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From the authors:

We would like to thank A.W.J. Bossink and colleagues for their comments.

With regard to Epstein–Barr virus (EBV) serostatus, our laboratory has a diagnostic interest in EBV serology and our experience would indicate that for the age ranges in our published study [1] (*i.e.* both patients and controls) there will be 100% seropositivity for EBV. In Northern Ireland (UK), 60% of 10 yr olds are seropositive; in adults, this figure rises to >95% (unpublished data; P.V. Coyle, Regional Virus Laboratory, Belfast Health and Social Care Trust, Belfast, UK; personal communication).

Regarding the possible contamination of sputum samples with EBV DNA present in saliva, we have found that there is good correlation between EBV in lower and upper respiratory tract specimens, which is not consistent with contamination. We and other labs see little evidence of latent EBV when testing whole blood or white blood cells, making the presence of B-cells in sputum unlikely to be a confounding factor.

On the point of PCR being unable to differentiate between DNA derived from active viral replication or latent infection, as we were not detecting latency in B-cells (as previously noted) and as EBV causes a productive infection in epithelial cells, it follows current knowledge [2, 3] that we were measuring active viral replication. This also makes the determination of the number of B-cells in the sputum irrelevant.

The final issue regarding potential dilution of specimens with hypertonic saline is unlikely to be significant as previously published work has shown that induced sputum separated from saliva is similar to lower respiratory secretions expectorated spontaneously [4]. In the setting of our previously published study [1], any dilutional effect was negligible within the context of an assay determining viral load over six logarithms.

We would also like thank W.B. Grant for his comments in relation to vitamin D and chronic obstructive pulmonary disease. These comments raise several interesting points in this area and highlight the need for further prospective studies in this group of patients.

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STATEMENT OF INTEREST

None declared.

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Extensively drug-resistant tuberculosis: is its definition correct?

To the Editors:

Two articles by MIGLIORI and co-workers [1, 2], which recently appeared in the *European Respiratory Journal (ERJ)*, may support the idea that the current definition of extremely drug-resistant tuberculosis (XDR-TB) [3, 4] is not the most adequate.

In recent years, XDR-TB has become a major concern as it leads to incurable TB in a significant proportion of patients [4, 5]. XDR-TB was first defined in March 2006 as multidrug-resistant TB (MDR-TB; resistance to isoniazid and rifampicin) plus resistance to at least three of the six second-line anti-TB drug groups (fluoroquinolones, aminoglycosides, polypeptides,