

Fig. 2. Caffey's Disease in Twins

the same time and at the same site is really fascinating.

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ORS in Feeding Bottle— A Cause of Concern

Diarrhea is one of the leading cause of death in children in developing countries, approximately five million children, under 5 years of age die each year because of

diarrhea(1). The introduction of oral rehydration by the WHO in 1971, has greatly simplified the treatment of cholera and other acute diarrheal diseases(2). The aim of oral fluid therapy is to prevent dehydration and reduce mortality.

One of the leading predisposing factor of diarrhea is bottle feeding, where inadequately prepared feeds leads to a daily supply of enteral pathogens to the child's gut. Moreover, improper dilution of feeds leads to malnutrition. Hence, it precipitates in vicious cycle of diarrhea-malnutrition-diarrhea, thereby enhancing morbidity and mortality among infants.

Traditionally, the ingredients for ORS are provided in a prepacked powdered form in the market, to be reconstituted in home. But now, sterilized reconstituted ORS is being offered in a bottle, providing a feeding bottle as an added attraction by the manufacturers (*Fig.*). This naturally

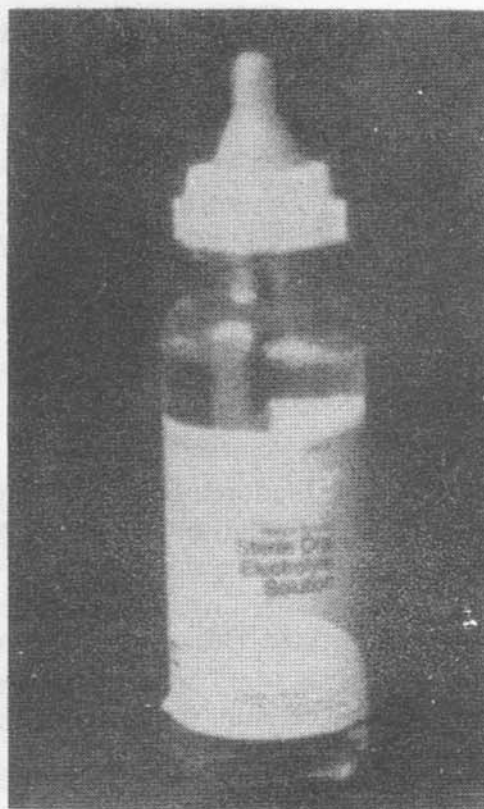


Fig. Pedialyte Feeding Bottle Containing ORS Solution

increases the cost of the preparation, ill-afforded by teaming millions of low socioeconomic status living in unhygienic environments which are most affected by diarrhea. The cost of Pedialyte (Abbott Lab.) containing reconstituted ORS is more (Rs. 15.55) than the cost of prepacked powered forms of ORS which varies from Rs. 5.50 to Rs. 8.15 only. More importantly, this also serves as indirect promotion of bottle feeding, since it provides an easy supply of feeding bottles in homes. This is also in confrontation with 'Doctors Declaration for Breast-feeding' adopted in Manila in 1989(3).

It should be our endeavor to appreciate this paradox, where mode of therapy is being offered aiming to treat a condition, but is infact contributing to further aggravating the disease.

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Limitations of BERA as a Diagnostic Tool

This is regarding the article by Anand *et al.*(1) where they have described the usefulness of Brainstem Evoked Response Audiometry (BERA) in neonates but have not mentioned the limitations of this test. Auditory brainstem response (ABR) testing is no doubt one of the best methods to detect auditory impairment in newborns but it is still not a perfect test because of its limitations:

1. The click-evoked response which is routinely used reflects mainly activation of the basal turn of the cochlea (the high-frequency portion). So the ABR is likely to miss a low-frequency conductive loss, especially one limited to frequencies less than 1000 Hertz(2,3).
2. Some patients with a high frequency loss may show normal ABR curves in which wave V latency shortens to normal at high intensity(3). Also, results from a patient with a steeply sloping high frequency loss could be misinterpreted to show a much more severe hearing impairment than in fact exists(2).
3. It samples only the subcortical auditory pathway and does not test 'hearing' which implies perceptual and integrative functions(4,5). Hearing disorders of central origin cannot be investigated(2).
4. There is no uniform standardized technique and test protocols as well as criteria for ABR failure vary from laboratory to laboratory.
5. The response is modified by many stimulus parameters like click rate,