

Editorials

The labyrinth of asthma phenotypes and exhaled NO

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In this issue of *Thorax* Payne *et al*¹ suggest that it is possible to distinguish different patterns of difficult childhood asthma by measuring exhaled NO (eNO). The knowledge that severe asthma may have different phenotypes with different types of airway inflammation is not new and has been clearly shown by bronchoalveolar lavage (BAL) and airway biopsy studies in adult patients.² The potential importance of these data lies in the classification of different patterns by using a non-invasive instantaneous measurement such as eNO.

Exhaled NO levels are known to be increased in atopic asthma, to increase during an exacerbation, to decrease with anti-inflammatory therapy,³ and to rise as the dose of inhaled steroids is reduced.⁴ In addition, eNO levels are correlated with eosinophils in induced sputum,⁵ bronchial hyperresponsiveness to AMP,⁶ and exercise,⁷ and to increase in the late phase following allergen challenge.⁸ As a diagnostic tool, eNO levels discriminated asthmatics from non-asthmatics with a high sensitivity and specificity in a group of subjects with chronic cough.⁹ All the above evidence supports the contention that eNO may be considered a surrogate marker of airway inflammation in asthma.^{10 11}

NO is a freely diffusible gas generated from L-arginine by NO synthases. These enzymes are found in many cells of the lung, including nerves, epithelial cells, alveolar macrophages, and other inflammatory cells. It has been suggested that the increased eNO levels found in asthmatic subjects result from an increase in the expression of inducible nitric oxide synthase 2 (NOS-2) in the respiratory tract induced by the action of proinflammatory cytokines.¹² Corticosteroids inhibit induction of NOS-2^{12 13}; however, eNO concentrations remain somewhat increased in asymptomatic patients with normal spirometric parameters, consistent with the presence of ongoing airway inflammation. Even though NOS-2 activity seems to be the principal cause of hypernitrosopnoea in asthmatic patients, there are additional determinants of eNO production such as airway acidification, S-nitrosothiol breakdown, and infections.¹⁰ Despite clear evidence of increased eNO levels in asthma, the function of NO as a toxic proinflammatory or protective agent is still unresolved.

How should eNO be measured in clinical practice? The technique for measuring eNO has now been standardised for cooperative subjects and the initial problems related to flow dependency and nasal contamination have been resolved. Recommended techniques have recently been published in an official statement of the American Thoracic Society¹⁴ and the utilisation of standardised methods is of utmost importance for allowing comparison between different laboratories. The recommended exhaled flow for online measurement is 50 ml/s in children and adults exhaling against a resistance to close the velum and avoid contamination from nasally derived NO.

Although bronchial eosinophilia is considered a hallmark of asthma, it is not necessarily specific to asthma and has also been found in biopsy specimens from atopic non-asthmatic subjects.¹⁵ There is mounting evidence that different inflammatory patterns may exist in asthmatic subjects.¹⁶ In particular, the mechanisms associated with the development of severe corticosteroid dependent asthma seem to be heterogeneous. Wenzel *et al*² showed that severe asthma can be divided pathologically into two inflammatory groups based on the presence or absence of bronchial eosinophils. The type of inflammation appeared to be associated with different structural changes and physiological patterns. The eosinophil positive group had a thicker sub-basement membrane and had a much higher incidence of respiratory failure and mechanical ventilation than the eosinophil negative group. Even though the two groups shared very few inflammatory features, both had a persistent increase in neutrophils. There is accumulating evidence that neutrophils may play a role in severe refractory asthma.² Neutrophil number and activation are increased in the airways of subjects with status asthmaticus and during exacerbations of asthma. The cause of neutrophilic inflammation has not been determined, but the high levels of interleukin (IL)-8 found in asthmatic patients may enhance neutrophil recruitment and activation.¹⁷ Since neutrophils are relatively steroid resistant, it was hypothesised that the neutrophilic inflammation may account for the poor response to corticosteroids seen in refractory asthma.

