Findings: Of the 76 cases, 70 infants fully cooperated with researchers. The number of male and female patients in case and control groups was, 19 versus 16 and 18 versus 17 respectively. The results revealed significant difference between two groups in lowering fever at 4, 5, 7 and 8 hours after treatment was initiated, but there is no significant difference at 2 hours after drug was administrated..

Conclusion: An alternating treatment of acetaminophen (15mg/kg) and ibuprofen (10mg/kg) 4 hours later is more effective than acetaminophen in lowering fever in infants 9 to 24 months old.

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IN INFANTS WITH AN INITIAL DIAGNOSIS OF TRANSIENT HYPOGAMMAGLOBULINEMIA OF INFANCY (THI), IS THE USE OF IV IMMUNOGLOBULIN WARRANTED?

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Introduction: THI is a defect in a child's endogenous immunoglobulin production. It presents early following the physiological catabolism of the remnants of maternal immunoglobulin, transferred trans-placentally during the course of pregnancy. Physiological hypogammaglobulinemia normalises by 2-4 months. However during prolonged THI; the infant is rendered susceptible to a range of bacterial infections. In severe cases intravenous immunoglobulin-G (IV-IgG) replacement therapy has been proposed as treatment.

Objectives: To analyse current experimental literature in order to assess the suitability of IV-IgG therapy for patients diagnosed with suspected THI. Assessment of therapeutic use of IV-IgG from retrospective case controls. Further qualification of when to use IV-IgG by assessment of additional factors: symptomatology, time to normalisation of immunoglobulins and comparison with other immunodeficiency syndromes.

Methods: PubMed - searched with MeSH term "hypogammaglobulinemia"; "transient hypogammaglobulinemia infancy", "hypogammaglobulinemia IVIg", "paediatric hypogammaglobulinaemia".

Results: Antibiotics are first-line treatment for recurrent infections. IV-IgG replacement therapy is not routinely warranted for symptomatic THI. Cases where infections are severe/resistant to conventional management, IV-IgG therapy can be considered.

Other primary immunodeficiencies requiring IVIG therapy present similarly to THI as recurrent infections. In contrast THI is self-resolving with a benign clinical progression if managed appropriately;

Conclusion: Most children with THI do not require IV-IgG, with the exception of severe life-threatening infections or ongoing bacterial respiratory infection despite prophylactic antibiotic therapy. In these circumstances trials of IV-IgG for 6-12 months are indicated.

There are no published studies that comprehensively assess the cost-effectiveness of IV-IgG replacement in any healthcare setting for THI.

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DISCREPANCY BETWEEN INTERFERON GAMMA RELEASE ASSAY AND TUBERCULIN SKIN TEST FOR DIAGNOSIS OF LATENT TUBERCULOSIS INFECTION IN BCG VACCINATED CHILDREN

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Background and aims: Tuberculosis is one of the major health problems in the world. Interferon gamma release assay (IGRA) is a novel tool for Mycobacterium tuberculosis infection diagnosis. The aim of our study was comparing the TST and human PPD based IGRA for diagnosing Latent tuberculosis infection (LTBI) in BCG vaccinated children.

Methods: Between august 2006 and may 2007 a total of 242 children aged 1month to 168 months (mean 21 months)whom admitted to different wards of Mofid children hospital and met the inclusion criteria were enrolled in a cross sectional study with sequential manner. Each patient was tested with both TST and human PPD based IGRA.