

9. **Butler T, Islam A, Kabir I, Jones PK.** Patterns of morbidity and mortality in typhoid fever dependent on age and gender: a review of 552 hospitalized patients with diarrhoea. *Rev Infect Dis* 1991;13:85-90.
10. **World Health Organization.** Department of Vaccines and Biologicals. Background document: the diagnosis, prevention and treatment of typhoid fever. Geneva: WHO. 2003:19-23
11. **Bhutta ZA.** Current concepts in the diagnosis and treatment of typhoid fever. *British Medical Journal.* 2006;333:78-82.
12. **Woodward TE, Smadel JE, Ley HL Jr, Green , Mankikar DS.** Preliminary report on the beneficial effect of chloramphenicol in the treatment of typhoid fever. *Ann Intern Med* 1948; 29:131-4.
13. **Mizra SH, Beeching NJ, Hart CA.** Multi-drug resistant typhoid: a global problem. *J Med Microbiol* 1996; 44:317-9.
14. **Setnthilkumar B and Praphakaran G.** Multidrug resistant *Salmonella typhi* in asymptomatic typhoid carriers among food handlers in Namakkal district, Tamil Nadu. *Indian Journal of Medical Microbiology.*2005;23(2):92-94.
15. **Sood S, Kapil A, Das B, Jain Y, Kabra SK.** Re-emergence of chloramphenicol-sensitive *Salmonella typhi*. *Lancet* 1999;353:1241-2
16. **Wasfy MO, Frenck R, Ismail TF, Masour H, Malone JL, Mahoney FJ.** Trends of multiple-drug resistance among *Salmonella* serotype Typhi isolates during a 14-year period in Egypt. *Clinical Infectious Diseases* 2002;35(10):1265-8.
17. **Raveendran R, Watal C, Sharma A, Oberoi JK, Prasad KJ & Datta S.** High level Ciprofloxacin resistance in *Salmonella enterica* isolated from blood. *Indian Journal of Medical Microbiology* 2008;26(1):50-3.
18. **Krishnan P, Stalin M, Balasubramanian S.** Changing trends in antimicrobial resistance of *Salmonella enteric* serovar typhi and *Salmonella enteric* serovar paratyphi A in Chennai. *Indian Journal of Pathology and Microbiology* 2009;52(4):505-8
19. **Chande C, Shrikhande S, Kapale S, Agarwal S, Fule RP.** Change in antimicrobial resistance pattern of *Salmonella typhi* in central India. *Indian J Med Res* 2002;115:46-8.
20. **Pegues DA, Ohl ME, Miller mSI.** *Salmonella* species, including *Salmonella Typhi*. In: *Principles and practice of infectious diseases.* 6<sup>th</sup> ed. Mandell GL, Bennet5t JE, Dolin R, editors. Churchill Livingstone: New York; 2005.p.2636-54.
21. **Mehta G, Randhawa VS, Mohapatra NP.** Intermediate susceptibility to ciprofloxacin in *Salmonella typhi* strains in India. *Eur J Clin Microbiol Infect Dis* 2001;20:760-1
22. **Dutta P, Mitra U, Datta S et al.** Ciprofloxacin susceptible *Salmonella typhi* with treatment failure. *J Trop Pediatr* 2001; 47:252-3
23. **Kapil A, Renuka, Das B.** Nalidixic acid susceptibility test to screen ciprofloxacin resistant in *Salmonella typhi*. *Indian J Med Res* 2002;115:49-54.
24. **Joshi S, Watal C, Sharma A, Oberoi JK, Prasad KJ.** Quinolones-drug of choice for enteric fever? *Indian J Med Microbiol* 2004;22:271-2.
25. **Wain J, Hoa NTT, Chinh NT et al.** Quinolone-resistant *Salmonella typhi* in Viet Nam: molecular basis of resistance and clinical response to treatment. *Clin Infect Dis* 1997;25:1404-10.
26. **Brown JC, Shanahan PM, Jesudason MV, Thomson CJ, Amyes SG.** Mutations responsible for reduced susceptibility to 4-quinolones in clinical isolates of multi-resistant *Salmonella typhi* in India. *J Antimicrob Chemother* 1996;37:891-900
27. **Martinez- Martinez L, Pascual A, Jacoby GA.** Quinolone resistance from a transferable plasmid. *Lancet* 1998;351:797-9.
28. **Gay K, Robicsek A, Strahilevitz J, Park CH, Jacoby G, Barrett TJ et al.** Plasmid mediated quinolone resistance in non-typhi serotypes of *Salmonella enteric*. *Clin Infect Dis* 2006;43:297-304.
29. **Rossi A, Lopardo H, Woloj M et al.** Non-typhoid *Salmonella* spp. Resistant to cefotaxime. *J Antimicrob Chemother* 1995;36:697-702.
30. **Winokur PL, Brueggemann A, Desalvo DL, Hoffmann L, Apley MD, Uhlenhopp Ek et al.** Animal and human Multidrug-resistant, cephalosporin-resistant *Salmonella* isolates expressing a plasmid-mediated CMY-2 AmpC  $\beta$ -lactamase. *Antimicrob Agents Chemother.* 2000;44:2777-83.
31. **Girgis NI, Butler T, Frenck RW, Sultan Y, Brown FM, Tribble D and Khakhria R.** Azithromycin versus Ciprofloxacin for treatment of uncomplicated typhoid fever in a randomized trial in Egypt that included patients with multidrug resistance. *Antimicrob. Agents Chemother.*1999;43:1441-1444.
32. **Parry CM, Ho VA, Phuong LT, Bay PVB, Lanh MN et al.** Randomized controlled comparison of ofloxacin, azithromycin and ofloxacin-azithromycin combination for treatment of multidrug-resistant and nalidixic acid-resistant typhoid fever. *Antimicrob Agents Chemother.* 2006;51(3):819-825.
33. **van den Bogaard AE, Stobberingh EE.** Antibiotic usage in animals: impact on bacterial resistance and public health. *Drugs* 1999;58:589-607.

