of infants with OFC.

Data Collection

Ethical clearance was obtained from the ethical committee constituted by the institution on 8/4/2016. The investigator obtained a written informed consent from authorities of Jubilee Mission Hospital, Thrissur.

After obtaining permission from the concerned authority, the procedure for data collection was explained to the study participants. The informed consent was obtained from the samples to audiotape the interview.

An in depth interview was conducted using a semi structured questionnaire. Each sample took 30-45 minutes for the completion of interview schedule. Coping module was administered after the completion of interview.Some of the mothers discussed their doubts briefly.

Data Analysis

Taped interview dialogue were listened to and transcribed in to verbatim. Thematic content analysis was done by Colaizzis analysis. It includes: -

- Read all the subjects description to acquire a feeling for them.
- Return to each protocol and extract signiûcant statements from each transcript.
- Spell out the meaning of each significant statement, known as formulating meanings.
- Organize formulated meanings into clusters of themes.
- Results so far are integrated into an exhaustive description of the phenomenon under study.
- Formulate the exhaustive description of the investigated phenomenon in as unequivocal a statement of identification as possible.
- A final validating step can be achieved by returning to each subject and asking about the findings so far [3].

Themes and subthemes in exploration of lived- in experience of mother of infants with OFC.

Themes	Subthemes
Physical dimension	Sleep disturbance Insomnia Difficulty to feed her child Tiredness Headache Breast engorgement Breast tenderness
Psychological dimension	Disappointment Mal adjustment Anxiety Fear to feed the child Guilty feeling Sadness Withdrawal from society Worries about Child's condition Neglect the child
Social dimension	Support from partner Support from family members
Spiritual dimension	Blaming God Strength from prayers
Economical dimension	Financial difficulties Inability to continue employment

Physical Dimension

Difficulty to feed her child

Most of the mothers 8(80%) experienced difficulty to feed her child. Some of the mothers Expressed that they experienced difficulty to feed her child due to less production of milk.

"I felt the child is not fed properly because of the milk secretion is less."

Few mothers expressed that difficulty to feed her child due to aspiration of milk coming through the nose.

"I can't feed the child, because while I am feeding the child, milk is coming through the nose, the child can't breathe and also the child becomes blue in color."

Sleep disturbance

The majority 6(60%) of mothers had sleep disturbances. Some mothers expressed that they had disturbed sleep due to tension.

"Thinking about my child's condition and future I had disturbed sleep."

One mother told that she had experienced disturbed sleep due to the child's condition.

"During the first few days after delivery, I was little tensed about my child, even though my mother was beside me, a slight noise made by the child would wake me up."

Insomnia

The most of the mothers 7(70%) experienced insomnia. Majority of mothers expressed that they had lack of sleep due to anxiety.

"I had tension about the condition of my child and her future which disturbed my sleep."

"Day and night seemed to be same for me.Since I was sleepless throughout as I had given birth to a girl baby, suffering from cleft lip. I am always thinkingabout the child. Whether the disorder would affect her for the whole life and whether due to this, she will have to face many problems in life."

Tiredness

Majority of mothers 6 (60%) felt tired. Some of the mothers expressed that they felt tired due to repeated hospitalization of the child and also due to lack of sleep.

"My child was admitted in ICU because he had cleft lip. Due to the admission of the child in ICU, I often had to go to feed the child that I had no time to take rest."

One of the mothers verbatim is as follows

"As per our customs and tradition, we got traditional treatment after delivery. But as my child has cleft lip, I was unable to take care of myself. I was deprived of the traditional treatment as others. It may be the only reason why I am tired Most of the time when compared to others."

Headache

6(60%) of the mothers experienced headache. Few mothers said that they felt headache due to the tension about child's condition.

"Thinking about child's condition, I used to experience headache."

"When I realized about the condition of the child, I was so tensed that I had a Severeheadache. In many situations it will subside only with T. Paracetamol."

One mother commented that she had giddiness followed by headache.

"I was concerned most of the time about my child. Due to that tension I had severeheadache. Mean while I experienced giddiness. It was difficult for me to remain constant for a single minute. I tend to be off balance. I was on Medication."

Breast engorgement

Few mothers 2 (20%) felt breast engorgement because of accumulation of milk in breast.

"During first few months, baby had not sucked the breast properly because of cleft lip. The breast became enlarged so I squeezed the milk to remove it from the breast."

One mothers complaints that fullness of breast

"During first few months, the child did not sucking the breast because of cleft lip. So I felt fullness of breast that the milk was accumulated in the breast and the breast became hard."

Breast tenderness

Few mothers 2(20%) experienced tenderness over the breast.

"My child had opening in his lip, so he was unable to suck the breast. Because of that the milk was accumulated in the breast, I felt slight pain in the breast during initial period."

One mother said "I didn't notice the tenderness around the breast because of my tension."

"Although I felt pain over the breast, I didn't notice the tenderness around it because I was always bothered about how to feed my child carefully without the entry of the milk into the gap."

Psychological Dimension

Disappointment

Some of the mothers 3(30%) expressed that they felt disappointment due to the facial deformity of the child.

"When I saw my child for the first time, I was so shocked, mentally down and imbalanced that I did not recover from the shock.

Even I wasn't able to accept my child. I didn't allow my child to lie near by my side. Due to this I sought counseling and I have undergone many counseling sessions."

One mother said that she faced lots of mental problems after delivery.

"Since I had to face many mental problems after the delivery of cleft lip baby. I was mentally down, imbalanced and had not shown any interest in any activity."

Maladjustment

Most of the mothers 5 (50%) had maladjustment to the unexpected situation (child with cleft lip).

"It was new experience to me. It took fifteen days to adjust with the situation. After fifteen days only I could hold the baby in my arms. "

Few mothers told that they had adjustmental problems in feeding the child.

"I had fear to feed the child. I couldn't adjust with the situation, so my mother used to help me to feed the child."

Anxiety

All mothers 10 (100%) experienced anxiety and worries regarding the child's condition.

"When I thought about child's condition, I was so anxious about how to take care of my child and what can I do for my child."

"After child's birth, I experienced anxiety regarding his condition and health."

Fear to Feed the Child

Majority 9(90%) of mothers had fear to feed the child due to aspiration of milk. Several mothers experienced that they had the fear during the time of feeding the child.

"While feeding the child, milk comes through the nose. Due to that the child can't breathe and turns blue. Due to this, l had difficulty to feed the child."

Some mothers said that they had less knowledge about child's condition and related to feeding.

"I had fear to feed the child because I did not know anything about the feeding technique of my child."

Guilty Feeling

Few mothers 2(20%) felt guilty because of the child's appearance.

"I felt guilty while travelling with my child."

"When we travel, my mother-in-law used to cover my baby with cloth, because my baby had cleft lip."

One mother told that

"I had two abortions. Now I feel stressed that because of me only, my child got Cleft lip"

Sadness

The majority 8(80%) of mothers feel sad. Some mothers expressed that they feel sad due to the child's appearance.

"I cried a lot when I saw cleft lip for my baby which I had not seen in anyone before."

"I was so sad when I saw opening seen in the lip for my baby."

Withdrawal from Society

Most of the mothers 6 (60%) experienced withdrawal from society. Some of the mothers expressed that they experienced withdrawal from society due to guilty feeling.

"I do not even take my baby out even for family functions with us because of the facial deformity and often relatives will ask lots of questions about the Condition of the child."

Worries about Child's Condition

Majority 4 (40%) of mothers had worries about child's condition

"After the birth of the child, I was worried regarding the future and health of my child. I was so worried as to how to take care of my child and what to do."

Most of the mothers experienced worries about child's condition due to poor feeding

"I couldn't breastfeed my child, because of that the child didn't gain adequate weight."

Neglect the Child

Few mothers 1(10%) neglected the child

One mother expressed that

"When I saw my child for first time, I was so shocked. Even I was not able to accept my child. I didn't allow my child to lie by my side. It was new experience to me; I took fifteen days to adjust with the situation. After fifteen days only, I took my baby in my hands."

Social Dimension

Support from Life Partner

Several mothers 4 (40%) had support from partner. Some of the mothers expressed that they got support from partner.

"My husband supported me saying that a baby is a gift from God which we should accept."

Few mothers expressed that support from the partner made her more confident.

"I got psychological support and courage from my husband to face the problems."

Support from Family Members

Some of the mothers 4 (40%) expressed that they got support from family members especially for taking care of the child.

"My family supported me by helping me to take care of my child while feeding, bathing."

Blaming from Family Members

Almost mothers 6 (60%) experienced blaming from family members. Majority of the mothers got blaming from her mother in-law and it made them psychologically down.

"My mother in law always blamed me for the condition of the child saying that in her family nobody had such a deformity and this is due to curse from God."

One mother narrated that

"Because of husband's family's influence, my husband did not even come to see my child and sent me a divorce notice."

Spiritual Dimension

Blaming God

Majority 6(60%) of mothers were blaming God after the birth of the child.

"Before delivery, I used to pray to God for a healthy baby, but I did not get what I wished and became angry with God."

One mother complaints that

"During pregnancy time, I used to pray with my husband, but now there exists a gap between God and me."

Strength from Prayers

Few of the mothers 3(30%) were strengthened from prayers

"I prayed to God for the success of the surgery and the good condition of the child."

"At that time there was a separation from God but now I feel that the baby is a gift from God and I thank him for the baby."

Economical Dimension

Financial Difficulties

Most mothers 7(70%) experienced Financial difficulties because of the cost of treatment.

