Primary Care Respiratory Journal (2004) **13**, 127—128

PRIMARY CARE
RESPIRATORY
JOURNAL

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EDITORIAL

What's in this issue?

Eleven people die every hour in the United Kingdom due to respiratory disease, according to a statement at the British Thoracic Society summer meeting in June 2004. Many of these deaths are due to respiratory infections. However, there is considerable evidence that these infections are inappropriately managed with antibiotics in primary care. Two papers address the subject of Lower Respiratory Tract Infections in this issue of the Journal. In his review [1], Professor Charles Feldman elegantly describes the difficulties and provides some solutions associated with diagnosis and management of lower respiratory tract infections (LRTIs) in the primary care setting; he focusses on the management of acute bronchitis, community acquired pneumonia and acute exacerbations of COPD. In his editorial on LRTIs, Professor Theo Verheij [2] emphasises the three main issues for health professionals in primary care; accurate diagnosis, use of antibiotics and application of evidence based principles - the latter being difficult due to the paucity of available data.

Occupational Asthma is the only potentially curable form of asthma. This month sees the launch of new guidelines on occupational asthma [3], sponsored by BOHRF (The British Occupational Health Research Foundation). In his editorial [4], Sherwood Burge, an international expert in this field, describes the features and predisposing factors of this condition, and addresses the important aspect for those of us working in primary care—how to identify those who may have occupational asthma. In their editorial, Josip Car and Aziz Sheikh discuss aspects of fasting related to use of medication in people with asthma [5]. Their paper provides helpful insight for clinicians managing patients with asthma during periods of religious fasting. In their conclusion they emphasise 'the importance of discovering what patients believe about asthma (or any other illness), and in reconciling differences between what doctors want patients to do and what patients think they should do for treating their asthma'.

Barton et al., in their systematic review [6] on the effectiveness of Continuing Medical Education (CME) for improving health outcomes of patients with asthma, were unable to make firm recommendations. This paper prompted us to commission an editorial by Monica Fletcher (Chief Executive of the National Respiratory Training Centre, Warwick, UK) [7]. She provides an insight into the problems faced by researchers investigating implementation and outcome related to education of health professionals. She also discusses the problems resulting from use of the Randomised Controlled Trial model to evaluate educational interventions, which are possibly more suited to qualitative research methodology. There is clearly a need for more research in this area.

Douglas Fleming previously reported data from the UK Weekly Returns Service which demonstrates a decline in the numbers of patients attending their GPs for episodes of asthma [8]. Henderson and colleagues [9] report a similar trend in their secondary analysis of routine anonymous data collected from 20 GPs for 50 weeks of the year since April 1998. This decline occurred mainly in children and the authors have not been able to explain this. Possible reasons for the Australian observation include the combination effect of the advent of availability of 'over the counter' bronchodilators coupled with an 'up front charge' for patients attending

1471-4418/$30.00
doi:10.1016/j.pcrj.2004.06.003

their GP. The authors optimistically suggest that this may be due to patients being more in control of their asthma, particularly those with more severe asthma.

Cleland and colleagues' investigation [10] of general practitioners (GP's) and patients views on smoking cessation in primary care provides a useful insight for those health professionals trying to help their patients stop smoking. Also on the theme of patient compliance, Jones and colleagues examined patients' perceptions of compliance with COPD medication as well as health related behaviours related to smoking cessation, exercise and diet. They discuss the concept of 'intentional non-compliance with medication' [11].

Three clinical papers in this issue will be of use to health professionals in primary care. We include two case reports, one on a 34-year old adult who aspirated a peanut [12] and another which focuses on a 60 year old lady who was referred to the chest clinic with a six-month history of cough and intermittent wheeze. [13]. The third relates to the identification of patients with undiagnosed COPD which is a real problem in primary care; the paper by Garcia-Pachon suggests that pulse oximetry is unhelpful in this regard [14].

References

[1] Feldman C. Appropriate management of lower respiratory tract infections in primary care. Primary Care Resp J 2004;13(3):159—66.

[2] Verheij T. Lower respiratory tract infections: not only less antibiotic prescriptions but also more evidence, please. Primary Care Resp J 2004;13(3):129—30.

[3] Nicholson PJ, Cullinan P, Gosmore C, Newman Taylor AJ, Burge PS. Guidelines for the prevention, identification and management of occupational asthma: Evidence review and recommendations. British Occupational Health Foundation, London 2004.

[4] Burge PS. New guidelines for the management of occupational asthma in primary care and occupational health. Primary Care Resp J 2004;13(3):131—2.

[5] Car J, Sheikh A. Fasting and asthma: an opportunity for building patient-doctor partnership. Primary Care Resp J 2004;13(3):133—5.

[6] Barton C, Sulaiman N, Liaw S-T. Continuing medical education for asthma in primary care settings: a review of randomised controlled trials. Prim Care Resp J 2003; 12(4):119—123. http://www.gpiag.org/journ/vol12_4/119_123barton.pdf.

[7] Fletcher M. Continuing medical education (CME) for primary care health professionals. Primary Care Resp J 2004;13(3):136—7.

[8] Fleming DM, Sunderland R, Cross KW, Ross AM. Declining incidence of episodes of asthma: a study of trends in new episodes presenting to general practitioners in the period 1989—98. Thorax 2000;55(8):657—61.

[9] Henderson J, Knox S, Pan Y, Britt H. Changes in asthma management in Australian general practice. Primary Care Resp J 2004;13(3):138—43.

[10] Cleland J, Thomas M, Pinnode H. The views and attitudes of general practitioners and smokers toward provision of smoking cessation advice: a qualitative study. Primary Care Resp J 2004;13(3):144—8.

[11] Jones RCM, Hyland ME, Hanney K, Erwin J. A qualitative study of compliance with medication and lifestyle modification in Chronic Obstructive Pulmonary Disease (COPD). Primary Care Resp J 2004;13(3):149—54.

[12] Samuel CL Leong, Kaleelullah S Farook. Case report: peanut aspiration in an adult. Primary Care Resp J 2004;13(3):171—2.

[13] Bhatia P, Karthik S, Dr. JFO'Reilly. STOP: THINK SERIES: An abnormal chest x-ray and "Asthma". Primary Care Resp J 2004;13(3):167—8.

[14] Garcia-Pachon E. Can pulse oximetry select patients for screening spirometry? Primary Care Resp J 2004;13(3):155—8.

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28 June 2004