

**EDITORIAL**

What's in this issue

The hygiene hypothesis, suggesting a relationship between naturally occurring infections and allergic diseases, has been around for a number of years [1]. In this issue, this subject is addressed in the form of a debate [2–5], accompanied by an editorial by Liu [6], of the National Jewish Medical and Research Center in Denver. Liu introduces and discusses the subject and also shares some of the findings from Denver on natural endotoxin exposure. In this lively debate, Gore and Custovic discuss the case for the hygiene hypothesis while Van Schayck and Knottnerus argue against its validity. While the hygiene hypothesis does not provide a clear argument for any course of action for either prevention or therapy, these three papers provide a strong case for further research in this field.

In his editorial, Professor Chris Griffiths [7] looks in detail at disparities in respiratory care and morbidity amongst ethnic groups, world wide, according to published literature. He stresses the need for accurate recording of ethnicity in day to day care and for more attention to be focused upon education systems for chronic disease management related to minority groups. Finally he calls for increased priority for research into relationships between ethnicity, racism and health care so that these issues continue to move up the list of political priorities.

Reggie Spellman suggested in 1996 that the use of treatment steps alone in guidelines, were inadequate for assessing patients' asthma control; he recommended using a combination of treatment and clinical findings [8]. The latest version of the GINA [9] guidelines includes a table to this effect, and the recent BTS/SIGN guidelines [10] do place more emphasis on enquiring about the effect of asthma on people's lifestyle when reviewing them. Two papers in this issue address the complex issues related to treatment and its effect on patients in terms of disease control, one on asthma [11] and another on COPD [12]. Wijnhoven and Kreigsman, report a general practice

cross-sectional study examining asthma control in conjunction with medication use in 661 adult asthma patients. Their study variables included respiratory symptoms, lung function, use of medication and current therapy step according to the Dutch GP guidelines. According to these criteria many of their patients were inadequately controlled.

GOLD [13] defined COPD as ... 'a progressive, and not fully reversible disease'. Spirometry alone cannot characterise the impact of treatment on patients with this disease. Reid et al. [12] report the proceedings and conclusions of a closed meeting of respiratory experts, who discussed developing a tool to complement spirometry in order to help primary care physicians assess treatment success in patients with chronic obstructive pulmonary disease (COPD). This panel of experts share their views on the subject of evaluating treatment success in these patients, in addition to lung function, and conclude a need for a standardised approach to symptomatic assessment. They suggest an aide-mémoire, or checklist, to help primary care practitioners recognise symptomatic benefit, and invite further discussion on its content, usefulness and validation.

In his review, David Bellamy, GPIAG Trustee and member of the NICE Guidelines working group for COPD [14–16], summarises their recommendations for diagnosis and management of patients [17]. The GPIAG together with many other organisations had an opportunity to contribute to these comprehensive guidelines—please refer to the first item of the News Section, p. 105, to see the GPIAG response. While extremely helpful in many aspects, the recommendation that ... 'reversibility testing is not necessary for diagnosing COPD in all patients', has aroused controversy. Bellamy describes the reasoning underpinning this recommendation, which is acceptable for the diagnosis of COPD. However, from a GP perspective, where undiagnosed patients consult with respira-

tory symptoms, reversibility is extremely helpful in differentiating asthma from COPD. This matter is addressed further on the GPIAG website discussion forum (<http://www.gpiag.org>).

Over 450 delegates attended the second Conference of the International Primary Care Respiratory Group (IPCRG) held in Melbourne earlier this year (<http://www.theipcrj.org>). Abstracts presented at this meeting are published in this issue of the PCRJ, pages 105–121. The officers of the IPCRG and organisers of this conference really managed to create an atmosphere of international collaboration and progress in the field of respiratory medicine in primary care. The next meeting will be in Oslo, under the new presidency of Dr. Anders Ostrem.

References

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