Primary Care Respiratory Journal (2007); 16(6): 329-330

Primary Care
RESPIRATORY JOURNAL
www.thepcrj.org

EDITORIAL

What's in this issue

As we mentioned in this section of the journal in the last issue, 2007 has been an exciting year for the *Primary Care Respiratory Journal (PCRJ)*. As a consequence of the agreement with our new publishers at the start of the year, we were able to set up a new journal website – www.thepcrj.org – which provides free worldwide online access to all *PCRJ* papers, past and present. From an ethical point of view, we are delighted to be able to provide free access to *PCRJ* papers for researchers and clinicians throughout the world. Furthermore, the provision of free online access has had an invaluable effect on the worldwide profile of the journal too. We present our annual review of 2007 on page 337.[1] This includes detailed website statistics for the *PCRJ* website showing the numbers of hits and downloads generated online. One of our major challenges is to raise awareness of papers published in the *PCRJ* so that they are then subsequently cited by authors; the worldwide accessibility of *PCRJ* papers online will almost certainly help drive this.

We hope you agree that there are some very interesting papers in this issue. The highlights are;

- Kevin Gruffydd-Jones, Mike Thomas and co-workers present a prospective observational pilot study on the use of exhaled nitric oxide monitoring in primary care.[2] This is the first published report on nitric oxide monitoring in primary care worldwide. Measuring the fraction of exhaled nitric oxide (FeNO) in exhaled air provides information about airway inflammation which can be used to assess the need for changes in inhaled anti-inflammatory medication and to predict the likelihood of asthma exacerbation. The authors set out to assess the feasibility and acceptability of performing the procedure on 22 adults and 15 children. Only two subjects were unable to perform the expiratory procedure, and acceptable measurements conforming to ATS/ERS recommendations were made on 232 out of 236 occasions with 211 of the measurements considered to be of the 'highest' quality. The authors conclude that FeNO monitoring is technically feasible and is acceptable to staff and patients in a primary care setting. In his excellent linked editorial, Ian Pavord puts this paper and the role of NO monitoring into context.[3]
- The Aerosol Drug Management Improvement Team (ADMIT) Working Group comprises some of the most influential names in respiratory medicine in Europe. In this issue of the *PCRJ* we publish the first in a series of review papers from the ADMIT Group on issues in inhalation therapy. The first paper focuses on asthma control, its definition, and whether or not we are managing to achieve control of asthma in the majority of our patients.[4] The authors present an algorithm which can be used in the consultation in order to ensure that patients are using their inhaled therapy appropriately and that it is suitable for them. Themes for future papers from the ADMIT Group include: the aims of therapy in patients with asthma and COPD; the characteristics of inhaled medication including side effects and their use in daily practice in stable and unstable disease; compliance issues; ways to optimise inhaler use; inhalation issues in children; inhalation devices in COPD; reasons to choose a specific device first; and the actions to be taken prior to altering an inhaled drug or its dosage. The introductory editorial by Richard Dekhuijzen and Graham Crompton sets the scene for the series.[5]
- Guarnaccia *et al* present a longitudinal follow-up study on 264 children with asthma who were managed according to a shared protocol between hospital specialists and primary care physicians based on the GINA guidelines.[6] The study involved 60 GPs working in the Brescia area of Italy who formed a working group under the auspices of the respiratory specialists at the Spedali Civili Children's hospital, and subsequently a total of 179 GPs participated. Mean follow-up for the children was 10 months. The authors present some excellent data showing that adhering to a GINA management guideline protocol led to symptomatic improvements, changes in disease status and classification, and a reduction in, and more efficient use of, asthma treatment.
- On a similar topic, we publish a study by Wiener-Ogilvie *et al* looking at general practices in the Borders region of Scotland and whether or not they comply with the three key recommendations of the British Asthma Guideline published in 2003.[7] The key recommendations were: that objective testing should be used to confirm a diagnosis of asthma prior to treatment; that a trial of add-on treatment should be provided before increasing the dose of inhaled

corticosteroid (ICS) above 800mcg/day for adults and 400mcg/day for children; and that asthma patients – particularly those who have been admitted to hospital – should be provided with written self-management asthma action plans. Fifteen practices participated, and compliance with the three recommendations varied markedly. Only 23% of patients reported having been provided with an asthma action plan, but 67% of patients reported having had a trial of add-on therapy prior to an increase in their ICS treatment. The authors conclude that interventions to enhance compliance with guideline recommendations will need to address the barriers to implementation including the need for better teamwork in practice.