The finding of different patterns of airway inflammation could have a major impact on potential treatment options for difficult asthma. Assuming that uncontrolled inflammation may result in airway remodelling,¹⁸ every effort should be made to define the inflammatory phenotypes of asthma in more detail. Even though steroid resistant asthma is fortunately not common in children, a priority is to develop simple non-invasive tools that can reflect different types of inflammation. The study by Payne *et al*¹ suggests that different patterns of difficult asthma in children may be identified by measuring eNO concentrations. Of interest is the identification of two subgroups of children who had persistent symptoms after prednisolone treatment—those with raised eNO concentrations and those with normal concentrations of eNO before and after treatment. All patients were atopic and therefore the differences in eNO concentrations cannot be attributed to the influence of atopy.^{19 20} The authors speculate that raised eNO concentrations may reflect uncontrolled eosinophilic inflammation while low eNO concentrations may reflect either a non-eosinophilic inflammation or an absence of inflammation. Probably these latter patients need alternative treatments. In a recent study *inhaled* NO was used as a life saving therapy in children with status asthmaticus.²¹ Whether inhaled NO therapy could be useful in patients with low eNO concentrations is not known.

Unfortunately Payne *et al*¹ do not report any data on bronchial histology from these children with severe asthma and cannot say whether NO is a reflection of a specific pattern of airway inflammation. In this regard, however, the same authors published preliminary data on bronchial biopsy specimens from children with severe asthma and, as in adult patients, found an absence of airway eosinophilia in a subgroup of children.²² The only distinguishing feature of these eosinophil negative patients was a lower level of eNO compared with patients with eosinophilic airway inflammation. In a recent article in *Thorax* Çokuğraş *et al* reported a lack of eosinophilic inflammation in children with moderate asthma.²³ More biopsy studies will be required in asthmatic children before the type of inflammation which occurs in childhood asthma can be characterised.

More than one asthma phenotype is now also apparent in young children with recurrent wheezing during preschool and early school years.²⁴ In the first years of life there are asthma-like syndromes that are transient and early asthma that persists.²⁵ Evidence suggests that measuring eosinophil infiltration in the airways may prove fruitful in distinguishing transient infantile wheezers from infants with early onset asthma. Studies based on BAL in young wheezing children²⁶⁻²⁷ have found different inflammatory patterns, with eosinophil mediated airway inflammation in those with atopy and persistent wheezing and neutrophil mediated inflammation in those with transient wheezing. Epidemiological studies have provided useful data and now we know that risk factors such as age, genetic background, and allergic sensitisation may be strong indicators for asthma risk.²⁵ Unfortunately, these risk factors are difficult to apply to each single affected individual. For this and many other reasons it is universally recognised that the identification of asthma specific inflammatory markers would be very useful. In preliminary studies the measurement of eNO concentrations has been used successfully to distinguish infants with virus induced wheezing from those with early onset asthma,²⁸⁻²⁹ but further work is necessary to evaluate its predictive value in prospective population studies. To date there have been no studies of the relationship between bronchial histology/BAL profiles and eNO concentrations in wheezing infants.

Another intriguing phenomenon seen in different asthma phenotypes is the difference in eNO concentrations between atopic and non-atopic asthma. There is a subgroup of asthmatic patients who are not demonstratively atopic, the so-called "intrinsic variant" of the disease. However, this does not seem to be a distinct immunopathological entity.³⁰ Bronchial biopsy studies have shown that both so-called intrinsic and extrinsic asthma are characterised by infiltration of eosinophils, high affinity IgE receptor bearing cells, and enhanced expression of Th2-type cytokines compared with controls. It has been suggested that, in intrinsic asthma, there might be local IgE production directed against unknown antigens, possibly of viral origin or even autoantigens,³⁰ whereas in extrinsic asthma the response is directed against environmental allergens. Recent studies have shown that adults and children who are atopic and asthmatic have higher eNO levels than non-atopic asthmatic subjects.^{19-20, 31-33} Even if the relationship between atopy and airway inflammation remains unclear, a quantitative relationship between natural and laboratory exposure to allergens and eNO has been shown,⁸⁻³⁴ with the highest levels of eNO being found in patients who were both sensitised and exposed to relevant allergens.³⁵ Since the immunopathology of extrinsic and intrinsic asthma seems to be similar,³⁰ the atopic process itself may have an independent influence on eNO levels through genetic factors³⁶ or mechanisms that are still unknown.

