LETTERS TO THE EDITOR

Revision of BTS guidelines for treatment of asthma

The paper by Ward et al confirms the findings of Laitinien et al showing that airways inflammation is present even in patients with mild asthma. This emphasises the importance of using anti-inflammatory drugs (steroids) as soon as the diagnosis of asthma has been confirmed, even in patients thought to have only "mild asthma". Without anti-inflammatory treatment, symptoms resulting from bronchial hyperresponsiveness are never controlled and optimal lung function is never attained. Over time, structural changes (remodelling) occur leading to a progressive decline in lung function and the risk of fixed obstruction (chronic obstructive pulmonary disease).

The present widespread dependence on bronchodilators in the UK may contribute to the fact that we have one of the highest respiratory death rates in Europe. The use of bronchodilators alone as in step 1 of the BTS guidelines should be discouraged, and treatment started at step 2 with regular inhaled corticosteroids to control symptoms and maximise peak flow rate. Bronchodilators should be used only as necessary for breakthrough wheezing. These principles have been used in Finland since 1994 with remarkable success in treating asthma. The new BTS guidelines would do well to follow their example.

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References

Authors’ reply

We would like to thank Dr Strube for his interest in our recent paper and his stimulating letter which is topical given that the new BTS guidelines on asthma management are currently in preparation. Our study was an attempt to investigate the interrelationships between airway inflammation, airway structural change (remodelling), lung function, and bronchial hyperreactivity to methacholine in patients with mild to moderate symptomatic asthma.

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The editors will decide as before whether to also publish it in a future paper issue.

Our paper is supportive of a further point, adding to work from others, which we feel is potentially substantiative, of possible importance to future guideline considerations, and perhaps relates to some of Dr Strube’s concerns. The potential paradigm shift is that determining appropriate treatment only by reference to symptoms and lung function, as in current international and draft BTS guidelines, or even against indices of inflammation, may be oversimplistic, with prolonged treatment necessary to benefit airway remodelling reflected by improvement in BHR. It should be recognised that this remains a hypothesis and, pragmatically, it is of interest that the inclusion of BHR as an asthma management tool in the UK is not resourced and is not currently practicable.

We also realise that the demanding and detailed preparation of the BTS asthma guidelines has followed a due process dependent on the available evidence base with “levels of evidence” leading to “grades of recommendation” and, in turn, to “recommended best practice”. If appropriate pathophysiological research relevant to the clinical questions does not exist, it cannot be included. We feel that longitudinal data that seek to integrate information on airway inflammation, airway hyperresponsiveness, lung function, and bronchial hyperreactivity and the effects of treatment are required. Such work, though demanding, is possible and would require multidisciplinary cooperation, dialogue, and appropriate support.

Chris Ward is a European Respiratory Society long term research fellow. The work was also supported by Australian NHMRC and a grant in aid from Glaxo Smith Kline.

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References
4 http://www.brit-thoracic.org.uk/guide/guidelines.htm
Chronic respiratory failure

The recent case report by Smyth and Riley1 describes an extremely uncommon chronic respiratory failure due to hypventilation secondary to brainstem stroke, and documents a new treatment option with medroxyprogesterone acetate. We recently saw two patients also with central hypventilation resulting in chronic type II respiratory failure and treated both with, among other things, medroxyprogesterone acetate (30 mg twice daily) with good results. The first patient, a 69 year old man with a medical history of glomus caroticum resection due to malignancy with postoperative radiotherapy, presented to our outpatient clinic with poliglobulia. Arterial blood gas analysis revealed marked hypoxaemia (Pao, 4.8 kPa) and hypercapnia (PaCO2 6.9 kPa). An intensive search for the cause showed no abnormality of the lung function indicated only marginal chronic obstructive pulmonary disease (FEV1/VC 68%) but his hypoxic ventilatory response was markedly decreased and his hypercapnic ventilatory response was almost abolished. The patient was treated with acetazolamide, theophylline, and medroxyprogesterone acetate and his blood gas tensions improved within days to normal values (Pao 10.3 kPa, Paco, 5.1 kPa).

In the second patient, a 68 year old man, was known from birth to have a hypothalamic pituitary gland dysfunction with (stable) adipsia, (queteeit index 53). He had complained of hypogonadism, general malaise, and dyspnoea on several occasions before being sent to our department. Arterial blood gas analysis revealed hypoxaemia and marked hypercapnia (Pao, 8.0 kPa, Paco, 7.2 kPa). She probably suffered from pituitary apoplexy. The patient was treated with acetazolamide, theophylline, and medroxyprogesterone acetate and his blood gas tensions improved within days to normal values. Furthermore, she no longer shows an intense weight reduction programme and has lost more than 10 kg in weight.

Acetazolamide has been shown to augment both the hypoxic and hypercapnic ventilatory response and to decrease Paco2 levels significantly in patients with chronic obstructive pulmonary disease (COPD).2,3 The mechanism of the effect is possibly due to a direct effect on the peripheral chemoreceptors (carotid bodies) as well as to an effect on cerebral blood flow regulation.3

It has been shown that medroxyprogesterone acetate also acts on the peripheral chemoreceptors (directly) as well as on the central receptors. Acetazolamide has been shown to hypventilate in cats.4 This was also found in hypercapnic COPD patients, indicating that medroxyprogesterone acetate acts centrally on the respiratory centres.5 This supports the hypothesis of medroxyprogesterone acetate in central hypventilation. Furthermore, the combined treatment of acetazolamide and medroxyprogesterone acetate increases ventilation and improves arterial blood gas values—that is, it decreases Paco2 to normocapnic values and increases Paco2 to almost normocapnic values in hypcapnic and hypercapnic patients with COPD.6

In conclusion, we agree with Smyth and Riley that medroxyprogesterone acetate can be used in patients with central hypventilation disorders.

