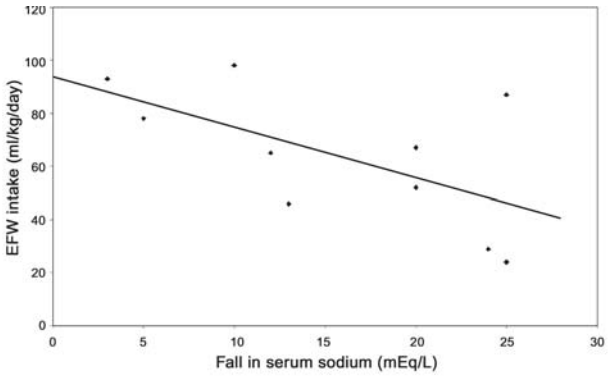

FIG.1 *Electrolyte free water (EFW) and fall in sodium.*

patients who developed hyponatraemia. It will be crucial to know whether this trend is seen in the other patients also (those who did not develop significant hyponatraemia), to test the hypothesis that fall in sodium is inversely related to EFW. It may be possible to understand whether the group that developed hyponatraemia is different from those who did not develop hyponatraemia and we can then 'focus on the inherent properties of the patient's physiology, rather than the inherent properties of the fluid being used' as suggested by Choong in the accompanying editorial(2).

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2. Choong K. Should we add more salt, or less water. Indian Pediatr 2009; 46: 573-574.

Reply

We thank Jain and Manchanda for their interest in our paper and raising valid issues regarding the fall of serum sodium and electrolyte free water (EFW) intake.

In ***Fig.*1** of our paper, we have depicted the observed relationship between fall of serum sodium and electrolyte free water intake. The line which runs diagonally is a theoretical line depicting expected fall in sodium following addition of EFW. Jain and Manchanda have provided a figure along with a regression line. We thank them for this effort. Their figure depicts the same point which we have emphasized in our paper *i.e.*, fall in serum sodium was not related to volume of EFW intake.

We also tried to look into the suggestion given by them regarding a similar figure for normonatremic patients to substantiate the hypothesis that fall in sodium is inversely related to EFW intake. This exercise seems improbable as it was difficult to get values for 'X' axis that represents fall in serum sodium. In the normonatremic group serum sodium changes were less dramatic and stayed within normal range. **Table *II*** of our paper, however clearly shows that the EFW intake (mL/kg/day) is inversely related to development of hyponatremia. EFW intake (mL/kg/day) in hyponatremic patients in the pre-hyponatremic phase was significantly lower than in patients without hyponatremia. (A *vs* C, 70.7 mL/kg/day *vs* 83.2 mL/kg/day; *P*=0.0001). Hence it seems that the development of hyponatremia was possibly related to factors other than EFW excess alone.

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