EDITORIAL

What's in this issue

The diagnosis of asthma poses an ongoing challenge for health professionals in primary care. In the last issue of the Primary Care Respiratory Journal (PCRJ) we published two papers related to difficulties in diagnosing childhood asthma [1,2]. This month we focus on adults, and in particular on the diagnosis of occupational asthma.

General practitioners (GPs) are sometimes accused of delayed or missed diagnoses, particularly of chronic conditions. The nature of general practice can make it difficult to make accurate diagnoses; patients present with symptoms which may be due to a variety of different underlying causes, and GPs certainly don't have the benefit of a letter from a colleague indicating possible aetiology. Further delays may arise from lack of continuity of medical care, with patients seeing different health professionals both during the working day and 'out of hours' [3]. In the United Kingdom, the recent trend for patients to be treated in 'walk-in centres' may further complicate matters, not least due to problems in communication between health professionals. GPs in a busy general practice may deal with patients suffering from more than 150 different medical problems in any one year. These factors all enhance the difficulty in identifying and diagnosing those patients suffering from chronic, as opposed to acute, conditions.

There is very little data from studies of occupational asthma in primary care [4,5]; and while it is estimated that one in 10 patients with new onset adult asthma may be due to exposure to factors at work [6], it is very likely that occupational asthma is underdiagnosed. How can the situation be improved? In a previous PCRJ editorial Sherwood Burge stated that occupational asthma is easy to diagnose; one possible solution, he sug-

gested, was that 'all adult asthmatics should be asked whether their symptoms improve on days away from work or on holiday' [7]. Two reviews, based on recent presentations from the launch of the new UK guidelines for the prevention, identification and management of occupational asthma [8], have been written up and are presented in this issue. The first, by James Douglas [9], a GP with an interest in occupational medicine, details the processes involved in diagnosing occupational asthma in practice. Secondly, Currie and Ayres review evidence on exposure to the various 'asthma-gens' which may induce occupational asthma [10]. It is clear, therefore, that an occupational history should routinely be obtained from adult patients with new onset asthma or rhinitis; occupational rhinitis often precedes occupational asthma [8,11]. Patients suspected of having work-induced or work-aggravated asthma should be referred to a specialist, particularly because, if diagnosed early enough, occupational asthma is potentially curable [8]. Health professionals working in primary care therefore have a challenging task in order to improve the identification and management of occupational asthma.

Asthma guidelines stress the need for patient self management action plans [12]. Recently, a number of papers have shown patient benefit from the use of flexible dosing schemes for asthma management (for example, [13]). In this issue, Greaves and colleagues analyse asthma outcomes (emergency care and Quality of Life) in general practice patients in terms of their pattern of corticosteroid medication use [14]. Rather than focusing upon compliance issues, as in other studies on dosing regimes [15], the authors have focused on outcomes; they conclude that a more flexible use of inhaled corticosteroids

coincided with better outcomes in mild asthma but not in patients with more severe asthma.

In a further paper on the subject of dosing regimes, Guest and colleagues [16] present data on the pharmaco-economics of single doses of inhaled steroids in asthma. The methodology used for evaluating health economic data has been criticized in the past [17]. In his editorial on this paper, Phillip Ind raises some pertinent and controversial points [18]. In particular, he questions the current UK approach within health service management which focuses predominantly on cost of medication and not adequately enough on outcomes.

Three papers in this issue from members of the General Practice Airways Group in three different Scottish University Departments of Primary Care contribute further to our knowledge and management of respiratory disease. McCowan and colleagues in Dundee have been studying the effect of guidelines on asthma management for many years, starting with the National Asthma Attack Audit [19]. Their observational study of routine review consultations of nearly 42000 patients with asthma, indicates a significant reduction in morbidity and use of reliever medication in patients reviewed more than once by a health professional [20]. Mike Thomas and colleagues from Aberdeen continue their work on the subject of dysfunctional breathing [21] with a cross sectional survey of 300 patients in a rural primary care setting [22]. They found that dysfunctional breathing may affect up to 1 in 10 people, and is more common in women and in people with asthma; these patients require training in breathing modification and not increased medication. From Edinburgh, Samantha Walker and Aziz Sheikh publish a questionnaire-based study on the prevalence of rhinitis amongst 10500 people in the UK already diagnosed with asthma [23]. 76% of patients with asthma reported symptoms indicative of rhinitis. They suggest that the diagnosis of rhinitis should be considered in all asthma patients.