"We already spend lots of money for infertility treatment and delivery. Now my baby has undergone surgical treatment due to the cleft lip. So I experienced some financial problems."

"Although we had some financial problems because of the treatment of the child, we tried to manage it on our own."

Inability to continue the employment

All of them 10 (100%) belong to the category of home makers. So no one has given the narrative description related to the discontinuing of the job.

Discussion

The present study was undertaken to explore the lived experience of mothers of infants with OFC. The main objectives of the study were to elicit the lived-in experience of mothers of infants with oral facial clefts and to prepare a module on coping strategy for the mothers of infants with oral facial Clefts. In this study 10 interviews were carried out with mothers of infants with OFC. Totally 5 themes were identified in the analysis such as physical dimensions, psychological dimensions, social dimensions, spiritual dimensions and economical dimensions.During the interview, investigator identified seven sub themes ofphysical dimension like sleep disturbances, insomnia, difficulty to feed the child, tiredness, headache, breast engorgement and breast tenderness. After the data analysis the researcher categorized psychological dimension into nine sub themes like disappointment, maladjustment, anxiety, fear to feeding the child, guilty feeling, sadness, withdrawal from society, worries about child's condition, and the neglecting of the child. The social dimension was categorized as three subthemes that were support from partner, support from family members and blaming from family members. The subthemes derived from spiritual dimension were blaming God and gaining strength from prayers. The last theme economical dimension was further divided into financial difficulties and inability to continue the employment.

Conclusion

This study explored the lived experience of mothers of infants with OFC. A mother who is having OFC child undergone through various physical, psychological, social, spiritual and economical changes should have positive as well as negative emotions. Findings of this study are useful for nurses in taking care of mothers during the hospitalization. Mothers must be involved in decisions and cares. They must be supported for reducing anxieties and stresses. If nurses understand the stress that mothers experience and adopt the principles of family centered care, mothers will feel supported throughout their journey of the child's treatment and it may alleviate the anxieties that were evident in this study.

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Original Article

Prevalence and Determinants for Risk Behavior in Management of Febrile Convulsion

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Abstract

The term febrile convulsion is not a diagnostic entity. It simply describes any seizure that occurs in response to a febrile stimulus. It usually occurs between the age of 3 months and 5 years and occurs in 2-4% of young children. At the time of convulsions, family members follow the different malpractices which leads child in risk behavior. So keeping this view in mind, the present descriptive study was conducted with quantitative research design. The demographic variables and structured check list was used to collect the data. The results were shown that almost 40% of samples practiced to shake and arouse the convulsing child. 33.3% were used to slap the baby while convulsions occurs, 20% of samples suck the discharge from the child's mouth and nose and another 20% used to keep the baby in prone position during the course of the convulsions. In this present study it was observed that, majority of them (60%) were follow the traditional practices due to fear of unconsciousness and death. lack of transportation is the second most common cause and poverty is the 3rd most common cause for risk behavior in management of febrile convulsion. Other causes were found to be least reasonable for risk behavior. Even though some traditional practice are having scientific reason but few don't have empirical evident that put the child under risk. Lack of awareness, knowledge, transportation facility and poverty is the leading cause for this risk behavior, Mass enlightenment campaign for the community, especially the rural, against use of harmful traditional remedies to treat febrile convulsion at home is strongly advised to prevent delayed treatment and associated complications.

Keywords: Febrile Convulsion; Febrile stimulus.

Introduction

The term febrile convulsion is not a diagnostic entity. It simply describes any seizure that occurs in response to a febrile stimulus. It usually occurs between the age of 3 months and 5 years and occurs in 2-4% of young children. The typical febrile convulsion is a generalized tonic clonic seizure lasting between a few seconds and 15 minutes, followed by a period of drowsiness. Febrile seizures tend to occur in families, although the exact mode of inheritance is not known [1].

Each year, about 150,000 children and adolescents in the United States will come to medical attention for evaluation of a newly occurring seizure disorder of some type. Between 2% and 4% of all children in Europe and the United States experience at least one convulsion associated with a febrile illness before the age of 5 years. The cumulative incidence of febrile convulsions among children ranges from about 1% in China to more than 8% in Japan and 14% in Guam. The peak incidence of a first febrile convulsion occurs in the second year of life. Between 0.5% and 1% of children and adolescents experience a seizure associated with other acute metabolic or neurologic

insults; most of these occur in the neonatal period. The incidence of epilepsy (recurrent unprovoked seizures) in children and adolescents seems relatively consistent across all populations studied, ranging from 50 to 100/100,000. The highest incidence of epilepsy is in the first year of life. West syndrome accounts for about 2% of all childhood epilepsy, Lennox-Gastaut syndrome for 1–2%, childhood absence epilepsy (pyknolepsy) for 10–15%, juvenile myoclonic epilepsy for 5%, and idiopathic localization-related epilepsy for 10%. Between 0.5 and 1% of children experience a nonrecurrent, single, unprovoked convulsive episode. Following are the estimated numbers of children and adolescents with newly diagnosed convulsive disorders in the United States for the year 1990: febrile seizures, 100,000; neonatal seizures, 4,000; other provoked seizures, 6,000; single unprovoked seizures, 10,000; and epilepsy, 30,000 [2,3].

The incidence rates is high in India are comparable to those in the developed world. The Yelandur survey estimated the prevalence to be 3.28-5.71/1000 whilst the more recent Uttarakhand survey [4] found a prevalence of 2.27 per 1000 population. An EEG is not indicated for simple Febrile seizure (FS). There is widespread consensus that regular anti-epileptic drugs are not recommended in simple FS. However, prophylactic oral or rectal diazepam or oral clobazam can be used with antipyretics. The risk factors for experiencing subsequent FS are onset of seizures at a younger age, seizures with low-grade fever, complex FS, multiple FS and positive family history of FS or epilepsy. The risk factors for experiencing subsequent epilepsy are pre-existing developmental delay, positive family history of epilepsy and complex FS. The risk from the Yelandur study was estimated to be 1.2%. Some of the febrile seizure associated epilepsy syndromes have recently described to be associated with mutations in sodium channel genes (SCN1A-related spectrum of epilepsies: Please see discussion that follows under the heading "Investigations") [5].

The study was conducted between December 2000 and February 2001. Our findings show that 71% of urban mothers compared to 25% of rural mothers attributed the cause of FC to fever (chi(2)=24.17: p<0.001). Seventy-five percent of mothers from rural community and 28.6% of urban mothers attributed the cause to witchcraft and/or evil spirits. Twenty-five percent of rural mothers also attributed abnormality of the spleen as a cause of FC. All the mothers, both urban and rural, were not directly involved in the management of the convulsive episode due to panic and confusion. Ninety-two percent of urban and all the rural mothers permitted the use of traditional medicine while 7.1% of urban mothers employed prayers during convulsion. Twenty percent of urban and twenty-two percent of rural mothers use urine (human and or cow's) for treating FC at home. Other home remedies include kerosene, fuel and crude oil. These all put the child under risk at pre hospital stage. The tradioonal practices vary from state to state and country to country [6]. By keeping this in view this study was conducted to know the traditional practices and derteminents for risk risk behaviors in villages of Jhunjhunu, Rajasthan, India.

"A cross sectional descriptive study to assess prevalence and determinants for risk behavior in management of febrile convulsion among parents of under five children at selected village in Jhunjhunu."

Objectives of the Study

1. To assess the prevalence of risk behavior followed for management of febrile convulsion among parents of under five children.
2. To assess the determinants for risk behavior for management of febrile convulsion among parents of under five children.

Method

Research Approach and Design

The research approach used for this study is Quantitative approach. A cross sectional descriptive study design was adopted to Prevalence and determinants for risk behavior in management of febrile convulsion

Target Population

Parents and care givers of under five children

Accessible Sample

Parents and care givers of under five children living in Jhunjunu

Sample Size: 15

Sample Design: Non probability purposive convenient sampling technique was adopted.

Development of Tool

The semi-structured questionnaire was developed after referring many literature and opinion from experts in the field.

• Description of the Tool: the Tool Consist Three Sections

Section-1 demographic Variables includes responder, age of the parent, educational status of respondent, occupation of the parent, type of family, number of children, religion, gestational age of child, Nearly Availability of health care services, Child age at first febrile seizure episode and area of residency.

Section 2: A checklist to assess commone traditional practices include Stimulate the convulsing child by slapping, Application of oil on eyes, Sudden refer the child to temple or untrained person, Apply cow urine on mouth, Skin laceration,Burns to the part of body, Place the child into prone position, Restrain the convulsing child , Shake and rouse the convulsing child, Application of olive oil on whole body, Start running of onion on back of child, Put spoon into mouth of child, Giving old shoes for smelling, Cardiac massage to relieve episode, Pour water to keep child cool and calm, Lower the child body temperature by using palm oil., Application of eucalyptus oil, Suck discharge from the child's nose and mouth , Giving iron metal in hand and others if any.

Section 3: a check list to assess determinants for risk behaviors includes Poverty, Poor knowledge and awareness, Lack of availability health facility, Lack of accessibility of health services due to distance, Lack of approachability of health services due to politics, Lack of transportation, Cultural belief, Family history of epilepsy/genetically problem, Forcing by others/ forefathers, Fear of death and unconscious, Lack of education and others if any.

