RESPIRATORY DISEASE

What’s the issue?

The main respiratory diseases and conditions are respiratory infections, asthma, influenza and pneumonia, pneumonitis (inflammation of the lung tissue which is not a specific disease but a sign of an underlying condition), bronchitis and emphysema, and other chronic obstructive pulmonary diseases (COPD).

Around 80% of lung cancer (see lung cancer section, www.hullpublichealth.org/jsna2017.html#56) and COPD (see the JSNA section on COPD, www.hullpublichealth.org/jsna2017.html#64) cases are directly attributable to smoking [99], and other lung conditions such as the common cold, asthma and influenza are made worse by smoking [99]. However, the health benefits are immediate after quitting smoking [110], with carbon monoxide levels in the blood drop to normal within 12 hours [271], circulation improves and lung function increases within 2-13 weeks [111], and coughing and shortness of breath decreases and start to regain lung function after 1-9 months [111].

In Hull for 2012-14, it is estimated that mortality from respiratory disease is responsible for around one-fifth of the life expectancy gap between Hull and England (19.6% for men and 29.0% for women). Over the three year period, there would be 169 fewer male and 234 fewer female deaths and life expectancy would increase by 0.53 and 0.73 years for males and females respectively if Hull experienced the same respiratory disease mortality rates as England [240].

What’s our situation?

There were 7,496 and 7,329 admissions for respiratory diseases for men and women respectively over the three year period 2008/09 to 2010/11 giving an annual average of 2,499 admissions of men and 2,443 admissions of women per year. The directly standardised admission rate was higher among men (188) compared to women (166) per 10,000 population [272].

In 2012-14 the under 75 directly standardised mortality rate (DSR) for all respiratory diseases was 65.7 per 100,000 men and 57.1 per 100,000 women, which was similar to the rate in 2001-03 (decrease of 6.3% for men and an increase of 6.4% for women). So there has been little change overall in the premature mortality rate over the last decade [82, 272]. Over the three year period, there were a total of 1,228 deaths (562 men and 666 women) in Hull due to respiratory disease, of which 341 (175 men and 166 women) were among those aged under 75 years [272], and 224 (110 men and 114 women) out of these 341 deaths were considered preventable [26, 77, 82, 272]. The under 75 DSR for respiratory disease considered preventable was more than twice as high in Hull as England for both men (42.1 versus 20.3 per 100,000 population) and women (41.7 versus 16.1 per 100,000 population). Since 2001-03, the premature preventable mortality rate had increased by 17% for men and by 49% for women in Hull compared to reductions of 16% and 6% for men and women in England respectively [26, 82, 272]. Given the prevalence of smoking in Hull, it is not surprising that the premature mortality rate for respiratory diseases is so much higher than for England, with almost half of respiratory disease deaths directly attributable to smoking, including almost 80% of COPD deaths [99].

For more detailed information, see the JSNA Toolkit: All Respiratory Disease report.

What are the strategic needs?

People should be aware that smoking can cause respiratory conditions such as COPD and make other respiratory conditions such as asthma worse. People should also be aware that stopping smoking has immediate health effects within lung function improving within a year. Not smoking should be seen as the norm, with the aim of creating a smoke free generation.

It is necessary to work together to ensure people understand the benefit of positive life choices and know how to access information and seek early support to change. In order to do this effectively,
health care providers need to work together with different communities to use existing assets to realise the benefit of positive life changes, and treating people as individuals.
People should attend their annual reviews (generally within primary care) for asthma and COPD so that they get the best on-going treatment for their condition.

References