

the standard "push as hard as you can for as long as you can" expiratory technique was used, we observed an annual mean of ~13 episodes of pre-syncope or syncope during spirometry. Since adopting the modified technique as our standard approach in 1994, we have observed no episodes of pre-syncope or syncope during spirometry in the context of performing >15,000 testing sessions yearly in our laboratory.

4) Streamlined spirometry technique. Our experience suggests that the difference between forced vital capacity (FVC) and slow vital capacity (SVC) most often relates to the patient's inability to sustain a forced expiration rather than true physiological air-trapping. A review of our laboratory database shows the mean difference between SVC and FVC from the same testing session in patients with airflow obstruction is 0.13 L, with 23% of patients showing a slightly higher FVC than SVC. As introduction of this modified technique has lessened the difference between FVC and SVC, we no longer routinely perform the SVC manoeuvre during spirometry and measure SVC only when determining lung volumes, thereby shortening the standard spirometry procedure considerably. On this basis as well, we recommend the modified expiratory technique to others.

Overall, in the context of our favourable experience with this modified expiratory technique in our initial report and over the subsequent 14 yrs, we recommend it to others and favour consideration of its endorsement in forthcoming official recommendations and guidelines as a useful strategy along with others (e.g. measuring the forced expiratory volume in six seconds [4]) to optimise spirometry measurements.

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STATEMENT OF INTEREST

None declared.

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From the authors:

In their letter, J.K. Stoller and K. McCarthy support a modified technique of forced expiration, which they proposed facilitates

the achievement of acceptability criteria for spirometry practice [1]. They rightly point out that their method of reducing effort part-way through the expiratory manoeuvre has been quoted but not endorsed in the recent American Thoracic Society (ATS)/European Respiratory Society (ERS) document on standardisation of spirometry [2]. We may understand the authors' disappointment for not seeing their method endorsed, but we think this is justified for the following reasons. As J.K. Stoller and K. McCarthy acknowledge in their letter, their method was originally proposed in a small study [1]. Moreover, the additional information they are now providing on their subsequent experience was, and still is, unavailable in the literature on which the ATS/ERS recommendations were based. Conversely, the only published paper quoted by J.K. Stoller and K. McCarthy [3] in support of their modified expiratory technique does not actually present relevant data, but just includes in the discussion a speculation about its possible advantages in terms of achievement of end-of-test criteria.

With regard to the difference between forced vital capacity (FVC) and slow expiratory vital capacity (SVC), it should be pointed out that, as initially reported in 1994 by the ATS [4], the latter may provide a more accurate determination of the true vital capacity than the former. Moreover, FVC may be largely different from SVC or inspiratory vital capacity in subjects with airway obstruction [5] and even in elderly normal subjects [6]. Under physiological conditions, ageing is associated with loss of elastic recoil and muscle fatigue during forced expirations, which may cause incomplete emptying of lung. Thus, we think it is not worthwhile to lose information that can only be derived from the correct performance of well-standardised manoeuvres.

Having said that, we do not think the method proposed by J.K. Stoller and K. McCarthy is to be neglected, but further evidence should be provided before it can be recommended in future guidelines.

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STATEMENT OF INTEREST

None declared.

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Antibiotics for chronic bronchitis: a meta-analysis that speaks only four languages

To the Editors:

We have read with interest the meta-analysis by SIEMPOS *et al.* [1] evaluating the use of different antibiotics for exacerbations of chronic bronchitis. We are puzzled by the criteria used to select the studies that were included in the analysis. The authors utilised a well-established methodology and quality criteria for the selection of randomised clinical trials, but only studies written in English, French, German or Italian were included in the analysis [1]. English is now accepted as the most common language in scientific literature; however, there is an increasing number of peer-reviewed scientific journals written in languages other than English that have published clinical studies with data relevant to the issue of this meta-analysis. In fact, among the top 25 respiratory journals ranked by impact factor there is one published in Spanish with an impact factor of 1.401 [2].

It is not clear to us why SIEMPOS *et al.* [1] have reviewed articles written in French, German and Italian and excluded the others. Most of the indexed non-English journals include English abstracts with information that may help verify the quality of the study. If the study proved to be scientifically important, there are individuals, organisations and companies that provide translation services that would help make the overall goals more accurate.

In the article by SIEMPOS *et al.* [1], five studies were excluded due to language selection. Considering that in one of the comparisons, conclusions were drawn based on only four studies, the inclusion of one or more of the excluded studies could have impacted on the final results. Furthermore, the authors did not provide references for the publications that were excluded. Provided with this information, the interested reader could compare the results of the excluded works with those of the studies included in the meta-analysis and verify whether this arbitrary exclusion could have potentially biased the results.

Therefore, we believe that the *European Respiratory Journal* should not accept exclusion criteria beyond those that are strictly based on science. The exclusion of studies based on the language of publication is simply unacceptable.

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STATEMENT OF INTEREST

None declared.

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From the authors:

We would like to thank M. Miravittles and co-workers for their interest in our meta-analysis [1]. They commented on our choice not to include randomised controlled trials (RCTs) in the meta-analysis that were written in languages other than English, French, German or Italian. In addition, they criticised the fact that the references of the excluded RCTs were not available. We welcome the letter by our respectable colleagues and would like to respond to the points they raised.

We would like to emphasise that our research team's policy regarding the reporting of meta-analyses is to provide the references of all excluded trials to secure transparency and reproducibility of our work. For instance, in another meta-analysis performed by our team that has been recently published in the *European Respiratory Journal* (ERJ), we have done so [2]. However, for the contribution under discussion, we would have to have provided 139 additional references (*i.e.* the number of the studies that were omitted for various reasons as explained in the relevant figure of our article); we considered that this number was probably excessive, given the space limitations of the ERJ.

We carefully reviewed the abstracts of the five RCTs that were excluded due to language restrictions [3–7]. None of them provided data relevant to the subject of our meta-analysis (namely the comparison of macrolides, quinolones and amoxicillin/clavulanate for the treatment of patients with