Hyaline membrane disease was confirmed on autopsy study [3]. In another epidemiological study, the single most important factor contributing to the mortality was respiratory distress (29.3%) followed by sepsis (24.4%) and birth asphyxia (16.2%) [4].

3. Inclusion criteria for hyaline membrane disease need to be specified. Usual criteria adopted is clinical and radiographic diagnosis of RDS, requiring mechanical ventilation and $FiO_2 > 0.3$. The reason for variation in reporting RDS is highlighted by the fact that there is no uniform protocol for diagnosis as has been well brought out by the authors in their introductory comments.

4. The study has been designed in the format of a descriptive cross sectional one. This design gives an idea of prevalence of disease and not incidence. To be scientifically correct, such study should define the population from whom the study sample will be selected, period of study, methodology of selection of study sample,

define the disease to be studied and lay down the diagnostic criteria.

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Reply

Dear Editor,

This refers on observation made in Letter to Editor in reference to the article titled "Incidence and Etiology of Respiratory Distress in New Born".

1. The clinical diagnosis of respiratory distress in new born was made by using criteria described in standard pediatric pulmonology text book [1] and Downe score is used for facilitating the clinical diagnosis of respiratory failure and not respiratory distress as such [2].

2. Aim of our study was to determine the etiological factors in respiratory distress in newborn, especially the incidence of hyaline membrane disease and not treatment modalities or their efficacy.

3. Standard inclusion criteria for all the etiological factors of

respiratory distress in newborn have been used in our study, however the same were not mentioned in material and methods because of space constraints.

4. Our study design gives an idea of incidence and not prevalence of respiratory distress in newborn as defined in standard textbook [3].

References

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DESIGN MODIFICATION OF THE BACKREST OF HOSPITAL BEDS IN THE ARMED FORCES : A PROPOSAL

Dear Editor,

The basic hospital bed (ordinance stores) is an iron/alloy based structure. The head end has an adjustable backrest, which is adjustable both in the vertical plane as well as the angle of inclination.

There is essentially no design flaw in the backrest. However, the beds are painted white from one end to other in preparation for staff visits/inspections. Over a period of time, because of the white paint the backrest refuses to adjust in all the desirable places, even the screw for tightening does not work. All this (done in the good spirit of making the bed look as 'White' as possible) leads to the not so recommendable uncommon sight and uncomfortable for the patients - the u/s backrest, with a propensity to dangle at difficult angles.

Despite being a witness to so many of these in the SSQs and have worked all these years, the impact of an u/s backrest had not affected me. It took the admission of my daughter to a tertiary care hospital

for me to realise that the discomfort a patient had to undergo with such a backrest and a simple design modification could provide a very simple practical solution to this problem.

Making the adjustable/sliding rod of pure stainless steel, instead of cast iron at present will serve two purposes :-

(a) It will not need to be re-painted as the steel would always remain 'stainless' and presentable.

(b) It will have the same strength as the cast iron.

The other design modification is to do away with the use of screws to fix the backrest at appropriate angles. Appropriate slots can be made on both the sliding rod as well as the 'back' portion of the backrest with steel hooks provided to lock in.

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