

a 'group of patients that often present paediatricians with a management dilemma' and which 'represents a valuable contribution to the literature'. We feel it is important to clarify a few points raised.

First, the criteria used for defining chronic cough in children (>3 weeks) was at the time of the study commencement the definition of chronic childhood cough. We acknowledge following the study completion (enrolment between 2004 and 2006) that the 2006 American College of Chest Physicians (ACCP) clinical practice guidelines in paediatrics changed the cough definition to >4 weeks and the reasons for this are discussed in the ACCP guidelines.³ Irrespective of this the median duration of cough in the treatment and placebo groups were 15 and 11 weeks respectively at enrolment, making a discussion of 3 versus 4 weeks of cough as inclusion criteria irrelevant.

Stark and colleagues argue that the verbal category descriptive score (VCD) is not the correct outcome measure to use and that cough resolution would be more appropriate. The VCD score has been used extensively in children of all ages and has been previously validated.⁴ As stated in the article, and shown in figure 3 and table 2, the children who improved had a cough score of 0.0 which indicates total cough resolution. The definition of primary outcome was cough resolution defined as >75% reduction in cough score for at least 3 days. While this may be argued as incomplete resolution, our a priori definition (as previously used⁵) is far better than just using a reduction in cough score. Further, a VCD score of 1 represents 'cough for one or two periods only' without any effect on daytime function.

As stated in the manuscript 'follow-up over a period of months' was not available in this cohort as it was not study design. Children can always have another episode of coughing illness and the issue of recurrent protracted bacterial bronchitis (PBB) should indeed be examined. We have since begun following a similar group of patients, with PBB, prospectively over a number of years and look forward to being able to shed further light on the long-term outcome of these children.

We agree with Stark *et al* that antibiotic therapy is not without implications. This manuscript is a RCT specifically designed to assess the efficacy of short-term antibiotic therapy in children with chronic wet cough. Current therapeutic guidelines recommend antibiotic treatment based on

Cochrane review, prospective⁶ and retrospective⁷ observational studies. This study is the first double-blind RCT to support these recommendations and provides the first high-level evidence for the inclusion of antibiotics in paediatric cough-specific guidelines as treatment for chronic wet cough and PBB.

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Contributors JM drafted manuscript. AC and HP edited and collaborated on ideas.

Funding ABC is funded by an Australian National Health and Medical Research Council Practitioner Fellowship (grant number 545216).

Competing interests None.

Provenance and peer review Commissioned; internally peer reviewed.

To cite Marchant J, Petsky H, Chang AB. *Thorax* 2013;**68**:297.

Received 28 November 2012

Revised 4 December 2012

Accepted 6 December 2012

Published Online First 15 January 2013



► <http://dx.doi.org/10.1136/thoraxjnl-2012-202885>

Thorax 2013;**68**:297.

doi:10.1136/thoraxjnl-2012-203059

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Letter in response to: Stark P *et al* Amoxicillin-clavulanate for chronic wet cough in children: cautious interpretation of study findings warranted

We thank Stark and colleagues¹ for comments on our paper and their interest in our recent randomised controlled trial (RCT) of amoxicillin-clavulanate compared with placebo for children with chronic wet cough,² which as they state are