- Finally, in another paper from the southwest of England, Gruffydd-Jones *et al* report on the needs of COPD patients after they are discharged from hospital following an acute exacerbation.[8] This was a qualitative study using home interview data and focus groups with triangulation against quantitative data. Several themes emerged; COPD patients recently discharged from hospital have high levels of depression and anxiety – with anxieties focussed on the fear of having another 'attack' and the uncertainty of social and medical care provision, particularly the provision of home oxygen therapy. The authors conclude that there is a need for improved hospital discharge procedures and community follow-up, including the provision of pulmonary rehabilitation and self-management strategies.

References

1. Levy ML, Stephenson P. Annual report for 2007 and plans for 2008. *Prim Care Resp J* 2007;**16**(6):337-40. doi:10.3132/pcrj.2007.00087
2. Gruffydd-Jones K, Ward S, Stonham C, Macfarlane TV, Thomas M. The use of exhaled nitric oxide monitoring in primary care asthma clinics: a pilot study. *Prim Care Resp J* 2007;**16**(6):349-56. doi:10.3132/pcrj.2007.00076
3. Pavord ID. Monitoring of exhaled nitric oxide in primary care. *Prim Care Resp J* 2007;**16**(6):331-4. doi:10.3132/pcrj.2007.00079
4. Dekhuijzen PNR, Magnan A, Kneussl M on behalf of the ADMIT Working Group. The ADMIT series – Issues in Inhalation Therapy. 1) The goals of asthma treatment: can they be achieved? *Prim Care Resp J* 2007;**16**(6):341-8. doi:10.3132/pcrj.2007.00081
5. Dekhuijzen PNR, Crompton GK. Issues in Inhalation Therapy: a new series of papers from the ADMIT Working Group. *Prim Care Resp J* 2007;**16**(6):335-6. doi:10.3132/pcrj.2007.00080
6. Guarnaccia S, Lombardi A, Gaffurini A, Chiarini M, Domenighini S, D'Agata E, Scumacher RF, Spiazzi R, Notarangelo L. Application and implementation of the GINA asthma guidelines by specialist and primary care physicians: a longitudinal follow-up study on 264 children. *Prim Care Resp J* 2007;**16**(6):357-62. doi:10.3132/pcrj.2007.00077
7. Wiener-Ogilvie S, Pinnock H, Huby G, Sheikh A, Partridge MR, Gillies J. Do practices comply with key recommendations of the British Asthma Guideline? If not, why not? *Prim Care Resp J* 2007;**16**(6):369-77. doi:10.3132/pcrj.2007.00074
8. Gruffydd-Jones K, Langley-Johnson C, Dyer C, Badlan K, Ward S. What are the needs of patients following discharge from hospital after an acute exacerbation of chronic obstructive pulmonary disease (COPD)? *Prim Care Resp J* 2007;**16**(6):363-8. doi:10.3132/pcrj.2007.00075

Paul Stephenson
Deputy Editor, *PCRJ*; The Christmas Maltings and Clements Practice, Haverhill, Suffolk, UK.

*Mark L Levy
Editor-in-Chief, *PCRJ*; Senior Clinical Research Fellow, Allergy and Respiratory Research Group, Division of Community Health Sciences: GP section, University of Edinburgh, Scotland, UK.

*Correspondence:
c/o GPIAG, Smithy House, Waterbeck, Lockerbie, DG11 3EY, UK.
Tel: +44 (0)1461 600639 Fax: +44 (0)1461 207819
E-mail: marklevy@animalswild.com

Available online at **http://www.thepcrj.org**