Ethical Clearance: No interventions involved so ethical clearance was not obtained

- *Data Collection:* Data was collected from 15 samples after getting consent, samples were selected with non probability purposive convenient sampling technique. The objectives and purpose were explained to get consent. The data was collected though in depth interview method in the natural setting, a semi structured questioner was used to collect data, and assess their common practices and cause for that. Data were entered into excel sheet for analysis and interpretation.
- *Analysis and Interpretations:* Descriptive statistics was used for interpretation of result. Tables, were used.

Result

Table 1: Frequency and percentage distribution of demographic variables N=15

S. No.	Demographic Variable	Frequency	Percentage (%)
1.	Responder		
	Father	10	66.7
	Mother	2	13.3
	Others	3	20
2	Age of Parent		
	Below 25 Year	6	40
	25-30 Year	4	26.6
	31-35 Year	2	13.3
	Above 35 years	3	20
3	Educational status of the respondent:		
	Illiterate	4	26.6
	1 to 10 std	6	40
	Higher secondary	3	20
	UG and PG	2	13.3
4	Occupation of the respondent :		
	Health care professionals	1	6.7
	Unemployed	5	33.3
	Employed	9	60
5	Type of family		
	Nuclear	5	33.3
	Joint	9	60
	Single	1	6.7
6	No. of children		
	1	5	33.3
	2	2	13.3
	3	1	6.7
	More than 3	7	46.7

7	Religion		
	Hindu	9	60
	Christian	0	0
	Muslim	6	40
8	Gestational age of the child		
	Pre term	0	0
	Term	14	93.3
	Post term	1	6.7
9	Nearly Availability of health care services		
	Yes	13	86.7
	No	2	13.3
10	Child age at first febrile seizure episode—		
	0-1 years	8	53.3
	1 to 2 years	1	6.7
	2 to 3 years	1	6.7
	3 to 4 yeas	2	13.3
	4 to 5 years	3	20
11	Area of residency:		
	Rural	6	40
	Urban	8	53.3
	Semi urban	1	6.7

Prevalence of Risk Behavior for Management of Febrile Convulsions

It was observed that out of 15 samples 5 (33.3%) were used to slap the baby while convulsions occurs. Were as 20% of samples used to refers the child to temple or untrained person during or after the course of convulsion. It was found that another 20% of samples were used to keep the baby in prone position during the course of convulsion. Almost 40% of samples practiced to shake and arouse the convulsing child. Only one (6.7%) sample tries to put some object in the mouth to prevent tounge bite. Out of 15, only 1 sample used to practice cardiac massage to relieve the episode. Were as 20% of samples suck the discharge from the child's mouth and nose.

Determinants of Risk Behavior for Management of Febrile Convulsions

It was shown that out of 15 samples, 5 (33.3%) samples were below poverty line and 66.7% of samples were having poor knowledge and awareness about management of febrile convulsion. Around 26.7% of samples have complaint that due to lack of accessibility, approachability and availibity of health care services was reason for their risk behavior for management of febrile convulsions.Almost 40% of samples were said that lack of transportation facility was the main reason and 4 (26.7%) were used to follow their cultural norms. It was also found 13.3% of samples were had a family history of convulsion and they follow the same remedy for febrile convulsions and the percentage of sample forced to follow their traditional practices. A majority of them (60%) were follow the traditional practices due to fear of unconsciousness and death.

Discussion

In this present study it was found that almost 40% of samples practiced to shake and arouse the convulsing child. Secondly, out of 15 samples 5 (33.3%) were used to slap the baby while convulsions occurs. Were as 20% of samples suck the discharge from the child's mouth and nose and another 20% used to keep the baby in prone position during the course of the convulsion.

To determine the knowledge, attitude and practice (KAP) of home management of febrile convulsion (FC), by mothers in the community, focus group discussions (FGD) were conducted in two communities, Uselu (urban) and Evbuomodu village (rural), both in Edo State, Southern Nigeria. The study was conducted between December 2000 and February 2001. Our findings show that 71% of urban mothers compared to 25% of rural mothers attributed the cause of FC to fever (χ^2=24.17: p<0.001). Seventy-five percent of mothers from rural community and 28.6% of urban mothers attributed the cause to witchcraft and/or evil spirits. Twenty-five percent of rural mothers also attributed abnormality of the spleen as a cause of FC. All the mothers, both urban and rural, were not directly involved in the management of the convulsive episode due to panic and confusion. Ninety-two percent of urban and all the rural mothers permitted the use of traditional medicine while 7.1% of urban mothers employed prayers during convulsion. Twenty percent of urban and twenty-two percent of rural mothers use urine (human and or cow's) for treating FC at home. Other home remedies include kerosene, fuel and crude oil. This finding support first objectives of this present study [7].

In this present study it was observed that, majority of them (60%) were follow the traditional practices due to fear of unconsciousness and death. lack of transportation is the second most common cause and poverty is the 3rd most common cause for risk behavior in management of febrile convulsion. Other causes were found to be least reasonable for risk behavior.

A study was conducted to explore factors associated with delay in seeking treatment outside the home for febrile children under five. Using a pre-tested structured questionnaire, all 9176 children below 5 years in Iganga–Mayuge Demographic Surveillance Site were enumerated. Caretakers of children who had been ill within the previous 2 weeks were asked about presenting symptoms, type of home treatment used, timing of seeking treatment and distance to provider. Children who sought care latest after one night were compared with those who sought care later. The result showed that, Those likely to delay came from the lowest socio-economic quintile (OR 1.45; 95% CI 1.06–1.97) or had presented with pallor (OR 1.58; 95% CI 1.10–2.25). Children less likely to delay had gone to drug shops (OR 0.70; 95% CI 0.59–0.84) or community medicine distributors (CMDs) (OR 0.33; 95% CI 0.15–0.74), had presented with fast breathing (OR 0.75; 95% CI 0.60–0.87), used tepid sponging at home (OR 0.43; 95% CI 0.27–0.68), or perceived the distance to the provider to be short (OR 0.72; 95% CI 0.60–0.87). This finding support second objectives of this present study [8].

Conclusion

The study shows that 40% were practiced to shake and arouse the convulsing child and (33.3%) were used to slap the baby while convulsions occurs. Sucking the discharge from the child's mouth and nose and keeping the baby in prone position during the course of the convulsion is practiced equally by 20% of samples and this found to be good practice. Even though some traditional practice are having scientific reason but few don't have empirical evident that put the child under risk. Lack of awareness, knowledge, transportation facility and poverty is the leading cause for this risk behavior, Mass enlightenment campaign for the community, especially the rural, against use of harmful traditional remedies to treat febrile convulsion at home is strongly advised to prevent delayed treatment and associated complications.

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The Nurse Teacher, the Nursing Students and the Counseling Process

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Abstract

World population exploded from one billion (1820) to 7.5 billion (2017) and the addition of millions of people each year is exacerbating problems of illiteracy, poverty, unemployment, jeopardizing the mental health of people leading to poor productivity, and escalation of social problems like violence and crimes. Problems of adolescent students are complex, since adolescence is considered as a period of stress and strain and full of turmoil. The demands of academic life are becoming increasingly stressful for students especially for nursing students. Counseling enhances, self-analysis, self-understanding, improves self-esteem, and also understanding of the world. The teacher counselor by taking special interest in the students, develops confidence, alleviates, fear and anxiety and creates students as successful professionals and responsible citizens.

Keywords: Counseling; Counseling Process; Teacher as Counselor**;** Nursing Programs; Study Skills; Online Counseling.

Knowing others is wisdom!
Knowing yourself is enlightenment!

Introduction

Leaders of many nations understand that positive mental health of their citizens is a valuable economic and social asset. Counseling has a strong tradition in almost every continent. Best examples of counselors to quote from history are Socrates and Plato, Hayden and Beethovan, Ramakrishna and Swami Vivekananda and Freud and Jung. The original mentor was described in 800B.C. by Homer in Greece, where Athena, in the guise of mentor, became the mentor of Odysseus' son Telemachus. The most widely acknowledged counseling situation in India is in the great Epic Bhagavat Gita where, in the battlefield of Kurukshetra, Lord Krishna counseled prince Arjuna. The old Indian adage; "Mata, Pita, Guru, Deivam" (Mother, Father, Teacher, God) reminds youngsters of the agents of counseling. In all cultures, the elders not only set the norms of behavior within that culture but also counsel the youngsters to follow the norms. In India, elders especially parents and teachers impart counseling in the form of advice and guidance and they consider it as one of their fundamental and sacred duty.

World population exploded from one billion (1820) to 7.5 billion (2017) and the addition of millions of people each year is exacerbating problems of illiteracy, poverty, unemployment, depletion of natural resources, urbanization and industrialization. The mental health of people is jeopardized leading to poor productivity, and escalation of social problems like violence and crimes. To cope up with the stress & to be a good citizen, counseling is needed.

Why Counseling is Necessary for Students?

Problems of adolescent students are complex, since adolescence is considered as a period of stress and strain and full of turmoil. The rapid growth and development, changes in the character of students,

changes in education system and pedagogy of institutions of higher learning as well of educational social, economical, political and technological changes have favored the development of student guidance and counseling services mandatory in all educational institutions. The demands of academic life are considered to be increasingly stressful for students. There are many "issues" commonly experienced by students in college that can sometimes pose major challenges to study, play, socializing, and living. (Jesse B. Davis - 1909, USA).

