

A breath of fresh air

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Symptoms of pulmonary disorder are one of the major reasons why patients seek advice from their doctor or pharmacist. They usually follow a seasonal pattern and are much more common during wintertime. Most symptoms follow common viral infections and are of a transient and self-limiting nature: very often the only therapy necessary is rest and simple symptomatic relief. Upper respiratory tract infections are rarely lethal, but they cause much morbidity and account for the loss of countless workdays, and school absenteeism.

The spectrum of respiratory disease fluctuates over time and reflects changing milieus and life-styles. The practice of pulmonary (or chest) medicine around a hundred years ago was mostly concerned with the diagnosis and treatment of infection and its consequences. Then, the tools were rudimentary and there was, of

necessity, complete reliance upon accurate physical examination. This issue of *Chronic*ill* features a paper by Ellul Micallef that not only affords insight into the medical scene prevailing many years ago but also details the pioneering work of Auenbrugger and Laënnec in the field of physical examination of the chest.

Their methods of rigorous direct observation are as valid today as they were then.

A hundred years ago, the use of X-rays to aid diagnosis was in its early infancy and the work of Robert Koch in the field of bacteriology was still being questioned and debated. Over the years, radiology and bacteriology became an integral part of the practice of chest medicine. The specialty is currently going through a phase of critical reappraisal and not only is there close cooperation with radiologists and microbiologists, but also with pharmacists, public health specialists, physiotherapists, nurse-practitioners and immunologists. The paper discussing pharmacogenetics of asthma therapeutics by Fenech and Ellul Micallef is a prime example of such collaboration and is evidence of a healthy blurring of demarcation lines between scientific disciplines.

The pattern of respiratory tract infection has changed significantly over the years and one now has to consider both the resurgence of "old" diseases such as tuberculosis as well as the emergence of "new" diseases, such as infection with Legionella and SARS. Indeed, the impact of widespread and frequent travel overseas has also had an effect on the epidemiology of respiratory communicable disease.

The rise in incidence of tuberculosis is multifactorial and the World Health Organisation predicts an increase of 57% in the EU and 10% in USA and Australia. Co-infection with TB and HIV only partly explains this rise and other factors are changes in patterns of human migration and in healthcare funding. In addition, the emergence of resistant TB strains poses a great challenge both to healthcare systems themselves, as well as to public health.

A hundred years ago, Sir William Osler referred to pneumonia as 'captain of the men of death'. Mortality from

this disease is no longer high; however in today's practice one often encounters difficulties in treating hospital-acquired pneumonia and lung infections in patients with compromised immunity. Treatment options today are incomparable with those available to Osler, while the antibiotic armamentarium at the disposal of physician and pharmacist is extensive, and one that is rapidly evolving to keep ahead of emerging resistance.

In developed countries, a sizeable portion of the workload of specialist respiratory teams consists of care of patients with non-communicable lung disease. Asthma has a rising incidence among all age groups in the Maltese community and the impact of this disease is felt at many levels, amongst them the increasing demands and costs for the provision of care. At an individual level, patients are rightly concerned about their quality of life and Cordina's paper in this Journal addresses this issue together with the

need for adequate and sustained control.

COPD is common among the middle-aged and elderly population and because of former patterns of cigarette smoking in Malta, it is much more prevalent among men. Epidemiological patterns taken from other EU states suggest a future increase in incidence in Malta, given the high prevalence of smoking among young women. Malta forms part of the Global Initiative for Chronic Obstructive Lung Disease (GOLD) and a paper in this Journal highlights the need to increase awareness of COPD, not only at an individual level, but also as a public health problem on a countrywide scale.

Evidence-based medical practice is here to stay, and guidelines for management are often used as standards of care. Locally, in the field of respiratory medicine there are two published sets of guidelines for management (Asthma and COPD) and another two are in the pipeline (Oxygen Therapy and Pulmonary Thromboembolic Disease).

The underlying methodology of these four sets of guidelines has been development by multidisciplinary groups and their basis upon systematic review of scientific evidence.

Cigarette smoking contributes to much morbidity and mortality among our community. Cancer of the lung, causally related to smoking, is the most common form of cancer among Maltese men and a forecast of increasing incidence among women mirrors the current gender-specific smoking pattern.

The year 2004 was a landmark for public health in Malta, in that significant anti-smoking legislation was implemented in the face of much opposition from many quarters. The restrictions on smoking in public places were long-awaited by the health care professions, but more importantly they were eagerly welcomed by the multitudes in our population who feel that it is their right to breathe clean air.