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From the authors:

Pulmonary specialists welcome increased communication and collaborative work with general practitioners in an attempt to find the most effective evidence-based methods to decrease the substantial morbidity and mortality of asthma and chronic obstructive disorder (COPD). In this issue of the *European Respiratory Journal*, P. White has highlighted one of the gaps in the evidence base for recommending increased utilisation of spirometry by primary care practitioners. The evidence is indeed weak, in that adding spirometry testing to methods already demonstrated to improve smoking cessation rates (such as counselling, nicotine replacement therapy and bupropion) will further improve the success rates. The published studies were either inadequately designed or had inadequate statistical power to answer this important question. However, several medications to halt the progression of COPD will probably become available in the next few years [1], so we should prepare for them by working to make office spirometry more effective in the primary care setting.

I admit that there are few studies which decisively prove that the addition of spirometry, to the history and physical examination of patients with respiratory symptoms, improves the ability of general practitioners to substantially improve patient-centred outcomes [2]. However, 20 yrs ago, the same could have been said of blood pressure measurements, or blood glucose and haemoglobin-A1c measurements for obese and diabetic patients, respectively. I characterise the tone of our chapter in the *European Respiratory Monograph* [3] as suggesting “cautious optimism.” A major goal of our recommendations is to minimise spirometry misclassification rates, which leads to the many caveats in our recommendations.

When using forced expiratory volume in six seconds reference equations, the average spirometry test session (with a range of 3–8 manoeuvres) is indeed shorter, because the end-of-test

criterion for an acceptable manoeuvre is much easier to meet (for children and patients with airway obstruction). Therefore, fewer manoeuvres are needed to meet the goal of three acceptable (including two repeatable) manoeuvres.

In our opinion, whoever coaches the patient to perform spirometry tests needs training and performance-based certification. In the UK, this person is usually the general practitioner (a physician), but in the USA, nurses or technologists often perform the testing. Sometimes a nurse practitioner, physician’s assistant, or chronic disease manager uses the results to diagnose or manage the patient.

In Tucson, Arizona, USA, I have seen bumper stickers which say “If I had known that I’d live this long, I would have taken better care of myself.” You have probably seen hundreds of patients dying from end-stage COPD, first diagnosed when their forced expiratory volume in one second was <1 L [4]. How many of them have wondered, “Since my lung disease was apparently slowly progressing for decades before I was finally diagnosed, why didn’t anyone tell me about it many years ago? I would have tried much harder to quit smoking.” I believe that our time and our limited smoking cessation resources should be preferentially targeted towards patients with the highest risks for smoking-related disease.

In conclusion, epidemiological studies have decisively demonstrated that airway obstruction is the second or third most important risk factor for morbidity and mortality in smoking adults.

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