Beginning life at college naturally generates both excitement and anxiety, may due to shift from home to hostel, school to college, academic responsibilities, not knowing the methods of studying or the methods of preparing for examinations, leisure time management, meeting new people, adjusting with peer group members, especially, socializing with opposite sex, etc,. If they have heterosexual problems, they may not be able to discuss it with their parents. Some quickly overcome, as they adapt to the new environment; For others, this transition become a problem which manifest as homesickness, feelings of anxiety, obsessive thoughts and/or physical ailments leading to poor health, poor academic performance and indulgence in antisocial activities.

In their adolescent period, students must know about their capacities, and they need professional guidance not only to know about themselves and their own potentials, also for right selection of course of study, names of reputed institutions, places of admission, job opportunities after higher studies, the expense for higher education, availability of scholarships, funds, etc,. They also need personal guidance to come out of the adjustment problems. Even though, the present younger generation has many educated assistance, they may be reluctant to approach the parents or elders and in some families the parents may be uneducated o r busy.

According to Denga (1987) a research study was conducted among secondary school students to assess the use of drugs which included pills, alcohol, hemp and the findings revealed that abuse of drugs had assumed unprecedented dimensions. Drug abuse is no doubt, a serious, social problem and it lends students vulnerable to, violating law, committing crimes, etc. The researcher highlighted the importance of counseling services for school students. A study was conducted by McKenzie et al (2015) to assess the effectiveness of counseling among students who had attended counseling service from 129 universities. Self report from students to evaluate the reliable and clinically significant changes before and after counseling revealed that majority of the students (92%) reported experiencing academic issues. Counseling was found to result in reliable change for 67% and clinically significant change for 40% of the students. Pressure from parents to score high marks and pressure from administrators of academic institutions resulted in increasing number of crimes, suicides and homicides committed by students and made counseling services mandatory in all schools and colleges in the modern days.

When did Counseling Programs Started?

Counseling programs in schools began in the United States, as early as in the 20th century. They started with the vocational guidance which is now called as career development counseling. Jesse B. Davis was the first to introduce the systematic school guidance program in the United States. In India, Patna University was the first institution which started counseling services in 1945. Guidance and Counseling services consolidated their position in India after the recommendation of the Mudaliar Secondary Education Commission (1952-1953). In India, the National Policy on Education(1986) also emphasized this need in very clear terms, making counseling services as imperative and integral component of program of any educational institution.

What is Counseling?

"Counseling is the skilled and principled use of relationship to facilitate self-knowledge, emotional acceptance, growth and the optimal development of personal resources. The overall aim is to provide an opportunity to work towards living more satisfyingly and resourcefully.

- *British Association for Counseling (1986)*

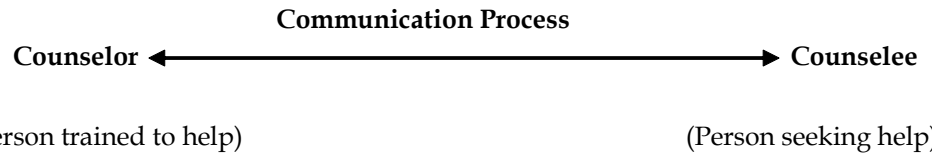
What is not Counseling?

Counseling is,

- Not giving the information, though information may be present.
- Not giving an advice though making suggestions and recommendations.
- Not interviewing, though interviewing is involved.
- Not the behaviors like persuading, threatening, compelling or use of physical force.
- Not the selection and assignment of individual to job.

- *Patterson (1967)*

Elements in Counseling Process



Communication Process

A seeking, that permits help to be given and received through communication between the counselor and counselee.

What are the Purposes of Counseling?

In the Educational Domain, counseling helps in the,

- Optimum development of individual.
- Understand the individual difference among the students.
- Understanding of the differential needs and abilities of the students.
- Selection of suitable courses from different type of courses.
- Enhancement of career prospects of the learners
- Qualitative improvement of education.
- Improvement of the internal efficiency of the school/college system.
- Coping up with trends in the educational system.
- Solution of educational problems.
- Solution of disciplinary problems.
- Reduction and elimination of the anti-social activities on campus.

In the Vocational Domain counseling helps to,

- Identify and develop the human potential.
- Increase the vocational efficiency.
- Adjust with co-workers towards meeting mutual goals.
- Work in complex work environment.
- Learn and facilitate the use of technological advancement.
- Plan and utilize man-power optimally.
- Accustom with changes in the conditions of industry and labor.
- Prepare individuals to meet the growing demands of the progressing country and to grow along with changing economic pattern of the country.

Why Counseling is Necessary for Nursing Students?

As of the stars in the sky, the problems of the nursing students are innumerable. Following are only a few, among the many problems faced by nursing students.

- The minimum age for entry in to Nursing course is 17 years and the nursing students are still adolescents, and it is natural to have emotional immaturity and to suffer from emotional turmoil.
- Nursing programs are conducted as residential programs and most of the colleges expect strict discipline from the students. They are away from their family and home and it may not be possible to visit their home often due to academic or economic reasons.
- As there is mix of students from different parts of the state or country there is chance to have difference of opinion. When they study together, they may have problems with interpersonal relations which usually manifest as conflict or violent behavior. Students may feel homesick or lost control over their environment.
- Traumatic events such as loss of a parent, illness or separation of a close friend just before joining college can cause significant psychological distress.
- Students are forced to adjust to the new learning environment which is complex, such as classroom, hospital and community which demands extra effort and some students end up with problems.
- Admitting children, against their desire, in nursing course, also adds up the problem. If a student joins nursing by force, without devotion for humanity, it becomes very difficult for her, to continue with nursing profession.
- The social scene at college can be anxiety-provoking, especially during the first year. While some students may be naturally outgoing, but most of them, are not. They have to work hard to make friends and if they fail in doing so, they may end up with frustration and anxiety.

- The syllabus and curriculum is very comprehensive which expect a lot of effort from the students. When they are not able to cope up with nursing curriculum, their academic performance becomes poor, and students may fail in the examinations.
- Unhappiness prevails, when things are different from expectations of student life (e.g. getting up early to attend clinical areas, playing a dual role as student and nurse as and when situation arises).
- Nursing students are expected to hide their own values and beliefs, at the same time, maintain good human relations with the patients and the health team members.
- Student may be under stress when caring patients with acute or chronic illness, death and dying, etc, which require emotional balance and mental maturity.
- Ongoing stress like, balancing with the actual potential and the expectations, can lead to isolation and depression.
- Students may join nursing course thinking that they will easily get job in abroad but may not be able to clear exams needed for entry.
- Nursing graduates when joining higher course, may not be able to cope up with increased workload, along with family pressure and economic burden.

What is the Role of a Teacher as Counselor?

Often nursing students will not know what questions to ask, what information they need, or what their options are (especially when applying to graduate programs). Teacher, who is taking the role of counselor, fully and completely without any ifs and buts, must accept the student as a worthy person. A good counselor can be of immense help as he or she can lessen confusion or conflict by getting to know students and being familiar with the kinds of suggestions and information that can be useful for them. Information is also provided on interpersonal relationship as students also face problems with parents, teachers, friends and others. He or she counsels the students on the following aspects.

- Orient themselves to the philosophy and objectives of nursing education.
- Helps them to identify the need of educational planning.
- Assists in making an appraisal of their abilities and interest.
- Orient with library, sports department, knowledge or tech park where computerization of student entries are made, and other facilities, available to them in the college and in the university.
- Guides them to choose specialization, according to their needs and interests.
- Developing appropriate study habits to study nursing.
- Improving study skills, organizing time to get satisfactory performance.
- Orienting them with clinical field and methods of clinical learning.
- Advising on importance of getting healthy food, mild exercising and getting adequate sleep, avoiding substances like, alcohol, nicotine, caffeine, to stay healthy.
- Making contacts and friends through shared activities such as joining in student organizations, sports club or cultural hub, etc.
- Engaging in a relaxation/meditation exercise and stopping negative, critical, unrealistic thoughts and increasing positive thoughts.
- Finding ways to let out strong feelings (e.g., journal, friend) and not to suppress them.
- Reminding self that, it is normal to experience psychological distress after a traumatic event.
- Remaining consistent with the routines (eating, sleeping, exercising, social activities), even if they feel they are unproductive.
- Spending some extra time not on the mobile phone but by relaxing (singing, drawing, dancing, etc) or talking to friends, family, or relatives.
- Making help available to students for coping with crisis situations.
- Providing information on profession such as rewards, conditions of employment, opportunities for advancements, the financial assistance, and fellowships for improving their prospects.
- Development of effective communication system within the college, hospital, hostel and home.
- Effective and appropriate use of resources available for the welfare of students.
- Prompt and early detection of disturbed or deviant behavior in pupils and referring them to medical, psycho therapy services.

The recent trend emerged in counseling is online counseling which the teacher counselor can make use of to counsel students particularly shy and

hesitant students. In online counseling, counseling services are offered through the Internet, via email, real-time chat, and video conferencing. Cohen and Kerr (1998) conducted a study on the effectiveness of online therapy versus direct counseling for treatment of anxiety disorders among students. They found that there was no difference in the level of change between the two modes as measured by the State-Trait Anxiety Inventory. So with less time, avoiding fear , anxiety, hesitation, and face to face embarrassment, students can be benefitted immensely through online counseling.

Conclusion

Counseling enhances, self-analysis, self-understanding, improves self-esteem, and also understanding of the world;. Teaching is a difficult task and not every teaching brings out students learning. The counselor no doubt, is instrumental for the student's development and achievement. The teacher counselor by taking special interest in the students, develops confidence, alleviates, fear and anxiety and creates students as successful professionals and responsible citizens.

