iii) The exclusion criteria do not mention children with congenital cyanotic heart disease. Should this group not have been excluded as the methodology adopted required monitoring of oxygen saturation and adjustment of \( \text{FiO}_2 \) to keep arterial oxygen concentration between 92-97\% and for calculation of saturation to \( \text{FiO}_2 \) (SF) ratio.

iv) We also want to know more about the Respiratory Clinical Score that was used to monitor the study children. This scoring system, as per our understanding, was not meant for use in children admitted to the PICU and on respiratory support [2]. Similarly, we also want to know about validation of this tool in Indian children? We feel that assessment of dyspnea using respiratory clinical score in children on HFNC would have been incorrect as the given score has many points like – “hyperactivity, increased coughing after play, decreased appetite” which cannot be assessed in the PICU and some scores like “agitation” are likely to be scored higher in the PICU setting with a child on respiratory support.

v) On going through the original article [3], with regard to use of COMFORT score, which in this study was used for assessing the tolerability of HFNC, we find scores for respiratory support which use responses that include “respiratory response” which is scored using terms like “resistance to ventilator, actively breathes against ventilator, fights ventilator etc.” similarly other heads like “muscle tone assessment facial tension assessment” which are inappropriate in this setting would have yielded inappropriate results. Modifications of this scoring system to use it to determine sedation and dose adjustments that need to be done depending on the assessed score. There is no mention about use of this score to change the dose of sedation or if the original score was used it may not again be appropriate.

vi) We would also want to know how the authors derived the determined sample size and assumed 50\% risk reduction and achieved the same in exactly one year.

vii) Table I mentions the total number of children in HFNC responders’ group to be 188 [1]. But on totalling the number of cases across diagnoses, the total sums up to only 186. There thus is missing data of 2 children. There are 2 extra diagnoses amongst the non-responders having 19 diagnoses versus 17 children. Even though we did consider the same child to have more than one diagnosis in the non-responders group, but having two less diagnoses compared to the total number of children in the responder group left us perplexed.

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AUTHOR’S REPLY
We thank the readers for their interest.

i) We agree that an RCT would have been ideal clinical design. If a comparator group of NIV is used, then there is a possibility of unnecessarily exposing large number of children to this modality when they could be successfully managed on lesser invasive support.

ii) The PALICC guidelines mention targeting a saturation of 92-97\% in children with mild ARDS [1]; similar targets have also been used in other studies [2]. For calculation of SF ratio, the PALICC guidelines recommend titrating \( \text{FiO}_2 \) to keep SpO2 between 92-97\%.

iii) Children with cyanotic heart disease were excluded.

iv) A respiratory clinical score with the following parameters was calculated: age specific respiratory rate scores 0 to 3, retractions 0 to 3, dyspnea 0 to 3, and wheeze 0 to 3. Total score ranged between 0 for normal and 12 at the extremes. This score has been used in the PICU to assess effectiveness of HFNC [3]. The score has not been validated in Indian children but there is no plausible reason to believe that RR, retractions, wheezing or dyspnea would be different in Indian children.

v) COMFORT score has also been used in non-ventilated patients in the PICU [4].

vi) For calculation of sample size, a baseline risk for need of ventilation as 16\% was assumed in children with respiratory distress presenting to the emergency [5]. We hypothesised that HFNC would reduce the risk by 50\% (absolute reduction of 8 percentage points). Using alphaerror of 0.05 and for 90\% power, we calculated a sample size of 178. To allow for potential 10\% recruitment failure rate, required sample size was increased to 200.

vii) We agree that numbers add to 186 for diagnosis, and regret the typographical error.

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