DPT

DEVELOPMENTAL PEDIATRICS TODAY

March 2020

Monthly e-Newsletter of IAP Chapter of Neurodevelopmental Pediatrics

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Editorial

Respected seniors and dear Friends,

Hope you all are doing well! As the whole world has been caught unawares with unprecedented Pandemic of such humongous proportions, following safety precautions and social distancing seems to be the only Early intervention to get some control in preventing the spread of COVID 19.

"With the unprecedented Lockdown in the whole country , first time in the history of mankind, man has stopped working for a living in order to live."

I guess Corona Virus has come to remind people and politicians that if you neglect healthcare sector, you will have to lockdown. Corona has come to remind us that how important hospitals and good healthcare infrastructure are to save lives. So, I hope after this experience the funds allocated by the government and people on health will increase.

'As the saying goes Health is wealth.'

Friends we must enjoy the finest things that life provides us such as beauty of nature, beautiful relationship that we all share on this platform, love, compassion, hope, kindness and creativity which all of us have in abundance and emerge as better doctors and finest human beings to make this world a better place to live in.

In all this chaos we must keep reminding ourselves and the parents that we can't stop taking care of the developmental aspects of all children whether neurotypical or atypical. The milestones which we achieve with lot of efforts in kids with NDD will regress and may require huge efforts to get back where they were.

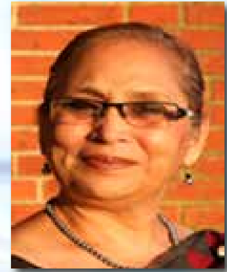
The highlight of this issue is a concept paper on "Developmental Nurse Counsellor "by Dr. M.K.C Nair. March 21 being International Downs syndrome day, there is a very informative writeup on Down's syndrome.

We all should stay safe, follow social distancing and hand hygiene plus avoid touching MEN (mouth, eyes, nose) to be able to tide over the crisis and preserve ourselves. Japan is the best example of disease containment following hygiene as a part of their culture and Singapore is best example of disaster preparedness and 100% quarantine of symptomatic patients well in time leading to disease containment.

Baseless fears lead to anxiety. So let's be positive and look forward to good times ahead.

Dr. Lata Bhat
Chief Editor

Chairperson's Message



Dear Colleagues,

Heartiest greetings to you all. I trust that this newsletter finds you all in good health and cheer while moving on to innovative ways of coping with the unprecedented predicament that we are in.

A worldwide lockdown has placed over 800 million children out of school as per WHO reports. Moreover, social distancing has been recommended and educational institutions to close. One needs to ponder about what happens to children with disabilities and those with special needs. Has any thought been given to our children who need close approximation for facilitation of their activities ? While on the other hand caregivers could be transmitting COVID-19 to their wards by their close handling. On the contrary normal children may be accommodated through online programmes.

The dilemma therefore is how to ensure continuity of the learning process in children with special needs to avoid regression.

As a child care professional, one needs to strategise delivery value instructions to the children and their families. A positive fallout is that our children are getting the whole family to be with. Families should develop and support strategies to prevent problems. It is a good idea to help parents to take advantage and use the naturalistic teaching strategies (NaTS) with multiple incidental teaching sessions with sibling involvement.

So get busy. This is the time to innovate teaching ideas to keep children and families focussed. Remain engaged, keeping continuity of the therapy sessions. Initiate parental programs of becoming Super Moms and Dads.

We just celebrated Down's Syndrome Day in March 21st and World Autism Awareness Day is round the corner. We have the digital media to keep us connected. Let us make use of it to spread awareness. All is not lost . There is always two sides of the coin.

Happy Reading !

Regards

Dr. Shabina Ahmed MD, FIAP
National Chairperson
Neurodevelopmental Pediatrics Chapter of IAP

Snippets from the Secretary

Development in Corona times !!!!

" World is a global village." - Marshall McLuhan

Season's greetings.

March is the month of the year when the spring flowers blossom and the air is filled with freshness bringing hope and joy. This year as we headed into March with lots of new ideas and plans for the month as can be seen in the section 'Month in Pics", little did we know that we will be reminded of the words of Marshall McLuhan who had coined the term "Global village" which describes the phenomenon of today's highly interconnected world that is being altered daily by transnational commerce, migration and culture. The novel corona virus originating from one corner of the world has spread to all the major continents in a very short span of time bringing the whole world to a grinding halt and filling it with sorrow, despair and death.

The whole country is now in a three week lockdown starting 25 March 2020; most of the developmental centres are closed. Should we panic? Or should we turn this into an opportunity. The fight against novel corona virus pandemic highlights the need for early suspicion and diagnosis followed by early intervention, something which is not new or novel for the developmental paediatricians who live by the same principles while caring for our young patients. The current issue includes a concept paper on 'Development nurse counsellor' by Dr MKC Nair as well as excellent guidelines on management of paediatric COVID-19 cases and interesting articles on Down syndrome and trichotillomania.

Let's all unite to support our country and its people in these difficult times. I am sure that we will come out stronger and better people.

**" The greatest development is achieved during the first years of life,
and therefore it is then that the greatest care should be taken.
If this is done, the child doesn't become a burden;
he will reveal himself as the greatest marvel of nature. "
- Maria Montessori**

Jai Hind!

Wg Cdr (Dr) KS Multani
National Secretary
IAP Chapter of Neurodevelopmental Paediatrics

Concept Paper

DEVELOPMENTAL NURSE COUNSELLOR

Prof. (Dr.) M. K. C. Nair, D.Sc.