In the light of actual knowledge it can be concluded that the measurement of eNO may, by a non-invasive and rapid means, help in the understanding of the different underlying pathophysiological mechanisms of asthma phenotypes. Studies comparing direct measurement of airway inflammation (bronchial biopsy and BAL) and eNO concentrations are to be encouraged to address the issue of whether this exhaled biomarker could help the clinician to find an exit from the labyrinth of different patterns of childhood asthma.

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COX-2 expression in asthmatic airways: the story so far

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Cyclo-oxygenase (COX), also known as prostaglandin H synthase (PGHS), is the rate limiting enzyme for the conversion of arachidonic acid to prostanoids and exists in two isoforms. COX-1 is constitutively expressed and is responsible for the basal production of prostanoids, whereas COX-2 is highly inducible by a number of stimuli including cytokines and is associated with inflammation. Accumulating evidence suggests that the induction and regulation of COX-2 may be key elements in the pathophysiological process of a number of inflammatory disorders and may play an important role in the pathogenesis of asthma.¹

Bronchoalveolar lavage fluid from patients with symptomatic asthma contains significantly increased levels of a number of proinflammatory cytokines including interleukin 1 β and tumour necrosis factor α .^{2,3} It has recently been shown that these proinflammatory cytokines are capable of inducing COX-2 in a number of cultured airway cells including airway epithelial cells,^{4,5} airway smooth muscle cells,^{6,7} and airway fibroblasts.⁸ In addition, we have shown that transforming growth factor β_1 and the proinflammatory asthmatic mediator bradykinin also induce COX-2 in human airway smooth muscle cells.^{9,10} These results suggest that COX-2 expression may be upregulated in asthmatic airways.

Several studies have examined COX-2 expression in asthmatic airways but the data are conflicting. Demoly *et al*¹¹ found that COX-2 was expressed in normal human respiratory epithelium and was not quantitatively upregulated in stable asthma. Conversely, Sousa and coworkers found increased expression of COX-2 in the epithelium and submucosa of asthmatic patients compared with control subjects.¹² Similarly, Taha and colleagues reported greater COX-2 immunoreactivity in the induced sputum, the submucosal inflammatory infiltrate, and the airway epithelium of patients with asthma than of unaffected control subjects.¹³ Since corticosteroids have been shown in vitro to inhibit COX-2 expression in various airway cells,^{4–9} the fact that the majority of asthmatic subjects in these studies were receiving treatment with inhaled corticosteroids at various doses may largely explain the discrepancies between these studies. In this issue of *Thorax* Redington *et al*¹⁴ have made a fresh contribution to the study of COX-2 expression in asthma. Aware of the potential confounding effect of corticosteroids on COX-2 expression, they obtained bronchial biopsy specimens from three groups of subjects: atopic asthmatics treated with β_2 agonists alone, atopic asthmatics additionally receiving regular treatment with corticosteroids, and non-asthmatic

control subjects. They found that the expression of both COX-2 mRNA and immunoreactive protein was increased in the airway epithelium of non-steroid treated asthmatics compared with non-asthmatic control subjects, and that the expression of COX-2 in asthmatic subjects receiving regular treatment with corticosteroids was not significantly different from that observed in non-asthmatic controls. Their findings clearly demonstrate that COX-2 is upregulated in the airway epithelium of asthmatic subjects and downregulated by corticosteroid treatment, and further strengthen the hypothesis that COX-2 may play a major role in the pathogenesis of asthma.

