

RECTIFICATION

In the article "Role of viruses and atypical bacteria in asthma exacerbations among children" from Drs. M. João Silva et al., recently published (2007;35/1: 4-9), the next rectification has been introduced:

ABSTRACT

Results: Of 54 eligible children, 37 nasal samples were obtained. Infectious agents were detected in 78 % of the cases. Rhinovirus was detected in 70.3 %, *Mycoplasma pneumoniae* in 16.2 %, enterovirus in 10.8 % and *Chlamydia pneumoniae* in 2.7 %. A coinfection was identified in 21.6 % of the samples. There was no significant correlation between current therapy status, severity of asthma or of the exacerbation and agents isolated. **Two distinct peaks of asthma exacerbation were found, 40,5 % in spring and 32,4 % in autumn. The highest number of cases was recorded in March and the lowest in August and January. Rhinovirus was detected in 27 % of the cases in autumn and in 24.3 % in spring.**

RESULTS

During the 12-month study period, 54 patients were screened for eligibility. Clinical reviews and agreement resulted in 17 exclusions. Data from the remaining 37 patients were analysed. Twenty one patients were males (56.8 %) with a mean age of 8.5 years (6 to 13). Asthma had already been diagnosed in 83.3 % of the children, 43.2 % more than 5 years before. Fever was present in 32.4 % and common cold symptoms in 51.4 % of the cases. Symptoms of rhinitis were recorded in 64.8 %. Asthma severity was intermittent in 21.6 %, mild persistent in 27 %, moderate persistent in 48.6 % and severe persistent in 2.7 % (table 1). Asthma exacerbation was mild in 54.1 %, moderate in 37.8 % and severe in 8.1 % (table 1). March had the highest and August and January the lowest number of cases (fig. 1). The seasonal distribution also showed two distinct peaks of asthma exacerbations, 40.5 % in spring and 32.4 % in autumn. The combination of conventional and molecular techniques detected infectious agents in 78.4 % of the cases. Rhinovirus was de-

tected in 70.3 %, *Mycoplasma pneumoniae* in 16.2 %, enterovirus in 10.8 % and *Chlamydia pneumoniae* in 2.7 % (fig. 2). A coinfection was identified in 21.6 % of the samples (rhinovirus + enterovirus in four patients; rhinovirus + *Mycoplasma pneumoniae* in two patients and *Mycoplasma pneumoniae* + *Chlamydia pneumoniae* in one patient). There was no significant correlation between isolated agents and the month of year but rhinovirus were detected in the spring in 24.3 % of the cases and in autumn in 27.0 % of the cases, $P = 0.02$ (table 1; fig. 3). **Rhinovirus was detected in 25 samples (40 % in autumn and 36 % in spring, table 1).** All isolated enterovirus were associated with rhinovirus infection and mostly in children with intermittent asthma (table 1). Half of the cases of *Mycoplasma pneumoniae* isolation had a coinfection (rhinovirus in two cases and *Chlamydia pneumoniae* in one case). There was no significant correlation between sex, age, common cold symptoms, current therapy status, severity of asthma or of the exacerbation, age of onset of asthma symptoms, presence of fever or rhinitis and the isolated agents. Children with current treatment step ≥ 2 had a coinfection in a larger number of cases (35 % vs 5.9 %, $P = 0.09$). The unique case of *Chlamydia pneumoniae* isolation had a coinfection with *Mycoplasma pneumoniae* and occurred in a child with a severe persistent asthma.

DISCUSSION (3th paragraph)

A significant seasonal pattern in rhinoviruses detection was found. Rhinovirus was detected in 25 samples (40 % in autumn and 36 % in spring, table 1) and isolated in autumn and spring in 27 % and 24.3 % of the cases, respectively (fig. 3). These results support the fact that the upper respiratory tract infections, specially by rhinovirus, are probably responsible for seasonal peaks of asthma-related hospital admissions as suggested by several studies^{8,9,10} and occurs mostly in spring and fall seasons. Eight patients that were excluded because they did not give informed consent came to the Emergency Pediatrics Department with asthma exacerbation in March and April which explains the low number of cases included on those months.

Table 1

Current treatment step								> 0.05
Intermittent	17 (45.9)	4 (23.5)	10 (58.8)	2 (11.8)	1 (5.9)	1	0	0
Mild persistent	11 (29.7)	2 (18.2)	6 (54.5)	0 (0)	3 (27.3)	1	2	0
Moderate persistent	9 (24.3)	2 (22.2)	3 (33.3)	0 (0)	4 (44.4)	2	1	1