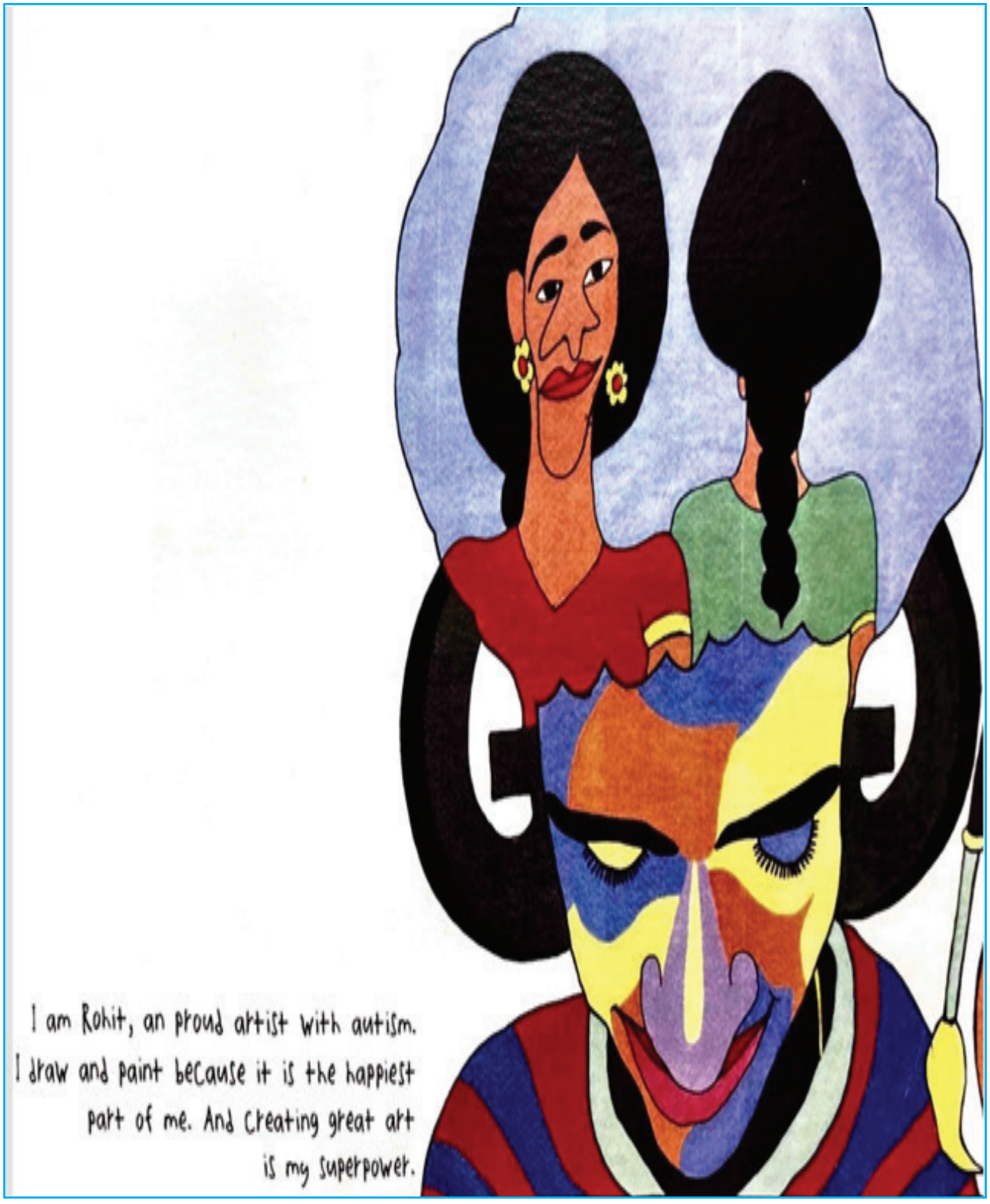
APRIL-JUNE 2026

DPT

DEVELOPMENTAL PEDIATRICS TODAY

Your monthly booster for developmental and behavioural news!

The Official Newsletter of the IAP Chapter of Neurodevelopmental Pediatrics



Chief Editor : Dr Samir Dalwai

DPT IN A GLIMPSE

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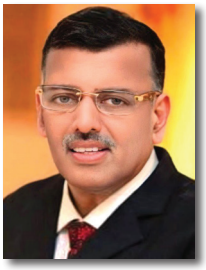

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INTERACTIONS - THE EDITOR - DR SAMIR H DALWAI

The 2nd of April marks a renewal of our commitment towards autism. Each year, our members dedicated to this cause continue to be creative and determined and excel at reaching the awareness of autism and its myraid interventions to all, along with hope of what is possible! I congratulate all who walk on this difficult path and pray that you continue to excel in your journey!

As years go by, and awareness of autism has reached levels never before seen, we must pause and take stock. My teacher, Dr Rashid Merchant, used to tell us as students, "Remember, what got you here, will not take you there!"

Having successfully learnt to navigate the 'awareness' building curve, we must now look at making this awareness worth it for the children and parents. It would be very unfair and unfortunate if after having identified the child with autism early, and bringing him under the intervention umbrella, we are unable to make a far greater impact on the eventual outcome of the child to lead as far as possible an independent dignified existence in society, as say ten years ago when the awareness was very limited. Hence, if we have invested one measure of resources into awareness, we must invest 10x the measure of resources to improve the interventions given to such a child.

Quality is not just a measure of how services are delivered but also what is the outcome of such services? Fortunately, good services are now available in almost every nook and corner of the country. Having offered that, we must turn to taking stock. We need to audit the improvements seen in children with whatever modality of service(s) we are offering, whether in the public sector or private. What is working versus what is not. What is truly a transformation towards the eventual goal of independent life versus what may end up as a permanent-support dependent system. And we must continually strive to out-perform our efforts at intervention. Yes, we are aware that somehow the practices around autism intervention make it almost universally 'accepted' that such independence may not be possible - with the current interventions - and that is exactly the point.

