 Reply

We would like to thank Prof. El-Kassimi for his interest in our article. It is our pleasure to respond to his valuable comments. Prof. El-Kassimi raised a concern about the definition of COPD used in our study and its relation to duration of tobacco smoking. We understand the concern here; however, we stated clearly in our study that a minimum of 5 years of smoking history means a range from 5 to 10 years, not a smoking history of 5 years only. Nevertheless, the risk of COPD due to smoking (GOLD updated 2010) is dose-related not time-related. Prof. El-Kassimi mentioned in his letter that GOLD does not state a cut-off time duration for the development of COPD among smokers.

He referred to other reports and CT findings, but in prevalence studies such as ours we cannot depend on debatable and controversial reports. We must instead use current standard guidelines (e.g., GOLD). In addition, Prof. El-Kassimi clearly stated in his letter that although smoking is the most common risk factor for COPD, there are other potentially important risk factors including genetic factors, indoor and outdoor air pollution (e.g., wood burning), and chest infections.

We adopted the GOLD and WHO definition of COPD and spirometry criteria for diagnosis of COPD. This definition does not differentiate between COPD and severe irreversible asthma. For epidemiological studies, we need to adhere to standard criteria and definition. A prevalence study always has some methodological limitations. In a prevalence study, screening for asthma is usually based on an asthma questionnaire that includes a detailed history of asthma symptoms and a history of atopy. Our study involved such a questionnaire. In addition, we
excluded all spirometry tests yielded in reversible airway obstruction, and all our patients were over the age of 40 years and all were smokers. We believe that these tools and criteria are enough to exclude most asthma patients. Indeed, asthma can be diagnosed in clinical practice based on symptoms alone in the majority of the patients without further testing. Other methods to differentiate asthma from COPD (e.g., CT scan, transbronchial biopsy) are beyond the aims of epidemiological (prevalence) studies.

Prof. El-Kassimi raised a concern about the high rate of excluded subjects due to poorly performed spirometry and he questioned whether this may reflect the poor reliability of these diagnostic tests. We respectfully disagree and believe that this is a strength rather than a weakness of the study. Excluding a large number of tests due to poor performance indicates that the research team was very meticulous and highly adherent to the American Thoracic Society (ATS) standards. All tests were reviewed by two investigators independently to make sure the quality of the flow-volume curves and time-volume curves followed the ATS criteria.

I would like to emphasize that our study is a prevalence study and should be interpreted from this angle.

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