Highlights from this issue

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Department of error!

'Oh — let no-one ever, ever doubt,
What nobody is sure about!' (Hilaire Belloc)

Hot off the Breath: the PANTHER-IPF trial dared to go where no man has gone before (at least for a very long time) and have a PLACEBO limb in a randomised controlled trial of treatment for IPF, and lo! Those randomised to the gold standard triple therapy arm did substantially worse, and this limb has rightly been terminated by the data monitoring board. On ***page 97***, McGrath and Millar dissect the implications of this for the current treatment of IPF. As researchers and clinicians, we should also consider the wider implications: why was a high class placebo controlled randomised double blind trial of immunosuppressive therapy in IPF proposed by Jon Britton's group in Nottingham not supported in the early 1990s? How many patients have suffered harm because we have been talked out of doing the best and most rigorous studies? Data always trump expert opinion, no matter how eminent the expert, and if the data are not compelling, eminent expert opinion should never be allowed to stand in the way of getting the data! There is some cause for optimism. We now have a clearer vision of the path research into IPF should take after the immunosuppressive era. Read Jenkins and colleagues' summary (***see page 179***) of a recent expert panel, Dinh-Xuan *et al*'s paper highlighting alveolar nitric oxide as a potential biomarker of scleroderma-induced lung disease (***see page 157***), Scott-Budinger *et al*'s paper on proteasomal inhibition (***see page 139***) and Milara *et al*'s paper on spingosomal-1-phosphatase as a potential player in epithelial to mesenchymal transition in IPF (***see page 147***) for some ideas on the leading areas for future research in what is very much an interstitial lung disease themed issue of *Thorax*.

Department of more error?

Inhaled corticosteroids (ICS) have revolutionised the treatment of childhood asthma, but in excess have caused great harm, including profound adrenal failure. So how best should they be used—religiously every day, or on a more intermittent basis? In the intermittent corner, from Finland where a number of great studies using an intermittent regime have been performed, Turpeinen *et al* lock horns with Ducharme from Canada, who advocates for continuous therapy (despite having been lead author on a great paper on intermittent ICS in another context!). Read the pro-con on ***pages 100 and 102***, and see where you stand. Or are we merely debating how many angels can dance on the head of a pin, because in fact patients will do their own thing, by design or default, anyway? Our suspicion is that only those with severe obsessive-compulsive disorder actually rigorously follow our advice. Or should we take Prozac and be more positive? Over to you.

Preventing occupational asbestos exposure in developing countries: low hanging fruit for public health clinicians

Despite a ban on use of asbestos in developed countries, worldwide use continues to rise, mainly in developing countries such as India and China. Most asbestos currently used is chrysotile, a form widely assumed to cause less pulmonary morbidity than amphibole. How secure is this belief? Wang *et al* report the result of a 37 year observational study of asbestos workers from the Chongqing plant in China, a plant that is thought to only use Chrysotile asbestos (***see page 106***). Compared to age and smoking matched control workers, asbestos workers were three times more likely to die of lung cancer and non-malignant respiratory disease and the risk of dying of lung cancer was clearly related to exposure. There was no definitive information on the risks of mesothelioma. As Cullinan and Pearce point out (***see page 98***), this is strong evidence against the amphibole hypothesis. The findings suggest that limiting exposure to all forms of asbestos is an important public health priority. Preventing deaths from this sort of occupational exposure is surely a more straightforward matter than preventing obesity or treating nicotine addiction. Our public health colleagues should take careful note.

Safe but not sound?

Nursing home pneumonia per se seems very little different from regulation community acquired pneumonia, but the mortality is higher, likely related to co-morbidity, and less active management (***see page 132***). But is this inevitable or right? Are those in nursing homes getting second division care, or is this appropriate comfort care when faced with the old-person's friend (note the absence of genderism!). Read the manuscript and decide for yourself. But remember, self-fulfilling prophecies are by their nature self-fulfilling.