The News section highlights the forthcoming UK Respiratory Primary Care Conference to be held in Cheshire in July, and the IPCRG Third World Conference to be held in Oslo in June 2006.

References

- [1] Ostergaard MS. Childhood asthma: reasons for diagnostic delay and facilitation of early diagnosis—a qualitative study. *Prim Care Respir J* 2005;14(1):25–30.
- [2] Mommers M, Swaen GMH, Weishoff-Houben M, Dott W, van Schayck CP. Differences in asthma diagnosis and medication use in children living in Germany and the Netherlands. *Prim Care Respir J* 2005;14(1):31–7.
- [3] Levy M. Delay in diagnosing asthma—is the nature of general practice to blame? *The Journal of the Royal College of General Practitioners* 1986;36(283):52–3.
- [4] Blanc PD, Eisner MD, Israel L, Yelin EH. The association between occupation and asthma in general medical practice. *Chest* 1999;115(5):1259–64.
- [5] de Bono J, Hudsmith L. Occupational asthma: a community based study. *Occupational Medicine (Oxford)* 1999;49(4):217–9.
- [6] Cullinan P, Cullinan P. Clinical aspects of occupational asthma. *Panminerva Medica* 2004;46(2):111–20.
- [7] Burge PS. New guidelines for the management of occupational asthma in primary care and occupational health. *Prim Care Respir J* 2004;13:131–2.
- [8] Newman Taylor AJ, Nicholson PJ. Guidelines for the prevention, identification and management of occupational asthma: Evidence review and recommendations. London: British Occupational Health Research Foundation; 2004. Last Accessed on 12-12-2004 <http://www.bohrf.org.uk/content/asthma.htm>.
- [9] Douglas J. If you want to cure their asthma, ask about their job. *Prim Care Respir J* 2005;14(2):65–71.
- [10] Currie GP, Ayres JG. Occupational asthmagens. *Prim Care Respir J* 2005;14(2):72–7.
- [11] Levy ML, Nicholson PJ. Occupational asthma case finding: A role for primary care. *Br J General Prac* 2004;54(507):731–3.
- [12] BTS/SIGN. British guidelines on the management of asthma. *Thorax* 2004;58(Suppl. 1):1–94. <http://www.sign.ac.uk/guidelines/fulltext/63/index.html>.
- [13] Ind PW, Haughey J, Price D, Rosen J-P, Kennelly J. Adjustable and fixed dosing with budesonide/formoterol via a single inhaler in asthma patients: The ASSURE study. *Respiratory Medicine* 2004;98(5):464–75.
- [14] Greaves CJ, Hyland ME, Halpin DMG, Blake S, Seamark D. Patterns of corticosteroid medication use: non-adherence can be effective in milder asthma. *Prim Care Respir J* 2005;14(2):99–105.
- [15] Claxton AJ, Cramer J, Pierce C. A systematic review of the associations between dose regimens and medication compliance. *Clinical Therapeutics* 2001;23(8):1296–310.
- [16] Guest JF, Davie AM, Ruiz FJ, Greener MJ. Switching asthma patients to a once-daily inhaled steroid improves compliance and reduces healthcare costs. *Prim Care Respir J* 2005;14(2):88–98.
- [17] Coyle D, Coyle D. Statistical analysis in pharmacoeconomic studies: A review of current issues and standards. *Pharmacoeconomics* 1996;9(6):506–16.
- [18] Ind PW. Editorial. Once daily inhaled steroids for asthma: how useful are pharmacoeconomic data? *Prim Care Respir J* 2005;14(2):62–4.
- [19] Neville RG, Clark RC, Hoskins G, Smith B. National asthma attack audit 1991–2. General Practitioners in Asthma Group [see comments]. *BMJ* 1993;306:559–62.
- [20] McCowan C. An academic, pharmaceutical and practice collaboration to implement asthma guidelines. *Prim Care Respir J* 2005;14(2):106–11.
- [21] Thomas M, McKinley RK, Freeman E, Foy C. Prevalence of dysfunctional breathing in patients treated for asthma in primary care: cross sectional survey, [comment]. *BMJ* 5-5-2001;322(7294):1098–100.
- [22] Thomas M. The prevalence of dysfunctional breathing in adults in the community with and without asthma. *Prim Care Respir J* 2005;14(2):78–82.
- [23] Walker S. Self reported rhinitis is a significant problem for patients with asthma. *Prim Care Respir J* 2005;14: 83–7.

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