Secondly, they have not mentioned the increments beyond 48 hours. Even the increments shown are not uniform, and Group B babies must not have received exactly half the volume of feeds as Group A. For example a 1.6 kg baby in Group A would receive 44-48 ml and 112 ml on days 1 and 2; while in Group-B a baby of similar weight would receive 32 ml and 60 ml on days 1 and 2. Consequently, the caloric intakes of both the groups are likely to have been different. Thirdly, according to the study protocol the babies in Group A must have reached the 150 ml/kg/day a day prior to reaching 100 cal/kg/day; and in Group B both must have reached it on the same day. *Table V,* however, shows different values (albeit the difference is small).

We also do not subscribe to the idea of administering dilute feeds to well preterm babies. Earlier, authors have recommended dilution of feeds in either very low birth weight infants(2) or neonates at risk for developing necrotizing enterocolitis(4). The physiological basis for this has been the belief that gradual introduction of feeds of dilute concentration, starting with small volumes allows for a build up of mucosal bulk, brush border enzymes and pancreatic function before full feedings are introduced(5). Another reason advanced is that dilute milk being less osmolar is likely to be emptied faster from the stomach(6).

These arguments actually support the basis for giving diluted milk feeds to convalescing preterms. We prefer to administer expressed breast milk to well preterms and do not think the findings of Sarna *et al.* can be extrapolated to such babies. Besides diluting human or formula milk also carries with it a theoretical risk of introducing infection. Perhaps, Sarna *et al.* should have added a third group in their study consisting of matched preterms who had been fed undiluted human milk in amounts comparable to Group B.

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Reply

We are pleased with the interest shown by Shenoi and Narang in our study. We would like to clarify the doubts raised by them on the issue. The routine in our

Nursery is towards 3 hourly feeds due to the large number of nursery admissions (delivery rate 15,000 per annum) and scant manpower resources (Nurses). Despite this schedule we have not documented hypoglycemia in any of our cases.

The feeding pattern consisted of enhancing the feed by 1 ml, 2 ml, 3 ml and 4 ml per day in the 4 respective weight groups in Group B and this increment was doubled in Group A till a volume of 150 ml/kg was reached. In *Table V* the values appear different because they have been taken to the second decimal. On a single decimal basis no difference exists.

The authors have agreed that very low birth weights and infants at risk for necrotizing enterocolitis (NEC) are advised half strength feeds; all our babies were premature and hence at a risk for developing NEC and besides our study has given a new facet to infant feeding with its advantages. We fail to understand how diluted formula feeds are at any greater risk than full strength formula feeds from the point of view of infection. Although there is no disputing the fact that breast milk is the best, but this study can be useful in situations where breast milk is not readily available.

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