is calf atrophy. The motor loss parallels the last developed vertebra and sensory loss is at a lower level. Bladder dysfunction is quite common because of failure of development of 2nd to 4th sacral nerve roots.

Children with sacral agenesis may show progressive neurological deficit so these patients should be followed up regularly clinically and radiologically to rule out surgically correctable lesions like tethered cord, dermoid cyst, lipoma, *etc.,* the correction of which will improve the patient. MRI is the ideal present day investigation for it if the patient can afford it as it provides excellent anatomic resolution and saggital and axial views can be obtained.

Renshaw classified sacral agenesis into four types(3): Type I-partial or total unilateral sacral agenesis; Type II-partial sacral agenesis with a partial but bilateral symmetrical defect and a stable articulation between ilia and a normal or hypoplastic first sacral vertebra; Type H-variable lumbar and total sacral agenesis with ilia articulating with the sides of the lowest vertebra present; and Type-lV-variable lumbar and total sacral agenesis, the caudal end-plate of the lowest vertebral resting above either fused ilia or an iliac amphiarthrosis. Our case belongs to Type III of Renshaw's classification. Treatment consists of correction of associated pathologies by neurosurgeon and orthopedic surgeon.

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Superior Sternal Cleft

Superior sternal cleft is a rare congenital anomaly. Only one case has been reported, to our knowledge, in the Indian literature(l).

A fullterm baby was delivered to a fourth gravida mother. His birth weight was 2880 g with Apgar score of 9, 10 and 10 at 1, 5 and 10 minutes, respectively. Examination showed a 'U' shaped depression in the upper sternal region durring inspiration (Fig. *1).* During expiration a large mass of tissue bulged in this region *(Fig. 2). A* hypopigmented cutaneous patch of 0.8 cm diameter with hyperpigmented rim was present in the region of the cleft (Fig. 2). On palpation a 'U' shaped notch in superior sternum extending upto the sternal angle could be appreciated.

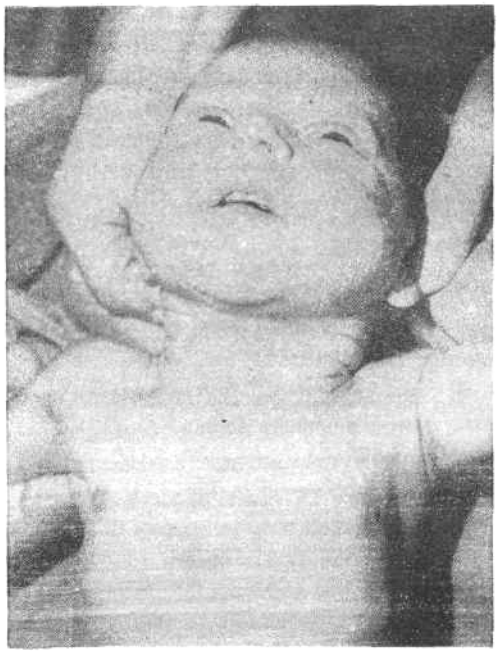

Fig. 1. U' Shaped depression in the upper sternal region during inspiration.

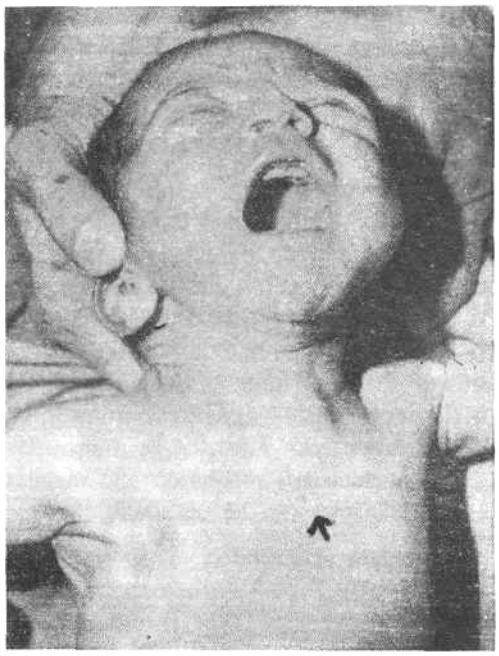

Fig. 2. Bulging mass in the upper sternal region during expiration and hypopigmented cu-taneous patch(↑) with hyperpigmented rim.

The chest radiograph showed a cleft in the superior sternum. The medial ends of the clavicle were 3.2 cm apart. ECG and echocardiography were within normal limits.

The neonate was asymptomatic, feeding and growing well. Surgical repair was advised which, however, was refused by the parents. The child was discharged after 10 days of hospital stay and is on regular followup. He is asymptomatic till 14 months of age when he was last followed up.

A total of twenty eight cases of superior sternal cleft have been previously reported(1). A recent review reports 16 cases from USA, 6 cases from Saudi Arabia, 2 cases from Australia and one from India(l), Mogiliner *et al.* have reported 3 similar cases from Israel(2).

Mogiliner *et al.* observed that cutaneous patch in the region of cleft was associated with skin-to-pericardium sinus tract(2). The cutaneous patch observed in the present case was not examined for a skin-to-pericardium sinus tract because of refusal of permission for surgical intervention.

Early surgery in the neonatal period is advocated for both symptomatic and asymptomatic cases(2). Symptoms may be in the form of paradoxical movement of the chest wall, cyanosis, dyspnea and recurrent chest infections. Operation for asymptomatic

cases is also recommended because: *(a)* presence of sinus connecting the skin to the pericardial cavity may lead to bacterial pericarditis; *(b)* vital mediastinal structures must be prevented from direct trauma; (c) many of these patients develop recurrent chest infection; and *(d)* the appearance of a child with its hearts bulgining through its chest wall is very disturbing to parents.

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Unusual Polydactyly Foot

Polydactyly is a developmental anomaly characterized by supernumery[1] digits. Polydactyly foot, although not as common as that of hand, is definitely not rare. The sexes are equally affected but there is a racial predilection in that blacks show an incidence of 3.6 per 1000 live births and whites an incidence of 0.3 per 1000 live births(l). The variations of polydactyly are numerous, the most common is postaxial and is associated with syndactyly and short toes. Preaxial duplication or duplication of the hallux and multiple polydactyly are rather unusual. We report an unusual case of polydactyly where the accessory toe arose from the dorsal aspect of the foot. Such a bizzare anomaly has never been reported hitherto.

A six-month-old boy presented to the Outpatient Department with an accessory toe arising from the dorsal aspect of the left foot. Examination revealed a fully developed toe with nail adenaxe measuring 4 cm in length *(Fig. 1)*. *X*-rays revealed three distinct phalanges articulating with the base of the middle metatarsal. There were no other associated abnormalities to suggest any genetic etiology. There was no history

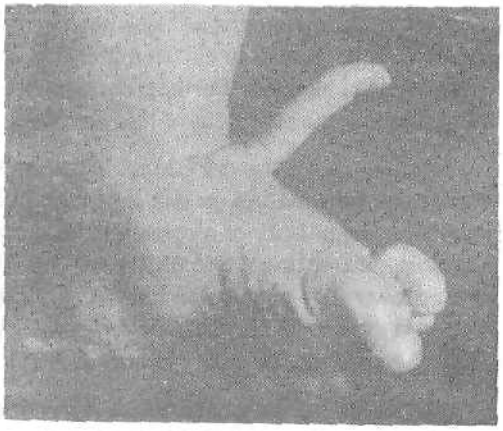

Fig. 1. Note well-formed accessory digit arising from the dorsal aspect of the foot.