

lowest (10%) within patients presenting co-morbidities and lower than the overall mortality. This finding reopens the debate about the low acute mortality of patients with COPD presenting with CAP. In fact COPD was a protective factor for treatment failure in one study.¹⁵ Although the rate of acute treatment with steroids in patients with COPD is not reported in the study of Ewig *et al*, it is highly likely that a high percentage of them could have received such treatment, which could have attenuated the lung and systemic inflammatory response leading to a lower mortality.¹⁶ On the other hand, recent information suggests that despite the fact that previous inhaled steroid treatment may increase the risk of hospitalised CAP¹⁷ it may be associated with lower CAP severity and consequently lower mortality.¹⁸

The number of patients requiring mechanical ventilation was lower compared with other studies, particularly in advanced ages. As recognised by the authors, this could be due to treatment limitations such as “do not resuscitate” orders, or avoiding intensive care unit admission in older ages and severely disabled strata. This issue could not be analysed in detail by the authors. These are factors that might have influenced the high mortality of German hospitalised patients with CAP in this large study. This is a common error in most retrospective studies of CAP. For future studies it is highly recommended to record these two variables in order to interpret reliable data on mortality more precisely.

Finally, this study confirms in a large population the good performance of CURB-65 to predict mortality in CAP in a three-class pattern, a score much easier and less tedious to calculate than the PSI¹⁹ and

which further simplifies similar scores such as CURB and CURB-65.

The data presented by Ewig *et al*⁴ are currently the most solid and informative data available about hospitalisation rates in patients with CAP. The information reported in this study reminds us that this is an acute illness which occurs particularly in the elderly, a population which is going to increase in the next decades. CAP in this population currently represents an enormous economic and healthcare burden, and this burden will increase substantially in future years. Programmes of prevention are the only effective way to decrease the magnitude of this problem.

Funding: Ciber de Enfermedades Respiratorias (Ciberes); el Ciberes es una iniciativa del ISCIII.

Competing interests: None.

Provenance and peer review: Commissioned; not externally peer reviewed.

Thorax 2009;**64**:1016–1017.
doi:10.1136/thx.2009.118299

REFERENCES

1. **Almirall J**, Bolibar I, Vidal J, *et al*. Epidemiology of community-acquired pneumonia in adults: a population-based study. *Eur Respir J* 2000;**15**:757–63.
2. **Almirall J**, Bolibar I, Serra-Prat M, *et al*. New evidence of risk factors for community-acquired pneumonia: a population-based study. *Eur Respir J* 2008;**31**:1274–84.
3. **Jokinen C**, Heiskanen L, Juvonen H, *et al*. Incidence of community-acquired pneumonia in the population of four municipalities in Eastern Finland. *Am J Epidemiol* 1977;**107**:977–88.
4. **Ewig S**, Birkner N, Strauss R, *et al*. New perspectives on community-acquired pneumonia in 388 406 patients. Results from a nationwide mandatory performance measurement programme in healthcare quality. *Thorax* 2009;**64**:XXX–XX.
5. **Osler W**. *The principles and practice of medicine*. New York: D. Appleton and Company, 1901.
6. **Mandell LA**, Wunderink RG, Anzueto A, *et al*. Infectious Diseases Society of America/American Thoracic Society consensus guidelines on the management of community-acquired pneumonia in adults. *Clin Infect Dis* 2007;**44**(Suppl 2):S27–72.
7. **Kollef MH**, Shorr A, Tabak YP, *et al*. Epidemiology and outcomes of health-care-associated pneumonia: results from a large US database of culture-positive pneumonia. *Chest* 2005;**128**:3854–62.
8. **Carratala J**, Mykietuk A, Fernandez-Sabe N, *et al*. Health care-associated pneumonia requiring hospital admission: epidemiology, antibiotic therapy, and clinical outcomes. *Arch Intern Med* 2007;**167**:1393–9.
9. **Venditti M**, Falcone M, Corrao S, *et al*. Outcomes of patients hospitalized with community-acquired, health care-associated, and hospital-acquired pneumonia. *Ann Intern Med* 2009;**150**:19–26.
10. **Celis MR**, Torres A, Zalacain R, *et al*. [Diagnostic methods and treatment of community-acquired pneumonia in Spain: NACE study]. *Med Clin (Barc)* 2002;**119**:321–6.
11. **Soriano JB**, Visick GT, Muellerova H, *et al*. Patterns of comorbidities in newly diagnosed COPD and asthma in primary care. *Chest* 2005;**128**:2099–107.
12. **Alfageme I**, Vazquez R, Reyes N, *et al*. Clinical efficacy of anti-pneumococcal vaccination in patients with COPD. *Thorax* 2006;**61**:189–95.
13. **Dambava PG**, Torres A, Valles X, *et al*. Adherence to guidelines' empirical antibiotic recommendations and community-acquired pneumonia outcome. *Eur Respir J* 2008;**32**:892–901.
14. **Kaplan V**, Angus DC, Griffin MF, *et al*. Hospitalized community-acquired pneumonia in the elderly: age- and sex-related patterns of care and outcome in the United States. *Am J Respir Crit Care Med* 2002;**165**:766–72.
15. **Menendez R**, Torres A, Zalacain R, *et al*. Risk factors of treatment failure in community acquired pneumonia: implications for disease outcome. *Thorax* 2004;**59**:960–5.
16. **Confalonieri M**, Urbino R, Potena A, *et al*. Hydrocortisone infusion for severe community-acquired pneumonia: a preliminary randomized study. *Am J Respir Crit Care Med* 2007;**175**:242–8.
17. **Ernst P**, Gonzalez AV, Brassard P, *et al*. Inhaled corticosteroid use in chronic obstructive pulmonary disease and the risk of hospitalization for pneumonia. *Am J Respir Crit Care Med* 2007;**176**:162–6.
18. **Malo de Molina R**, Mortensen EM, Copeland LA, *et al*. Outpatient inhaled corticosteroid (ICS) therapy decreases mortality in patients with chronic obstructive pulmonary disease (COPD) and pneumonia. *ATS International Conference*. San Diego, California. May 15–20, 2009.
19. **Capelastegui A**, Espana PP, Quintana JM, *et al*. Validation of a predictive rule for the management of community-acquired pneumonia. *Eur Respir J* 2006;**27**:151–7.

