

Response to comment on “Impact of expansion of telemedicine screening for retinopathy of prematurity in India”

We thank the authors query on our article.^[1,2] Our aim was to impress upon our readers the impact of expansion of our current tele-retinopathy of prematurity (ROP) model in Karnataka, to other states where ROP either already is, or expected to become, a major public health problem.

However, as is evident, these are mere estimations. The only true index we have for this estimation is the ongoing KIDROP dataset, pooled from previous publications^[3-5] and our experience, which has been used in the manuscript.^[2]

By estimating “survivors” we must suppose that this is the minimum number who will be admitted to the neonatal units after discounting for infant mortality.^[2] In reality, early neonatal mortality rates should have been used. However, reliable figures are unavailable at this time. Furthermore, we first estimated the number who “could be” <2000 g at birth, and then calculated the incidence of “any stage” and “treatment requiring” ROP from this “guesstimate.”^[2]

If these were underestimating the problem as suggested, then in Karnataka, of the 14,153 babies who would survive, approximately 500 infants would require treatment annually, if we use 3.5% as suggested by the author. In the real world experience from KIDROP, we treat 210–250 babies in a year, which is approximately 7% of those with any stage ROP (3169 infants). This measure is closer to our previously published incidence^[3] and this is why we chose to use this method in the manuscript.^[2] Hence, an underestimation as suggested by the author is unlikely.

Only real data from state wide ROP screening operations from these suggested states in the future will decide how local conditions impact variation in disease incidence. Until then, one estimate is as good as another.

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Conflicts of interest

There are no conflicts of interest.

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