

2. The rate of sepsis and RDS were higher in the 2001-02 cohort but several other adverse factors including PDA and IVH were more common in the 2009-10 cohort. Hence it is difficult to attribute any of these factors as isolated or independent causes for mortality and morbidity in either cohort.
3. The two cohorts did not differ significantly in the baseline characteristics. Gestational age, birth weight (except for a 40g difference), gender, SGA, obstetric complications, Apgar scores at 1 and 5 minutes were comparable between the two groups. The only two factors that might have had an impact is the use of antenatal steroids and surfactant therapy.
4. We agree that the rates of mechanical ventilation were similar between the two groups. We actually meant high frequency ventilation when we referred mechanical ventilation. We thank you for pointing this out.
5. We agree with the authors that we did not compare the severity of illness score among the two cohorts. Using such a score could have improved the comparability between the two cohorts. This has already been mentioned as one of the drawbacks of our study.

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Pediatric Empyema Thoracis – Role of Conservative Management

We read with interest the recent article [1] regarding conservative management of empyema thoracis. The authors comment that local availability and cost, especially with surgical techniques such as videoscopus-assisted thoracic surgery (VATS), limits surgical options. However, often the advantages of surgery are not discussed with the family. Children are often referred late to the pediatric surgeon in a malnourished state [2]. The families usually end-up spending all their meager resources on consultations and prolonged courses of expensive broad spectrum antibiotics far more than the cost of surgical debridement in a government hospital.

Ultrasonography at admission showed pleural thickening in two, loculations in six and organized fluid in seven patients. However, computed tomography (CT) of the chest showed loculation, collapse and pleural thickening in all three patients where it was done. These bear out the fact that accurate staging is possible only with a contrast enhanced CT scan [2]. While we agree that patients in early stage (Stage I) do not require surgery, those in Stage II and III recover faster with surgical intervention (VATS or open surgery). Interestingly, there is no mention of staging of the disease [3] in this study. What is disturbing to note is that in this series, at discharge, pleural thickening was present in 84% with overcrowding of ribs in 60%. This persisted in 44% and

32%, respectively at 6 weeks follow-up, with 8% having scoliosis and one unexplained mortality.

We have published a large series of surgically managed Stage III pediatric empyema thoracis [4]. Our experience has been that complete removal of pus and debris – that is often too thick to come out of a standard chest tube – and the thick pleura encasing the lung surface leads to full lung expansion. This promotes early recovery and discharge from hospital [4,5]. Contrast enhanced CT scan improves decision making regarding early surgical intervention avoiding prolonged antibiotic treatment, morbidity and mortality.

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