

Dr. Ravikumar and Dr. Baranwal highlight a challenge in providing singular recommendations that will be appropriate for a heterogeneous group of children with septic shock treated across a wide array health care settings. Indeed, even a particular health care setting may have access to variable resources over time. This challenge led the panel to acknowledge that because “medical care for children with septic shock and other sepsis-associated organ dysfunction is necessarily carried out within the confines of locally available resources”...the Surviving Sepsis Campaign International Guidelines for the Management of Septic Shock and Sepsis-Associated Organ Dysfunction in Children guidelines will need “translation to treatment algorithms or bundles and standards of care [that] account for variation in the availability of local health care resources” (1).

The highest quality of evidence for fluid bolus therapy in children with features of septic shock comes from the FEAST trial, which demonstrated harm for bolus fluid expansion compared to maintenance fluid therapy in the absence of severe hypotension (2). Although this study was well-conducted and internally valid, the inclusion a specific patient population (e.g., high rates of malaria and anemia and children vulnerable to low plasma oncotic pressure (3, 4)) in one health care setting (with limited to no access to advanced supportive and intensive care) limits generalizability to other children and health care settings. This includes limited generalizability to health care settings in low- or middle-income regions where basic critical care interventions (including monitored fluid bolus, oxygen, inotropes, intubation, hand ventilation and clinical monitoring) can be administered outside of a formal pediatric intensive care unit (PICU). Therefore, we agree with our colleagues that the recommendation against bolus fluid administration while starting maintenance fluids in healthcare systems *with no availability of intensive care and in the absence of hypotension* applies to settings lacking even the basic critical

care capabilities, and not to those where pediatric critical care interventions can be provided outside a formal PICU. It is the ability to locally administer or transfer to access ventilatory and hemodynamic support and close clinical monitoring that defines “availability of intensive care”, not the presence or absence of a formal PICU.

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