EDITORIAL

What's in this issue

The audit on management of allergic rhinitis by Ryan and colleagues in this issue [1] highlights a worrying situation, leading them to conclude that there is "considerable scope for improvement in general practitioner (GP) awareness and management of allergic rhinitis". A recent United Kingdom (UK) survey of 240 GPs concerning management of allergic disease in primary care detailed a great need for more training in this field [2]. This survey also highlighted that many patients with complex allergic problems, including food allergy, were being managed in primary care, by health professionals not necessarily trained in these areas, presumably because specialist services were either not available or there were extremely long delays in getting appointments. There is clearly a need for further training for primary healthcare professionals in the field of allergy. The question is: who is going to provide this training? In his editorial [3] Nasser discusses the options for improving allergy services through education and training, and concludes that expansion of secondary care allergy provision must precede any proposed primary care initiatives.

However, chronic disease management currently occurs mainly in the primary care sector, and managing allergic disease accounts for a substantial proportion of this work. In the UK, there have been proposals for management of many chronic conditions by GPs or Practitioners with a Special Interest (GPwSIs or PwSIs) in these disease areas. The discussion paper by Ryan et al. [4] discusses the minimum skill level and training requirement for practitioners in the field of allergy, and also serves as a basis for discussion on the subject of provision of allergy care in general practice. Nasser discusses this proposal in detail in his editorial.

Impermeable bedding covers are used in an attempt to reduce exposure to house dust mite

(HDM), particularly for sensitised patients. Whether or not this improves asthma control has been researched intensively for the last three decades. A recent narrative review [5] of 30 clinical trials involving bedding encasement for treating asthma found that only four of these trials reported significant reduction in dust-mite allergen exposure with concomitant reduction in bronchial hyperresponsiveness (BHR). As in many other studies [6], the review found reduction in exposure to mite allergen in ten of the studies, but BHR was not significantly reduced in asthmatic patients as compared to controls. The authors concluded that "although bedding encasement might be an effective asthma treatment under some conditions, when implemented in clinical trials by asthma patients, its effectiveness is inconsistent and appears to be, at best, modest". One of the studies [7] reviewed by Recer [5], which reported no clinical effect in asthma patients, made it clear that this related to the use of allergen-impermeable covers, *as a single intervention*. In this issue of the journal, de Vries and colleagues [8] report their study of 160 asthmatic patients (about 30% of those invited) in which the prevalence of those sensitive to HDM was 48.8%. This is at the lower end of the reported range for prevalence and the authors postulate that this may be related to the fact that 25% of this population were using bed covers. They don't report on the relationship between the reduction in HDM sensitivity and other medication or HDM reduction measures.

The accuracy of spirometry testing and the need for its interpretation in primary care has been the subject of a number of papers published in this journal over the last year [9–15]. Indeed, the debate continues with the letter by White in this issue [16]. Akhtar and Wilson [17] remind us that there is a need for better training in

this field. In their study comparing spirometry test results obtained in a pulmonary function laboratory with those obtained in primary care, they found that practice nurses significantly underestimated spirometry measurements and overdiagnosed COPD. This clearly has implications in the UK for the current Quality Outcomes Framework (QOF) criteria for COPD, which includes prevalence as part of the formula used to pay practices.

Dyspnoea is a common complaint by patients consulting in primary care. Alison McConnell's comprehensive review [18] on inspiratory muscle function, training and dyspnoea describes the physiology and management of patients with asthma and COPD. She details the lack of access to pulmonary rehabilitation for people with COPD, particularly in the UK, and makes a strong case for the use of inspiratory muscle training as a viable alternative for these patients. Despite declaring a potential conflict of interest, the evidence is persuasive. I was particularly interested to see details of gender differences in perception of dyspnoea in asthma sufferers, because there is a growing literature on the effects of gender on respiratory disease; this was the subject of a fascinating symposium at the recent American Thoracic Society Meeting in San Diego. There is certainly scope for considerable research in this field of respiratory medicine.

Finally, the News section contains details of the GPIAG submission to the QOF criteria review, as well as news on a GPIAG assessment tool which aims to increase awareness of the need for rhinitis assessment during patients' asthma reviews. There is also information on the third IPCRG Conference to be held in Oslo in June 2006, the UK Healthcare Commission review of COPD, news from the NRTC and the RTC, and an announcement regarding the launch of the new European Forum for Primary Care.

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