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## What's in this issue

Following the Primary Care Respiratory Journal's (PCRJ's) success in obtaining Medline listing in February this year, we have now received more detailed feedback from the Medline Literature Selection Review Committee. In terms of its overall quality (scientific merit, the quality of the editorial board and its independence, and production quality) the PCRJ scored 4 out of 5, corresponding to an 'excellent quality' rating. In terms of its overall importance to clinicians, educators and students it also scored 4 out of 5, which corresponds to a 'very high importance' rating. We were all delighted that the PCRJ received such high scores.

The Journal's success is a tribute to its contributors and readers, but it is also a tribute to the International Editorial Board which has expanded considerably over the last two years. One of the main challenges for the Editorial Board is to develop new ideas for the Journal so that the PCRJ continues to be essential reading for its readership. At a Board meeting held during the recent International Primary Care Respiratory Group (IPCRG) third Biennial World Conference in June, the Board decided to start a new 'Journal round-up' section in the PCRJ. The aim of this section is to provide reviews and critical analysis of important papers which have been published recently in other journals – papers which the Board consider to be essential reading for primary care health professionals, either because they will influence clinical practice or because they are controversial and need to be assessed critically. We hope that this section becomes an invaluable feature of the journal, and we would welcome your input and letters relating to any of the papers that are featured.

In patients on low to moderate doses of inhaled steroids whose asthma is not controlled, addition of a long acting beta-agonist bronchodilator (LABA) is the first choice for prescribers [1]. LABAs are available either as stand-alone inhalers, or as combination inhalers containing a fixed dose of LABA with a fixed dose of inhaled corticosteroid (ICS). Possibly in response to marketing pressure from the pharmaceutical industry, many health care professionals, when consulted by asthma patients whose asthma is uncontrolled on low doses of ICS, tend to prescribe combination ICS/LABA inhalers before carefully checking inhaler technique, modifying the dose, or trying alternative formulations of ICS. In the UK this practice has almost certainly resulted in high prescribing costs for fixed dose ICS/LABA combination therapy, and has led to considerable downward pressure on prescribing costs being exerted by primary care organisations (PCOs). However, some clinicians prescribe initial add-on medication in the form of a separate inhaler for the LABA, and if this helps, the prescription is later converted to a fixed dose combination ICS/LABA inhaler after a three-month (or so) review. This method ensures that the medication is appropriate and it also delivers a cost effective solution. Rarely, however, some clinicians are prescribing LABA monotherapy without ICS treatment, a practice which does not comply with Guideline recommendations [1,2].

As we go to press, there is renewed controversy over the safety of LABAs. Are these drugs safe, and what are the issues? A recent editorial in the Journal of the Royal Society of Medicine [3] has called for LABA prescribing in the UK to be much more closely monitored and possibly even

hospital-based only. The concerns are focussed largely on the SMART study [4], a large US-based study published recently, but also on a recent meta-analysis on the safety of LABAs written by Salpeter et al. [5].

We have therefore invited a number of reviews in the form of pro-con debates and we publish the first of these – on the safety of LABAs – in this issue. In his comprehensive review [6], Professor Harold Nelson from Denver discusses in detail the evidence that these drugs are safe. He draws an important distinction between the safety data on LABAs when used alone, and when used in combination with anti-inflammatory ICS treatment. He deals in considerable detail with the methodological details of the SMART study – writing with particular authority because he was first author of the study – thereby explaining why we need to be cautious about extrapolating its findings. In addition, Alan Kaplan, the chairman of the Family Physician Airways Group of Canada, has critically reviewed the Salpeter et al. meta-analysis as part of our new Journal round-up section [7]. The main message from Nelson's review and Kaplan's critique is that the evidence for LABA safety is strong, *as long as* LABAs are used only in conjunction with anti-inflammatory medication (ICS) when treating patients with asthma [1,2,8].

In previous issues of the PCRJ we have published various papers relating to the difficulties encountered in general practice when performing spirometry or in accessing spirometry services [9–12]. When performing a spirometry manoeuvre, patients with COPD often need to exhale for longer than 6 seconds in order to achieve their forced vital capacity (FVC), i.e., to achieve a flat volume-time plateau. This is difficult for many elderly patients and for people with severe airflow limitation. Replacing the FVC measurement with the forced expiratory volume at 6 seconds (FEV<sub>6</sub>) value in the diagnosis of bronchial airflow limitation would reduce the required maximal forced expiratory time to six seconds. In their study of nearly 4000 elderly subjects, Hasse Melbye et al. [13] conclude that the FEV<sub>1</sub>/FEV<sub>6</sub> ratio appears to be a good substitute for the FEV<sub>1</sub>/FVC ratio. In his excellent editorial, Paul Enright [14] discusses the case for using the FEV<sub>1</sub>/FEV<sub>6</sub> ratio and questions the widespread promotion of the GOLD criteria [15] for detecting COPD in smokers – an FEV<sub>1</sub>/FVC ratio < 0.70 – because they may cause high misclassification rates.

In their survey of 6000 people with chronic respiratory disease (asthma and COPD), Ikäheimo et al. [16] describe the influences on various factors

related to relief or worsening of asthma symptoms. They share details of the Finnish system for registering and reimbursing prescription expenses and the results of the responses from 78% of those surveyed. Of notable interest this paper has clearly demonstrated the adverse effect of smoking on patients' wellbeing. The short report by Fernandes et al. [17] describes how a practice developed its participation in a health forecasting project developed by the UK Met Office (the UK's national meteorological service) into an audit to assess and improve the knowledge of patients with moderate to severe COPD [18].

As usual, the News section reports from the GPIAG, IPCRG, and other relevant organisations.

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