Highlights from this issue

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Cheap is cheerful – and certainly adequate

We are delighted to have a strong line-up of asthma papers this month. Our editors' choice (***see page 328***) investigates the safety of long acting beta$_2$ agonists (LABA) with and without inhaled corticosteroids. A recent audit in *Thorax* showed that LABA monotherapy is still depressingly common in the UK and it likely accounts for the mortality concerns that have fuelled several multimillion dollar FDA mandated studies of LABA safety. The authors used administrative health database records to compare asthma related hospitalisations (accepted as a proxy of mortality in the ongoing safety trials) in patients taking LABA and inhaled corticosteroids with those taking either drug alone. Patients taking LABA alone were 2–3 times more likely to be hospitalised compared to those taking inhaled corticosteroids alone. Reassuringly, those taking LABA with inhaled corticosteroids had no excess hospitalisation, although use of the latter for more than 75% of the year was required for full protection. Dare we suggest that this is an acceptable and much cheaper way of investigating LABA safety?

A novel therapy travelling in Stephenson's Rocket?

One great advantage of combination treatment is that use of LABA with an inhaled corticosteroid occurs 100% (or more likely, 0%!) of the time. Eric Bateman and colleagues (***see page 312***) introduce us to a new once daily combination inhaler delivering new drugs (Fluticasone furoate and Vilanterol) via a new delivery devise (ELLIPTA). What they could also have provided but didn't is a new approach to applying this treatment. Their study shows that the once daily LABA Vilanterol delivers the anticipated small reduction in exacerbation frequency compared to Fluticasone Furoate alone in patients who have persistent airway dysfunction and symptoms. The studied population had surprisingly low exacerbation frequency suggesting good control of lower airway inflammation. However, no information is provided on this key aspect of the disease. This is an important omission. Is the addition of a LABA the right thing to do in the minority of patients with problems associated with persistent eosinophilic airway inflammation despite taking (and adhering to) an inhaled corticosteroid? We think not and feel that an excellent opportunity to better define the LABA responsive population was missed. What do you think?

You couldn't make it up!

Allergen immunotherapy in many parts of the world is the Del Boy treatment modality of choice – the quickness of the hand empties the wallet with no discernable evidence of benefit to the victim. But we also know from Steve Durham's landmark paper (*N Engl J Med* 1999;341:468–75) that allergen immunotherapy is the only known truly disease modifying therapy for allergic rhinitis, and given our inability to do anything other than control asthma symptoms rather than alter the course of the disease, merits further investigation. Till *et al* (***see page 335*** **Hot topic**) used mice and men to study epitopes of Timothy Grass pollen (see cover) and found that p26 was promiscuous (no, not French politics but it binds to a wide range of HLA class 11 alleles and is also found in other grasses, so is of wide relevance). Pre-treatment of mice with p26 resulted in T-cell regulation to allergen. The editors were delighted to read that the effects are mediated in part through Itch – not a cause of skin excoriation but a factor which regulates a key peripheral tolerance pathway. Is it possible that somewhere out there is an immunologist with a sense of humour? Please make yourself known to us and contribute to *Thorax*, if so!

Fifty shades of grey

Your editors have been prone to rather undignified crowing over English cricketing prowess and are now looking somewhat foolish in consequence. However, although the cricket results are dire, can we claim to be doing better with cystic fibrosis (CF) treatment in the UK? The London CF collaborative have previously shown that in CF babies diagnosed by newborn screening lung function remains stable or improves over the first year of life, rather than deteriorates as shown by other groups, notably from Down Under (*Thorax* Published Online First: 26 September 2013. doi:10.1136/thoraxjnl-2013-204023). The same group have now shown that at a year of age, structural manifestations of CF are minor, again unlike what other groups have reported. Even the author of the scoring system they used could only score air trapping reproducibly (***see page 320***). If it isn't reproducible, should you do the test at all (another variant of VOMIT syndrome)? But surely in 2014 it is better to score CT scans quantitatively, rather than taking numerical data, converting them to grey dots and then eyeballing the results? However even that may be inadequate if there is day to day biological variability in very mild CF.

Things ain't what they spleen to be

Visually this month's *Thorax* must be amongst the best recently. This still is from a bronchoscopic video linked to the case based discussion (***see page 396***) – what did cause the 'asthma'? The Pulmonary Puzzle (***see page 395***) is a 58-year-old woman who survived shooting and a colonic tumour – or will she, given that multiple thoracic nodules were discovered? See if you can put it all together before looking at the answer. Finally, we show an unusual cause of haemoptyis (***see page 399***); yet more proof that paediatrics needs to be a compulsory part of training in adult thoracic medicine.