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A Review of Heart Transplantation in Children

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Abstract

A heart transplant is an operation to replace a diseased heart with a healthy one from another person. Treatment of patients suffering from end-stage heart failure (HF) leaves surgeons with limited options makes the indication of transplantation. According to the International Society for Heart and Lung Transplantation, approximately 350-500 pediatric heart transplantation procedures are performed worldwide each year, about 12% of the of the total number of heart transplants performed. An estimated 10% of congenital heart disease cases have been deemed uncorrectable. One of the most common indications for infant heart transplantation had been hypo plastic left heart syndrome (HLHS), which occurs in about one in 6000 live births. Congenital cardiomyopathy occurs in approximately one in 10,000 live births. Survival in excess of 20 years after pediatric heart transplantation has been achieved. Most programs now report that more than 70% of their recipients survive at least 5 years.

Keywords: Heart Transplantation; Congenital cardiomyopathy; congenital heart disease; Hypo plastic left heart syndrome (HLHS).

Introduction

"It is infinitely better to transplant a heart than to bury it to be devoured by worms"

-By Christian Barnard

(Father of Heart Transplantation.)

Cardiac transplantation in infants and children has been an accepted therapy since its successful application to infant recipients began in 1985. If a child needs a heart transplant, Parents probably feeling lots of emotions all at once-including anger, sadness, confusion, and frustration. These feelings can become overwhelming, especially when the child is waiting for a new heart. Heart transplant is an operation that replaces a dysfunctional heart with a healthy heart from another person who has had brain death but whose heart is working normally.

Adrian Kantrowitz performed the world's first pediatric heart transplant on December 6, 1967, at Maimonides Hospital in Brooklyn, New York, barely three days after Christian Barnard's (father of heart transplantation) pioneering procedure of the world's first adult human heart transplant on Louis Washkansky on December 3, 1967 at the Groote Schuur Hospital in Cape Town, South Africa. In India Dr. Cherian performed the first coronary artery bypass surgery in 1975. He also performed the country's first heart transplant, first infant cardiac surgery and the first heart and lung transplant in 1999. Recently (2015) cardiologist successfully performed a heart transplant on a two year old boy from Russia named Baby. Gleb was diagnosed with restrictive cardio myopathy at Fortis Malar hospital, Chennai.

According to the International Society for Heart and Lung Transplantation, approximately 350-500 pediatric heart transplantation procedures are performed worldwide each year, about 12 % of the of the total number of heart transplants performed.

Indications

Congenital malformations are still the most common indication for infant heart transplantation. An estimated 10% of congenital heart disease cases have been deemed uncorrectable. One of the most common indications for infant heart transplantation had been hypoplastic left heart syndrome (HLHS), which occurs in about one in 6000 live births. Congenital cardiomyopathy occurs in approximately one in 10,000 live births. The most common indication for heart transplantation in older children is cardiomyopathy.

The severity of heart failure in children

- Stage A
- At risk for developing heart failure
- Stage B
- Abnormal cardiac structure or function but no symptoms of heart failure
- Stage C
- Abnormal cardiac structure or function
- Past or present symptoms of heart failure
- Stage D
- Abnormal cardiac structure or function,
- Requiring continuous intravenous (IV) infusion of inotropes or prostaglandin E_1 (to maintain patency of the patent ductus arteriosus-PDA)
- Requiring mechanical ventilatorand circulatory support

The Indications as follows

- Cardiomyopathy
- Dilated cardiomyopathy
- Hypertrophic cardiomyopathy
- Restrictive cardiomyopathy
- Cardiac tumors
- Congenital cardiac defects
- Anatomically uncorrectable congenital heart diseases
- Correctable conditions associated with high operative risk.
- Infections
- Toxins(either endogenous or exogenous) that causes damage to myocardium

Contraindications

Some of the absolute contraindications for pediatric heart transplantation include,

- Irreversible elevated pulmonary vascular resistance
- Malignancy
- Ectopia cordis (congenital malformation in which the heart is abnormally located either partially or totally outside of the thorax.)
- Active systemic infection
- Severe primary renal or hepatic dysfunction
- Multi-organ system failure
- Major CNS abnormality
- Infection with HIV or chronic active hepatitis B or C
- Severe dysmorphism
- Marked pre maturity(< 36 weeks)
- Small size(< 1800 g)
- Positive findings on drugs screen.
- Lack of family support systems.

Heart Transplant Team

The team members, who work together to make sure that the child has a successful transplant, probably will include

- Cardiac surgeons
- Cardiologists
- ***Advanced Practice Nurses***
- Anesthesiologists
- Transplant pharmacists
- Radiologists
- Physical therapists
- Nutritionists
- Transplant coordinators
- Child Life specialists
- Psychologists
- Social workers
- Resource specialists

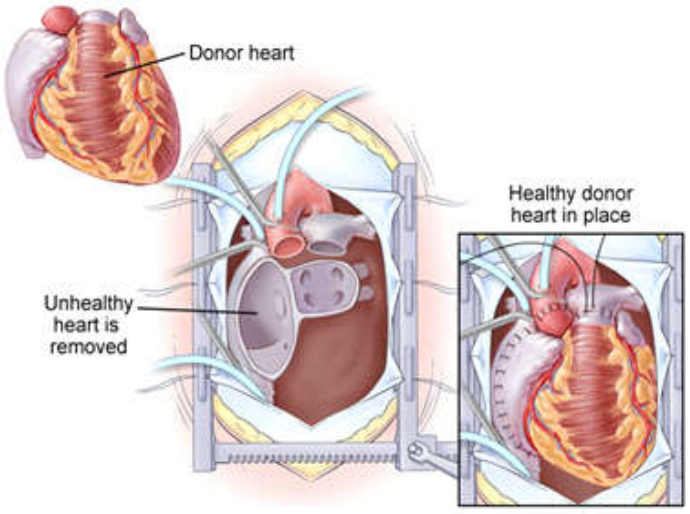
The transplant team will evaluate the child to determine whether a transplant will be beneficial and whether the child is a good candidate for a transplant. The evaluation will include a medical history, a physical examination, and some tests and diagnostic procedures like an Echocardiogram, an Electrocardiogram (also known as an ECG or EKG), Cardiac catheterizationand biopsy.

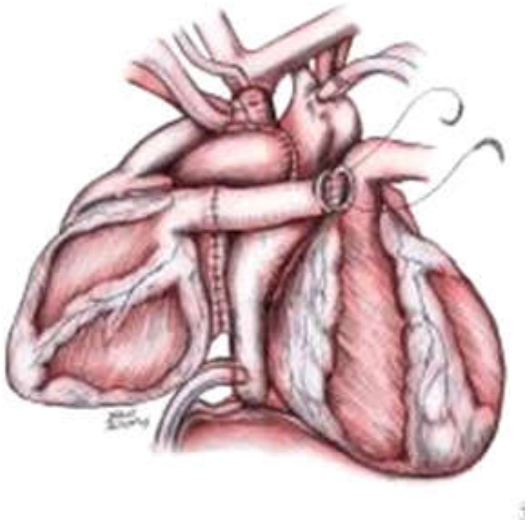
A surgical team can be dispatched from the transplantation center and can travel up to 500 miles to retrieve the needed Heart. An ischemic time up to 4 hours is considered acceptable. This allowable ischemic time permits an approximate travel time of 2.5 hours with remaining time required to implant the heart in to the patient.

Heart Transplant Procedure

Once a compatible donor organ is located, the recipient will be evaluated and started on medications in preparation for transplantation. Once the patient is under anesthesia the surgeons begin the process by exposing the chest cavity through a cut in the rib cage. The normal functioning of the body is kept intact by a mechanical pump[ECMO, LVAD etc.] that circulates blood through the body while the diseased heart is removed after opening up the pericardium. However the back part of the left atrium is left in place. In a method called as 'Orthotopic procedure', the donor's heart is carefully trimmed and sewn to fit the remaining parts of the old heart. 'Heterotopic' heart transplantations refers leaving the recipient's heart in place and implanting a new heart to act as an additional pump or piggy back heart; this type of heart transplant rarely done in children.

The patient is given immunosuppressant both before and during the surgery in order to prevent rejection. After a successful transplantation the patient is shifted to the ICU for recovery. The duration of stay in the hospital will depend on the patient's health and how well the recipient's body is responding to the new heart.





Heart Transplant Life Expectancy and Survival Rate

There have even been rare instances where the recipients have survived for more than two decades. Generally, the heart transplant survival rate immediately after the surgery is 95% in most of the centers. If the patient survives after the first thirty days, then there are 90% chances that he/ she will cross the coveted one year mark.According to a survey conducted by the American Heart Association, the average survival rates after heart transplantation as follows

Survival rate (In yrs.)	Male	Female	Children
One year	88%	77.2%	80-90%
Five-year	73.1%	67.4%	<70-80%

Survival in excess of 20 years after pediatric heart transplantation has been achieved. Most programs now report that more than 70% of their recipients survive at least 5 years. However, although an additional 5 years of life is important for all, the goal of pediatric heart transplantation is to provide as much of a normal life span for these children as possible. The donor supply remains inadequate.

Improved public and physician awareness of donor issues is the most important factor in increasing donor supply because many potential donors are not identified as such.

