

procedure with variable block sizes will be used to maximize unpredictability". Thus, as pointed out in the Commentary [3], the procedure used to generate the randomization sequence is 'unclear'.

2. The authors' assertion: "computer-generated block randomization done independently by the USA based study statistician" is not found either in the Supplementary data [1] or the published trial protocol [2]. The published paper [1] states that the external statistician performed allocation concealment (and not random sequence generation). The Commentary [3] already reported that allocation concealment was adequate.
3. The supplementary data [1] (Contents page) states that Blinding is described in Section 5.3 on page 23; however this section is missing in the text. The published protocol [2] states "TSB will be estimated using standard methods" without commenting on blinding. Thus it does not appear that blinding of the outcome assessor was done, hence it was described as 'Inadequate' [3]. Although many randomized trials cannot (and need not) include blinding of outcome assessors, the importance in this trial has already been highlighted previously [3].
4. The Supplementary data [1] and published protocol [2] have two different sample size calculations. The former describes a sample size of 124 infants (days of phototherapy not mentioned), whereas the latter describes the sample size as 560 treatment days. Neither affects the assessment that there is lack of

clarity for information provided on the number of infants in the safety analysis [3]. It is important to note that this criterion has to be evaluated in trials for each outcome.

5. What can we learn (and apply) from this trial? Filtered sunlight could be efficacious for mild(er) neonatal jaundice (recall that the threshold was 3 mg/dL lower than standard practice) and can be used if (i) intensive monitoring is performed (as in the trial) and (ii) adequate backup phototherapy units are available (as about 1 in 7 babies would require phototherapy). Unfortunately, the trial does not explore whether we can predict which babies will require phototherapy, making it necessary to have back-up arrangements.

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Is Newborn Hearing Screening Worthwhile in India?

We congratulate and appreciate Dr Paul for setting up a newborn hearing screening program in Kerala, and reporting about it [1]. If it has to be replicated in other areas of the country a few more details are needed. Is the charge of Rs 150 per child, a one-time payment, and does it cover repeat tests in those who need it. Was the program supported by any grant?

The author had screened 1,01,688 babies, out of which 15123 failed the first test and of these 1,634 babies failed the second screen. Finally, deafness was diagnosed in 162. Assuming no further charges were made for repeat

tests, the cost of detecting one case of deafness works out to be approximately Rs. 100,000. In addition, unnecessary anxiety may be caused to 15% of the mothers who were informed that their child had failed the hearing test initially.

Only profound hearing defects are picked up by these screening tests. The author states that hearing loss must be detected before 6 months of age. Most mothers would easily pick up the cues of lack of responsiveness to sound before the child reaches the age of 6 months. One wonders if this screen is really useful and cost-effective in India.

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Author's Reply

1. Charge of Rs. 150/- per child is a one-time payment and covers repeat testings. Program was not supported by any grant.
2. The Cochin model of Universal Newborn Hearing Screening (UNHS) is a huge social investment for early detection and intervention. The social, emotional and physical cost of the 162 cases of deafness detected cannot be quantified just with money. The screening has a futuristic and prophylactic utility; it creates awareness for the future among the profession and the lay public to look out for possibility of hearing impairment. By paying Rs.150/-, screen negative parents are happy that their child has normal hearing and screen-positive parents are relieved their child's problem is detected early for effective management.
3. Surveys have shown that 14% mothers reported anxiety to a positive screen [1]. It is also reported that regardless of anxiety, 90% of all respondents were glad that their children had a hearing test and thought that universal hearing screening was a good idea [2]. We reiterate to the parents that the next level of

testing is undertaken to rule out for good if there is hearing impairment or not. It is soothing for most parents. Therefore, the anxiety is only similar to any other screening tool that is used in medicine.

4. Screening tests pick up hearing loss up to 30-35 db and not profound hearing loss.
5. It is unreasonable to claim that most mothers pick up deafness in children before the age of 6 months on their own. Responses to conventional sound cues are crude and non-standardized and should never be resorted to, when we have better, non-invasive standardized procedures.

Considering all these, the apprehension that the tool is not cost-effective in India does not stand to reason. The usefulness and cost-effectiveness of Newborn Hearing Screening procedure prompted the Ministry of Health and Family Welfare, Government of India to include Newborn Hearing Screening in 'Rashtriya Bal Suraksha Karyakaram' 2013.

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Year of Mnemonics and Acronyms

The President of Indian Academy of Pediatrics (IAP) Dr Pramod Jog, in his Presidential Address [1], conveys a plethora of messages and advice. His inimitable style, employing mnemonics and coining acronyms, is attractive and amusing, but the messages (like many others in the past) may soon be forgotten. As examples, I refer to "comprehensive child care" (CCC) from 1996, which regularly appeared on IAP's paper mail, and "Avoid Antibiotic Abuse" (AAA), suggested more recently. The former (CCC) was adopted to emphasize that the practice of Pediatrics should not be confined just to treating sick children and carrying out preventive measures, but also addressing various problems of the underprivileged children in the community. The IAPCANCL (Child Abuse

& Neglect & Child Labor) Group was eventually established. Its members have worked and advocated on behalf of needy children. Unfortunately, the CANCL group has received very little support from the IAP. A plea to IAP Branches and even a group of members to adopt a village, for a number of activities, would be a most valuable contribution. Individual members can surely devote two hours or more per week to work for the society. Pediatricians are the largest antibiotic abusers, prescribing these drugs for diarrhea and upper respiratory infections. AAA must be vigorously advanced.

The President rightly observes that practitioners are very busy with clinical care and have very little energy left for research work. However, his advice to them to write case-reports is likely to prove very difficult to follow. Even if one is able to write a case-report, hopefully not in the style of the publication being cited [1], it would have a slim