Emeritus Professor in Developmental, Behavioural and Adolescent Pediatrics

Director, NIMS-Spectrum-Child Development Research Centre

NIMS Medicity, Neyyatinkara, Thiruvananthapuram

Email: cdcmkc@gmail.com Mob: 9447121689

Neuro-developmental disorders (NDDs), the major group that lead to disabilities later on, compromise the development and attainment of full social and economic potential at individual, family, community, and country level. Neuro-developmental disorders (NDDs) include; (i) Autism Spectrum Disorders, (ii) Attention Deficit Hyperactivity Disorders, (iii) Intellectual Disability, (iv) Learning Disability, (v) Visual Impairment, (vi) Hearing Impairment, (vii) Speech and Language Disorder, (viii) Epilepsy, (ix) Cerebral Palsy, and (x) Neuro-Muscular disorders. An INCLEN study covering a sample of 3,964 children across five sites in India, estimated the prevalence of neuro-developmental disorders as 9.2% among children of 2-6 years and 13.6% among children of 6-9 years. There was no significant difference according to gender, rural/urban residence, or religion and almost one-fifth of these children had more than one neuro-developmental disorders(1). In the Indian context, it appears that reduction of low birthweight should be the central point of our thoughts and actions, whether it is for reduction of mortality, morbidity, childhood disability or poor scholastic performance(2).

Rashtriya Bal Swasthya Karyakram (RBSK) with emphasis on 4Ds - Developmental delays, Disabilities, Deficiencies and Diseases among children and Rashtriya Kishore Swasthya Karyakram (RKSK) with focus on “Adolescent Care Counselling” are the two innovative programs of Government of India, for the welfare of children and adolescents. The major limitation in implementation of the programs is the lack of professionally trained medical/nursing personnel, capable of organizing the District Early Intervention Centres (DEICs) under RBSK and Adolescent Counselling programs under RKSK. Under these circumstances, it is proposed to have one year IAP Fellowship Training Program for B.Sc. Nurses as “Developmental Nurse Counsellor”, who anyway need one year clinical or teaching experience as a prerequisite to apply for M.Sc. Nursing. More over with the proposal to convert all Diploma nursing to B.Sc. Nursing there is going to be a large pool of B.Sc. nurses with four years theoretical, clinical and practical experience made available. Their services could be effectively used in the community for RBSK, RKSK and Immunization activities and the limited availability of qualified MBBS doctors

could be compensated, except for prescription of drugs.

The aim of the "Developmental Nurse Counsellor" Training Program is to provide one year specialized skill development training to B.Sc. nurses to enable them to identify early any infant or toddler at risk for developmental delay or a child with established developmental disorder and to be able to provide nursing care and therapeutic interventional services for attaining maximum potential in motor, social, cognitive, adaptive and conceptual skills. This would help reduce unavoidable impairments (neurological) becoming disability (functional) and disability becoming handicap (social), thus helping the child to accomplish elementary education and also function independently in the society.

The basic nursing training with focus on bio-psycho-social model of management of diseases, along with comprehensive and thorough hands-on training imparted to the trainee nurses will produce competency in immunization practices, developmental assessment in well-baby clinics, help organize neuro-developmental follow-up and early stimulation programs for NICU graduates, management of children with neuro-developmental disorders, neurobehavioral disorders, various childhood disabling conditions and provide counselling to children and adolescents in the community. The pilot experience of training B.Sc. Nurses as Developmental Nurse Counsellor has been very successful.

There are many institutions in India, both in Government and Private sector with availability of multi-disciplinary team as now present at our centre, with a multidisciplinary team consisting of the Developmental Paediatrician, Developmental Therapists, Audiologist/Speech Therapists, Physiotherapists, Occupational Therapists, Optometrists, Nurse Educators, Special Educators, Clinical Psychologists, and related medical specialists, all functioning in an inter-disciplinary way under the same roof and provide therapeutic interventional services for children and adolescents.

As Developmental Nurse Counsellor program is conceived essentially as a skill development program emphasis would have to be on hands on training in the following;

1. Childhood medical aspects – Lactation counselling; Immunization; Feeding practices, etc.
2. Assessment and Therapy based on;

o CDC grading for Head Holding, Sitting and Standing

o Developmental delay using Trivandrum Development Screening Chart (TDSC) 0 – 6 years(3);

o Language delay using Language Evaluation Scale Trivandrum (LEST) 0-6 years(4,5);

o Communication delay using Trivandrum Autism Behavioural Checklist (TABC)(6);

o Preschool Readiness using Nursery Evaluation Scale Trivandrum (NEST) – Abridged (4-6 years)(7);

3. Assessment and Intervention for major Neurodevelopmental Disorders(8) using;

o Autism Spectrum Disorder: INCLEN Diagnostic Tool for ASD (INDT-ASD)(9)

o Attention Deficit Hyperactivity Disorder: INCLEN diagnostic tool for ADHD (INDT-ADHD)(10)

o Neuromotor Impairments: INCLEN Diagnostic Tool for NMI (INDT-NMI)(11)

o Epilepsy: INCLEN Diagnostic Tool for Epilepsy (INDT-EPI)(12)

4. Specific disability assessment and intervention skill training; Early developmental stimulation, Developmental therapy, Infant hearing screening, Pure Tone Audiometry, Early language stimulation, Prevocational activities, Special education, Task analysis, Picture exchange communication (PECS), Sensory integration.

5. Adolescent medical aspects – Scholastic issues, Prevention of Lifestyle diseases, Adolescent Mental Health, Adolescent Reproductive Health, all using different segments of Teenage Screening Questionnaire–Trivandrum (TSQ –T)(13).

6. Adolescent counselling aspects – Principles of counselling, Process of counselling, Mental health counselling, Reproductive health counselling, Pre marital counselling, etc..(14)

Our pilot experience of conducting Developmental Nurse Counsellor training at the institutional level have demonstrated feasibility and acceptability of the same. Hence it is proposed that IAP Neurodevelopmental Chapter take it up to meet the increasing national demand for professionals with comprehensive training in Developmental, Behavioural Pediatrics and Adolescent Counselling.

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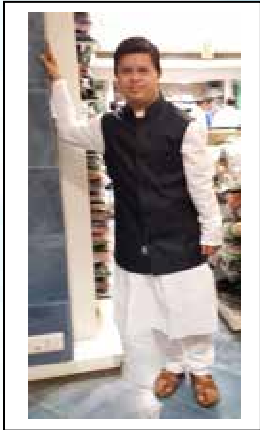

DOWN'S SYNDROME: MAKING INDEPENDENT A CHALLENGE FOR PEDIATRICIANS

Dr. Suchit Tamboli
Ph.D. Pediatrics, M.U.H.S.
Developmental and Behavioral Pediatrician
Ahmednagar

Down Syndrome is the most common chromosomal abnormality affecting newborn infants. It was first described by John Langdon Haydon Down in 1866. The chromosomal basis of the disorder was detected by Lejeune et al in 1959. It occurs due to Trisomy of chromosome 21 which is generally due to non-disjunction in meiosis. It may also be the result of Robertsonian translocation and mosaicism in small number of cases. It occurs in about 1in 920 live births in India.

