EDITORIAL

What's in this issue

This has been an exciting couple of months for the *Primary Care Respiratory Journal (PCRJ)*. The profile of the journal continues to rise inexorably, and this was evident by the interest shown in the *PCRJ* at the recent ERS Congress in Stockholm. Apart from the ever-increasing quality and clinical relevance of the papers published in the journal – with relevance not just to the primary care respiratory community but also to our colleagues in secondary care – one of the main reasons for the *PCRJ*'s increased profile is the journal website (www.thepcrj.org) which provides free worldwide access to *PCRJ* papers. This is of immense benefit to authors, since it guarantees immediate PubMed (Medline)-listed availability of their work to a worldwide audience. As a consequence, the *PCRJ* is reaping the benefit in terms of paper submissions and increased numbers of citations for *PCRJ* papers.

At the Annual General Meeting of the International Primary Care Respiratory Group (IPCRG), and also at the *PCRJ* International Editorial Board meeting – both of which took place during the ERS meeting – Mark Levy presented website data from the last seven months. These show that the *PCRJ* website is receiving up to 14000 visits a month, and some papers have been downloaded over 6000 times. We will give a fuller account of the website statistics – together with a list of the most highly-cited *PCRJ* papers – when we present our review of the year in the December issue. Suffice to say that we are delighted with the progress the *PCRJ* has made over the last few months.

There are three main overlapping themes in this issue of the *PCRJ*. The first is the use of Asthma Action Plans (AAPs) and their role in patient self-management; the second theme focuses on the roles and training levels of healthcare professionals in the provision of respiratory disease management in both primary and secondary care; and the third theme relates to the success (or lack of success) of educational interventions for healthcare professionals and the lessons to be learned for future training and teaching. The highlights in this issue, therefore, are as follows;

- Ring *et al* present a systematic review on the use of AAPs, with the expressed aim of investigating how best to encourage health professionals to promote the use of AAPs by patients.¹ This is an excellent and detailed review of the subject, which was commissioned by Asthma UK (Scotland) and NHS Quality Improvement Scotland. The

authors conclude that effective promotion of AAPs requires interventions to initiate and also to sustain AAP use by health professionals and patients with asthma. Overall, there is a lack of robust evidence for general practitioners (GPs) and practice nurses on the best and most practical ways to sustain AAP use over the longer term. There is a need for further research, but this systematic review is an excellent place to start.

- Upton *et al* publish the results of a comprehensive survey on the roles of primary care respiratory nurses in the UK and their level of training for those roles.² The survey was conducted by Education for Health, formerly the UK National Respiratory Training Centre, with input from research units in Manchester and Edinburgh. This is likely to be a highly influential paper, since the previous UK national survey on this topic³ has been cited frequently. In this nested survey, response rates from the 500 practice nurses who received a questionnaire were around 75%. In terms of their practice roles, nurses were divided into those who had 'basic', 'intermediate' or 'advanced' roles. Of the 255 nurses with an advanced role in asthma management, 20% did not have any formal accredited training, and of the 215 nurses who had an advanced role in COPD management, 52% had had no formal training. Though there have been great strides made in the management of respiratory disease in primary care – particularly in the management of COPD – the authors conclude that these results have clinical governance implications for both practices and Primary Care Trusts.
- Linked with the two previous papers, Cleland *et al* describe in this issue an exploratory pragmatic cluster randomised trial of nurse training in the use of asthma action plans.⁴ The results of the study were disappointing, in that there was no significant improvement in patient outcomes after the educational intervention for the nurses. However, in her excellent editorial, Walker⁵ confirms the value of this work and the insight that it provides for further research in the field. She lists the important points to be considered when designing evaluations of complex educational interventions in primary care, and these include: understanding the barriers to health professional participation in research studies; the sort of outcome measures to be used; the

importance of measuring the impact of training on professional knowledge, confidence, competence and behaviour; and the importance of routine data entry in day-to-day general practice.

- Medford and Pepperell present an audit of the management of spontaneous pneumothorax (SP) in a district general hospital.⁶ This study is another example of the effectiveness – or ineffectiveness – of an educational intervention. After an initial audit of the British Thoracic Society (BTS) 2003 guidelines on the management of SP, many of the junior doctors received an hour-long teaching session on the BTS guidelines and were informed of the results of the first audit; SP management was then re-audited. Disappointingly, there were very few significant changes in the quality of care between the first and second audits, and the authors give sensible explanations for this as well as suggestions for future training. Even though GPs see very few cases of pneumothorax, the condition is nevertheless an important differential diagnosis in the management of any patient presenting with acute or sub-acute dyspnoea – with or without chest pain – in primary care, and it is good to know how patients are managed after we admit them.
- From South Africa, Green *et al* publish the results of a questionnaire survey of patients with allergic rhinitis which constitutes part of the South African Allergic Rhinitis Care Programme.⁷ Out of 1181 responses, over 1000 people felt miserable due to allergic rhinitis, over three-quarters suffered sleep disturbance, nasal congestion was a common and frequent problem, and a variety of perceived concerns around having and being treated for allergic rhinitis were identified which suggest multiple reasons for non-adherence. The authors conclude that, since allergic rhinitis is largely a doctor-diagnosed condition, there is a significant problem with inappropriate, insufficient or incorrect treatment, and that education for both patients and doctors is urgently required.
- Occupational asthma is the only form of asthma which can be cured if it is diagnosed and treated early enough. The paper by Fishwick *et al* in this issue is therefore a challenge to all of us who work in primary care.⁸ Ninety-seven consecutive patients from six secondary care centres with a special interest in occupational asthma were recruited into the study. 96% had consulted their GP at

least once with work-related respiratory symptoms. By the time the patients were seen in secondary care, their symptoms had been present for a mean duration of 44 months – but in one case symptoms had been present for 27 years. The authors conclude that there are significant diagnostic delays for patients with occupational asthma in the UK, and that guideline dissemination, training, and improved communication will be required to improve the overall management of this condition.

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