



EDITORIAL

What's in this issue

The General Practice Airways Group (GPIAG) was founded in 1988, by six general practitioners with a special interest in asthma. Since then, the group has gained world-wide recognition as an authoritative professional body. The GPIAG Professorial Unit at Aberdeen University, led by Professor David Price is firmly established [1], the GPIAG education team is active in the UK and internationally and the *Primary Care Respiratory Journal*, which evolved from a newsletter is now in its ninth year. This March 2004 issue, is the first to be published by Elsevier on our behalf and we hope you like the new look.

While we were very proud to be able to publish the journal, as it were, on a home computer until now, we are confident of major improvements in the future now that the journal is now under the Elsevier banner. What's new? Papers will be published online via Science Direct (<http://www.sciencedirect.com>) within 8 weeks of acceptance with the result that they are available much quicker than previously. These will be followed by the printed version, which is available on subscription. We are no longer going to publish the journal in full on our website, however, we will continue to publish the abstracts, with links to the full version subscription details are available on the website <http://intl.elsevierhealth.com/journals/pcrj/> and within the printed version of the journal.

Should we be using spirometry or peak expiratory flow measurements to monitor patients with COPD? This is a common question asked at primary care education meetings. Mike Morgan, in his editorial [2] discusses the subject, while the issues related to spirometry versus peak flow measurement in patients with COPD are debated further by Chavannes and White [3–6]. They argue for and against the use of spirometry, respectively.

It is nearly 15 years since the first paper on patient self management plans (SMPs) for asthma [7], however, despite being recommended by experts [8,9], only one in five patients with asthma

are provided with these. The editorial by Peter Gibson [10] author of a widely quoted systematic review on the subject [11], eloquently describes the reasons for using SMPs, the barriers to implementation and some possible solutions. The major barrier appears to be a mismatch between patients' expectations and general practitioners' beliefs regarding the use of SMPs. Holt and colleagues' comprehensive review [12] describes the practical aspects of tailoring SMPs to the needs of patients, while the study by Haughney et al. [13] describes the patients perspective of asthma care. In their study, many of their 517 asthma subjects described their asthma control as satisfactory, despite high levels of morbidity—similar to the previous findings of Turner-Warwick, where 26% of 2928 patients waking every night regarded their asthma as mild [14]. The discrepancy between patients' needs and their perceptions of provision of care described in this study highlights an urgent need for a different approach to asthma education and empowerment of patients with asthma.

The widespread use of objective quality of life instruments requires some flexibility on the part of researchers. There are a number of advantages of unsupervised versus supervised completion of questionnaires; in addition, many subjects are unable or unwilling to attend for interview in person which has resulted in the emergence of postal questionnaires. The main disadvantage of unsupervised completion being the absence of someone to ensure the forms is completed properly. Pinnock and colleagues [15], attempted to reduce the number of completion errors by sending a QOL questionnaire together with a modified instruction sheet. While their response rate was good, resulting in a useable sample of data, the unsupervised completion errors were significantly greater.

Many have argued that we could dispense with lung function measurement (PEF and spirometry)

and focus patients' asthma treatment through the use of 'symptom only' SMPs. However, poor perception by patients of asthma severity is a strong argument against this approach [16]. The paper by Ehrs and Larsson [17] demonstrates improvement in quality of life after treatment of asymptomatic patients with abnormal lung function. There is clearly a role for both approaches.

There are many patients in primary care, with chronic respiratory disease, who are being treated with inhaled steroids. While some of these people may indeed have asthma, and others, COPD with a degree of reversibility or improved quality of life due to medication. However, there are patients who clearly should not be on long term inhaled steroids. What do we do with these patients? Schermer and colleagues [18] have investigated the effects of stopping inhaled steroids in 201 subjects with COPD. They found an overall probability of these patients developing an adverse outcome which seems to be higher in women.

Finally, the news section, details some of the developments related to the European Respiratory Society and some of the courses we will be running this year. For further details refer to the GPIAG website at <http://www.gpiag.org>.

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Mark L. Levy (-Editor-in-Chief)
 GPIAG, Edgbaston House, 3 Duchess Place
 Edgbaston, Birmingham B16 8NH, UK
 Tel.: +44-121-4548219; fax: +44-1461-207819
 E-mail address: marklevy@animalswild.com
 (M.L. Levy)

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