Consanguinity, previous abortions, parental exposure to drugs and chemicals, tobacco and alcohol use by father were found to be some of the risk factors for Down syndrome in India. If mother's age is more than 35 years then the chances of getting Down syndrome is 1:80. Nowadays with the advanced technologies we can identify Down Syndrome at 12 weeks of gestation.

The syndrome is identified clinically by a cluster of physical and psychological characteristics consisting of brachycephaly, flat face, hypertelorism, flat bridge of nose, epicanthal folds, small low set ears, small open mouth, protruding tongue, high arched palate, clinodactyly, simian crease in palms, wide web between first and second toes, hypotonia and intellectual defect. Personality characteristics of good tempered, placid, and affectionate persons have been described but not substantiated.

They are socially adept, less prone to psychopathology and have better visuo-spatial processing capabilities but generally poor in expressive language, auditory-verbal processing, and memory and motor coordination. Substantial proportion of them shows poor attention, impulsivity, aggression and stubbornness.

The prevalence of Attention Deficit Hyperactivity Disorder (ADHD) was found to range from 31.3% to 43.9% in various studies.

Vision plays a fundamental role in the acquisition of interpersonal, hand-eye coordination, reading and language skills. Various types of visual input, refractive errors, higher order aberrations, impaired convergence, impaired accommodation and visual processing difficulties have been described in Down Syndrome.

There is history of delayed milestones in these children. Ideally child should have social smile at 2 months, head holding at 4 months, sitting at 8 months and at 1 year the child should stand without support, utters da-da, ba-ba, ma-ma and understands what we say to them. In Down Syndrome there is delay in global development.

We can identify these children at birth. Hence, the stimulation program can be started since birth. Mother is considered as a therapist of the child and Standardized Indian Stimulation Programs like Trivandum Balvikas Program by Dr. M.K.C. Nair and Hindi Version of Portage Education by Dr. Tehel Kohli from Chandigarh University. These programs are given from birth as all of us know that 85% brain development occurs in first 1.5 years. These programs help the child to become independent and the abnormality is reduced by 40% if it is started at birth. These children are interested in music. While teaching them if we use rhythmic music, they learn earliest.

Aim of Early intervention is to give stimulation in gross motor, fine motor, mental development, social development, expressive language and receptive language for first 6 years. Sometimes mother need help of physiotherapist and speech therapist. It is included in Disability Act 2016 and from 1st std. to 10th std. these children get benefit for their academic career.

We should teach them according to their mental age. We must start teaching them from where they understand. I have seen many children who have been independently working in the society. Many of them can excel in sports, small businesses.

Ankur Dhokriya is a prototype child of success stories in last 28 years. His IQ was 68 (Mild Retardation) as his stimulation programs started since birth he became independent in his life by passing 12th standard. Such stories give immense satisfaction in our field.

On the eve of World Down Syndrome Day today we all should come together to make these children independent in the society and lead normal life as their peers.

Tricky(cho) tillmania: an interesting case review

Dr Akhila Nagaraj (IAP fellow NDBP)
Dr Kirthika Rajaraman (Developmental Paediatrician)
Dr Nandhini Mundkur (Director)
Centre for Child Development and Disability, Bangalore

Body Focussed Repetitive Behaviour (BFRB) is a term used for any repetitive self-grooming behaviour (e.g., pulling, picking, biting or scraping of the hair, skin or nails) that results in damage to the body. Trichotillomania is characterised by repetitive pulling out of one's hair (from the scalp, eyebrows, eyelashes or elsewhere on the body). According to the Diagnostic and Statistical Manual of Mental Disorders (5th edition) of the American Psychiatric Association, trichotillomania is defined as meeting the following five criteria:

- Recurrent pulling out of one's hair, resulting in hair loss.
- Repeated attempts to decrease or stop hair pulling.
- The hair pulling causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The hair pulling or hair loss is not attributable to another medical condition (e.g., a dermatological condition).
- The hair pulling is not better explained by the symptoms of another

mental disorder (e.g., attempts to improve a perceived defect or flaw in appearance in body dysmorphic disorder. [1]

We had two interesting cases of trichotillomania this month. The first was our follow up of Attention deficit hyperactivity disorder (ADHD). A 9-year-old boy on ADHD medication, whose father had reported hair loss that he had observed in his son over the last 2 months. We advised a dermatology consultation. He was diagnosed to have trichotillomania and put on SSRI by the psychiatrist (outside). This was reported to us on subsequent follow up. The second case was a 7-year-old girl, who was referred to us with a diagnosis of trichotillomania. In both our cases it was not noticed by the parents initially, till they noticed hair around the house. Our first child reported later that he pulled his hair in a stressful situation like studying or not completing work. Second child could not remember when she pulled her hair. But her sibling reported that she did when she was at home or sometimes at school when she was alone. She was ridiculed for pulling her hair and was upset. The parents also reported that they had observed nail biting.

Picture: Observed hair loss over scalp

Common age of onset is in pre- or early adolescence (9-13 years) it has been reported as early as 12 months of age. In the younger age group there is an equal gender distribution. In adolescents, girls are affected more often than boys. The etiology is mostly unknown, though genetic and environmental factors are implicated. Parents rarely notice their child 's hair pulling behaviour [2,3].

Two types of hair pulling have been described for trichotillomania: automatic and focused. Focused pulling occurs in response to stress, sadness, anger or anxiety. Children often fall in the automatic type and do not recall the actual pulling. Children might pull their hair in a relaxed environment or when no one is around so this might not be noticed by the parents. The scalp is the most common area of hair pulling [2,3].

