associated findings were anomalies of the head and neck (48%), heart (44%), skeleton (22%), genitourinary tract (24%), central nervous system (10%), gastrointestinal tract (6%), and miscellaneous minor anomalies (8%)(3). Additional findings that have been reported in association with congenital hypoplasia of depressor angularis oris are 4p deletion, Klinefelter syndrome, isolated CD4 deficiency and Treacher-Collins like facial appearance(4).

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Torsion of Vermiform Appendix

A 9-year-old boy presented to us with a 16-hour history of abdominal pain localized to right iliac fossa and repeated bouts of non-bilious vomiting. There was no previous history of abdominal pain. On examination, the patient was febrile (100º), had tachycardia (112/min) and tenderness and guarding in right iliac fossa. There was no rigidity; psoas and obturator tests and Rovsing's sign were negative. Rectal examination was inconclusive. A clinical diagnosis of acute appendicitis was made. Other than mild leucocytosis, pre-operative blood investiga-tions were essentially normal. At operation, 8 cm long retrocecal appendix was revealed that had torted 270º clockwise just distal to its base. The appendix was only minimally inflamed. There was no associated fecolith, adhesions, lipomas or mucocoele. A routine appendicectomy was performed. The post-operative period was uneventful. Histo-pathological evaluation revealed non-specific inflammation of the appendix.

Torsion of vermiform appendix is an extremely rare condition with only about 25 cases reported in world literature since its first description in 1918(1). The condition is pre-operatively indistinguishable from acute appendicitis and the diagnosis is usually made intra-operatively(2). The features that are commonly associated with torsion of appendix include long appendix and pelvic position of the appendix(1). The direction of rotation although variable, was more frequently counterclockwise(1). The site of the torsion is

variable, it could be at the base or about 1 cm or more distal to the base(1).

The available literature regarding pathophysiology, mostly conjectural, suggests that the torsion of the appendix could either be a primary event or secondary to other pathologies. The proponents of 'primary' etiology blame it on the fan- shaped meso-appendix having a narrow base and the absence of azygotic folds that normally attach the appendix laterally(3). The other school of thought is that mucocele, lipoma, fecolith or inflammation causes distension of appendix rendering it unstable and more likely to twist. One postulation says that a fecolith could act as a point around which an irregularly contracting appendix might pivot(1). Absence of inflammation in few of the removed specimens supported the view(4). Another view is that inflammation of the appendix is the primary event with the resulting disten-sion of the distal part of appendix render- ing it unstable and making it prone to torsion(5).

One of the interesting speculations has been that intermittent appendicular torsion may be responsible for recurrent right iliac fossa pain in some children(4).

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Post Intra Ventricular Hemorrhage Neonatal Cranial Diabetes Insipidus

Cranial diabetes insipidus (DI) is a rarely reported complication of severe intra-ventricular hemorrhage (IVH). It needs for its diagnosis in the neonatal period. One such case reported in this communication.

Case Report

A male baby was born at 29 weeks of gestation to a 35-year-old mother by emergency cesarean section which was necessitated because of prolonged rupture of membrane, maternal sepsis, foetal bradycardia and breech presentation. Despite antenatal steroid the baby had a stormy initial period as he developed respiratory distress and subsequently Persistent Pulmonary Hypertension of Newborn

(PPHN) needing high ventilatory supports, inotropes and prostacyclin to stabilise. He had a further episode of severe desaturation and bradycardia along with tonic convulsion on day 2. Cranial ultrasound scan confirmed suspected intracranial bleed with a bilateral Grade (IV) IVH and midline shift.