

immunosuppressed individuals(2). A single oral dose of Ivermectin (200 µg/kg) has been reported to be more effective than multiple doses of thiabendazole(3). CVID is a syndrome characterized by hypogammaglobulinemia with phenotypically normal B cells(4). These patients are prone to infection with pyogenic organisms and also intestinal parasites, for example, *Giardia lamblia* and strongyloidiasis. An interesting observation is that CVID can resolve transiently or permanently in-patients who acquire human immunodeficiency virus (HIV) infection. The management includes a judicious use of antibiotics and regular IVIG therapy.

It is mandatory to evaluate children and adolescents with immunodeficient states for parasitic infestation such as *Giardia* or *Strongyloides* especially when they present with diarrhea and protein losing enteropathy. These infestations may present with worsening of underlying symptoms. A negative stool examination does not exclude infection and a duodenal biopsy and aspiration would be of immense help in the diagnosis.

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Esophageal Foreign Body Mimicking Esophageal Atresia

A neonate, handed over to mother after a normal examination, was brought back at 4 hours with regurgitation of first feed, drooling of saliva and respiratory distress. An 8F stiff catheter could not be passed beyond 9 cm from the gum margin. X-ray showed the tube in the lower neck with normal lung fields and stomach gas. A diagnosis of esophageal-

atresia (EA) with tracheo-esophageal fistula (TEF) was made. Thoracotomy revealed normal esophagus and trachea without a fistula. A gastrostomy was performed. Symptoms continued in the postoperative period. Flexible endoscopy and CT scan showed a mass in the upper esophagus. Rigid endoscopy, performed with a view to obtain biopsy, showed a whitish "mass". A 2 cm ball of cotton wool was removed and the child recovered. In retrospect it was found that a relative had put honey soaked cotton wool in

the child's mouth after birth as a religious custom.

Most reported cases of esophageal FB in infants have been of accidental ingestion presenting well beyond the neonatal period(1). We did not come across a report of a case as young as 4 hours.

We are inclined to change our practice after this experience. We now choose to perform preoperative bronchoscopy in clinically diagnosed EA. It confirms or excludes the diagnosis, defines the level, number and size of

the fistula, and also the fistula can be occluded to improve ventilation.

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Continuous Positive Airway Pressure—A Gentler Approach to Ventilation

Read with interest the article by Upadhyay, *et al.*(1). Our unit has been using this technique for the past ten years.

1. The use of nasal CPAP has dramatically brought down the need for intubation and mechanical ventilation. There are several commercially available CPAP devices, *e.g.*, Hudson CPAP, Argyle CPAP, INCA prongs, Infant Flow Driver (IFD), Aladdin II *etc.* The Hudson Prongs system (Hudson-RCI, Temecula, CA 92589) was created and used at Columbia in 1973. Biggest prongs that comfortably fit the nostrils are used to avoid loss of pressure. Flow required is affected by the degree of "leak" of gas from the infant's nose and mouth and can be 6 L/min or greater. The advantage is that the adequacy of flow can be seen and heard. If the leak is high the flow causing bubbling is too low which

then stops. If the flow is too high the bubbling becomes very vigorous. IFD needs flows in excess of 8 L/min to generate pressures around 5 cm H₂O. The "expiratory" limb of the IFD is unusual in that it is open to the atmosphere. Potentially, the baby can inspire with a higher flow than that delivered through the inspiratory limb, reducing possibility of the pressure falling with large inspirations. More research is needed to clarify its clinical importance. Our experience favors HP system, probably due to the high frequency like effect.

2. The general effect of mouth closure is to raise pharyngeal pressure and it may fall significantly if the mouth is open even slightly. Our unit uses special caps, which come along with a chinstrap to avoid the fluctuations in the delivered pressure seen with intermittent mouth opening. CPAP sometimes causes gaseous distension, but this is uncommon, as the tone in the upper and lower esophageal sphincters is higher than the applied CPAP. It seems appro-