in which therapeutic failure was more frequent in patients who did not receive treatment with antibiotics,[2] Butler et al. found no evidence of harm. However, the robust evidence for the role of CRP point-of-care testing in antibiotic stewardship has resulted in its adoption in varying degrees in ambulatory settings around the world. In the United States, for example, where inappropriate antibiotic prescribing remains particularly high, CRP point-of-care testing remains unavailable in ambulatory settings, as does testing

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TO THE EDITOR: Butler et al. used the Clinical COPD Questionnaire (CCQ) but did not use the COPD Assessment Test (CAT). CAT test results would be of interest, since a CAT score of 10 or higher indicates an increased risk of exacerbation in patients with COPD, whereas there is no indicator for increased risk of exacerbation in the CCQ.[1] Moreover, the 2018 and 2019 Global Initia-

tive for Chronic Obstructive Lung Disease (GOLD) guidelines recommend the CAT as one component of the grading of symptom burden and as a means of categorizing patients into one of four groups according to severity of symptoms (A through D, with group A having the least severe symptoms and group D the most severe),[2] all of which leads to the question of whether there was selection bias in the trial. The inclusion of patients with low CAT scores or those in GOLD group A or B would make it difficult to extrapolate the results of the trial to all patients.

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No potential conflict of interest relevant to this letter was reported.

1. Jo YS, Yoon HI, Kim DK, Yoo CG, Lee CH. Comparison of COPD Assessment Test and Clinical COPD Questionnaire to predict the risk of exacerbation. Int J Chron Obstruct Pulmon Dis

tients who were randomly assigned to the CRP-guided group overall had a slightly better condition-specific quality-of-life measure. Randomization was stratified according to the number of Anthonisen criteria present, and key characteristics were well balanced between the two groups. It is unlikely that the two groups would have differed in terms of CRP level, since the values for all measures obtained at baseline were similar. Ours was a pragmatic trial: since the use of a finger-prick blood test may influence patients' subsequent adherence to the protocol and willingness to seek help, our decision to refrain from testing patients in the control group was especially important to accurately estimate the effect on patients' subsequent behavior.

We agree with Verbakel et al. that cost-effectiveness data can be used to support decisions related to reimbursement. We disagree with Yildiz