Dear Editor,


De Vries and Drent address important aspects of the differences between and the problems with 'quality of life' (QOL) and 'health-related quality of life' (HRQOL) measurement. I agree on the necessity to strengthen focus on the differences between the disease specific and the generic instruments.

The letter from De Vries and Drent, especially the references, makes one happy to learn how far the Dutch have come in the process of validating disease-specific questionnaires, especially since this is in a relatively small language and culture, concerning the size of the population. What was stressed in the editorial was the fact that we have developed some very useful generic and disease-specific instruments, but this has been achieved by fiery souls from different academies only. The present status is that we have sufficient knowledge to conduct studies with HRQOL and QOL measurements, and what was stressed in the editorial was the fact that HRQOL questionnaires have been developed for a minority of diseases only and only in few languages and cultures. In my opinion, this is the major factor limiting the propagation of HRQOL measurements, and that was why the paper by De Vries et al. (1) was welcomed. It pointed to alternative methods e.g. the focus group, in cases where no specific questionnaire exists.

I can fully agree with De Vries and Drent on the necessity of cultural appropriateness, or in other words, cultural translation of questionnaires. In fact I found this aspect so important that it was focused on in the editorial title (2). At present we do have HRQOL questionnaires for several diseases, often in the English or American languages. But we need instruments for the investigation of minorities concerning language, e.g. Dutch or ethnicity, for examples, Inuit, and the task to produce these instruments seems tremendous. That is why alternatives are needed and proposals are welcome. This also holds for the specifications we have to demand from our generic questionnaires and that is why the SF-36 has an advantage, probably being the one questionnaire validated and translated into most languages and cultures, thus facilitating transcultural comparisons of results.

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References


Re: Dose proportionality of fluticosone propionate hydrofluoroalkane pressurized metered dose inhalers (pMDIS) and comparability with chlorofluorocarbon pMDIS [Respir Med 2000; 94 (Suppl. B): S10–S16]

I read with interest the recent article by Kunka et al. which concluded that HFA and CFC formulations of fluticasone propionate pMDI produced similar lung deposition and no difference in systemic exposure at microgram equivalent doses (1). The conclusion of similar lung deposition with the 125 μg formulation, on the basis of lung bioavailability, is not supported by the ratio of HFA:CFC for plasma fluticasone propionate concentration as area under curve: 0.67 (90% CI 0.57–0.79). For the same 125 μg formulation, despite the difference in plasma fluticasone propionate concentration, there appeared to be no difference in the uncorrected 24-h urinary cortisol excretion, where the ratio was found to be 1.04 (95% CI 0.82–1.32). It is conventional practice to report 24-h urinary cortisol corrected for creatinine excretion. It also seems bizarre that the investigators have gone to all the trouble of collecting the serial 24-h plasma fluticasone propionate concentration, but appear to have omitted collecting blood samples over the same time profile for 24-plasma cortisol, as this would have permitted proper pharmacokinetic/pharmacodynamic modelling.

Furthermore, fluticasone propionate was administered as single doses, and since it has a large volume of distribution, with preferential partitioning in to the systemic tissue compartment rather than blood (due to its high lipophilicity), it would be more clinically relevant to evaluate what happens with chronic dosing at steady-state, where there would be a much greater degree of adrenal suppression due to equilibration between the two compartments (2). After all, in real life, patients take fluticasone repeatedly twice daily, not as a single dose. In this situation it is more likely that differences between the two formulations would become evident, as suggested by differences between the pharmacokinetic profiles for the 125 μg formulation in the study by Kunka.

In this respect, a previous evaluation was made in healthy volunteers, where steady-state twice daily administration of HFA and CFC fluticasone propionate (250 μg formulations) were given in doses of 500, 1000 and 2000 μg daily,

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References