Dear Editor,

ADDRESSING BARRIERS TO IMMUNISATION USING A TAILORED APPROACH

Leask and Danchin report that 6 months after introduction of the 'No Jab, No Pay' Federal Legislation, which requires children to be fully immunised to qualify for a range of tax benefits and supplements, there was an increase of just 0.94% of 1-year olds who were fully immunised in Australia.[1] Although this change in immunisation coverage represents a 12% decrease in children previously missing out, it is not the panacea that closes all coverage gaps. As Leask and Danchin claim, access barriers to health services or delayed reporting to the Australian Immunisation Register (AIR) are likely to be responsible for most children recorded as not up-to-date.[1]

In the Hunter New England Local Health District, we have empirical evidence to support this claim. We conducted a study utilising the World Health Organization's 2013 Guide to Tailoring Immunization Programmes (TIP).[2] Despite achieving high coverage rates at the district level for 1-year olds (93.1%), our study exposed pockets of low coverage in some SA2s that have persisted for 4 years. In one local urban area, 1-year olds were particularly represented; in 2016, 344 (37.8%) were not fully vaccinated; in 2015, 300 (33.0%); in 2014, 320 (35.2%) and in 2013, 408 (43.2%) (ABS 2011 Census data used to calculate rates). Despite AIR data limitations, these numbers are alarming. No evidence of vaccine objection amongst under vaccinated families was found (Thomas *et al*., in preparation). One year after implementation of the 'No Jab, No Pay' legislation, there had been no impact on 1-year olds, the age group most vulnerable to many vaccine preventable diseases. Relying on district wide or even SA3 level data can conceal areas of concern where relatively large numbers of children are missing out on the benefits of immunisation.

Although Federal incentive-based coverage targets for States and Territories exist, these do not hone in on individual communities that may not be benefiting from safe and effective immunisation. Micro-level (SA2) data is available for all Australian local health districts, and local health authorities are encourage to use tools, such as TIP, to systematically identify gaps and work with local interest groups to develop solutions most likely to be effective in communities where the 'one size fits all' approach has proven ineffective. We are working with service providers and community groups to address the barriers faced by the most disadvantaged members of this community that have not been addressed by the strident policy initiative, building on existing strengths and developing sustainable locally specific solutions.

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Conflict of interest: None declared.

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Dear Editor,

RIGHT VENTRICULAR MASS IN A NEONATE

An 18-day-old full-term baby boy was referred to our cardiology clinic for evaluation of a pericardial effusion seen on fetal ultrasound. He was otherwise well and did not have any cardiorespiratory compromise. Echocardiography revealed a large mass involving solely the right ventricular (RV) free wall, measuring 3.5 × 1.6 cm (Fig. 1a). This did cause mild flow acceleration through the RV outflow tract; however, there was no significant inflow or outflow gradient. He subsequently underwent a cardiac magnetic resonance imaging at 4 months of age, which revealed a 5.4 × 2.6 × 1.7 cm lobulated myocardial soft tissue mass involving the inferior free wall of the right ventricle (Fig. 1b). The signal and enhancement characteristics of the mass were most consistent with a cardiac fibroma. The mass did not have arterial phase hyperenhancement or T2 hyperintensity as would be expected of a haemangioma, and the myocardial delayed enhancement pattern was not consistent with rhabdomyoma. The intramyocardial location with minimal heterogeneity and the lack of cystic elements were inconsistent with teratoma. Subsequently, Holter monitoring for occult ventricular arrhythmias was negative. He has been since seen at 12 and 18 months of age in the paediatric cardiology clinic. He continues to do well with no symptoms or signs of haemodynamic compromise and is growing appropriately (Fig. 1d). On his last echocardiogram at 18 months of age, the RV mass has decreased to 2.5 × 1.4 cm (Fig. 1c).

Cardiac fibroma is the third most commonly seen primary cardiac tumour with an estimated prevalence of ~12–16%.[1,2] Cardiac fibromas have to be differentiated from other primary cardiac tumours, such as rhabdomyoma (most common) and teratoma (second most common), myxomas and haemangiomas. Cardiac fibromas have been seen in patients with Beckwith–Wiedemann syndrome, basal cell carcinoma and Gorlin's syndrome. With new imaging modalities, such as computed tomography scan or magnetic resonance imaging, it is now possible to non-invasively distinguish tumour types.[3,4] Such differentiation is important as the management strategies differ based on the tumour type. The decision to intervene must be based on the presence of haemodynamic compromise and weighed against the risks of the surgery. Various surgical approaches include partial removal to relieve obstruction, use of palliative procedures (Blalock–Taussig shunt) to augment pulmonary blood flow and complete excision, and in some cases transplantation is required for tumours that cannot be

