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From the authors:

We thank Ernesto Crisafulli, Mónica Guerrero, Alfredo Chetta and Antoni Torres for their differentiated perspective on the topic of hospital readmission of chronic obstructive pulmonary disease (COPD).

We agree that hospital readmission is a complex surrogate parameter whereby the short period after dismissal is related to a fragile health condition of the patient. The close correlation of readmission to increased mortality is another indicator of this vulnerable condition of the COPD patient, following acute exacerbation.

The pilot project of the European audit analysed only readmissions of the COPD patients due to respiratory reasons, in order to assess the risk related to the original hospital admitted exacerbation. This was also very well described in the data by HURST *et al.* [1], who demonstrated that the first exacerbation is followed by a second in nearly one-third of patients within 8 weeks. Moreover, we found a correlation of the readmission rate and the severity of respiratory failure during the first admission and in line with other publications, a consecutive increase in mortality after readmission [2–4]. GUERRERO *et al.* [5] reported a correlation with hypercapnia but not with the rate of ventilatory support, not even with admission to intensive care units. This is opposite to our study, which relates the risk of readmission to the severity of the exacerbation (respiratory acidosis, need of ventilation) and not only to disease severity. The need for ventilatory support is an expression of reduced ventilatory capacity in the acute situation and we know that muscle fatigue and overload in accordance with systemic corticosteroids have a potential for critical illness myopathy or neuropathy [6, 7]. Therefore, in the short course after exacerbation ventilatory support was identified as an indicator of an instable condition and a risk factor for readmission.

Due to the observational character of the European COPD Audit study we are not able to predict the potential for the prevention of readmission or death by a single measure of care. However we observed a huge variation of care within each participating country and between countries according to the treatment of acute respiratory failure and the referral to rehabilitation after discharge. The analysis of the level of adherence to management recommendations of acute exacerbation of COPD showed a disappointing result of only 15% of accordance with suggested standard procedures [8]. These findings mirror the ignorance towards the challenge of acute exacerbation of COPD on admission as well as a passive attitude towards ongoing COPD management after discharge. The complexity of COPD exacerbation and of COPD patients overall should not result in reduced treatment approaches.

Therefore, we think that it is high time to accept hospital admitted acute COPD-exacerbation as a risk profile that needs a strict acute care programme and a secured follow-up management starting with post-acute rehabilitation including noninvasive ventilation and long-term oxygen therapy for according patients.

Complexity management is requested as a holistic approach in knowledge-management driven programmes, according to the combination of each single evidence-based intervention that may be suitable to the patients' risk profile as suggested by KIRSCHNER *et al.* [9].

The assessment of quality of care is a powerful tool to monitor the changes in management and promote the discussion of care models. MCCARTHY *et al.* [10] showed a successful implementation of an improved COPD management at the emergency department after identification of weaknesses. The pilot of The European Audit intends to be a start for such activities.



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It is high time for a holistic approach to COPD exacerbation including each suitable intervention to the risk profile <http://ow.ly/iUok300hb8V>

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European idiopathic pulmonary fibrosis Patient Charter: a missed opportunity



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To the Editor:

The European charter for idiopathic pulmonary fibrosis is a welcome document [1], highlighting unmet needs in patients which will inform policy makers across Europe. However, it is sad that an important opportunity to involve children with interstitial lung diseases (ILDs) has been missed. There is a current pan-European paediatric ILD consortium [2] which could have been used to access these children and families. Our own work also highlighted similar themes [3]: diagnostic delay, the need for improved holistic care and written information, and also interestingly highlighted a previously undescribed issue, the high prevalence of feeding disorders in these children. So the European Charter, excellent as it is, sadly represents a lost opportunity to represent the needs of children with rare lung diseases to health commissioners.



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Children with ILD should also have been included in the IPF European Charter
<http://ow.ly/ZBfA0>

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