

Letters to the Editor

DIFFICULT TREATMENT PROBLEMS IN RESPIRATORY DISEASE

Sir, The allusion to the beneficial effect of corticosteroids in selected patients with chronic obstructive pulmonary disease (COPD) made by Mortimer¹ and by others² calls into question the traditional dichotomisation between allergic airways disease (so-called asthma) and smoking-related airways disease (so-called COPD). Notwithstanding the differences in aetiopathogenesis, these two disorders are better understood in terms of the degree of impairment of airflow obstruction, and its reversibility, yielding a spectrum which is characterised, at one extreme, by the type of reversibility which is compatible with re-attainment of normal lung function as in classical asthma, and at the other extreme, by the coexistence of irreversibility and severe functional impairment exemplified by end-stage asthma³ and by emphysema. Occupying the middle ground are patients who, regardless of aetiopathogenesis, show a combination of degrees of reversibility, typically of the order of, at most, 30 per cent and of permanent impairment of lung function.⁴ Many of these patients also seem to be the ones who show a beneficial response to long-acting beta adrenergic agonists^{5,6} and to theophylline derivatives^{7,8} in various clinical trials, again seemingly regardless of underlying aetiopathogenesis. The documented beneficial effects with inhaled corticosteroids in allergic as well as in non-allergic patients with chronic, partially reversible, airflow obstruction,^{9,10} support the therapeutic concept of identical molecules of stepped care across the board, in all patients with generalised airflow obstruction irrespective of preconceptions about underlying mechanisms of aetiopathogenesis. In other words, it would be more beneficial if the similarities between asthma and COPD were to be emphasised to a greater extent rather than the differences between those two conditions. This would help to maximise both the use and benefits of currently available treatment modalities.

OMP Jolobe

REFERENCES

- ¹ Mortimer IL, Lessons from a Symposium on difficult treatment problems in respiratory disease held in the College on 25 October 1996 *Proc R Coll Physicians Edinb* 1997; 27:485-90.
- ² Overbeek SL, Kerstjens HAM, Bogaard JM *et al*. Is delayed introduction of inhaled corticosteroids harmful in patients with obstructive airways disease (asthma and COPD)? *Chest* 1996; 110:35-41.
- ³ Backman KS, Greenberger PA, Patterson R. Airways obstruction in patients with long-term asthma consistent with 'irreversible asthma' *Chest* 1997; 112:1234-40.
- ⁴ Eliasson O, Degraff AC. The use of criteria of reversibility and obstruction to define patient groups for bronchodilator trials. *Am Rev Respir Dis* 1985; 132:858-64.
- ⁵ Pauwels RA, Lofdahl C-G, Postma DS *et al*. Effect of inhaled formoterol and budesonide on exacerbations of asthma. *N Engl J Med* 1997; 337:1405-11.
- ⁶ Ramirez-Venegas A, Ward J, Lentine T *et al*. Salmeterol reduces dyspnoea and improves lung function in patients with COPD. *Chest* 1997; 112:336-40.
- ⁷ Evans DJ, Taylor DA, Zetterstrom O *et al*. A comparison of low-dose budesonide plus theophylline and high-dose inhaled budesonide for moderate asthma. *N Engl J Med* 1997; 337:1412-8.
- ⁸ Murciano D, Aubier M, Lecocguic Y *et al*. Effects of theophylline on diaphragmatic strength and fatigue in patients with chronic obstructive pulmonary disease. *N Engl J Med* 1984; 311:349-53.
- ⁹ Weir DC, Burge PS. Effects of a high dose inhaled beclomethasone dipropionate, 750mcg and 1500mcg twice daily, and 40 mg per day oral prednisolone on lung function, symptoms, and bronchial hyperresponsiveness in patients with non-asthmatic chronic airflow obstruction. *Thorax* 1993; 48:309-16.
- ¹⁰ Kerstjens HAM, Brand PLP, Hughes MD *et al*. A comparison of bronchodilator therapy with or without inhaled corticosteroid therapy for obstructive airways disease. *N Engl J Med* 1992; 327:1413-9.

A NEW APPRAISAL OF REDUCING CHOLESTEROL IN THE PREVENTION OF CORONARY HEART DISEASE

Sir, Contributing to the fascination of the 'mechanics' of clinical decision-making is the paradoxical nature of disease presentation and clinical outcome which has as its paradigm the almost counter-intuitive observation that the reduction in coronary heart disease (CHD)-related mortality, now attainable through the use of 'statins'.¹ This observation, nevertheless, coexists with the recognition that, in patients with a high prevalence of CHD, such as the 65-74 age group, an inverse correlation between blood levels of cholesterol and all-cause mortality exists.² Additionally, the failure to recognise that 'both the decline in serum cholesterol level and the associated high mortality might be caused by a third factor, such as increased prevalence of chronic disease,' could, as the authors state, 'help explain why several studies have not found an association of serum cholesterol with coronary risk among the elderly'.² Hence, perhaps, the absence of firm recommendations from the Standing Medical Advisory Committee regarding the use of statins in patients aged >70.³ With the benefit of an adjustment for markers of poor health in patients aged >65, a correlation can be established between hypercholesterolaemia and CHD-related mortality, along with a relationship between the fall in serum cholesterol and a reduction in CHD-related mortality,⁴ justifying the call made in the recent review of 'Current Medicine' to abandon the conservative approach to the management of hypercholesterolaemia in the elderly.⁵

OMP Jolobe

REFERENCES

- ¹ Scandinavian Simvastatin Survival Study Group. Randomised trial of cholesterol lowering in 4444 patients with coronary heart disease: the Scandinavian Simvastatin Survival Study (4S). *Lancet* 1994; 344:1383-9.
- ² Pekkanen J, Nissinen A, Vartiainen E *et al.* Changes in serum cholesterol level and mortality: a 30-year follow-up. *Am J Epidemiol* 1994; 139:155-65.
- ³ Standing Medical Advisory Committee. The use of statins. London: Department of Health, 1997 11061 HCD August 97(04).
- ⁴ Maria-Chiara C, Guralnik JM, Salive ME *et al.* Clarifying the direct relation between total cholesterol levels and death from coronary heart disease in older persons. *Ann Intern Med* 1997; 126:753-60.
- ⁵ Oliver MF. A new appraisal of reducing cholesterol in the prevention of coronary heart disease. *Proc R Coll Physicians Edinb* 1997; 27:408-17.