Galileo was killed for having proposed that the earth was not flat but round. I'm sure the 21st century will be kinder to those who challenge well-established hegemonies. And what better place to do that than the land of a 5,000 year old civilisation.

In these pages, you will find attempts to change the trajectory, and sometimes, even the trend of what has been going on! These pages offer you the space to share your ideas, thoughts, experiences- let us use them to usher in an era of unimagined transformation for autism.

Best regards,

Dr. Samir H. Dalwai
Developmental–Behavioural Pediatrician

JOINT ATTENTION

MESSAGE FROM CHAIRPERSON

As developmental paediatricians, our clinical focus extends beyond immediate medical management—we are deeply invested in how children navigate their everyday environments, particularly education. In our work with children with special needs, we frequently reference the concepts of integration and inclusion. While often used interchangeably, they represent two fundamentally different philosophies of care, accessibility, and education. Understanding this distinction is vital for our clinical practice, our advocacy, and the guidance we offer families and institutions.

Integration focuses primarily on location—placing a child with special needs into a mainstream classroom under the premise of "bringing the child into the existing system." Under this model, the child is expected to adapt to the pre-existing structure, curriculum, and pace of the school. Additional support may be introduced, but the broader system remains largely static. Integration essentially asks, "Can the child fit in here?" If a child struggles—such as a student on the autism spectrum placed in a standard classroom with standard teaching styles—the difficulty is often viewed as the child's limitation rather than a structural shortfall.

Inclusion, by contrast, shifts the paradigm by seeking to "change the system to fit the child." Rather than forcing the child to conform to an inflexible environment, inclusion focuses on meaningful participation and belonging—addressing how the child learns and feels part of the community. The entire school ecosystem adapts through flexible curricula, multi-sensory teaching methods, tailored assessments, and supportive physical environments. Differences are valued as rich contributions to the learning experience rather than mere burdens to accommodate. For that same child on the autism spectrum, an inclusive setting provides visual schedules, sensory breaks, peer-buddy support, and modified lessons that benefit the entire classroom.

Inclusion is now globally recognized as the gold standard because it shifts the locus of responsibility from the child to the system. Inclusion asks the far more powerful question: "How do we make this work for the child?"

As developmental paediatricians, we hold a vital dual responsibility. First, we must empower the child for integration through early detection and early intervention, building the essential skills and capabilities they need to navigate the world. Second, we must serve as passionate advocates for inclusion, using our collective voice to encourage schools, communities, and policymakers to reshape environments so every child can thrive. Let us continue to bridge these two responsibilities, strengthening our children while building a world fully prepared to welcome and value them.

Warm regards,

Dr. Zafar Meenai
Chairperson
IAP Neurodevelopmental Chapter -2026

JOINT ATTENTION

MESSAGE FROM SECRETARY

Dear Colleagues,

In our busy pediatric practices, between managing acute illnesses and vaccination schedules, subtle developmental red flags often slip through the cracks. While motor and physical milestones receive prompt attention, the early signs of Specific Learning Disabilities (SLD) can remain invisible until a child experiences severe academic or behavioral failure.

In India's demanding academic environment, children with early language, reading, or executive function difficulties are frequently mislabeled as "lazy" or "inattentive." By the time they reach middle school, crucial early intervention windows have closed, and their self-esteem is deeply damaged.

As the first point of contact, we can change this trajectory without adding lengthy evaluations to a five-minute consult. Simply asking, "How is the child coping academically and socially compared to peers?" can reveal vital clues. Watch for preschoolers struggling with nursery rhymes or fine-motor tasks, and early-primary children failing to grasp letter-sound associations or persistently reversing letters.

Recognized under the RPWD Act (2016), SLDs require targeted support. DPT newsletter in this edition gives special attention to this often neglected aspect of pediatric care. Editorial team requires a special mention for selecting this theme.

Let us commit to spotting these early cues and referring patients for timely psycho-educational assessments. A moment of vigilance in our crowded clinics today can rewrite a child's entire future.

Warm regards,

Dr. Lal DV Nair
Secretary,
IAP-Neurodevelopmental Pediatrics Chapter

Social Communication
From the States and State Coordinators

Dr Pubali Deka

Autism Awareness Month, April 2026 was celebrated across the country with great enthusiasm through a wide range of academic and community-based activities organised by members of IAP Neurodevelopmental Chapter. Throughout the month, chapter members conducted academic programs,scientific sessions,public awareness campaigns,parent education initiatives,and community outreach activities.These events engaged medical professionals, parents, educators,caregivers and the general public , fostering greater awareness ,early identification , evidence based intervention, and social acceptance of individuals with autism spectrum disorder.The enthusiastic participation of chapter members from across the country made the month-long observance a resounding success.

West Zone Developmental CME 2026, Nagpur

CME on Autism Spectrum Disorder, Guwahati , Assam

Autism awareness day , Nagpur

Saveetha Child Development Centre , Chennai

Government Medical College & Hospital, DEIC , Thiruvallur

Communication board innaugauration at children's park,Telangana

Parent training Session, Indresh Medical College, Dehradun

Parent awareness program ,Vadodara, Gujrat

CME on Autism ,RKDF Medical College, Bhopal

Plantation drive on Autism Day, Meerut

CME on Autism, women wing IAP Gurgaon

Parent training workshop, MGM Medical College, Indore

Symposium, Sir Gangaram Hospital, New Delhi

Autism Awareness Program, KLE CC Hospital & MRC, Belgaum

Seminar on Autism, JLNMCH, Bhagalpur

Autism Awareness Activity, CNBC &MGM Medical College

Awareness program, LG Government Hospital

Autism Awareness Program, Parul University, Vadodara

Rainbow CDC & children's hospital, Hyderabad

Autism awareness walk, Central Delhi

Autism month activity , Orissa

Autism awareness program, anganwadi centre, Zaffarpur, District -Ambala, Haryana

CME on autism , Indore

CME on autism, Shri Sankaracharya Institute of Medical Sciences, Bhilai, Chattisgargh

