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From the authors:

We would like to thank S. Teramoto and co-workers for the important issues they raised. While appraising their comments, it is important to make a distinction between the use of severity rules inside and outside hospital settings. Looking at the available literature, we think that the pneumonia severity index (PSI) and CURB-65 (Confusion, Urea >7 mmol·L⁻¹, Respiratory rate ≥ 30 breaths·min⁻¹, Blood pressure (systolic value <90 mmHg or diastolic value ≤ 60 mmHg)) are both valid and useful in hospital settings. However, it is an interesting suggestion to improve CURB-65 by introducing more detailed age groups in the score. In primary care, PSI and CURB-65 are less useful for various reasons. Regarding the predictive value of age, the results of our study [1] showed that age >80 yrs was a better predictor of outcome than age categories between 65–80 yrs. Probably as there are a lot of healthy individuals aged 65–80 yrs in primary care who have a low risk for poor outcome.

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STATEMENT OF INTEREST

None declared.

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Oral antibiotics prior to hospitalisation for community-acquired pneumonia

To the Editor:

SCHAAF *et al.* [1] postulate that antibiotics prior to hospitalisation with community-acquired pneumonia may be protective because of a slightly lower death rate and lower C-reactive protein concentration, leukocyte count and acute physiology score in the 13 out of 105 patients that received them. Since AUSTRIAN and GOLD [2] demonstrated a reduction in mortality from 80 to 17% in bacteraemic pneumococcal infections treated with penicillin, the death rate for this condition has changed little. A 2006 study has suggested that deaths in patients with community-acquired pneumonia are far more likely to be due to host factors rather than antibiotic choices [3].

It is possible that such host factors could lead to some patients having better outcomes, subacute presentations and more time before hospitalisation in which to receive oral antibiotics. Conversely, those patients with worse outcomes may show more acute presentations, removing the option of

pre-hospitalisation antibiotics. Information on the number of days that patients were unwell prior to admission may help to answer this in part. Given the inaccuracy with which doctors make the diagnosis of community-acquired pneumonia, this is an important point [4–6], since pharmaceutical companies might be predicted to use potentially misleading conclusions such as this to encourage primary care physicians to prescribe antibiotics to anyone who might have community-acquired pneumonia, with potential for increased levels of antibiotic resistance, unnecessary costs and potential side-effects.

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STATEMENT OF INTEREST

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