

circumference measurement in newborns. *Clin Pediatr (Phila)*. 2014;53:456-9.

AUTHORS' REPLY

We thank the readers for critically evaluating our research study [1]. The queries raised are addressed below:

1. Small for gestation age (SGA) infants are anatomically and physiologically distinct from appropriate for gestational age (AGA) infants [2]. However in our study, on calculating regression equation predicting insertional length (IL, in cm) from the weight (kg) among AGA and SGA neonates, the results remained similar (both regression coefficient and intercept) as follows:

$$\text{IL (overall population, cm)} = \text{wt (kg)} + 4.95$$

$$\text{IL (AGA population, cm)} = 1.1 \times \text{wt (kg)} + 4.928$$

$$\text{IL (SGA population, cm)} = 1.1 \times \text{wt (kg)} + 4.922$$

2. We accept that the sample size required in different groups (calculated *post hoc* from our results) is more than the number of infants enrolled. However, there was no prior study that had reported gestation or weight-based normograms of optimally placed endotracheal tube on ultrasound to guide us. Therefore, we conducted a pilot study on 15 infants in two weight categories. To derive adequate sample size in five weight categories and four gestation categories, a pilot study would require about 80-100 infants, which was not feasible for us.

3. Median (IQR) day of enrollment of the neonates was 3 (1-9) days. None of the study subjects had cephalhematoma or subgaleal bleed. Neonates with caput succedaneum enrolled on day 1 had their head circumference measurement repeated after 48 hours of life, not only for our study but also as a standard clinical protocol because resolution of caput succedaneum takes few days [3]. We agree that our study had male preponderance and the possibility of calculating sex-specific normative data of optimally placed endotracheal tube on ultrasound based on adequate sample size needs to be explored.

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Periviable Birth – The Ethical Conundrum: Few concerns

The article by Nimbalkar and Bansal [1], published recently in *Indian Pediatrics*, must have caught attention of many clinicians. We were looking forward to discussions around real time delivery room dilemmas in day-to-day life as well as some operational working algorithms/flowcharts that would help making decisions easier in such difficult situations. Through this communication, we have tried to complement the content in this article. Nevertheless, we agree with the author that there is an imminent need to collect our own outcome data in extreme preterm infants to enable framing national guidelines for management of periviable babies.

1. In the section on “The Ethics of Decision-making in the Delivery Room” authors have made a generic discussion around the principles of ethics rather than some practical ethical dilemmas faced by a clinician in a delivery room.
2. At the outset, it may have been good to define a ‘live birth’, What are ‘signs of life’, what constitutes providing either ‘full life support’ or ‘comfort care’ *etc.* While the Neonatal Resuscitation Program (NRP) guidelines mention first examination of ‘Heart Rate’ after the end of initial steps, do we really examine heart first when dealing with difficult situations of periviability to assess signs of life?
3. Authors have majorly (and infact theoretically rightly so) used gestational age (GA) cut-offs as the main guiding criteria that dictate decisions and actions in tricky situations around periviability. But surely such