Nasopharyngeal carriage of organisms in children aged 3 to 59 months diagnosed with severe community acquired pneumonia. Indian Pediatr. 2016;53:125-8.
2. Barbour ML. Conjugate vaccines and the carriage of *Haemophilus influenzae* type b. Emerg Infect Dis. 1996;2:176-82.
3. Greenberg D, Givon-Lavi N, Newman N, Bar-Ziv J, Dagan R. Nasopharyngeal carriage of individual *Streptococcus pneumoniae* serotypes during pediatric pneumonia as a means to estimate serotype disease potential. Pediatr Infect Dis J. 2011;30:227-33.

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].

***MEENU SINGH AND AMIT AGARWAL**
Department Of Pediatrics,
Advanced Pediatrics Centre,
PGIMER, Chandigarh, India.
**meenusingh4@gmail.com*

REFERENCES

1. Patel AB, Bang A, Singh M, Dhande L, Chelliah LR, Malik A, *et al*. A randomized controlled trial of hospital versus home based therapy with oral amoxicillin for severe pneumonia in children aged 3 – 59 months: The IndiaCLEN Severe Pneumonia Oral Therapy (ISPOT) Study. BMC Pediatrics. 2015;15:186.
2. Simbalista R, Araújo M, Nascimento Carvalho CM. Outcome of children hospitalized with community acquired pneumonia treated with aqueous penicillin G. Clinics (Sao Paulo). 2011;66:95-100.
3. Cherian T, Mulholland EK, Carlin JB, Ostensen H, Amin R, de Campo M, *et al*. Standardized interpretation of paediatric chest radiographs for the diagnosis of pneumonia in epidemiological studies. Bull WHO. 2005;83:353-9.
4. Singh M, Agarwal A, Das RR, Jaiswal N, Ray P. Nasopharyngeal carriage of organisms in children aged 3 to 59 months diagnosed with severe community acquired pneumonia. Indian Pediatr. 2016;53:125-8.

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

to carry out the screening test and documentation. The screener travelled to the identified locations, screened the babies, and provided the provisional reports, following which formal report was mailed to them.

From October 2010 to December 2015, we screened a total of 1716 babies. 809 babies were from well-baby nurseries and 907 babies were from neonatal intensive care unit. 299 babies failed the first screen, but only 66 out of 299 appeared for rescreen. Eighteen babies failed the rescreen and were recommended BERA testing. However, none of the babies turned up for BERA testing or could not be tracked further.

Poor follow-up for rescreening and diagnostic BERA was the greatest challenge to our endeavor. As compared to the experience from Kochi [3], the number of children we screened is much less and follow-up is poor. The dropout of children could possibly be due to lack of effective communication between the screener and the parent, which may be due to lack of background in speech and hearing. We plan to overcome this by introduction of an audiologist to coordinate the patient screening and place audiology interns to carry out the screening. We believe that a centralized two-tier approach is the best and most economically viable approach to neonatal hearing screening, provided adequate communication is established by the screening personnel, so as to ensure a proper follow up.

***JANET VARGHESE AND NEETA NAIK**
EN1 Neuro Services, Kanakia Zillion, LBS Marg, Kurla (West), Mumbai, Maharasthra, India.
**janet.en1neuro@gmail.com*

REFERENCES

1. Singh V. Newborn hearing screening: Present scenario.Indian J Community Med. 2015;40:62.
2. Paul AK. Early identification of hearing loss and centralized newborn hearing screening facility-the Cochin experience. Indian Pediatr. 2011;48:355-9.
3. Paul AK. Centralized newborn hearing screening in Ernakulam, Kerala–Experience over a decade. Indian Pediatrics. 2016;53:15-7.

Transfusion-associated Necrotizing Enterocolitis

We read with interest the recently published article on relationship between packed red blood cell (PRBC) transfusion and severe form of necrotizing enterocolitis (NEC) [1].

The association between NEC and blood transfusion has been reported previously in case control studies but no strong evidence is available till now [2]. The authors have concluded that blood transfusion-associated NEC (TANEC) is severe, and is mainly a surgical form of the disease (stage 3a+3b), but number of TANEC cases with this staging and their comparative value in the other NEC group are not reported. Authors also mention that TANEC group was more likely to be of blood type B+ and less likely to be type A+. Data for this inference are not available in the results. Also, in the present study, we feel there are many confounders. The mean birth weight (992.8 g) and gestation age (27.3 weeks) in TANEC group was less compared to other NEC group. A multivariate analysis adjusted with these confounders is important. Significant number of more females in TANEC group is a new finding in the study not reported previously.

The association between NEC and blood transfusion demands a strong evidence of multi-center prospective randomized trial while addressing the confounders.

RAHUL P BHAMKAR
Department of Pediatrics, Sir HN Reliance Foundation Hospital, Mumbai, India.
dr.rahulbhamkar@gmail.com

REFERENCES

1. Garg PM Ravisankar S, Bian H, Macgilvray S, Shekhawat PS. Relationship between packed red blood cell transfusion and severe form of necrotizing enterocolitis: A case control study. Indian Pediatr. 2015;52:1041-5.
2. Mohamed A, Shah PS. Transfusion associated necrotizing enterocolitis: A meta-analysis of observational data. Pediatrics. 2012;129:529-40

Transfusion-associated Necrotizing Enterocolitis: Authors' Reply

We agree that association between packed red blood cell (PRBC) transfusion and necrotizing enterocolitis (NEC) has been reported multiple times over the past 20 years but investigators are still hard-pressed to provide a cause-and-effect relationship between the two entities.