From the authors:

We thank Aggarwal and colleagues for their comments on our article [1]. They raise four important points for discussion. First, that tuberculosis (TB) is a chronic disease, and duration of symptoms is an important factor differentiating tuberculous from non-tuberculous pneumonia. Secondly, that in India a large proportion of the population is infected with TB, thus making prior exposure to TB of questionable relevance as a risk factor. Thirdly, that absence of risk factors should not mean exclusion of TB. They suggest that patients with pneumonia should have a sputum test for acid-fast bacilli, even in the absence of risk factors, in areas of high burden of TB. Fourthly, that more prospective research is needed from TB endemic countries.

In regards to the first point, it is true that tuberculous pneumonia typically presents as a chronic process. However, it can definitely present as an acute disease. In a systematic review, the mean time from the onset of symptoms to healthcare presentation ranged from 4.9 days to 162 days across different studies; the pooled average time was 31.7 days in low- and middle-income countries [2]. We think that disease duration is an important factor to account for. In patients with respiratory symptoms for more than 3 weeks, the investigation for TB is absolutely recommended. In patients with an acute presentation, perhaps the use of a clinical predictive model will aid in suspecting the diagnosis.

In regards to the second point, the assumption that the composite variable prior history of TB/recent exposure to TB/history of positive purified protein derivative is of no relevance in countries with high TB burden may not necessarily hold true. Furthermore, the variable is part of a model and is not to be used individually for decision making.

In regards to the third point, while absence of risk factors does not exclude TB, it makes it less likely. As with any diagnostic test, the model needs to be interpreted in the context of the disease prevalence [3]. The positive predictive value of a model tends to be higher, and the negative predictive value, lower, in areas with high disease prevalence.

In regards to the last point, we agree that more prospective studies from TB endemic countries are needed and we welcome collaborations in this endeavour. Once again, we would like to thank Aggarwal and colleagues for their thoughtful comments regarding our manuscript.

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Addressing comments on risk factors for TB in CAP <http://ow.ly/thaoQ>

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