It is always important to see when parents noticed it, sites of hair loss, associated problems (hair, skin, medical, body -focused repetitive behaviours), clues (hair fallen on bed, on clothes) or triggers (family, school, physical issues, illness) or activities surrounding the hair pulling (sleep, tension, fatigue, rest) and the age of diagnosis [2,3].

Psychotherapy approach: Cognitive Behaviour Therapy (CBT) is the recommended treatment for BFRB. CBT includes [4]:

Therapy	Components	Example
Habit reversal training (Useful for short-term improvement)	• Awareness training • Competing response training • Social support	• ball up their hands into fists and tighten their arm muscles and "lock" their arms so as to make pulling or picking impossible at that moment. • provide positive feedback when the individual engages in competing responses.
Comprehensive behavioural treatment (Limited data)	Assessment, Identify and Target the Five domains: Sensory, Cognitive, Affective, Motor, and Place (SCAMP)	• Barriers such as gloves, Band Aids, medical tape or hats are used to raise awareness • Modify environment like remove mirror, dim light in bathroom to reduce behaviour • use a wide tooth comb, koosh ball or Silly Putty as a sensory substitute.
Acceptance and commitment therapy (Used with above therapies)	promotes an increased acceptance of, and tolerance for, urges to pick or pull, without acting to reduce or eliminate them.	Understanding, feeling and experiencing but not responding to an urge or emotion.
Dialectical behaviour therapy (Used with above therapies)	four modules including mindfulness, interpersonal effectiveness, emotion regulation and distress tolerance.	Focus ,accept and tolerate powerful emotions without acting on them

Drug therapy not recommended. Selective serotonin-reuptake inhibitors (SSRI) can help if co existing anxiety or depression is present, but does not help in treatment per se. Few trials have demonstrated N-acetyl cysteine (NAC) to be useful especially in adults. Other medications of interest have included opioid antagonists, mood stabilisers and dopamine blockers. Still there is no single or combination of medications approved by the Food and Drug Administration (FDA) for the treatment of BFRBs [3,4].

Children do best when their parents are supportive and compassionate without being judgmental. But hair ingestion can cause severe gastrointestinal problems and should be evaluated. Younger the age group, better the prognosis. BFRBs can cause shame and isolation, but they are manageable with treatment and support.

We plan to use above mentioned psychotherapy with our children and sensitise the family to the same. Hope to update our progress with them in the forthcoming issues!

Take home message

- TTM is not uncommon, needs high index of suspicion.
- Who, why (triggers and problems), when (age, parent's observation, clues), where (sites), how (to treat), what (associated problems): 5 W and 1H can be very useful to arrive at diagnosis.
- Behavioural therapy is recommended, not medication.

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IAP Chapter of Neuro Developmental Pediatrics
IAP Fellowship in Developmental and Behavioral Pediatrics
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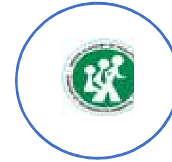


IAP Chapter of Neuro Developmental Pediatrics is happy to announce the invitations from various Child Development Centre / Institutes / Medical Colleges for Accreditation for the IAP Fellowship in Developmental and Behavioral Pediatrics for the year 2020 under the aegis of Indian Academy of Pediatrics. We are thankful to Honorable National President CIAP Dr. Bakul Parekh and Hon' National Secretary CIAP Dr. GS Basavaraj for their support and blessings. We are also thankful to Prof MKC Nair Sir and the National Chairperson 2020 IAP Chapter of Neuro Developmental Pediatrics Dr Shabina Ahmed and National Secretary Wing Commander Dr KS Multani for their support and guidance.

The IAP Fellowship Program was launched in 2015 with an aim to provide training to Pediatricians in the subject of developmental and behavioral pediatrics and to develop competency in skills required for developmental assessment, planning and implementation for Early Intervention Programs for infants and toddlers *at risk* / developmental delays and children with various neuro developmental and associated behavioral disorders. The training program has received an overwhelming response. At present, the program is running successfully at 12 Child Development Centre's across the country.

Applications are invited from the interested Child Development Centers / Institutions / Medical Colleges who are willing to join in and run the Fellowship Training Program.

Last date to apply: 30th April 2020
How to apply: Please write to the following email id for Application Form for Institute Accreditation or visit our website www.iapndp.org

jeeson1955@gmail.com kawaljit000@gmail.com shabinaloveschildren@gmail.com
chhaya_sam@yahoo.co.in cdgiap@gmail.com

Accreditation: This fellowship is accredited by Indian Academy of Pediatrics

Send the Filled Application Forms to:
Dr. Jeeson Unni
Co – Chairperson, Accreditation Committee, IAP Fellowship Governing Council
50/1459, Cheeran House, Vidyanagar, Kochi- 682020
04842315718, 9847245207 jeeson1955@gmail.com

For Further enquires Contact:
Dr. Chhaya Sambharya Prasad
National Coordinator, IAP Fellowship in Developmental and Behavioral Pediatrics
Director, Centre for Autism & Intellectual Developmental Disorders, ASHA, Chandigarh
SCO 909, First Floor, NAC Market, Solitaire Block, Housing Board Chowk, Mani Majra, Chandigarh – 160101
9356108559, 8146558559 chhaya_sam@yahoo.co.in

GOVERNING COUNCIL IAP FELLOWSHIP IN DEVELOPMENTAL & BEHAVIORAL PEDIATRICS
Dr SS Kamath – Chairperson Advisory Committee
Dr Abraham Paul – Chairperson Accreditation & Inspection Committee
Dr Jeeson Unni – Co Chairperson Accreditation & Inspection Committee
Dr Samir Dalwai – Chairperson Academic Committee
Dr Chhaya Prasad – National Coordinator, IAP Fellowship In Developmental & Behavioral Pediatrics

IAP CHAPTER OF NEURO DEVELOPMENTAL PEDIATRICS 2020

IAP CHAPTER OF NEURO DEVELOPMENTAL PEDIATRICS

OBJECTIVES

IAP Fellowship in Developmental and Behavioral Pediatrics

Indian Academy of Pediatrics

Following are the objectives of the IAP Fellowship in Developmental and Behavioral Pediatrics. After completion of the course the fellows will be able to serve in areas as mentioned below.

