Response

To the Editor:

We thank Dr Horita and colleagues for their interest in our article in *CHEST*.[1] We agree with their views that adjunctive corticosteroid treatment may be indicated for severe community-acquired pneumonia (CAP) because of its beneficial effects on the length of hospital stay, the length of time to clinical stability, and the risk of acute respiratory distress syndrome. Allowing for the risk of infection escalation due to corticosteroid use before effective antimicrobial drugs are administered, and the negative results of early meta-analyses, current guidelines do not recommend the use of corticosteroids in CAP.[2,3] More recently, with the publication of large-size randomized trials and meta-analyses, some benefits of corticosteroids have been found in the management of CAP, especially in patients with severe CAP.

Although inconsistent results on mortality in severe CAP are found between the studies by Horita et al[4] and our study[1], we believe that many factors may have contributed to the differences between these studies. Most published studies concerning corticosteroid use for severe CAP have been small, which may have had a negative impact on the accuracy of conclusions (usually overestimating the true results).[5] Our trial sequential analysis indicated that the cumulative evidence on corticosteroids for severe CAP is still unreliable and inconclusive. We believe that additional randomized and placebo-controlled trials on corticosteroids and severe CAP are needed to help form therapeutic guidelines and clinical decision-making.

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Does Influence of Maternal Smoking on Childhood Asthma Differ by Age and Personal Smoking Habit?

To the Editor:

We read with great interest the recent study published by Farber et al[1] in *CHEST* (March 2016) on the relationship of maternal smoking and childhood asthma. The authors demonstrated that maternal smoking was associated with a diagnosis of asthma, prescription of quick-relief medication, and visit to the ED, even after adjusting several confounders including age, sex, ethnicity, and insurance type. However, we would like to bring up two points of concern.

First, childhood wheezing is categorized into several phenotypes based on distinct pathophysiological mechanisms,[2,3] and the dominant phenotype differs by generation. For example, "transient early wheeze," which is associated less with sensitization to indoor environment than with late-onset wheeze or persistent wheeze, is more frequent in early childhood wheezing than in late childhood wheezing.[3] In the study by Farber et al,[1] children whose mothers smoked tended to be older than those whose mothers abstained; as such, the strength of the association between maternal smoking and children's asthma may have been influenced by this age gap. We would therefore like to know whether the association between maternal smoking and childhood asthma is altered at all upon age-stratified analysis.