Reply to Bradley

To the Editor—We thank Dr John S. Bradley [1] for his editorial commentary in which he nicely describes the problems in accomplishing a good treatment study in children. However, he comes to a conclusion [1, p. 1212] which is not quite true: that we had a 10% failure rate in the short-term (10 days of antimicrobial) treatment group. There was not a single failure among those 63 patients.

To some extent, it might be a matter of defining a "failure." In a treatment study, one may deem any patient whose medication has deviated a bit from the protocol a failure, but here the interpretation is not that straightforward.

In our article [2], the second table showed 5 children in the 10-day treatment group who received antimicrobials longer, but by no means did they all fail the initial treatment. The point is that we kept the preset criterion that the CRP level had to be decreased to $\leq 20$ mg/L before the agent was discontinued. As we explained [2, p. 1207], we currently do not necessarily wait that long if recovery is otherwise likely. It is quite obvious that antimicrobial could have been discontinued after 10 days in most of these 5 cases, because it is not known if, say, a level of 50 mg/L or a 75% decrease from the highest level would serve as well as $\leq 20$ mg/L, which we have used for $>25$ years [3, 4]. Thus, his statement "knowledge of a 10% [clinical] failure rate (perhaps higher for hip infections)" [1, p. 1212] is not supported by our study [2].

We also do not think that, in septic arthritis, a "treatment failure will certainly impact the quality of life for the rest of the child’s life" [1, p. 1212]. In our study, the child with 2 late reinfections demonstrated that a catastrophe hardly follows a recurring osteoarticular infection if the infection is treated promptly. Septic arthritis is not bacterial meningitis.

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Potential conflicts of interest. All authors: no conflicts.

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