

EDITORS' CHOICE

- The concept of 'lung age' is often used as a way of explaining to patients about the deterioration of their lung function caused by smoking. "You're telling me I've got the lungs of a 98-year old, Doctor?!" Equations for estimating lung age from the FEV₁ value were first developed by Morris and Temple in 1985, and given the paramount importance of smoking cessation for patients with COPD, there is renewed interest in the concept of 'lung age'. In their paper on pg 242, Newbury *et al.* compared the original Morris lung age equations with contemporary Australian lung age equations as applied to an independent dataset. They conclude that their new equations have internal validity, and that the Morris equations are in need of review. However, in their thought-provoking editorial (pg 197), Quanjer and Enright question the whole use of 'lung age' and its effectiveness in helping patients stop smoking – whilst making the point that if lung age equations are to be used, the equations need to fit the local population. In their letter in response to Quanjer and Enright's editorial, Parkes and Greenhalgh strongly defend the use of lung age as a means of informing smokers and promoting behavioural change, stating that we shouldn't get rid of the concept of lung age simply because the equations aren't reliable (pg 295). Finally, in his letter on pg 286, Hansen congratulates Newbury *et al.* on their study and compares the Newbury lung age equations with those published recently by his group. ***We will be delighted to publish more correspondence on this topic in the next issue. Write to us and submit your letter online – see the author instructions at www.thepcrj.org.***
- How should we best diagnose and manage community acquired pneumonia (CAP) in primary care? Earlier this year, we published a primary care summary of the BTS CAP guidelines (Levy *et al.* *PCRJ* 19(1):21-7). On pg 237, Evertsen *et al.* report a study on adult patients consulting with respiratory tract infection (RTI) in an outpatient integrated health care setting in Wisconsin, USA. Documented fever and abnormal auscultation findings were the best predictors for labelling an acute RTI as pneumonia and for arranging a chest X-ray. In their excellent editorial on pg 200, Newbegin and Macfarlane put this paper into context.
- Elsewhere, Davidson *et al.* review the impact of ethnicity on asthma care (pg 202), the fifth paper in the ADMIT series by Pedersen *et al.* on inhaler selection for children with asthma is on pg 209, Angier *et al.* publish a primary care summary of the BSACI guideline on managing allergic and non-allergic rhinitis (pg 217), and on pg 260 Hurst and colleagues present their findings on the use of a 24-hour Telephone Support Service for high risk patients with COPD.

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