Highlights from this issue

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LUNG CANCER OUTCOMES AND THE INVERSE CARE/NEED A CAR LAW.

Cancer and pleural disease are our first 2015 themed issue. Four excellent lung cancer papers and a linked editorial by Mick Peake (***see page 108***) highlight marked inequalities in access to lung cancer care as a result of socioeconomic and geographic factors. Forrest *et al* (***see page 138***; ***Editors' choice***) suggest that this is due to less access to treatment, although O'Dowd *et al* (***see page 161***) propose that delayed diagnosis remains a potentially important cause of early death. Mick Peake reminds us that the inverse care law is alive and kicking in housing estates near you and suggests that we need to be much smarter in targeting public health campaigns to these areas. Living far way from a specialist surgical centre also emerged as a risk factor for early lung cancer death. Two papers from the UK and Australia respectively (***see page 146***; ***page 152***) show that this is associated with a reduced lung cancer resection rate. Finding solutions to these inequalities is not straightforward, particularly in Australia where distances between patients and the surgical centre might be several hundred kilometres. It is still true that it's better to be rich and ill than poor and ill; even in the UK, riches buy you a better class of enemy, mobility and better NHS treatment.

DOWN THE DRAIN?

The 'see one, do one, teach one' approach to practical procedures was alive and well when your editors were in charge of chest drain insertion as Stone Age medical SHOs at Musgrove Park Hospital in Taunton. Now increasing numbers of trainees have access to first class training, certified training courses and well-run, hospital-based pleural services. A BTS audit (***see page 189***) found increasing numbers of hospitals offering a dedicated pleural service, physician led medical thoracoscopy and lead clinicians in charge of chest drain safety. This has to be progress, as is the development and validation of a chest drain insertion competency test (***see page 186***). A study of 9320 inpatients in Los Angeles (***see page 127***) shows that chest drain insertion is very safe when done by an expert dedicated pleural service. Their detailed analysis supports some of the less well evidence based recommendations of recent guidelines (ie, increasing risk of re-expansion pulmonary oedema with increasing fluid removal) but suggests that others are even shakier than your editors' practical skills.

FOUR BROKEN UMBRELLAS

These are anaemia, arthritis, asthma and COPD; and the difference between them is that the first two have been discarded, whereas the respiratory community cling religiously to the other two as ineffectual comfort objects in the howling rain. Freddy Hargreave taught us long ago to cut through these terms and discuss inflammation and fixed and variable airflow obstruction. From Argentina, we publish the prolonged follow up of a cohort of children post-adeno-virus obliterative bronchiolitis (***see page 169***), many of whom have a persistently very abnormal FEV_1/FVC ratio. They have fixed airflow obstruction and no evidence of inflammation whatever – is this or will it become COPD? Of course, some may have another co-existent airway disease which will give super-added inflammation or bronchial reactivity, and treatment should be tailored individually. But this is another condition coming to an adult chest clinic near you, which will need to be distinguished from smoker's airway disease (***see page 103***). Eosinophilic airway inflammation has been a prime target for anti-T_H2 monoclonals, so what is the best non-invasive biomarker for airway eosinophilia? The simple blood eosinophil count beats periostin (hitherto the blue-eyed boy of adult airway disease) and exhaled nitric oxide (***see page 115***, ***Hot Topic***). An accompanying editorial (***see page 105***) points out that periostin may not be dead yet – other assays coming on line may be superior. Either way, we are witnessing the painful dawning of 21st century airway medicine; but the dinosaurs are still alive, well and have an obstructive phenotype, unfortunately.

RULE IN OR RULE OUT?

Evidence based medicine is all the rage, and the many BTS guidelines are thoughtful, well appreciated and scholarly. So who could object to Blakey *et al*'s panegyric for rule-based medicine (***see page 110***)? Enter the Rosenthal! Mark, aided and abetted by the Dalai Lama and George Bernard Shaw, argues that rule based medicine can be pernicious and inferior to clinical judgement (***see page 112***). The medical soap *House* is invoked by both disputants, perhaps not commonly sourced by Cochrane. Of course, never let a good story be spoiled by a few facts. Asthma guidelines (another battleground in the debate!) have never been better evidence based, but the National Review of Asthma Deaths (https://www.rcplondon.ac.uk/sites/default/files/why-asthma-still-kills-full-report.pdf) has shown that exactly no lessons have been learned over decades, and that deaths could be prevented by following simple rules. So as always, rules should rule if they are good, but in rare circumstances experts may need to invent their own. The wife of one of us promised to obey at the wedding service, but only if her husband was talking sense; maybe the right approach to rules?

AN INCONGRUOUS PHOTOMICROGRAPH

Do you smell a rat? What happened to the Australian adolescent who did? If you cannot work it out, turn to the Case Based Discussion from Down Under, ***see page 194***.