

## Guest editorial

### Pulmonology

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The current issue of *CME* on respiratory diseases is timely and appropriate for several reasons. Respiratory-related symptoms, either with regard to the upper or lower respiratory tract, are responsible for almost 50% of consultations in general practice. Respiratory complaints are also the most common reason for HIV-infected persons to seek healthcare, either at primary or secondary level. Almost 12% of the nation's population are co-infected with HIV, and in some communities these rates are as high as 40%. This edition of *CME* on common and significant respiratory conditions faced by practitioners at primary care level in the public and private sectors, is therefore appropriate and important. Public health emergencies, such as TB and HIV, have now been eclipsed by concerns about drug-resistant TB. Multidrug-resistant TB (MDR-TB) and extensively drug-resistant TB (XDR-TB) have a high mortality, and almost 10 000 patients with MDR-TB are currently being treated in South Africa. Of even more concern is the emergence of resistance beyond XDR-TB (totally drug-resistant TB (TDR-TB)), resulting in large numbers of patients in whom therapy has failed and who are being discharged back into communities.

It is therefore appropriate that Dr G Calligaro and myself from UCT draw attention to the fact that, despite drug-resistant TB comprising less than 3% of the total caseload in the country, it is already consuming approximately 45% of the total national TB budget of ~R1.6 billion (including drugs, personnel, services, etc.). In keeping with the theme of pulmonary infections, it is interesting to note that in many HIV-endemic parts of South Africa, the commonest organism isolated in patients presenting to hospital with a community-acquired pneumonia is *Mycobacterium tuberculosis* and not *Streptococcus pneumoniae*.

Drs J Bruwer and E Batubara and Professor C Koegelenberg from Stellenbosch University provide an excellent review of a commonly encountered clinical condition, i.e. pleural effusion. They highlight the diagnostic pitfalls, particularly when diagnosing TB. It has now become clear that widely available, newer diagnostic tools such as the GeneXpert MTB/RIF assay perform poorly on TB pleural effusates. By contrast, biomarkers such as unstimulated interferon-gamma or adenosine deaminase, together with the clinical presentation, are substantially more accurate than nucleic acid amplification tests. The old adage holds true: There is no one-size-fits-all when it comes to diagnostics. The authors provide a practical approach in a South African context.

Dr B Allwood and Professor G Ainslie from the University of Cape Town (UCT) provide an excellent overview of sarcoidosis, a multisystem granulomatous disorder that may be confused with TB. It is not infrequently encountered in hospital practice, and primary care practitioners should be aware of this condition. The broader teaching point is that everything that 'looks like TB' is not necessarily TB. Failure to respond to antituberculosis therapy or the presence of other clues should alert the practitioner to the possibility of an alternative diagnosis such as sarcoidosis.

Other common conditions seen in clinical practice are airways diseases, i.e. asthma and chronic obstructive pulmonary disease (COPD). About 10 - 15% of the population suffer from one of these disorders. Dr I Kalla from Wits provides an excellent overview of this very broad topic, and highlights important new treatments for and approaches to these diseases in the 21st century. In asthma, as in many other disorders, it is becoming apparent that

there are distinct sub-groups or phenotypes based on clinical presentation, inflammatory markers and responses to therapy. Dr Kalla outlines these in more detail.

Also important in clinical practice is pulmonary thrombo-embolic disease, highlighted by Professor A Goolam-Mahomed from the University of Limpopo.

Dr K Nyamande from the University of KwaZulu-Natal provides a succinct overview of community-acquired pneumonia, one of the top 10 culprits in the World Health Organization's global killer list.

Dr B Schär from Wits provides a cogent overview of idiopathic pulmonary fibrosis and nonspecific interstitial pneumonia, the two common idiopathic interstitial pneumonias. Again, awareness of these entities is critical when faced with a patient from the appropriate age group with slowly progressing dyspnoea.

As the burden of HIV, TB and community-acquired pneumonia increases in South Africa, fuelled by poverty and HIV, recognition of the relevant respiratory conditions, including TB, HIV-associated lung disease, pleural effusion, and community-acquired pneumonia is critical. However, it is also important to be aware of the non-communicable diseases such as airway and interstitial lung diseases, as they form a critical part of routine clinical practice. I hope that the articles in this edition of *CME* will be useful for your clinical practice. Always bear in mind that a good history, clinical examination and some thought about the differential diagnosis are paramount for good and cost-effective management of patients with respiratory symptoms.