Decision Letter (JCQ-2025-0043)

From: jcqeic@gleampub.com

To: chinsmd@gmail.com

CC: chinsmd@gmail.com

BCC:

Subject: Journal of Clinical Question - Decision on Manuscript ID JCQ-2025-0043

Body: 7-Jan-2026

Dear Dr Hara:

Manuscript ID JCQ-2025-0043 entitled "Aspiration Pneumonia Versus Community Acquired Pneumonia: Differences in Clinical Characteristics, Functional Status, and Mortality Predictors" which you submitted to the Journal of Clinical Question, has been reviewed. The comments of the reviewer(s) are included at the bottom of this letter.

The reviewer(s) have recommended publication, but also suggest some revisions to your manuscript. Therefore, I invite you to respond to the reviewer(s)' comments and revise your manuscript.

To submit your revised manuscript, follow the below steps.
1. Access to https://mc.manuscriptcentral.com/jcq and log into the site.
2. Click "Author" at the top left of the screen at "Home" page.
3. Click "Manuscripts with Decisions" on Author Dashboard page.
4. Click "create a revision" on the manuscript you are going to revise.
5. The system creates your revision manuscript form. Provide your comments about the revised points at the response field, fill in on each field step by step as same as you did for the original submission, and submit your revised manuscript.
IMPORTANT: Your original files are available to you when you upload your revised manuscript. Please delete any redundant files before completing the submission.
Your manuscript number has been appended to denote a revision.

You will be unable to make your revisions on the originally submitted version of the manuscript. Instead, revise your manuscript using a word processing program and save it on your computer. Please also highlight the changes to your manuscript within the document by using the track changes mode in MS Word or by using bold or colored text.

Once the revised manuscript is prepared, you can upload it and submit it through your Author Center.

When submitting your revised manuscript, you will be able to respond to the comments made by the reviewer(s) in the space provided. You can use this space to document any changes you make to the original manuscript. In order to expedite the processing of the revised manuscript, please be as specific as possible in your response to the reviewer(s).

IMPORTANT: Your original files are available to you when you upload your revised manuscript. Please delete any redundant files before completing the submission.

Because we are trying to facilitate timely publication of manuscripts submitted to the Journal of Clinical Question, your revised manuscript should be uploaded as soon as possible. If it is not possible for you to submit your revision in a reasonable amount of time, we may have to consider your paper as a new submission.

Once again, thank you for submitting your manuscript to the Journal of Clinical Question and I look forward to receiving your revision.

Sincerely,
Professor Richard Isaacs
Editor in Chief, Journal of Clinical Question
jcqeic@gleampub.com

[Editor's Comments]
Associate Editor
Comments to the Author:
1. Check grammar and flow for minor errors.
2. Ensure all abbreviations are defined on first use in both abstract and main text.
3. Add ORCID IDs for authors if available

[Reviewer(s)' Comments]
Reviewer: 1

Comments to the Author
This study examines the clinical, functional, and prognostic differences between aspiration pneumonia (AP) and community-acquired pneumonia (CAP) in a large, two-center patient cohort. The use of propensity score matching, the emphasis on functional status (ADL), and the clinical applicability of the results are strengths of the study. The text is generally well structured, the methodology is appropriate, and the findings are consistent.

I still think there are a few points that need to be revised.

1- The AP definition is based on the “attending physician diagnosis.”
This creates a risk of misclassification bias. This should be emphasized more clearly in a sentence in the Discussion or Methods section.
2- Fungal isolation and Gram-negative rates have been reported.
However: The distinction between colonization and the actual causative agent is unclear. The impact on treatment decisions has not been discussed.

Reviewer: 2

Comments to the Author
This retrospective observational study compares aspiration pneumonia and community-acquired pneumonia with respect to clinical characteristics, functional status, and predictors of in-hospital mortality. The study addresses an important clinical question, particularly relevant to aging populations, and incorporates functional status and propensity score matching to strengthen causal inference. The manuscript is generally well written, methodologically sound, and clinically meaningful. However, several major issues require clarification or correction, particularly regarding the definition of aspiration pneumonia, consistency and clarity of multivariable analyses, and methodological justification for propensity score matching. Addressing these concerns would substantially improve the rigor, transparency, and interpretability of the findings.
Major Revisions
1. Aspiration pneumonia is defined retrospectively based on the attending physician’s diagnosis combined with radiographic findings. While this reflects real-world practice, it raises concerns regarding diagnostic heterogeneity and misclassification bias, especially in older adults where AP and CAP often overlap. Clarify whether standardized diagnostic elements (e.g., witnessed aspiration, dysphagia, impaired consciousness, neurologic disease) were consistently documented. Specify whether swallowing assessments (e.g., speech-language pathology evaluation, videofluoroscopy) were available for any patients. Expand the limitations section to explicitly discuss the potential impact of physician-dependent diagnosis on internal validity.
2. Propensity score matching includes PSI and ADL status as matching variables, despite both being key prognostic factors and outcomes of interest. This raises concerns about potential over-adjustment and attenuation of clinically meaningful differences.
Minor Revisions

