

# Following Nero: fiddle while Rome burns, or is there a better way?

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*The Shorter Oxford Dictionary* defines 'exacerbation' as 'an increase in the severity of a disease'—which does not imply reversibility or otherwise. However, we wonder how many chest physicians define exacerbation as 'an acute and temporary deterioration in either symptoms or signs (and for the sophisticated, biomarkers)' of asthma, chronic obstructive pulmonary disease (COPD) or whatever. We know that many of our patients do not understand the term; some confuse it with exasperations. The editorial by Mark FitzGerald<sup>1</sup> (see page 365) proposes to discard this term in favour of the phrase 'lung attack'. Is this mere sensationalism or trendy fiddling with what actually works well (as with the Church of England discarding the *Book of Common Prayer* in favour of series 17.2)? We do not think so, and in fact we believe it is a challenge to the Thoracic community to wake up and get real.

We suspect that the generally accepted view of exacerbation is that it is like the exasperation of falling over on an icy road—temporarily inconvenient, but reversible by dusting oneself down and taking paracetamol and whisky. In the

setting of many lung diseases, this is an absolute travesty. Cystic fibrosis (CF) is probably the most severe chest disease of young people. CF lung attacks are not mere transient inconveniences necessitating expensive and intrusive treatment; ~25% of patients do not recover to baseline forced expiratory volume in 1 s (FEV<sub>1</sub>),<sup>2–3</sup> and repeated CF lung attacks are associated with an accelerated decline in lung function.<sup>4</sup> COPD lung attacks are responsible for 1 in 8 hospital admissions and have mortality rates and costs comparable with those of heart attacks. Repeated asthma lung attacks in adults are associated with a more rapid decline in lung function,<sup>5</sup> a well known risk factor for COPD. In a posthoc analysis of the START study, in children and adults, but interestingly not in adolescents, there was an accelerated decline in spirometry in those experiencing an asthma lung attack while on placebo, but not on budesonide.<sup>6</sup> Importantly, the protective effect of budesonide suggests that 'something CAN be done'. Whether in CF or asthma the 'exacerbations' were related to poor compliance or the intrinsic severity of the disease is irrelevant to the question of whether 'lung attack' is a useful term. What is clear is that what has hitherto been called 'exacerbation' is not a temporary inconvenience, but a sign of a worse prognosis which should call forth immediate action.

FitzGerald rightly compares our limp response to 'exacerbation' of whatever chest disease we happen to be treating with the cardiologists' focused response to

'heart attack'. We should emulate them, and hopefully changing the name may startle us out of thinking in the rut. So: (1) a lung attack is not a temporary inconvenience, it can be associated with permanent damage and is a sign of a worse outlook unless something is done; (2) a lung attack should prompt a full review of all aspects of the problem, including co-morbidities, management, adherence, adverse environmental factors and psychosocial issues; and (3), we are happy for potential *Thorax* authors to use 'lung attack', qualified by the disease (asthma, COPD, CF, etc.) as a Key word and within their article.

So, what do you think? Are we overreacting or is there a real case for re-branding exacerbations? Is 'lung attack' the best term or can you think of a better one (one of us prefers lung strikes)? Please let us know via the correspondence column.

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