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CORRESPONDENCE

Ventilator-Associated Pneumonia in Pediatric Intensive Care Unit: Correspondence

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To the Editor : We thank Gnanaguru et al. for their informative editorial commentary based on our recent article entitled "Study of ventilator-associated pneumonia in a Pediatric Intensive Care Unit" published in the Indian Journal of Pediatrics [1, 2]. However, we wish to clarify on certain issues raised in the editorial commentary and place on record our point of view.

The editorial commentary states that the diagnosis of ventilator-associated pneumonia (VAP) was based on microbiological confirmation in our original study. This interpretation/ reading of our manuscript is completely erroneous. Also, as stated in the editorial commentary, the interpretation that our incidence of VAP was less (than other Indian studies) because of the use of microbiological criteria as mandatory in the diagnosis of VAP is also incorrect. As stated in the methods section of our manuscript, we strictly used the Center for Disease Control and Prevention—CDC / NNIS criteria for the diagnosis of 15 episodes on VAP in our study (the CDC / NNIS criteria have been given in the appendix of our original paper) [2]. The microbiological data on the culture of endotracheal aspirates (ETA) was just given as an additional information but was not used by us to mandatorily diagnose VAP. We agree with the editorial commentary that the endotracheal aspirates (ETA) may not truly reflect the organisms causing VAP [1, 2]. This is also corroborated by the fact that ETA were positive in 8 out of 15 episodes of VAP and were also positive in patients without VAP (21 cultures positive) in our study (please see Table 2 of our study) [2]. Thus we wish to strongly refute the statement from the editorial commentary that ETA was the method used by us in the diagnosis of VAP. We used only the CDC/ NNIS criteria (clinical and radiological) for the diagnosis of VAP in our study [2]. Our inability to use bronchoalveolar lavage or protected specimen brush technique for the microbiological diagnosis has already been mentioned in our manuscript. [2]

The commentary states that we should have given the details of ICU staffing, disinfection routines and use of bundles [1]. The staffing pattern and infrastructure was a part of the initial draft of our manuscript, but was felt to be un-necessary during the review process and hence was deleted (as per the wish of the reviewers). We take this opportunity to give details about the same. Our nine bedded tertiary care, well equipped Pediatric ICU (total admissions about 500–600 per year) is supervised by three senior doctors/faculty (Professor, Associate Professor and Assistant Professor- one each) and assisted by two intensive care fellows. It is manned by postgraduate students (about 11 resident medical officers divided in rotation duties round the clock). An on-call Assistant Professor is available for emergency consultations after office hours. The intensive care fellows (post MD/DNB) are replaced every year and resident medical doctors are rotated every 3 mo. There are only five staff nurses divided in rotation duties round the clock (for nursing duties), one sister-in-charge and one senior day nurse (both performing mainly administrative duties). Regarding the disinfection routines, disposable breathing/ ventilator circuits and disposable HME filters were used during the study period. VAP bundles were not used in our study.

Finally, we agree with the conclusion by Gnanaguru et al. that more studies are needed to evaluate the interventions for reducing incidence of VAP and formulate guidelines for the

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treatment [1]. We felt the necessity to point out these facts so that our article [2] and the editorial [1] on the same is read in proper context.

Conflict of Interest None.

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References

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