1. Specify that functional status was assessed using the Barthel Index when first mentioned.
2. Improve readability of Figure 1, particularly font size and labeling of absolute numbers and percentages.
3. Reduce repetition of results already described in the Results section.
4. Consider adding a short paragraph on implications for clinical pathways, such as dysphagia screening or rehabilitation planning.
5. Explicitly mention the absence of frailty indices, cognitive status, and formal nutritional assessments as additional limitations.

Date Sent: 7-Jan-2026

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Author's Response to Decision Letter for (JCQ-2025-0043)

Aspiration Pneumonia Versus Community Acquired Pneumonia: Differences in Clinical Characteristics, Functional Status, and Mortality Predictors

Dear Editor and Reviewers,

We would like to thank the Editor and the Reviewers for their careful evaluation of our manuscript and for their constructive and insightful comments. We believe that addressing these suggestions has substantially improved the clarity, rigor, and clinical relevance of our work. All changes have been incorporated into the revised manuscript, and key modifications are detailed below.

Editor's Comments
1. Check grammar and flow for minor errors.
Response: We appreciate the reviwer's comment on this point. We have carefully revised the manuscript to correct grammatical issues and improve overall clarity and flow throughout the text.

2. Ensure all abbreviations are defined on first use in both abstract and main text.
Response: We appreciate the reviwer's comment on this point. All abbreviations are now defined at first mention in both the abstract and the main manuscript

3. Add ORCID IDs for authors if available
Response: We appreciate the reviwer's comment on this point. ORCID IDs have been added for all authors for whom this information is available.

Reviewer: 1

Comments to the Author
This study examines the clinical, functional, and prognostic differences between aspiration pneumonia (AP) and community-acquired pneumonia (CAP) in a large, two-center patient cohort. The use of propensity score matching, the emphasis on functional status (ADL), and the clinical applicability of the results are strengths of the study. The text is generally well structured, the methodology is appropriate, and the findings are consistent. I still think there are a few points that need to be revised.

Comment 1: The AP definition is based on the "attending physician diagnosis." This creates a risk of misclassification bias. This should be emphasized more clearly in a sentence in the Discussion or Methods section.
Response: We appreciate the reviewer's comment on this important point and fully agree with the concern raised. We have now explicitly emphasized the potential for misclassification bias associated with physician-dependent diagnosis in the Methods section: "However, because AP classification relied on clinical judgment documented in medical records rather than standardized diagnostic criteria, the potential for misclassification bias cannot be excluded." In addition, we have highlighted this issue in the Discussion as a study limitation: "First, the retrospective design may introduce information and misclassification bias, as AP was defined based on attending physician diagnosis and medical record documentation."

2 Fungal isolation and Gram-negative rates have been reported. However: The distinction between colonization and the actual causative agent is unclear. The impact on treatment decisions has not been discussed.
Response: We appreciate the reviewer's insightful comment. We have clarified in the Discussion that the reported microbiological findings, particularly fungal isolates, may represent colonization rather than true causative pathogens and that these data were analyzed descriptively rather than to establish etiologic causality. We also acknowledge that, due to the retrospective design and limitations in clinical documentation, we were unable to directly assess how microbiological findings influenced treatment decisions, including antibiotic selection and management strategies. This clarification is reflected in the revised Discussion: "Differences in initial antibiotic selection between AP and CAP may reflect clinicians' anticipation of broader pathogen coverage in suspected AP. Fungal and Gram-negative organisms were more frequently isolated from sputum cultures in the AP group; however, these findings may represent airway colonization rather than true infection. The retrospective design precluded evaluation of how culture results influenced subsequent treatment decisions."

Reviewer: 2
This retrospective observational study compares aspiration pneumonia and community-acquired pneumonia with respect to clinical characteristics, functional status, and predictors of in-hospital mortality. The study addresses an important clinical question, particularly relevant to aging populations, and incorporates functional status and propensity score matching to strengthen causal inference. The manuscript is generally well written, methodologically sound, and clinically meaningful. However, several major issues require clarification or correction, particularly regarding the definition of aspiration pneumonia, consistency and clarity of multivariable analyses, and methodological justification for propensity score matching. Addressing these concerns would substantially improve the rigor, transparency, and interpretability of the findings.