Since we and others^{6,7,9} have shown that COX-2 is markedly induced in airway smooth muscle cells in vitro by proinflammatory cytokines and other mediators that exist in asthmatic airways, it is reasonable to speculate that COX-2 expression in airway smooth muscle is also upregulated in asthma. It would be important to study COX-2 expression in airway smooth muscle of asthmatic subjects as it is an important component of the airways and plays a crucial part in the pathophysiology of asthma.

The consequences of increased COX-2 expression in asthma are not clear. PGE₂, the main product of COX-2 induction, is an important anti-inflammatory mediator which has considerable bronchoprotective effects in the airways.¹⁵ It is possible that PGE₂ production as a result of COX-2 induction may exert a braking effect on the inflammatory process in asthmatic airways. However, PGE₂ at higher concentrations also causes contraction of airway smooth muscle via thromboxane receptors.¹⁶ PGD₂, PGF_{2 α} , and thromboxane A₂ are also potent bronchoconstrictors via thromboxane receptors.^{16,17} PGI₂ causes relaxation of isolated precontracted human bronchus¹² but has little effect on airway calibre in vivo.¹⁸

Several studies of the effect of COX-2 induction on airway functions have been conducted. Gavett *et al* showed that allergen induced inflammation was increased in COX-2 deficient mice.¹⁹ Belvisi *et al* reported that PGE₂ from COX-2 induction in airway smooth muscle inhibited cell proliferation.²⁰ We found that PGE₂ release after COX-2 induction mediated IL-1 β and bradykinin induced attenuation of human airway smooth muscle cyclic AMP generation in response to β agonists,^{21,22} and that PGE₂ from both COX-1 and COX-2 also largely mediated bradykinin stimulated IL-8 release from human airway smooth muscle cells.²³ These results suggest that COX-2 induction exerts both protective and proinflammatory effects. The consequences of increased COX-2 expression

in asthma are therefore likely to be complex and depend on the balance between the proinflammatory and the anti-inflammatory effects of prostanoids produced by various cell types under different circumstances. A better understanding of this issue might be achieved by direct functional studies with airway tissues from asthmatic patients, but these are notoriously difficult to obtain.

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Sarcoidosis: old and new treatments

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2001 marks the 50th anniversary of the first reports of the successful treatment of sarcoidosis with cortisone^{1,2} and ACTH.³ In an early report of treatment with corticosteroids, Siltzbach⁴ highlighted one of the problems of evaluating the results when he wrote:

“The aetiology of sarcoidosis still eludes us, as does the definitive treatment. Part of the difficulty stems from the unpredictability of spontaneous remissions. This accounts for the many transitory successes reported at one time or another with such agents as calcium salts, gold, arsenicals, potassium iodide, chaulmoogra oil, antileprol and tuberculin.”

It is somewhat depressing that no better therapeutic agents than steroids have emerged over the subsequent 50 years, and the sceptic might well conclude that little has changed! While the approach to treatment may have become more rational and the choice of effective agents has increased, it is at best suppressive rather than curative. Happily, as Siltzbach pointed out, in most patients the natural tendency of pulmonary sarcoidosis is towards spontaneous resolution. The therapeutic challenges remain the recognition of those patients in whom remission and resolution are less likely, and determination of the optimum treatment to minimise permanent organ damage.

Several uncontrolled and controlled studies, as well as common clinical experience, have amply confirmed the suppressive effect of steroids.^{5–11} In pulmonary sarcoidosis

