

was given every  $\geq 2$  minutes if sedation goal was not achieved [3].

- (v) If midazolam was being used for sedation as mentioned above, then it is difficult to rely on the results because the time to achieve sedation and recovery would have also been affected by midazolam. Applying a regression analysis in the outcome variables would have been more justified [4].

*Funding:* None; *Competing interests:* None stated.

**GAURAV GAUTAM AND DAISY KHERA\***

*Department of Pediatrics,  
All India Institute of Medical Sciences,  
Jodhpur, Rajasthan, India.  
\*daisykhera78@gmail.com*

## REFERENCES

1. Gunathilaka PK, Jat KR, Sankar J, Lodha R, Kabra SK. Propofol versus fentanyl for sedation in pediatric bronchoscopy: A randomized controlled trial. *Indian Pediatr.* 2019;56:1011-6.
2. Horn E, Nesbit SA. Pharmacology and pharmacokinetics of sedatives and analgesics. *Gastrointest Endosc Clin N Am.* 2004;14:247-68.
3. Wang Z, Hu Z, Dai T. The comparison of propofol and midazolam for bronchoscopy: A meta-analysis of randomized controlled studies. *Medicine (Baltimore).* 2018;97:e12229.
4. Schneider A, Hommel G, Blettner M. Linear regression analysis: Part 14 of a series on evaluation of scientific publications. *Deutsches Ärzteblatt International.* 2010;107:776.

## Authors' Reply

We thank the readers for their interest in our article [1]. The authors have pointed out few issues; most of these were already addressed in the article. Following are our responses to the points highlighted [2].

- (i) We have mentioned various aspects of conduct of the trial in detail in the study methods. The limitation of the study being an open label study have been clearly mentioned in the discussion. For an open label study, we took various measures to reduce the risk of bias. However, to take care of the bias better, a blinded study - a double dummy design - would have to be performed. To reduce the bias, regarding cough score, secretion score, bronchoscopist and an independent observer assigned the scores independently (these details were mentioned in the manuscript).
- (ii) The mean and standard deviation values for oxygen saturation are correct. A standard deviation of 1.5 or

1.4 when mean value is 99.1 does not mean that some values were more than 100; this is a common misconception. The standard deviation is one of the measures of dispersion. For baseline saturation, the maximum value was 100% in both arms while the lowest values were 94% and 95% in the propofol and fentanyl arms, respectively; this suggests that there was a skew to left. The median (IQR) values were 100% (98%, 100%) and 100% (98%, 100%), respectively in the propofol and fentanyl arms.

- (iii) We have clearly highlighted the indications for use of midazolam in the methods. After the initial 180 seconds, there was another indication "In addition, midazolam was administered at a dose of 0.1 mg/kg (maximum dose of 5 mg) bolus at a time up to maximum of two doses, for those who had inadequate sedation to continue procedure irrespective of the arm [1]". The time to achieve adequate sedation was 15.7 (4.4) seconds in propofol group and no child received midazolam initially; however, 11 children received midazolam later during the conduct of the procedure in the propofol group for the above-mentioned indication.
- (iv) We agree with the details of midazolam provided by the authors. The frequency of administration of midazolam doses in our study is supported by the range of time of onset of action. We used the same protocol of administration of midazolam in the two arms of our study.
- (v) In the propofol group, no child needed midazolam to achieve appropriate sedation within first 180 seconds; some of them had to be administered midazolam later to maintain sedation for the overall procedure. Therefore, the superiority of propofol over fentanyl for the primary outcome is unlikely to be affected by adjusting for midazolam usage.

**RAKESH LODHA AND SK KABRA\***

*Department of Pediatrics,  
All India Institute of Medical Sciences,  
New Delhi, India.  
\*skkabra@hotmail.com*

## REFERENCES

1. Gunathilaka PKG, Jat KR, Sankar J, Lodha R, Kabra SK. Propofol versus fentanyl for sedation in pediatric bronchoscopy: A randomized controlled trial. *Indian Pediatr.* 2019;56:1011-6.
2. Gautam G, Khera AD. Sedation in pediatric bronchoscopy: Propofol versus fentanyl. *Indian Pediatr.* 2020;57:479-80