EDITORIAL

What's in this issue

Last year was an important year for the *Primary Care Respiratory Journal (PCRJ)*. The Journal obtained Medline/Index Medicus listing in February, and this led to an increase in the number and quality of paper submissions as the year progressed. However, we start 2007 with another landmark in the Journal's development – a new publisher. Having been published by Elsevier for the last three years, the time has come for us to move on. We are indebted to Elsevier for their help and support of the Journal throughout this time, but we are keen to make the *PCRJ* available as widely as possible throughout the world to any healthcare professional with an interest in primary care management of respiratory disease and allergy. One of the most important mechanisms for doing this is to have free online access to the Journal without any charges for authors. This has always been one of our long-term aims. We are therefore delighted to announce that the *PCRJ* is now being published by Sherborne Gibbs Ltd, who have undertaken the task of providing worldwide marketing of the *PCRJ* as well as free online access throughout the world. Copyright and ownership of the Journal remains with the UK General Practice Airways Group (GPIAG), and the *PCRJ* is also proud to remain the official journal of the International Primary Care Respiratory Group (IPCRG). We look forward to our new working relationship with Sherborne Gibbs, and, with the help of our readership, we hope to achieve our next goal – achieving a citation index – in the near future.

It seems fitting to start the year off with papers from two internationally-renowned experts in paediatric respiratory disease writing about the diagnosis of asthma in children under five years of

age. In his editorial, Søren Pedersen¹ reminds us of the difficulties we face when trying to establish the severity of children presenting with airflow obstruction. In particular he draws attention to the fact that audible wheeze in schoolchildren will only be present when the FEV₁ is reduced by at least 30-40%. Diagnosis of asthma in pre-school children remains one of the most difficult challenges in primary care. Most children of this age cannot use peak flow meters and more sophisticated tests are not available in primary care settings. We therefore need to have a good understanding of the differential diagnosis of respiratory diseases in children presenting with respiratory symptoms. Unfortunately, many guidelines on disease management start with an assumption that the diagnosis is already established. However, in primary care we are confronted by patients presenting with non-specific symptoms which may or may not be the first presentation of chronic respiratory disease and which may have many other possible aetiological causes² – and we are expected to sort out the possible differential diagnoses during a ten-minute consultation... In his review, Andrew Bush³ has provided us with an up-to-date, comprehensive guide through the diagnostic process for the common and less common conditions with which our paediatric patients may present. He has also summarised very clearly which children we should be considering for referral to specialist colleagues. This review should be read by any healthcare professional throughout the world who cares for children in a primary care setting!

In a previous paper, Halbert *et al.* drew our attention to the wide range of prevalence of diagnosed COPD (0.23 to 18.23%) in published research papers.⁴ Worldwide, COPD mortality has

continued to increase against a background of decline in other disciplines such as cardiovascular disease (data from NHLBI/NIH/DHSS, quoted in Gold Guidelines).⁵ Therefore, we welcome the paper by Tinkelman *et al.* on underdiagnosis of COPD in their study population of 818 patients from Aberdeen, Scotland and Denver, Colorado.⁶ About half of their patients with previously undiagnosed COPD were confirmed as having COPD according to Gold criteria⁵ on post-bronchodilator spirometry. As the authors demonstrate in their paper, this does not seem to be an isolated finding – they report results of no less than three other large studies with similar findings. However, is this really a reflection of underdiagnosis or a result of the method for determining ‘normal values’ for spirometry? Quanjer and Schermer, in their discussion paper on this subject,⁷ make an excellent case against acceptance of the Gold criteria for diagnosing COPD, particularly in elderly patients.

Since the Chief Medical Officer convened and reported on a United Kingdom National Allergy Advisory Group (NAAG) in 2005 to address concerns raised in the House of Commons,⁸⁻¹⁰ allergy management has been high on the agenda. In the UK, facilities for diagnosis and management of patients with allergic disease are few and far between. Many general practitioners (GPs) have little training and expertise in managing these conditions. Following the report of the NAAG, Sheikh and colleagues have investigated provision of allergy undergraduate teaching and training in one Scottish Medical School. Their second report is detailed in this issue¹¹ where they have revealed gaps in allergy training.

We are very familiar with the effect of COPD exacerbations on health-related quality of life, reduction in lung function and reduced life expectancy – this was discussed in a previous editorial in this journal.¹² In their prospective study of 112 patients with moderate to severe asthma, Lloyd and colleagues¹³ have demonstrated the deleterious effect of asthma exacerbations on health-related quality of life. This was further reduced in those patients requiring hospital admission. This study acts as a reminder to all of us in primary care that we should pay particular attention to those patients suffering asthma exacerbations. They should be reviewed carefully by someone with a special interest in asthma, either in primary or secondary care. An exacerbation is a clear indication that intensive action is required both by the health professional as well as the patient. The review should at the very least include checking the patient’s inhaler technique as well as the nature and dosage of their medication.

Gender differences have been reported for asthma consultations in the past. However, in this issue, we publish a large epidemiological study¹⁴ in which the presentations of asthma, allergic rhinitis and eczema are compared simultaneously from birth to late adulthood. Consultation rates for asthma peaked at 4-6 years in both sexes, with a second peak in adolescence. Male predominance for asthma and allergic rhinitis was found in childhood with a switch to a female predominance after adolescence. Whereas the female predominance for both asthma and allergic rhinitis was evident throughout adult life, the female predominance for eczema was only evident during the female reproductive period.

As usual, our News section reports news from the GPIAG, IPCRG, and other related organisations worldwide, and our Journal round-up section contains a review of an important paper on the development of childhood allergy.¹⁵

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Mark L. Levy*

Editor-in-Chief, PCRJ

Senior Clinical Research Fellow

*Division of Community Health Sciences:
GP Section, University of Edinburgh, UK*

*c/o GPIAG, Smithy House, Waterbeck,
Lockerbie, DG11 3EY, UK

Tel.: +44 (0)1461 600639; fax: +44 (0)1461 207819

E-mail address: marklevy@animalswild.com

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