

### Authors' response

We thank Hatipoglu and Gozdas for the comments on our paper on the role of procalcitonin (PCT) in febrile patients<sup>1</sup>. The PCT levels in patients with hospital acquired infection were higher than community acquired infection cases ( $P<0.05$ ), however, there were no significant differences in the levels of CRP, IL-6 and SAA. Patients with hospital acquired infection had higher PCT values, which could be because Gram-negative bacteria were the main pathogenic bacteria in nosocomial infection.

We agree that *S. pneumoniae* is the most common aetiological agent of community acquired pneumonia. Most pneumonia patients showed negative result on sputum bacterial culture; nosocomial infection pathogens such as *Acinetobacter baumannii*/

*calcoaceticus*, *Klebsiella pneumoniae* and *Pseudomonas aeruginosa* were the commonest positive culture isolates. Some patients had history of hospitalization and/or use of antimicrobial drugs before they were admitted to our department, which also could be a reason for non-isolation of *S. pneumoniae* in this study. In addition, *S. pneumoniae* had been detected in some patients in other hospitals before they were transferred to our department.

There was no difference in the kind of infection and bacteria between patients of bacterial infection group with low and high PCT levels. Local infection and detection time might be related to low PCT levels.

The vast majority of bacterial infection group patients in this study survived. Because our primary

objective was to assess the diagnostic value of PCT for bacterial infection in febrile patients, the utility of PCT in the prognostic evaluation was not the aim of this study.

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### Reference

1. Qu J, Lü X, Liu Y, Wang X. Evaluation of procalcitonin, C-reactive protein, interleukin-6 & serum amyloid A as diagnostic biomarkers of bacterial infection in febrile patients. *Indian J Med Res* 2015; 141 : 315-21.