Vernekar Hospital, Belgaum

PINCER GRASP- JOURNAL SCAN

DIGITAL ECOSYSTEMS, CHILDREN, AND ADOLESCENTS : POLICY STATEMENT

Tiffany Munzer, Joanna Parga-Belinkie, Libby Matile Milkovich, Suzy Tomopoulos, Taiwo Ajumobi, Corinn Cross, Roslyn Gerwin, Sheri Madigan, and the Council on Communications and Media

PEDIATRICS Volume 157, Issue 2, February 2026:e202507532

Dr Kawaljit Singh Multani

Key Takeaways: AAP Digital Media Policy Statement 2026

1. The Core Paradigm Shift

- From "Screen Time" to "Ecosystem": Focus shifts from strict hour limits to regulating design features (autoplay, algorithms, dark patterns) engineered for maximal retention.
- Socioecological Approach: A child's media use is shaped by broader environments — individual maturity, family dynamics, platform design, and policy.
- Child-Centered vs. Engagement-Based: Calls to replace predatory monetization and engagement features with privacy-focused, age-appropriate design.

2. Developmental Health Impacts

- Early Childhood (0–5 yrs): Under 18 months cannot transfer 2D media to real-world context. Using tablets to soothe delays emotional self-regulation and language development. Co-viewing slow-paced, educational media remains beneficial.
- School-Aged (6–12 yrs): High-quality apps support learning, but fast-paced or excessive use impairs attention, academic performance, and eye health (myopia).
- Adolescents (13–18 yrs): Early teens (11–14) are most vulnerable to algorithmic amplification of body dysmorphia, anxiety, and depression. Neurodivergent youth face higher risk for problematic use.

3. Actionable Recommendations

For Pediatricians:

- Use the 5 C's evaluation framework (Child, Content, Calm, Crowding out, Communication).
- Provide empathetic counseling rather than parental shaming.
- Screen digital habits routinely alongside sleep and development.

For Parents & Caregivers:

- "Crowd In" essential routines: Protect

sleep, physical activity, and family meals before allocating screen time.

- SCREEN OUT low-quality content: Avoid Shallow learning, Commercials, Rapid pacing, Excessive gamification, Extreme content, and No clear outcome.
- Smart Devices: Base phone ownership on maturity (e.g., using AAP PhoneReady), keep bedrooms screen-free, and turn off devices 1 hour before bed.

For Policy & Industry:

- Privacy by Default: Ban targeted ads, auto-play, and behavioral profiling for minors.
- Product Safety Standards: Regulate youth digital products like physical consumer goods (e.g.,food, auto safety).
- Institutional Protection: Enforce evidence-based phone policies in schools and fund public, ad-free digital and physical spaces.

FROM GENERAL TO JOURNAL

READING & WRITING – REVIEW OF THE HANDBOOK CHAPTERS

Dr Anjali Gokarn

Developmental & Behavioral Disorders in Adolescence

By
Dr. Dilip Patel, Dr Swati Bhave

1. Most developmental and behavioral disorders begin in early childhood but often become more evident during adolescence because of increasing academic, social, and emotional demands.
2. Common disorders include Intellectual Disability, ADHD, Autism Spectrum Disorder, Learning Disorders, Speech and Language Disorders, Tic Disorders, and Developmental Coordination Disorder.
3. Assessment should focus on overall functioning, including body function, body structure, activities, participation, and the impact on daily life.
4. Intellectual disability is diagnosed by significant limitations in intellectual functioning and adaptive behavior, using standardized assessments appropriate for age and culture.
5. Learning disorders affect specific academic skills like reading, writing, or mathematics despite normal intelligence and adequate educational opportunities.
6. Clinical presentation commonly includes poor scholastic performance, language and communication difficulties, behavioral problems, and emotional issues such as anxiety or depression.
7. Always look for associated conditions, especially ADHD, anxiety disorders, depression, disruptive behavior disorders, and substance use.
8. A comprehensive evaluation should include medical, developmental, psychological, behavioral, family, and educational assessment to identify strengths, weaknesses, and comorbidities.
9. Management requires a multidisciplinary approach, involving pediatricians, psychologists, special educators, speech and occupational therapists, counselors, and family support, with medications used only when indicated.
10. Early identification, individualized educational support, behavioral interventions, parental involvement, and regular follow-up greatly improve academic performance, social functioning, and long-term outcomes.

PRE-LINGUISTIC SKILLS: THE BUILDING BLOCKS OF EARLY COMMUNICATION

Dr. Shyamal Kumar, Dr Avinash Kumar
Correspondence:
Dr Shyamal Kumar, Reborn CDC, Dhanbad
Dr Avinash Kumar, Assoc. Professor, SNMMCH, Dhanbad

Introduction

Language development is one of the most remarkable achievements of early childhood. While parents often celebrate a child's first spoken word, communication begins much earlier. Long before children learn to speak, they develop a series of social, cognitive, and communicative abilities that prepare the brain for language acquisition. These foundational abilities are collectively known as pre-linguistic skills.

The first three years of life represent a period of rapid brain growth and neuroplasticity, during which repeated social interactions shape neural pathways responsible for communication. During this period, infants learn to look at people, respond to voices, share attention, imitate actions, use gestures, vocalise purposefully, and understand simple words. Together, these abilities create the foundation upon which spoken language develops.

Failure to acquire these skills may be one of the earliest indicators of communication disorders, highlighting the importance of developmental surveillance and early intervention.

What Are Pre-Linguistic Skills?

Pre-linguistic skills are the non-verbal communication and interaction skills that enable a child to understand, engage with, and communicate with others before the emergence of spoken language. Rather than representing isolated milestones, these skills form a developmental continuum that prepares children to understand the purpose of communication and eventually use meaningful words.

Before a child can speak, he or she must first learn to attend to people and objects, share experiences with others, recognise that communication has a purpose, take turns during interactions, imitate actions and sounds, and use gestures to express needs. These experiences provide the neurological and behavioural foundation for later language learning.