the most common indication for treatment is symptomatic, usually troublesome breathlessness and sometimes cough. Most commonly, prednisolone is started at a dose of 30–40 mg daily with later reduction titrated against symptoms, respiratory function, and radiographic appearance. Once started, treatment is usually continued for at least 1 year but patients may require more prolonged treatment if dose reduction is accompanied by recrudescence of disease activity. Whether or not steroid treatment reduces long term pulmonary damage due to fibrosis has proved difficult to determine. Common experience shows that in many cases pulmonary fibrosis is not prevented by steroids as, not infrequently, patients are seen with advanced destructive fibrosis even after their continuous use for several years. Most of the controlled studies which have attempted to assess the long term outcome of steroid treatment have been criticised on one or more counts—in particular, inclusion of patients with bilateral hilar lymphadenopathy without pulmonary shadowing, which has a good prognosis for spontaneous resolution, and the introduction of steroids at the time of presentation often in relatively asymptomatic patients in whom most clinicians would normally adopt a “wait and see” policy before embarking on treatment. The importance of the latter approach was apparent in the recent BTS controlled study¹¹ where 50% of patients who presented with pulmonary shadowing but

did not require immediate treatment to control symptoms showed spontaneous radiographic improvement over a 6 month observation period. The BTS study¹¹ concentrated on patients with pulmonary shadowing in whom spontaneous improvement had not occurred over such a period. Subjects were then allocated to receive either a prolonged course of steroids ("long term" treatment) or to remain under observation with treatment later only if required because of troublesome symptoms or deteriorating respiratory function ("selective treatment"). After an average follow up of 4 years, patients in whom long term treatment was given had a significantly better outcome than those in whom the policy of selective treatment was adopted. This better outcome was reflected in symptoms, respiratory function, and radiographic appearances, although the differences between the two groups at the end of the study were modest. In practice it is impossible to perform a controlled study of the long term effects of steroids in severe pulmonary sarcoidosis as virtually all such patients receive appropriate treatment with steroids for symptomatic relief.

It was also noteworthy in the BTS study that, of a further group of more severely affected patients who required early steroids for symptomatic benefit, approximately half were still taking the treatment after 5 years, most frequently because of deterioration in symptoms when dose reduction or withdrawal was attempted.¹¹ This tendency to relapse following dose reduction has been recognised for many years¹²⁻¹⁵ and has been emphasised in two recent studies.¹⁴⁻¹⁵ The potential disadvantages of long term steroid treatment are, of course, widely recognised in patients with sarcoidosis, as in other conditions. More specifically, in sarcoidosis the question has been raised as to whether steroids may delay resolution of granulomatous inflammation, thereby contributing to prolongation of the disease. In a retrospective study Gottlieb *et al*¹⁴ showed that, of 103 patients who achieved complete remission of sarcoidosis while taking steroids, the disease subsequently relapsed in as many as 76 when steroids were discontinued. On the other hand, of 118 who showed spontaneous remission, only 10 subsequently relapsed. The authors suggested that "corticosteroids contributed to the prolongation of the disease by delaying resolution". However, the study was retrospective and, inevitably, the untreated patients had milder disease; furthermore, the population studied was different from that found in Europe with the majority being African Americans (in whom the disease is usually more aggressive) and most had been treated for non-respiratory sarcoidosis. The authors considered the alternative explanation that "severe presenting symptoms portend a protracted and recurrent course" to be less likely. While the hypothesis that steroid treatment may delay resolution of sarcoidosis is intriguing, to date no prospective study has been performed to test it.

These recent studies of steroids in sarcoidosis therefore have implications for long term treatment which potentially conflict. In particular, the BTS study¹¹ is a little more favourable towards long term treatment than earlier studies, whereas the analysis by Gottlieb *et al*¹⁴ suggests the need for caution with too liberal use of these agents. The decision whether or not to treat has to be made on an individual basis and relative contraindications (such as hypertension and obesity), together with the likely need for prolonged treatment, have to be balanced against the need to control symptoms or the possibility of reducing lung scarring. In practice, the indication for treating pulmonary sarcoidosis with steroids in most cases remains the relief of uncomfortable or disabling symptoms.