Complications and Follow-Up

Even after a successful transplantation, the medical practitioner should be on the lookout for various complications such as acute rejections, bleeding from suture lines, ascending infections, cardiac allograft vasculopathy, renal failure, malignancy etc. it is essential to monitor the child for signs of infection and rejection, including fever, tiredness, difficulty breathing, vomiting, weight gain, and poor appetite.In the long term, regular checkups are needed to monitor for complications. At first, these checkups will occur often (perhaps weekly). They gradually become less frequent, though, and eventually may be necessary only once or twice a year.

Conclusion

Many kids who have heart transplants live normal, healthy lives once they recover from surgery. Some feel better than they ever have before. Even though it is a costly line of treatment it has been a miraculous breakthrough in the medical field in the care of children with abnormal congenital cardiac defects. Heart transplant's prognosis is uncertain and places a person on a lifelong financial burden and drug therapy; it is still opted as the most sought out therapy for end stage congestive heart failure. General public awareness and media attention focused on the need for donors have also contributed to an increase in the available donor pool and transplantation activity.

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Case Report

Managing Newborn with Paroxysmal SupraVentricular Tachycardia

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Abstract

The incidence of paroxysmal supra ventricular tachycardia is approximately 1-3 cases per 1000 persons, with a prevalence of 0.2% [1]. Children may be asymptomatic or they may present with minor palpitations or more severe symptoms. Parents, mostly detect PSVT in children as tachycardias and heart failure signs, such as poor feeding, sweating and shortness of breath. The electrophysiological studies have helped to determine that the pathophysiology of SVT involves abnormalities in impulse formation and conduction pathways. The most common mechanism identified is reentry [2]. Infants require medical treatment because of the difficulty to recognize symptoms of tachycardia and a risk of heart failure leading to poor quality of life. Adenosine and beta blockers are drug of choice. Patients who present at <5 years old have a high likelihood of outgrowing their SVT and may not require chronic therapy.

Keywords: Paroxysmal Supraventricular Tachycardia; Heart Failure; Antiarrhythmic Drug.

Introduction

Paroxysmal supraventricular tachycardia (PSVT) is most frequent arrhythmia in newborns and infants. Prevalence [1] of SVT is approximately 2 per 1,000. Incidence of PSVT is about 36 per 100,000 people per year. A coordinated electrical signal is required for the heart muscle cells to contract in a coordinated way and generate a heartbeat. Normally, an electrical signal is generated in special pacemaker cells found in the sinoatrial (SA) node located in the right atrium or upper chamber of the heart. In PSVT, there is a "wiring" problem in the AV node and instead of having just one pathway for electricity to travel to the ventricle, there are two. This allows electricity to circle back and cause the atrium to beat more quickly than it should normally. Heart rate more than 220bpm in children below one year and higher than 180 bpm in children above one year is suspicious for PSVT. In 40%of cases, PSVT arises in first year of life [2] its incidence in the neonatal period has not been estimated adequately (1 out 15,000-25,000 live births). A predisposing condition (congenital heart disease, medication, concomitant infection) is found in 15% of cases [3]. PSVT related tachycardia in newborn present as poor feeding, crying, irritability and sweating.

Case Report

Two month old single term, male, appropriate for date, non-consanguinity born in a Hindu family, at hospital through normal vaginal delivery to second gravida mother was admitted to our tertiary care facility. The baby cried immediately after birth. Initially the baby was admitted in a private hospital for first 8 days after birth. The neonate showed symptoms of rapid respiration, difficulty in feeding, cough and cold was intermittently present. No history of fever was present. Neonate heart rate was above 280/min. CXR was suggestive of cardiomegaly

with CT ratio 64%. ECHO showed LV dysfunction with LEF 20%.

The baby was administered Inj Dobutamine for cardiogenic shock, PSVT was aborted by Inj Adenosine and Amiodarone. Inj IVIG was administered suspecting myocarditis.

The baby was referred to our tertiary centre because of recurrent PSVT which was not subsiding. At the time of admission the baby was lethargic, had poor feeding. On examination heart rate 120bpm, respiratory rate 38/min. No radio -radial or radiofemoral delay was present. Investigation CRP - 0.32, LDH – 386, CPK - 85 (Range 40 - 226), Thyroid ProfileT3 164.43 ng/dL (70-170), T4 13.5 mcg/dL (4.5-12.5), Vit D -19.43mg/ml. ECHO report suggested of mild LV dysfunction post myocarditis.

Treatment: Child received IVIG 2gm/kg over 2 days in view of suspicion of myocarditis. Developed cardiogenic shock for which Inj Dobutamine was administered. Child hemodynamically improved (EF improved from 20% to 40%) but continued to have irregularly irregular HR. Chid was continued on propranolol and lasix. EF improved to 50%. During hospital stay child continued to have frequent atrial ectopic with intermittent episodes of SVT lasting 15 - 30 seconds. Holter study was done. Beta blocker doses were gradually increased with careful monitoring. The frequency of ectopic had decreased, and also the child did not develop SVT at least for 72 hrs before discharge.

Discussion

Paroxysmal supraventricular tachycardia (PSVT) is episodes of rapid heart rate that start in a part of the heart above the ventricles. According to their underlying electro-physiological mechanism, supraventricular tachycardia's are divided into 1) reentrant tachycardia and 2) automatic tachycardia [4].

Ectopic atrial tachycardia, which may originate at any point in the atria without involving in its mechanism the sinoatrial node. This is a well-organised tachycardia, whose normal sinus rhythm is replaced by high-frequency impulses (in the newborn up to 250-300/min) originating from a small area of the atrium. Atrial ectopic tachycardia is a relatively infrequent arrhythmia in newborns; it accounts for not more than 5-10% of all supraventricular tachycardias. In newborns PSVT is not recognised unless the episode continues for 12-24 hours causing decreased cardiac output. Baby will show the signs of congestive heart failure such as vomiting, sweating, tachypnea and cold skin which may develop rapidly [5]. Other examinations like assessing intensity of first and second sound, presence of pathological murmurs, radial and femoral pulses. The first step in evaluation is to check the hemodynamic status.

A small proportion of children who have PSVT may present with shock. If the child is hypotensive or has poor capillary refill, one must start immediate measures to restore effective perfusion, including securing reliable intravenous (IV) access and supine positioning [6]. Adenosine is drug of choice, which causes a block at the level of the sinoatrial node and of the atrioventricular node. As it has a short half life, it must be administered in fast bolus followed by saline bolus. The initial recommended dose is 0.1mg/kg. If it's ineffective to subside it can be increased from 0.2mg/kg to 0.5mg/kg [77].

If any respiratory issues are present then adenosine should be administered only if good intravenous access is present. For infants born with a history of foetal PSVT, doctors choose to give maintenance antiarrhythmic therapy postnatal. Digoxin has long been the drug of choice in antiarrhythmic prophylaxis for PSVT. Success rates range between 42% and 75% [8]. Beta-blockers, in particular propranolol, are commonly used to prevent the recurrence of neonatal PSVT in cases where digoxin is contraindicated.

Conclusion

Most infants with ectopic atrial tachycardia at < 6 months of age will be free from atrial tachycardia after 12 months of antiarrhythmic therapy [9]. Parents of the children affected with PSVT should be educated to assess the pulse of the child and detect early signs of tachycardia like irritation, sweating, dyspnoea, chest pain, dizziness, fainting. Education regarding medicine dosage is required. Frequent follow up is necessary to maintain the dosage in therapeutic range. Management of PSVT should be individualized. Many children with paroxysmal supraventricular tachycardia do not require any therapy. The decision to proceed with treatment should be based on the frequency and severity of symptoms and on the effect of arrhythmia on the quality of life.

Contribution

Thomas Nisha has the prime responsibility of data acquisition and draft preparation and review of

literature. She is the first author for the paper. Thomas Nisha and Mathew Rejish did manuscript revision and editing.

Mathew Rejish will act as guarantor for the paper.

Compliance with ethical standards

Written informed permission was obtained from the parents before data collection. Since it is a clinical case report, no ethical approval was required for the article.

Conflict of Interest: None

Source of Funding: None

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Case Report

Case Discussion on Patients with Bronchial Asthma

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Abstract

Bronchial asthma is a disease characterized by an increased responsiveness of airways to various stimuli. It manifests by widespread narrowing of airways causing paroxysmal dyspnea, wheezing or cough. For this comparative study 3 patients were randomly selected from paediatric wards of AIIMS, Patna who were diagnosed with Bronchial asthma. Proper history collection was done among samples about etiology, diagnostic measures, clinical features and regarding management. Adequate medical and nursing care provided to patient helped in improvement in disease condition

Keywords: Bronchial Asthma; Etiology.

Introduction

Bronchial asthma is a disease characterized by an increased responsiveness of airways to various stimuli .it manifests by widespread narrowing of airways causing paroxysmal dyspnea, wheezing or cough. The diffuse obstruction to airflow is reversible in a large majority of cases, either spontaneously or in response to treatment. Bronchial reactivity is necessary component of asthma.

For this comparative study 3 patientswere randomly selected from paediatric wards of AIIMS Patna who were diagnosed with Bronchial asthma

The details of patient are as follows;

Demographic data	Patient XX	Patient XY	Patient XZ
Age	7 years	6 years	4 years
Sex	Male	Female	Female
Evolko id	1434188	1392260	134578
Date of admission	10/07/2017	05/07/2017	31/06/2017

Definition

Bronchial asthma is a disease characterized by an increased responsiveness of the airways to various stimuli. It manifests by widespread narrowing of airways causing paroxysmal dyspnea, wheezing or cough.

