Highlights from this issue

doi:10.1136/thoraxjnl-2012-202493

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All in the mind?

There is an increasing realisation of the interactions between the mind and the airway, with appreciation that mental stress impacts asthma. This is not the start of the slippery slope back to asthma being due to lack of moral fibre, but rather the realisation that there is more to asthma treatment than selecting the right coloured inhaler, and (radical idea, this) actually ensuring it is used. Pbert *et al* (Editors' choice: ***(see page 769)***) compared two 8-week interventions, a mindfulness training program and a 'placebo' of a healthy living course (which naturally your editors study assiduously every day). There was a beneficial effect on asthma quality of life score a year later and perceived stress, although not in lung function or number of patients with well-controlled asthma. It is known that stress amplifies the inflammatory response to inhalant allergens (*Am J Respir Crit Care Med* 2002;**165**:1062–7) and it would have added value if induced sputum or exhaled nitric oxide had been measured in this trial. Nonetheless, this manuscript is an important proof of concept that non-pharmacological interventions may have medium term beneficial effects in asthma. Will this message be remembered in the flood tide of pharmaceutical advertisements?

Rethinking the 'emperor of all maladies'

Resection rates for lung cancer are steadily rising in England ***(see page 811)***. This is good news as it implies more equitable access to Thoracic Surgery. Can it be assumed that this translates to better outcomes? Perhaps not as Treasure and colleagues ***(see page 759)*** remind us that crude 5-year survival figures after resection of lung cancer are unchanged over 30 years, despite substantial improvements in pre-operative diagnostics, post-operative care and the appointment of Tsars, the setting up of committees and the production of political hot air to try to improve the way we do things. We are also reminded that no study has conclusively shown that the outcome of early stage lung cancer is better in patients who have surgery. Some lung cancers may be inherently aggressive and others IDLE (InDolent Lesion of Epithelial origin), a concept that Detterbeck ***(see page 842)*** suggests deserves urgent further investigation in these days of screening mania. Anyone who has read Mukherjee's wonderful book *The Emperor of all Maladies* will be aware that a number of very brave and determined breast cancer specialists successfully changed views on the wisdom of aggressive surgical treatment. Treasure and colleagues, and Detterbeck seem to us to be in the same mould.

Age and beauty

A recurring theme has been the importance of not diagnosing disease in a normal healthy person, by failing to appreciate the normal age-related changes in lung function. In particular, the use of the FEV_1/FVC ratio to diagnose COPD in normal healthy old people has been severely mauled in the Journal. In this issue, Verbanck *et al* ***(see page 789)*** have studied the age-related changes in nitrogen washout, to see if the known age-related changes in alveolar structure can give a detectable signal with this technique. This is particularly timely, given the resurgence of interest in this and other methods (such as inert gas wash-out) of studying distal airway function. Lung clearance index (LCI) has previously been shown to be higher in the first year of life than in the rest of childhood, but to plateau throughout the pre-school years to young adulthood. In this manuscript, LCI, and also indices of diffusion and convective function (S_{acin} and S_{cond} respectively) showed a progressive elevation with age (or maturity, as the Editors-in-Chief prefer). This careful study underscores that advanced age is not a disease, and should not be diagnosed as such.

A winner of the ridiculous acronym competition

Our regular readers will remember that in April we offered the prize of a dinner for two at McDonalds with Professor Pavord (going Dutch) for the respondent who came up with the most ridiculous acronym for '*a pneumothorax that results in significant respiratory or haemodynamic compromise that reverses on thoracic decompression*'. We are delighted to announce that Dr Furness from Darlington is the winner ***(see page 833)***. Surprisingly, the prize offer has not yet been taken up even despite Professor Bush offering to join the party at the prize-winner's expense.

The hole in the wall gang?

'Hello, hello, hello! What's going on ere, then?' Turn to ***(see page 847)*** … to find out about an ingenious cross-disciplinary approach to a tricky problem.