

much lower yield than methacholine challenge testing in terms of asthma diagnosis in treated patients.

My intuitive enthusiasm for spirometry use is dampened by the reality that there is a lack of strong evidence on how we might best use this simple and important test. The question of whether appropriate quality control of spirometry can be ensured at the primary care level requires further study. Until such data are available, we should beckon family physicians who are not yet regularly using spirometry with a more tempered call to task.

Anthony D'Urzo MD MSc

Chair and cofounder, Primary Care Respiratory Alliance of Canada, Toronto, Ont.

Competing interests: None declared.

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The authors respond:

We thank Anthony D'Urzo for his thoughtful comments. Our editorial stated that "asthma and chronic obstructive pulmonary disease are routinely confused clinically in adults and can only be reliably distinguished with objective testing."¹ We did not mean to imply by this that objective testing is always successful in distinguishing asthma and chronic obstructive pulmonary disease. Indeed, we agree with D'Urzo that there are many cases in which spirometry cannot separate the 2 conditions. However, there are many other cases in which asthma and chronic obstructive pulmonary disease

can be distinguished clearly and in such cases spirometry often provides the only objective means of doing so.

Because optimal treatments for asthma and chronic obstructive pulmonary disease are often different, it is important to distinguish between these 2 conditions if at all possible. As with any other diagnostic test, spirometry alone does not make the diagnosis. Instead, the results of spirometry must be interpreted within their clinical context to establish or rule out a diagnosis. Therefore, further diagnostic testing is often needed, but this does not justify omitting spirometry nor does it remove the necessity of making a firm diagnosis whenever possible for our patients at some point during their chronic illness.

D'Urzo challenges our recommendation that spirometry should be mandatory in the management of asthma and instead suggests a strategy of treating first and testing later with methacholine challenge. Although we respect D'Urzo's point of view, we stand by our position. The proposed alternative strategy, although it would ensure that truly asthmatic patients were treated promptly, would result in many other patients being treated unnecessarily with medications that would not benefit them. Also, methacholine challenge is not ideal as an initial test because it cannot reliably distinguish asthma from other obstructive lung dis-

eases such as chronic obstructive pulmonary disease, it often produces false-positive results if done within 6 weeks of a viral respiratory tract infection, and it may produce false-negative results if a controller medication has already been initiated.² Moreover, as methacholine challenge testing is even less available than spirometry, we fear that we would be advocating unattainable standards if our recommendations matched those of D'Urzo.

Given that spirometry can be administered at the point of care to confirm or rule out the presence of airflow obstruction reliably before a treatment decision is made, why not use it? Where barriers exist that challenge the feasibility of this approach, we must overcome them rather than succumb to them, to ensure that we provide our patients with the best care.

Matthew B. Stanbrook MD PhD

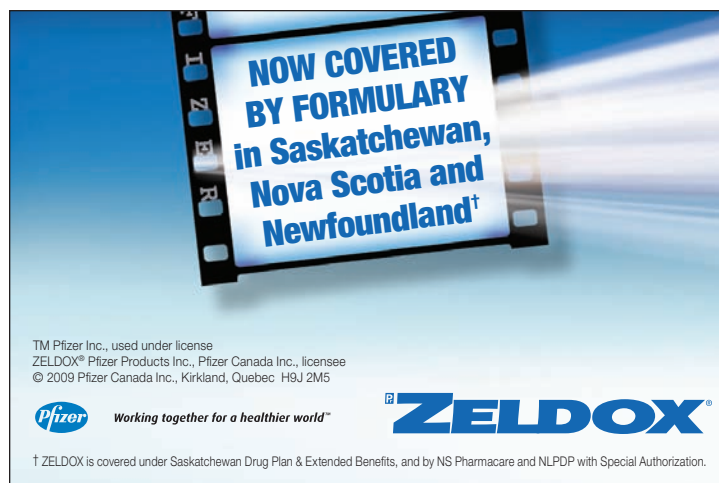
Deputy Editor, Scientific, *CMAJ*
Alan Kaplan MD
 Chair, Family Physician Airways Group of Canada, Richmond Hill, Ont.

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