The diffuse obstruction to airflow is reversible in a large majority of cases, either spontaneously or in response to treatment. Bronchial reactivity is necessary component of asthma.

Incidence

It is most common choric lung disease in childhood, affects 8-10% of children in urban area and 5-8% in rural area. It affects boys before puberty and in girls after puberty.

Etiology

Book picture	Patient XX	Patient XY	Patient XZ
The most common cause of asthma results from allergic hyperresponsiveness of trachea and bronchi to irritants.The precipitating factors include viral infections,airpollution ,animal dander,dust,pollen ,certain physiological and psychological stress .A familial tendency is also noticed in oetiology	Inhalalation of dust Upper respiratory tract infections	History of maternal and paternal grandmother	Allergy Familial history of asthma

Pathophysiology

Airway obstruction is caused by

- Oedema and inflammation of mucous membrane lining airways
- Excessive secretion of mucous inflammatory cells and cellular debris
- Spasm of smooth muscle of bronchi

Obstruction is diffuse but not uniform

Asthma has been classified as atopic, nonatopic, mixed, exercise induced or aspirin induced. Inhalation of allergen leads to a biphasic response with early and late reactions ultimately causing bronchoconstriction.

Early reaction starts within 10 min of exposure to allergen.it is characterized by release of histamine, leukotrenes,prostaglandins, platelet activating factor and bradykinin from the mast cell following interaction of allergen with specific mast cell bound Ig E. All these substances use bronchoconstriction, mucosal oedema and mucous secretion which manifests as airway obstruction. The phase is inhibited by B2 agonists drugs.

Late phase occurs in about two-thirds of patients. It develops 3-4 hr later and peaks at 8-12 hr.The release of mast cell mediators is not prevented by premedication with beta 2 agonist. However ,its inhibited by premedication with steroids suggesting airway narrowing is mainly due to an inflammatory reaction and mucosal oedema.This phase presents as clinical asthma.

Clinical Features

Book Picture	Patient XX	Patient XY	Patient XZ
The clinical features include; • Dyspnoea • Air Hunger • Anxiety • Cough • Wheeze (expiratory in nature) • Tachypnoea • Complaints of chest tightness • Costal retractions • Diaphoresis • Severe case cyanosis	• Breathlessness • Low grade fever with chills and rigor • Productive cough	• Tachypnoea • Breathing difficulties • Chest tightness	• Dyspnoea • Productive cough • Wheezing • Chest retractions • Mild cyanosis

Diagnosis

Book Picture	Patient XX	Patient XY	Patient XZ
The diagnosis of Bronchial asthma include; • History collection • Physical examination • Laboratory investigations • Chest radiography • Pulmonary function test • Skin prick testing and serological testing to identify environment allergens • Frontal and lateral radiographs shows infiltration and hyper expansion of airways	• History collection • Physical examination • Lab investigations- Na-132 k-3.9 hb-11.2 platelets-17900 WBC-12000 Neutrophil-84	• History collection • Physical examination • Chest Xray (PA view) • Lab investgations- ESR-45mm/hr Hb-12.40 WBC-14000 • Blood culture and sensitivity	• History collection • Physical examination • Lab investigations- Hb-11.20 Haematocrit-36 RBC-4.47 Platelet count-179 Neutrophil-84 Lymphocyte-12 Eosinophil-2 ESR-26

Management

Book picture	Patient XX	Patient XY	Patient XZ
The management include • Bronchodilators • Expectorant therapy • Corticosteroids and antibiotics • Respiratory therapy • Occupational therapy	• Nebulization 5mg over 20 min • Oxygen inhalation by nasal prong • Hydrocortisone 100 mg IV stat • Maintain fluid intake	• Oxygen inhalation through nasal prongs • High fowlers position • Chest physiotherapy • Antibiotics-ceftriaxone	• High fowlers position • Antibiotics-azithromycin • Ipratropium nebulization • Oxygen inhalation by nasal prongs

Discussion

Bronchial is a common childhood disease prevailing in children.There are various precipitating factors which are called as trigerrs in asthma.

All precipitating factors pertaining to patient were identified adequate care was provided and there was improvement in condition of patient after medical and nursing care .

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Erratum

Article Titled "**Internet Addiction and Teens' Vulnarability**"

By Farzana Begum

Published in

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In the above article, the wrong Abstract and keywords were published by oversight. The Correct abstract and Keywords is here and now read as

Abstract

A high prevalence of internet addiction is observed in various age groups across the world. Teenage is a transitional phase between childhood to adult hood, lots of physical and psychological changes occur and their needs varying. Internet plays a pivot role in contributing those needs. The current study is an attempt to organise the possible underlying causes and impacts of internet addiction, especially among teenagers. Finally the paper suggests that educating both teenagers and their parents regarding the proper use of internet will help to prevent and manage internet addiction.

Keywords: Internet; Addiction; Teens; Vulnerability.

Mistake is regretted **Editor-in -chief**

News & Notes

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Coping Strategy for Mother of Child with OFC

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Cleft lip contains an opening in the upper lip that may extend into the nose. The opening may be on one side, both sides, or in the middle. A cleft palate is when the roof of the mouth contains an opening into the nose. These disorders can result in feeding problems, speech problems, hearing problems, and frequent ear infections.

Main Problems of Child

- Babies with a cleft palate will have difficulty feeding
- More chance to get ear infections
- It can affect their hearing.
- Difficulty with speech,
- Teeth will not develop normally in the area of the cleft,
- Reduce the self-esteem
- Psychological problems
- Nutritional problems

Coping Stategy

For the Physical Problems of Child

- As soon as possible the Surgical treatment should be initiated for baby
- Use the special teats and bottle
- Use a small plastic plate to cover the cleft in the mouth while feeding.
- ❖ Mother can express breastmilk and give it by a bottle.
- ❖ Feed the baby in slow manner
- If there are problems feeding a baby with a cleft palate, consult the specialist
- Babies with a cleft lip but not a cleft palate not have feeding problems
- They can breastfeed, but the mother may need to block the cleft with her thumb or breast tissue to enable the baby to get a good seal on the breast.
- ❖ Children will need ongoing speech therapy
- The child will need orthodontic and other dental treatment.

How to Overcome Psychological Problems of Mother

- The disease condition is cured after the surgery
- After the surgery the disease will not occur in future
- Giving Your Child the Power of Positive Attitude
- Compare the photos of child after each surgical treatment
- Focus on strengths rather than weaknessesof the child
- Positive Expectations Bring out the Best in Your Child
- Passing on Beliefs That Actually Work and Make Sense
- Trust and Include Your Child–"*You Will Manage*"
- Open up Your Kid's View on the World with

Positive Language

- Make Your Day Easier by Tuning in to and Understanding Your Child
- Always strive towards positive honesty
- Respecting Your Kid, Will Make Your Kid Respect You
- Shower Your Kid with Your Full Presence
- Unconditionally Support Your Kid to Build High Self Esteem
- Try not to evaluate your kid's actions in terms of accomplishments or failures
- Try not to use punishment, threats or bribes as ways to correct your kid's communication
- Ask someone for their opinion or advice on how to handle the situation
- Get more information to help make decisions
- Accept help with daily tasks and responsibilities, such as chores or child care
- Get emotional support from someone who understands you and cares about you
- Acceptance is a process that takes time. You may need to remind yourself to be patient
- Many of the coping strategies listed below are useful ways of managing your emotions
- Spend time at your place of worship or get together with others who share your beliefs
- Talk with a respected member or leader of your spiritual community
- Record the voice of child each month and check the effectiveness of therapy
- Don't neglect /over product the child
- Consider him as a normal child
- Understand each other & don't blame each other

Coping with Stress

- Manage your emotions
- Seek out support
- Focus on the positives
- Make a plan of action
- Take care of your relationships
- Self-care
- Spirituality
- Accept the situation first
- Balance the emotions
- Manage your thoughts
- Choose the distractions
- Going for a drive or walk
- Leisure activities, exercise, hobbies
- Housework, yard work or gardening
- Watching TV or movies
- Spending time with friends or family
- Use the problem solving techniques

Social Support

- Avoid negative relationships
- Be patient
- Maintain the relationships
- Be a joiner
- Get more from the support you have
- Let go of unhealthy ties
- Involve in daily activities
- Share the problems with another person
- Maintain the good interpersonal relation ship

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Stress & Well-Being

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Stress comes up when you feel the demands of a situation or event are too much to manage. It can come up with everyday situations

- Changes in a relationship
- Changes in housing arrangements
- The death of a family member or friend
- Losing a job or other source of income

3 Basic Dimensions of Mental Health and Well-being

Thoughts

The way you think about something has a big impact on your mental health. Changes in your thoughts often go along with changes in your mental health. When you feel well, it's easier to see positive aspects. When you aren't well, it's easy to get stuck on negative things and ignore positivethings.

Behaviour

behaviours are the helpful or harmful things you do. Other people can usually see your behaviours. Changes in behaviour often go along with changes in mental health.

Emotions

That are the way you feel. They can be pleasant or unpleasant. Changes in emotions often go along with changes in mental health.