Major Revisions
1. Aspiration pneumonia is defined retrospectively based on the attending physician's diagnosis combined with radiographic findings. While this reflects real-world practice, it raises concerns regarding diagnostic heterogeneity and misclassification bias, especially in older adults where AP and CAP often overlap. Clarify whether standardized diagnostic elements (e.g., witnessed aspiration, dysphagia, impaired consciousness, neurologic disease) were consistently documented. Specify whether swallowing assessments (e.g., speech-language pathology evaluation, videofluoroscopy) were available for any patients. Expand the limitations section to explicitly discuss the potential impact of physician-dependent diagnosis on internal validity.
Response: We appreciate the reviewer's thoughtful comment regarding the potential for diagnostic heterogeneity and misclassification bias. As same as Reviewer one pointed. AP was identified retrospectively based on the attending physician's diagnosis in combination with radiographic findings, reflecting real-world clinical practice. However, because AP classification relied on clinical judgment documented in medical records rather than standardized diagnostic criteria, the potential for misclassification bias cannot be excluded.
With respect to standardized diagnostic elements, clinical features such as witnessed aspiration events, dysphagia, impaired consciousness, and underlying neurologic disease were not uniformly classified or systematically documented in all patients. Swallowing assessments, including speech-language pathology evaluations, were typically performed prior to oral feeding when clinically indicated; however, detailed swallowing-assessment data (e.g., videofluoroscopic findings) were not consistently available for all cases due to the retrospective study design. We have expanded the Limitations section to explicitly acknowledge that the retrospective, physician-dependent diagnosis of AP may introduce information and misclassification bias and could affect internal validity. Specifically, we now state: "First, the retrospective design may introduce information and misclassification bias, as AP was defined based on attending physician diagnosis and medical record documentation."

2. Propensity score matching includes PSI and ADL status as matching variables, despite both being key prognostic factors and outcomes of interest. This raises concerns about potential over-adjustment and attenuation of clinically meaningful differences.
Response: We appreciate the reviewer's insightful comment regarding the inclusion of PSI and ADL in the propensity score model. These variables were included because they represent key baseline characteristics that differ substantially between aspiration pneumonia and community-acquired pneumonia and strongly influence prognosis. Adjusting for PSI and ADL was intended to reduce residual confounding and to create clinically comparable groups at admission.
We acknowledge that matching on disease severity and functional status may attenuate effect estimates. However, this approach was deliberately chosen to provide a conservative assessment of whether aspiration status independently influences outcomes beyond baseline severity and functional impairment. The persistence of significant differences after matching supports an independent association. We have clarified this rationale in the Methods section and explicitly acknowledged in the Limitations that inclusion of PSI and ADL may have attenuated effect estimates and underestimated the total impact of aspiration pneumonia on outcomes.

Minor Revisions
1. Specify that functional status was assessed using the Barthel Index when first mentioned.
Response: We appreciate the reviewer's comment on this point. This has been clarified at first mention in both the abstract and the main text.

2. Improve readability of Figure 1, particularly font size and labeling of absolute numbers and percentages.
Response: We appreciate the reviewer's comment on this point. Figure 1 has been revised with larger font size and clearer labeling of absolute numbers and percentages.

3. Reduce repetition of results already described in the Results section.
Response: We appreciate the reviewer's comment on this point. Redundant descriptions in the Discussion have been removed or condensed.

4. Consider adding a short paragraph on implications for clinical pathways, such as dysphagia screening or rehabilitation planning.
Response: We appreciate the reviewer's comment on this point. We have added a short paragraph in the Discussion addressing implications for clinical practice, including the potential role of dysphagia screening and rehabilitation planning as follows "These findings have important implications for clinical pathways in pneumonia, supporting routine dysphagia screening at admission, particularly in older or functionally impaired patients, and early multidisciplinary involvement, including swallowing rehabilitation and nutritional support. Integrating these interventions into standardized care pathways may reduce complications, improve resource utilization, and enhance outcomes in patients with AP."

5. Explicitly mention the absence of frailty indices, cognitive status, and formal nutritional assessments as additional limitations.
Response: We appreciate the reviewer's comment on this point. These factors are now explicitly acknowledged in the Limitations section as follows "Second, although propensity score matching improved group comparability, residual confounding from unmeasured factors, such as frailty indices, cognitive status, swallowing function, nutritional status, and oral-hygiene practices, may remain."

Once again, we sincerely thank the Editor and Reviewers for their valuable feedback. We believe that the revisions have strengthened the manuscript and improved its clinical relevance and transparency. We hope that the revised version meets the expectations for publication.

Best Regards
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