

Highlights from this issue

Andrew Bush, Ian Pavord, *Editors*

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**MY NAME IS LYNTON CROSBY, KING OF MINISTERS
LOOK ON MY WORKS, YE VULNERABLE, AND DESPAIR!**

So the government have not been venal or vapid in pulling out of plain packaging for cigarettes, but 'very sensible'. Maybe they would think waiting and seeing whether having brakes fitted to cars or wings to aeroplanes is also 'very sensible'. The cover of *Thorax* this month has been left plain as a mark of respect for the thousands who will take up smoking and die as a result of this 'very sensible' decision. Are e-cigarettes the answer? John Britton brings a lifetime of tobacco control campaigning and a richly deserved CBE (Congratulations!) to bear on the issue (see page 904). He argues cogently that they are safer than smoking, and as a step down to quitting are, as with nicotine patches, to be encouraged. Three caveats: (1) safety in pregnancy is not established and we know from animal work that nicotine per se damages the developing lungs, although likely not as badly as the rest of the cancer cocktail inhaled; (2) they must not be marketed as a step up to smoking cigarettes and already worrying images of attractive women with e-cigarettes are appearing; and (3) it looks likely that the tobacco industry, with their well-known track record of openness and integritous behaviour will be marketing them—so what else will be slipped in to be inhaled? This last is like putting Pol Pot in charge of Higher Education (come to think of it, maybe this Government would consider this to be 'very sensible' too?).

SLEEPING A BIGGER SLEEP THAN WE THINK?

A characteristically thorough Danish database study compared 2998 young people aged 0–19 years diagnosed with obstructive sleep apnoea (OSA) with 11 974 controls (see page 949, *Editors' choice*). They report a formidable list of conditions associated with OSA both prior to, and after, the diagnosis (infection, endocrine, metabolic and

many others). This could be laughed off as Berkson's bias (and do please look this up if you don't know what it is, before rather than in the painful aftermath of rejection of a manuscript reporting associations between diseases). However, what cannot be laughed off is the reported 5-year death rate in these young people of 70 per 100 000 for cases versus 11 per 100 000 controls, a hazard ratio 3.39 at a minimum. Clearly more effort is needed in identifying these patients (and paediatric sleep medicine in the UK is way behind most of the rest of the developed world), understanding mortality and doing something about it.

LIKE THE CIRCLES THAT YOU FIND, IN THE WINDMILLS OF YOUR MIND?

We give intravenous antibiotics for a cystic fibrosis (CF) lung attack (pulmonary exacerbation) and we know the patient has had a CF lung attack because they get intravenous antibiotics (eat your heart out, Noel Harrison!). Given the prognostic significance of CF lung attacks and their value as a clinical trial endpoint, surely we must do better? Nick *et al* (see page 929, *Hot topic*) have shown that peripheral blood leukocyte gene expression (RNA) is a great predictor of response to treatment of a CF lung attack, beating CRP and FEV₁ and performed even better when added to these conventional markers. Importantly, the results were validated in an independent cohort. Encouragingly for those techno-illiterates who regard a HapMap as the genetic equivalent of a pavement pizza, the significance required measurements of only six of the ten genes they studied. More molecular signatures and fewer windmills, please!

30 DAY MORTALITY AND COPD LUNG ATTACKS. IS THE HORSE OVER THE HILLS AND FAR AWAY?

Thirty day mortality is becoming a standard metric for assessing quality of in hospital care. Walker *et al* (see page 968) assess this for COPD lung attacks using hospital episode statistics from inpatient episodes

occurring between 2006 and 2008 in 150 acute hospitals. The overall 30 day mortality of 11.3% varied widely between years suggesting that the ability of this measure to identify quality differences might be limited. Unexpectedly, variables felt to be associated with better quality of care were generally not associated with better outcomes. This might be because the quality of primary care is an important determinant of the outcome of COPD lung attacks but it is also likely that COPD lung attacks are a much more complex and heterogeneous entity than other acute medical events where relationships between quality of care and outcome are more easily seen. Mike Morgan (see page 897) suggests that assessing mortality as a quality metric is a little like shutting the stable door after the horse has bolted. He argues that other measures such as patient reported outcomes, assessments of process and provision of care bundles would be better. Another Tsar task for Mike, in between fighting the tobacco industry on every front while his feet are pushed up his nostrils by ministers eager to be 'very sensible'!

A NEW TAKE ON EXTRACORPOREAL OXYGENATION?

This young motor cyclist came off second best with a road guard barrier, yet was home in 10 days! What's it all about? See *Images in Thorax*, page 982.