Are you experiencing signs of stress

Changes in your Body

- Headache
- Rapid breathing and heart rate
- Tense muscles
- Insominia
- Fatigue

Changes in your Behaviors

- Withdrawing from others
- Fidgeting, feeling restless
- Smoking, drinking or using drugs more than usual
- Avoiding stressful situations

Changes in your Feelings

- Feeling worried or confused
- Feeling angry or irritable
- Feeling overwhelmed or helpless
- Feeling like you can't cope

Changes in your thoughts

- Struggling to concentrate, remember or make decisions
- Lack of self-confidence
- Having a negative attitude towards yourself and your life

Managing stress

Focus on what you can do

- Resist the urge to give up or run away from problems—these coping choices often make stress worse in the long run

Manage your emotions

- Try not to bottle your emotions up. Try expressing your feelings by talking or writing them down
- Try not to lash out at other people. Yelling or swearing usually pushes people away when you need them the most

Seek out support

- Ask friend or family member for their opinion or advice on how to handle the situation
- Get more information to make decisions
- Accept help with daily tasks and responsibilities, such as chores or child care
- Get emotional support from someone who understands you and cares about you

Focus on the positives

- Focus on strengths rather than weaknesses—remind yourself that no one is perfect
- Look for the challenges in a situation by asking, "What can i learn from this?" Or, "how can i grow as a person?"
- Try to keep things in perspective
- Try to keep a sense of humor
- Remind yourself you are doing the best you can give the circumstances

Make a plan of action

- Identify and define the problem
- Determine your goal
- Brainstorm possible solutions
- Consider the pros and cons of each possible solution
- Choose the best solution for you—the perfect solution rarely exists
- Put your plan into action
- Evaluate your efforts and choose another strategy, if needed

Self-care

- Eat healthy foods and drink plenty of water throughout the day to maintain your energy
- Do exercise regularly or do something active on a regular basis
- Avoid using alcohol or drugs as a way to cope
- Explore relaxation techniques like meditation or yoga etc.
- Try to balance work and play—too much work can eventually lead to burnout
- Spend time on things you enjoy, such as hobbies or other activities
- Get a good night's sleep

Take care of your relationships

- Be assertive about your needs rather than aggressive or passive. Being assertive means expressing your needs without hurting others
- Try not to confront others in a mean-spirited or antagonizing manner
- Accept responsibility, apologize or try to put things right when appropriate
- Talk to others who are involved and keep them informed about your decisions

Spirituality

- Consider spiritual practices that fit with your beliefs, such as prayers
- Spend time at your place of worship or get together with others who share your beliefs
- Talk with a respected member or leader of your spiritual community

Acceptance

- Denying that the problem exists may prolong your suffering and interfere with your ability to take action
- Acceptance is a process that takes time. You may need to remind yourself to be patient
- Death, illness, major losses or major life changes can be particularly difficult to accept
- Try not to get caught up in wishful thinking or dwell on what could have been

Distractions

- Going for a drive or walk
- Leisure activities, exercise, hobbies
- Housework, yard work or gardening
- Watching TV or movies
- Playing video games
- Spending time with friends or family
- Spending time with pets
- Surfing the internet or sending e-mail
- Sleeping or taking a short nap when used for short periods of time. These forms of distraction create opportunities to solve the problem

Problem -Solving

Step 1- I think I have a problem. How do I fix it?'

Pay attention to your feelings

Negative feelings often point to problems. When you pay attention to these feelings, you often recognize the problems sooner. For example, feeling angry whenever you talk to your boss may be a sign that there is a problem at work.

Make a list

Write out a list of the problems you need to fix before they turn into bigger problems. Some problems seem to stick around. Other problems seem to go away, but they pop up later on.

Look for opportunities

Don't focus on the negative parts of the situation. Look for any opportunities or challenges instead. If a problem seems less scary, you're more likely to try to solve it.

Step 2 -'What's the problem?'

You can't solve a problem until you know what the problem is. In order to do that, ask yourself these questions:

1. What is the situation right now? • What's making me feel upset?
2. What would I like the situation to be? • How would things be if I weren't upset?
3. What are the obstacles? • What's standing between me and my ideal situation?

Be as specific as possible If your definition of the problem is vague, it's hard to know where your solution should start

Step 3-How will I know when I get there?'

Choose a goal for your problem.

The **SMART** principle may help you set goals: Goals should be

S pecific

M easurable

A ttainable

R ealistic and

T ime-limited

Step 4-'What are some possible solutions?'

It's easy to come up with the same ideas over and over again. When it comes to difficult problems, the first ideas aren't always the best

Step 5-'what's the best solution?'

Always pick the best solution for you—the perfect solution rarely exists. The key is to pick the solution that has the most benefits and the least costs. There will probably be some negatives to any solution. Use the following questions as a guide to picking the best solution.

Step 6-put your solution into action

After you've picked a solution, you need to make a plan of action! Write down the steps it will take to carry out your solution. You're more likely to take action if you know exactly what you need to do.

Step 7-check up on your progress

It's a good idea to track how well your solution is actually working. If your problem is resolving itself, be sure to reward yourself for a job well done. If your solution isn't working, you can check to see what might be wrong. Remember, even the best plans don't always work as expected.

Anger Management

1. Emotions

Relaxation

You can't be relaxed and angry at the same time. Think of anger as your boiling point. If you turn down the temperature, you keep yourself from boiling over. Learning to relax can help lower your daily arousal level.

Then, when you're provoked, you have a much greater distance to travel before you get .

Humor

It is also difficult to be angry when you're laughing. It is easy to take life's annoyances too seriously. Making an effort to see the humor in your frustrations and aggravations can help to combat an automatic angry reaction.

2. Thinking Pattern

Manage Your Thoughts

A good way to lower anger is to manage angry thoughts about the situation.

Take the following steps:

- Examine the evidence—what evidence supports your view of the situation?
- Look for alternatives—what are some alternative ways of viewing the situation or conflict

Empathy

You may feel angry when you think that the other person's behavior was intended to hurt you in some way. Often, other people's behavior has nothing to do with you personally.

3. Behaviours

Problem-Solving

Anger management is a strategic and calculated confrontation aimed at solving a problem. The trick to managing anger well is to have a problem-solving goal.

This means making sure that your response to your angry feelings is directed at solving the problem. Don't take your feelings out on everyone around you; use them in a directed way to solve the problem.

Being Assertive Without Being Aggressive

How you communicate depends on your goals. Your goals (even when angry) may include improving a valued relationship, maintaining your self-respect, solving problems

Social Support

1. Don't be afraid to take social risks

It's easy to assume that other people know what you need, but this usually isn't true. You may need to tell others what you need. Be as specific as possible in your requests. However, be careful not to overwhelm your support providers.

2. Get more from the support you have

Ask the people you know to help you broaden your networks. If you have recently become single, ask your friends to introduce you to other single people your age. If you have recently come out, ask your friends to introduce you to others in the community.

3. Reach out

Ask the people you know to help you broaden your networks. If you have recently become single, ask your friends to introduce you to other single people your age. If you have recently come out, ask your friends to introduce you to others in the community

4. Create new opportunities

You may create new opportunities to meet others when you step outside of your usual activities. For example, you may meet new people when you join a club or group or get involved in an organization

5. Let go of unhealthy ties

Walking away from any relationship is painful—even when the relationship is causing harm—but it may be necessary. For example, if you're trying to quit drinking and your friends only ever want to spend time in bars and clubs, you may decide to let them go. Use your judgment, though. It may be possible to spend less time with certain people without fully abandoning the friendship.

6. Make a plan

Sometimes, the best way to find the support you need is through a support group. If you need support for a highly specific problem, like managing a health problem, a formal support group may be the best option.

7. Be a joiner

Making new friends can take time. You may need to meet many new people to make just one new friend. Building intimacy also takes time. It can take several months to feel close to someone and feel like you can count on their support.

8. Be patient

Negative relationships are hard on your emotional health. Some negative aspects may be obvious, such as abuse. Other times, they may be more subtle, such as excessive dependence or control issues.

9. Avoid negative relationships

You're more likely to build strong friendships if you are a good friend, too. Keep in touch with your support network, offer support to others when they need it and let them know that you appreciate them.

10. Take care of your relationships

You're more likely to build strong friendships if you are a good friend, too. Keep in touch with your support network, offer support to others when they need it and let them know that you appreciate them.

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Standard journal article

[1] Flink H, Tegelberg Å, Thörn M, Lagerlöf F. Effect of oral iron supplementation on unstimulated salivary flow rate: A randomized, double-blind, placebo-controlled trial. J Oral Pathol Med 2006; 35: 540-7.

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Article in supplement or special issue

[3] Fleischer W, Reimer K. Povidone iodine antisepsis. State of the art. Dermatology 1997; 195 Suppl 2: 3-9.

Corporate (collective) author

[4] American Academy of Periodontology. Sonic and ultrasonic scalers in periodontics. J Periodontol 2000; 71: 1792-801.

Unpublished article

[5] Garoushi S, Lassila LV, Tezvergil A, Vallittu PK. Static and fatigue compression test for particulate filler composite resin with fiber-reinforced composite substructure. Dent Mater 2006.

Personal author(s)

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No author given

[8] World Health Organization. Oral health surveys - basic methods, 4th edn. Geneva: World Health Organization; 1997.

Reference from electronic media

[9] National Statistics Online—Trends in suicide by method in England and Wales, 1979-2001. www.statistics.gov.uk/downloads/theme_health/HSQ 20.pdf (accessed Jan 24, 2005): 7-18. Only verified references against the original documents should be cited. Authors are responsible for the accuracy and completeness of their references and for correct text citation. The number of reference should be kept limited to 20 in case of major communications and 10 for short communications.

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