mentioned.

4. The patient was put on diltiazem as he had normal LV function (EF 50%) and no pulmonary congestion.

5. The comments in the letter to the editor do not have relevance to the case under discussion. It was not the intention of the authors to discuss the management strategies of NQWMI. This was only a case report on an individual having recurrent angina after a NQWMI.

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Lt Col JS Duggal

Classified Specialist (Medicine & Cardiology), Military Hospital (CTC), Pune

Say No to MMR; Epidemiological Reasons : A Rebuttal

Dear Editor,

Refer correspondence titled 'Say no to MMR; Epidemiological Reasons' (MJAFI, 2000;56:275-6). We do not agree with the various contentions of the correspondent regarding vaccination for Mumps and Rubella.

Mumps vaccine was introduced in the US in 1967 and routine use was recommended in 1977 [1]. This led to a steady decrease in the incidence rate of cases. In 1995 only 906 cases of mumps were reported in the US as compared to 185,691 cases in 1967 [1]. A relative resurgence was seen in the mid 1980s when outbreaks occurred in high schools, college campuses and in workplaces [1]. However, even at its peak the incidence rate never rose beyond 7 per 100,000 population as compared to almost 90 per 100,000 population in the prevaccination era [2]. Thus even though there was an epidemiological shift there was no actual increase in incidence. As regards sterility, we submit that this will occur only as a consequence of bilateral orchitis and it has been uniformly agreed that sterility following mumps is rare [1,3].

UK adopted a programme of selective immunisation as recommended by the correspondent. Adolescent school girls and women at high risk (nurses, teachers) were immunised with rubella vaccine [4]. However, despite an uptake rate of 90 percent it was found that 2.8 percent of young women were still susceptible to rubella [5]. The UK Government accepted that complete immunisation of the target population was not a realistic goal and therefore adopted

universal childhood immunisation in 1988 [5].

We entirely agree that India should learn from the mistakes of other countries. India has a well developed programme of immunisation in childhood with high uptake rates. We should do our best to utilise this to attempt to eradicate these diseases from the country.

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Lt Col J Dutta*, Lt Col AV Paranjape*

*Reader, Department of Preventive & Social Medicine, Armed Forces Medical College, Pune - 411 040, *Medical Officer (Preventive & Social Medicine), 324 Field Ambulance, C/o 56 APO.

Say Yes to MMR : Ethical, Scientific and Practical Reasons

Dear Editor,

This refers to the letter published in your journal about saying no to MMR vaccination since it had caused an epidemiological shift of the diseases towards older age after its introduction [1]. MMR is being advocated by the Indian Academy of Paediatrics (IAP) based on the recommendations of its Immunization Committee. The choice of MMR vaccine was based on the experience of several researchers on the need to protect women of childbearing age from rubella infection as there are several published data to show that congenital rubella syndrome (CRS) occurs with some frequency in our country, though the true magnitude is not known as our epidemiologists have yet to generate sufficient qualitative and quantitative data [2,3].

MMR was introduced at 15-18 months in India to prevent CRS, mumps and more importantly to give a second dose of measles, so as to help those children with primary vaccine failures (though the net result will be no better than that of a single dose at 15-18 month, but with the added advantage of protection against measles during the interval of 9 months to 15-18 months) [4]. This is an indirect strategy that aims to protect women of childbearing age from exposure to rubella virus by interrupting its transmission via a herd

immunity effect and hence leading to a rapid reduction in cases of congenital rubella [5]. On the other hand, the immunization of adolescent girls, direct strategy, does not interfere appreciably with the transmission of the rubella virus and mainly aims to protect women of childbearing age from the disease [6]. This was initially being followed in UK and Japan and the vaccine was recommended only for schoolgirls (10-12 years) and susceptible women but it had little impact on the incidence of congenital rubella and the British authorities had to change to US strategy which was a three-step programme i.e., vaccination of all infants at 12-15 months, the second dose at 4-6 years or should complete the schedule by 11-12 years and thirdly, screening women of child bearing age for rubella immunity and vaccinating those susceptible. Since then the incidence in UK has remained low similar to US.

We have almost negligible epidemiological data, no health economic assessment of the disease and its prevention and our government assumes that the nation cannot afford to give these vaccines to all children without realizing that the cost of prevention will be more than repaid, several fold higher, and will be richer if we take disease prevention honestly and seriously.

To accept therapy, one must first accept the presence of the