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What constitutes a “clinically significant” bronchodilator response in children?

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The worldwide disagreement with regard to what constitutes a “clinically significant” BDR has long been a source of confusion for clinicians and can hinder an appropriate asthma diagnosis and therefore “disturb” its management <http://bit.ly/2VONQhR>

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To the Editor:

We read with great interest the recent paper of DE JONG *et al.* [1] evaluating the contribution of a detailed history and a variety of diagnostic tests, including spirometry and bronchodilator tests, to diagnosing asthma in 111 children. In the methodology section, with regard to their definition of a “clinically significant” bronchodilator responsiveness (BDR), the authors only considered the forced expiratory volume in 1 s (FEV₁) and applied the following two thresholds: $\geq 10\%$ increase (no reference was cited) and $\geq 12\%$ increase (according to the National Institute for Health and Care Excellence (NICE) [2]). Their approach could be a source of confusion for at least three reasons.