

The concerns raised by the authors regarding lack of safety of cooling methods used in the Neonatal units in India and lack of data on safety and efficacy of cooling when initiated after 6 hours of age have been addressed in our manuscript [3]. The NICHD Neonatal Research Network data from high-income countries on cooling for neonatal encephalopathy between 6 and 24 hours of age was recently published [4].

A large phase III randomized controlled trial of whole body cooling is currently ongoing in several public sector tertiary neonatal units in India, Bangladesh and Sri Lanka [5]. All recruited babies are having detailed neuro-developmental follow up at 18 months using Bayley III Infant and Toddler Assessment. Once completed, this would be the largest ever cooling trial and should provide the definitive answer for safety and efficacy of cooling therapy in these settings. We agree, until these data are available, cooling therapy in Indian neonatal units should be considered as experimental, and it may be prudent to obtain informed parental consent after discussing the risk benefits.

SUDHIN THAYYIL¹ AND SEETHA SHANKARAN²
¹Centre for Perinatal Neuroscience,

Department of Pediatrics,
 Imperial College London, UK; and
²Department of Neonatal Perinatal Medicine,
 Wayne State University, USA.
¹s.thayyil@imperial.ac.uk

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Medical Council of India Revised Criteria for Research Publications: A Dilemma

With reference to the special editorial published recently in *Indian Pediatrics* [1], we have a few more suggestions to offer. As per recent MCI notification regarding credit for only first and corresponding author [1], in our opinion all authors should get their due credit. A way forward can be to give weighted scores to all authors in the serial order of their authorship. This may prevent pressure of gift authorship, as even the last author will get some credit points for his/her contribution with regards to publication [2]. Moreover, scores can be assigned to publications in indexed, non-indexed, national or international journals. Similarly, the indexing agencies can also be scored rank-wise and weighted scores can be assigned accordingly. This systematic transparent method of weighted scoring in every aspect of publication will lay a foundation for common, uniform and objective system of evaluation for researchers all over India.

The editorial [1] further comments that two/five/seven/ten of best papers should be considered for promotion in the academic ladder – but how to evaluate or rank the best papers? This question still remains unanswered. The suggested systematic scoring mechanism can also help here.

One more point to ponder is that why only 'original research' papers are to be considered for promotion of faculty [3]. As 'research' is just a part of Medical teacher's job, the other publications like editorials, commentaries, short articles, case series should also be considered; though, maximum marks/credits can be allotted for research articles. All of these contribute to new ideas, innovations and dissemination of scientific reasoning and thoughts. Every manuscript – whether it is a case report, systematic review or meta-analysis – contributes in one way or other for generating new evidence.

In today's paperless era, it is all the more essential that some quality e-journals should be recognized and included for credits of publication. It will pave the way for medical teachers to fulfill the eligibility for appointment and promotion. As a result, the new medical colleges being started by the government as a policy measure at district level will not face the shortage of

faculty members [4].

The primary job of a faculty member is teaching; therefore, research publications should not be made mandatory for promotions. If it has to be mandatory, the criteria for considering of publications should be based on a reasonable scoring system. This will result in original and honest research work by only those who are zealous and really interested in bringing new evidence to the fore, and prevent unethical publication practices and mushrooming of predatory journals.

VIJAY KUMAR BARWAL AND GOPAL ASHISH SHARMA*

*Department of Community Medicine,
Indira Gandhi Medical College, Shimla, India.
gashish.commed@gmail.com

Outcome of Pediatric Living Donor Liver Transplantation in India

We read with interest a recent article by Mohan, *et al.* [1] who have summarized their experience of 200 pediatric living donor liver transplantations in one of the largest series from the country. We would like to highlight some issues with the study.

Authors have mentioned using Pediatric end stage liver disease (PELD) scores (>10 for age <12 years), and Model for end-stage liver disease (MELD) scores (>15 for age >12 years) for listing for liver transplantation in patients with chronic liver disease (CLD) as per Western guidelines [2]. This statement requires careful interpretation as these scores are not at all meant to be used for listing a patient or deciding the need of liver transplantation in an individual patient. The above statement infers that a patient with a PELD score of <10 or a MELD score of <15 would not be listed irrespective of his/her clinical status. Quoting the same guidelines, every CLD patient who develops worsening of hepatic functions (intractable ascites, progressive encephalopathy, uncorrectable coagulopathy and/or, recurrent infections; and not just uncontrolled portal hypertension), mandates evaluation for liver transplantation [2]. These severity scores are meant to be used only in countries having proper organ allocation mechanisms for diseased donor transplantation, and that too, only for deciding the priority and not for listing. In

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resource-constrained settings, where a vast majority of liver transplantations are living donor related, these scores have limited practical utility, except for prognostication. Thus, using fixed cut-offs for deciding need of liver transplantation in CLD is far from being an ideal strategy.

Despite having a long study period of 13 years, vital information on post transplant follow-up, including attrition/loss to follow-up, drug compliance rates, renal outcomes is missing from the reported study. Reasons for lower incidence of vascular complications, any trend (if seen) in the incidence of complications over the study period, and actual modifications in transplant protocols over the study period (to improve the outcomes) require further clarification [3]. Also, predictors of morbidity and mortality, if studied in the study cohort, would have added much needed information to the national database [4,5].

VIKRANT SOOD AND SEEMA ALAM*

*Department of Pediatric Hepatology,
Institute of Liver and Biliary Sciences,
Vasant Kunj, New Delhi, India.
seema_alam@hotmail.com

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