The way forward: the International Primary Care Respiratory Group 2nd World Conference, Melbourne, 19–22 February 2004

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The IPCRG is fostering international links between primary care clinicians and researchers

Over 450 primary care clinicians and researchers from around the world gathered for the second conference of the International Primary Care Respiratory Group (IPCRG) in Melbourne in February 2004. The IPCRG is an international umbrella organisation for national primary care respiratory interest groups.[1] It was established as a charitable company in June 2000 by general practitioners (GPs) and other primary care health professionals from several countries, including Australia, at a meeting of the United Kingdom GP asthma group. Australian GPs have been actively involved in all aspects, including the executive, since its inception. The organisation currently has 21 member countries, represented by national organisations. Australia is represented by the National Asthma Council.

The aims of the IPCRG are to provide an international network for research in community settings, to guide and disseminate evidence-based guidelines appropriate for primary care professionals (eg, GPs, nurses, pharmacists and healthcare workers), and to provide practical resources for "respiratory professionals" in community settings around the world. Those involved in IPCRG include such diverse groups as GPs, respiratory scientists, asthma educators, pharmacists and physiotherapists.

The theme of the 2004 conference was "the way forward" in managing respiratory disease in primary care. Major topics were asthma, allergy and chronic obstructive pulmonary disease (COPD), while tuberculosis, community-acquired pneumonia and quality-of-life measurement also received substantial attention. Topics were covered from the perspectives of clinical care, people and public policy, and practical training, with plenary sessions, workshops and submitted papers and posters.

Core issues arising

Proactive models of care should be developed and tested. Most primary care respiratory management is reactive, and not organised or systematic. Different models of evidence-based proactive care need to be developed and tested. New models presented at the conference included telephone consultations for asthma review, integrated decision support, nurse-led asthma clinics, practice-based professional development programs linked to patient audits, and community-based pharmacy outreach programs.

Guidelines need to be translated into daily practice. Several internationally developed guidelines for asthma, COPD and rhinitis cannot be implemented in primary care (Professor Onno van Schayck, Faculty of Medicine, University of Maastricht and University of Nijmegen, The Netherlands). Several plenary sessions discussed how best to link guidelines to clinical practice in general practice and other forms of primary care, including nurse-run asthma clinics and Aboriginal community-controlled health services. The "consensus" was that a model centred on the respiratory complaints described by the patient at presentation is more sustainable and may be more effective (eg, a model centred on "cough" may be superior to one centred on "COPD").

The link between allergy and asthma must be applied in clinical practice. Evidence is emerging that effective management of allergic rhinitis may ameliorate and prevent asthma (Associate Professor Mini Tang, Head, Department of Immunology, Murdoch Children's Research Institute, Melbourne, and Dr Jacques Bouchard, St Joseph's Hospital, La Malbaie, Quebec, Canada). As almost 45% of the Australian population is atopic, and about a third suffer allergic disease (Professor Robyn O'Hehir, Head of Allergy and Respiratory Medicine, Alfred Hospital, and Monash University, Melbourne, and the Cooperative Research Centre for Asthma, Sydney), a number of speakers stressed the need to consider allergy assessment in all patients with asthma.

Undiagnosed asthma and chronic obstructive pulmonary disease must be identified more efficiently. Effective management is now available for people with early signs of asthma and COPD and will substantially improve their quality of life (Dr Christine Jenkins, Director, Clinical Trials Unit, Woolcock Institute of Medical Research, Royal Prince Alfred Hospital, Sydney).

More precise assessment of disease severity is needed. The severity of asthma and COPD needs to be specified more precisely to maximise the benefits and minimise the risks of interventions. Smoking-cessation programs, appropriate use of inhaled corticosteroids and long-acting bronchodilators, pulmonary rehabilitation, and self-management strategies all have a role, depending on severity of the condition (Dr Christine Jenkins).

Major topics discussed

Asthma. With the recent release of the report on the global burden of asthma,[2] Professor Richard Beasley (Director, Medical Research Institute of New Zealand, Wellington, New Zealand) highlighted the increasing prevalence of asthma, particularly in Asia. He maintained that the explanation is still uncertain, but multifactorial, with environmental factors, increasing urbanisation and the increasing prevalence of allergic disorders all implicated. This suggests that addressing the increase in prevalence will require multifaceted responses by clinicians, public health physicians, consumers, industry and governments (eg, by providing all essential drugs to treat people with asthma in all Asia-Pacific countries). He argued that primary care is a substantial part of the solution and has specific challenges, including development of simple algorithms for patients who present with vague symptoms of cough, shortness of breath and wheezing.