## LITERATURE REVIEW

### Initiation of dialysis at higher GFRs: Is the apparent rising tide of early dialysis harmful or helpful?

*Steven Jay Rosansky et al Kidney International 2009,76,257-261.*

Over the past decade a trend of increasing estimated glomerular filtration rate (eGFR) at the initiation of dialysis for treatment of end-stage renal disease (ESRD) has been noted in the United States. In 1996, only 19% of patients began dialysis therapy with an eGFR of greater than 10 ml/min/1.73m<sup>2</sup> (denoted as 'early start'), but by 2005 the fraction of early start dialysis patients had risen to 45%. This review examines US dialysis data, national guidelines, and publications relevant to the early start phenomenon. It is not known whether early start of dialysis is beneficial, harmful or neutral with respect to the outcome of dialysis treatment for ESRD. Available data indicate that mortality while on dialysis therapy may be higher in those subjects with early start. Comorbidities present at the time of dialysis initiation do not appear to be a major driving force for early start patients. As well, residual kidney function in these patients is a major contributor to total urea or creatinine clearance. This can be a positive factor for patient outcomes and might be compromised by early start. Finally, we estimate the dollar cost of early start to the US Medicare-supported ESRD program. Properly designed, prospective and randomized studies may help to clarify the benefit or harm of early start of dialysis for ESRD.

### Liver Transplantation in India: The Past, Present and Future: A.S. Soin

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Liver transplantation (LT) in India, a distant dream till 1998 has now become a well established and highly successful procedure. Presently, 400 liver transplants are done annually of which 40% cases are done in Sir Ganga Ram Hospital, Delhi. Initially, the cadaveric LT was done but this did not pick up due to social and administrative problems. So, the focus shifted to living donor transplantation. Till date, we have performed nearly 463 liver transplants and doing 140 cases annually. Our current success rate is over 95%, amongst highest in the world. The marked improvement in our results has been due to team efforts of experts in transplant surgery, hepatology, anaesthesia and critical care, transfusion medicine, chest medicine, nephrology, diagnostic and therapeutic radiology, etc. Any patient with acute or chronic liver disease that leads to the inability to sustain a normal quality of life or that results in life-threatening complications should be considered a candidate for LT. The indications include fulminant hepatic failure (King's college criteria) and chronic liver disease (MELD score >15, CTP score >9, HRS, SBP, refractory ascites, recurrent HE). LT can be done in HCC with no extrahepatic spread. Currently accepted absolute contraindications to LT by most programs include HIV positivity, spontaneous bacterial peritonitis (SBP) or other active infection, severely advanced cardiopulmonary disease, extrahepatic malignancy that does not meet cure criteria, active alcohol or substance abuse, and inability to comply with immunosuppression protocols because of psychosocial situations.

For LT to become more popular and accessible, we need to train more transplant experts, cut down the cost of procedure by using more indigenous medicines and equipment, involve insurance companies and also promote decreased organ donation through proposed Government of India National Organ Transplant Programme.

## ERRATA

JIMSA Vol.22, Issue No. 4 Oct.-Dec. 2009 Page No. 230 Article: **Minimally Access Techniques For Menorrhagia**, the names of the authors may please be read as S.S. Trivedi, Monika Madaan (not S.S. Trivedi, Monika Nagpal).

The error is regretted.

Editor, JIMSA