1. To develop an excellent understanding of the early child development, factors affecting growth and development, developmental neurology, neuro-developmental disabilities, genetic disorders, sensory impairments, behaviour problems, emotional problems, child guidance, parenting skills, behaviour therapy and counselling, amongst children and adolescents.

2. To develop expertise in neuro developmental assessment for high risk newborns / NICU graduates and planning neuro developmental follow ups, providing counselling for mothers / caretakers of infants at risk.

3. To develop proficiency in early identification and early stimulation program for high risk newborns / infants at risk.

4. To develop proficiency in history taking and clinical examination of children with developmental delays and deviancies.

5. To develop skills and proficiency in documentation, record keeping and reporting of infants and children identified with developmental delays and deviancies.

6. By providing their services and competency in skills required for developmental assessment, planning and implementation for early identification and early intervention for infants and toddlers *at risk* / and children with developmental delays and rehabilitation for children with neuro developmental disorders.

7. To develop skills and proficiency for Prevention of severe disabling conditions in children through Early Identification and Early Intervention by effectively coordinating with a Multi disciplinary team consisting of Clinical Psychologists, Occupational Therapists, Speech Therapists, Physiotherapists, Special educators, Parents, Caretakers etc and other medical fraternity including Paediatric Neurologists, Orthopedicians, Paediatric Ophthalmologists, Gynaecologists, Geneticists etc.

8. By helping other rehabilitation professionals to develop competencies in organizing the early interventional services.

9. To develop proficiency in clinical examination, record keeping, and documentation for children and adolescents with special needs.

10. To develop proficiency in role of Play in Learning and Instructive methodology for children, types and stages of play, methods and role of play therapy.

11. To develop excellent understanding of the sensory components, sensory issues and sensory disorders, and integrating the stimulation program to improve sensory imbalances.

12. By assisting infants and children with special needs to attain his or her maximum potential in areas of motor, social, cognitive, adaptive and conceptual skills for integration in the society.

13. To prepare children with developmental disorders for elementary education and for integration in the society.

14. By enhancing Parents participation and helping parents and society to develop a 'Right Attitude' towards a Child and or an Adolescent with Special Needs and empowering them with the right knowledge and techniques for interventions in home environment.

15. As a specialist in the science of early childhood development, and childhood disability by delivering high quality clinical outcome in every single case through awareness, advocacy and promotion of implementation of governmental policies

16. As doctor with Special Interest and Specialist Role by helping to avoid professional role confusion and Integrating all work aligned with the Government's Practices and Policies (SNCUs, RBSK)

17. The fellows will be able to set up independent Child Development Centres catering to the health and educational needs of children with special needs in the society.

18. The fellows will participate in the Community programs and National programs to train various multi-purpose health workers, Anganwadi workers, ASHA's, ANM's at the PHC's in early identification and early referrals to appropriate centres for interventional services.

19. The fellows will be able to seek and analyze rationally any recent advances and or new literature with information about diagnostic or interventional services for childhood disabilities and will practice evidence based therapeutic and non therapeutic modalities.

20. The fellows will develop proficiency in conducting research work independently and will be able to fill in the lacunae created by lack of evidence based practice in the field of childhood disability in India.

21. The fellows will exhibit communication skills of high order and demonstrate compassionate attributes towards children and adolescents with disabilities.

22. The fellow will develop expertise and aptitude in communicating with families and parents of children with disabilities.

23. The Fellows will also get an exposure to the Community Based Rehabilitation Programs and will get skilled in carrying out similar programs.

24. The Fellowship course also aims at enhancing awareness among pediatricians regarding approach to and management of school going children with poor scholastic performance.

25. The trained Fellows in turn would be able to conduct awareness programs for the school management, teachers and parents so that the problems of this 'invisible handicap' are dealt with on a war footing by everyone dealing with children in our country.

Disability, both visible and invisible affects 1 in 4 to 1 in 5 children throughout the world. With advent of SNCUs (Special Neonatal Care Units) India is poised to drastically reduce its NMR (Neonatal Mortality Rates) but the burden of Disability will remain high in NICU Graduates. Disability is commoner in resource limited nations like India. Early Detection and Expert Early Intervention have been shown to be the best policy to decrease the rates and degrees of disability in children. More and more doctors are needed to tackle the situation, and more expert training is required to reach out and help the children at risk. The IAP Chapter of Neuro Developmental Pediatrics has initiated this Fellowship Program, under the aegis of Indian Academy of Pediatrics to take forward and support the cause in the country. We invite all Pediatricians with the passion to learn and be the change in the society, to come and join the fellowship program and get equipped with the right knowledge and expertise to serve the children and adolescents of the country.

GOVERNING COUNCIL IAP FELLOWSHIP IN DEVELOPMENTAL & BEHAVIORAL PEDIATRICS

DR SS KAMATH – CHAIRPERSON, ADVISORY COMMITTEE

DR ABRAHAM PAUL – CHAIRPERSON, ACCREDITATION & INSPECTION COMMITTEE

DR JEESON UNNI – CO CHAIRPERSON, ACCREDITATION & INSPECTION COMMITTEE

DR SAMIR DALWAI – CHAIRPERSON, ACADEMIC COMMITTEE

DR CHHAYA PRASAD – NATIONAL COORDINATOR, IAP FELLOWSHIP IN DEV & BEH PEDIATRICS

With Blessings and Guidance of Prof MKC Nair, Vice Chancellor, Kerala University of Medical Sciences

IAP CHAPTER OF NEURO DEVELOPMENTAL PEDIATRICS

Central IAP COVID Bulletin - 21st March 2019

IAP appeals to all members to abide by the advisories issued by the Ministry of Health and Family Welfare. This bulletin is brought by Central IAP to keep the members updated on what is to be followed by the members in this outbreak. This bulletin will be updated regularly.

Covid 19 is mainly transmitted by respiratory droplets from a Covid-19 infected person. The droplets can travel upto a distance of 1 to 2 metres (upto 6 feet). It can also spread by touching the virus contaminated surface or object and then touching one's mouth, face and eyes.

Clinical features:

Fever, Dry cough, fatigue, vomiting, diarrhea, headache, sore throat, coryza, conjunctivitis.