Why Are Pre-Linguistic Skills Important?

Communication develops through relationships rather than vocabulary alone. Children first discover that their behaviours influence others—through eye contact, smiling, pointing, vocalising, and shared play. Repeated positive interactions strengthen neural networks responsible for social communication, language comprehension, and expressive language.

Research consistently demonstrates that delays in pre-linguistic skills frequently precede speech and language delays. Children with autism spectrum disorder, developmental language disorder, hearing impairment, intellectual disability, and global developmental delay often show deficits in one or more of these foundational abilities. Conversely, a child with few or no spoken words but strong pre-linguistic skills generally demonstrates good readiness for future language development.

The Three Pillars of Pre-Linguistic Skills

For practical clinical assessment, pre-linguistic skills can be understood within three interrelated domains.

1. Social Interaction Skills

These skills enable children to connect with people and participate in reciprocal interactions. They include responding to people, maintaining eye contact, sharing joint attention, taking turns, and initiating social interaction. These are often the earliest skills affected in children with autism spectrum disorder.

2. Communication Intent Skills

Communication begins when children understand that their behaviour can influence another person. This domain includes using gestures, vocalising purposefully, requesting, responding to communication, and initiating interactions. These behaviours demonstrate intentional communication and form the bridge between non-verbal communication and spoken language.

3. Learning and Cognitive Readiness Skills

Language learning also depends on a child's ability to attend, imitate, play functionally, understand words, and sustain engagement during interactions. These skills provide the cognitive foundation necessary for acquiring vocabulary and following increasingly complex instructions.

Clinical Assessment

Observation remains the cornerstone of assessing pre-linguistic skills. Rather than relying solely on developmental history, clinicians should observe children during natural play and interaction with caregivers.

Key questions include:

- Does the child respond to people?
- Does the child share attention with another person?
- Can the child participate in simple turn-taking?
- Does the child imitate actions or sounds?
- Are gestures used meaningfully?
- Does the child vocalise intentionally?
- Does the child understand simple words and directions?
- Does the child initiate communication independently?

Assessment of these domains provides valuable insights into a child's readiness for language development and helps identify children requiring further evaluation.

Parent-Mediated Intervention

Parents are the child's first communication partners, and everyday routines provide countless opportunities to strengthen pre-linguistic skills. Meals, bath time, dressing, book reading, household chores, and play all create natural situations for communication.

Simple strategies include positioning oneself within the child's visual field, encouraging the child to "find" the caregiver with their eyes, using the "Show–Hold–Give" approach during interactions, incorporating gestures while speaking, shifting from constantly initiating interactions to responding to the child's attempts, creating opportunities for requesting, modelling playful vocalisations, and introducing new environments and materials to encourage exploration and communication.

These approaches require no specialised equipment and can be integrated easily into daily family routines, making them practical and effective components of early intervention.

Conclusion

Pre-linguistic skills are the true building blocks of communication. Before children learn to speak, they learn to attend, connect, imitate, gesture, vocalise, understand, and interact. These early abilities prepare the brain for language acquisition and provide valuable opportunities for identifying children at risk of communication disorders.

Routine assessment of pre-linguistic skills should become an integral part of developmental surveillance in paediatric practice. Equally important, empowering parents to nurture these skills during everyday routines transforms ordinary moments into powerful opportunities for language learning. Early recognition, timely intervention, and responsive caregiving can significantly influence a child's communication trajectory, reinforcing the principle that every word begins with meaningful interaction.

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INTERESTING CASES

SUDDEN-ONSET BEHAVIOR CHANGE IN AN ADOLESCENT WITH AUTISM: THINK BEYOND THE DIAGNOSIS

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Jamshedpur, Jharkhand

Introduction

Children with developmental delay and autism often exhibit challenging behaviors. Some of these behaviors are core diagnostic features of the underlying disorder while others are attributed to comorbid neurodevelopmental conditions. Underlying neurological disability like spasticity, pain, seizures, sleep disturbances and illness can all exacerbate behavior disturbance and significantly affect the life of the care givers. Unmet psychological and emotional needs, sensory overload and communication barriers are often overlooked and commonly less understood factors which manifest as behavior challenges. All these challenging behaviors may vary in frequency, duration and severity across the spectrum of neurodevelopmental disorder and even in an individual child. Challenging behaviors are often more troublesome to the caregivers than other difficulties experienced by the children with neurodevelopmental disorders. Sudden change in behavior often portents a significant underlying medical or psychological cause which needs to be addressed appropriately. Here is an interesting case of a child with Autism who presented with sudden change in behavior.

Case Summary

16 years old boy was brought with complaints of sudden increase in behavior issues from the last 7-10 days. He would laugh for no apparent reason, keeps repeating what he has heard throughout the day (delayed echolalia) and shouts a lot in crowded places. He became very restless and kept moving around, refusing to sit for more than a few minutes. He also started sleeping late in the night and slept less than his usual sleep requirement. Fifteen days prior to onset of these symptoms, he had an episode of fever lasting for a few days and this was followed by extreme weakness and lethargy for 1 week during which he mostly remained in bed. A few days later, parents noticed the changes in his behavior which prompted them to seek medical advice. There was no history of any recent change at home or any change in his daily routines. There was no evident pain in any part of body, nor was he suffering from constipation to account for sudden increase in behavior issues.

This boy had a significant past history. He had delayed crying after birth and was admitted in NICU for 5 days during which he also had seizures. Subsequently he achieved all his milestones late. While he became age appropriate for his motor milestones, there was delay in both social and language milestones and he was diagnosed with Autism Spectrum Disorder. He had been on speech therapy where he learnt to speak in 2 word sentences, mostly if instructed. His speech was unclear and even parents could understand only half of what he said. At present the child was not enrolled in any school or in any structured intervention program and was mostly at home with minimal interventions.

After discharge from NICU, he was on anti-seizure medication (ASM) for 3months. At 4 years of age, he started having unprovoked seizures for which he was started on ASM. The dose of the ASM was adjusted for breakthrough seizures. He became seizure free at 6 years of age and ASM was tapered and stopped after 2 years of seizure free period. Currently he has been seizure free off ASM for the last 8 years. Family history revealed the history of 1 episode of febrile seizure in the boy's 1st cousin.

