letters

TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and can be submitted on disk or sent by email to: Clinicalmedicine@rcplondon.ac.uk.

Maintaining a professional approach to life

Editor – I enjoyed the last issue's *Conversation with Charles* (Clin Med July/August 2004, pp 384–6) and agree with most of the points made in it, but I was sorry to see Coemgenus perpetuate the common misquotation of the remark attributed to Lady Thatcher that 'there is no such thing as society'.

What she actually said was: 'There is no such thing as "Society", it is composed of a multitude of individuals', which surely expresses a very different meaning. We can all differ in our political views, but let's get our facts right!

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In response

Editor – I know that Charles would feel flattered by and grateful of Dr Harper's remarks. I do not think I need to go back to Charles on this one. I am sure that he was well aware of the full quotation and would accept that the upper case should have been used. However, in apologising for this error, he would add that the full text only serves to make his point. It demonstrates that she failed to recognise that Society has a metaphysical existence, which is greater than the sum of its individuals and has traditions and ethics, which transcend them. This modern difficulty with the metaphysical underlies many of the ills of today's Society. To give another example he might refer Dr Harper to the *Conversation*, 'A crisis of identity'.[1]

References

1 Coemgenus. A crisis of identity. *Clin Med* 2002;**2**:82.

COEMGENUS

Combination long-acting β_2-agonists and inhaled corticosteroids in chronic obstructive pulmonary disease

Editor – I read with great interest the CME article on outpatient management of chronic obstructive pulmonary disease (COPD) (*Clin Med* May/June 2004, pp 220–4). The issue of fixed combination devices with inhaled corticosteroids (ICS) and long-acting bronchodilators (LABAs) is an interesting one. I agree there is good evidence for their superiority over monotherapy with ICS or LABAs alone.[1] Indeed, there are logical scientific reasons why such a combination may be superior.[2] Fixed dose combinations are also attractive from a compliance point of view. However, they may be limited by allowing less flexibility in dose adjustment (mainly due to the finite dose response of the LABA, especially in the case of salmeterol). Taking both drugs but separately allows greater flexibility in dose adjustment of ICS, which although of greater importance in asthma, is still relevant to COPD.

Firstly, I am interested to know what studies have been done on fixed dose LABA/ICS combinations versus the same combination but not in fixed form. Secondly, if such studies showed superiority for the fixed dose combination, could this be related to the temporal and spatial importance of LABA/ICS delivery to maximise their synergistic effect, rather than to improved compliance? Thirdly, if no superiority of either mode is demonstrable, might there be an argument against fixed dose combinations to allow greater flexibility of dose adjustment of the ICS. Finally, obviously this may have more relevance to asthma where dose reduction frequently occurs and I wonder about the same studies in asthmatics?

References

1 Calverley P, Pauwels R, Vestbo J, Jones P *et al*. Combined salmeterol and fluticasone in the treatment of chronic obstructive pulmonary disease: a randomised controlled trial. *Lancet* 2003;**361**:449–56.
2 Barnes PJ. Scientific rationale for inhaled combination therapy with longacting β_2-agonists and corticosteroids. *Eur Respir J* 2002;**19**:182–91.

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In response

Thank you for the interest and the comments. Fixed dose combinations of ICS and LABAs in COPD have not been tested against the two components given separately and it seems unlikely that the two regimens would differ on clinically relevant end points. The advantage of fixed dose combinations is the ease of use, hopefully increasing compliance. This has, however, not been shown.

Flexibility of dose of ICS is an issue in the treatment of asthma but it does not seem to be a major problem with fixed dose combinations in COPD. So far, all studies with ICS in COPD have been done with fixed doses and from the findings there is little to indicate a need for variable dosing of ICS in COPD as in asthma. Regarding LABAs, doses above those usually recommended have been shown to decrease quality of life (Health Status) compared to the recommended doses of salmeterol and formoterol.

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