immune response plays a fundamental role in the evolution to distress. (3) The role that immunomodulators could play in therapy acquires more relevance, such as phosphodiesterase inhibitors (i.e. pentoxifylline), due to their activity-decreasing pro-inflammatory cytokines (7), or inhaled corticoids, aimed at exerting a local immunomodulation. The misuse of systemic glucocorticoids and antibiotics in SARS has lead to secondary infections, pathological fractures and avascular necrosis. Teophylline and Nedocromil sodium are drugs capable of preventing inflammatory cell recruitment into the airway wall. An early instauration of an immunomodulatory therapy guided for the levels of proinflammatory cytokines could aid in preventing the instauration of respiratory distress. (4) The design of vaccines should avoid those SARS coronavirus antigens that could lead to an immune-mediated inflammatory damage. (5) The animals used to test any vaccine have to be adults. If they are too young, it would be logical to find no adverse effects. (6) Paediatricians should be aware of mild symptomatic children who could transmit the virus to close adult contacts (patients with a more severe course), and confirm any case suspicious of SARS. In conclusion, children present particular features that could aid our understanding of adult SARS.

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CORRESPONDENCE SECTION

How reliable is clinical assessment in neonatal jaundice?

Dear Sir,

We have read with great interest the article by Riskin et al. (1), which appeared in a recent issue of the journal. The authors have investigated the value of eye measurement (so-called “Bili Eye”) in predicting the serum total bilirubin levels in 283 healthy term newborns at 63.8 ± 21.6 h of life. They have reported a very significant positive correlation between bilirubin clinical assessments (8.8 ± 2.3 mg/dl) and serum total bilirubin (STB) levels (8.8 ± 2.4 mg/dl), although the 95% CI of the observers’ mean estimations is not zero despite such sensitive assessments. We have some comments about the methodology and conclusions of the study.

Although it is stated that there were intra- and inter-observer variations in estimations of bilirubin, we cannot observe these variations in each physician’s assessments. Further, there seem to be no significant differences between inter-observer estimations (r-values between 0.622 and 0.795). If the primary aim of the study was to bring alternatives to use hour-specific nomograms (2–4), then it should be strictly and statistically defined how experienced and how well trained a clinical neonatal practitioner should be, to use or to have a “Bili Eye”. And, finally, how could the authors conclude that “using this method STB levels need to be measured only in significantly jaundiced babies” while they did not compare newborns with and without significant hyperbilirubinaemia? However, we wonder, and one might easily conclude that the value of “Bili Eye” remains to be determined in significantly jaundiced newborns (with STB levels of ≥12–13 mg/dl), considering the absence of any significant correlation even between zone-to-zone clinical assessment and STB levels of ≥12 mg/dl (5). The efficacy of “Bili Eye”
in predicting the future development of significant hyperbilirubinaemia rather than using hour-specific bilirubin nomograms may be another aspect that would further be investigated.

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Reply to Sarici et al.

Dear Sir,

We have read with great interest the letter of Dr S. Umit Sarici, Dr Göknuş Candemir and Dr Faruk Alpay, and thank them for their comments. Their interest in the subject of clinical estimation of neonatal jaundice shows how important the discussion is about clinical diagnosis of jaundice. We appreciate the place that the journal Acta Paediatrica kindly provided for our manuscript and this important following discussion about the subject.

We would like to clarify the issue of intra- and inter-observer variations in estimations of bilirubin. Intra-observer variations, i.e. comparison of estimations for the same physician checking the same baby at different times, and inter-observer variations, i.e. comparison of estimations of several physicians estimating the same baby at the same time, were done. These data were not presented in the manuscript, since we had only a limited number of observations because of the way this study was designed (please refer to the Methods section in our article). However, even from these limited observations, we could have noted that the issue of intra- and inter-observer variations needs further attention, as we stated in the Discussion section. The r-values (Pearson correlation coefficients) found for the four participating physicians are indeed not very different, but are important as they reflect different levels of accuracy in the estimation of clinical jaundice compared to the serum total bilirubin (STB) measured in the lab. These differences may stem from experience and training, but may also reflect different levels of physiological sensitivity of the eye to colour, which definitely exist between different humans. The important point is that, in spite of these differences, all could give relatively accurate estimations of clinical jaundice with acceptably good r-values.

As for the clinical experience of the four participating neonatologists, all were very well trained with 10–25 y of clinical experience in paediatrics in general, and neonatology specifically. As stated in the Discussion, in such a preliminary study we desired to check the best optimal settings for clinical estimation of jaundice, which also includes the most trained physicians. However, further studies are needed in order to consider the clinical ability of other health care providers to estimate clinical jaundice in newborns. Previous studies have shown encouraging results (1, 2), especially if training was provided. Our results should encourage us to further study this subject.

Our primary aim was by no means to look for an alternative to the use of hour-specific nomograms (3). This work of Bhutani et al. has provided us with valuable data on the predictive value of pre-discharge STB levels for subsequent clinically significant neonatal hyperbilirubinaemia. We also want to stress again the importance of other contributors to the clinical evaluation of jaundice, especially risk factors like SIB with significant neonatal jaundice, ABO incompatibility or glucose-6-phosphate dehydrogenase deficiency. What we have been trying to show was that clinical assessment of jaundice could substitute the initial step of Bhutani’s approach. Instead of universal routine sampling of pre-discharge STB levels of all newborns, which is time and cost consuming, one could use clinical estimation of jaundice in all, and selective pre-discharge sampling of STB levels only in those who appear jaundiced. In a previous work (4), we have also shown that trained physicians had good ability to