While the parents were interviewed, this boy kept moving around the room and kept on speaking some sentences which were difficult to understand. Intermittently he shouted and made a guttural sound from his throat (vocal tics). Often, he pulled his parents to tell them to go back home. He had a tall stature with a prominent nose, although no major dysmorphic features were noted. He had bilateral flat feet with genu varus and was mildly pale. Although he had mild axial hypotonia, there was no other neuro-deficit which was found.

Investigation and Diagnosis

The sudden onset of symptoms following a febrile illness suggested a para infectious or post infectious etiology most likely involving an immune mediated pathology. Along with a routine blood count, vitamin B12 levels and thyroid function tests, anti- streptolysin O (ASO) titer was ordered. His investigations revealed macrocytic anemia with normal vitamin B12 levels and normal thyroid function. However, his ASO titer was very high (649 IU/ml). Based on the clinical and lab findings and exclusion of other possible etiologies, a diagnosis of PANDAS (Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections) was made.

Management

He was given a course of oral co amoxiclav for 3 weeks along with NSAIDS for 5 days. For his hyperactivity and sleep disturbance, he was prescribed Resperidone. The parents were informed about the diagnosis and they were trained for home interventions for behavior management. On follow up after 2 weeks, there was significant improvement in behavior and sleep and parents confirmed that he had reached his premorbid state. This was also an opportunity to encourage the parents for goal based home intervention plans and they have been undergoing training

and implementing strategies as a commitment to help their son overcome his challenges.

What is PANDAS?

PANDAS is a clinical diagnosis defined by the sudden onset or relapse of obsessive-compulsive disorder (OCD) and/or tic disorders in children, triggered by a group A beta-hemolytic streptococcal infection. To diagnose PANDAS, the patient must fulfill the following criteria:

1. Presence of OCD and/or tics- multiple, complex or unusual tics- sudden and severe enough to interfere with normal daily function
2. Pediatric onset: typically between 3 years of age and puberty, although can be seen in late adolescent age
3. Symptoms present with an acute, explosive onset and follow an episodic course with dramatic severity
4. Association with Group A Streptococcal (GAS) infection- clear temporal link to recent Group A strep infection (proven via throat culture or elevated anti-streptococcal titers)
5. Association with Neurological Abnormalities: concomitant presence of abnormal movements (chorea-like), motor hyperactivity, emotional lability, or severe anxiety.

Management includes- eradication of infection with appropriate antibiotics, immune modulation depending upon severity of the disorder and psychiatric or behavioral therapy.

Conclusion

Sudden and significant behavioral change in a child with autism should be regarded as a clinical symptom rather than simply an exacerbation of the underlying neurodevelopmental disorder. A careful assessment for medical, neurological, psychological and environmental triggers is essential, particularly when the change is acute and follows a recent febrile illness. In the present case, the abrupt onset of hyperactivity, sleep disturbance and new vocal tics following a febrile illness, together with an elevated ASO titre and subsequent improvement following treatment, led to the consideration of PANDAS. The case highlights the importance of recognizing treatable medical causes of behavioral deterioration in children with neurodevelopmental disorders. A structured, multidisciplinary approach that combines identification and treatment of the underlying trigger with behavioral intervention and caregiver education can facilitate recovery and significantly improve the quality of life of both the child and family.

Take-home messages

1. Sudden behavioral deterioration in a child with autism warrants a search for an underlying medical or neurological trigger, rather than being labelled simply as a behavioral manifestation of autism.
2. A recent febrile or infective illness followed by abrupt onset of behavioral or neuropsychiatric symptoms should raise suspicion of a post-infectious/immune-mediated process.
3. The emergence of new vocal or motor tics, marked hyperactivity, emotional/

behavioral change and sleep disturbance may provide important diagnostic clues to PANDAS.

4. Communication difficulties in children with autism can mask pain, illness and other internal symptoms, making careful history-taking from caregivers and observation of change from the child's baseline particularly important.
5. Management should be multidimensional, addressing the suspected underlying trigger as well as sleep, hyperactivity, behavioral difficulties and caregiver education.
6. Caregiver observations are invaluable, particularly in children with limited verbal communication, because parents are often the first to recognize a clinically meaningful departure from the child's usual behavior.

SPOTTER-156 Q

Dr Anoop Verma

Clinical Vignette

An 8-year-old boy was brought by his parents because of an unusual facial appearance noticed since early childhood. They report that the facial asymmetry has become more apparent with growth. There is no history of birth trauma, facial injury, facial weakness, feeding difficulty during infancy, or developmental delay.

On examination, the child has marked asymmetry of the lower face. The chin appears deviated from the midline. The lower jaw appears underdeveloped on one side, resulting in facial imbalance and dental malalignment.

Examine the photograph carefully and answer the following questions.

1. Enumerate the important clinical findings visible in this child.

2. Which anatomical structure appears primarily affected in this child?

3. What are the important differential diagnoses in this child?

4. What associated abnormalities should be specifically looked for during examination?

5. What investigations would help establish the diagnosis and define severity?

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SPOTTER-156 A1

Dr Anoop Verma

1. Enumerate the important clinical findings visible in this child.

Answer

- Facial asymmetry involving the lower half of the face.
- Deviation of the chin from the midline.
- Apparent unilateral mandibular hypoplasia.
- Malocclusion and irregular dental alignment.
- Reduced prominence of the mandibular angle on one side.
- Skeletal rather than muscular facial asymmetry.

Clinical Pearl

The chin usually points toward the hypoplastic side of the mandible.

2. Which anatomical structure appears primarily affected in this child?

Answer

The abnormality predominantly involves:

- Mandible (especially ramus and body)
- Temporomandibular region
- First and second branchial arch derivatives

Explanation

The facial asymmetry is largely due to unequal mandibular growth rather than facial nerve dysfunction.

