LETTERS TO THE EDITOR

DIAGNOSIS OF ACUTE BRONCHITIS

To the Editor:

In the December issue of the *Journal* Smucny and colleagues[1] attempted to answer whether antibiotics are effective in managing acute bronchitis. All trials included in their meta-analysis defined acute bronchitis as an acute productive cough without clinical evidence of pneumonia. As expected, these trials were clinically heterogeneous. And if Smucny and coworkers state these differences represent clinical reality, we agree.

All physicians, especially those in family practice, have to deal with reasonable diagnostic uncertainty concerning the condition "acute bronchitis,"[2] since no reference standard exists for acute bronchitis. Furthermore, it seems that diagnoses are often given to justify antibiotic treatment rather than the other way around,[3] and such treatment choices can be better explained by the signs and symptoms than by diagnosis in family practice.[4]

Considering the poor accuracy of the diagnosis of acute bronchitis in family practice, evidence about the effectiveness of antibiotics in coughing patients might be most desirable (ie, the way Fahey and colleagues[5] presented the results of their meta-analysis).

This consideration also has implications for further research, searching for clinically useful characteristics to identify subgroups of patients who will benefit from antibiotics. Likewise, it should start with coughing patients, not patients labeled as having acute bronchitis.

Consequently, we believe the only evidence that provides relevant answers for family practice is evidence for the conditions family physicians can accurately diagnose. Evidence for acute bronchitis does not exist.

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The preceding letter was referred to Drs Smucny, Becker, Glazier, and McIssac, who reply as follows:

Dr Coenen and colleagues have raised an excellent point about uncertainty regarding the diagnosis of acute bronchitis that deserves further discussion. A number of studies (surveys and retrospective chart reviews) have demonstrated that physicians do not have a uniform definition of acute bronchitis;[1-4] diagnostic criteria in textbooks vary as well. It has been elegantly argued by others that a uniform definition of acute bronchitis should be formulated and accepted for future therapeutic trials to have meaning.[1]

In spite of these difficulties, we chose to include acute bronchitis in our title to refer to a clinical syndrome that family physicians recognize, even if they do not uniformly agree on what symptoms and signs indicate a diagnosis of this condition. In fact, the titles of 7 of 9 papers in our meta-analysis included acute bronchitis (the other 2 used cough and purulent sputum in the title instead). Also, of the 9 trials in the meta-analysis by Fahey and coworkers,[5] 8 were also included in our meta-analysis, so we in essence were examining the same syndrome, even though our reviews had different titles. Since all of the papers we included in our review limited patient enrollment to individuals without known underlying pulmonary disease who had an acute productive cough, another appropriate (and perhaps better, albeit longer) title for our review could have been "Are Antibiotics Effective Treatment for Acute Productive Cough in Patients Who Do Not Have Known Underlying Pulmonary Disease?"

Clinicians may never agree on a uniform clinical definition of acute bronchitis, and we agree with Coenen and colleagues that it may indeed be more appropriate for future studies of potentially useful therapies to be titled with regard to the patients' clinical presentation instead of an imprecise diagnosis. Regardless of the title, however, it is important for studies to be limited to specific subgroups of patients, or at least explicitly report outcomes by subgroups. Ideally, subgroups would be identified on the basis of symptoms (eg, duration of cough), signs (eg, wheezing), and additional, easily obtainable data (eg, C-reactive protein[6]). Using the trials thus far (of both antibiotics and β-agonists), it seems unlikely that all patients with what is commonly referred to as acute bronchitis will merit a specific treatment. Rather, it is more probable that there are specific

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subgroups of patients that may benefit from specific therapies, and this is the clinically useful information that family physicians require to optimally manage this common, if imprecisely defined, condition.

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Comparing the US and UK Health Care Systems

To the Editor:

The idea of centering a health care system around primary care makes sense.[1] However, there are good reasons why this approach is possible in the United Kingdom, but so far miscarries in the United States. In the United Kingdom, the ratio between primary care doctors and specialists is about 50-50; in the United States, it is roughly 35-65 with specialists in the majority. Until primary care doctors get more clout, they will not be able to change our present system very much. Managed care tried to do what primary care doctors could not do for themselves by making them gatekeepers. But simply calling them gatekeepers without giving them any real power, made primary care doctors' position in the medical hierarchy weaker than before. Indeed, they have become overworked, demoralized, and distracted by being overburdened with administrative red tape. For example, many primary care doctors have had to raise their office overhead significantly by hiring more personnel to attend to the endless referrals that have to be made when patients need to see a specialist.

Also, because a national health system has been in effect in the United Kingdom for 50 years or so, I imagine that patients are more realistic about the limits of health care. For that reason, malpractice cases and the demand for specialists are much lower there. In the United States, primary care doctors feel tremendous pressure to refer patients; something their British colleagues do not have to contend with. For several generations, indemnity insurance has conditioned patients to see whoever they wanted because their insurance paid for it. Though managed care is trying to change this, it will require a few generations for patients to become accustomed to it.

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1. Koperski M, Rodnick JE. Recent developments in primary care in the United Kingdom: from competition to community-oriented primary care. J Fam Pract 1999; 48:141-5.

The preceding letter was referred to Drs Koperski and Rodnick, who reply as follows:

Dr Volpintesta raises 2 important points concerning the differences between the US and UK health care systems. Some further clarification may aid the debate.

General practitioners (GPs) in the United Kingdom have not always been happy with their lot. They were virtually ignored for the first 20 years of the National Health Service (NHS) and they were considered to have fallen off the hospital ladder, where their presence was generally unwanted. In 1966, they threatened the government with mass resignation through the British Medical Association, their trade union. The vast majority of GPs signed postdated resignation letters that were sent to the BMA during negotiations. The subsequent agreement transformed the role of general practice in the United Kingdom during the following 2 decades.

Although the United States has shown an astonishing ability to change its health care system, many patients and payers in the United States are not happy with the current system. As Dr Volpintesta points out, primary care physicians constitute only 35% of the medical workforce in the United States, and within that, family physicians constitute only approximately 15% of the workforce. If the issues hinge on physicians leading the needed changes in the US system, all primary care physicians must work together and be willing to act together, as UK colleagues did 33 years ago.

Dr Volpintesta's other point, that patients in the United Kingdom may be more realistic about the limits of health care, is also an important one. Surprisingly, the number of individuals opting out of the NHS for private health insurance has not grown in the last few years. However, we expect patients in the United Kingdom will adopt some of the ways of their American counterparts and become more involved in their health care. We hope that through the commissioning of care by GPs, the system can be more responsive to their needs and will not undergo some of the major disruptions that are occurring in the United States.

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