Price and colleagues do not mention any ethical issues. Accordingly, I am at a loss as to how to respond to the title of their letter. I note that Price and colleagues write on behalf of the “Respiratory Effectiveness Group Collaborators.” Perhaps if their group were renamed the “Respiratory Comparative Effectiveness Group Collaborators” they would feel less obligated to defend the use of observational studies.

Author disclosures are available with the text of this letter at www.atlsjournals.org.

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Surrogate Consent for Genetic Testing, the Reconcert Process, and Consent for Long-Term Outcomes in Acute Respiratory Distress Syndrome Trials

To the Editor:

Advancing critical care research is necessary to improve patient outcomes and has been defined as a priority for our healthcare system (1). However, most critically ill patients are initially incapacitated due to their acute illness, and are unable to participate in informed consent for research participation decisions (2). Therefore, surrogates make decisions for patients and often do so without a priori knowledge of the patients’ wishes. The surrogate consent process to enroll critically ill patients into research studies is complex. During the initial consent for a clinical trial, surrogates may also be asked to consent for the collection of biospecimens from the patient, including genetic material. Though consent rates for most genetic studies are generally high, individuals who are able to consent for themselves often have concerns regarding the use of their genetic material (3). In addition, racial and ethnic disparities have been reported in the willingness of individuals to consent to their own participation in genetic studies (4–6). However, whether surrogates are willing to consent for the collection of genetic material from critically ill patients has not been previously determined.

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References

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Vitamin C Should Be Tested against Exercise-induced Bronchoconstriction

To the Editor:

An ATS Clinical Practice Guideline reviewed treatments for exercise-induced bronchoconstriction (EIB) and commented briefly on vitamin C (1). The authors identified two controlled trials (2, 3) in which vitamin C halved the fall in FEV1 after exercise, but the authors did not calculate confidence intervals (CIs) for the effect.

A third randomized, double-blind, placebo-controlled trial on vitamin C and EIB has also been published (4) and was included in a metaanalysis (5). The pooled relative effect estimate of three trials (2–4) indicated a 48% reduction (95% CI, 33 to 64%; P < 0.001) in the postexercise FEV1 decline when vitamin C was administered before exercise (5). The third study (4) needed imputations to include it in the metaanalysis, but it also reported that vitamin C decreased the proportion of participants who suffered from EIB by 50 percentage points (95% CI, 23 to 68; P < 0.001); this calculation did not need data imputations (5). The ATS Guideline comments that the evidence for vitamin C was limited by imprecision (1). The CIs calculated in the metaanalysis are, however, particularly narrow (5).

The total number of participants in the three vitamin C trials is only 40. Nevertheless, the trials were performed in three different decades and on two different continents. The criteria for EIB differed, and the mean age of the participants was 25 and 26 years in two studies (2, 3) but 14 years in the third study (4). Still, all of the studies are consistent with a 50% reduction in the fall in FEV1 after exercise. It is not evident how far this 50% estimate can be generalized, but the close estimate in such different studies suggests that vitamin C is probably beneficial for several people who suffer from EIB.

The ATS Guideline considers that the burden of dietary modification might limit the usefulness of vitamin C (1). However, two of the vitamin C studies administered the vitamin as a single dose 1 to 1.5 hours before exercise (2, 4), which is no more burdensome than administering a β2-agonist before exercise (1).

Further research on the effect of vitamin C on EIB should be performed. Nevertheless, given the safety and low cost of vitamin C, and the positive findings in the three EIB studies, it seems reasonable for physically active people to test vitamin C if they suffer from EIB (5).

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References

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