Author's Reply

We thank the reader for the interest shown in our paper.[1] Even after excluding the babies born between October to December 2000, the incidence of overall EOS and culture positive sepsis for 12 months has remained the same (EIS overall: 20.7 *vs* 20.3/1000 LB, and culture positive sepsis: 8.6 *v/s* 9.1/1000 LB.) We agree that infant risk factors studied are not exclusively for sepsis; but in fact no disease condition in the neonate has exclusive signs and symptoms. Unless one conducts sepsis screen and starts on antibiotics pending culture at the earliest suspicion, one may lose the infant. None of these symptomatic infants actually had sepsis work-up immediately after birth, but were done later (within 72 hours), as clinically they were suspected to have sepsis.

The incidence of early onset sepsis in the maternal risk factor negative group (8 out of 1607) was only 0.5% overall and 3 out of 1607 (0.2%) for culture positive cases, irrespective of prematurity, asphyxia and VLBW and not 22% as per the comment. This is significantly different from the incidence of 20.6% in EOS and 9% in culture positive infants with maternal risk factors. Therefore, it is not justified to do a sepsis work-up for 500 newborns without maternal risk factors in order to diagnose one infant (0.2%) who is likely to develop culture positive EOS. In case, one does not start antibiotics in any baby, the one baby who is likely to have benefited from the antibiotic therapy is anyway going to become symptomatic even before culture reports are available. It seems to be a waste of resources, both material and manpower, which our country can ill-afford and also does not seem ethical from the point of view of the neonates. However, in those with maternal risk factors, since 1 in 5 are going to develop EOS, both screening and antibiotics are warranted in which case antibiotics are stopped after 48 hours in culture negative cases.

Although case fatality was 19.4% in EOS compared to 13.3% in culture positive EOS, the difference was not statistically significant. Besides, among EOS infants, incidentally there were more number with complications such as NEC, although culture was negative. Hence we cannot conclude that the cause of death was unrelated to sepsis; in fact it was definitely related to sepsis.

Although neonatal factors such as prematurity and VLBW operate from birth, it seems illogical to do early sepsis screen to rule out a late onset sepsis. A high index of suspicion is required to rule out LOS. In fact, among 6 infants who had screening for EOS and who later developed LOS in 5/6 (83%), the cultures were negative in the initial screening.

In conclusion, we would like to underscore the fact that in asymptomatic infants, screening for EOS is warranted only in the presence of maternal risk factors. Of course, it is standard practice to perform sepsis work-up in suspected cases of sepsis.

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