

one year cessation rate in smokers with AL was 10.8% versus 8.4% in smokers with NLF (NS)."

Why are these findings being interpreted over-optimistically as evidence of the value of screening for mild COPD? The most likely reason is wishful thinking, since the evidence suggests the opposite conclusion to that supported in the editorial by Mannino. Perhaps it simply arises from the frustrating recognition that COPD is common in adults but is predominantly undiagnosed.

There is a serious consequence from promoting early detection of COPD if there is no evidence that it makes any difference. Putting resources into spirometry for the early detection of COPD draws resources from more effective work, the most compelling of which in this context is general smoking cessation. In the study by Bednarek *et al*,¹ 71 people needed to be screened for every additional 1 year smoking quit achieved. This is equivalent to a cost of about €650 per additional smoking quitter.

Smoking cessation is the most important intervention in the primary and secondary prevention of COPD. It is equally important in the primary and secondary prevention of cardiovascular disease and many cancers including lung cancer. Until there is some definite advantage to be gained from the early detection of COPD in improving cessation rates among smokers, there is no justification for promoting spirometric screening for mild COPD as a separate public health strategy. On current evidence, screening to detect mild COPD is not warranted and will waste resources that would be better employed to promote smoking cessation in general.

Patrick White

Department of General Practice and Primary Care,
King's College London, 5 Lambeth Walk, London
SE11 6SP, UK; patrick.white@kcl.ac.uk

References

- 1 **Bednarek M**, Gorecka D, Wielgomas J, *et al*. Smokers with airway obstruction are more likely to quit smoking. *Thorax* 2006;**61**:869–73.
- 2 **Mannino DM**. Spirometric screening: does it work? *Thorax* 2006;**61**:834–5.
- 3 **Gorecka D**, Bednarek M, Nowinski A, *et al*. Diagnosis of airflow limitation combined with smoking cessation advice increases stop-smoking rate. *Chest* 2003;**123**:1916–23.
- 4 **Zielinski J**, Bednarek M, Gorecka D. [National Program of Early Detection and Prevention of COPD in the years 2000–2002]. *Pneumonol Alergol Pol* 2005;**73**:116–21.

Authors' reply

The World Health Organisation estimates that chronic obstructive pulmonary disease (COPD) affects 600 million people and that three million die every year from COPD. It is expected that, in 2020, COPD will be the third main cause of death worldwide.¹ Until now these estimates have proved valid. This worrying situation calls for action.

In the National Program of Early Detection and Prevention of COPD in Poland, >90 000 "healthy" smokers aged 40 years or more performed spirometric tests. It was found that 20.3% of them had signs of airflow limitation compatible with a diagnosis of COPD, and 72% of these already had moderate or severe airflow limitation. None had previously consulted their family physician about their respiratory problems and most of them needed immediate further evaluation and treatment.²

By combining spirometric testing with anti-smoking advice, sustained quitting of smoking was achieved in 16% of the COPD group and 11% of the "healthy smoker" group.³ Similar results were obtained in the earlier pilot study based on a small group of subjects not included in the current study.⁴ These results are better than those obtained by general antismoking advice.⁵ The Lung Health Study confirmed that smoking cessation slows down the accelerated decline in forced expiratory volume in 1 s which occurs in patients with COPD with newly diagnosed disease. As many as 96.7% of subjects with moderate COPD who quit smoking still had moderate disease after 11 years of follow-up compared with 81.9% of those who continued to smoke. The initial success of quitting smoking in this group of patients turned out to be long lasting, with 93% still non-smokers after 11 years.⁶

Even if the cost of one additional person quitting smoking using our approach is €650, this is roughly half the cost of 1 year of treatment for one patient with COPD in the UK (US\$1245).⁷ It is also equivalent to the cost of one life-year saved by antismoking advice only, which ranges from €385 to €797.⁸

Although there is a lack of evidence of benefit related to the early diagnosis of mild COPD by spirometric testing,⁹ this does not mean that such benefit does not exist. Fifty years ago systemic hypertension was frequently diagnosed when a patient had a stroke. Now early diagnosis and treatment of systemic hypertension are obligatory.

Early diagnosis of COPD defines a group of smokers at risk not only for the progression of COPD but also for lung cancer or ischaemic

heart disease. Antismoking advice is an integral part of early diagnosis which will prevent many deaths from these diseases. For evidence of the benefits, we will have to wait.

**Michał Bednarek, Dorota Gorecka,
Jan Zielinski**

2nd Department of Respiratory Medicine, National Research Institute of TB and Lung Diseases, 26 Płocka St, 01–138 Warsaw, Poland; m.bednarek@igichp.edu.pl

References

- 1 **Murray RP**, Anthonisen NR, Connett JE, *et al*. Effects of multiple attempts to quit smoking and relapses to smoking on pulmonary function. Lung Health Study Research Group. *J Clin Epidemiol* 1998;**51**:1317–26.
- 2 **Zielinski J**, Bednarek M, Gorecka D, *et al*. Increasing COPD awareness. *Eur Respir J* 2006;**27**:833–52.
- 3 **Bednarek M**, Gorecka D, Wielgomas J, *et al*. Smokers with airway obstruction are more likely to quit smoking. *Thorax* 2006;**61**:869–73.
- 4 **Gorecka D**, Bednarek M, Nowinski A, *et al*. Diagnosis of airflow limitation combined with smoking cessation advice increases stop smoking rate. *Chest* 2003;**123**:1916–23.
- 5 **Silagy C**, Stead LF. Physician advice for smoking cessation. *Cochrane Database Syst Rev*, 2001;CD000165.
- 6 **Anthonisen NR**, Connett JE, Murray RP. Smoking and lung function of Lung Health Study participants after 11 years. *Am J Respir Crit Care Med* 2002;**166**:675–9.
- 7 **Wouters EF**. Economic analysis of the Confronting COPD survey: an overview of results. *Respir Med* 2003;**97**(Suppl C):S3–14.
- 8 **Cornuz J**, Pinget C, Gilbert A, *et al*. Cost-effectiveness analysis of the first-line therapies for nicotine dependence. *Eur J Clin Pharmacol* 2003;**59**:201–6.
- 9 **Agency for Healthcare Research and Quality**. Use of spirometry for case finding, diagnosis, and management of chronic obstructive pulmonary disease (COPD). AHRQ Publication No 05-E017-2, 2005. www.ahrq.gov/downloads/pub/evidence/pdf/spirocopd/spiro.pdf (accessed 10 April 2006).

CORRECTION

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In table 1 of Somocurcio JG, Sotomayor A, Shin S, *et al* (Surgery for patients with drug-resistant tuberculosis: report of 121 cases receiving community-based treatment in Lima, Peru. *Thorax* 2007;**62**:416–21) in the May issue the expansions of the abbreviations SM, CM, CS and PAS are streptomycin, capreomycin, cycloserine and para-aminosalicylic acid, respectively.