

increases the cost of the preparation, ill-afforded by teaming millions of low socioeconomic status living in unhygienic environments which are most affected by diarrhea. The cost of Pedialyte (Abbott Lab.) containing reconstituted ORS is more (Rs. 15.55) than the cost of prepacked powered forms of ORS which varies from Rs. 5.50 to Rs. 8.15 only. More importantly, this also serves as indirect promotion of bottle feeding, since it provides an easy supply of feeding bottles in homes. This is also in confrontation with 'Doctors Declaration for Breast-feeding' adopted in Manila in 1989(3).

It should be our endeavor to appreciate this paradox, where mode of therapy is being offered aiming to treat a condition, but is infact contributing to further aggravating the disease.

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## Limitations of BERA as a Diagnostic Tool

This is regarding the article by Anand *et al.*(1) where they have described the usefulness of Brainstem Evoked Response Audiometry (BERA) in neonates but have not mentioned the limitations of this test. Auditory brainstem response (ABR) testing is no doubt one of the best methods to detect auditory impairment in newborns but it is still not a perfect test because of its limitations:

1. The click-evoked response which is routinely used reflects mainly activation of the basal turn of the cochlea (the high-frequency portion). So the ABR is likely to miss a low-frequency conductive loss, especially one limited to frequencies less than 1000 Hertz(2,3).
2. Some patients with a high frequency loss may show normal ABR curves in which wave V latency shortens to normal at high intensity(3). Also, results from a patient with a steeply sloping high frequency loss could be misinterpreted to show a much more severe hearing impairment than in fact exists(2).
3. It samples only the subcortical auditory pathway and does not test 'hearing' which implies perceptual and integrative functions(4,5). Hearing disorders of central origin cannot be investigated(2).
4. There is no uniform standardized technique and test protocols as well as criteria for ABR failure vary from laboratory to laboratory.
5. The response is modified by many stimulus parameters like click rate,

click intensity, polarity, number of stimuli, filter band width(6,7) and by some subject variables, especially maturation. Roberts *et al.*(8) found that most ABR failures were due to immaturity. Hence the interpretation of the ABR wave forms requires indigenous normative data and also a high level of expertise and experience(2).

6. The test is time-consuming and the equipment is expensive. The environment of the test must be free from high levels of acoustic and electrical interference.
7. Abnormal ABRs in the newborn period are often transient(4) and many infants are normal on follow up. The reverse can also be true. A normal ABR does not preclude the later development of auditory impairment. Nield *et al.*(9) reported 11 infants with normal ABR at discharge from the NICU who were later found to have significant sensorineural hearing loss. Because of these limitations, any infant who 'fails' ABR should, on follow up, undergo conventional audiometry to get a more comprehensive audiologic picture.

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## Segmental Dilatation of the Ileum

Segmental dilatation of the ileum is a rare malformation usually seen at its junction with the vitelline ducts. Only 27 cases have been previously reported in the English literature up to 1985. Bell *et al.*(1) suggested the term 'ileal dysgenesis' in order to distinguish this condition of the ileum from primary vitelline duct anomalies like Meckel's diverticulum or omphalomesenteric cyst.