Lesson from "Fate of Rejected Paper"

I read the recent publication on fate of rejected paper with a great interest [1]. In this work, Dewan, *et al*. concluded that "Rejection of a manuscript by IP does not preclude publication, but rejected manuscripts are published more often in non-pediatric journals or journals with a lower impact factor, although the occasional exception exists' [1]. Indeed, this might reflect the nature of the authors who usually take the challenge by submitting the papers to high impact journals. The interesting point is whether the recommendation/suggestion from the first journal is useful for modification or revision of the papers before submitting to the new journals. Another interesting point is why there is difference in the decisions on the submitted papers by two different journals.

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REFERENCES

1. Dewan P, Gupta P, Shah D. Fate of articles rejected by *Indian Pediatrics*. Indian Pediatr. 2010;47:1031-5.

Short-course Antibiotics for Neonatal Septicemia

We are concerned about a few issues involved in the recently published study on short-course antibiotics for probable neonatal septicemia [1].

Though the authors rightly excluded the extremely low birth weight (ELBW) neonates from the study, considering preterm (neonates >30 wk gestation) and term neonates together may put the former at disadvantage since the risk of escalating sepsis is higher in preterms [2]. The authors have not indicated, how many cases in short-course group were term newborns. Similarly, there are major differences in the etiology, spectrum and severity of early and late onset sepsis; therefore, it may not be logical to combine these two in one study group. Moreover, even in early-onset cases, babies whose mother received antibiotics during labor fare differently and decision to continue antibiotic therapy has to be individualized [3].

The need for limiting the duration of empirical antibiotic therapy in newborns with high suspicion of sepsis is a good idea to avoid emergence of antibiotic resistance and limit the duration of hospital stay and the costs involved. However, such a strategy, probably, is prudent in late-onset sepsis cases started on broad-spectrum and higher antibiotics (like meropenem, etc.) to treat culture-negative sepsis.

Finally, since we treat the disease and not the terminology of 'probable sepsis', one should keep in mind that, among early-onset cases, newborns with *probable sepsis* who recovered within 48 to 72 hours were *probably not sepsis* and needed no antibiotics at all.

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REFERENCES

1. Saini SS, Dutta S, Ray P, Narang A. Short course versus 7-Day course of intravenous antibiotics for probable neonatal septicemia: A pilot, open-label, randomized controlled trial. Indian Pediatr. 2011;48:19-24.
2. Stoll BJ. Infections of the neonatal Infant. *In*: Kliegman RM, Behrman RE, Jenson HB, Stanton BF eds. Nelson Textbook of Pediatrics.18th ed. Philadelphia: Elsevier Saunders; 2007. p.794-811.
3. Polin RA, Parravicini E, Regan JA, Taeusch HW. Bacterial sepsis and meningitis. *In*: Taesch HW, Ballard RA, Gleason CA, eds. Avery's Diseases of the Newborn. 8th ed. Philadelphia: Elsevier Saunders; 2005. p.551-77.

REPLY

It is not true that the spectrum of organisms causing early onset sepsis is greatly different from that causing late onset sepsis in the developing world. Unlike developed countries, the spectrum is largely

similar [1,2]. Barring the fact that meningitis is more commonly associated with late rather than early onset sepsis, the more fulminant form of disease is in fact early onset sepsis, mortality is higher in early onset sepsis. Therefore, early onset sepsis is certainly not "more benign". In any case, these contentions are of little relevance to the core clinical issue which is that the current standard of care of probable sepsis does not distinguish between early and late onset sepsis as far as the duration of antibiotics is concerned. Our intervention (of shortening the duration) therefore was pragmatic and common to both early and late onset sepsis.

It is often easy to be wise in hindsight and say that a particular patient with probable sepsis was actually "probably not septic" and needed no antibiotics. However, when viewed prospectively in a real-life situation, most clinicians would treat a probable sepsis (defined by us as persistence of clinical signs for at least 6 hours plus positive CRP) empirically and then try to minimize the exposure to unnecessary antibiotics, based on clinical course and culture results. This is exactly what we attempted to do in this pilot trial.

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REFERENCES

1. Zaidi AK, Huskins WC, Thaver D, Bhutta ZA, Abbas Z, Goldmann DA. Hsopital acquired neonatal infections in developing countries. Lancet. 2005;365:1175-88.
2. NNPD network. National Neonatal Perinatal Database – report for the year 2002-2003, New Delhi: 2005.

Etiology and Clinical Spectrum of Constipation in Indian Children

I seek comments from the authors on their recent article [1] related to constipation in children.

Recommendations of the North American Society for Pediatric Gastroenterology and Nutrition for constipation [2] were updated in 2006 [3]. These guidelines and others [4], recommend testing for hypothyroidism, hypercalcemia, celiac disease and chronic lead exposure in children with constipation who respond poorly to standard treatment. Authors have not reported any case of hypothyroidism in their series of children. Is there need for testing for hypothyroidism in children with constipation who respond poorly to standard treatment in Indian set-up?

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REFERENCES

1. Khanna V, Poddar U, Yachha SK. Etiology and clinical spectrum of constipation in Indian children. Indian Pediatr. 2010;47:1025-30.
2. Baker SS, Liptak GS, Colletti RB, Croffie JM, DiLorenzo C, Ector W, *et al.* Constipation in infants and children: evaluation and treatment. A medical position statement of the North American Society for Pediatric Gastroenterology and Nutrition. J Pediatr Gastroenterol Nutr. 1999;29:612-26.
3. Baker SS, Liptak GS, Colletti RB, Croffie JM, DiLorenzo C, Ector W, *et al.* Clinical Practice Guideline. Evaluation and Treatment of Constipation in Infants and Children: Recommendations of the North American Society for Pediatric Gastroenterology, Hepatology and Nutrition. J Pediatr Gastroenterol Nutr. 2006;43:e1-e13.
4. Clayden GS, Keshtgar AS, Carcani-Rathwell I, Abhyankar A. The management of chronic constipation and related fecal incontinence in childhood. Arch Dis Child - Educ Prac. 2005;90:ep58-ep67.

REPLY

In pediatric practice it is important to look for hypothyroidism whenever there is some suspicion, especially in infants. As a matter of policy we look for organic causes in all infants presenting with constipation during infancy and we do thyroid profile (T3, T4, and TSH) in them. In our study population there were 11 cases of infants (up to 12 months of age) but none of them were found to have hypothyroidism [1]. Due to the newborn screening program in the West, North American Society for Pediatric Gastroenterology, Hepatology and