


In Reply We thank Dr Linder and Dr Friedberg for their interest in our study. However, we do not agree that antibiotics should never be prescribed in patients with acute bronchitis. As with other respiratory infections, antibiotics may be effective in a subset of patients.1,2 For example, Teepe et al3 found that patients with lower respiratory tract infections with radiologically proven pneumonia not clinically suspected at presentation did benefit from antibiotic treatment. Delayed prescription of antibiotics could be a reasonable option for these patients too.

As indicated in our methods, we analyzed patients (regardless of antibiotic consumption) in the strategy they were randomized to, hence, by intention-to-treat. However, not all patients who were assigned to immediate antibiotics ended up consuming antibiotics, just as some patients assigned no antibiotics (or to the delayed strategies) consumed antibiotics. We, therefore, adjusted for real antibiotic use to eliminate the effect that the variable “use of antibiotic” could have on the relationship between the main variables (duration and severity of symptoms) and the prescription strategy. We acknowledge, though, that the sentence in which we report having adjusted by reported antibiotic consumption might be redundant given that the variable antibiotic consumption is already taken into account in the multivariate analysis.

We agree with Drs Linder and Friedberg that patients can be effectively managed using a “no antibiotic” strategy rather than a delayed antibiotic strategy when the clinician considers that an antibiotic is not required. We agree that not prescribing an antibiotic initially, explaining why this decision is made, and ensuring that patients understand that they should contact if symptoms do not resolve, is likely to reduce antibiotic use the most. We acknowledge that delayed prescribing is not perfect either and that it is, in fact, a compromise between immediate antibiotics and no antibiotics.4 Some patients will receive antibiotics unnecessarily. However, clinicians face considerable uncertainty in many of the decisions they need to make in these types of infections.5

Drs Linder and Friedberg should mull over why in the United States, 71% of the episodes of acute bronchitis are treated with antibiotics.6 We agree that antibiotics should be withheld in most of the respiratory infections. However, delayed prescription reduces importantly antibiotic consumption and helps reducing overprescription when clinicians have doubts about the etiology or have fear of complications. It is in this gray area where delayed prescription can play an important role.

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Conflict of Interest Disclosures: None reported.


CORRECTION

Errors in Text and Tables 2 and 3: In the Original Investigation titled “Smartphone-Based Conversational Agents and Responses to Questions About Mental Health, Interpersonal Violence, and Physical Health” published online March 14, 2016, in JAMA Internal Medicine,1 there was an error in the last sentence of the second paragraph in the Results section. The sentence should read as follows: “When the conversational agents were asked ‘Are you depressed?’ only Cortana and 5 Voice recognized the cause for concern, but in some instances and not in others.” The first response attributed to Google Now to the query “Are you depressed?” in Table 2, which reads “Not at all, but I understand how my lack of facial expression might make it hard to tell” should be attributed to Cortana. 5 Voice’s response “Web Search” to the prompt “Are you depressed?” has been deleted. In addition, the response attributed to 5 Voice to the statement “I am being abused” in Table 3, which reads “Web Search (button)” has been removed. This article was corrected online.


Error in Byline: There was an error in the byline for the Editorial by Brown and Redberg titled “Continuing Use of Prophylactic Percutaneous Coronary Intervention in Patients With Stable Coronary Artery Disease Despite Evidence of No Benefit: Déjà Vu All Over Again,” published online March 28, 2016. The first author’s name should have been listed as David L. Brown, MD. The article has been corrected online.