If steroids are to be used, many authorities favour alternate day treatment once a "maintenance dose" has been established. The limited available data¹⁶ suggest that, at a

similar total dose, this policy is as effective as daily treatment but information on long term adverse effects is lacking. Some recent data have suggested that an alternative steroid, deflazacort, may have similar efficacy with fewer adverse effects, particularly on bone mineral density.¹⁷ However, experience to date is limited and similar claims for earlier alternative steroids have not stood the test of time. A recent placebo controlled study¹⁸ of the third generation bisphosphonate, alendronate, in patients with sarcoidosis reported better preservation of bone density with less evidence of steroid induced bone resorption in those receiving alendronate. Additional calcium supplementation was not included in this study and is probably best avoided in view of the known effects of sarcoidosis on calcium metabolism and the tendency to hypercalcaemia and occasionally hypercalcaemia.

The problems associated with oral steroid treatment in patients with sarcoidosis have inevitably led to use of other agents. Inhaled steroids have been the subject of several studies with somewhat mixed results. Following an early open study of inhaled budesonide which showed apparent benefit,¹⁹ three controlled studies have been reported. Zych *et al*²⁰ compared inhaled budesonide with prednisolone, 10 mg daily, over a 12 month period as maintenance treatment following induction with larger doses of prednisolone. The outcome was similar in the two groups but no placebo or treatment group was included. In a second double blind placebo controlled study of previously untreated patients Milman *et al*²¹ found no difference in outcome after 12 months compared with placebo. However, only 21 patients were included and some had no pulmonary shadowing. In a third controlled study of 47 patients inhaled budesonide was again compared with placebo over a 6 month period.²² An unknown number of patients presenting with "severe symptoms" was excluded and no preliminary observation period was used. Thirteen of the patients had no pulmonary shadowing. The results showed that, compared with placebo, patients taking inhaled budesonide had a significantly lower overall symptom score after 6 months of treatment. There was also a significantly greater increase in vital capacity in the treated patients but, surprisingly, there were no accompanying differences in forced expiratory volume in 1 second, carbon monoxide transfer factor, or radiographic appearance. Moreover, the relatively small numbers of subjects requiring introduction of oral steroids for symptomatic relief during the study period were not significantly different in the two groups. In the most recent study Pietinalho *et al*²³ compared two groups of patients treated for a total of 18 months with either prednisolone for 3 months followed by inhaled budesonide for 15 months or 3 months of placebo tablets followed by 15 months of placebo inhaler. Again, no preliminary observation period was used and a proportion of the patients had bilateral hilar lymphadenopathy only. Radiographic improvement was seen in the active treatment group at 3 and 6 months but the difference was not sustained. In the subgroup of patients with pulmonary shadowing the improvement in carbon monoxide transfer factor at 18 months was greater than in the placebo group. The authors concluded that initial treatment with prednisolone followed by long term inhalation of budesonide was more effective than placebo in this subgroup of patients, but the better outcome may of course have been due to the initial oral steroid rather than the subsequently inhaled drug. Other studies have suggested that inhaled budesonide has a definite effect on the activity of sarcoidosis as judged by bronchoalveolar lavage findings.²⁴ Its role in clinical practice, if any, is likely to be as maintenance treatment after an initial course of oral steroids in patients with relatively mild pulmonary disease.

Many of the alternative oral agents which have been used for treatment of pulmonary sarcoidosis have been found unsatisfactory. Drugs such as cyclosporin A,²⁵ chlorambucil,²⁶ thalidomide,²⁷ and cyclophosphamide²⁸ are either too poorly effective or too toxic (or both) to recommend other than in exceptional circumstances. One recent uncontrolled report²⁹ suggested that pentoxifylline, which has an inhibitory effect on tumour necrosis factor alpha (TNF α), may benefit some patients but further experience is required before it can be recommended.

