Editorial

The first issue of Thorax was published 32 years ago. Until recently, the journal was owned by the British Medical Association but its contents and editorial policy were controlled by the Thoracic Society. From the beginning of this year, as a result of a new agreement, Thorax will be owned jointly by the British Medical Association and the Thoracic Society.

We hope that our readers will take pleasure in the newly designed cover, the first change in external appearance since the journal’s inception. Our changes are not limited to the outward appearance of Thorax. The Editorial Board has been enlarged to achieve or augment representation in many special branches of thoracic medicine and surgery although the editors will also continue to appoint other prominent experts to assess the work of contributors.

Beginning with this issue, we shall publish regular editorials on topical or controversial subjects. We hope that these will disentangle matters of confusion, question strongholds of dogmatism, and sometimes express an individual and eccentric point of view. Thorax will also publish correspondence concerning our original contributions and will print authors’ replies to comments on and criticism of their work. A lively correspondence column adds spice to the meat proffered by the original papers and, we hope, will stimulate further discussion. On page 10 is the first of a series of articles on the historical aspects of chest medicine. We should like to think that these will have a particular appeal to our younger readers, who might wish to acquire a sense of historical perspective in relation to the study of chest disease.

Until now it has been necessary to reject a high proportion of the isolated case reports submitted to us, solely because of lack of space. Many of these deserve publication, either because the condition has not previously been described, or because they reveal an unusual pattern of behaviour in an otherwise well-known disease. We hope to publish a larger selection of these case reports by offering to authors the alternative of publication as ‘short reports’ limited to 600 words. Details appear on the inside front cover.

Thorax publishes original work in every field of chest medicine and the related basic sciences. A review of the subjects covered in recent years has shown a deficiency of papers on anaesthesia, microbiology, radiology, and industrial medicine. We should like to encourage original work in these important specialties. Contributions on these subjects will be welcomed and given special consideration.

Thorax has always maintained a high standard in the content of its original contributions and in the quality and number of its radiographs and photomicrographs. The editors will continue to follow the ideals of excellence established by their predecessors and in these respects Thorax has not changed.

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Asthma—contrasts in care

It may be estimated that at any time approximately 2% of the population are suffering from asthma, and that in Britain two in every thousand asthmatics die of the disease each year. Asthma afflicts people of all ages and, while it is easily recognised in young non-smokers, it is frequently misdiagnosed as bronchitis or emphysema among the elderly. It is a frequent experience for chest physicians to see patients who have been disabled by years of breathlessness and yet whose whole life may be improved dramatically by simple treatment. Even when asthma has been correctly diagnosed, it is still commonplace to see the patient treated with old, often potentially addictive, barbiturate-containing drugs without attempts to monitor their efficacy and in a haphazard and arbitrary manner. Patients are still warned not to overuse their aerosol bronchodilators but are given no advice on what to do if these become ineffective. Severe exacerbations of the disease are frequently treated with a change of bronchodilator rather than by the introduction of the necessary corticosteroids.

Any doctor working in an asthma clinic is quickly impressed by the number of misconceptions in the minds of his colleagues about the
disease. The importance of psychological factors is
usually stressed in referral letters, and patients
are usually treated with sedative drugs. Yet it is
remarkable how quickly the anxiety or depression
melt away when the patient finds a doctor who
realises that its primary cause is the fear of death
in an attack rather than vice versa. The over-
protective, anxious mother suddenly becomes
normal again when her child stops waking in the
night with terrifying attacks and is no longer too
tired in the morning to go to school. Patients are
often referred for ‘desensitisation’ when their
attacks are provoked by everything from colds to
exertion and when there is scant evidence that
any presently used technique is of any value.
Children are prevented from playing games rather
than given cromoglycate, and steroids are with-
held or withdrawn from patients because of their
potential danger without the actual danger to the
patient from his asthma being assessed by measure-
ment of his peak flow.

In almost no other field is the gap between
diagnostic and therapeutic knowledge and its
general application so great. It is hard to under-
stand why this should be so as the principles of
diagnosis—to demonstrate reversibility of airways
obstruction—and of treatment—to reverse the
obstruction by one or more of only three types of
drug—are so simple. Even though the fundamental
biochemical and immunological mechanisms of
the disease remain ill-understood, the management
of asthma both from day to day and in acute
severe attacks has been well studied and in many
aspects may be based on the results of properly
conducted controlled trials. Most new drugs intro-
duced for the management of asthma may also be
used in the knowledge that their efficacy has been
convincingly demonstrated. The blame for this
failure of communication must rest with hospital
physicians, who have been so slow to adapt them-
selves to changes in the understanding of a
common disease, and with epidemiologists, who
have successfully publicised the dubious toxicity of
our most useful remedies without pointing out the
therapeutic alternatives.

It is interesting to contrast the management of
asthma with that of diabetes, another chronic
disease punctuated by life-threatening episodes.
How many physicians would manage diabetes
without measuring the blood and urine sugar
levels? Yet these same physicians usually feel able
to look after severe asthmatics without ever
measuring their peak flow rate or arterial blood
gases. The analogy with diabetes may be taken
further. In both diseases, proper management de-
PENDs on education of the patient to understand
his condition, to recognise signs of deterioration,
and to adjust his own treatment accordingly. In
many cases the patients find they know more
about their disease than the doctor, a situation
that the less flexible among us find difficult to
tolerate. Patients with these diseases seem pre-
pared to attend busy special clinics where they
can discuss any problems with and receive advice
from a physician who has much experience of the
condition. However, there are too many asth-
matics to be catered for by such clinics, and the
proper place for their long-term care is in general
practice. Only when all physicians and general
practitioners equip themselves with a cheap device
for measuring peak flow and with a basic knowl-
edge of modern asthma therapy will life become
more bearable for the majority of asthmatics and
will unnecessary deaths be prevented. The major
problem in asthma today is the education of the
profession about the disease.

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