TABLE I–*Summary of Various Skin Lesions.*

No.	Name of lesion	Total (n=1046) No. (%)	Full term (n=834) No. (%)	Preterm (n=212) No. (%)
Benign				
1.	ETN	515 (49.2)	417 (50.0)	98 (46.2)
2.	Mongolian spots	931 (89.0)	751 (90.0)	180 (84.9)
Dermatitis				
1.	Seborrhic dermatitis	71 (6.8)	58 (7.0)	13 (6.1)
2.	Diaper dermatitis	36 (3.4)	25 (3.0)	11 (5.2)
3.	Candidiasis	1 (0.1)	1 (0.1)	0 (0)
Sepsis related				
1.	Sclerema	32 (3.0)	17 (2.0)	15 (7.0)*
2.	Erythema, necrosis	111 (10.6)	51 (6.1)	60 (28.3)*

* Significant difference between full term and preterm babies (p <0.05).

skin lesions were positive *(Pseudotnonas*-50%, *Klebsiella-25%* and *E. colt*- 10%). Mortality of these babies was over 50% and these skin lesions indicated bad prognosis Child 1962; 103:617-621.
in neonatal septicemia.

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A Cheap Alternative to a Stadiometer

As a pediatrician, accurately measuring my patients' height has been a recurring problem. A stadiometer is relatively costly and painting the height scale on the wall

s, d Laborious, often inaccurate and has to be redone after every repainting of the room. I have devised a simple method which I find very useful. An ordinary tape measure with markings in millimeters can be stuck to the back of a door or wall making sure the zero end touches the floor and the tape is stuck vertically. The advantages are: is *(i)* it is simple and easy to implement; (ii) it is cheap ca tape costs between Rs. 5 to 6), *(iii)* it is accurate; and *(iv)* it can be temporarily detached if the wall or door is to be repainted.

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Safe Bilirubin Level for Term Babies with Non-Hemolytic Jaundice

Dhaded *et al.(1)* have recommended a cut-off level of 20 mg/dl for exchange transfusion in term babies with non-hemolytic jaundice. This is based on their observations that 21 out of 86 (25.8%) babies with bilirubin level of more than 20 mg/dl developed kernicterus in their study group. It is well known that apart from bilirubin levels *per se,* many other factors determine bilirubin toxicity. As the babies in the study were referred from other hospitals for treatment of jaundice, it is likely that details of risk factors may not have been known. No specific mention has been made about the presence or absence of risk factors except in 2 babies with birth asphyxia who developed kernicterus with bilirubin level of more than 20 mg/dl.

We at Jaslok Hospital and Research Center have followed 17 term babies with non-hemolytic jaundice from birth to a varying period of 1-3 years of age. They had peak bilirubin levels ranging from 25-35 mg/dl during the first week of life. All these babies were born at our hospital *without any risk factor.* After joint decision of atleast two of the authors, they were neither given phototherapy nor an exchange transfusion.

Infants with peak levels above 30 mg/dl were subjected to BERA testing which was normal in all babies. These babies have been followed regularly for a year and beyond and have achieved normal growth development, hearing, speech and neurological status. We have had term babies with risk factors and preterm babies with or without risk factors who were treated according to individual merit at bilirubin level of less than 20 mg/dl.

While larger studies are needed to address this issue, we seem to endorse 'a kinder, gentler approach'(2) in the evaluation and treatment of non-hemolytic jaundice in term newborns in absence of risk factors documented by proper assessment. We also suggest that BERA testing may be used as an objective guide in decision making in clinically healthy looking infants.

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