Highlights from this issue

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Remembering Freddy Hargreave

Respiratory Medicine lost a giant of airway disease research with the sudden death of Freddy Hargreave in June. Freddy devoted his career to the development of objective measures to assess airway disease. Notable achievements included developing a method to assess airway responsiveness, the first clear demonstration of a long term effect of allergen challenge on airway function and the development of induced sputum as a means to assess lower airway inflammation non-invasively. He trained a large number of current airway disease researchers. I count myself as being very fortunate to be one of their numbers. Paul O'Byrne and colleagues recount all that was special about Freddy (***see page 1101***). His approach was heavily influenced by clinical researchers at the Brompton and Hammersmith hospital in the late 1960s and was facilitated by a close and long-standing collaboration with his friend Jerry Dolovich at McMaster University. He focused on clinical issues of immediate importance to patients and his ideas came from taking a detailed history and careful analysis of the problems patients presented to him. This approach is seen by many as old fashioned and outdated in the modern era of molecules, genes, huge databases and even larger computers. Freddy never forgot that the clinician is in a privileged and unique position to identify and resolve important clinical problems.

Hot topic: walking by faith and not by sight

The striking cover picture this month is taken from a paper by Ishida and colleagues on virtual navigation bronchoscopy (***see pages 1072***). This technique allows a radial EBUS bronchoscope to be navigated to an area of interest so that biopsies can be taken from a small peripheral lesion. Sensitivity was higher than radial EBUS bronchoscopy alone, and the examination was shorter. However, sensitivity was still only 80%, so this technique cannot be used to exclude malignancy with confidence. Will virtual navigation bronchoscopy become an important addition to our diagnostic algorithms? Rintoul and Slade (***see page 1027***) suggest that it might, particularly in the subgroup of patients who also have potentially important mediastinal lymph node enlargement as the technique could be combined with standard EBUS sampling of the mediatinum. Prevent VOMIT (see previous Airwaves)—we need innovative approaches to deal with the large numbers of patients found to have small peripheral lesions on lung imaging and we welcome the contribution from Ishida *et al* This is a very hot topic and we'd welcome hearing more on the thoughts and research findings in this area.

More than just another wearisome initiative!

Most of us have long grown weary of being pestered by apparatchiks with ideas about quality—indeed, if one tenth of the energy expended on new initiatives was actually used to improve the lot of patients, we would work in a much better world. So is 'quality improvement' just more of the same? Indeed not; the US Cystic Fibrosis Foundation has made it a powerful tool to effect genuine improvements. Quon and Goss show how individual centres can drive up standards by identifying key metrics (nutrition, spirometry), and comparing their performance with the rest of the network. Most importantly, it works. Of course it requires a grown-up dialogue with the public—will everyone react positively to drive improvement if a centre is in the bottom half for results, or react 'shock, horror, probe—50% of doctors are below average!'? In a companion piece, McIntyre and Shojania discuss the key methodologies required for conducting and reporting such initiatives. It is true that the key metrics in cystic fibrosis may be easier to measure than in other diseases, but surely their example should inspire us to emulation. *Thorax* will publish quality improvement studies if they are novel and methodologically sound. Importantly, should not we now be driving the use of these tools in our own practice, rather than waiting for them to be imposed from on high? ***See page 1106***.

The times they are a-changing

We are all used to spot checks of peak flow and spirometry in the clinic, and taking a cursory look at diary cards, secure in the knowledge that most points in the latter will have been entered at random. However if (a huge if, electronic recording being a *sine qua non*) accurate records over time can be recorded, we may be able to use powerful mathematical techniques to tease out new information, for example, exacerbation risk. In this issue, Urs Frey's group extend their previous work, re-analysing data from previous studies, to show that these techniques give additional information about asthma control, but underlying disease severity is an important factor; what works for moderate asthma does not necessarily work for more severe disease. The work raises the exciting possibility that more than just a cross-sectional snap-shot is needed to phenotype asthma. The work may seem a long way from the clinic, but with ever cheaper and more sophisticated mobile devices, if future work shows this to lead to improved clinical outcomes, even the mathematically challenged Editors may be able to use these techniques. ***See page 1036***.

Editor's choice: gone but not to be forgotten

More on the importance of childhood disease. Paediatric oncologists are more successful than ever before at curing childhood cancer, but the scars of treatment remain. Especially important for adult chest physicians to reflect on the high prevalence of pulmonary function abnormalities in childhood cancer survivors. What will be the implications as they start to age? An important study for new young investigators to conduct. ***See page 1065***.