Reviewer's report

Title: Acinetobacter baumannii nosocomial pneumonia: Is the outcome more favorable in non-ventilated than ventilated patients?

Version: 3 Date: 13 February 2013

Reviewer: Nele Brusselaers

Reviewer's report:

Thank you for revising the article. I do have the feeling that the results are presented more adequately, which is important since the main findings are indeed counter-intuitive.

I do have some more suggestions, which I think are crucial to present the data more cautiously and clearly. I believe the findings are interesting, but they could easily be misinterpreted.

Major:
1. Possible explanations for these results could be patient characteristics, pathogen virulence and treatment related factors, as also mentioned by the authors. It could also be that the time of diagnosis or other diagnostic variables differ? If VAP patients are more closely monitored for signs of infection, they will also receive adequate (antimicrobial) treatment earlier, which in turn will probably influence outcome. I think this is an important hypothesis/argument to mention in the discussion.
2. I believe these 4 possible explanation groups could be responsible for the results, and should be mentioned in the abstract.
3. Please add the proportion of patients with malignancies in the discussion. I think this also might be a major factor (among the patient characteristics) which influences the outcome. Thus 46 vs. 29% of cancer in HAP vs VAP will probably have a major influence on the results (as also suggested by the logistic regression). This could be because cancer patients are more susceptible for Acinetobacter pneumonia and its consequences; but the higher HAP mortality might also be because the cancer patients were at the end stage of their cancer and would die anyway. I wonder therefore, if these differences in mortality still stand after exclusion of the cancer cases.

Minor (but essential):
4. Please add sentence in methods about that footnote in table 1 (where mechanically ventilated patients could be treated: ICU, respiratory care centre, respiratory ward or common ward
5. Please provide number/proportion of patients diagnosed per diagnostic technique in results (N=93 by ETA, and 3 by BAL in VAP; what about the HAPs?)
6. Please mention the statement that you standards of care etc did not change
significantly over the study period in discussion (or methods).

7. You did mention the quantitative thresholds for VAP diagnosis for BAL and ETA; but you don’t mention which qualitative or quantitative thresholds are used for HAP (ETA, BAL, sputum or pleural effusion). Please add this in the methods.

8. Please revise sentence on page 7 line 11: “non-chronic obstructive pulmonary disease (COPD) chronic lung diseases”... I suppose you’re talking about chronic and non-chronic lung diseases but the word order got mixed up.

9. Please mention in methods that antimicrobial therapy was mainly based on ATS/IDSA guidelines (combined with clinical judgment)

10. Please clarify in text and/or table 1 how many HAP patients received mechanical ventilation after pneumonia onset (not clear in table 1 – where you mention the number of patients admitted to the ICU). Are those the patients who died?

11. Tables: please use same amount of decimal places in tables (some numbers are written as 9.25, others as 9.3 or 9)

12. Please clarify that ICU admission after pneumonia in HAP patients entails mechanical ventilation

**Level of interest:** An article whose findings are important to those with closely related research interests

**Quality of written English:** Acceptable

**Statistical review:** Yes, and I have assessed the statistics in my report.

**Declaration of competing interests:**

I declare that I have no competing interests