mentioned those in the "In-Patient Asthma Treatment" section of our manuscript as novel therapies in asthma management. A meta-analysis of nebulized and intravenous magnesium sulfate has shown positive outcomes in patients with asthma exacerbations, with a heavy slant of evidence in those patients with severe air-flow obstruction.[8]

3. We wholeheartedly agree with Mr Miller's statement and conclusions on the benefit of asthma education, not only in the emergency department, but across all venues in the continuum of care of children with asthma visits.[9] In a previous published manuscript by Kallstrom and Myers,[10] we expressed the opportunity for respiratory therapists to make an large impact by being "key members of the asthma disease-management team, in acute-care settings, patients' homes, out-patient clinics, emergency departments, and in the community. Utilizing respiratory therapists as disease managers allows patients to be treated faster and more appropriately, discharged to home sooner, and decreases hospital admissions. Respiratory therapist are leaders in the emerging field of asthma disease management."

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**REFERENCES**

1. Myers T, Tomasio L. Asthma: 2015 and beyond. Respir Care 2011;56(9):1389-1410.
2. Dolovich MB, Ahrens RC, Hess DR, Anderson P, Dhand R, Rau JL, et al. Device selection and outcomes of aerosol therapy: evidence- based guidelines: American College of Chest Physicians/American College of Asthma, Allergy, and Immunology Chest 2005;127(1):335-371.
3. Hess DR. Aerosol delivery devices in the treatment of asthma. Respir Care 2008; 53(6):699-723.
4. Rubin BK. Bye-bye, blow-by (editorial). Respir Care 2007;52(8):981.
5. Janssens HM, Tiddens HA. Facemasks and aerosol delivery by metered dose inhaler-valved holding chamber in young children: a tight seal makes the difference. J Aerosol Med 2007;20(Suppl 1):S59-S65.
6. Iles R, Lister,P, Edmunds AT. Crying significantly reduces absorption of aerosolized drug in infants. Arch Dis Child 1999;81: 163-165.
7. Peters S. Continuous bronchodilator therapy. Chest 2007;131(1):286-289.
8. Mohammed S, Goodacre S. Intravenous and nebulised magnesium sulphate for acute asthma: systematic review and meta-analysis. Emerg Med J 2007;24(12):823-830.
9. Jones MA. Asthma self-management patient education. Respir Care 2008;53(6): 778-786.
10. Kallstrom TJ, Myers TR. Asthma disease management and the respiratory therapist. Respir Care 2008;53(6):770-777.

## CORRECTION

In Table 1 of the paper "Acute lung injury: prevention may be the best medicine" by Litell JM, Gong MN, Talmor D, and Gajic O (Respir Care 2011;56[10]:1546–1554), the definitions for the $P_{aO_2}/F_{IO_2}$ ratio for ALI and ARDS were inverted. The corrected table appears below.

Table 1. American-European Consensus Conference Criteria for Acute Lung Injury and Acute Respiratory Distress Syndrome

| | Chest Radiograph | $P_{aO_2}/F_{IO_2}$ (mm Hg) | Pulmonary Artery Occlusion Pressure |
|---|---|---|---|
| ALI | Diffuse bilateral infiltrates | ≤300 | ≤ 18 mm Hg or no clinical evidence of left atrial hypertension |
| ARDS | Diffuse bilateral infiltrates | ≤200 | ≤ 18 mm Hg or no clinical evidence of left atrial hypertension |

ALI = acute lung injury
ARDS = acute respiratory distress syndrome
(Adapted from Reference 4).