

READERS' FORUM

We agree: ERS classification of preschool wheeze is not useful

Sir,

The recent work by Shultz et al. about the reliability of classifying preschool wheeze into episodic viral or multiple trigger contributes greatly to clear up the usefulness of such classification proposed by an ERS Task Force (1). The guidelines produced by that group avoided the use of the term asthma for preschool wheezers and defined the aforementioned temporal patterns of wheeze to decide the suitable treatment (2). The observation that half of the children could evolve from one to other pattern in just 1 year discloses its inconsistency and answers the questions raised about the dangers of creating a flawed classification (3). We bring some other arguments against that classification:

1. Although 'episodic (viral) wheeze' is a meaningful name, 'multiple-trigger wheeze' suggests the need for other evident agents. But in this study it only means that wheezes can appear apart from a cold, and in the ERS guideline it meant that symptoms could persist between episodes (what about the triggers?).
2. In everyday practice, most of the children have very similar and slowly progressive episodes. Free intervals can be very short. It is very difficult to clearly assign each patient to the proper group.
3. Frequently, wheezing episodes are supposed to be caused by a virus (a cold). But some episodes could be triggered by an upper airway asymptomatic viral infection. The absence of a cold would become irrelevant for classification.

Asthma is being understood as a syndrome with multiple categories. There is no advantage in classifying patients when we do not get any profit of it. Our group understands and manages childhood asthma (better than preschool wheeze) basing on two points:

1. Childhood asthma is our preferred label, whichever the age, for recurrent symptoms of reversible bronchial obstruction.

Somehow, childhood asthma fills the space between bronchiolitis (single first-second episode) and 'established' asthma (in older children and adults). Diagnosis of childhood asthma depends on the presence of a syndrome (wheezing or bronchial episodes), on the absence of other diseases, and on the response to asthma treatments. Wheezing is only a symptom, not a disease. It can be a surrogate diagnosis of asthma in epidemiological studies but not in a clinic. Remission is not an obstacle for the diagnosis.

2. Classifying childhood asthma is of no proven help to choose the best treatment for a single patient. The response to anti-inflammatory drugs (inhaled steroids or montelukast) is not predictable on the basis of the information available in clinical practice. We are compelled to follow a trial-and-error strategy in search of the best treatment for the patient (4). Individual or social factors may induce to try first with one or the other drug, but it is only the response of the patient what decides the right choice.

Should future investigations help us to classify patients for a better treatment or prevention, all of us will get profit of it. But designing a theoretical and artificial classification is useless. We ask the ERS and its Task Force to let us diagnose asthma in preschoolers and to avoid difficult to apply and not proven classifications. As Schultz wrote and his present work seems to confirm, no classification is better than an incorrect classification (3).

References

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Vaccination coverage of Greek paediatric healthcare workers against seasonal and A/H1N1 influenza

Dear Editor,

Almost 2500 years after the oath by Hippocrates (Island of Kos, 460 BC - Larissa, 377 BC), who emphasized the ethical obligation of doctors 'to care, otherwise to do not harm', healthcare workers have the responsibility as well as the ethical obligation not to harm their patients. To date, it has been well demonstrated that vaccination of healthcare workers against influenza has considerable indirect effects on the health of patients, especially in patients, who are at high risk for influenza (1). As data on the vaccination coverage among paediatric staff in Greece against influenza are limited (2), we conducted a questionnaire-based survey assessing their coverage in two tertiary paediatric hospitals in Athens, Greece ('Penteli' Children's Hospital and 'Aghia Sofia' Children's Hospital) at the beginning and at the end of the winter 2009-2010 (Table 1). Of the 105 participants at the beginning of the winter, only eight (7.6%) had ever received even one dose of the vaccination against seasonal influenza in the past years, while only