

Dandy Walker malformation. The child was sent to Pediatric Surgery Department for further management, where he was lost to follow up.

Numerous brain abnormalities accompany the Dandy Walker malformation including agenesis of corpus callosum, polymicrogyria, agyria, aqueductal stenosis, Klippel Feil syndrome, microcephaly, syringomyelia, *etc*(3). None of these were seen in our case. It may also be associated with maternal exposure to isotretinoin in first trimester of pregnancy. Familial forms have been reported with autosomal recessive inheritance(4,5).

It is recommended that any infant presenting with delayed motor development having dolicocephalic head with prominent occipital shelf, a cranial ultrasonography or CT scan head should be done to rule out any surgically remedial cause. It is also important from the point of view of prognosis and early diagnosis prenatally in the next pregnancy(2).

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Thin Meconium Stained Liquor—What is the Right Approach ?

Suresh *et al.*(1) in their article on

meconium stained liquor (MSL) have again kicked the dust that was settling down. The current consensus is that thin meconium stained liquor shall be considered as similar to clear liquor and may not require postnatal endotracheal suctioning other than intrapartum

suctioning(2,3). The authors have challenged this, but their data is meagre and does not confirm what they argue.

Table II in the article shows thin meconium in trachea in 51.9% of the cases, whereas *Table III* shows thin meconium in trachea in 54.8% of the cases! *Table IV* shows that out of 9 babies who had intrapartum suctioning alone only one baby developed Meconium Aspiration Syndrome (MAS) (11.1%), while of those who received both intrapartum suctioning and endotracheal suctioning, 16.1% developed MAS thus clearly showing that unnecessary interventions create more problems only!

A little bit of thin meconium in the trachea and lungs will at best cause a mild respiratory distress which will settle down in 24-48 hours. Hence the contention that such babies do not require vigorous endotracheal suction at birth and be treated as similar to clear liquor(2). Trying to intubate an actively crying, vigorous and slippery baby will only cause pharyngeal and laryngeal trauma and further cause unnecessary hypoxia. Splinting the chest in an active-

ly crying baby is also not recommended.

Hence we cannot agree with the recommendation of the authors. These babies if not asphyxiated, require only intrapartum suctioning. Once the baby cries actively, thin meconium would have passed to the peripheral airways and there is no point in doing endotracheal suctioning. Attempting to intubate an active baby especially by inexperienced hands will do more harm than good.

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Hypernatremia and ORS

The Editorial on ORS was comprehensive and most important issues involved were touched upon(1). I have had the occasion to see a large number of infants with hypernatremia during

my years at Benghazi, Libya, and in our study on gastroenteritis, hypernatremic dehydration accounted for 14.6% cases (2). The incidence in the newborn period was even higher (23.7%)(3). Since even transient hypernatremia may have undesirable consequences, all aspects of the problem need to be addressed from time to time.