

Rebuttal: Must family physicians use spirometry in managing asthma patients?

NO

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It is not appropriate for Drs Kaplan and Stanbrook to suggest that physicians who do not use spirometry should not manage patients with asthma.¹ Such comments do not provide constructive guidance about clinical management and might serve to challenge the central role of family physicians in asthma care. Interestingly, it appears that Kaplan and Stanbrook are now supporting my side of the debate. They state that "empiric treatment of presumed asthma is acceptable only if followed by objective measurements of lung function to confirm clinical suspicion." This position seems very similar to my suggestion to treat and refer for methacholine challenge testing, as this approach will identify most patients with suspected asthma.²

My colleagues appropriately highlight that a single spirometry test might not always be successful in diagnosing or ruling out asthma definitively, but they offer no practical strategy for how physicians should manage patients with suspected asthma but normal spirometry values; for example, how many spirometry tests should be performed before referral for methacholine testing? How should a patient waiting for methacholine testing be managed in the interim? If we consider that most asthma patients in primary care have normal spirometry (with only a small minority exhibiting substantial changes in airway calibre after bronchodilator challenge),² the approach of Kaplan and Stanbrook would result in the undertreatment of most asthma patients who are likely to be encountered in primary care.

To date, there are no studies that outline how to best make use of spirometry for asthma diagnosis and evaluation of undifferentiated respiratory symptoms in primary care. Kaplan and Stanbrook's comments that spirometry testing "can provide your patients with better

care" are not followed by a single cited reference. It seems counterintuitive (at this time) to recommend a management approach that might provide a very low diagnostic yield at the time of testing when more informative strategies exist.² Recommendations related to the role of spirometry in asthma diagnosis and management should be based on medical evidence that is strong and relevant to clinical challenges encountered in primary care. Otherwise, we have no way of knowing whether we are doing more harm than good.

Stanbrook and Kaplan might suggest that their comments are taken out of context. However, by linking underuse of office-based spirometry to substandard care, they are sending a message that family physicians might be part of the problem of suboptimal asthma management, including diagnosis.¹ Although the many guidelines cited by Kaplan and Stanbrook recommend spirometry testing for asthma management, the benefits of this strategy remain unproven in the primary care setting. More research is needed to understand whether office-based spirometry is superior to other approaches in terms of confirming diagnosis and improving relevant asthma control end points.

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Competing interests

None declared

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This rebuttal is a response from the authors of the debate in the February issue (*Can Fam Physician* 2010;56:126-9 [Eng], 130-3[Fr]). See www.cfp.ca.