

put into baby's mouth. Mother needs to press in with thumb and fingers while at the same time pushing back towards her chest wall. This elongates and narrows the areola, which enables baby to latch on more easily. Whatever method a health worker suggests for the treatment of inverted nipple, the most important message which needs to be given to the lactating mother is correct latching technique. If a mother properly holds the baby to her breast, half the battle is won. At the same, time instructing the mother to start lactating soon after birth is of paramount importance. With flat or inverted nipples, it is particularly important to put baby to mother's breast as soon after the birth as possible.

Retracted Nipples – Innovative Solutions

The observation on a single case by the authors of the recent article, seems generally an unaccepted procedure though has been successful in the case [1]. The fundamentals of human research ethics are (a) respect for persons, (b) beneficence and (c) justice. Regardless of limitations, these principles must guide the behavior of all individuals in planning, conducting and sponsoring human research. Respect for persons recognizes the capacity and right of all individuals to make their own choice and decision. An important component of these principles is the need to provide special protection to vulnerable persons. Women might also be considered a vulnerable group. In some cultures, women must defer to men in the decision making process, making true voluntary consent difficult.

Retracted Nipples

We read with much interest the correspondence by Rathi and Mandliya on a novel approach to correct retracted nipples by using husband as a suction machine [1]. The method is not novel and has already been described in the Breast Feeding Promotion Network of India (BPNI) Manual on "Infant and Young Child Feeding Counseling: A Training Course" for treatment of retracted nipples [2]. We are also concerned with the social and cultural

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REFERENCES

1. Rathi S, Mandliya J. A Novel approach to correct retracted nipples. *Indian Pediatr.* 2011;48:245.
2. Chakrabarti K, Basu S. Management of Flat or Inverted Nipples with Simple Rubber Bands. *Breastfeeding Medicine.* 2011 Jan. 8 (E-pub ahead of print).

Although, in their communication, the authors have brought out a point stating "the natural relation between husband and wife should overcome any inhibitions for something which will go a long way for their baby", to practice this novel procedure for retracted nipple cure may not be possible for many situations and therefore cannot be fully adopted. It may be difficult for any clinician to describe and monitor the process in practice. Cultural inhibition could be another factor for the reproducibility of this procedure and may generate some wrong insistence and practices among men on women for the benefit of the baby for which some alternative, including existing proven practices should be tried.

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REFERENCE

1. Rathi S, Mandliya J. A novel approach to correct retracted nipples. *Indian Pediatr.* 2011;48: 245.

acceptability of this method in our set up. We feel that other methods for treatment of retracted nipples are more acceptable and should be preferred.

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REFERENCES

1. Rathi S, Mandliya J. A novel approach to correct

retracted nipples. Indian Pediatr. 2011; 48: 245.
2. Infant and Young Child Feeding Counselling: A Training

Course, New Delhi: . Breastfeeding Promotion Network of India; 2006. S14-62.

Overestimation of Prevalence of Vitamin A Deficiency among Rural Preschool Children of West Bengal, India

We read with interest the recent communication on the prevalence of Vitamin A deficiency (VAD) among rural preschool children of West Bengal [1], and urge caution in extrapolating the VAD burden because the survey methodology was prone to overestimating the magnitude of deficiency.

Night blindness was also assessed between 12 and 24 months of age: The presence of night blindness cannot be reliably identified among children between the ages of 12 and 24 months. The World Health Organization (WHO) has therefore recommended that the age group of 24-71 mo should only be included for assessment of night blindness amongst children [2].

Conjunctival xerosis (X1A) as an independent indicator of VAD: VAD is only one of the several causes of conjunctival xerosis; thus the reliability of this sign (X1A) for independent assessment of VAD in field conditions is questionable [3,4]. Conjunctival xerosis is clinically expressed as marked dryness or unwettability; the affected area appears roughened, with fine droplets or bubbles on the surface, rather than smooth and glistening. These changes are best detected in oblique illumination and the abnormalities are often overlooked or, in apparent overcompensation, over-diagnosed. Thus, changes in the conjunctival xerosis by themselves are not an accurate basis for estimating prevalence of clinical xerophthalmia [2,3].

Interpreting serum retinol estimates: According to WHO [2], a major disadvantage of using serum retinol concentration as an indicator of vitamin A status is that retinol concentrations are decreased by acute and underlying chronic infections. The authors did not report simultaneous serum C reactive protein levels to detect overt or subclinical infections for an apt interpretation. Serum retinol concentrations are under homeostatic control over a broad range of body stores and may reflect

body stores content only when it is very low or very high. Further, the WHO concludes that there is no direct evidence of the serum cut-off value where functional consequences including morbidity and mortality effects, begin to occur [3]. No data has been provided to reassure that the dried blood spot on filter paper did not underestimate the serum retinol levels due to transport conditions.

In view of the declining trend of VAD in several regions of the country, it would have been pertinent to state the year of the survey to put the findings in true perspective. It would also be prudent to caution that these overestimates from the poorest segment of population are not inadvertently extrapolated to the entire state for programmatic purposes.

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REFERENCES

1. Arlappa N, Balakrishna N, Laxmaiah A, Nair KM, Brahmam GN. Prevalence of clinical and sub-clinical vitamin A deficiency among rural preschool children of West Bengal, India. Indian Pediatr. 2010;48:47-9.
2. Report of a joint WHO/UNICEF consultation. Geneva, World Health Organization, 1996 (Review version, WHO/NUT/96.10).
3. Sommer A. Vitamin A deficiency and its consequences: A field guide to detection and control. Geneva: WHO; 1995.
4. Reddy V, Rao V, Reddy M. Conjunctival impression cytology for assessment of vitamin A status. Am J Clin Nutr. 1989;50:814-7.

REPLY

As the author stated, we have not assessed the night blindness, the early symptom of VAD in 12-24 month children. Only four children (0.1%) had night blindness among 3932 children of 1-2+ years i.e. 12-36 months. However, the four children are in the age group of 24-36