> The point is not who is right and who is wrong about airborne transmission. The point is not science, but safety. Scientific knowledge changes constantly. Yesterday's scientific dogma is today's discarded fable. When it comes to worker safety in hospitals, we should not be driven by the scientific dogma of yesterday or even the scientific dogma of today. We should be driven by the precautionary principle that reasonable steps to reduce risk should not await scientific certainty.[4]

Second, the author indicates that withholding NIV in the SARS epidemic in Toronto, Canada, in 2003 was associated with an increase in the number of deaths due to complications of invasive ventilation. While we agree that avoidance of intubation is desirable in appropriate patients, we were unable to find any published evidence to support this statement. Countering this argument is the fact that a systematic review of NIV in the treatment of hypoxemic respiratory failure concluded that there was insufficient evidence to support the routine use of NIV in this disorder (of which SARS is a subset). In fact, a recent systematic review of NIV in hypoxemic respiratory failure in patients without chronic obstructive pulmonary disease and patients without cardiogenic pulmonary edema failed to support a mortality benefit.[5]

While we would all prefer to have more scientific information to guide us in the development of disaster-management protocols, we can only make the best and *safest* judgments with the data that are currently available. We therefore respectfully disagree with McCracken; on balance, the data do not support a safe role for NIV in the treatment of patients in the setting of pandemic respiratory infection.

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CORRECTION

In the article "The clinical impact of new long-term oxygen therapy technology" by Dunne PJ (Respir Care 2009;54[8]:1100-1111) the XPO_2 setting for Maximum F_{IO_2} at 20 breaths/min should be setting 2 (not 5), as reported in reference 57; also, reference 57 should be among the sources for compiling this table. We regret this error.

Table 1. Performance Characteristics of Several Models of Portable Oxygen Concentrator

Model	Company	Weight (lb)	Maximum Oxygen Production (mL/min)	Flow Settings	Pulse Settings	Maximum Bolus Size (mL)	Maximum F_{IO_2} at 20 breaths/min
FreeStyle	AirSep, Buffalo, New York	6	480	NA	1–3	26	0.27 at setting 3
Inogen One	Inogen, Goleta, California	10	750	NA	1–5	26	0.29 at setting 5
XPO_2	Invacare, Elyria, Ohio	7	900	NA	1–5	42	0.24 at setting 2
EverGo	Respironics, Murraysville, Pennsylvania	10	1,050	NA	1–6	36	0.32 at setting 6
Eclipse 2	SeQual Technologies, San Diego, California	17	3,000	0.5–3.0 L/min	1–6	96	0.42 at setting 6

F_{IO_2} = fraction of inspired oxygen
NA = no data available
(Adapted from References 26, 28, and 57.)