INDIAN PEDIATRICS

stool examination report was negative for any ova and cysts. The Pathologist reported that the black objects under study were not worms but of vegetable origin. On taking detailed dietary history it was found that those 'worms' appeared in the stool following ingestion of banana. Mother of the child was reassured about the nature of the 'worms'.

The edible part of banana is sweet pulp and core consists of a string of sterile seeds. The pulp is light cream in color, though the seeds are slightly darker but are not visible distinctly. These become slightly visible sometime in over ripened banana. The author could not find any explanation for the change of color of the banana seeds from cream color to black color in this case. In the first week of April, 1994 a 5month-old male child was brought with the complaint that the child sometimes passed large number of 'eye lashes' in the stool. In the light of the above mentioned case mother was enquired if she was giving any banana to the child? The child had not been introduced banana so far. On taking a detailed dietary history it was found that the child was being given crushed but not finely powdered roasted 'Chhuharas' (dried dates) sometimes, and these 'eye lashes' appeared in the stool following ingestion of 'Chhuharas'.

Yash Paul,

A-C-4, Gayatri Sadan, Jai Singh Highway, Bani Park, Jaipur 302 016.

Simpler Tools for Peritoneal Dialysis of Term Newborns and Young Infants

Acute renal failure (ARF) is common in children in underdeveloped countries(l). Peritoneal dialysis is supposed to be quite effective, rather preferable to hemodialysis to deal with ARF at this age(l). Recent text books of Pediatric Nephrology(2,3) and other workers(4) have advised the use of neonatal/pediatric peritoneal catheter (after trimming it) for this purpose which also needs a "Y" connection set along with it. Since limitation of space in the peritoneal cavity of newborns and young infants makes it difficult to insert the rigid peritoneal stylet catheter, several workers have tried various substitutes such as suction catheter tip(5), No. 16 F plastic catheter(6), angiocath(7), neonatal chest drain(8), etc. in the past but no subsequent interest has been shown in them. Non availability/restricted availability of neonatal size acute peritoneal dialysis catheter and "Y" connection sets in our country pose hindrances for dialyzing at this age. Moreover, at present a pediatric acute peritoneal dialysis catheter costs

about Rs 300/- and a "Y" connection set costs Rs 50-200 making the whole procedure expensive. Constrained by these situations, recently we have dialyzed two children (aged one and a half months and three months, weighing 3.3 kg and 5.5 kg, respectively) upto 72 hours satisfactorily by inserting No. 16 IV cannula into the peritoneal cavity and connecting it to a disposable three way cannula. The "Y" connection set was substituted by two ordinary IV infusion sets, one of which connected the dialysate bottle to the cannula while the other drained outflow fluid from the cannula to the drainage bottle. In both of our cases, the dialysis could be accomplished with ease. This technique has the following added advantage over conventional dialysis: (a) It is least traumatic to the patient; (b) The chance of damaging any viscus is less; (c) It is cheaper since it obviates the need for procuring the neonatal peritoneal dialysis catheter and "Y" connection sets; and (d) Dialysis can be performed even at peripheral/small hospital settings and nursing homes. In the past, Steele et al. (7) have used No. 14 angiocath to dialyse 13 preterm infants weighing between 300 g and 1400 g and found this device quite useful. Alexander(2) has advocated the use of angiocath in children weighing <1000 gas an alternative. However, we find this can be extended to the first half of infancy and can be performed in children weighing upto 6 kg though the upper age and weight limit is difficult to define at present. We advocate liberal use of this simple modification which could be life-saving for some sick neonates and young infants who cannot be transported to well-equipped centres due to various

reasons, especially in under-developed countries.

B. Rath, S. Gopalan, Samir Gupta, R.K. Purl, B. Talukdar, Department of Pediatrics,

Maulana Azad Medical College and Associated LNJPN Hospital, New Delhi 110 002.

REFERENCES

- Barrett TM. Acute renal failure. *In:* Pediatric Nephrology, 2nd edn. Eds Holliday MA, Barratt TM, Varnier RL. Baltimore, Williams and Wilkins, 1987, pp 766-772.
- Alexander SR. Peritoneal dialysis. *In:* Pediatric Nephrology, 3rd edn. Eds Hollitiay MA, Barratt TM, Avner ED, 1994, pp 1339-1363.
- Gruskin AB, Baluarte HJ, Dabbagh S. Peritoneal dialysis. *In:* Pediatric Kidney Diseases, Vol I, 2nd edn. Ed Edelmann CM. London, Little Brown and Company, 1992, pp 827-916.
- 4. Mattoo TK. Acute peritoneal dialysis in newborn babies. Indian Pediatr 1992, 29: 1591-1596.
- Swan H, Gerdon HH. Peritoneal lavage in the treatment of anuria in children. Pediatrics 1949, 4: 586-595.
- Segar WE. Peritoneal dialysis in the treatment of boric acid poisoning. New Eng J Med 1960, 262: 798-801.
- Steele BT, Vigneux A, Blatz S, *et al.* Acute peritoneal dialysis in infants weighing <1500 g. J Pediatr 1987, 110: 126-129.
- 8. Mizrohi S, Barak M, Junski I. Simple technique for bed side peritoneal dialysis in neonates. Nephron 1988, 48: 258.