References

Caffeine and exhaled nitric oxide

We read with interest the paper by Bruce et al7 which reported a significant decrease in exhaled nitric oxide (NO) levels 1 hour after caffeine consumption. However, we do not believe that this study has fully clarified the relationship between caffeine consumption and exhaled NO levels.

When ascertaining the normal ranges for offline exhaled NO measurements we observed that some individuals had raised baseline NO levels. For example, we observed that some individuals had increased NO levels 1 hour after caffeine consumption. However, we do not believe that this study has fully clarified the relationship between caffeine consumption and exhaled NO levels.

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References

Morbid obesity and hypsomnolence in several members of an ancient royal family

Recent studies have described an inherited basis for the sleep apnoea syndrome, as suggested by reports of families with multiple affected members.8 We present evidence indicating that several members of the Ptolemaic family, the royal family that ruled Egypt from 305 to 30 BC, suffered from obesity and sleep disordered breathing. Most of the information was reported by the Greek philosopher and historian Athenaeus (170–230 BC). The family’s pedigree with all affected individuals is shown in fig 1. Magas I (case 1) was morbidly obese, whereas his son Magas II (case 2) and his sister Arsinoe III were extremely obese. Ptolemy II was not an energetic man and he disliked physical exertion. Although he lived to the age of 62, he was troubled by ill health throughout most of his life. Ptolemy IV the Philopator (case 3),
was described as licentious even by the standards of his contemporaries. Calvin Wells reported that he was obese and he languished in habitual lethargy, perhaps because of chronic illness.\textsuperscript{4} Ptolemy V Epiphanes (case 4) also developed extreme obesity and used to fall asleep during social and political events. Athenaeos wrote: “One day, Aristomenes, his Prime Minister and chief advisor, had the effrontery to nudge the king awake when he dozed off during a diplomatic reception”.\textsuperscript{5} Ptolemy VI Philometor (case 5) was portrayed as “good and kind” and “apt to be lethargic and inert”. Justinus added that he was extremely obese and sluggish.\textsuperscript{5} Ptolemy VIII Evergetes II (case 6) was morbidly obese.\textsuperscript{7} Apart from naming him Evergetes (benefactor), Alexandrians labelled him Kakergetes (malefactor) and—because of his obesity and large belly—“Physkon” (large bubble). Ptolemy VIII’s belly was so large that its circumference was wider than two arms extended. In order to cover his belly he wore a long tunic that extended down to his ankles with sleeves up to his wrists. Because of his obesity he was unable to walk, apart from an occasion when he went to meet the Roman Consul Skipion, the African. In a poem entitled “Ptolemy VIII Evergetes II or Kakergetes” the Greek poet Constantine Cavafy wrote: “Most obese, slothful Ptolemy Physkon, and due to gluttony somnolent observed: wise poet your verses are somewhat exaggerated….. And from obesity heavy as a stone, and from veracity somnolent the unalloyed Macedonian could scarcely keep his eyes open.”

Ptolemy X Alexander I (case 7) was so grossly obese that he had a man on either side to help him walk.\textsuperscript{7} He was idle, drunken, and extravagant in his lifestyle. From these descriptions it is clear that obesity was present in all of them and, in at least four of the seven kings, there were reports of daytime somnolence. This dynasty was probably the first reported family with sleep disordered breathing that had a familial predisposition.

References

3 Strabo. XII. 1. 5.
5 Polybius. XXXIX. 7.
6 Posidoniou. Athens, XII: 549c.

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BOOK REVIEW

Clinical Management of Chronic Obstructive Pulmonary Disease


According to the publishers, this book is a comprehensive review of recent evaluative and management strategies aimed at practising clinicians. In the past, most of the volumes from this epic series have concentrated on selective aspects of the scientific basis of respiratory disease and therefore attracted the interested specialist. As on previous occasions, the format follows the pattern of a series of reviews written by acknowledged scientific experts. As usual the book is expensive, and is wide in scope with over 90 collaborators and more than 1000 pages. Unlike a textbook, however, the content lacks strong editorial control and it is effectively a collection of individual reviews. The quality of the chapters is therefore inconsistent. Some authors have clearly accepted their brief and produced excellent reviews. In particular, the chapters on radiology, dyspnoea, genetics, and trial methodology are outstanding. However, many other chapters fall short and there is evident “resting on laurels” in some areas. The book does cover many other interesting facets of COPD but clinicians who purchase this book will also be aware of substantial omissions in clinical areas of COPD care that are currently being developed. There is, for example, very little on rehabilitation or the organisation of services. There is nothing at all on nursing intervention, terminal care, travel, or self-management. There is, however, a welcome attempt to cover the global issues surrounding COPD.

This is an expensive book which contains some excellent chapters. However, the overall volume is slightly disappointing and would compare badly with a thoughtfully structured comprehensive textbook. In the past this series has worked well where it examines the leading edge of research. In this instance the more general reader may find better value in a textbook but could still profit from borrowing a copy from the library.

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