We would like to thank Koulaouzidis *et al.* for their interesting comments.

We agree that the serum-ascites-albumin gradient (SAAG) >11 g/l is an indicator of portal hypertension. Since the article is focused on ascites in cirrhosis we took the liberty of stating that an SAAG ≥11 is *indicative* for a hepatic cause, not diagnostic. As can be seen in our *table 1*, extrahepatic causes for ascites were recognised.[1]

It was not our intention to suggest that all diagnostic tests should always be done in all patients with ascites. We agree that these diagnostic tests come into different stages of the ascites investigation algorithm. The leucocyte cell count is indeed the most important diagnostic test in ascites. It is the golden standard in diagnosing spontaneous bacterial peritonitis (SBP). However, as stated in our article, when the aetiology of ascites is not certain, additional testing such as amylase and triglyceride concentration is often necessary. Electronic coulter counting of cells in ascites may define cells as leucocytes which in fact may be malignant cells, so in selected cases we think there is still a place for cytology and immunology of ascitic fluid.

Table 1. *Aetiology according to the serum ascites albumin gradient*

<11 g/l	Infection
	Nephrotic syndrome
	Malignancy
	Pancreatitis
≥11 g/l	Cirrhosis
	Budd-Chiari syndrome
	Veno-occlusive disease
	Alcoholic hepatitis
	Congestive heart failure

Leucocyte esterase reagent strips have been examined in several studies as a bedside diagnostic tool for SBP. The studies differ in methodology and the results of these studies are contradictory.[2,3]

The final comment on our article made by Koulaouzidis *et al.* concerns the subgroup of patients with SBP eligible for albumin infusion. This is in line with our assumption that those patients with Child Pugh score C, i.e. those with severe liver dysfunction, benefit most from the addition of albumin to the treatment regimen.

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