Highlights from this issue

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PLAIN, VENAL OR VAPID?

The Reverend Sydney Smith remarked that he 'must believe in the Apostolic succession, there being no other way of accounting for the descent of the Bishop of Exeter from Judas Iscariot'. The decision to exclude plain packaging of cigarettes from the Queen's speech suggests that this Apostolic succession is not confined to the episcopate. Everyone knows that legislating against smoking works and indeed in this issue, Sims *et al* (Hot Topic; ***see page 619***) estimate nearly 2000 adult admissions from asthma attacks were prevented per year by the last round of smoke free legislation. Australia has introduced plain packaging—why not the UK? What possible down side (other than to the industry) is there to passing this measure? David Simpson, once Director-General of ASH (he of 'giving Rothman's a Queen's Award for industry is like giving the top prize at Crufts to a rabid dog' fame), suggested that one cannot do better than listen carefully to the tobacco industry and then do the opposite. We are reluctant to believe Ministers are stupid or corrupt, despite some ill-advised acceptance of corporate tobacco hospitality; so why no plain packaging? OK, no gain without pain, but when the only possible pain is to the industry and the potential gain is to patients, isn't this a no-brainer? Hopefully the decision will be changed rapidly; otherwise some might think that Mr Naughtie's unfortunate Spoonerism on the then Culture Secretary <http://www.youtube.com/watch?feature=player_ embedded&v=F1G6osCnsbA> was more prescient than he realised.

HOME MANAGEMENT OF PNEUMOTHORAX. WORTH A FLUTTER?

The typical inpatient management of primary spontaneous pneumothorax strikes us as an accident waiting to happen. Unnecessarily large chest drains inserted unnecessarily by unnecessarily inexperienced doctors at an unnecessarily antisocial hour seems to be the order of the day. Previously fit and healthy young patients then parade around the ward with a large portal for infection inserted in their chest. Thankfully, most fall out before too much harm is done. Could home management be any worse? Fraser Brims and Nick Maskell think not (***see page 664***; Editors' choice). Their meta-analysis of admittedly poor quality clinical trial data suggests that around 80% of patients could be managed successfully and safely with outpatient treatment using a lightweight one-way flutter valve. The findings are encouraging and provide an excellent basis for a definitive randomised controlled trial.

ON THE ATTACK AGAIN

Cystic fibrosis (CF) is the respiratory disease *par excellence* in which basic science has delivered paradigm-changing therapies very rapidly, as the recent meteoric rise of Ivacaftor has illustrated. It is likely that most benefit will come from applying these therapies soon after CF diagnosis by newborn screening. However, anyone who has witnessed a Richter scale 17 toddler temper tantrum will wonder how any physiological outcome measures could ever be determined in this age group. Byrnes *et al* (***see page 643***) now report that CF pulmonary exacerbations, or attacks, in the first 2 years are associated with adverse outcomes, whether the attack definition is broad church (any increase in respiratory symptoms) or narrowed down to those requiring admission to hospital. In an accompanying editorial, Sanders and Goss (***see page 608***) rightly state that the next step is evidence that these early CF lung attacks are actually preventable by treatment before they are used as a clinical trials end-point, although the fact that frequency was less in children given antistaphylococcal prophylaxis suggests they may be. This work does open up the possibility of a novel end-point in CF clinical trials in pre-schoolers, and turns an even brighter spotlight on the importance of acute lung attacks on long term lung health in 'chronic' diseases.

COPD CONTROL PANEL AND ANOTHER FLUTTER

Alvar Agusti and William MacNee have been leaders in the move away from a narrow, one size fits all, lung-function-based assessment paradigm for COPD. The new revised GOLD strategy advocates assessment of multiple more clinically relevant aspects of the disease, and a degree of individualisation of the treatment approach based on a more complete understanding of the relationship between current symptoms and future risk. They acknowledge that the volume and complexity of information that needs to be organised and integrated is a growing challenge. Their suggested approach is to copy aircraft pilots and use a control panel which organises clinical measures into three disease domains: severity, activity and impact (***see page 687***). Another approach is to focus on aspects of the disease that can be modified (*see McDonald et al, page 691*). In this respect, eosinophilic airway inflammation is interesting as we have existing and new treatment possibilities. Could anti-IL-5 monoclonal antibodies have a role in preventing COPD lung attacks? So confident is this editor that he has a wager of an expensive bottle of Rioja with the more sceptical Alvar Agusti (and the other editor thinks Alvar must now have his corkscrew at the ready).

IT'S ME 'ORMONES, DR

No, not as you might think the Editors in Chief wrestling with the male menopause, but this pleural effusion in a 51-year-old woman. The CT scan is our front cover illustration, and if you are still stumped, the answer is in Pulmonary Puzzles (***see page 697***).