Lesson from "Fate of Rejected Paper"

I read the recent publication on fate of rejected paper with a great interest [1]. In this work, Dewan, *et al*. concluded that "Rejection of a manuscript by IP does not preclude publication, but rejected manuscripts are published more often in non-pediatric journals or journals with a lower impact factor, although the occasional exception exists' [1]. Indeed, this might reflect the nature of the authors who usually take the challenge by submitting the papers to high impact journals. The interesting point is whether the recommendation/suggestion from the first journal is useful for modification or revision of the papers before submitting to the new journals. Another interesting point is why there is difference in the decisions on the submitted papers by two different journals.

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Short-course Antibiotics for Neonatal Septicemia

We are concerned about a few issues involved in the recently published study on short-course antibiotics for probable neonatal septicemia [1].

Though the authors rightly excluded the extremely low birth weight (ELBW) neonates from the study, considering preterm (neonates >30 wk gestation) and term neonates together may put the former at disadvantage since the risk of escalating sepsis is higher in preterms [2]. The authors have not indicated, how many cases in short-course group were term newborns. Similarly, there are major differences in the etiology, spectrum and severity of early and late onset sepsis; therefore, it may not be logical to combine these two in one study group. Moreover, even in early-onset cases, babies whose mother received antibiotics during labor fare differently and decision to continue antibiotic therapy has to be individualized [3].

The need for limiting the duration of empirical antibiotic therapy in newborns with high suspicion of sepsis is a good idea to avoid emergence of antibiotic resistance and limit the duration of hospital stay and the costs involved. However, such a strategy, probably, is prudent in late-onset sepsis cases started on broad-spectrum and higher antibiotics (like meropenem, etc.) to treat culture-negative sepsis.

Finally, since we treat the disease and not the terminology of 'probable sepsis', one should keep in mind that, among early-onset cases, newborns with *probable sepsis* who recovered within 48 to 72 hours were *probably not sepsis* and needed no antibiotics at all.

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REPLY

It is not true that the spectrum of organisms causing early onset sepsis is greatly different from that causing late onset sepsis in the developing world. Unlike developed countries, the spectrum is largely