

CORRESPONDENCE

Correspondence on the paper by Bridevaux *et al*

We read with interest the important prospective natural history study of respiratory virus infections (RVI) in lung transplant recipients by Bridevaux *et al*.¹

Although the authors were unable to find an association between acute rejection and RVI, they acknowledge the possibility that RVI might predispose to chronic rejection, bronchiolitis obliterans syndrome (BOS). The association between BOS and RVI has been highly discussed in the literature, but a recent meta-analysis by Vu *et al*² remained inconclusive on the connection. In view of this, we wonder whether the authors have analysed the association of incident RVI with BOS in their cohort.

We were surprised at the authors' conclusion that "... asymptomatic carriage is rare" for several reasons. First, the frequency of surveillance testing did not appear to be frequent enough to exclude a high rate of self-resolving infections (ie, infections may have occurred between screening tests). Second, we note that RVI were detected in 14% of routine screening/surveillance visits. And finally, the proportion of positive viral tests was 10% at screening visits even among those without any symptoms. These data all suggest that RVI might be substantially more common than previously recognised and not necessarily predicted by symptomatology. It was unclear from the Methods section whether bronchoscopies were performed for surveillance or only for cause. It would be of interest if the authors could clarify this issue and provide positivity rates of bronchoalveolar lavage done for surveillance versus for cause. Future studies will be needed to define any significance (or not) of asymptomatic versus symptomatic RVI in terms of clinically relevant outcomes (risk for subsequent bacterial/fungal superinfection, chronic allograft injury/dysfunction, etc).

An additional point of interest is the connection between viral infection of the upper and lower respiratory tracts. We wonder whether the authors could supply any data to support the assumption that infections are first identifiable in the upper airways before progressing to the lungs.

We thank the authors for their continued investigation of this important topic and informative paper.

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Correction notice This article has been corrected since it was published Online First. The correspondence details have been amended.

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