AUTHOR'S REPLY

We appreciate the readers' critical appraisal of our study by reader. Maternal antibiotics were administered only for medical or obstetric indications such as Premature rupture of membranes (PROM), and chorioamnionitis. The frequency of PROM was comparable in the two groups. Use of antibiotics was restricted to those who had a diagnosis of probable or definite sepsis; the proportion of such babies being 43.9% in the aggressive group and 65.9% in conservative regimen (P=0.16). Delayed cord clamping and use of probiotics were not in practice during the study period. The low occurrence of NEC rates in the present study could be due to several reasons. The study enrolled neonates eŠ750 g birth weight, and none of them were <26 weeks. These are the neonates at the highest risk of NEC. Further, mortality in the present study was much higher compared to Vermont Oxford data or ADEPT cohort with few extremely preterm survivors. Neonates who survived had a mean (SD) gestation 32 (2.2) weeks compared to those who had died 29 (2.5) weeks.

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Can Small for Gestational Age Status Affect the Weight-based Formula for Calculation of Insertional Length of Endotracheal Tube in Neonates?

The normative data for placement of endotracheal tube published recently in Indian Pediatrics [1] paves the way for a less invasive alternative of diagnosing a very commonly encountered issue of endotracheal tube (ET) malposition, that too in a time bound manner. However, we have the following queries:

1. The anatomical measurements of larynx and trachea based on gestational age of a neonate are considered to be more accurate than the weight-based measurements as the later can be influenced by intrauterine growth retardation [2] *e.g.,* a 28 weeks, 700 grams small for gestational age (SGA) neonate will have a lengthier larynx and trachea compared to a 26 weeks appropriate for gestational age (AGA) neonate of the same weight. This issue is of more significance in countries where the incidence of SGA is high [3]. Approximately, 20% of the neonates in this study [1] were SGA. We would like to know if these SGA neonates were excluded while calculating the weight-based formula for ET tube insertion depth?

2. The authors have calculated the sample size based on a pilot study including only two groups of neonates based on weight alone (<1500 g and >1500 g). However, in the final results, they have provided nomograms for multiple subgroups based on weight as well as gestational age. We would like to point out that based on the calculated mean and SD of some of these subgroups, the required sample size falls short in some of them.

3. While deriving the regression equation for insertion length from the various anthropometric parameters, mean age of enrolment at baseline, which might determine some of the factors affecting the head circumference such as caput succedaneum, cephalhematoma and subgaleal bleed, was not mentioned [4]. Moreover, amongst the enrolled neonates, almost 75% are males. As female neonates are constitutionally smaller compared to their male counterparts, can these nomograms be extrapolated to female neonates?

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