off in the normal population would be challenging and not feasible. The Government run laboratories in the district and state headquarters can pitch in and publish district- or state-wise OD cut off based on the previous samples tested, which can be regularly updated with time.

Timely diagnosis is crucial in reducing morbidity and mortality of ST in children, and since ST PCR is not freely available everywhere, earliest laboratory confirmation is often done by serology by IgM ELSIA after 5-7 days of fever onset [2]. While IgM ELISA serology testing to diagnose ST is affordable, easy-to-use, with reasonable diagnostic accuracy for screening and diagnostic purposes, regional cut-offs should be identified and maintained by regional health authorities and should be validated from time to time in order to prevent misdiagnosis.

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AUTHORS' REPLY

We thank the authors for their comments about our article [1]. In exercises of determining the cutoff for diagnostic tests, it is inevitable that some amount of misclassification would always happen. We always try to minimize this risk but there is no way to eliminate it altogether. It is thus possible that the published studies, by using the cut-off of OD values of >0.5, would have over-estimated the proportion of *Orientia tsutsugamushi* infection among probable scrub typhus patients. We also feel that conducting well-planned epidemiological studies to estimate regional cut-offs in scrub typhus endemic area would be challenging without involving credible laboratories. Such studies would need sera from sufficient number of patients with detailed granular data on clinical details from a given region. The feasibility of involving district/state public health laboratories and using previous samples, as suggested by the authors, would therefore need a careful consideration before such studies are initiated.

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Variation in Tribe-Specific Mortality Indicators of Child Health in India: Emphasizing Tribe-Specific Action Plan

Under-five mortality exhibits uneven distribution, incurring heavy toll among tribal population compared to non-tribal population in India. This necessitates the persistent need for research on tribe-specific indicators of child mortality and life expectancy in India. In this context, Verma, et al. [1] provided tribe-specific estimates of infant mortality rate (IMR), under-five mortality rate (U5MR) and expectation of life at birth (LEB) for 123 tribes in India using Census 2011 data. As is evident from the study, majority of selected tribes depicted higher IMR and U5MR than the national average and the total scheduled tribe (ST) population. The study not only highlighted immense difference in these estimates among tribal and non-tribal population, but also the differences in the estimates among tribes residing in different states and even within the same state.

The above findings are critical with respect to availability of maternal and child health care services and the sporadic success of related government flagship programs in achieving universal health coverage in tribal areas. Although the study acknowledges the need to develop programs to reduce the gap in child mortality and life expectancy within tribal population and between tribal and non-tribal populations, but it left scope for many unaddressed questions. It is important to explore the factors underpinning such huge gap in the indicators of child mortality and life expectancy among tribal and non-tribal populations in India.

Socio-cultural, economic and environmental factors varying across states and social groups play a critical role in uneven distribution of child mortality and life expectancy between tribal and non-tribal populations and even within tribal

population. Although various government programs and policies have been implemented to curb infant and childhood mortality and improve the maternal and child health (MCH) status, but these do not exhibit uniform improvement across all sections of society [2]. The investigators of the present study used Census 2011 data, which is about a decade old, and may not characterize currently prevailing conditions in tribal communities. In addition, the authors have also highlighted the limitations of the indirect method used to estimate IMR, U5MR and LEB.

Nevertheless, the present research has an added value in the absence of any other tribe-specific data source and estimates. The study opens the door for further research to explore disparities among tribal groups in health-seeking behavior so as to address differences in child mortality and life expectancy. Cultural acknowledgement, economic improvement and political empowerment are utmost crucial to address these disparities [3]. The inherent diverse nature of tribal population in India necessitates tribe-specific data. It is important to involve tribal people in the development of the tribe-specific data so as to ensure that indigenous values, beliefs, and notions related to health and wellbeing are captured effectively in the data system [4]. There is a need for ensuring 'pro-culture' tribe-specific action plans to address the disparities in child mortality rates and life expectancy among tribal communities.

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CLIPPINGS

Acute heart failure in multisystem inflammatory syndrome in children (MIS-C) in the context of global SARS-CoV-2 pandemic (*Circulation. 2020;142:429-36)*

This is one of the first studies describing MIS-C, a Kawasaki-like illness occurring after exposure to SARS-CoV-2. The study included 35 children admitted for cardiogenic shock, left ventricular dysfunction, and severe inflammatory state in 14 centres in France and Switzerland.

Median age at admission was 10 years and median duration between the first clinical symptoms and symptoms of heart failure was 6 days. None of the patients met criteria for typical Kawasaki disease. About 80% were admitted directly to the intensive care unit due to cardiogenic shock. Two-thirds required invasive mechanical ventilation while one-fourth required use of veno-arterial extracorporeal membrane oxygenation. Echocardiography at admission revealed depressed left ventricular systolic function in all, with normal left ventricular dimensions in 29 of 35 patients. Dilatation of the coronary arteries was found in 17% with coronary aneurysms in none. All patients received intravenous immunoglobulin, with adjunctive steroid therapy used in one-third. Complete recovery of left ventricular function was observed in 71% of patients 2 days (median) after admission. Median ICU stay was 7 days and no patient died.

The authors postulated that the rapid resolution of systolic dysfunction, together with mild to moderate troponin elevation, suggests that the mechanism of acute heart failure in children is myocardial stunning or edema, rather than inflammatory myocardial damage as in adults.

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