chronic obstructive pulmonary disease (COPD). Llor and Naberan also express surprise at the timing of the second document, a reaction which we respect but do not share, even though in our opinion the reasons for publishing the second document are made quite clear and have the backing of no fewer than 5 scientific societies.

We are more concerned about the affirmations made in the letter from these doctors on scientific aspects of the consensus document. They make 3 objections that we consider to be scientifically inaccurate: *a)* they question the use of the criteria of Anthonisen et al[1] in outpatients with mild or moderate chronic bronchitis; *b)* they consider that macrolides should not be included among recommended treatments for exacerbations of chronic bronchitis, given that 35% of *Streptococcus pneumoniae* and 30% of *Haemophilus influenzae* strains are resistant to them; and *c)* they express doubts about the effectiveness of prescribing telithromycin in exacerbations of chronic bronchitis.

According to Llor and Naberan, the criteria of Anthonisen et al[1] have only been validated in patients with moderate or severe chronic bronchitis enrolled in hospital settings. However, on reading the methods section of the study by Anthonisen et al, it becomes clear that the patients enrolled received treatment as outpatients on the recommendations of their general practitioner and a specialized nurse. Secondly, the study by Anthonisen et al included patients over 35 years of age with a diagnosis of COPD and a forced expiratory volume in the first second (FEV_1) less than 70%; the results of the study are therefore applicable to all patients who fulfill these requisites.

The study does not analyze the correlation between the FEV_1 and the benefits derived from treatment with antibiotics, nor does it classify the severity of chronic bronchitis in terms of FEV_1.

It is surprising that Dr Llor questions the validity of these criteria when, he himself recommended their use in a recent publication without taking into account the severity of chronic bronchitis or differentiating between levels of FEV_1.[2] Furthermore in the same publication Llor and Mayer recommended treatment with erythromycin as an alternative to amoxicillin.

With reference to the inclusion of macrolides among empirical treatments of acute attacks of COPD, we would like to point out that macrolides have a proven beneficial antiinflammatory effect in respiratory infections that should not be overlooked.

Some studies show that in cases of bacteremic pneumonia caused by macrolide-resistant *S pneumoniae* the use of macrolides can be the cause of a higher percentage of therapy failures.[3,4] However,

Author's Reply to "Was Another Consensus Document on Treating Exacerbations of Chronic Obstructive Pulmonary Disease Needed?"

To the editor: We have read with interest the letter sent by Drs Llor and Naberan in which they criticize the recently published consensus document on the use of antimicrobial agents in exacerbations of

this has definitely not been demonstrated in patients with COPD.

In our opinion, these considerations justify the inclusion of macrolides, as an alternative treatment only, in exacerbations of COPD (see page 63 of Anthonisen et al:[1] "Macrolides should be considered as an alternative in cases where, for some reason, the other recommended treatments cannot be used.")

As far as telithromycin is concerned, it is known that the recommended dose of 800 mg/day achieves a maximum plasma concentration of about 2 mg/L and a concentration in bronchial mucosa higher than 4 mg/L.[5] The minimum 90% inhibitory concentration of telithromycin for *H influenzae* is 2 mg/L.[6] Clinical experience has shown that in patients with exacerbations of chronic bronchitis, a 5-day regimen with telithromycin is as effective as a 10-day regimen with cefuroxime axetil or with amoxicillin-clavulanic acid, in terms of both clinical improvement and bacteriological eradication.[6]

J.A. García-Rodríguez
On behalf of the Consensus Group

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