

To the Editors:

We read with interest the article by CHOUDHURY *et al.* [1] in a recent issue of the *European Respiratory Journal*. The authors investigated the reasons for hospital admission in pneumonia patients with a CURB-65 (confusion, urea >7 mmol·L⁻¹, respiratory frequency ≥ 30 breaths·min⁻¹, systolic blood pressure <90 mmHg or diastolic blood pressure ≤ 60 mmHg and age ≥ 65 yrs) score of 0–1, in order to identify the potential for improving outpatient management. However, the conclusion of the study is discordant with the objectives. The authors conclude that their study supports the recommendation from international guidelines that pneumonia severity scores should be used as an adjunct to clinical judgment when determining the need for hospitalisation. However, there are several issues regarding this study that should be mentioned. First, in order to avoid selection bias when recording the causes of admission, a prospective cohort study design should be applied and not a retrospective review by independent reviewers as mentioned by the authors. Secondly, in order to arrive at the authors conclusion that international guidelines should be used as an adjunct to clinical judgment when deciding on hospitalisation, the authors should have *a priori* strict criteria according to the severity of illness (CURB-65) as to which patients with community-acquired pneumonia need to be admitted and which do not. Therefore, strict admission criteria may facilitate the identification of variables that may be important for clinicians at the time of admission, in order to overrule CURB-65. Thirdly, we believe that clinical judgement is not equivalent, generalisable and infallible for every physician caring for patients with pneumonia. As suggested previously, certain physicians are more likely to appropriately manage patients with community-acquired pneumonia compared with others, and this may influence the results of the authors' observations [2, 3]. Finally, we agree with the authors that a prospective cohort design is desirable in order to appropriately address these questions.

P.J. Marcos*, M.I. Restrepo^{#,†,‡,§} and H. Vereza*

*Pulmonary Disease Dept, Complejo Hospitalario Universitario de A Coruña, A Coruña, Spain. #Veterans Evidence-Based Research, Disseminations and Implementation Center (VERDICT), [†]Audie L. Murphy Division, South Texas Veterans Health Care System, [‡]Division of Pulmonary and Critical Care Medicine, and [§]Division of Hospital Medicine, Dept of Medicine, University of Texas Health Science Center at San Antonio, San Antonio, TX, USA.

Correspondence: P.J. Marcos, Servicio de Neumología, Complejo Hospitalario Universitario de A Coruña, A Coruña 15006, Spain. E-mail: pedro.jorge.marcos.rodriguez@sergas.es

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REFERENCES

- 1 Choudhury G, Chalmers JD, Mandal P, *et al.* Physician judgement is a crucial adjunct to pneumonia severity scores in low-risk patients. *Eur Respir J* 2011; 38: 643–648.
- 2 Menendez R, Torres A, Zalacain R, *et al.* Guidelines for the treatment of community-acquired pneumonia: predictors of adherence and outcome. *Am J Respir Crit Care Med* 2005; 172: 757–762.
- 3 Bewick T, Cooper VJ, WS Lim. Does early review by a respiratory physician lead to a shorter length of stay for patients with non-severe community-acquired pneumonia? *Thorax* 2009; 64: 709–712.

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From the authors:

We thank A.M. Collins and co-workers, and P.J. Marcos and co-workers for their interest in our article [1].

It is encouraging to see that similar results were obtained by A.M. Collins and co-workers in their retrospective study. An effective supported home-care scheme for mild community-acquired pneumonia (CAP) would be the way forward.

We also agree with P.J. Marcos and co-workers that our study was only a stepping stone to identifying the pertinent issue of who needs hospital admission in low-risk CURB-65 (confusion, urea >7 mmol·L⁻¹, respiratory frequency ≥ 30 breaths·min⁻¹, systolic blood pressure <90 mmHg or diastolic blood pressure ≤ 60 mmHg and age ≥ 65 yrs) CAP. A prospective study is highly desirable, as this would also help us to devise criteria for early supported home-care discharges in stable patients with mild CAP.

G. Choudhury and A.T. Hill

Respiratory Medicine, Royal Infirmary of Edinburgh, Edinburgh, UK.

Correspondence: G. Choudhury, Respiratory Medicine, Royal Infirmary of Edinburgh, 51 Little France Crescent, Edinburgh EH16 4SA, UK

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REFERENCES

- 1 Choudhury G, Chalmers JD, Mandal P, *et al.* Physician judgement is a crucial adjunct to pneumonia severity scores in low-risk patients. *Eur Respir J* 2011; 38: 643–648.

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