conservatively in neonatal intensive care unit. Abdominal distension decreased gradually. He passed stools on day 5 of admission. Repeat *X*-ray abdomen showed no air fluid levels. He was started on feeds gradually and discharged on day 18 of life. His serial USG abdomen showed gradual decrease in right adrenal hematoma with complete resolution by six weeks of age with no calcifications and normalization of size. Baby was thriving well at follow up and is now of nine months age.

Right adrenal gland is more affected (70%), as against bilateral (5-10%) affection [2], because the right adrenal gland is more likely to be compressed between liver and spine and, the right adrenal vein drains directly into the inferior vena cava. The various etiological factors attributable are difficult or traumatic delivery, perinatal asphyxia, and prematurity, apart from disorders of hemostasis [3]. The usual presentation is asymptomatic to anemia, hypotension, hyperbilirubinemia, bluish discoloration of scrotum and palpable abdominal mass [4].

Most cases of NAH can be managed successfully by conservative measures [4]. Shrinkage develops over weeks, and later corresponds to the shape and size of the normal adrenal gland. Although uncommon, neonatologists and radiologists are likely to encounter a newborn with NAH presenting as intestinal obstruction due to mass effect and need to be aware that it can be managed conservatively.

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Epidermal Nevus Syndrome with Neuronal Migration Defect

Epidermal nevus Syndrome (ENS) describes the association of epidermal hamartomas and extracutaneous abnormalities [1]. Epidermal nevi follow the lines of Blaschko. The majority of the extracutaneous manifestations involve the brain, eye and skeletal systems. Several subsets with characterized clinical features have been delineated including the Nevus sebaceous syndrome, Proteus syndrome, CHILD syndrome, Becker Nevus syndrome, nevus comedonicus syndrome and phakcomatosis pigmentokeratotica [1]. Epidermal nevi have been associated with benign and malignant neoplasms. A rare case of ENS with CNS abnormalities is reported.

A 4-years-old boy presented with uncontrolled seizures of tonic type and severe retardation. His vision and hearing seemed intact. There were no abnormalities in skull, spine or eyes. A facial nevus involved the right side of the mid and lower face and extended down onto the right side of the neck where it appeared much darker with thickening of the skin. However, the nevus did not cross the midline.

Brain MRI revealed right hemimegaencephaly and polymicrogyria in the right parietal region with poor grey-white differentiation and increased signal intensity in the right hemispheric white matter in T2 weighted sequences. A diagnosis of ENS, most likely of Nevus Sebaceous type was made as brain malformations are not typical in the other subtypes of ENS.

Solomon, *et al*. [2] proposed the term to describe the association of epidermal hamartomas and extracutaneous abnormalities; 50% of patients with ENS have neurologic involvement [3]. Ocular choriostomas and colobomas are the most common ocular findings associated with ENS [4].

ENS had been reviewed by Sugarman [1] and more recently by Brandling-Bennet and Morel [5]. Diagnosis is essentially clinical and histological differentiation between the different subgroups of ENS are not always possible. We did not perform biopsy as consent of parents was not obtained.

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Zinc Supplementation for Growth of Preterm Infants

I have serious concerns regarding the methodology and conclusions of the study by Islam, *et al*. [1] published in October 2010 issue on the effect of zinc on the growth of preterm babies. Contrary to the author's statement, the study by Penny, *et al*. [2] did not find any difference in growth in Peruvian children. Islam's study claims to be a double blinded randomized controlled trial (RCT) but masking was questionable. Allocation concealment was also not described. The study objective was vague *i.e.* difference in "growth" (and not length/weight for age) in premature babies. The sample size was calculated on incidence of low birthweight (and not prematurity) instead of difference in a growth parameter, and was not powered to estimate a mean difference of length/weight. A table of comparison of baseline characteristics (with the 95% CI) was absent. The postnatal age, gestational age or other baseline growth confounders were not adjusted for in the analysis. Enrolment age ranged from 7-21days but the reason for this variability or distribution between the two groups was not stated. Adherence to medications on follow up, the definition of "respiratory illness" or "diarrhea" or their evaluation was not explained. The frequency of vomiting and loose stools and how they distinguished between "loose stools" and "diarrhea" is unclear. The author states that 15 infants were excluded from growth analysis but Table II shows otherwise. Both intention to treat and per protocol analysis should have been conducted. In absence of a sound RCT(or mention of a trial registration), the authors concluded the beneficial impact of zinc on growth of LBW preterm babies (although the study was conducted in appropriate for age preterm babies), on reduction of diarrhea and also proposed its recommendation. Although two meta-analysis have reported the beneficial effect of zinc supplementation on length of infants but there has been significant heterogeneity among studies [3,4]. Subsequently an Indian study in 2052 term LBWs showed no growth impact of zinc [5]. So more evidence is needed to evaluate zinc in low birth weights. It is also suggested that authors and reviewers adhere to the CONSORT statements before publishing such RCTs. Presumably a study of negative results with such methodological limitations (which the authors failed to discuss) may not have been published.

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