EDITORIAL

What's in this issue

The Primary Care Respiratory Journal (PCRJ) has evolved considerably over the years, and 2005 has been another landmark year in that the journal is now a bi-monthly publication, with six issues a year. Paper submissions to the journal have trebled over the last two years, and as the official journal of the General Practice Airways Group (GPIAG) and the International Primary Care Respiratory Group (IPCRG), the PCRJ has become established as the pre-eminent journal for those involved in primary care respiratory medicine throughout the world – as shown by the fact that this issue contains papers from France, Denmark, Australia, Sweden, the USA, and the UK. To mark this stage in the journal's evolution, and as the GPIAG prepares for its Annual Conference in Cheshire on the 8th/9th July, we include in this issue an editorial on the development of the journal over the last ten years together with some ideas that we have for the future [1]. There would, of course, be no future for the journal without its readership, and we are enormously grateful for your support over the years. If you have specific ideas as to how you feel the journal should be developing, either generally or as a response to our editorial, please let us know by writing to us at publishing@gpiag.org.

All of us regularly see patients presenting in late Spring with their 'hay fever' or allergic rhinitis symptoms, which include sneezing, watery eyes, and nasal congestion. A quick scramble for the prescription pad is usually followed by a prescription for treatment with anti-histamines and nasal corticosteroids. Yet there is a proportion of patients with severe morbidity whose symptoms we never seem able to control. Østergaard and colleagues, from Denmark and Norway, present a challenging and thought-provoking review on

the role of a single injection of intramuscular corticosteroid for the treatment of severe hay fever [2]. Their review does not support a high level of concern for the side-effects of injectable corticosteroid treatment, and they think that current guidelines are too dismissive of this treatment option. However, they do also wonder at the paucity of evidence on this topic. On the other hand, in his powerful editorial, Bousquet expresses his concern at these conclusions, encapsulated by the Latin dictum *Primum non nocere*, 'first do not harm' [3]. He insists that only the safest medications can be recommended for this non-fatal condition, and states that the authors have underestimated the side-effect profile of injectable corticosteroid. What do you think? We would be delighted to receive correspondence on this important topic, which we will fast-track for publication over the next two issues of the journal. We have already been able to fast-track an immediate response by the Review authors to Professor Bousquet's Editorial, which we have included in our Letters section in this issue [15].

We include four Original Research papers in this issue. Martyn Partridge's team from Imperial College, London, present a pilot study using two different methods to quantify the prevalence of obstructive sleep apnoea in an inner-city multi-ethnic population – postal questionnaires, leading to only 28% usable responses, or screening during pre-registration health checks, which was considerably more productive [4]. Of those patients who did reply to the questionnaire, 55% reported loud snoring, and 34% reported daytime sleepiness according to the Epworth Sleepiness Score. The prevalence of symptoms in younger patients presenting for their health check was

considerably lower, and the practice staff who participated found the experience both interesting and educational.

From Melbourne in Australia, Barton et al present a qualitative paper on the attitudes of asthma caregivers to written asthma action plans (WAAPs) [5], work which accompanies their quantitative paper which we published in the PCRJ last year [6]. The use of WAAPs by caregivers fell into three distinct groups: those who use WAAPs studiously; those who use them haphazardly and modify them as they see fit; and those who don't use them at all. In particular, providing a WAAP for a child's school is identified as an important issue, and the authors make the point that the start of the school year is an opportunity for clinicians to review and to update the WAAP.

Lisspers and her co-workers from Uppsala in Sweden report on the organisation of asthma care in 240 primary health care centres throughout Mid-Sweden [7]. They obtained an astonishing 99% response rate from the health care centres, which provides almost complete mapping of asthma care in the region, and in addition they performed a survey on the use of spirometry. In order to quantify the care being provided, they used the seven criteria for a complete primary care asthma clinic already established by the Swedish Respiratory Group in Primary Care: 53% of the centres reported that they had an asthma clinic, and of these 30% fulfilled all seven criteria and were 'complete' clinics. The most common unfulfilled criterion was that relating to time allocation for the practice nurse.

Chris Griffiths and his team from Queen Mary's in London report a qualitative study examining how asthma specialist nurses influence primary care management of asthma [8], which was carried out alongside their randomised controlled trial in the socially-deprived multiethnic area of East London [9]. Effective liaison between practices and the specialist liaison nurse was considerably more likely if practices prioritised asthma care, if the general practitioners (GPs) trusted their practice nurses to manage chronic disease effectively, if the GPs recognised specialist nurse expertise and acted on the nurse's advice, and if practices had simple systems in place in order to deal with the specialist nurse's recommendations. The challenge is to ensure that practices prioritise chronic disease care, and that the credibility of specialist nurses amongst GPs is increased.

In their Discussion paper, Steve Holmes and Kevin Gruffydd-Jones, on behalf of the GPIAG Education Sub-Committee, propose best practice recommendations for the appraisal and professional

development of GPs with a special interest (GPwSIs) in respiratory medicine [10]. This follows on from an earlier paper on the process of accreditation by portfolio for respiratory GPwSIs [11]. As usual with a Discussion paper, we will publish any letters sent to us on this topic, so that the authors and the GPIAG as a whole can gauge the response. In our 'Stop, think' section, Samantha Walker and Aziz Sheikh give a summary of the issues when managing a patient presenting with urticaria [12], whilst in our Short Reports section, Rupert Jones and colleagues present a pilot study of an inexpensive mobile spirometry service provided for seven practices in Plymouth in the UK [13]. Our other Short Report comes from the Bronx in New York, USA. Iheagwara et al report a very interesting study which assessed the ability of paediatric doctors and nurses to use spacer device/metered dose inhaler (MDI) combinations according to the manufacturers' criteria [14]; the majority didn't know how to use the MDI/spacer correctly, and they suggest that clinicians should be formally assessed on their ability to use MDI/spacer combinations before teaching patients themselves. Food for thought...

Finally, our News section provides the latest news from the GPIAG and IPCRG, as well as news from other organisations relevant to the primary care respiratory scene.

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