Table I Comparison of Primary and Secondary Outcomes as per Appropriateness for Gestational Age

Outcomes	*Two-hourly group (n=110)*	*Three-hourly group (n=99)*
Appropriate for gestational age		
Time to reach full enteral feeds (n=100)[a]	5.27 (1.73)	4.90 (1.17)
Hypoglycemia	4 (3.64)	3 (2.97)
Episodes of feed intolerance	8 (7.27)	5 (5.1)
Necrotising enterocolitis	0	2 (1.98)
Small for gestational age		
Time to reach full enteral feeds (d)[a]	5 (1.49)	5.36 (2.09)
Hypoglycemia	2 (3.08)	4 (5.41)
Episodes of feed intolerance	5 (7.69)	7 (9.46)
Necrotising enterocolitis	4 (6.15)	3 (4.05)

Values in no. (%) except [a]mean (SD). All P values >0.05.

trial to growth restricted neonates which are considered at higher risk for adverse outcomes. The SGA neonates were overall at significantly higher risk for NEC (7 vs 2; *P*-0.016) as compared to appropriate for gestational age, irrespective of feeding schedule.

iii) We agree with the point raised over excluding neonates with absent or reversed end diastolic flow (A/REDF). However, at the time of commencement of the study (2017) our unit policy was withholding feeds for first 24 hours and thereafter slow advancement of feeds (10-20 mL/kg/day) in neonates with A/REDF [2]. For the index study we planned rapid advancement of feeds (30 mL/kg/day) for all enrolled infants and the team was worried over the rapid advancement of feeds in A/REDF population. Therefore, inclusion of neonates with A/REDF would have either led to deviation from the protocol. Also, as of now, three-hourly feeding is not a standard of care. Therefore, to ensure uniformity in study protocol and to ensure safety we excluded neonates with A/REDF. We are also aware of the Cochrane review published in 2017 (after commencement of our study) showing no evidence of increase in NEC with rapid advancement of feed in these neonates [3].

iv) We agree that it is an important outcome. However, we did not objectively record this data.

v) None of the neonates in the study received probiotics.

vi) Due to high volume of admissions and rapid turnover we did not record time to reach full oral feeds and the duration of the transition in neonates who were on tube feeds at enrolment. However, as per our policy the spoon feeds are started at 31 weeks of postmenstrual age.

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Artificial Intelligence in Medical Education

Artificial Intelligence (AI) is bringing a great transformation in all spheres of life including healthcare sector. Recent work has proved that AI techniques have a great potential in making healthcare facilities affordable and easily accessible [1]. AI promises early diagnosis of diseases, improved patient care and facilitating continuous monitoring of patients. However, for an optimized use of AI for healthcare, doctors and AI experts need to collaborate. Thus, it is desirable that medical graduates have a good understanding of data science and AI techniques, they are going to need to handle it in the near future.

Researchers have developed powerful high-performance AI tools in healthcare to predict the occurrence of many chronic diseases like cancers, diabetes, etc. [2]. Many AI tools have already been approved by regulatory authorities to diagnose diseases, and are being used in primary healthcare centres of rural areas in developed countries like USA [3]. As the healthcare policy-makers are looking forward to amalgamating AI in healthcare sector, it is high time that medical education curriculum be updated to include formal education of emerging medical professionals in this technology. Introduction of AI in medical education curriculum has previously also been suggested [4]. Curriculum should be focussed on AI literacy rather than expertise. AI researchers/data scientists may act as resource persons to conduct faculty development programs in AI for medical faculty. The subject must be taught making sure that complex mathematics is avoided, and the concepts are explained in an easy way. For the medical students, emphasis should be laid on population health and evidence-based medicine. Clinicians should have a formal training of using AI tools to spot anomalies, forecast patterns from medical data and make decisions. Medical students may be provided with an opportunity to see and observe simple concepts of data mining working with small data science projects to enable them to use AI techniques to get meaningful information from data.

There is a pressing need to build an ecosystem where AI experts, data scientists and medical practitioners collaborate to ensure optimal utilization of AI in healthcare sector. For this to happen, it is desirable to orient medical student of today to AI to enable him to use the same tomorrow.

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Cerebral Abscess: A Delayed Complication of Electrical Burns

A 6-year-old boy suffered electrical injury when his head accidentally came in contact with a loose electrical wire of a room cooler. The child lost consciousness transiently and presented with burns on the scalp to a local practitioner. The entry and exit wounds were noticed in the parieto-temporal areas on the right and left sides of the scalp, respectively. Neuroimaging revealed tiny hemorrhagic contusions in the right frontal and parietal areas. Child received oral antibiotics and daily dressing. Two months later, the child presented to us with fever and left-sided focal seizures of one day duration, along with history of episodic irrelevant talking and shouting during the preceding two days. On examination, the child was conscious, with weakness in the left upper limb and left-sided supranuclear facial nerve palsy. The deep tendon reflexes were brisk with bilateral extensor plantar reflexes. The child did not have any signs suggestive of meningeal irritation and there was no papilledema. The laboratory investigations were unremarkable. Magnetic resonance imaging of the brain revealed an ill-defined lesion (38 × 27 × 36 mm) with peripheral blooming in the right frontoparietal lobe with significant perilesional edema, associated with peripheral enhancement of the lesion with associated patchy leptomeningeal enhancement. Focal calvarial thinning was seen in the left posterior high parietal region. A possibility of right cerebral abscess with associated cerebritis and meningitis was kept. The child was treated with intravenous ceftriaxone, vancomycin and metronidazole along with intravenous phenytoin and mannitol. The child had repeated uncontrolled seizures and died within 24 hours, before neurosurgical intervention could be done.

The presentation of electrical injuries in children can be unique as these may involve uncommon sites and the severity may be greater as the percentage of fat may be lesser as also the different surface area to volume ratios compared to adults [2]. Low voltage circuits seen in domestic settings are usually less damaging; however, alternating current is more injurious than direct current. Blood vessels and brain tissue, due to the high fat content, are more vulnerable to thermal effects of current [3]. Previously, electric burn of skull in association with cerebral contusion and intracranial infection was reported in a patient who had a successful outcome following timely surgical intervention [4]. Unfortunately, neurosurgical intervention could not be undertaken in this child due to delayed presentation in the hospital.

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