



ELSEVIER

EDITORIAL

Global integrated guidelines are needed for respiratory diseases

More than one billion people in the world suffer from chronic respiratory diseases, the majority of which are asthma, chronic obstructive pulmonary disease (COPD) and rhinitis.

Clinical practice guidelines for asthma, COPD and rhinitis exist in many countries [1,2] and some are now trans-national. GINA (the Global Strategy for Asthma Management and Prevention) was the first global guideline on asthma [3], GOLD (the Global Initiative for Chronic Obstructive Lung Disease) is the world's leading guideline on COPD [4], and ARIA (Allergic Rhinitis and its impact on asthma) is the major guideline on rhinitis and its links with asthma [5]. For developing countries, the International Union has issued asthma guidelines [6], though the ARIA document did address the problems of rhinitis and asthma in developing countries. The World Health Organisation (WHO) Practical Approach to Lung Health (PAL) is a syndromic approach for the diagnosis and treatment of respiratory symptoms in primary health care centres of low- and middle-income countries [7]. For asthma, implementation of guidelines has led to a drastic reduction in mortality and severity in developed countries [8], developing countries [9] and deprived populations [10].

However, there are many limitations to the use of these guidelines. Firstly, they are not widely accepted by general practitioners (GPs). With the advent of guidelines for chronic respiratory diseases, and given the high prevalence of respiratory disease seen in primary care settings, it is important to investigate the knowledge, attitudes, and practices of primary care physicians

with regard to guidelines. It is well known that clinical practice guidelines for respiratory diseases are poorly implemented in primary care [11,12]. In order to gain better acceptance of chronic respiratory disease guidelines in primary care, there is a need for the publication of guidelines written specifically by GPs. Secondly, guidelines are usually limited to one of the chronic respiratory diseases and do not take into account co-morbidities and the differential diagnosis in the primary care setting. Since many patients with chronic respiratory diseases are more elderly and may suffer from other chronic diseases, the integration of multiple chronic disease management programs onto a single platform will be the next step in co-ordinating and improving the care of patients with multiple respiratory diseases [13]. The links between rhinitis and asthma are of importance [14] and the ARIA guideline is the first guideline to take into account the co-morbidities between asthma and rhinitis [5]. Tobacco smoking, COPD and asthma are often intertwined [15] but these interactions are not sufficiently investigated in clinical trials and are not presented in guidelines. Thirdly, most of the guidelines do not take into account patients living in developing countries.

The practical IPAG handbook [16], and the IPCRG Guidelines presented in this special issue of the Primary Care Respiratory Journal, represent the first attempt to combine guidelines for the major chronic respiratory diseases of the developed countries (asthma, COPD and rhinitis) in an elegant format, and to provide guidance specifically for GPs. They are based on the GINA [3], GOLD

[4], and ARIA [5] guidelines, and are therefore evidence-based. A major point is that these IPCRG Guidelines have been written by a very large expert group of primary care physicians and it is likely that they will be more suited to GPs than their parent guidelines. Furthermore, the IPCRG Guideline paper on management of rhinitis [17] is overall in accordance with ARIA.

The accurate diagnosis of chronic respiratory diseases is essential in primary care, and these IPCRG Guidelines contain a paper focussed entirely on diagnosis and differential diagnosis [18]. It is clearly written, evidence-based, and will be of great help to the primary care physician. Interestingly, it differentiates the diagnosis depending on the age of patients, and the differential diagnosis is easy to follow for each age group.

Many patients are not diagnosed until their chronic respiratory disease is severe enough to affect daily activities and to cause time off work or school. In particular, the diagnosis of occupational respiratory disease is often made too late, resulting in perpetuation of symptoms and subsequent impairment despite cessation of exposure [19]. Interestingly, the IPCRG guidelines attempt to make an early diagnosis in the primary care setting where patients with mild or recent disease are seen [18].

As with any guideline document, these IPCRG guidelines will need to be updated in the future, mostly because the science concerning chronic respiratory diseases is moving very fast and guidelines are based on published evidence. Allergen-specific immunotherapy is changing and sub-lingual immunotherapy is now a validated option for the treatment of rhinitis [20]. Chronic rhinosinusitis has not been discussed but it represents a major disease and clinical guidelines have been published recently [21]. The IPCRG guidelines will need to be expanded for their use in developing countries. Updates of GINA and ARIA are pending and it is evident that changes in these guidelines will need to be reflected in the IPCRG guidelines. These issues need to be seriously considered but can be resolved easily with future updates of these IPCRG guidelines.

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