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Reply to "Allergic bronchopulmonary aspergillosis, bronchiectasis severity, and clinical outcomes"



To the Editor:

We sincerely thank Jhang et al¹ for their thoughtful comments and interest in our article. We are pleased that our findings have stimulated meaningful discussion and appreciate the opportunity to respond to the important points raised.²

1. Treatment adherence: We fully agree that adherence to therapy plays a critical role in determining clinical outcomes, including lung function and exacerbations. In our clinic, patients are routinely followed up at 3- to 6-month intervals, and the inhaler technique is assessed at each follow-up visit. However, owing to the retrospective design of our study and the absence of standardized adherence metrics in our clinical records, we were unable to objectively evaluate adherence. We acknowledge this limitation and agree that future prospective studies should incorporate validated adherence metrics to understand its influence better.
2. Comorbidity burden: We appreciate the suggestion to incorporate comorbidity indices, such as the Charlson Comorbidity Index. Although this index includes conditions such as myocardial infarction, hypertension, diabetes, and peptic ulcer disease, these are unlikely to have a direct influence on bronchiectasis or lung function in patients with allergic bronchopulmonary aspergillosis (ABPA). In addition, given that our cohort consisted of individuals with asthma, chronic obstructive pulmonary disease was not considered a separate comorbidity in this context. Most patients were relatively young and had minimal comorbidities, making it unlikely that the comorbidity burden significantly influenced our findings. Nonetheless, future studies incorporating formal comorbidity scoring may help delineate the independent effect of bronchiectasis severity on ABPA outcomes.
3. Health care utilization: We also concur that differential health care utilization can introduce surveillance bias in observational research. Whereas our study ensured structured follow-up through scheduled clinic visits, the frequency of additional health care encounters was not systematically recorded.

Once again, we thank Jhang et al¹ for their constructive insights. Their suggestions will undoubtedly inform the design of future prospective studies in ABPA.

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Another nonpharmacologic procedure for cessation of refractory chronic cough



To the Editor:

Dr Vertigan,¹ a renowned speech pathologist who has contributed extensively to the literature of chronic cough, discusses nonpharmacological approaches to chronic cough. She states that the most widely reported nonpharmacological intervention for the management of chronic cough is cough control therapy typically provided by speech and language pathologists. However, a controlled trial of speech therapy by Dr Vertigan showed statistically significant improvement but not cough cessation, and the magnitude of effect was modest.² A subsequent multicenter study of physiotherapy with speech and language therapy also resulted in a statistically significant effect from modest improvement.³

In contrast, suggestion therapy has provided complete cessation of chronic cough in over 100 children⁴ and many adults.⁵ An explanation for this nonpharmacological treatment of chronic cough is the clinical effect of suggestion therapy described in the psychology literature.⁶ A unique form of suggestion is provided by hypnosis.⁷ Cessation of cough by hypnosis has been reported in children but not yet in adults.

In the section titled Future Directions, suggestion therapy could be considered a potentially important nonpharmacological means of attaining cough cessation in patients with functional chronic cough (ie, those with no physical cause for chronic cough).

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Reply to "Another nonpharmacologic procedure for cessation of refractory chronic cough"



To the Editor:

We thank Dr Weinberger for his letter,¹ in which he claims that suggestion therapy results in complete resolution of cough. Dr Weinberger stated that suggestion therapy could be considered a potential nonpharmacological treatment.

It is possible that nonpharmacological approaches explained in our article² might contain an element of suggestion therapy. Speech pathology cough control therapy is multifactorial and the mechanisms for improvement require further investigation. It is also likely that there are subgroups of individuals with chronic cough with differences in sensitivity and neural processing.^{3,4} As we increase our understanding of phenotypes and endotypes of patients with chronic cough, more specific therapies may be able to be defined.

Dr Weinberger advocates for the success of suggestion therapy based on the number of e-mails received from grateful patients. It is imperative that any studies of chronic cough treatment encompass a sound study design including prospective recruitment, a placebo arm, random allocation, blinded outcome assessor, robust outcome measures, and clear inclusion and exclusion criteria.⁵ The placebo arm is particularly important given the known placebo effect in chronic cough trials.^{6,7} To our knowledge, suggestion therapy as described by Dr Weinberger has yet to be evaluated in a randomized control trial.

Further research into nonpharmacological treatments for chronic cough is needed to progress this field. Ultimately the

aim is to help our patients, and this cannot be done without rigorous scientific research.

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Considerations in comparative effectiveness of asthma biologics



To the Editor:

We read with interest the article by Hung et al,¹ which provided robust real-world evidence comparing the effectiveness of dupilumab versus mepolizumab and benralizumab in reducing asthma exacerbations across multiple countries. The use of a new-user, active-comparator design and propensity score matching within the TriNetX platform is a noteworthy methodological strength. However, we would like to highlight several considerations that may influence the interpretation of their findings.

First, the study design may introduce survivor bias due to the differential timing of biologic approval. Patients who initiated mepolizumab or benralizumab before the availability of dupilumab and who derived benefit would have been excluded, potentially underestimating the effectiveness of these earlier biologics.² In addition, the study lacks data on standardized asthma control metrics such as the Asthma Control Test or Asthma Control Questionnaire, which are critical to contextualize exacerbation risk and biologic response.