EDITORIAL

What's in this issue

Over the last few years there has been a much-needed explosion of interest in primary care diagnosis and management of chronic obstructive pulmonary disease (COPD). This has been precipitated by numerous factors, not least the publication of national¹ and international^{2,3} guidelines on COPD management. In the UK, the inclusion of COPD diagnosis and management targets in the Quality Outcomes Framework (QOF) section of the 2004 General Medical Services Contract⁴ also increased the pressure on general practitioners (GPs) to improve their management of COPD. Reliable and reproducible spirometry testing is a prerequisite for diagnosing and managing COPD, and without the use of spirometry diagnostic errors are likely to occur.⁵ General practices therefore have the option of developing spirometry expertise in-house, but concerns have been expressed about quality.⁶ Other ways for general practices to access good quality spirometry have been proposed and reported previously in this journal: a mobile spirometry service provided by a respiratory specialist nurse and a GP with a special interest (GPwSI) in respiratory disease;⁷ hospital-based clinics run by a GPwSI;⁸ a Community Respiratory Assessment Unit;^{5,9} and a primary care COPD Support Service.¹⁰

In this issue of the *Primary Care Respiratory Journal (PCRJ)*, we have two papers on COPD diagnosis which focus on the importance of spirometry in primary care. Sichletidis *et al.* report a study on 319 Greek patients, aged over 40, who had been diagnosed clinically by their GP with COPD in the absence of spirometry testing and who had been given bronchodilator treatment.¹¹ After spirometry, only half of the patients fulfilled the GOLD diagnostic criteria³ for

COPD; the other half either received alternative diagnoses such as nasal obstruction, asthma and restrictive pulmonary disease, or were shown not to have any pulmonary disease at all. This paper reaffirms the importance of spirometry in the diagnosis of COPD, and the fact that errors are very likely to occur if spirometry isn't used.⁵ In the second paper, Johansen *et al.* report from Norway on the success of a short decentralised 13-hour training course run for GPs, their practice nurses and staff, with a view to improving in-house expertise in performing spirometry.¹² Prior to the training course only 9% of GP referrals contained any information on basic spirometric parameters such as forced expiratory volume in one second (FEV₁) and forced vital capacity (FVC); after training, this figure increased more than six-fold to 56%, thereby confirming a dramatic improvement in the use of, and interpretation of, spirometry.

Asthma is a variable disease, and the use of written asthma action plans – which advise patients on how to vary the dose of their medication at the start of an exacerbation – is recommended strongly in international asthma guidelines.^{13,14} One of the aims of asthma action plans is to increase patients' sense of control over their asthma via their self-management of the disease. However, uptake of asthma action plans is poor. In her excellent editorial,¹⁵ Helen Reddel outlines some of the reasons behind the poor uptake of asthma action plans, not least the fact that one of the standard components of previous action plans – advice to double the dose of inhaled corticosteroid at the start of an exacerbation – is not based on any evidence... In addition, she focusses on patients' perception of self-management strategies, particularly in the

context of the study by Haughney *et al.* on patient 'enablement' which we publish in this issue,¹⁶ and in the context of recent studies investigating variable dosing regimes of combination inhaled corticosteroid (ICS)/long-acting beta-agonist (LABA) inhalers.

'Patient enablement' is a concept which incorporates patients' understanding of their asthma, as well as their ability to cope, to participate in treatment decisions, and to take increased responsibility for their asthma management. The method used by Haughney and colleagues¹⁶ required a modification of a previously-reported Patient Enablement Instrument (PEI), a questionnaire which was presented to 228 patients at the end of a larger study looking at outcomes for patients treated with either a fixed or a variable dosing regime of an ICS/LABA combination inhaler; 124 patients had been using their budesonide/formoterol combination inhaler on the adjustable dosing regime, and 104 patients had been using the same inhaler on the fixed dosing regime. A significantly greater number of patients using the adjustable dosing regime (57% versus 43%) had a high PEI score, and the conclusion is that the adjustable dosing regime improves patient enablement with all the attendant benefits that should accrue.

For those readers who have a predilection for the history of medicine, we include in this issue a fascinating historical review of inhaled therapy over the last 2000 years written by Mark Sanders,¹⁷ which contains some superb photographs and diagrams of various sorts of inhaler device that have been used throughout the ages. The Discussion paper by Lee on the early management and staging of lung cancer¹⁸ complements the review on lung cancer screening by Read *et al.* which we published in the December 2006 issue,¹⁹ and Onno van Schayck and Marianne Stubbe Østergaard, two of our International Editorial Board members, publish excellent critical reviews of two recent papers on the use of leukotriene receptor antagonists in children in our Journal round-up section.^{20,21} As usual, our News section presents news and information from the GPIAG, IPCRG, and other related organisations worldwide.

Finally, as we reported in our last issue,²² the *PCRJ* is now being published by Sherborne Gibbs. As part of the new publishing arrangement we provide free worldwide online access to all *PCRJ* papers – including not just the current issue but all past papers as well. The website address is <http://www.thepcrj.org>. Have a look at the website, tell your colleagues, and let us know if you have any suggestions by contacting us at

info@gpiag.org. Our next issue, due to be published in time for the GPIAG Annual Conference on 22nd June, will be a redesigned 'new-look' journal to commemorate the 20th anniversary of the founding of the GPIAG.

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