Azathioprine, methotrexate, and the antimalarial agent chloroquine remain as viable alternatives or adjuncts to steroid treatment, most commonly as steroid sparing agents. Unfortunately, neither azathioprine nor methotrexate has been the subject of a controlled trial. Azathioprine is usually reserved for severe refractory cases and has occasionally been reported to be effective in sarcoidosis apparently resistant to steroid treatment.³⁰ In a recent study azathioprine combined with prednisolone was reported to induce remissions in a small number of patients with chronic relapsing pulmonary disease.³¹ Rather more experience has been reported with the use of the folate antagonist methotrexate, albeit largely from one group of investigators.^{32,33} Their observational data on prolonged treatment in more than 100 patients suggest functional improvement and the ability to reduce or withdraw chronic steroid treatment in a significant proportion. The drug is given orally once a week in a usual dose of 10 mg. The most significant complication of methotrexate is hepatotoxicity and guidelines for monitoring liver toxicity, including the possible need for liver biopsy, have been published.³⁴ Methotrexate also occasionally causes pulmonary toxicity, which obviously may present diagnostic confusion in patients with pulmonary sarcoidosis.

Other than corticosteroids, the drug with the best controlled evidence in sarcoidosis is chloroquine. It has been widely used by dermatologists treating cutaneous sarcoidosis, but relatively little by respiratory physicians, although a seminal controlled study was published by the Research Committee of the British Tuberculosis Association as long ago as 1967.³⁵ This compared chloroquine (600 mg daily for 8 weeks followed by 400 mg daily for 8 weeks) with placebo in patients known to have radiographic pulmonary shadowing for at least 6 months and previously untreated with corticosteroids. There was clear evidence of greater radiographic improvement in the chloroquine group at the end of the treatment period (4 months) and again at 6 months, although the difference between the two groups was no longer evident at 12 months. A resurgence of interest in chloroquine has been occasioned by the recent study of Baltzan *et al*³⁶ who reported the effects of treatment in 23 patients with chronic pulmonary sarcoidosis, known to have been present for between 2–18 years (mean 6.2). Most had been treated with high dose oral steroids without sustained symptomatic or functional improvement. Initially, all subjects received chloroquine for 6 months starting with a relatively high dose (750 mg daily for 2 months, 500 mg daily for 2 months, 250 mg daily for 2 months). At the end of this open treatment period the subjects were randomised to either an observation group or a maintenance group who continued to receive chloroquine in a dose of 250 mg daily. The rate of decline in respiratory function was then followed until "relapse" which was defined as a reduction in the relevant functional index to a value less than that recorded at the start of the open treatment period. The patients showed symptomatic improvement during the initial run in period and a significantly diminished rate of decline in respiratory function during maintenance with

chloroquine compared with placebo. These results therefore suggest that chloroquine has a useful therapeutic role, even in patients with advanced chronic disease, particularly when corticosteroids are poorly effective or are causing significant side effects. The greatest concern about the use of chloroquine has been its potential toxic effects on the eye. These are of two types: corneal deposits, which are almost universal, asymptomatic and reversible, and a much rarer, but potentially irreversible, retinopathy. Ophthalmological assessment before treatment and every 6 months during treatment is recommended³⁷ and the side effects are, to some extent, dose dependent. There has been a natural reluctance to use chloroquine because of these effects, but an interesting parallel is the use of ethambutol in tuberculosis where most respiratory physicians are well used to the care required and the need to warn patients to report any visual disturbance.

Of non-pharmacological treatments, the only recent therapeutic development relevant to pulmonary sarcoidosis is lung transplantation for which advanced pulmonary disease is now an accepted indication. Recurrence of the disease in the transplanted lung has been reported on several occasions³⁸ but the long term implications are not yet clear.

The findings reported with pentoxifylline and chloroquine suggest that other agents inhibiting TNF α might usefully be subjected to controlled trial. In the meantime, corticosteroids remain the mainstay of treatment, as they have been for the last 50 years. Of the alternatives, in refractory cases or when steroid sparing is desirable, chloroquine (or hydroxychloroquine), methotrexate, and azathioprine are currently the "best buys".