Can be classified as

1. Mild to Moderate (no pneumonia or pneumonia without distress),

2. Severe (dyspnea, respiratory frequency =30/minute, blood oxygen saturation =93%, PaO2/FiO2 ratio <300, and/or lung infiltrates >50% of the lung field within 24-48 hours)

3. Critical (respiratory failure, septic shock, and/or multiple organ dysfunction/failure)

As per data from China:

In general population, mild 80%, severe 15% and critical 5%

In children, Mild to moderate in majority cases; severe about 2.5% and critical about 0.2%

Covid Case definition

A patient with acute respiratory illness (fever and at least one sign/ symptom of respiratory disease (e.g., cough, shortness of breath) AND a history of travel to of residence in a country/area or territory reporting local transmission (See NCDC website for updated list) of COVID-19 disease during the 14 days prior to symptom onset;

OR

A patient / Health care worker with any acute respiratory illness AND having been in contact with a confirmed COVID-19 case in the last 14 days prior to onset of symptoms;

OR

A patient with severe acute respiratory infection (fever and at least one sign/symptom of respiratory disease (e.g., cough, shortness breath) AND requiring hospitalization AND with no other etiology that fully explains the clinical presentation;

OR

Central IAP COVID Bulletin - 21st March 2019

A case for whom testing for COVID-19 is inconclusive

Laboratory Confirmed case: A person with laboratory confirmation of COVID-19 infection, irrespective of clinical signs and symptoms.

Mandatory notification by practioners

Self declaration forms regarding travel history should be made available.

If any patient is found to be a Covid Supect as the Case definition below, the patient should be isolated in the hospital and tested for Covid at the designated centre.

Information of all such cases should be given to the State helpline and also to National helpline. Email can also be sent at ncov2019@gov.in

National Helpline numbers :

+91-11-23978046, Toll free 1075

Helpline Email id: ncov2019@gov.in

The following is the State wise list:

S.No.	State	Helpline numbers
1	Andhra Pradesh	0866-2410978
2	Arunachal Pradesh	9536055743
3	Assam	6913347770
4	Bihar	104
5	Chhattisgarh	077122-35091
6	Goa	104
7	Gujarat	104
8	Haryana	8558893911
9	Himachal Pradesh	104
10	Jharkhand	104
11	Karnataka	104
12	Kerala	0471-2552056
13	Madhya Pradesh	0755-2527177
14	Maharashtra	020-26127394
15	Manipur	3852411668
16	Meghalaya	108
17	Mizoram	102
18	Nagaland	7005539653
19	Odisha	9439994859

20	Punjab	104
21	Rajasthan	0141-2225624
22	Sikkim	104
23	Tamil Nadu	044-29510500
24	Telangana	104
25	Tripura	0381-2315879
26	Uttar Pradesh	18001805145
27	Uttarakhand	104
28	West Bengal	3323412600

S. No	Name of Union Territory (UT)	Helpline numbers
1	Andaman & Nicobar Islands	03192-232102
2	Chandigarh	9779558282
3	D & N Haveli	104
	Daman & Diu	104
4	Delhi	011-22307145
5	Jammu	1912520982
	Kashmir	0194-2440383
6	Ladakh	01982-256462
7	Lakshdweep	04896-263742
8	Puducherry	104

Current testing strategy (as per ICMR Version 3, dated 20/3/2020):

All asymptomatic individuals who have undertaken international travel in the last 14 days:

- They should stay in home quarantine for 14 days.
- They should be tested only if they become symptomatic (fever, cough, difficulty in breathing)
- All family members living with a confirmed case should be home quarantined

All symptomatic contacts of laboratory confirmed cases.

All symptomatic health care workers.

All hospitalized patients with Severe Acute Respiratory Illness (fever AND cough and/or shortness of breath).

Asymptomatic direct and high-risk contacts of a confirmed case should be tested once between day 5 and day 14 of coming in his/her contact.

Direct and high-risk contact include those who live in the same household with a confirmed case and healthcare workers who examined a confirmed case without adequate protection as per WHO recommendations.

Central IAP COVID Bulletin - 21st March 2019

IAP recommendations for Outpatient practices:

Scheduling of Daily OPD Appointments:

Schedule appointments for OPD patient requesting not to come for routine visits or routine immunization for next couple of weeks and to come to OPD only if essential to be seen.

Instruct those with respiratory symptoms to visit the OPD wearing mask.

Separate time slots can be provided for those with fever and respiratory symptoms at the time of appointment.

Encourage patients to come on time at the allotted appointment time.

For those practioners who do not have an appointment system:

Keep a notice outside the clinic in local language to kindly return if they have come for regular vaccine or routine visit.

In the waiting Room

Instruct to inform receptionist immediately of travel history (both domestic and international), priortise seeing this patient. Self declaration forms to be kept.

Receptionist should wear a mask.

Encourage use of hand sanitizer before entering the examination area.

Display posters of cough etiquette and hand hygiene.

Space out chairs to about 6 feet distance if possible. Patients can wait in their private car(if feasible) and called at allotted times to prevent overcrowding.

Ensure cleaning of high touch surfaces like door knobs, receptionist table, seating chairs, toilet seats frequently (atleast every 2 hourly). Infant weighing scales needs to be wiped cleaned between each infant weight. If facility is available, lay disposable sheet between infants.

Floor should be cleaned atleast 3 times in a day. The heads of the mop should be cleaned in the beginning and in the end and dried in sunlight.

In the examination room

The doctor should wear a surgical mask. Do not touch the face, eyes and mouth especially while adjusting face masks or spectacles.

It is preferable to wear a buttoned apron above clothes. The arms should be bare below the elbows.

Do not wear ties, blazers, rings, bangles, etc. Keep nails trimmed. This will apply to all health care providers.

Clean the diaphragm of stethoscope with cotton and hand sanitiser and perform hand hygiene between every patient.

Central IAP COVID Bulletin - 21st March 2019

If facilities are available, use disposable tissue sheets between patients. If using uncovered examination table, it is better to wipe clean the surface between patients with respiratory symptoms and when visibly soiled.

