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EDITORIAL

Guidelines and shared care for asthma and COPD

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Shared-care constructions between general practitioners and pulmonary physicians are seemingly attractive for asthma and COPD patients. Thus they have to be implemented in further guidelines. However, anticipation that rapid changes will occur in treatment options towards optimal disease management justifies rapid adjustments in these strategies and requires investigations as to their ultimate benefit in disease outcome.

Many general practitioners (GPs) and pulmonary specialists in the Netherlands are faced with increasing numbers of patients attending their practices with symptoms and signs of asthma and/or chronic obstructive pulmonary disease (COPD). So far, asthma and COPD cannot be cured. Thus, GPs and pulmonary specialists have to pay attention to an individual's needs when providing care to improve the wellbeing and quality of life of these patients. Furthermore, they have to install an optimal individual treatment strategy to prevent exacerbations and deterioration of these diseases.

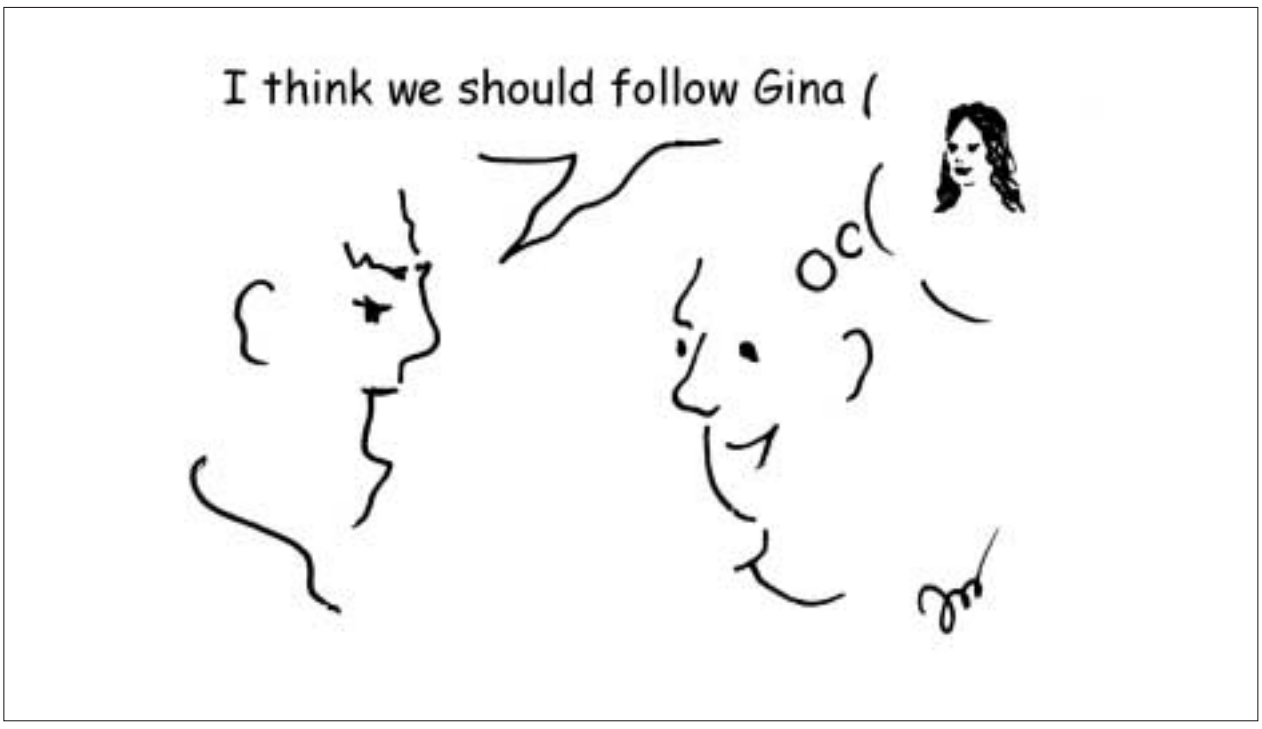
Asthma is one of the most common diseases encountered in clinical medicine, in both children and adults. It is one of the classic diseases recognised by Hippocrates over 2000 years ago, yet today it is still underdiagnosed. Main symptoms of asthma are attacks of breathlessness and wheezing that may occur both during the daytime and at night. Asthma is a variable disease in time and intensity that affects an individual's quality of life and cognitive performance, and it is associated with work and school absences, emergency consultations and hospital admissions. Asthma patients are predominantly under general practice care, and specialist visits only occur when the disease is severe or treatment does not have the anticipated beneficial effects.

COPD is recognised to cause significant morbidity in adult individuals. The main symptoms are cough and shortness of breath. Furthermore, the disease is associated with reduced quality of life, work absence and increasing numbers of exacerbations and/or hospital admissions, especially in advanced disease. COPD is the only chronic disease worldwide with an increasing incidence and mortality. Several studies show stabilisation of mortality rates in men over the last decade, but a continued rise in women. In advanced disease, COPD patients improve with rehabilitation and oxygen treatment, yet mortality rates are high and cannot simply be prevented.

Management of asthma and especially COPD implies long-term follow-up with a periodical review of the patient's condition and comparison with the treatment objectives. To this aim primary care physicians and specialists have been given a framework for management by specific guidelines, the Global Initiative for Asthma (GINA) and Global Initiative for Chronic Obstructive Lung Diseases (GOLD). These guidelines are based on the best-validated current concepts of COPD and asthma pathogenesis and the available evidence on the most appropriate management and prevention strategies. However, they do not encompass the notion how the interaction between GPs and specialists can be best applied in clinical practice.
Hence, it is of great interest that in the current issue of the Netherlands Journal of Medicine, Schermer and colleagues report their cross-sectional study with 29 participating pulmonary physicians. The study assessed whether the Dutch GP guidelines functioned according to the participating

pulmonary physicians' view on interaction between GPs and lung specialists with respect to optimal patient care. The asthma treatment available in 2003 is adequate for symptomatic control in many patients. Therefore, it is not surprising that strategies for collaboration between GPs and specialists were agreed quite easily. However, the approach in COPD is less clear. No studies have been performed as to the best consultation and back-referral strategies between GPs and pulmonary physicians. This will, however, prove very difficult to study. The lack of clear cut-off points for referral of patients may be largely attributed to the lack of knowledge on the best treatment strategies. In the past year a new treatment has been introduced for COPD and it can be anticipated that more treatment strategies will follow. This will again change the approach for referral and back-referral.

The current study constitutes a good start for further optimisation of shared-care constructions between GPs and pulmonary physicians in clinical practice. Thus, it may have implications for future changes in asthma and COPD guidelines in the Netherlands. However, further studies are needed to establish whether this will also result in a better outcome for these diseases.



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