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EDITORIAL

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What's in this issue

The links between cigarette smoking and respiratory disease, particularly chronic obstructive pulmonary disease (COPD) and lung cancer, have been well known for many years. Yet most governments have not legislated against smoking in public places; this is to their detriment in terms of the economic effects of ill health amongst the workforce and the astronomical costs to their respective health services. In this issue Sichletidis et al. report on the high prevalence of cigarette smoking (over 40%) in doctors, medical students and teachers in Northern Greece [1]. This is particularly important, since these are the professionals (or future professionals) who ought to be giving an example to the pupils, students, and patients under their care. In an accompanying editorial, van Schayck and Kaper summarise the evidence on the effect of smoking on COPD and also provide us with some worrying statistics [2]. They estimate that if current smoking rates continue, by the year 2030 cigarettes will cause 3 million and 7 million deaths per year, respectively, in the western and developing worlds.

The terms 'disease severity', 'severity of illness' and 'degree of airflow obstruction' are not used consistently by clinicians when referring to COPD. In his editorial [3], David Halpin discusses these terms in relation to COPD. He also discusses the rationale for the use of 'multi-dimensional' factors in estimating severity of COPD, rather than simply using spirometry alone. The paper by Steuten et al. [4] provides an example of this. They recruited 317 COPD patients from primary care, classified their severity according to GOLD stages [5], and related this to other measures of breathlessness, fat free mass (FFM) and Body Mass Index (BMI).

Interestingly, they confirm, as others have found [6], that BMI alone is of relatively less importance in determining disease severity. They conclude that it is necessary to be aware of dyspnoea severity and the nutritional aspects of COPD management in order to avoid underestimation of disease severity in primary care. This information should be of help in deciding who needs referral for exercise training and nutritional intervention, particularly if these services are of limited availability—such as in the United Kingdom at present.

Defining COPD exacerbations is a complex issue and health care professionals struggle to agree on this. Adams and colleagues [7] tackle the problem in a qualitative study by exploring the notion of exacerbations from the perspectives of 27 COPD patients from three countries. They selected patients for interview on the basis of a consultation for unscheduled treatment for their COPD within the last six weeks. After analysis of the discussions, they classify patients' perceptions of the need for consultation regarding COPD exacerbations into four categories: 'frightening change'; 'change in sputum colour'; 'gradual deterioration'; and 'opportunistic diagnosis'. This classification may be of help in creating a useable, measurable definition of COPD exacerbations for evaluating patient control and for use in clinical research.

The recently published Eastern Region Confidential Enquiry into asthma deaths [8] concluded that 80% of asthma deaths were in patients with identifiable psychosocial risk factors, and that 'at-risk asthma registers' should be set up in primary care using criteria based upon its findings and other previous confidential enquiries—as highlighted in national guidelines [9]. However,

the authors did stress that there was no published evidence that 'at-risk' registers were effective [8]. In this issue, Noble et al. [10] describe the first-ever published study on the implementation and evaluation of an at-risk asthma register established within one general practice in the UK. This is a small case-controlled pilot study in which 3% of their total asthma patients fulfilled the criteria for being 'at-risk' by having severe asthma plus adverse psychosocial factors. After implementation of the register, these at-risk patients suffered fewer adverse outcomes than previously, with a reduction in hospitalisation, accident and emergency (A&E) attendances and nebulisations. Nevertheless, there is a potential problem: if primary care health professionals focus only on those patients 'at risk', might other patients, without clear recognisable risk factors, be treated inadequately? Perhaps what we need to do in primary care is to monitor and follow-up aggressively all those patients with active asthma (i.e. those on treatment in the last year). In addition, we need to be flexible in our management approach and to be on a 'high state of alert' when consulted by asthma patients with respiratory symptoms, particularly if they have psychosocial problems [10,11]. We would be delighted to receive correspondence on the issue of 'at-risk' asthma registers – this is an important topic for discussion and one which requires more research.

Oxygen saturation levels (SaO₂) provide primary care health professionals with a means of measuring the severity of acute asthma in all patients, particularly in those pre-school children who cannot perform peak expiratory flow measurements. Oxygen saturation levels can also be used to assess treatment progress during management of uncontrolled asthma; if the levels fail to increase despite treatment, or when oxygen is discontinued, hospital admission is advised [10,11]. The decision whether or not to admit preschool children to hospital for uncontrolled asthma can be helped considerably by pre-treatment measurement of oxygen saturation. Therefore, it is extremely surprising that Cunningham and McMurray found that less than 4% of the general practices they surveyed had access to pulse oximetry [12]. No doubt more work needs to be done to increase the availability of SaO₂ monitoring in primary care.

A study on the relationship between house dust mite (HDM) allergen exposure level and inhaled corticosteroid (ICS) dosage in HDM-sensitive patients who are self managing their asthma is presented by de Vries et al. [13]. Interestingly, the authors state that one of their findings – that no difference was found in the proportion of

patients who could taper off ICS dosage according to different HDM allergen exposure levels – was unexpected. We also include in this issue a Case report on a five-year old patient who presented with presumed asthma but who actually had Juvenile Laryngeal Papillomatosis [14].

After its absence from the previous IPCRG Guideline issue, our News section returns containing various GPIAG and IPCRG news announcements.

Finally, we are delighted to share with you the news that the Primary Care Respiratory Journal has just recently been accepted for full listing on Medline/Index Medicus. More on this to come in our next issue.

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