Biowaste generated should be managed by local waste management protocols.

Cleaning agents in health care setting

Dry sweeping or vacuum cleaners is not recommended.

Detergent solution gives effective cleaning. Mechanical cleaning is most important step. This can be followed with disinfectant use. If there is shortage of hospital disinfectants, decontamination may be performed with 0.1% sodium hypochlorite (dilution 1:50 if household bleach at an initial concentration of 5%). Surfaces that may be damaged by sodium hypochlorite may be cleaned with a neutral detergent followed by 70% concentration of ethanol.

Preferably avoid use of nebulisation to prevent aerosol generation. Child can be given metered dose bronchodilator inhalers with spacer and mask.

General

All health care workers to perform thorough hand hygiene before leaving health facility and on reaching home take a bath. Also clean mobile surfaces with hand sanitizer. Avoid carrying non essential items to and fro health care centres.

Encourage dissemination of correct information in the society. Encourage healthy indoor activities for children like playing indoor games like chess, carom etc, doing art work, reading books. Discourage increased screen time for children.

Recommendations on wearing Masks

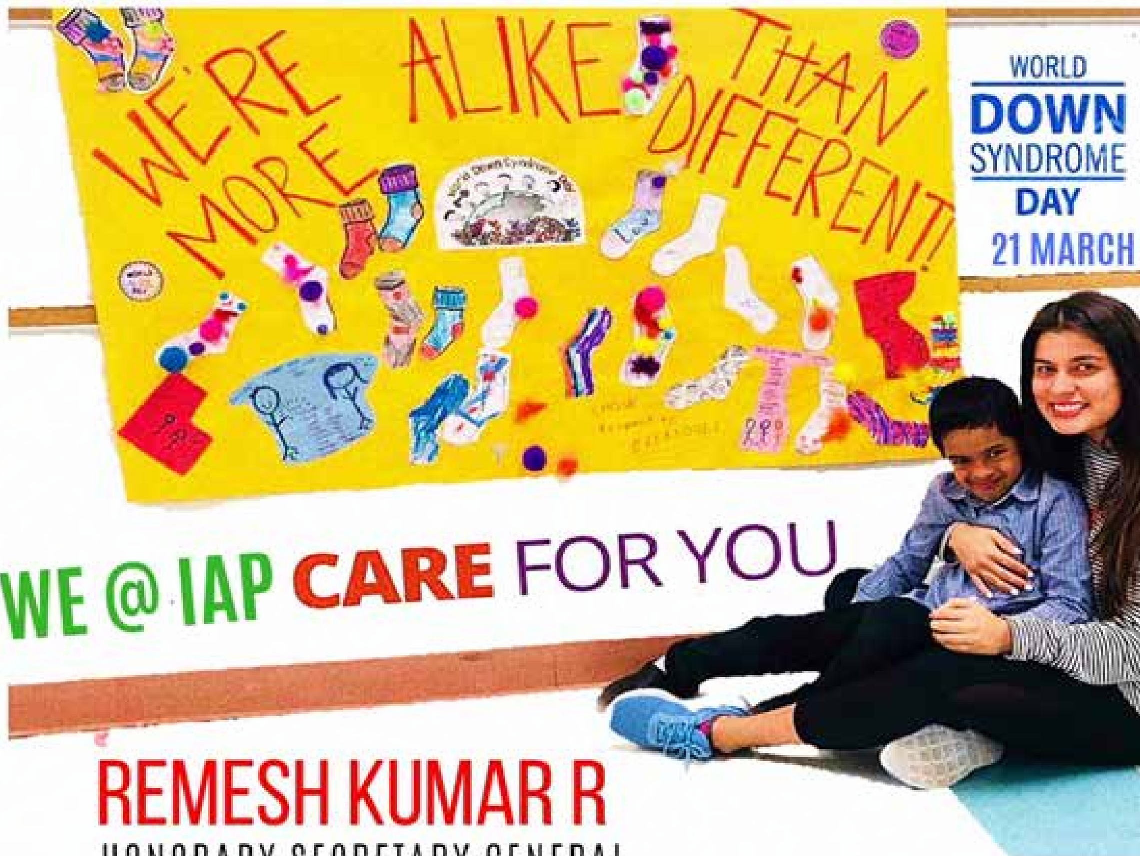
All health care workers and those having symptoms need to wear surgical mask.

N95 mask is recommended when dealing with Covid affected patient or during any aerosol generating procedure like intubation, resuscitation, collecting nasopharyngeal samples,etc.

