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Statement of Interest: None declared.

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From the authors:

I wish to thank D.P. Steinfort and co-workers for their correspondence which describes another temporal infectious complication related to endobronchial ultrasound-transbronchial needle aspiration (EBUS-TBNA). New technology integration into current procedures utilised in clinical practice can evolve rapidly, often before thorough understanding of potential limitations and complications can be appreciated and reported. Early EBUS-TBNA experience had been contained within several highly experienced bronchoscopy programmes; however, the technology is spreading rapidly among all levels of academic and community practice worldwide. In 2003, the American College of Chest Physicians recommended 50 supervised procedures to attain competence in EBUS [1]. These recommendations preceded widespread experience with convex probe-EBUS bronchoscopy and did not delineate between convex probe- and radial probe-ultrasound competence. The question remains as to whether the infectious complication risk from EBUS-TBNA will be greater than that reported for regular TBNA. I have concerns that the infection complication rate may prove to be higher with EBUS-TBNA than conventional TBNA as thoracic physicians may not only perform more EBUS-TBNA, but may be more aggressive with their biopsies. As thoracic physicians go forward with this technology, it is important to recognise the possibility of infectious complications and record and report them so, as a medical field, we understand how to avoid these complications and how to identify who may be at greatest risk.

I concur with D.P. Steinfort and co-workers that patients with infectious symptoms following EBUS-TBNA should be evaluated for a possible infectious complication and empiric antibiotics should cover oral and nasopharyngeal organisms given the proposed contamination route. It would have been interesting to confirm the aetiology of the infectious source in the case reported by D.P. Steinfort and co-workers if a naso-oropharyngeal swab or blood cultures would have demonstrated *Streptococcus pneumoniae*. I agree with D.P. Steinfort and co-workers that, at this time, prophylactic antibiotics are not indicated for EBUS-TBNA. The current Infectious Disease Society of America guidelines regarding either surgical or endocarditis antibiotic prophylaxis do not recommend antibiotics unless the respiratory mucosa is to be violated in the setting of a high-risk patient (previous endocarditis, mechanical valve or congenital heart disease) [2, 3]. Two questions arise from this recommendation. First, does TBNA violate the respiratory mucosa as defined in the Infectious Disease Society of America guidelines? Secondly, do endocarditis risk factors alone define high-risk patients in whom EBUS-TBNA is performed? Rather, should high-risk be defined by lesion (cystic or necrotic lesion) or procedural characteristics (repeated passes, extended needle penetration depth)? Ultimately, I do not feel that prophylactic antibiotics will become routine for EBUS-TNBA. By presenting a provocative and controversial topic, I hope to encourage others to report their EBUS-TBNA complications to better ascertain the infection risk of this new technology. Only by relying on diligent reporting of infectious complications (or other complications) by thoracic physicians as general experience with EBUS-TBNA increases will we be able to appreciate what patient- or lesion-specific characteristics might predispose to infection and warrant prophylactic antibiotics consideration in the future.

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