Clinical Pearl

"The face tells a story; asymmetry tells where development went astray."

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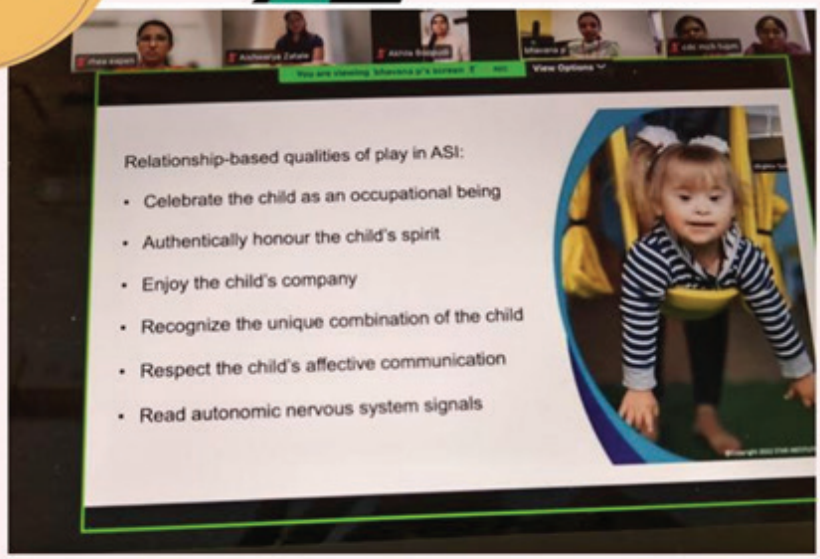
Cooing & Babbling -Fellowship Program

Babbling and Cooing

Fellowship activities started in March 2026 this year and have followed a structured format just like the past couple of years, in which fellows collaborate with local mentors from their respective centers and experts from diverse centers across India. Every Tuesday, a structured Zoom meeting is conducted with the local mentor and an expert from another center, specifically designed to strengthen the clinical, academic, and leadership foundation of our Developmental and Behavioral Pediatrics (IAP DBP) fellows. Additionally, this approach broadens their perspective and helps them learn from practices at other centers. During these sessions, fellows discuss important topics as well as 1–2 complex cases each week, focusing on differential diagnosis, assessment tools, and evidence-based management.

Interaction and Participation with Our Fellows



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Fellowship program

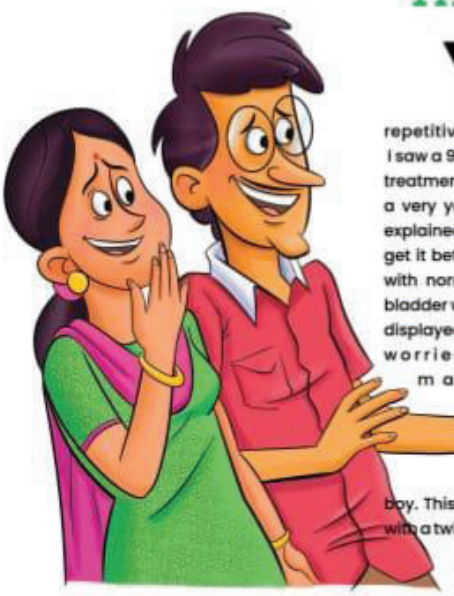
Fellowship Academic Program March-May 2026

Date	Topic	Prensenter Name	Mentor Name	Senior Expert
10-03-2026	Introductory	Dr. Sameer Dalwai (National Convenor, Academic Council)		
17-03-2026	Neurosensory-1	Dr.Sakshi Agarwal	Dr. Nandini Mundkur	Dr. Manju George
24-03-2026	Neurosensory-2	Dr.Bhavana	Dr. Udayakumar	Dr. Nandini Mundkur
07-04-2026	Neuromotor- 1	Dr.Ritu Gupta	Dr Praveen Suman	Dr Maria Lewin
21-04-2026	Neuromotor-2	Dr.Rhea Eapen	Dr S.Subramanian	Dr Sharmila Patil
05-05-2026	Neuromotor-3	Dr.Akhila Boppudi	Dr. Nandita DSouza	Dr. Manju George
12-05-2026	Neurogenetic-1	Dr.Chaitra Harish	Dr Samir Dalwai	Dr. Roopa Srinivasan
19-05-2026	Neurogenetic-2	Dr.Pranav Malik	Dr Samir Dalwai	Dr Praveen Suman

SUDDEN BURSTS OF LAUGHTER

Dr Leena Deshpande

THE GAME OF SHOTS?



You have all heard and seen games where hearing a particular phrase or word, everyone drinks something because the word or phrase is repetitive. I had such a 'game' in my clinic today! I saw a 9 year old boy with a simple problem. It needed simple treatment and having to stop tea that he had been taking from a very young age. After hearing the parents and the boy, I explained about what the problem was and the simple way to get it better. I finally said that he was a perfectly normal boy with normal kidneys and this was just an irritability in the bladder which was temporary. The boy's face had a wide smile displayed permanently now! The parents had been very worried and anxious as it had been present for many months/years. They kept on recounting what had been done and kept asking the same questions repeatedly. My answer also was a repetition explaining that he was a normal boy. This became a game for the boy! The boy looked at me with a twinkle in his eye and started opening his fingers to count the number of times I was telling his parents the same thing (that he is a normal boy!). Even his parents realised that.

You will not believe but he counted upto 7!! Yes,there were so many anxious questions. And all of them required the same answer!! In fact towards the end of my consultation, as the mother asked me questions, I pointed at the boy and said that he will answer the query!! He did not even say a word and only opened one more finger!! He had a lot of fun in the clinic as did myself!!

