

Second, outcome as well as complications of CPAP will also depend on flow rate and peak end expiratory pressure (PEEP). Authors have not mentioned about flow rate and PEEP in their study [4].

Third, authors have used Silverman-Andersen score – that is primarily used to assess respiratory distress in premature baby – and Modified Pediatric Society of New Zealand Severity Score. These scores have not been validated as an outcome measure in infant with bronchiolitis [5].

Finally, the information about weight, length and Z-scores are missing, which are important baseline characteristics. In table II, the value of standard deviation are greater than the mean value. It will be better if these data would have been presented as median and interquartile range.

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Nasal Continuous Positive Airway Pressure for Bronchiolitis

In the January 2018 issue of *Indian Pediatrics*, Lal, *et al.* [1] reported that nasal continuous positive airway pressure (nCPAP) helped to reduce respiratory distress significantly compared to standard care in infants. We have certain queries and comments:

Bronchiolitis is a dynamic disease which requires frequent monitoring and management accordingly [2]. So, why did the author choose to see the effect of CPAP on

children with bronchiolitis for initial first hour only? Improvement in first hour of admission does not prove the long-term efficacy of the modality. As bronchiolitis has become a major cause of morbidity and bed occupancy in our setting, it would have been very informative had they reported on the effect of CPAP on treatment outcomes like requirement of mechanical ventilation and duration of hospital stay.

Authors have used two scoring systems, Silverman-Anderson Score and Modified Pediatric Society of New Zealand Severity Score, for assessing their secondary outcome. Silverman-Anderson scoring system is mainly used for monitoring respiratory distress in preterm neonates [3]. Though they have used an intention-to-treat analysis, changes in respiratory rate have been compared only in those children who completed the study. The pressures and the type of interface used for the CPAP has not been mentioned. All of these above-mentioned factors make the generalizability of the study doubtful in our set up.

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AUTHORS' REPLY

Using CPAP for Bronchiolitis

The main point of criticism of our study [1] by all these readers is that we assessed only for benefits over the first hour of admission. This is a valid point. The reason for such protocol was the ethical issue. Theoretically, it was not logical to use CPAP (that increases dead space [2]) to treat a condition like bronchiolitis, which is characterized by air trapping [3]. This is why we decided to study this modality for the first hour, while we closely monitored the child, ready to switch to more conventional modalities if the baby's distress increased. Most babies did well on CPAP, and this was continued after the 1-hour study period, but the protocol was to study distress (improvement or