airway and asthma symptoms. This sequence of symptoms and response is consistent with the main finding of our study, which was a reduction in asthma exacerbations. The main difference was the prominence of heartburn in our study and the prominence of upper airway symptoms in the reported case. However, many patients in our study also had symptoms of globus, hoarseness, and cough, and the patient in the reported case also had heartburn.

Second, the severity of acid reflux and gastroesophageal reflux (GER) symptoms may predict a greater degree of improvement in asthmatic symptoms and pulmonary function in response to a PPI.1–3 Drs. Menon and Morice suggest that the symptom complex associated with LPR in asthmatics with ongoing asthma symptoms would also predict symptomatic and pulmonary function improvement with a PPI. However, atypical GER symptoms such as hoarseness compared to typical GER symptoms such as heartburn have not been obviously more successful in identifying patients whose asthma symptoms are likely to respond to a PPI.3 Our study also examined cough, globus, and hoarseness and found no difference in these symptoms with a PPI.4 In addition, several randomized, placebo-controlled trials5–7 have been inconsistent in demonstrating that a PPI resolves symptoms of LPR. These various observations indirectly suggest that LPR symptoms would not have been substantially more discriminatory than other symptoms such as heartburn in identifying patients whose asthma symptoms and pulmonary function would benefit from a PPI. However, to clarify the role of treatment of LPR to reduce asthma symptoms and improve pulmonary function, a properly performed randomized controlled trial is needed.

Our study suggested that patients with GER whose asthma is treated with an inhaled corticosteroid plus other long-term asthma control therapy such as long-acting β2-agonists are more likely to have a reduction in asthma exacerbations and improvement in asthma-specific quality of life with a PPI.4 A more recent study8 found that asthmatics receiving a long-acting β2-agonist in addition to an inhaled corticosteroid and/or a leukotriene modifier are more likely to have improvement in morning and evening peak expiratory flow. Clearly, as stated in the penultimate paragraph of our article, much more work is needed to identify patients whose asthma is most likely to benefit from acid suppressive therapy.

Influence of Spirometry on Patient Management in Diagnostic Studies Unknown

To the Editor:

In a recent article in CHEST (October 2005),1 Dales et al reported on the influence of spirometry on physicians’ diagnoses of airflow obstruction and the planning of patient management. In a rural setting, the authors documented the physician’s diagnosis before and after spirometric results became available. Physicians reported that, regardless of a change in diagnosis, they would change patient management in 15% of the patients. The management changes were specially directed at counseling patients to stop smoking or at modifying medications. The authors recommended more research on the impact of spirometry on such clinically important end points as changes in diagnosis, management, and patient outcomes.

In our view, this study was directed at the role of spirometry in screening rather than the diagnostic impact of spirometry. All subjects included in the study (mean age, 59 years) visited their primary care physician for any reason and were smokers. A questionnaire was used to assess patients with respiratory symptoms and diseases whose conditions were likely to benefit from review by the physician. No information was presented on the results of physical examinations. In this screening setting, 15% of the physicians would alter their planned management regardless of the outcome of spirometry. The results confirm the conclusion of a review9 that spirometry should not be used to screen smokers for COPD in primary care because it is not yet known whether diagnosing COPD at an early stage would help patients to stop smoking.

Carrying out spirometry in the primary care setting is justified in terms of test validity, provided that the practice staff has been trained sufficiently.3 However, little is known about the diagnostic impact of spirometry,4 and it is important to get more insight into the sensitivity and specificity of spirometric testing of respiratory complaints in the primary care population. Chavannes et al3 reported in a study using simulated cases that spirometry results influence physicians’ decision making by reducing the number of alternative diagnoses, and by increasing the number of appropriate referrals and the use of diagnostic courses of prednisolone therapy. Empirical studies on the additional diagnostic value of spirometry are scarce. Preliminary results of a study by Yawn et al6 demonstrated in an experimental setting that spirom-
etry in addition to a questionnaire administered in the primary care setting, changed the management plans in 21% of patients. Spirometry results may change the diagnosis and/or management of the disease by the demonstration or exclusion of airflow obstruction, which can be assessed through before-and-after testing. However, such designs may easily overlook the confirmative role of spirometry results. Particularly when the signs and symptoms are conflicting, spirometry improves the diagnostic accuracy in subjects in whom COPD is part of the physician’s differential diagnosis and is therefore a useful diagnostic tool. This may play a role in much more than 21% of cases. We promote the performance of further research to explore these epidemiologic and additional values of spirometry in a primary care setting.

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To the Editor:

We screened > 1,000 primary care patients for airflow obstruction and assessed the clinical impact of screening.1 This resulted in physicians making a new diagnosis of unsuspected airflow obstruction in 9% of patients, and having a prior diagnosis of airflow obstruction removed in 11%. Physicians reported that based on spirometry results, they would change management in 15%. Poels et al2 state that “the results confirm that spirometry should not be used to screen smokers for COPD because it is not yet known if [early] diagnosis will help patients stop smoking.” We would agree with this if diagnosing COPD is of no benefit to the patient, if determining that a patient received a misdiagnosis of COPD is of no value, and if a physician’s decision to change management is of no consequence. Knowing a patient has airflow limitation allows the physician to consider vaccination, exercise prescription, and medication that improve quality of life.3 Discovering that a patient does not have airflow obstruction allows the physician to consider other causes of the symptoms that initially prompted the diagnosis, such as cardiac disease. Concerning future research, we agree with Poels et al2 on the importance of assessing spirometry as a diagnostic tool for primary care patients presenting with respiratory complaints. It would be helpful to develop techniques to improve the quality of the test and its interpretation in primary care. Finally, now that we know spirometry can detect new cases and physicians are willing to consider management changes, we need to assess the impact of these actions on the quality of life of the patients, the important end result.

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Renin-Angiotensin System Blockade and COPD

To the Editor:

In a recent article in CHEST (December 2005),1 Matsuyama et al found that nutritional support with a diet that is rich an omega-3 polyunsaturated fatty acids had antiinflammatory effects and improved exercise tolerance in patients with COPD. However, they did not mention whether the studied population was receiving treatment with angiotensin-converting enzyme (ACE) inhibitors or angiotensin II type 1 receptor blockers. Increasing evidence2–4 has suggested that renin-angiotensin system blockade exerts an antiinflammatory action in many systems. Furthermore, in COPD patients, lower ACE activity has been shown to be associated with improved pulmonary hemodynamic variables and improved tissue oxygenation during exercise.5 Therefore, therapy with ACE inhibitors or angiotensin II type 1 receptor blockers, which should be recommended in most patients with COPD, might have been a confounder in the study by Matsuyama and colleagues.1

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