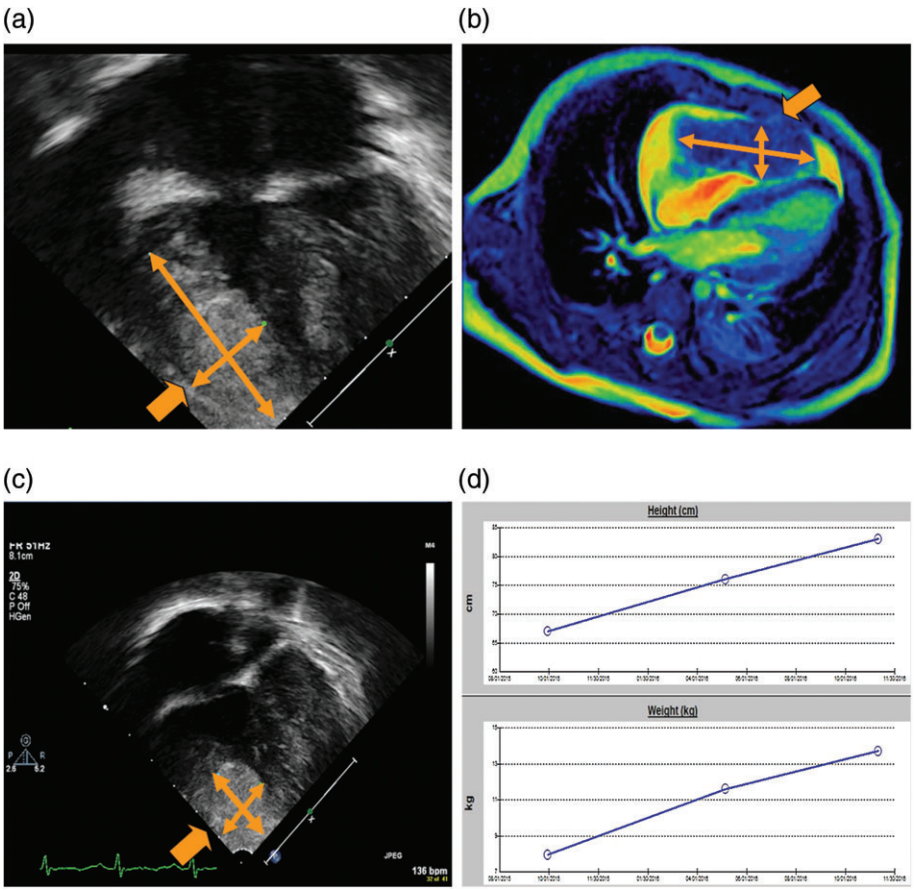

Fig. 1 (a) Echocardiogram revealing a mass involving right ventricular free wall, measuring 3.5 × 1.6 cm. (b) Cardiac magnetic resonance imaging revealing a 5.4 × 2.6 cm mildly lobulated myocardial soft tissue mass involving the inferior free wall of the right ventricle. (c) Echocardiogram done at 18 months of age showing that the right ventricular mass has decreased to 2.5 × 1.4 cm. (d) Growth chart showing that he continues to grow and gain weight.

safely resected. Although fibromas rarely regress, our case demonstrates that they can do so; thus, conservative management may be a valid option in the absence of any haemodynamic compromise or intractable arrhythmias.

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Conflict of interest: None declared.

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Dear Editor,

A RARE CAUSE OF DYSPHAGIA IN CHILDREN: PRIMARY CRICOPHARYNGEAL ACHALASIA

Dysphagia can occur as a result of oropharyngeal and oesophageal disorders. Failure of cricopharyngeus muscle relaxation at the appropriate time during the swallowing process in the absence of other motor or neurological abnormalities is defined as primary cricopharyngeal achalasia (PCA).[1,2] PCA is rare in children and paediatric patients usually present with choking, nasal reflux while feeding, dysphagia and malnutrition.[3] Treatment options for PCA include medical or surgical dilatation of the upper oesophageal sphincter (UES).[4] Herein we report the successful treatment of a 2-month-old patient with PCA, so as to increase awareness of this rare entity, especially among clinicians with paediatric patients. The rarity of PCA in paediatric patients and its successful treatment make this case particularly interesting.

A 2-month-old female presented with vomiting, feeding intolerance and nasal reflux immediately after breastfeeding since birth. She was born full-term following an uncomplicated pregnancy;