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Reply

We appear to be moving from a stage of 'corticosteroids are contraindicated in acute pyogenic meningitis' to 'may be given' and now to 'should be given'. However, the third stage has not really arrived yet. It is being widely acknowledged that further studies are required to make definite recommendations on this subject. The limited data that is available has been interpreted in different ways by various workers. Thus, while our views are at variance to the views being expressed by Gulati *et al.*, it is interesting to know the recommendation made by some other reviewers.

1. Smith(1) in February, 1989 stated that at the bedside he would administer corticosteroids only to a severely ill patient.

2. McCracken and Lebel(2) in March, 1989 emphasized that favorable effects of dexamethasone (DM) therapy have been observed only in patients of *H. influenzae*, meningitis; too few patients with meningococcal or pneumococcal meningitis have been treated to assess efficacy. The trial by Girgis *et al.*(3) was reported after these comments in August 1989. In this study there were 56 patients with *H. influenzae* infection, 106 with pneumococcal infection and 267 with meningococcal infection. However, the antibiotic therapy included chloramphenicol given intramuscularly. This drug is known to be not well absorbed when given by this route. Hence, in our opinion the results of this study should be interpreted with caution. McCracken and Lebel recommend DM in all cases of bacterial meningitis, including the mild cases.

3. Kaplan(4) in March, 1989 examined the issue of making dexamethasone as a routine therapy in children with bacterial meningitis. He concluded that it would be premature to recommended DM therapy routinely for children with bacterial meningitis.

4. McCracken(5) writing on the current management of bacterial meningitis in December, 1989 opined that routine use of DM in bacterial meningitis is problematic and the decision should be based on the physician's assessment of the published data.

5. The question of DM therapy for bacterial meningitis in children has also been scrutinized by the Committee on Infectious Diseases 1989 to 1990 of the American Academy of Pediatrics, and their recommendations published in July 1990(6). The report states that DM reduces the risk of deafness after *H. influenzae* meningitis, although additional placebo-controlled studies are required before unqualified recommendations can be made. The utility of dexamethasone in treatment of pneumococcal or meningococcal meningitis is not

yet known. The Committee prohibits the use of DM is suspected or proved aseptic or nonbacterial or partially treated meningitis. DM is also not recommended for those younger than 2 months and those with congenital or acquired anomalies of the central nervous system, with or without placement of a prosthetic device. The report further states that if DM is used it should be given alongwith the first dose of antibacterials, in mild cases as well as severely ill patients and only in proven/ strongly suspected cases of bacterial etiology. Measurement of hemoglobin concentration and examination of stools should be performed regularly. If malena or gross blood is observed, DM should be stopped and patient observed closely for possible transfusion therapy.

Our conclusion after a more thorough review of all the available published literature is that some children with bacterial meningitis appear to be benefitted to a limited extent by dexamethasone treatment. However, the currently available data does not help us in identifying all such patients who are likely to benefit so that only they may be exposed to DM.

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Do Not Clamp the Umbilical Cord Too Close

We report a case of gangrene of the intestine due to tying of the umbilical cord very close to the abdomen in a newborn with hernia of the umbilical cord.

A 2.2 kg first born male infant born of a full term normal vaginal delivery was noticed to have a small umbilical swelling at birth. The delivery was conducted under medical supervision. The neonate passed meconium at birth. The baby was brought on the ninth day of life with history of bilious vomitings and abdominal distension of 5 days duration. Careful examination of the umbilicus revealed that it was black and about 3 cm in diameter. The base of the umbilicus was having a ligature. The abdomen was grossly distended and visible intestinal loops were seen. An erect *X*-ray of abdomen showed dilated small bowel loops. The baby was explored after adequate resuscitation by a right upper transverse incision. The ileocecal region and 4 cm of the distal ileum were strangulated by the ligature around the umbilicus and were