Reply

Dear Editor,

It was a pleasure to see the interest generated in our article and we are thankful to the reader for bringing forth his observations. He is also right about the fact that Garg et al.¹ did mention that a low platelet count may lead to a haematoma formation which in turn may lead to compression of the nerve trunk. This too might be an added contributing factor in addition to the immunopathological process. However in our case an MRI brain and orbits as well as an MRI angiography was carried out and it did not reveal the presence of any haematoma involving the abducens nerve. Thus we feel that in this particular case it was solely the immunopathological phenomenon responsible.

REFERENCE

1. Garg RK, Malhotra HS, Jain A, Malhotra KP. Dengue-associated neuromuscular complications. *Neurol India*. 2015;63(Jul–Aug (4)):497–516. <http://www.ncbi.nlm.nih.gov/pubmed/26238884>.

Col Avinash Mishra
Senior Advisor (Ophthal), Command Hospital (Eastern Command),
Kolkatta -27, India
E-mail address: avim27@gmail.com

<http://dx.doi.org/10.1016/j.mjafi.2015.08.006>
0377-1237/

© 2015 Published by Elsevier B.V. on behalf of Director General,
Armed Forces Medical Services.

Letter to the Editor

Fifth serotype of dengue virus: What we should prepare for?

Dear Editor,

We read with extreme interest the original article titled “Discovery of fifth serotype of dengue virus (DENV-5): A new public health dilemma in dengue control” by Mustafa et al. published in *Med J Armed Forces India* 2015;71:67–70.¹

The author mentioned that “the likely cause of emergence of the new serotype could be genetic recombination, natural selection and genetic bottlenecks¹” and also noted that “there is no indication of the presence of DENV-5 in India¹.” Mustafa et al.¹ also discussed on the problems with developing vaccine and vector control. For sure, there are limited reports on DENV-5. However, it should be noted that the diagnostic tool for DENV-5 is limitedly available. In the area with heavy endemic of dengue, there can be many underdiagnosed cases. In addition, the serotyping is not routinely done in several settings.² Without a report does not mean there is actually no case or there would not be any case in the future. Preparedness should be discussed. First, knowledge is very important. Education to the general practitioners, physician, medical personnel, and public health care workers is needed. Gathering information, sharing, and distributing information among the group should be done. This can be the key factor in successful disease surveillance on the new upcoming disease. Second, there should be preparation for a new diagnostic tool for the new DENV-5. This can be the way for early diagnosis

and prompt management of the problem. Finally, it should be noted that not only DENV-5 infections but also other virus infections are considered important new emerging hemorrhagic diseases that we have to follow and correspond.³

REFERENCES

1. Mustafa MS, Rasotgi V, Jain S, Gupta V. Discovery of fifth serotype of dengue virus (DENV-5): a new public health dilemma in dengue control. *Med J Armed Forces India*. 2015;71 (January (1)):67–70.
2. Wiwanitkit V. Dengue fever: diagnosis and treatment. *Expert Rev Anti Infect Ther*. 2010;8(July (7)):841–845.
3. Wiwanitkit S, Wiwanitkit V. Acute viral hemorrhage disease: a summary on new viruses. *J Acute Dis*. 2015;4(4):271–272.

Beuy Joob*
Sanitation 1 Medical Academic Center, Bangkok, Thailand

Viroj Wiwanitkit^{a,b,c,d,e}

^aVisiting Professor, Hainan Medical University, China

^bVisiting Professor, Faculty of Medicine, University of Nis, Serbia

^cAdjunct Professor, Joseph Ayobabalola University, Nigeria

^dProfessor, Senior Expert, Surin Rajabhat University, Thailand

^eHonorary Professor, Dr DY Patil Medical University, India

*Corresponding author. Tel.: +66 24658292
E-mail address: beuyjoob@hotmail.com (B. Joob)

<http://dx.doi.org/10.1016/j.mjafi.2015.11.015>
0377-1237/

© 2016 Published by Elsevier B.V. on behalf of Director General,
Armed Forces Medical Services.

Received 27 November 2015
Available online 23 February 2016

Reply

Dear Editor,

On behalf of the authors, I thank the readers for their keen interest and valuable comments regarding our article. The following comments are submitted herewith in response to the readers:

1. Although there is no indication of the existence of DENV-5 in India, the presence of DENV-5 cannot be ruled out in toto; especially in inaccessible forest canopies where non-human primate hosts are found in abundance and deforestation activities are being resorted to; leading to disturbance in the ecological balance and a possible spillover from the sylvatic to the human cycle.
2. As has been rightly brought out by the readers, the diagnostic tools for DENV-5 are limited and cases of DENV-5 may not be diagnosed even if they occur. The role of health education of the general public and more importantly; the health care workers at the community level using a bottoms up approach cannot be over-emphasised. They play an important role in creation of an information superhighway as far as disease diagnosis, treatment and prevention is considered.

3. Newer diagnostic modalities need to be developed with more stress on serological identification of DENV-5; which, as of now seems to be difficult in a poor resource setting such as ours; with dengue being a disease more of the rural and per-urban areas where such facilities are either poorly developed or may be even non-existent.
4. We agree with the readers that the present day scenario requires surveillance for disease with a high case fatality ratio such as Ebola and other haemorrhagic fevers, SARS, influenza, MERS and other respiratory infection viruses. DENV-5 on the other hand; with the limited data available, is a milder infection.

Lt Col M.S. Mustafa
Officer Commanding, Station Health Organisation, Chennai, India
E-mail address: msmustafa2001@yahoo.co.in

<http://dx.doi.org/10.1016/j.mjafi.2015.11.015>
0377-1237/

© 2016 Published by Elsevier B.V. on behalf of Director General,
Armed Forces Medical Services.

Letter to the Editor

Evaluation of management of hypoglycemia in in-patients

Dear Editor,

I read with extreme interest the original article titled “Study of a structured action pathway and persistent monitoring tool among nurses to achieve cent percent management of hypoglycaemia in in-patients: A measure of quality of healthcare” by Mishra et al. published in *Med J Armed Forces India* 2016;72:27–32.¹

The authors have studied an important aspect of in-patient care and intervened to improve the management of in-patient hypoglycemia by a systematic introduction of a protocol to enable the para-medical staff to act in the golden period to minimize morbidity and mortality associated with this dreaded complication of hyperglycemia management. This practical application can be implemented in all hospital settings for improving quality of care.¹

However, the study has many weaknesses, which I would like to highlight:

Data were extracted from hospital records, patient case records, and hospital Quality Flash matrix (QF) in terms of total number of cases receiving insulin and total number of episodes of hypoglycemia documented and reported. Patients on oral hypoglycemic alone were left out, although they form a large subset of in-patients with hypoglycemia.

The data on hypoglycemia have been derived from hospital records retrospectively after a period of time and not in real-time.

The source of data on “actual episodes of hypoglycemia” recorded on QF has not been clarified and it is not clear as to how are these different from “nurse documented hypoglycemia”.

References on incidence of hypoglycemia episodes on insulin therapy and its management are old and are from the times when human insulins, NPH, and lente insulins were