

The observations made by me in 2004 and by Vashishtha in 2008 indicate that little progress has happened in the control of tuberculosis in Western UP. The effectiveness of the RNTCP program in controlling tuberculosis in adults and children in this region is questionable. The role of practicing pediatricians must be appreciated for the control and management of tuberculosis in children in the region. Only with their active involvement it might be feasible to develop an integrated computerized system with a district hospital or medical school taking the lead to ensure compulsory follow up of each child with tuberculosis and attempt contact tracing using available community resources.

**Pankaj Garg,**  
Unit 71, 105 Bridge Road,  
Westmead Hospital Staff Accomodation, Westmead,

NSW 2145, Australia.  
pankajparul8@rediffmail.com  
pankajg@chw.edu.au

#### REFERENCES

1. Vashishtha VM, John TJ. Prevalence of *Mycobacterium Tuberculosis* infection in children in Western Uttar Pradesh. *Indian Pediatr* 2010; 47: 97-100.
2. Garg P. Childhood tuberculosis in a community hospital from a region of high environmental exposure in north India. *Journal of Diagnostic and Clinical Research* 2008; 2: 634-638.
3. IAP Working group. Consensus statement of IAP working group: Statement on diagnosis of childhood tuberculosis. *Indian Pediatr* 2004; 41: 146-155.

## Score for Neonatal Acute Physiology II

We read with interest the article by Sundaram, *et al.*(1). One of the main objective of this paper was to evaluate the ability of SNAP score II for the prediction of death in septicemic neonates. In the study subjects, the mortality was 62.5% (25 of the 40 enrolled subjects died). What clinical use would be any predictive score when the population itself is at such a high risk of mortality? As in the study, by applying the SNAP II score the predictive ability went up by 15.5% (i.e. from baseline 62.5% to 88%). How will a patient benefit if the clinician says the risk of death is 2/3rd or 3/4th.

**Srinivas Murki and Ashish Jaiswal**  
*Fernandez Hospital,*  
*Bogulkunta, Hyderabad, India.*  
srinivas\_murki2001@yahoo.com

#### REFERENCE

1. Sundaram V, Dutta S, Ahluwalia J, Narang A. Score for neonatal acute physiology II predicts mortality and persistent organ dysfunction in neonates with severe septicemia. *Indian Pediatr* 2009; 46: 775-780.

In a recent article(1), the authors have cited their own primary study(2) as reference no 6, on "adapted criteria" for organ dysfunction adapted from article in reference no 10. I retrieved reference no 6(2) but could not find any adaptation criteria. Secondly, it is known that among low birth weight (LBW) babies, small for gestational age (SGA) babies have differing hormonal responses to stress(3) which can affect physiological response in return. In this study, 30% of enrolled babies were SGA. I wonder as to what was the impact of SGA status on SNAP II scores?

**Baljeet Maini,**  
*MMIMSR, Mullana,*  
*Ambala 133 203, Haryana, India.*  
b\_maini@rediffmail.com

#### REFERENCES

1. Sundaram V, Dutta S, Ahluwalia J, Narang A. Score for neonatal acute physiology II predicts mortality and persistent organ dysfunction in neonates with severe septicemia. *Indian Pediatr* 2009; 46: 775-780.
2. Venkataseshan S, Dutta S, Ahluwalia J, Narang A. Low plasma protein C values predict mortality in low birth weight neonates with septicemia. *Pediatr Infect Dis J* 2007; 26: 684-688.