takes time. Secondly, DNA PCR demonstrated lower sensitivities at birth and 4 weeks of 68.4% and 87.5%, respectively. One infant who was PCR negative at 6 weeks became positive during the second sampling after stopping breast feeds. This we attributed to breast feeding (25 % of total transmission). Moreover, we recommend further studies in Indian setting to assess the effect of formula feeding in HIV transmission, and overall mortality and morbidity.

Confounding variables like HIV staging of mother, CD 4 counts, mode of delivery, antenatal bleeding per vaginum, prolonged rupture of membrane were comparable as given in ***Table* I** in the study [7]. None of the four women had other sexually transmitted diseases during pregnancy. Hence, ART can be singularly taken as the protective factor.

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Nasopharyngeal Carriage of Organisms in Children With Severe Pneumonia

We read with interest the recent article in Indian Pediatrics by Singh, *et al*. [1], and have the following comments to offer:

1. It is not clear why authors excluded children with radiological evidence of consolidation and pleural effusion.
2. Though children with consolidation were excluded, the results state that 63.9% children had infiltrates on chest *X*-ray, which is a bit confusing.
3. The table titled 'Frequency of organisms in nasopharyngeal secretions in children with community acquired severe pneumonia' divides the patients in to 'Home' and 'Hospital'. The basis of such categorization is not clear from the methodology whether they indicate the place of specimen collection or the type of care the patients received.
4. Serotyping of the pneumococcal isolates could have helped in vaccine development.
5. As the conjugate *H. influenzae* vaccine is known to reduce the nasopharyngeal carriage of the organism [2], the data on immunization status of the children would have been interesting as many of these children might have received this vaccine as per latest National Immunization Schedule.
6. Nasopharyngeal carriage of Pneumococcus in children with pneumonia has been used as a surrogate marker for invasive disease [3]. The data on treatment received by the children and their outcome would have enlightened the readers about the clinical utility of the isolates and their antibiotic, susceptibility in the absence of a blood culture.

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Nasopharyngeal Carriage of Organisms in Children With Severe Pneumonia: Authors' reply

1. The current paper was a part of a multicentric randomized controlled trial for oral amoxicillin administered at hospital *vs*. home [1], published elsewhere. The children with effusion or consolidation were excluded as they required special care and hospitalization for longer durations, and were therefore excluded.
2. The word 'consolidation' has been used to refer end point consolidation which means a significant pathology that means a dense or fluffy opacity that occupies a whole of the lobe or entire lung that may or may not contain air- bronchograms. The term 'infiltrate' was used to define non endpoint infiltrations which include minor patchy infiltrates that are of no sufficient magnitude to constitute primary endpoint consolidation [2,3].
3. The categorization of patients was based on the place of administration of oral amoxicillin *i.e.* whether it has been administered in a hospital setting or at home.
4. Serotyping would have helped definitely but it was beyond the scope of this study as it was focused on treatment of community-acquired pneumonia with oral amoxicillin, and was not directed towards the etiology of the disease [1].
5. The patients were enrolled between 2009 to 2011. Hib vaccination was not a part of national immunization at that time.
6. The pneumococcus isolates and their antibiotic susceptibility has been shown in the manuscript [4].

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Centralized Newborn Hearing screening in Mumbai: Success or Failure?

In India, two children are born with hearing impairment per hour which amounts to 1/2000 to 1/10000 live births. 18000 children with hearing impairment are added to our population every year [1]. Universal newborn hearing screening is mandatory in most developed countries. WHO's Newborn and Infant Screening Report (November 2009) postulates a 1-3-6 rule for newborn hearing screening programs, in which neonates should be ideally screened before 1 month of age, diagnosed by 3 months of age, and intervened by 6 months of age. Presently, Kochi seems to be the only city in India to have centralized new born hearing screening program [2]. The program has screened 1,01,688 babies and identified 162 babies with hearing loss [3].

We started centralized newborn hearing screening in October 2010 and have continued it till date. A two-tier screening approach with oto-acoustic emissions, and brainstem evoked response audiometry (BERA) was followed. A health care worker was identified and trained