REPLY

We thank Murki S, *et al.* and Maini B for showing interest in our article and for their comments.

Firstly, the high baseline risk of death (62.5%) observed in our study is due to the inclusion of relatively more sick neonates due to stringent inclusion criteria. However we felt it was prudent to test a clinical tool that can improve the predictive ability further to prognosticate and triage the clinical care in severely sick neonates. The negative likelihood ratio (LR^-) was 0.47 making a posttest probability of dying equal to 43% if the SNAP II score is below 40. This amounts to an absolute decline of 20% from the baseline risk. If, on the basis of a relatively simple tool like SNAP II, the risk categorization can be separated into 88% versus 43%, the information is valuable both for the clinician as well as the patient.

In response to the comments from Maini B, the criteria for organ dysfunction were adapted by us from Barton P, *et al*.(1) and were used in the primary study(2). It was not published but only cross referred in our primary study due to limitation of space. SGA is a potent perinatal variable that can modify the risk of mortality independent of the other physiologic derangements. SNAP-perinatal extension II is an admission score derived by the addition of SGA and two other independent perinatal variables with SNAP II to enable prediction of risk of mortality(3). However, we could not use SNAPPE II for the obvious reason of it being an admission score. To the best of our knowledge, no literature is available as of now that has specifically analyzed the effect of SGA status on the performance of SNAP II.

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