

## Letter to the Editor

Editor,

The COPD guidelines aimed at primary care that were published in *Asthma in General Practice* in December<sup>1</sup> are to be applauded. The majority of patients with mild and moderate COPD are managed in primary care, and clear pragmatic guidelines aimed at this group of physicians are clearly of value.

I am, however, concerned about the issue of GP access to reliable spirometry, an area assumed in these guidelines, as indeed it is in all other published guidelines. There is full agreement that accurate measurements of spirometric parameters such as FEV<sub>1</sub> and FVC are essential for the diagnosis, classification of severity and assessment of responsiveness to treatment in this condition. The BTS guidelines recommend that primary care physicians treating COPD should have ready access to spirometry either from a surgery-based spirometer or through an open-access service of some sort, and does consider some of the implications of this recommendation.

Unfortunately, access to spirometry is far from being standard at present, and many GPs have difficulty in obtaining reliable spirometry readings on their patients. This can lead to misdiagnosis and to inconsistent and suboptimal treatment for these patients. There are various possible solutions to this problem. One is that all GPs should obtain spirometers for their surgeries either at their own expense or provided by the health authority or primary care group (PCG). Considerations relevant to this solution include cost issues, calibration and maintenance of equipment, training of technical staff performing the test and interpretation of the results. It is possible that many GPs would view spirometric assessment and performing bronchodilator and steroid reversibility tests as an unwelcome addition to their busy working day.

Another possible solution is open-access services provided from a local hospital-based unit with or

without interpretation and comments on the results. These services already operate in some areas, but many secondary care chest physicians have doubts as to the usefulness of such provision, and resent the extra workload generated for them and their staff.

With the advent of PCGs, another option becomes feasible – PCG-commissioned spirometry services. It would be possible for a single or group of PCGs to obtain equipment and to train a technician to perform spirometric testing for the GPs in the group. Interpretation and comment on the results could be provided by suitable local expertise if required, although most PCGs already have the necessary skills within their own membership to do this.

Economies of scale could result, and the investigations could be integrated into agreed prescribing and clinical governance frameworks for the management of COPD. If this service were to be coordinated by a local primary/secondary care interface group and in conjunction with locally agreed-upon protocols, it is hoped that the result would be consistent, pragmatic and seamless standards of care for COPD patients delivered by all the doctors and nurses caring for this disease.

We live in interesting times and there are many potential benefits from the forthcoming changes to the structure of the National Health Service to which we should be alert. Perhaps this is a moment at which those of us who are interested in COPD should take a proactive role to ensure that we and our colleagues have adequate access to spirometry.

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1. van Schayck CP, van Herwaarden CLA, Barnes PJ, *et al.* Recommendations based on guidelines on the management of mild to moderately severe chronic obstructive pulmonary disease: Some practical applications in primary care. *Asthma Gen Pract* 1998;6(3):35–9