

increasing the RDI for vitamin D is not the solution but ensuring adequate exposure to sunlight is. Therefore, the ICMR Committee agreed outdoor physical activity as a mean to achieve adequate vitamin D. This is reflected in their recommendations and they make no specific suggestions for vitamin D intakes in different groups [3]. However, under situations of minimal sunlight exposure, a specific recommendation of a daily supplement of 400 IU (10 µg) has been suggested.

In references quoted by authors of this correspondence around 95% subjects were vitamin D deficient; hence, doses to prevent vitamin D deficiency would be insufficient. However, other Indian studies have shown a good response to 600 IU vitamin D supplementation per day with little difference between 600 and 1000 IU doses [4,5].

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Transcutaneous Bilirubin Measurement in Preterm Neonates Receiving Phototherapy

Pendse, *et al.* [1] published their unique study on transcutaneous bilirubin measurement in preterm neonates in a recent issue of *Indian Pediatrics*. I would like to draw authors' attention on certain issues.

Authors state that preterm neonates >28 weeks and <37 weeks of gestation having clinically detectable jaundice were included in study. Jaundice first becomes evident on face and progresses in a cephalocaudal direction to involve chest, lower abdomen/ thigh and soles/ palms [2]. Clinically detectable jaundice up to what level was defined for inclusion in the study? Recently, visual inspection of jaundice as being reliable indicator is increasingly debated [3-5].

Authors also acknowledge that no additional blood investigations except for total serum bilirubin before

starting phototherapy (PT) and at 12 hours of PT were done for the purpose of study. Exclusion criteria mentioned in the study include conjugated hyperbilirubinemia, evidence of hemolysis or poor perfusion [1]. How preterm babies having conjugated hyperbilirubinemia or evidence of hemolysis were decided clinically? Babies of mothers who are Rh-negative should ideally had a blood type, Rh and Coombs test done at birth as some unsensitized Rh-negative mothers would have needed Anti-D immunoglobulin within 72 hours after delivery.

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AUTHORS' REPLY

We thank the readers for highlighting few important points related to our study on comparison of transcutaneous bilirubin measurement with total serum bilirubin levels in preterm neonates receiving phototherapy [1]. We completely agree that visual inspection of jaundice in preterm infants is fraught with problems, and may be unreliable. But in developing countries with plenty of preterm neonates in the NICUs, it can serve as a valid screening tool and help triage the neonates which need to be tested for jaundice earlier in comparison to others. We screened eligible neonates for jaundice and tested them if their visual assessment as per Kramer's scale [2] was above the cut-off for that

particular gestation [3]. In addition, we used a stool colour chart [4], to exclude conjugated jaundice. We did not perform additional investigations for the purpose of the study, but in circumstances like Rh-negative mother, we definitely performed the required investigations as per our unit policy.

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Neonatal Endocrine Labomas: Few Concerns

We read the article by Chittawar, *et al*. [1], and would like to appreciate the authors for highlighting the important but under-recognized pitfalls in sampling and interpretation of endocrinology reports of neonates. However, there are certain points we would like to highlight, which might bring more clarity in interpreting endocrine values in neonates.

1. The total calcium values are slightly lower in neonates; however, ionized calcium values are comparable to older children and adults [2]. The low total calcium values are due to low serum protein levels. Therefore, correction formulas/nomograms to convert total calcium into ionized calcium may not be valid in neonates.
2. Authors stated that the cut-off for the diagnosis of hypoglycemia is ≤ 45 mg/dL in first 24 hours. There is no mention whether it is blood glucose or plasma

glucose. As per recent recommendations of Pediatric Endocrine Society, during first 48 hours of life, plasma glucose target should be >50 mg/dL, and after 48 hours it should be 60 mg/dL [3].

3. With increasing survival, evaluation of extreme preterm babies with maternal hypothyroidism is an upcoming challenge. There is very less normative data in extreme preterm neonates. Currently most commonly used absolute cut-offs for hypothyroidism are T4 <6.5 ug/dL and TSH >20 mU/L. However, as per the available data in this population (23-27 weeks), the normal TSH value is 0.2-30.3 mU/L and normal mean T4 is as low as 4 ug/dL [4]. Therefore, before labeling as hypothyroidism and starting therapy, one must see gestation and postnatal age-specific nomograms.
4. Level of growth hormone, IGF-I, and IGFBP-3 at birth are significantly different in intrauterine growth restricted (IUGR) babies compared to appropriate for gestation age (AGA) babies [5]. As per WHO 2013 report, 47% of babies in India are small for gestational age (SGA), and out of which about 10% will remain short and need evaluation. Also, these are