

## Highlights from this issue

Andrew Bush, Ian Pavord, *Editors*

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**THE INHALER FROM UNCLE**

Times change, but does the way we deliver medications to the airways? Those of us old enough to remember episodes of 'The Man from UNCLE' will recall computers filling a whole room, with whirring reels of tape, less powerful than what we now routinely carry in our pocket. Have these Usain Bolt-like speedy advances been matched in the way we deliver medications to the airway? Mark Everard (*see page 891*) thinks not; he argues that current inhalers would be outmoded in Jurassic times, and are about as functional as Stonehenge (not perhaps in those words!). These current Neanderthal devices are poorly used by patients, and this contributes to morbidity and even mortality in airway diseases. He argues that a radical rethink is needed. There have been advances in nebuliser technology, but even these devices are far from ideal, which is a pity, as ever more nebulised agents are developed. In this issue, Phase II studies of nebulised Arikace (amikacin) in cystic fibrosis (CF) are reported from the prolific US CF Foundation Therapeutic network (*see page 818*). However, it will be argued that it should be reserved for the increasingly prevalent atypical *Mycobacterial* infections in CF, an example of where commercial interests and clinical needs may clash head on. Good also to report research in an unfashionable and evidence-free area like bronchiectasis (*see page 812*). Nebulised ciprofloxacin (like Arikace, liposomal based and administered once daily, a boon for the patients) delayed the time to first bronchiectasis lung attack in a Phase II study. Good to see the importance of lung attacks being recognised in all airway diseases as clinically relevant and as trial endpoints.

**WHY DIDN'T THE THORACIC SURGEON CROSS THE ROAD?**

Because of a new culture of caution that is spreading among the surgical community, triggered by the likely publication of national surgeon-specific mortality data. Readers of *Thorax* may be concerned that uncharacteristic risk-averse behaviour in

thoracic surgeons might lead to a reduction in resection rates for lung cancer and a reversal of the current encouraging trends in lung-cancer mortality. One way around this is to be better at predicting risk, for which results can then be stratified. Powell *et al* (*see page 826*, Editors' choice) use data generated by the National Lung Cancer Audit to derive a new risk score. This looks to be more useful than existing measures as it includes fewer subjective measures and provides data on mortality over 90 days. Prospective validation is needed but David Waller (*see page 799*) sees this as a potentially important tool to facilitate patient-doctor communication and to counter excessive risk-averse behaviour. Heaven forbid that thoracic surgeons should change their spots and turn their scalpels to scrap metal!

**THE DINOSAURS STRIKE BACK!**

However, not all that is new is necessary (a great relief to the editorial dodderers above). Do we need the new diagnostic tests for tuberculosis under all circumstances? Ling *et al* (*see page 860*, **Hot Topic**) show that in a high prevalence area, T-SPOT.TB added nothing to conventional testing including good old-fashioned history and examination, chest radiography and tuberculin skin testing in more than 500 smear-negative children suspected of having tuberculosis. These are really important findings, because this is a group who are difficult to diagnose, many of whom were young infants at particular risk of major complications such as tuberculous meningitis. The further importance is because high prevalence areas for tuberculosis and lack of resources are as inextricably linked as politicians and spin-doctors; this sort of study should lead to important cost savings without compromising clinical care.

**UVULOPALATOPHARYNGOPLASTY AND PROVENT: ALTERNATIVES TO CPAP OR CRAP?**

This issue includes two well done trials of alternative treatment strategies for

obstructive sleep apnoea. The trial of uvulopalatopharyngoplasty (SKUP<sup>3</sup>, *see page 846*), in common with most surgical trials, was unblinded but did have the considerable merit of reasonable numbers, standardisation of the surgical approach and the use of blinded polysomnography to derive outcomes. Our editorialist, Eric Kezirian, saw it as a 'substantial contribution to obstructive sleep apnoea surgery research' (*see page 801*). The bottom line was that surgery significantly reduced the apnoea-hypopnoea index (AHI) and did so independently of tonsil size. In contrast, the effect of Provent, an expiratory nasal resistance device on AHI and symptoms was no better than those of a placebo device (*see page 854*). The authors suggest that Provent cannot be recommended, even for short-term holiday use. So scope to SKUP, but prevent Provent is the order of the day.

**LABOURING IN VAIN?**

This 30-year-old man (*see cover picture also*) presented with haemoptysis. Work out why, before turning to *Images in Thorax* (*see page 894*). For your bonus ball (before turning to the answer!), what is the connection with the case-based discussion (*see page 889*)?

**Competing interests** None.

**Provenance and peer review** Commissioned; internally peer reviewed.

