the community. The post-effectiveness of the vaccine has been proven, and the World Health Organization has recommended its use in developing countries. We are all aware that a majority of Indian doctors have immunized their children with the vaccine.

Then why are we still debating whether and which newborns in India should be vaccinated? The real issues are elsewhere. First, who will pay for vaccinating millions of newborns, year after year for 25-30 years, before hepatitis B ceases to be a problem? Secondly, do we have the infrastructure for such a large-scale vaccination program in the community, and to complete it efficiently so that 90% of all Indian babies are protected?

Two days after this article was published, our institution received a circular from the Ministry of Human Resource Development through the University Grants Commission, forwarded by the University of Mumbai to all its colleges, making vaccination against HBV compulsory for all students, teachers and employees. So, while the academia is still debating the merits and demerits of HBV vaccination of newborns, the Union Government has recommended immunization of all adults!

This reminds us of Blumberg’s philosophical essay on the problems with HBV. The Indian HBV vaccination scenario is part of this “Daedalus effect.” We talk of preventing HBV infection by vaccination and yet reuse sclerotherapy needles in the new millennium! Isn’t it time that academic societies like the ISG played an active role in disseminating sensible advise to our patients, countrymen, and our governments?

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References

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Reply from the authors
The issues involved are not as clear-cut as Drs Peshwe and Mohandas state. In February this year, we published a letter in the Lancet showing how the WHO’s figure of 250,000 persons dying each year in India from hepatitis B can be arrived at by wrongly projecting figures from Taiwan. The validity of the WHO recommendation for universal immunization based on such faulty projections is therefore questionable.

Peshwe and Mohandas ask who will pay for the program and who will ensure that 90% babies are covered. This is a very pertinent point, especially as we know the coverage for DPT (a much cheaper vaccine) in some areas is less than 20%.

Finally, they question the wisdom of the Union Government in recommending immunization of adults. This happens in many countries: the clout of vested interests and vaccine manufacturers can subvert national interests.

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Reference

Tea or tobacco:
etiology of esophageal cancer in India

We read the article by Chitra et al., and were surprised at the finding that drinking three cups of tea daily would increase the risk of esophageal cancer more than with smoking. The authors should have discussed this new finding. Tea is supposed to actually lower the risk for many cancers, except when it is of the salted type (as in Kashmir), which is rich in nitrosamines. We believe the finding in this study is because of confounding or bias, which is common in case-control studies. It is likely that excess tea consumption is either a recall bias or is a confounding factor because of the liquid diets patients with dysphagia consume.

Only 63% of cases in the study used tobacco, which is much lower than what is reported from other parts of India. Does this mean that 37% of southern Indians have other causes for esophageal cancer? In our center, about 84% of patients with esophageal cancer admit to the use of tobacco; when patients with tobacco stains on teeth are asked how they got it, an additional 8% admit to the use of tobacco (unpublished observations). In other words, 92% of patients with esophageal cancer have exposure to tobacco in some form. This is very important from a preventive viewpoint. We must strive to eradicate tobacco usage in India.

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We believe that the chances of recall bias cannot be exclusive for tea. This should be applicable as well to alcohol, tobacco and other dietary factors.

The finding reported by us gives an odds ratio for tea consumption ³3 cups per day as 3.3 (1.7 to 6.1). The patients were drinking anywhere up to 15 cups a day. A report from the National Institute of Nutrition observed the risk of esophageal cancer to be 2.4 (1.5-3.9) when ³2 cups of tea per day was taken.1 Tea drinking has been considered as a risk factor for cancer in Kashmir. Coimbatore, situated in the foothills of the Nilgiris, has a cooler climate, and hence it is possible that the residents here drink tea more often. Our preliminary observation necessitates a study on the constituents of the tea in the Nilgiris belt of Tamil Nadu state.

Confounding or bias is largely eliminated in case-control studies by the matching of socioeconomic characteristics and place of residence. An in-depth interview with sufficient probing is unlikely to have resulted in an error in data collection. Also, many behaviors do not leave physical changes that can be confirmed by observation. We could have done a logistic regression on these data, but the number of cases and controls with individual factor was small and hence the confidence interval obtained for the log co-efficient and the log odds would permit us to get a true picture of the effect of tea alone.

We believe that tobacco usage in southern India is less compared to other parts of the country; in support is the higher prevalence of lung cancer in Mumbai for example, as compared to southern states like Karnataka and Tamil Nadu. Four major cancer registry areas in India document cancer of the oral cavity, including the pharynx, as the most common cancer in men. The next common sites of cancer are the stomach and lung in Bangalore and Chennai, whereas the lung is the second most common site for risk of cancer in Mumbai and Delhi.2 Phukan et al3 also report that the risk for esophageal cancer associated with tobacco smoking and alcohol consumption is less in Assam than that associated with the chewing of betel nut. This study did not however look into the association with consumption of tea.

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References

Symptomatic sinus bradycardia with infliximab

Infliximab, a chimeric human-murine monoclonal antibody, has been used as therapy in patients with severe ulcerative colitis. Various adverse effects have been reported with infliximab; the commonly reported cardiac side effects are exacerbation of congestive heart failure, hypotension and syncope.1 Symptomatic disorders of cardiac rhythm associated with its use have been reported only rarely.2

A 22-year-old man presented with recent flare of ulcerative colitis. He had been on oral mesalamine (2.4 g daily) since a year and a half. Physical examination showed pallor, pulse 94/min, blood pressure 110/70 mmHg. Abdominal examination revealed mild tenderness in the left iliac fossa. Laboratory data included hemoglobin 10.6 g/dL, WBC count 9600/cumm (69% polymorphs) and ESR 72 mm in first hour. Blood sugar, biochemical renal and liver tests, serum electrolytes, and coagulation profile were normal; blood culture, stool routine and culture, and CMV serology were negative; serum albumin was 2.6 g/dL. Colonoscopy revealed active disease with diffuse hyperemia, edema, friability, with discrete ulcerations. The disease activity index was calculated as 240. He was started on intravenous fluids, hydrocortisone and parenteral epiophenoxacin and metronidazole. However, there was no significant improvement in the frequency of stools and bleeding per rectum.

He was started on infliximab (Remicade; Schering Plough) 300 mg infusion over 4 hours on day 5 of hospitalization. One hour following transfusion he complained of fainting and dizziness and had heart rate of 39 beats per minute and blood pressure of 100/70 mmHg. Electrocardiography showed sinus bradycardia with normal axis, QRS complexes and QTc interval. Serum electrolytes including serum calcium and magnesium were normal. His heart rate improved to 70 beats/min with injection of atropine, which had to be repeated twice over the next 24 hours. The bradycardia did not recur after 24 hours. Echocardiography, exercise ECG and Holter studies, which were done later, were normal. There was no family history of cardiac disease in the young.

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