bilateral ventricular enlargement and a small left communicating porencephalic cyst. His ABRs were absent on day 26 (Fig. 1), though binocular flash evoked visual responses (VER) were normal. Thirteen days after the insertion of a ventriculo-peritoneal shunt, ABRs were present (Fig. 2).

While the change in ABRs shown by our patient may be explained by hypoxia or maturation, the degree of increased response, the short time interval between examinations (19 days), and the presence of VERs makes this unlikely. An alternative explanation is that raised intracranial pressure is transmitted to the perilymph within the cochlea via the cochlear canaliculus, which is still patent in neonates,³ suppressing cochlear function. Additionally the integrity of the auditory pathways may be affected by the raised cerebrospinal fluid pressure. This may be mediated by distortion of the dorsal cochlear nucleus, which lies in a vulnerable position adjacent to the lateral foramina of the fourth ventricle, or simply by stretching of the eighth nerve. The use of ABR to assist in the decision of when to intervene surgically in posthaemorrhagic hydrocephalus deserves investigation.

Fig. 1 Auditory brainstem responses in a 26 day old infant with posthaemorrhagic hydrocephalus.

Fig. 2 The same infant after insertion of ventriculo-peritoneal shunt, 45 days.

References

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- 3 Duvall AJ, Quick CA. *Ann Otol Rhinol Laryngol* 1969;**78**:1041.

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Rectal examinations and acute appendicitis

Sir,

I warmly welcome the paper by Dickson and MacKinlay¹ for I have not thought that rectal examinations in children were helpful in acute appendicitis, and indeed I have tried to persuade my junior staff to refrain from these. For example, I found recently that in one child up to four rectal examinations were carried out in a period of five to six hours—initially by the general practitioner, then the casualty officer, the admitting senior house officer, and finally the registrar! In these days of considerable and regular sexual abuse, it would not be surprising if the parents were concerned about this strange practice of frequent rectal examination. Indeed, I would go so far as to say that routine rectal examinations in children are not justified and certainly not helpful during recovery after operation.

I wonder whether the authors have discussed the routine fourth day postoperative rectal examination with the ethical committee, for I cannot see any value in carrying out this procedure at that time. I would like to see the BPA Committee on Child Abuse make a firm recommendation that rectal examinations in children, including the regular use of suppositories should cease forthwith, though I realise that some rectal medications are of use.

Reference

- 1 Dickson AP, MacKinlay GA. Rectal examination and acute appendicitis. *Arch Dis Child* 1985;**60**:666-7.

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Drs Dickson and MacKinlay comment:

We thank Mr Cudmore for his notes on our paper and are pleased he agrees with our observations.

Our aim was to show that in most cases of appendicitis the diagnosis can be made without the need for rectal examination. In others, of course, the only physical signs may be elicited rectally.

We too have encountered cases of appendicitis, often clearly diagnosed on abdominal examination yet having a