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Main steps of COPDX checklist for diagnosis and management of chronic obstructive pulmonary disease[5]

C – Confirm diagnosis
- Presence and history of symptoms
- Smoking – history and willingness to quit
- Spirometry – measure FEV_1 and FEV_1/FVC and assess reversibility of airflow limitation

O – Optimise function
- Including check of smoking status, optimal therapy and exercise status

P – Prevent deterioration
- Essential steps (including pneumococcal and annual influenza vaccination)
- Risk-factor reduction (including help with smoking cessation)

D – Develop self-management plan
- Including referral for pulmonary rehabilitation or to respiratory physician or hospital, if appropriate

X – Manage eXacerbations
- Including ensuring understanding of importance of early treatment for exacerbations; regular review

Emerging evidence pointed to a need to ensure that the lowest dose of inhaled corticosteroid is used to control symptoms. Some newly recognised side effects include dental and vision problems. Up to 45% of people taking moderate amounts of inhaled corticosteroids report some side effects (Professor Thys Van der Molen, Department of General Practice, University of Groningen, The Netherlands). Van der Molen commented that primary-care clinicians often do not have the time or tools to identify these less well known side effects.

Severe acute respiratory syndrome. Associate Professor Cheong Pak Yean (Family Physician, Faculty of Medicine, National University of Singapore) described Singapore's response to the epidemic of severe acute respiratory syndrome (SARS). The strategy involved detecting, isolating and "ring-fencing" the virus at four levels — the border, hospital, community, and primary care. Border defence involved screening travellers for possible SARS as they entered Singapore. The hospital defence involved managing all people with SARS (or possible SARS) in hospital, with use of personal protective equipment by staff (masks, gloves, gowns, and goggles) plus barrier nursing in single-patient isolation rooms. Community defences included mass education, twice-daily temperature measurement for any suspected cases, and closure of "at-risk" gatherings, such as markets. In primary care, strategies used included GP education campaigns, telephone information hotlines, and "fever and evacuation" rooms in GP surgeries (separate rooms for patients with suspected SARS awaiting evacuation to hospital).

Chronic obstructive pulmonary disease. Identifying people with early smoking-related lung damage would seem a major task. The number of people with COPD in Australia will increase significantly over the next 10–15 years; the estimated prevalence may well exceed 300 000 cases (Professor Justin Beilby, Department of General Practice, University of Adelaide, SA), and the total number of COPD sufferers (both diagnosed and undiagnosed) could range from 620 000 to 2.6 million cases.[3] A GP-friendly algorithm based on the recently completed COPDX guidelines[4] was presented. Fitting on two A4 pages, this has since been refined and released (Box).

Symptom-based questionnaires. There was much discussion about GPs identifying specific conditions, such as undiagnosed COPD. Professor David Price (General Practice Airways Group, Professor of Primary Care Respiratory Medicine, University of Aberdeen, UK) reported on a study of the link between symptoms and results of spirometry testing in 417 current or former smokers recruited from primary-care practices in the United Kingdom and the United States. Predictors were identified that may be useful in identifying early COPD, as measured by spirometry, including:

- Age group (in years).
- Pack-years smoked (*How many cigarettes do you currently smoke each day [if you are an ex-smoker, how many did you smoke each day]? What is the total number of years you have smoked cigarettes?*).
- Recent cough (*Have you coughed more in the past few years?*).
- Breathing-related work loss (*During the past 3 years, have you had any breathing problems that have kept you off work, indoors, at home, or in bed?*).
- Hospitalisation for breathing problems (*Have you ever been admitted to hospital with breathing problems?*).
- Recent breathlessness (*Have you been short of breath more often in the past few years?*).
- Cold usually goes to the chest (*If you get a cold, does it usually go to your chest?*).

It was agreed that these questions require validation among other communities before they can be used as predictors in everyday clinical practice.

Conclusion

This was the second IPCRG conference, the first being held in Amsterdam in 2002. The developing international IPCRG networks have now begun developing innovative research programs, such as further validation of the symptom-based questionnaires discussed above. These programs will become the platform for the next conference, to be held in Oslo in 2006. The IPCRG research subcommittee has begun developing a strategic plan for the group — a challenge, because of the diversity of the member countries and the variable access to resources and research expertise across the group. However, meeting the challenge through sharing expertise and skills may also be a great opportunity for IPCRG.

Competing interests

H J F was paid to act as moderator, chairman and speaker at the AstraZeneca and GlaxoSmithKline satellite symposia held outside the scientific conference program. No other competing interests were identified.

References

1 International Primary Care Respiratory Group. Available at: www.theipcrg.org (accessed Mar 2004).
2 Masoli M, Fabian D, Holt S, Beasley R. Global burden of asthma. Global Initiative on Asthma. 2004. Available at: www.ginasthma.com (accessed Mar 2004).
3 Crockett A, Cranston J, Moss J. Chronic obstructive pulmonary disease (COPD): an economic statement. Brisbane: Australian Lung Foundation, 2002.
4 McKenzie DK, Frith PA, Burdon JGW, Town GI. The COPDX Plan: Australian and New Zealand Guidelines for the management of Chronic Obstructive Pulmonary Disease 2003. *Med J Aust* 2003; 178 (6 Suppl 17 Mar): S1-S40.
5 The Australian Lung Foundation. COPD-X checklist. Available at: www.lungnet.org.au/download_pdf/COPD%20Checklist_130504_3.pdf (accessed May 2004).

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