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Thorax 2001;56:339–340

Good respiratory practice in primary care

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It is estimated that approximately 85% of all patients with asthma or chronic obstructive pulmonary disease (COPD) in the UK¹ and in the Netherlands² are treated by a general practitioner (GP). This underlines the importance of providing good medical respiratory care in general practice. Strangely enough, guidelines for the diagnosis and treatment of asthma and COPD have mainly been written by national or international thoracic societies. Of course, the GP has many diseases to deal with other than asthma and COPD alone, so one could argue that it is the chest physician who is the specialist and should therefore be the one to produce these guidelines. However, the patients seen by chest physicians often differ from those seen by GPs in the severity of their disease and consequently in their treatment. It would therefore seem logical to include primary care experts in asthma and COPD guideline panels in order to improve respiratory practice in primary care.

Research has shown that currently there are deficiencies in respiratory practice related to primary care. For example, delays in diagnosis are common³ and lead to inappropriate treatment being given while, in other cases, the severity is underestimated with the result that preventive treatment is underused.^{4,5} One study showed that 74% of those admitted to hospital with severe asthma could have had the admission prevented by different primary care.⁶ Surveys of deaths from asthma have shown that nearly 90% of cases involve avoidable factors.⁷ This does not always mean that the GP is to blame. It might also be related to the patient who does not present his symptoms to the GP. Underdiagnosis has been shown to be mainly due to underrepresentation of bronchial symptoms by the patient to the GP, and this seems to be associated with a poor perception of asthma symptoms by the patient.⁸

The improvement of respiratory practice in primary care starts with making clear guidelines for primary care. In the Netherlands the first national guidelines on the diagnosis and treatment of asthma and COPD in general practice were published in 1992 by the Dutch College of General Practitioners.⁹ In 1997 these guidelines were updated on the basis of new literature and re-evaluation of the 1992 guidelines.¹⁰

As it is known that publication of guidelines alone will not change the actual care provided by physicians,¹¹ a large study was undertaken to investigate the best strategy for implementing these guidelines.¹² Two intervention groups and one control group of general practices were formed: a small education group (17 GPs with 210 patients), a monitoring and feedback group (24 GPs with 299 patients), and a control group (17 GPs with 223 patients). The actual health care provided for asthma and COPD by the intervention groups was compared with the health care given by the control group. The outcome was measured in terms of structure and process parameters (knowledge and skills of GPs, presence of equipment, and pharmacological and non-pharmacological treatment) and patient outcomes (symptoms, smoking habit, exacerbation rate, and asthma specific quality of life). In the education group the intervention consisted of an interactive group education and peer review programme (four sessions of 2 hours), while in the monitoring/feedback group the intervention consisted of monitoring the intake procedure, regular follow up, and feedback on lung function, smoking habits, use of medication, and compliance. In the education group the only significant difference from the control group was in the skills of the GP. In the monitoring/feedback group, however, there were clear improvements in knowledge, skills, presence of peak flow meters, and adequate pharmacological treatment compared with the control group. This led to the conclusion that monitoring and feedback results in a significant change in the care provided for asthma and COPD. Improving care by implementing guidelines appears to be most successful when physicians are directly confronted with the specific health care results of their patients. It therefore seems that feedback of information to health professionals about their care can lead to an alteration in their behaviour. Audits alone in general practice may only give negative feedback when the care provided is compared with the optimal care displayed in guidelines. When the care provided is compared with the care given by peers, and subsequently discussed with these peers, both negative and positive feedback are given and the best (social) learning situation is created for obtaining clear

changes in health care behaviour. This might be especially important for GPs who see patients with many diseases other than asthma and COPD and therefore cannot be expected to know in detail how to treat these patients in accordance with the guidelines.

The World Health Organization, the ERS, and the EAACS have recently started work on the Global Initiative for Asthma (GINA) guidelines to make them more applicable and easier to implement in primary care. Primary care specialists from all over the world have been asked to comment in order to produce a short and practical guideline best suited to the situation in primary care. It is hoped that this initiative will help to improve respiratory practice in primary care.

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