cases and ankyloglossia would have disappeared spontaneously with time. Speech would also develop normally in these children.

Only rarely, the errors of speech articulation can be attributed to tongue-tie. These patients develop compensatory speech patterns whereby mass movement of the body of the tongue is substituted for discrete motion of the tip of the tongue (/s/, /z/, /t/, /d/, /l/, /n/, /th/)(1). These patients are not difficult to diagnose, as they are unable to protrude the tongue beyond the incisors. Rarely, they may actually have pseudocleft at the tip of the tongue as a result of short tethered lingual frenulum *(Fig.)*. In such patients, surgical release is definitely indicated. But one comes across only a handful of such patients in his/her whole career.

Release of tongue-tie may sound a minor procedure but has distinct possibility of letting surgeon's prestige down with bleeding, infection or injury to Wharton's duct. General anesthesia given along may have its own inherent problems. So, a strict patient selection is advised. Parents should be given a better understanding of the entity and should be warned of the potential hazards.

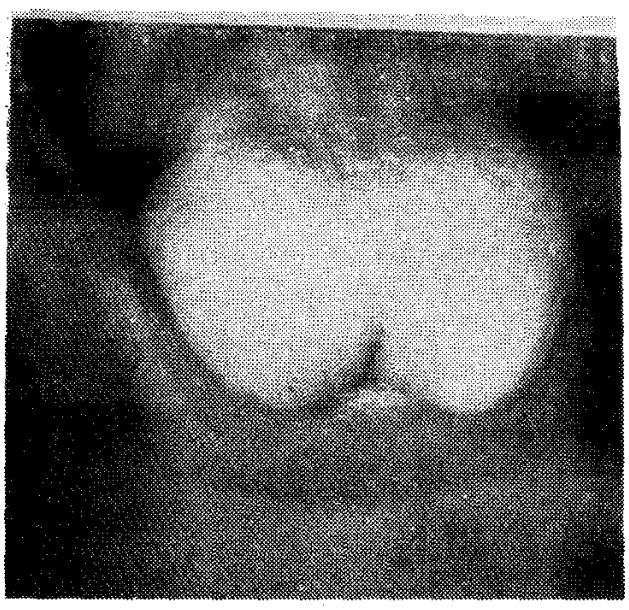

Fig. Pseudocleft of tip of tongue resulting from short tethered lingual frenulum.

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Present Status of Neonatal Care in India

The recent Editorial(1) gives in depth information on the present status of neonatal care in India. Doctors are probably managers because their overpowering desire to effect changes by technical supremacy makes their vision dull, and concepts hazy about overall human, social and economic impact.

I agree that the Neonatal Mortality rate should be reduced but it is also necessary to provide rehabilitation to cases who survived serious neonatal illness and now show long term sequelae. The chief causes which contribute to neonatal mortality include immaturity, birth injury, congenital anomalies, hemolytic diseases of new born and conditions of the placenta and the cord(2). Neonates who survive these illnesses may suffer from long term morbidity including mental retardation, cerebral palsy and congenital heart disease. The family and the society will have to bear the

sorrow and anguish of children with these handicaps. The psychological trauma which the family bears is tremendous which no amount of money, time or medical expertise can alleviate.

Is this the reason why many medical personnel are not motivated to salvage critically sick neonate? Will such medical personnel buy and maintain latest medical equipment and keep their knowledge up-to-date? Planners and policy makers need to motivate doctors by providing adequate rehabilitation mechanisms at grass-root level for such handicapped neonates. Medical personnel must be assured to appropriate long term care so that the family and society do not have to bear the financial and psychological burden of rearing of handicapped child.

Let us ponder over the relevance of such handicapped neonates who survive relevance of a serious illness but live a poor quality life, particularly in our country. This, however, does not, at the moment, imply a sanction for active or passive killing of such cases who live with serious morbidity and handicap. However, it would certainly raise the issue of euthanasia, in near future if technical supremacy overpowers nature's rule of survival of the fittest.

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Reply

Dr. Baldwa has raised some of very pertinent questions in relation to the Editorial(1). I fully endorse the views ex-pressed regarding the need to provide appropriate rehabilitation facilities to all neonates who survive with major handicaps. Provision of these facilities is a costly proposition and in our country where even a neonate is not considered a patient and no resources are allocated, providing rehabilitation facilities is considered beyond the scope of affordability. However, these constraints should not come in the way of providing the best-possible treatment of such children.

Dr. Baldwa has suggested that moral ethical and legal justifications are necessary before improving the health statistics of the country. Life saved by successful resuscitation for a child who fails to breathe is the best justification morally, legally or ethically and infact denying this facility to an unborn child (who may end up as stillborn) would be highly unjustifiable on all counts. It is true that nearly one-fourth of asphyxiated babies die. However, an overwhelming majority of the remainder are normal in spite of seizures(2). The risk of cerebral palsy in severely asphyxiated newborns is 5-10% as compared to 0.2% in the general population. However, in a long term follow up of children with hypoxic ischemic encephalopathy, 65-82% of babies were performing normally and were indistinguishable from their peer group(3). Data from the National Collaborative Perinatal Project(4) and the British National Child Development Study(5) suggest that perinatal factors of labor and delivery contribute little to the incidence of mental retardation and seizures. Only 3-13% infants