patients with poor physical health, any contribution from impaired vision is difficult to distinguish from that of comorbid disorders. Health utility measures such as the standard gamble and time trade-off techniques are also inappropriate. Elderly people have problems understanding the hypothetical concepts of the percentage of risk of death that they would be prepared to accept to avoid chronic ill health or the number of years of life they would be prepared to trade for a perfect cure for their medical condition. Also such questions would be difficult for elderly people to answer given their shorter life expectancies.

Most visual functioning questionnaires assess the impact of visual loss on daily living but do not measure social or psychological functioning. Though some questionnaires—such as the National Eye Institute visual functioning questionnaire—do measure psychological aspects of visual impairment, they are unresponsive to small differences in visual acuity. The authors of the review recommend their own instrument the MacDQoL,° which measures the impact of age related macular degeneration on quality of life and can discriminate between mild and moderate disease. The usefulness of this tool is difficult to assess, however, as what constitutes mild or moderate age related macular degeneration is not defined.

Vision is a complex neurosensory task mediated by both eyes, so that wet macular degeneration in one eye does not necessarily affect quality of life. The commonly measured surrogate marker visual acuity also correlates poorly with the severity of retinal changes. Many people develop adaptive strategies over time that cannot be captured in cross sectional studies and are difficult to control for even in longitudinal studies. Thus, the criticism that most existing visual functioning questionnaires lack the sensitivity to differentiate severity of disease would appear to be unduly harsh, as appropriately designed large longitudinal studies have not yet been undertaken.

Mitchell and Bradley state that despite the development of promising new treatments,° none has used an effective measure of quality of life to evaluate benefit. Treatments that are unpleasant, need repeated administration, and cause adverse effects are likely to reduce quality of life even though they may improve visual acuity. An ideal instrument for use in wet macular degeneration will be responsive to changes in visual function and quality of life as well as capture satisfaction with treatment. Such an instrument is needed now.

Usha Chakravarthy
professor of ophthalmology and
vision sciences
(u.chakravarthy@qub.ac.uk)
Centre for Vision Science, Queen’s University of Belfast, Belfast BT12 6BA

Competing interests: None declared.

2 Evans JR, Fletcher AE, Wormald RP. Age-related macular degeneration causing visual impairment in people 75 years or older in Britain: an add-on study to the Medical Research Council trial of assessment and management of older people in the community. Ophthalmology 2005;111:515-7.
doi 10.1136/bmj.39009.360736.80

Spirometry in chronic obstructive pulmonary disease
Is available, yet underused in general practice

C hronic obstructive pulmonary disease affects about 1% of the total UK population1 and is a major cause of disability and mortality worldwide. Timely diagnosis and subsequent staging of severity of disease both require spirometry, which in theory can be performed by trained general practitioners (GPs) and their practice staff. However, numerous barriers impede the implementation of spirometry in primary care.

Several guidelines exist for the management of patients with chronic obstructive pulmonary disease, including those from the UK National Institute for Health and Clinical excellence (NICE)2 and the Global Initiative for Chronic Obstructive Lung Disease (GOLD; www.goldcopd.com). All guidelines stress the central role of spirometry in diagnosing and managing the disease in primary care, but this does not guarantee that GPs will use this technique consistently in the care of patients with respiratory symptoms.

Several models to provide spirometry test results exist, depending on local circumstances; these include regional primary care diagnostic services and hospital based lung function laboratories with open access for primary care patients. However, the most practical and timely solution is for GPs to have their own spirometer in the practice.3 In the United Kingdom about 80% of general practices own a spirometer,° but these instruments are still scarce in large parts of the world.

1 BMJ 2006;333:870–1
A European alcohol strategy
Will the opportunity be missed?

This month the European Commission must decide whether to adopt a strategy to deal with the adverse health consequences of alcohol. The strategy has been awaited eagerly by Europe’s public health community since it was first mooted five years ago, but it could fall at the last hurdle. It may be the victim of a carefully planned attack by representatives of the alcohol industry, using tactics associated with tobacco manufacturers.

Alcohol related disease accounts for almost 8% of the overall burden of disease in Europe.1 One factor contributing to the current level of consumption is the single European market, testified to by the existence of vast retail outlets around Calais that thousands of British travellers visit each week. Yet the single market has implications that go far beyond this type of cross border trade. Countries such as Sweden and Finland had longstanding stringent controls on alcohol sales that restricted access to low cost alcohol. After they joined the European Union in 1995 they had to dismantle important parts of their policies,1 and over the next decade death rates from cirrhosis in Finland rose by 50%.2 The industry has also used the single European market, testified to by the existence of


doi 10.1136/bmj.38987.47872.80


doi 10.1136/bmj.38987.47872.80