Dilemma of Academia and Organizers in IAP

Two recent communications in the pages of *Indian Pediatrics* [1,2] very eloquently underline the significance of the title above. While I urge the readers of the journal to read both the articles fully, I refer to lines relevant to the context of the present communication.

Editor's Desk [1] discusses (or proposes as a "must"), inter alia, "need for a "code of conduct" on which academia-industry relationship must subsist." They further add at the end of the article, "Practitioners need to take charge of updating their knowledge *themselves (italics mine!)*. The information fed by the pharmaceutical industry (*do we include Vaccine companies too*?, *again italics are mine*) needs to be seen, smelled, tasted and scrutinized for its content; before digesting it finally!

President's Page [2] states, inter alia, at the end of the last but one paragraph, "We are thankful to the vaccine manufacturers *viz*. GSK, MSD, Sanofi and Wyeth-Pfizer for their magnanimous scientific grants and *more importantly for their non-interference, non-influence in the science,...*" (*italics, mine*)

When both the views, each authentic in its own right, get paradoxically juxtaposed in our own Journal with a very high impact factor of 1.04 [3], how should a practitioner take up a stand *vis-à-vis* his/her child patients and their non-affording parents, especially when more and more pediatricians in the market pool seem to be assuming role as "vaccinologists" or "vaccine specialists" following the training from National Vaccicon ToT, rather than clinicians following Immunization committee of IAP (IAPCOI), which brings out its instructional publications of consensus every year. Incidently, on the President's Page, there is no mention of this committee's role in huge success (or otherwise!) of Vaccicon on *all parameters and also the flood of congratulatory and complimentary messages (italics mine, yet again).*

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Neonatal Resuscitation Program: 2010 Guidelines – Points to Ponder

The new NRP 2010 guidelines on neonatal resuscitation were published more than two years ago [1]. There are lot of variations in practice because of some difficulties in interpretation and feasibility of certain recommendations. We would like to point out few issues which need clarity.

First, the concept of "observational care" has been removed. As per the new algorithm, those neonates who do not require positive pressure ventilation after initial steps of resuscitation and do not have labored breathing or persistent cyanosis subsequently are supposed to be given to the mother for "routine care". Though this is true for term neonates, preterm neonates need close monitoring, irrespective of resuscitation needs and many of them may require special care. Though it is implied that such newborns will be transferred from delivery room to an appropriate area, the algorithm does not explicitly state so. Since the algorithm is meant to be used by all levels of workers, it needs to be clarified that routine care in these neonates will be provided in a step down nursery or a intensive care unit depending on the maturity level and the anticipated problems.

Second, due to the removal of the question pertaining to meconium staining of the amniotic fluid, there is some confusion about the approach to be adopted for meconium stained liquor. The NRP now states that in a baby not breathing, watch for meconium staining of skin or meconium in oral cavity to decide about ET suction. However, this may not be easy for all level of workers. As a result, a non-vigorous baby will not receive endotracheal (ET) suctioning and instead would go