ROLLING OVER – THE OTHER SIDE -
NEWS THAT IS PATH BREAKING

PRECISION GENETICS AND TRISOMY RESCUE

Dr Sreetama Chowdhury

CRISPR/Cas9-Mediated Trisomy Rescue in Down Syndrome: Balancing Scientific Innovation with Neurodiversity The neurodiversity movement has transformed the way clinicians, researchers, and society view individuals with developmental, genetic, and behavioural differences. It emphasizes that neurological and genetic diversity are natural aspects of human variation and advocates for the dignity, autonomy, and inclusion of every individual. Children and adults with Down syndrome have unique strengths, personalities, and meaningful contributions to society, and advances in healthcare, education, and community support have significantly improved both life expectancy and quality of life.

At the same time, Down syndrome is not solely a difference in cognition or learning style. It is a multisystem genetic condition caused by trisomy 21 that may affect the development and function of several organ systems. Individuals with Down syndrome have an increased prevalence of congenital heart disease, gastrointestinal malformations, thyroid dysfunction, hearing and visual impairment, immune dysregulation, obstructive sleep apnoea, and an increased risk of certain haematological malignancies such as childhood leukaemia. These medical conditions may substantially influence health, functional independence, and longevity, highlighting the importance of continuing research into therapies that address the biological basis of the disorder while respecting the individuality of those who live with it.

One emerging area of research is CRISPR/Cas9-mediated trisomy rescue. Experimental studies have demonstrated selective targeting of the supernumerary chromosome 21 in cultured cells, restoring a normal chromosomal complement in some cells and partially normalizing gene expression. Despite promising laboratory results, this technology remains preclinical and faces major scientific and safety challenges before clinical application. The development of genome-editing technologies also raises profound ethical questions. While correcting the underlying genetic cause of Down syndrome could potentially reduce the burden of serious medical complications, any intervention must be carefully weighed against respect for neurodiversity, disability rights, and the intrinsic value of individuals

living with Down syndrome. The goal of future therapies should be to improve health and reduce suffering rather than to diminish acceptance or inclusion of people with genetic differences.

As research progresses, transparent discussions among clinicians, scientists, ethicists, individuals with Down syndrome, advocacy groups, and families will be essential. If genome-editing interventions become technically feasible during prenatal development, parental decision-making should be supported through comprehensive, balanced, and non-directive genetic counselling while carefully considering the medical benefits, scientific uncertainties, ethical implications, and respect for parental autonomy when contemplating interventions that would alter the genetic constitution of a developing individual.

IAP- Chapter of NeuroDevelopmental Pediatrics

"SAKSHAM"

Empowering stake holders; Reducing disability barriers

Program:

Stake holders & Roles:

- Developmental pediatrician: Clinical training- early identification and management of developmentally supportive care
- IAS/district collector/MP/MLA: Administrate guidances on disability related schenmes, entitlments
- IPS- Police commissioners- training oncyber security, child protection
- Media- Content creation, awareness camps, dissemination of information
- Educational strategies, inclusive class rooms, learning support
- Family members: Knowledge of rights, caregiving strategies, community supportss.
- Government,:state/central, NGO's NIEPD

Training scheduling:

- National Level TOT- online- 3 hours
- District level workshops- Pan India- 3hrs -Off-line (9.30am-1pm or 2-5.30pm)
- Training through SAKSHAM module: for Pediatrician, administrators, security, media.
- Groups for training: Pediatricians, GPs, Anganwadi workers, Therapists,
- Pre/post test, Feedback- google forms

Contents:

1. High risk Infant Developmentally supportive care- 30 min
2. Autism -early diagnosis & Habilitation- 30 min
3. Scholastic concerns- 30 min
4. Cyber security & safety-By IPSOfficer- 30 min
5. Disability beniits/ administrative issues- IAS officer- 30 min
6. Positive role of Media- awareness campaigns- media- 30 min

Budget/expenditure

Total Expenditure / workshop- Rs 35,000-40,000/-
High tea- Rs 30/head
Momentos & stationary- Rs5000/-
Faculty- 10,000/-

Membership Form

Indian Academy of Pediatrics

Chapter of Neuro Developmental Pediatrics

Membership Application Form

(Please fill in capital letters; All Information Mandatory; Pl do not leave any blank spaces)

1. Surname:_____First Name:_____Middle Name:_____
2. Date of Birth _____
3. Central IAP Membership Number (For Pediatricians Only) :_____
4. Permanent address: ……..
……
……
5. Office Address……
……
…… …… ……
6. Email:…….. Landline Telephone:……..
7. Mobile Phone Number (1)……(2)……
8. Present Work Status: Private___Govt.__Medical College__Voluntary Agency ___
9.

Qualifications	Name of University	Year of Passing
MBBS		
MD Pediatrics		
DCH		
DNB Pediatrics		
Others		

10. Areas of Interest of Work _____

P.T.O

Membership Form

11. Membership Subscription:

a) Life Membership for Central IAP Members – Rs 1500

b) Life Associate Membership for Doctors other than Pediatricians – Rs 1500

c) Life Affiliate Membership for All Other Professionals – Rs 1500

12. On online transfer please e-mail the scanned form with transfer details to cdgiap@gmail.com **with cc to** kawaljit000@gmail.com

NAME OF ACCOUNT – **IAP CHAPTER OF NEURO DEVELOPMENTAL PEDIATRICS**
PAYABLE AT ERNAKULAM
FEDERAL BANK LTD
ERNAKULAM / KATHRUKADAVU
ACCOUNT NUMBER **16860100040046**
IFSC CODE – **FDRL0001686**

Signature of the Applicant with date:

For Office Use Only Membership No……

…… Particulars of the receipt: Cheque / D.D

No……Bank…….

