Scoring systems in the intensive care units (ICUs) allow assessment of the severity of disease and predicting mortality. They also help in allocation of resources and benchmarking performance when compared to other units and hence to development of skills within a unit. Several scores are used with good correlation and validity. The choice often lies in ease of calculation and applicability and the number of parameters required for the scoring system. Geographical preferences also play a role. The pediatric logistic organ dysfunction scoring system (PELOD) score was developed in France in 19991 and updated to PELOD 2 in 2013 by the original authors2 and is popular there, and the Pediatric Index of Mortality2 (PIM2)3 was devised by Shann’s group in Australia and is used in that subcontinent. Pediatric risk of mortality (PRISM) III4 is probably the most cumbersome but widely used, especially in the American subcontinent.

It is highly unlikely that today a child will die in a pediatric ICU (PICU) without ventilation or inotropes and usually with both. Hence to say that intubated patients have a higher mortality is really irrelevant. What is more startling is the high mortality (17/23 i.e., 74%) attached. So, it is disingenuous to conclude that “Mortality rate increases with increase in PELOD 2 score i.e., higher the PELOD 2 score, higher the mortality.”5 This is exactly what the scoring system is designed to tell you. From a deranged coagulation profile to a background leukemia. They also describe the mortality associated with various systems. This would be a subanalysis of the group and not a commentary on the PELOD system itself.

All scoring systems correlate higher values with morbidity and mortality and that is the very premise on which they are devised, as the worse the values of any parameter, the higher the score value attached. So, it is disingenuous to conclude that “Mortality rate increases with increase in PELOD 2 score i.e., higher the PELOD 2 score, higher the mortality.”5 This is exactly what the scoring system is designed to tell you.
In this comparison of five scoring systems6 (Table 1), where score for each patient was calculated on all scoring systems, it was seen that there was very good correlation among all different systems used. Hence, it probably matters very little what system is used in a unit. What matters is how its interpreted and what the unit does with the data.

Using it as a quality improvement tool internally or by comparing its data with that of similar units nationally and internationally would be important. Predicting mortality as an end point in itself has very little meaning. We neither counsel the family based on the score and nor should we allow the score to guide our attitude toward further management lest a poor prognostic score should lead to a laxity in attitude and a self-fulfilling prophesy. This study would therefore have had greater meaning had it defined to what purpose the scoring was being done, as simple validation of the PELOD 2 score adds no new finding to the literature.

In conclusion, in PICUs in India, we should use standard scoring systems and preferably we should, as a body, agree upon one system so that we can pool and compare data and use the data for research and quality improvement.

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