

national or state level, preferably along with implementation of universal newborn screening for CAH, so that affected individuals can be tracked and not allowed to slip between fault lines. Meanwhile, pediatricians who see these patients for the first time should also record their phone numbers and addresses, and ensure that the patients remain in follow-up. For families that are completely unwilling to come to terms with the diagnosis, the option of legal relinquishment and placement of baby in a recognized adoption agency may be exercised as a last resort.

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## Evisceration of Gut Through Post-surgical Drain Site in a Neonate

Intra-abdominal drainage following routine abdominal surgery continues to be a controversial subject [1]. The evisceration of various organs through drain site has been commonly reported in adults but is rarely seen in neonates. We report a case of small bowel loop evisceration out of the drain site in a 9-day-old neonate who was operated for duodenal atresia.

A newborn boy was admitted to the neonatal intensive care unit (NICU) of this hospital because of antenatal detected double bubble appearance in antenatal ultrasound of mother. At birth, the child weighed 2275 g and appeared vigorous, with normal spontaneous respiration. X-ray abdomen showed double bubble appearance in upper abdomen. Gastrograffin dye study confirmed the diagnosis of duodenal atresia. On day-2 of life, laparotomy was performed and duodeno-duodenostomy was done. An abdominal glove drain was brought out through a right iliac fossa stab incision approximately 8 mm. The intraoperative course was uneventful and child was shifted back to Neonatal medical unit. The patient responded well in the postoperative period. Feeding was started gradually from 5th post operative day. The drain was removed on the sixth postoperative day. On the 7th post operative day, a loop of small bowel prolapsed through the drain site while he was crying (**Fig.1**). The child was shifted to operation theater. The prolapsed gut through the drainage site was healthy, slightly congested. It was reduced after enlarging the wound, and the drain site was closed with

few interrupted absorbable sutures. The patient recovered well and was discharged on 11th postoperative day.

Drain site gut prolapse after abdominal surgery is a rare complication of drain insertion [2]. Increased morbidity and mortality have been noted in patients with drain site hernia, especially if strangulation of the loops of bowel sets in [3]. Other complications include drain site sepsis, bleeding from abdominal wall vessels, kinking and knotting of drains, and incisional hernia. Most reported cases of gut evisceration involved a drain site with an external diameter of greater than 10 mm. Predisposing factors for herniation through a drain site include general debility, increased intra-abdominal pressure and steroid administration [4]. The recommendations to reduce the risk of prolapse or hernia



**FIG.1** Prolapse of gut through the drain site.

include use of drains measuring less than 10 mm in external diameter, use of "Z" insertion method, and making a purse-string for closure of the defect after removal of the drain [5].

Drains are not a substitute for good surgical techniques and must be used with caution. Careful insertion, and regular post-operative and post-removal inspection is recommended.

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## Simultaneous Two Site Blood Culture in Diagnosis of Neonatal Sepsis: Few Concerns

We read with interest the recent research paper by Tomar, *et al.* [1] in *Indian Pediatrics*. We have following comments and queries:

1. In the present study, authors mentioned that there was no polymicrobial growth in any of the cultures; what was the reason for this finding? Most of the studies in neonates report a frequency of 4% to 25% polymicrobial infections out of all bloodstream infections [2,3].
2. The results of this study differ from study by Sarkar, *et al.* [4], and author attributed it to small sample size and inclusion of inborn babies only in the study; however, to us it seems more due to gross differences in rates of culture positivity in two studies (9.2% vs 46%).
3. In the present study, incidence of candidemia was very high (one-third of total culture positive infections); is there any peculiarity in the study population for this heterogeneous result?
4. Although sending two blood cultures simultaneously improves diagnostic yield, it will add cost to patient care, demands more manpower, and will cause more pain to neonate. The problem of false positivity can be overcome by time to positivity (TTP) of blood culture. Various studies have given time to positivity for individual class of organism beyond which it can be considered as contaminant [5].

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## AUTHORS' REPLY

We are thankful to the readers for giving us the opportunity to provide clarifications on our research.

1. Polymicrobial bacterial infections are often related to surgical interventions, complex congenital cardiac diseases, abdominal surgeries and lipid infusions [1]. We have a separate unit for surgical patients and we do not use lipid infusions for parenteral nutrition. These factors might partly explain absence of this phenomenon in our patients.
2. Difference in results from an earlier study [2] has been attributed to inclusion of outborn babies