Amount……..Date……

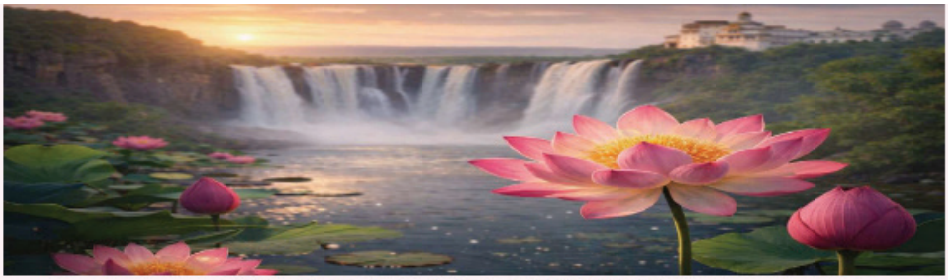
PAST OFFICE BEARERS OF THE CHAPTER

YEAR	CHAIRPERSON	SECRETARY
	Dr Pratibha Singhi	Dr Nandini Mundkur
2002-2004	Dr Nandini Mundkur	Dr Abraham K Paul
2004-2006	Dr Hanumantha Rao	Dr Jacob Roy
2006-2010	Dr Abraham K Paul	Dr SS Kamath
2010-2013	Dr SS Kamath	Dr Samir H Dalwai
2013-2015	Dr Samir H Dalwai	Dr Prameela Joji
2015-2017	Dr Samir H Dalwai	Dr Chhaya S Prasad
2017-2019	Dr Jeeson C Unni	Dr Leena Srivastava
2019-2023	Dr Shabina Ahmed	Dr KS Multani
2024	Dr Leena Srivastava	Dr Shambhavi Seth
2025	Dr KS Multani	Dr Shambhavi Seth

NATIONAL CONFERENCES OF THE CHAPTER

Sl No	Year	Place	Organizing Chairperson(s)
1	2004	Bhubaneswar	Dr J Sarangi, Dr Arabindo Mohanty
2	2005	Hyderabad	Dr Hanumantha Rao
3	2006	Cochin	Dr Abraham K Paul, Dr S S Kamath
4	2007	Bangalore	Dr Nandini Mundkur
5	2008	Meerut	Dr Priyanka Jain
6	2009	Mumbai	Dr Tanmay Amladi, Dr. Samir Dalwai
7	2010	Delhi	Dr Monica Juneja
8	2011	Chandigarh	Dr Chhaya Prasad
9	2012	Nagpur	Dr Deepti Jain
10	2013	Cochin	Dr Abraham K Paul, Dr SS Kamath
11	2014	Bhopal	Dr Zafar Meenai
12	2015	Madurai	Dr Santhosh Rajagopal
13	2016	Mumbai	Dr Samir Dalwai
14	2017	New Delhi	Dr H Pemde, Dr Shambhavi Seth
15	2018	Hyderabad	Dr Himabindu Singh
16	2019	Pune	Dr Leena Srivastava
17	2020	eNCDP	Dr KS Multani
18	2021	eNCDP 2.0	Dr KS Multani
19	2022	Kolkata	Dr Atanu Bhadra
20	2023	Guwahati	Dr Shabina Ahmed
21	2024	Bangalore	Dr Adarsh E
22	2025	Trivandrum	Dr Deepa Bhaskaran

23RD NATIONAL CONFERENCE OF IAP CHAPTER OF NEURO DEVELOPMENTAL PEDIATRICS 2026



TARGET AUDIENCE

- Paediatricians
- Paediatricians with special interest in Developmental Paediatrics
- Developemental Pediatricians
- Physicians
- Neonatologists
- Child Psychiatrists
- Paediatric Neurologists
- Medical students including Undergraduate & PG students.

23RD NATIONAL CONFERENCE OF IAP CHAPTER OF NEURO DEVELOPMENTAL PEDIATRICS 2026

INTERNATIONAL NEURODEVELOPMENTAL PEDIATRIC CONFERENCE

23rd National Conference of IAP Chapter of Neuro Developmental PEDIATRICS , 2026

PRE- CONFERENCE WORKSHOP
11th DECEMBER 2026

CONFERENCE REGISTRATION DETAILS

Registration Category	Early Bird (Till 31st May)	1st June – 31st July	1st Aug – 31st Oct	Spot Registration
IAP Members	₹ 6000/-	₹ 7500/-	₹ 8500/-	₹ 10000/-
Non-IAP Members	₹ 7000/-	₹ 8500/-	₹ 9500/-	₹ 11000/-
PG Students	₹ 5000/-	₹ 6500/-	₹ 7500/-	₹ 9000/-
Paramedical Staff	₹ 5000/-	₹ 7500/-	₹ 8500/-	₹ 10000/-
Senior Delegates (>70 years age)	Free	Free	Free	Free
Workshops	₹ 1000/-	₹ 1000/-	₹ 1000/-	—

Account Name: ASSOCIATION OF PEDIATRICIANS IN REWA
Account No. : 6239000100058390
Bank Name: Punjab National Bank
Branch: Shyam Shah Medical College, Rewa
IFSC CODE: PUNB0623900

Payment-Related Queries
Dr Naresh Bajaj (9399372171)
Dr Karan Joshi (9425184975)
Dr Ravikant Mishra (7947436196)
Dr Deepak Dwivedi(7869918636)

- To register, please fill the google form :
https://docs.google.com/forms/d/e/1FAIpQLScXsImAvVG2-x2wCla3v0Jr-ZLpeDyJfN9C6lDGuvKLXDf-8A/viewform?pli=1

**Transportation from Katni ,Rewa Railway Station,Jabalpur and Rewa Airport will be

23RD NATIONAL CONFERENCE OF IAP CHAPTER OF NEURO DEVELOPMENTAL PEDIATRICS 2026

Proposed Accommodation Sites

Name of Resort	Accomodation capacity (rooms)	Prices /night (Approximate)
Tiger's Den	32	6000₹
Nature 's Heritage	30	6000₹
Aranyak Resort	32	6000₹
Mowgli	41	6000₹
Bandhav Vilas	18	8500₹
Lemon Tree	28	6000₹
Bundela	23	6000₹
Bamboo Grove	10	9000₹
Blue Lotus	06	4000₹
Maati Jungle Resort	–	4000₹
Olive Resort	10	4000₹
MPT	28	6000₹
Ashoka	22	3500₹
Whispring grass	06	3000₹
Dharohar Kothi	–	3500₹
Sun Resort	–	3500₹
Jungle Kothi	16	3500₹
Maharaja Kothi	24	4000₹