Thorax 2009: another great year!

J A Wedzicha, S L Johnston

We are delighted to be able to let you all know that *Thorax* has continued to have a very successful past year. As usual, we nervously awaited the impact factor announcements in June 2009 and we were all delighted with the news that surpassed our expectations that our impact factor for 2008 had risen to the highest ever for *Thorax* at 7.069. This increase in the impact

factor is due to the high quality papers and reviews that you have all submitted to the journal for publication. We have thus maintained our position as the second highest ranked respiratory journal in terms of impact factor, behind the *American Journal of Respiratory and Critical Care Medicine*. During the last year, we have published a number of original papers and guidelines that are likely to be highly cited, and we can see the *Thorax* impact factor rising even further in June 2010. Please

continue to send us your very best papers over the coming year.

There has been a sharp rise in the numbers of submissions to the journal over the past few months that may reflect the rise in impact factor and we have nearly 1600 submissions over the past year, which is the highest number of submissions ever received by the journal. As usual the submissions come from all over the world and we are continuing to see a rise in submissions from outside Europe. BMJ Publishing have also introduced a “Portal” whereby authors can submit to more than one journal. In the event of rejection by the first-choice journal, papers and any associated peer reviews in the event of rejection are

Correspondence to: Professor J A Wedzicha, Thorax Editorial Office; j.a.wedzicha@medsch.ucl.ac.uk

passed to the second choice, and thus down the portal. Our publication lag time between acceptance and publication in the print version is now short and under 3 months, though papers are also posted in the "Online First" section of the *Thorax* web site as soon as they are accepted for publication. We are publishing in this issue the names of the peer reviewers who have helped us assess papers over the past years. We are especially grateful to all our reviewers for their expertise and time they have given to the journal.

Since the start of our editorship, we have always tried to ensure that there is something in *Thorax* each month of interest to all readers, and thus educational features are important for the success of the journal. Our "Pulmonary Puzzle" feature with a question and answer format has proved very popular and we are suggesting that a number of submitted case reports are converted into this format. We are encouraging authors of case reports to submit them in the "Puzzle" format. However, we have discussed the value of case reports at our editorial board meetings and decided that we should continue to publish selected case reports, as they do play an important role in describing novel case descriptions or a new adverse effect of a particular treatment. The "Images in Thorax" series

has been running for some time and is very popular with authors; they are also available on the *Thorax* web site in a collection. We are very grateful to Mark Fitzgerald (Associate Editor) who has edited the case reports, Puzzles and Images so well and made them such a valuable educational resource for our readers. Our Lung Alerts have proved very popular, and are organised and edited by Angshu Bhowmik and Jenni Quint. We have decided to start a Thorax Podcast feature, and the first one can be found on the web site this month.

We would like to thank our excellent and skilful team of Associate Editors, most of whom have been with us now for 7 years and have contributed to the high quality of the journal by selecting only the very best papers for publication. This year we have been joined by two new Associate Editors—Andy Fisher (Newcastle, UK) and Jack Gibson as Statistical Editor (Nottingham, UK). We would like to thank Richard Sands, *Thorax* Journal Manager, who has provided us with much valued support this year. We are grateful to Julia Dimitriou our editorial assistant for all her hard work in the daily running of the journal and to Kathryn Walsh our *Thorax* production editor. We are also grateful to Sheila Edwards, Mike Morgan and the British

Thoracic Society (BTS) for their support of the journal over the year.

During our editorship, we have very much valued the annual meetings of the Advisory Board and Associate Editors. These meetings have enabled us to discuss the direction of the journal, while at the same time teaching us about issues relating to peer review, publication ethics and technological advances in publishing. We held our usual breakfast meeting of the Thorax International Advisory Board at the American Thoracic Society in San Diego, USA in May 2009, which again was well attended. We would like to thank the Advisory Board members for their support and contributing to the lively debates. The Associate Editors meeting was held in October 2009 in BMA House, London, and again was very well attended, with presentations, excellent discussions and concluded by a very enjoyable dinner. We are grateful to Richard for organising such a memorable *Thorax* day for us all. Finally we would like to wish all our readers all over the world a very Happy Christmas and Successful New Year 2010.

Competing interests: None.

Provenance and peer review: Commissioned; not externally peer reviewed.

Thorax 2009;64:1017–1018.
doi:10.1136/thx.2009.130369