

in terminally ill patients because of an unreasonable fear of producing opioid dependence. Prescribing inadequate drug dosage or using medication for an insufficient period of time to treat the patient. Eg: sub-therapeutic doses of antibiotics promote the development of bacterial resistance.

Promoting rational prescription by training of medical practitioners should be a priority in order to improve prescribing practices.^[2] Medical students and interns training should include elements of a rational prescription in their curriculum.^[3] Medical auxiliaries should be given formal training in clinical pharmacology and therapeutics related to a selected group of drugs. A suitable drug manual should be provided to auxiliary health workers for the selection of appropriate drugs and dosage regimens. It should include information on warnings, precautions and contraindications. The prescribing practices of auxiliary workers should be reviewed on regular basis.

To build up rational drug use, drug information should be provided to all medical and paramedical staff of any health service.^[4] Hospital Committee should follow WHO accreditation guidelines in the maintenance of essential drugs list, review and monitoring of prescribing practices by physicians of the hospital, development of standard treatment regimens and cost of medication prescription on a single occasion and for a course of therapy.

The adverse reactions of drugs leading to morbidity and mortality of patients can be minimized or even eliminated by following rational prescription norms.

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Homicidal Organophosphate Poisoning in Young Infant

Sir,

Organophosphate (OP) poisoning is potentially fatal but completely treatable condition that is still prevalent in our country. Early recognition and judicious management prevent mortality. It is rarely reported in young infants where history may not be forthcoming. The initial presentation can some times be

misleading.

A previously healthy 6 months old male infant, presented with altered sensorium, cyanosis, copious oro-pharyngeal secretions, and refusal of feeds of sudden onset. On examination baby was afebrile, lethargic and hypotonic, with copious secretions in the mouth and nostrils. Skin showed mottling. Bilateral pin-point pupils were not reactive to light. Initially the patient was diagnosed as respiratory failure. Emergency management was started and baby was intubated and ventilated. We suspected OP poisoning, but parents denied history of exposure to OP poison. Clinically the case was of OP poisoning, hence treatment was started with Atropine infusion 0.05mg/kg/hr and 25mgs of Pralidoxime (PAM) /kg/dose.^[1] after collecting blood sample for cholinesterase levels. After 6 hrs, baby showed improvement with dilatation of pupils, decreased oro-pharyngeal secretion.^[2] Atropine was continued for 5days and baby was discharged after a week. Retrospectively, the mother revealed that they were living in a joint family, and that whenever she was busy, the baby was looked after by the co-sister who has only female children. It is possible that she might have poisoned the baby because of jealousy. Accidental poisoning is also a possibility. Before discharge, the parents were counselled. Organophosphate compound inhibit cholinesterase activity and affect central and

peripheral muscarinic and nicotinic receptors.^[3] Pinpoint pupils and oro-pharyngeal secretions even in the absence of previous history of serious illness are important in suspecting poisoning in this child. Decreased cholinesterase levels and improved condition with Atropine and PAM confirmed the diagnosis. Strong clinical suspicion and initiation of specific and supportive treatment saved this infant.

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