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# Highlights from this issue

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## NRAD: NO MORE REGULAR ASTHMA DEATHS

The Hot off the Breath on the National Review of Asthma Deaths (NRAD) made depressing reading for your editors, who are well old enough to have seen it all before (*see page 209*). In all age groups NRAD identified fundamental errors in risk assessment, dangerous over-prescribing of reliever inhalers, the absence of regular review, and lack of engagement in personalised asthma action plans (PAAP). Winter and Levy make the excellent suggestion that computerised prescribing systems could be configured to provide an alert when relievers are over-prescribed. Otherwise their recommendations are much the same as those made as far back as 1974. KISS (Keep It Simple, Stupid) is good, but should we not also fundamentally rethink how asthma is assessed and managed? Would risk stratification help? Exhaled nitric oxide (FeNO) and blood eosinophil count are more strongly associated with the risk of severe asthma attacks in adults and likely benefit of regular inhaled corticosteroids than traditional assessments. Might targeting a high risk, high benefit group help sceptical patients engage long-term with their brown inhaler and PAAP? Would primary care perform tests that actually relate to clinically important outcomes? The cynical part of the editorial team reckons we should get the simple things right first. If doctors can complacently prescribe dozens of blue inhalers to a single patient in a year, how can we expect them to perform or interpret even the simplest adjunct test? We must somehow make NRAD mean: No more Regular Asthma Deaths. Finland managed it many years ago—why can't the UK pause the endless frenetic reorganisations of the NHS and actually do something effective about a real problem?

## ACUTE AND SPECIALTY CARE

The word 'Audit' tends to prompt profound somnolence, but we publish two that are actually highly relevant and useful. The first comes from Leicester, a leading respiratory centre (at least it has become so since some Professorial dead wood went to Oxford). Here clinicians have bucked the national trend and are more engaged in acute care, where they use innovative

models. One (*see page 291*) is an out-patient suspected pulmonary embolus service. This was safe and effective and saved 692 bed days per year, which nationally equates to a staggering saving of 44,000 bed days annually. Our second audit deals with multidrug resistant (MDR) TB. Problems arise because treatment regimens are complex and unfamiliar, and associated with serious side effects. Jessica Potter and colleagues (*see page 297*) describe an excellent new on-line resource which supplies state of the art information on the ins and outs of the drugs used including the baseline tests required before treatment is started, toxicity monitoring guides and individual drug monographs. Both are great examples of tackling important clinical problems creatively, surely a more constructive approach than moaning about how busy the medical take is, and why your manuscript was turned down by *Thorax*.

## A MOTHER'S PLACE IS IN THE WRONG

And she may remain in the wrong long after her children have flown the nest. A huge Norwegian study has shown that if she smoked while pregnant with her daughter, her daughter's children have an increased risk of asthma (*see page 237, Editor's choice*). The potential mechanisms are reviewed in an editorial (*see page 207*). Epigenetics is trendy and the popular culprit, however germline reprogramming immediately after fertilisation means that many epigenetic changes are lost. Nonetheless there are published examples where epigenetic changes may have contributed to wheeze. Incidentally, although daughters of mothers who smoked in pregnancy were three times more likely to smoke in pregnancy themselves, the overall rate of pregnancy smoking has fallen dramatically from 25% in the Grandmothers. Slowly and painfully, and despite the best efforts of certain politicians whose pockets are lined by the industry, tobacco wars are being won. But the memory may linger on longer even than we feared. What will be the fate of the great grandchildren? And future generations?

## SUPERPOWER, SUPER LUNG FUNCTION

Spirometry is one of the key quality assurance measures in cystic fibrosis (CF), and

thus it is worrying to see that CF patients age six years have better spirometry in the USA than in the UK; the gap narrows and indeed crosses over at age 30 (*see page 229, Hot topic*). Not good reading for UK CF paediatricians! And we cannot blame ascertainment bias; a galaxy of editorial talent, also straddling the pond, re-analysed the UK data omitting the 20% most disadvantaged without materially affecting the conclusions (*see page 203*). One pertinent and unanswered question (or attempted cop out, to put it another way) is, do normal USA children have higher spirometry than normal UK children? In which case, differences may be CF unrelated. We cannot blame late diagnosis—the USA children were actually diagnosed on average slightly later. It would be good to repeat the analysis on newborn screened children, and in this regard the recently reported excellent UK outcomes are reassuring (*Thorax* 2014;69:320–7 and 910–7). Nonetheless, this manuscript is a timely reminder that comparing outcomes is good, and may be a wakeup call, in this case to focus on what we are doing in the pre-school years. We all like to kid ourselves we are the best (*see above!*). But are we really?

## ANOTHER NOTCH IN THE BELT?

And another wheezy middle aged woman, with a far from routine flow volume loop (below). More of the brown and blue inhalers, measure blood eosinophils and FeNO, or another approach? See the *Pulmonary Puzzle* (*see page 302*) if you cannot work it out (or even if you can).