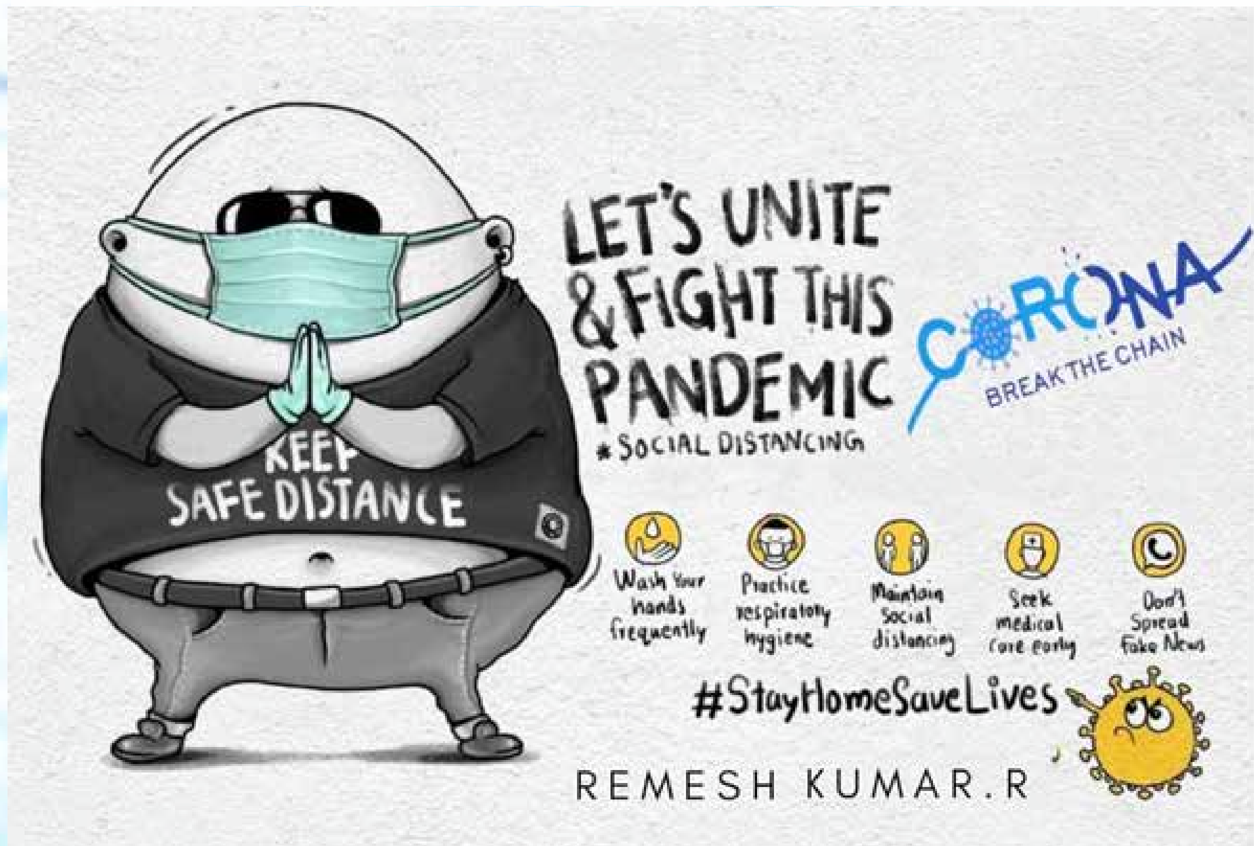
No mask is recommended for non-health care associated personnel who is asymptomatic.

Masks should fit properly without leaving gap between face and mask. It should not be touched on the front part. It should be removed after 6- 8 hours or when it becomes damp. It should be disposed by removing from backside into the yellow dustbin and should not be reused or stored in pocket, drawer, etc.

IAP COVID 19 COMMITTEE



WE'RE MORE ALIKE THAN DIFFERENT!
WORLD
DOWN
SYNDROME
DAY
21 MARCH
WE @ IAP CARE FOR YOU
REMESH KUMAR R
HONORARY SECRETARY GENERAL ,
CENTRAL IAP 2018 & 2019



LET'S UNITE & FIGHT THIS PANDEMIC
* SOCIAL DISTANCING
CORONA
BREAK THE CHAIN
KEEP SAFE DISTANCE
Wash Your hands frequently
Practice respiratory hygiene
Maintain Social distancing
Seek medical care early
Don't Spread Fake News
#StayHomeSaveLives
REMESH KUMAR.R

Month in Pics

Babylon's Newton Child Development and Support Center Jaipur

Dr Swati Ghate (Pediatrician, Adolescent Health Specialist (PGDAP) and MA in Clinical psychology) and a team of specialist doctors and therapists are running a multidisciplinary CDC in Jaipur, by the name **Babylon's Newton Child Development and Support Center.**

We have with us Pediatric endocrinologist, pediatric orthopedician, Pediatric ENT specialist, dentists, OT, PT, ABA, Speech therapist, remedial educators, psychologists, dieticien, social worker and the like. They take up NICU follow up and cater to developmental delays and behavioural and scholastic issues of mainstream children and children with special needs. Regularly conduct outreach awareness activities as well as in-house academic and support activities.

Conduct sessions for teachers on Behavioural issues in children and adolescents with special reference to NDDs.

Organised a session for parents on World legal awareness day, regarding rights of disabled children. A lawyer and Dr Sitaraman put forth their views. Parents queries were resolved to some extent.

Month in Pics

**Workshop conducted for the staff
on Behaviour management and Strategies
by Mrs. Kavita Kamat, Behaviour Analysts,
Director of Laurel Behaviour Support services, Canada**

Month in Pics

Program for Socio emotional learning for preschool children parents conducted in Navkis school on 7th March 2020

Month in Pics

Dr. Himani Narula Khanna as a faculty organised by IAP Amritsar Chapter on Neurodevelopmental Disorders -

Standard guidelines in diagnosis and Management of Autism spectrum Disorders held on 16 Feb 2020 .

Month in Pics

Bayley training workshop organised by Neurodevelopmental Paediatric Chapter and GMC Bhopal. Dr. Ravi was the resource person and organising secretaries were Dr. Zafar Meenai and Dr. Jyotsna Shrivastava. 30 Paediatricians attended the workshop.

1 COVID-19 PARENTING
One-on-One Time

Can't go to work? Schools closed? Worried about money? It is normal to feel stressed and overwhelmed.

School shutdown is also a chance to make better relationships with our children and teenagers.
One-on-One time is free and fun. It makes children feel loved and secure, and shows them that they are important.

Set aside time to spend with each child

It can be for just 20 minutes, or longer – it's up to us. It can be at the same time each day so children or teenagers can look forward to it.

Ask your child what they would like to do

Choosing builds their self confidence. If they want to do something that isn't OK with physical distancing, then this is a chance to talk with them about this.
(see next leaflet)

Ideas with your baby/toddler

- Copy their facial expression and sounds
- Sing songs, make music with pots and spoons
- Stack cups or blocks
- Tell a story, read a book, or share pictures

Switch off the TV and phone. This is virus-free time

Ideas with your teenager

- Talk about something they like: sports, music, celebrities, friends
- Cook a favorite meal together
- Exercise together to their favorite music

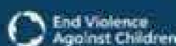
Ideas with your young child

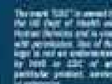
- Read a book or look at pictures
- Make drawings with crayons or pencils
- Dance to music or sing songs
- Do a chore together – make cleaning and cooking a game
- Help with school work

Listen to them, look at them. Give them your full attention. Have fun!

For more information click below links:

Parenting tips from WHO | Parenting tips from UNICEF | In worldwide languages | EVIDENCE-BASE





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