suctioning(2,3). The authors have challenged this, but their data is meagre and does not confirm what they argue.

Table II in the article shows thin meconium in trachea in 51.9% of the cases, whereas *Table III* shows thin meconium in trachea in 54.8% of the cases! *Table IV* shows that out of 9 babies who had intrapartum suctioning alone only one baby developed Meconium Aspiration Syndrome (MAS) (11.1%), while of those who received both intrapartum suctioning and endotracheal suctioning, 16.1% developed MAS thus clearly showing that unnecessary interventions create more problems only!

A little bit of thin meconium in the trachea and lungs will at best cause a mild respiratory distress which will settle down in 24-48 hours. Hence the contention that such babies do not require vigorous endotracheal suction at birth and be treated as similar to clear liquor(2). Trying to intubate an actively crying, vigorous and slippery baby will only cause pharyngeal and laryngeal trauma and further cause unnecessary hypoxia. Splinting the chest in an actively crying baby is also not recommended.

Hence we cannot agree with the recommendation of the authors. These babies if not^asphyxiated, require only intrapartum suctioning. Once the baby cries actively, thin meconium would have passed to the peripheral airways and there is no point in doing endotracheal suctioning. Attempting to intubate an active baby especially by inexperienced hands will do more harm than good.

P.M.C. Nair,
Associate Professor of Pediatrics and Neonatologist, SAT Hospital, Trivandrum 695 001.

REFERENCES

1. Suresh GK, Sarkar S. Delivery room management of infants born through thin meconium stained liquor. Indian Pediatr 1994, 31:1177-1181.
2. Wiswell TE. Meconium and tracheal aspiration. Pediatrics 1992, 90: 475-476.
3. Narang A, Nair PMC, Bhakoo ON, Vashisht K. Management of meconium stained amniotic fluid: A team approach Indian Pediatr 1993, 39: 9-13.

Hypernatremia and ORS

The Editorial on ORS was comprehensive and most important issues involved were touched upon(l). I have had the occasion to see a large number of infants with hypernatremia during my years at Benghazi, Libya, and in our study on gastroenteritis, hypernatremic dehydration accounted for 14.6% cases(2). The incidence in the newborn period was even higher (23.7%)(3). Since even transient hypernatremia may have undesirable consequences, all aspects of the problem need to be addressed from time to time.

The sodium content of drinking water in Benghazi was high—20.8 to 56 mMol/L(4) and we assumed the high incidence of hypernatremia to be related to the high sodium content of the water(2). In case WHO ORS is prepared using water with a high sodium content, the solution will, inevitably, contain undesirable levels of sodium. Therefore, regional modifications of ORS are essential.

As rightly pointed out, 90 mMol/L sodium may not be essential during maintenance therapy. One wonders if there is a case for follow-on ORS with a lower sodium content.

Harjit Singh,
P.O. Box 12836, Dubai, UAE.

REFERENCES

1. Mehta MN. ORS: Controversies and perspectives. 1994, 31: 895-900.

2. Singh H, Naguio O, Elzouki AY. Hypernatremic dehydration in infantile gastroenteritis: Possible role of drinking water. *In:* Pediatric Infectious Diseases in Arab Countries, Ed A Y Elzouki. Chichester, John Wiley & Sons, 1987, pp 61-64.

3. Jaiksihan, Elzouki AY, Singh H, *et al.* Hypernatremia in the newborn infant. Ann Trop Pediatri 1986,6: 221.

4. Mir NA, Elzouki AY. Oral rehydration solution and electrolyte content of water. Arch Dis Child 1984, 59: 903.

Steroids in Bacterial Meningitis

The editorial "Recent trends in the management of acute bacterial meningitis"(l) was very informative. But it failed to address if steroids can be recommended when ampicillin and chloramphenicol are used. Studies in 1960's, failed to demonstrate consistent beneficial effects when steorids were added to ampicillin plus chloramphenicol in the treatment of meningitis(2). So this practice did not receive acceptance. Recent studies showed beneficial effects of steroid therapy when the antibiotic used was a 3rd generation cephalosporin.

The minimum inhibitory concentration (MIC) of ceftriaxone against common meningeal pathogens is very low. Thus ceftriaxone achieves a CSF concentration that is 228 times the MIC of *H. influenzae* as compared to 15 times for chloramphenicol and 40 times for ampicillin(2). Such high CSF concentrations of ceftriaxone lead to rapid bacterial killing and release of bacterial products, thus triggering an intense inflammatory response. High CSF levels of endotoxin following cetriaxone are reported in the literarure(3). In this situation steroids are effective in controlling the inflammation. Due to the lower effective CSF concentrations achieved, the problem of excessive inflammatory response must be theoretically less when we use ampicillin or chloramphenicol for treat-