



## EDITORIAL

## What's in this issue

With the substantial body of evidence showing benefit from beta-blockers for patients suffering from ischaemic heart disease (IHD), general practitioners (GPs) are under considerable pressure to prescribe beta-blockers for all IHD patients. But what about patients with IHD who also happen to have asthma? Is it advisable or indeed safe to prescribe beta-blockers in these circumstances, and to what potential medico-legal risks are GPs exposing themselves if they do prescribe? The review by Ashrafiyan and Violaris [1] together with two focussed editorials on this subject by Dekhuijzen and Artan [2] and Panting [3] address this question. In their editorial Dekhuijzen and Artan conclude that where individual patient assessment indicates benefit from beta-blockade, selective  $\beta$ -blockers with Intrinsic Sympathomimetic Activity should be prescribed for people with mild to moderate asthma [2]. They do, however, urge caution in interpreting the published data on the effects of these drugs in people with asthma, mainly on the grounds that these studies are short term and do not clearly define the severity of asthma in those recruited. In their comprehensive review, encapsulating the 'pro' viewpoint, Ashrafiyan and Violaris [1] detail specific recommendations for prescribing these drugs in people with asthma; they characterise the nature of asthma, the preferred drugs, the need for patient education, and finally highlight a clear need for a register of asthmatic patients prescribed beta blockers, so that the long term benefits and sequelae can be evaluated. Panting writes with considerable authority as the Medical Director of the UK Medical Protection Society, and gives a clear and succinct summary of the medico-legal issues involved [3].

GPs are inundated with many different guidelines for management of chronic diseases. Do they work? This is a difficult question to answer and in many cases remains unanswered. While Chronic Obstructive Pulmonary Disease (COPD) guidelines have been around for some time, not many papers have been published on methodology for evaluation and implementation [4–6]. In this issue we publish a paper by Guest et al. [7], an observational, parallel group, cluster-controlled study comparing UK general practice management of two groups of COPD patients recruited between 1999 and 2001. The primary aim was to measure the health-related quality of life (HRQL) of COPD patients managed according to British Thoracic Society (BTS) guidelines [8] or usual clinical practice over one year. Two hundred and seventy-nine and 230 patients, respectively, were included for final analysis. No significant differences were found in airway function, healthcare resource use and disease-specific quality of life indicators according to the St George's Respiratory Questionnaire. There were some significant differences in health status between patients managed at active 'BTS' practices compared with controls as measured by another indicator, the SF-36. Whilst this study was based on guidelines from 1997, and despite the fact that it found scant evidence of improvement in the active 'BTS' group, the methodology and detailed account of the study limitations provide an excellent basis for further research of more recent evidence-based guidelines for COPD management [9–11].

In their survey, Bellamy and Harris [12] assessed asthma control and perception of control in 802 asthma patients and 809 GPs from seven countries. In keeping with other recent surveys, an extremely

high proportion of patients reported poor asthma control, with subsequent lifestyle restrictions. While most GPs questioned believed that total asthma control was possible, it is evident that this is not being achieved! In their editorial addressing the issues raised by this survey, Cleland and Price [13] conclude that one explanation for this could be sub-optimal communication within the consultation. They suggest that appropriate treatment goals should be set individually by taking into account what matters to patients in terms of symptom control.

We include in this issue selected abstracts from the recent Annual Conference of the GPIAG, which was extremely successful and enjoyable for all concerned – as described in the review of the conference in the News section. Finally, we publish a very interesting case report and short review on Acute Chest Syndrome, the most serious complication of sickle cell disease, in a patient from Pennsylvania, USA [14].

## References

- [1] Ashrafian H, Violaris AG. Beta-blocker therapy of cardiovascular diseases in patients with bronchial asthma or COPD: The pro viewpoint. *Prim Care Resp J* 2005;14(5):236–41.
- [2] Dekhuijzen PNR, Artan K. Beta-blockers and asthma: A safe combination. *Prim Care Resp J* 2005;14(5):229–30.
- [3] Panting G. Asthma and beta-blocker prescription: a medico-legal view. *Prim Care Resp J* 2005;14(5):231–2.
- [4] Brand C, Hutchinson A, Jones C, MacGregor L, Landgren F, Campbell D. Clinical practice guidelines: Barriers to durability after effective early implementation. *Int Med J* 2005;35(3):162–9.
- [5] Tinelli C, Pistoria A, Rezzani C, Biino G, Marinoni A, Grassi M, et al. Evaluation of the efficacy of the Italian guidelines on COPD: A cluster randomized trial. *Monaldi Arch Chest Dis* 2003;59(3):199–206.
- [6] Jones RCM, Copper S. Does implementing COPD guidelines improve patient care and save money in practice? *Asthma in Gen Prac [Prim Care Resp J]* 1999;7(1):12–5.
- [7] Guest JF, Varney SJ, Diggle J. Impact of the British thoracic society chronic obstructive pulmonary disease guidelines on patients' health status, healthcare resource use and health-related quality of life. *Prim Care Resp J* 2005;14(5):242–51.
- [8] The COPD Guidelines Group of the Standards of Care Committee of the BTS. BTS Guidelines for the management of chronic obstructive pulmonary disease. *Thorax* 1997;52(5):1–32.
- [9] National Institutes of Health NHLaBl. Global Initiative for Chronic Obstructive Lung Disease. Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease. <http://www.goldcopd.com/>. 2004.
- [10] National Institute for Clinical Excellence Chronic obstructive pulmonary disease: management of adults with chronic obstructive pulmonary disease in primary and secondary care. <http://www.nice.org.uk/>. 15-2-2004.
- [11] IPAG Expert Panel on behalf of the International Primary Care Respiratory Group. IPAG Diagnosis and management Handbook. <http://www.ipagguide.org/>. 2005.
- [12] Bellamy D, Harris T. Poor perceptions and expectations of asthma control: Results of the International Control of Asthma Symptoms (ICAS) survey of patients and general practitioners. *Prim Care Resp J* 2005;14(5):252–8.
- [13] Cleland J, Price D. Achieving optimal asthma control: Can this be informed by recent studies of professional – patient communication? *Prim Care Resp J* 2005;14(5):233–5.
- [14] Islam T, Usman M, Khanman F. New Pulmonary infiltrates in a 19 year old with sickle cell crisis. *Prim Care Resp J* 2005;14(5):259–61.

*Editor-in Chief, PCRJ*  
Mark L. Levy\*

*Clinical Research Fellow, Division of  
Community Health Sciences: GP Section  
University of Edinburgh c/o GPIAG  
Smithy House, Waterbeck  
Lockerbie DG11 3EY, UK*  
\* Tel.: +44 1461 600639  
fax: +44 1461 207819

*E-mail address: marklevy@animalswild.com*

Available online at [www.sciencedirect.com](http://www.sciencedirect.com)

SCIENCE @ DIRECT®

Available online at <http://www.thepcrj.com>