Table: Prevalence of hepatitis B surface antigen in different tribes in India

State	Tribe	Population sampled (n)	HBsAg (n.; %)	Ref.
Andaman and	Andamanese	27	1 (3.70)	1
Nicobar Islands	Onges	58	18 (31.00)	
	Nicobarese	1144	267 (23.30)	
	Shompens	37	14 (37.80)	
	Jarawas	64	42 (65.60)	2
Madhya Pradesh	Baiga	91	4 (4.40)	3
	Halbas	67	2 (3.00)	4
	Gonds	123	16 (13.00)	
	Kawars	58	6 (10.30)	
	Oraons	118	10 (8.50)	
	Bhils	397	73 (18.40)	
	Bhilals	122	23 (18.90)	
	Barelas	429	76 (17.70)	
Rajasthan	Bhils	536	55 (10.26)	5
Maharashtra	Raj Gond	450	126 (28.03)	5
	Kolam	106	15 (14.15)	
	Naik Gond	42	4 (9.52)	
	Pradhan	43	3 (6.98)	
Arunachal Pradesh	Not mentioned	296	25 (8.50)	6
Andhra Pradesh	Lambada	890	46 (5.20)	7
Tamil Nadu	Tribes of Kolli hills	161	3 (1.86)	8
Ladakh (Jammu and Kashmir)	Ladhakis	144	14 (9.72)	9

suggested the possibility of blood-sucking arthropods in the transmission of the infection.[2]

The *chi* square for heterogeneity among the studies was significant, indicating that the studies were heterogeneous. Another limitation of the present study is the fact that HBsAg prevalence in some of the tribes was assessed more than 25 years earlier. However, in absence of any vaccination program, it does not appear likely that the HBsAg rates could have changed significantly over the years.

Our study indicates that the prevalence of HBsAg among the scheduled tribes of India is much higher than that in the general population. As the tribes comprise a sizeable proportion of the population in different States in India, hepatitis B vaccine should be included in the immunization program for tribal children.

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Association of asthma and allergic rhinitis with celiac disease

The association of celiac disease (CD) with bronchial asthma and allergic rhinitis has been investigated

previously, with variable results.[1-6] We present our data on such an association in a largely in-bred population of about 400,000 persons residing in the Maltese Islands in the Mediterranean Sea.

Patients previously diagnosed to have CD (based on serological tests and duodenal biopsy) and attending a medical out-patient clinic answered a questionnaire designed to determine whether they had previously been diagnosed to have asthma or allergic rhinitis. They were also asked about symptoms suggestive of asthma; patients with such symptoms but no prior diagnosis of asthma underwent physiological lung tests to look for undiagnosed asthma. All patients provided informed consent. The frequency of asthma and allergic rhinitis in CD patients was compared with data from the International Study of Asthma and other Allergic Conditions in Childhood in the Maltese Islands (ISAAC1997), using *chi*-squared analysis.

All 86 patients (age range 16-69 [median 43] years; 65 female) answered the questionnaire about CD and asthma. They constituted 21% of the 409 patients with CD in the Maltese islands included in a register kept for controlling free prescription of gluten-free foods.

Of 86 respondents, 24 (27.8%; 21 female) had asthma, including 22 with known asthma and 2 with previously undiagnosed asthma; the frequency of asthma in CD patients was higher than that reported in the general Maltese population (11.1%; $p<0.00005$).[7] In addition, four non-asthmatic patients (one smoker, two ex-smokers, one non-smoker) reported wheezing in the absence of respiratory tract infection in the past; they however had normal pulmonary function tests. Another woman with CD gave history of wheezing and cough after exercise. She was a non-smoker, had family history of asthma, and her lung function tests showed 10% reversibility in FEV1 after the administration of bronchodilator. Another patient had nocturnal cough; he was an ex-smoker, had family history of asthma, and had normal lung function tests.

In 16 patients, asthma preceded CD by 3 months to 39 years (median 20 years). Among these patients, gluten-free diet had led to improvement in asthma in 6 patients, possible improvement in 2 patients, and no change in 8 patients. In the remaining 8 patients, asthma followed CD by 2 to 14 years (median 8). Thirty-one of 86 patients with CD and 11 of 24 patients with CD and asthma gave family history of asthma among first-degree relatives.

Eighty-two patients (62 female) answered the questionnaire about allergic rhinitis. Of these, 36 (44%) suffered from allergic rhinitis; this frequency was higher than that reported in the general Maltese population (32.3 %; $p<0.05$).[7]

Our findings suggest that asthma and allergic rhinitis are more common in CD patients than in the general population in Malta. In patients with atopic diseases, index of suspicion for CD should be high.

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Pancreatic pseudocysts in brothers: familial, environmental or incidental?

A 42-year-old non-alcoholic man presented with upper abdominal pain and gradually increasing mass of 2 years and 6 months duration. There was no past history of acute pancreatitis, trauma, gallstone disease, jaundice or tuberculosis. Examination revealed a 6 cm x 7 cm ill-defined intra-abdominal mass in the epigastrium. The rest of the examination was unremarkable. Laboratory investigations and plain radiographs of the chest and abdomen were normal. Ultrasonography revealed a thick-walled cystic mass, 6 cm x 6 cm, in the lesser sac with internal echoes and echogenic debris. The head and body of the pancreas was irregular and appeared shrunken. A diagnosis of chronic pancreatitis with pancreatic pseudocyst was made. He underwent laparoscopic cystogastrostomy and made satisfactory recovery.