EDITORIAL

PROTOCOL-DRIVEN ALLERGY

The practice of medicine has traditionally been based on a combination of scientific knowledge, art and "clinical eye". Medicine is not an exact science; diseases have a genetically diverse substrate (human beings) influenced by many imponderable factors. Some of these are endogenous, depending on the patient's psychology and state of mind, while others are exogenous, such as those influenced by the environment, the patient's socioeconomic status and intelligence, diet, and epidemiological factors, among many others.

Therefore, medicine cannot be said to be an exact science, since each individual is distinct. Although evaluating all the symptoms presented by a patient may lead to a diagnosis or suspected diagnosis, which will require confirmation through complimentary investigations, the interpretation that each individual gives to his or her ailments will differ according to the above-mentioned factors, while treatment response can vary, depending on many circumstances, some involving the idiosyncratic nature of the individual and others involving dose, the appropriateness of the treatment, and strict treatment compliance.

Nevertheless, the attempt to structure medical knowledge so that both diagnostic and therapeutic criteria can be unified on the one hand, and patients can be helped to provide sufficiently objective information for their symptoms and state of mind, as related to the disease, to be evaluated on the other, is both logical and laudable. For several years, guidelines attempting to do just this have been issued in allergy, as in other specialties. Most of these guidelines concern respiratory disease, rhinitis, asthma and atopic dermatitis[1-3].

Guidelines covering everything from the concept of asthma to its epidemiology, etiopathogenesis and treatment are well known. There is no lack of algorithms attempting to be useful especially in the diagnosis of asthma and the various steps involved in its treatment. These algorithms are frequently presented in the form of ladders or the colors of traffic lights, presumably to make them more comprehensible to patients when self-management is recommended. The utility of these guidelines, which are periodically updated, is undoubted, although the various versions on the same subject issued by different societies, even within the same country, only leads to confusion and a lack of uniform criteria[4-7].

Equally, evaluating symptoms to establish severity criteria is fraught with difficulties, since frequency, intensity, seasonality, age, environmental factors, and other variables must be taken into account, and in the case of asthma, respiratory function must also be considered, all of which leads to a diversity of criteria, which in turn can be debated, such as, for example, basing the severity of asthma on the frequency of symptoms but not on their intensity, evaluation of which requires observation of the patient, physical examination and assessment of respiratory function, data that can be objectively evaluated by the physician[8].

Even though attempts have been made to simplify them, questionnaires to determine the patient's status, the intensity of symptoms or their diagnostic value are generally excessively complex and consequently it should come as no surprise that the value of the responses decreases as the interview progresses[9]. Indeed, responses differ between written and video questions showing the symptoms and signs of asthma[10].

There is also interest in determining quality of life in allergic patients. To do this, several questionnaires are available, which should be completed by adult patients and by children above a certain age. The validity of the responses can depend on highly diverse premises, such as the patient's mood when completing the questionnaire, an excessive number of items requiring a response, comprehension of each of these items, suitability of the items to the patient's intelligence and the terminology used when the questionnaire is translated and culturally adapted to the country in which it will be applied. Thus, the results should be interpreted with caution[11-14].

Despite all these proposals to study allergic patients, their use will probably be highly restricted; this is especially true of patient questionnaires but also applies to diagnostic-therapeutic guidelines, except when these are used in controlled studies, whatever their aim. They are of doubtful use to physicians as they go about their work, since the criteria underlying daily clinical practice are knowledge and experience[15,16].

In conclusion, the words of the great spanish clinician, Professor Gregorio Marañón, published more than 50 years ago in "A Critique of Dogmatic Medicine", continue to be valid "medicine is science, art and skill in equal measure. However the eagerness to convert what used to be a priestly and enigmatic profession into an integrated science, exact and infallible, leads it into a thousand difficulties every day and sometimes into situations of uneasy compromise, if not mortal danger"[17].

F. Muñoz-López

REFERENCES

1. ARIA Workshop Report. Allergic rhinitis and its impact on asthma. J. Allergy Clin Immunol. 2001;108 Suppl 5:S147-334.
2. Nation Institute of Health. Global Strategy for asthma management and prevention (GINA). Revised 2002. www.ginasthma.com.
3. Eichenfield LF. Consensus guideline in diagnosis and treatment of atopic dermatitis. Allergy. 2004;59 Suppl 78:86-92.
4. Vermeire PA, Rabe KF, Soriano JB, Maier WC. Asthma control and differences in management practices across seven European countries. Respir Med. 2002;96:142-9.
5. Pauwels R. Formoterol-where does it fit in the current guidelines? Respir Med. 2001;95 Suppl B:S30-4.
6. Demoly P, Crestani B, Leroyer C, Magnan A, Mounedji N, Humbert M. Control and exacerbation of asthma: a survey of more than 3000 French physician. Allergy. 2004;59:920-6.
7. Stempel DA, Fuhlbrigge AL. Defining the responder in asthma therapy. J Allergy Clin Immunol. 2005;115: 466-9.
8. Bacharier LB, Strunk RC, Mauger D, White D, Lemanske F, Sorkness CA. Classifying asthma severity in children. Mismatch between symptoms, medication use and lung function. Am J Respir Crit Care Med. 2004;170:426-32.
9. Baiardini I, Braido F, Fassio O, Tarantini F, Pasquali M, Tarchino F, et al. A new tool to assess and monitor the burden of chronic cough on quality of life: Chronic Cough Impact Questionnaire. Allergy. 2005; 60:482-8.
10. Crane J, Mallol J, Beasley R, Stewart A, Asher MI. Agreement between written and video questions for comparing asthma symptoms in ISAAC. Eur Respir J. 2003;21:455-61.
11. Juniper EF, Guyatt GH, Feeny DH, Griffith LE, Ferrie PJ. Minimun skills required by children to complete health-related quality of life instruments for asthma: comparison of measurement properties. Eur Respir J. 1997;10:2285-94.
12. Roberts G, Hurley C, Lack G. Development of a quality-of-life assessment for the allergic child or teenager with multisystem allergic disease. J Allergy Clin Immunol. 2003;111:491-7.
13. Tauler E. Calidad de vida en pacientes con asma en las edades pediátricas. Allergol et Immunopathol. 2000;28:168-75.
14. Alonso E y Grupo Valair. Estudio de utilización y validación clínica de la versión española del cuestionario de calidad de vida para niños con asma (PAQLQ) y el diario de los cuidadores del niño asmático (DCA). Estudio VALAIR. Allergol et Immunopathol. 2000;28:175-83.
15. Rabe KF, Adachi M, Lai CKW, Soriano JB, Vermeire PA, Weiss KB, et al. Worldwide severity and control of asthma in children and adults: the global asthma insights and reality surveys. J Allergy Clin Immunol. 2004;114:40-7.
16. Lenfant C. Clinical research to clinical practice-lost in translation? New Engl J Med. 2003;349:868-74.
17. Marañón G. Crítica de la Medicina Dogmática. Espasa-Calpe, S.A. Madrid; 1950.