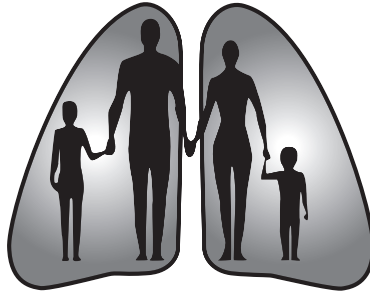
FPAGC NEWSLETTER



FPAGC

FAMILY PHYSICIAN AIRWAYS GROUP OF CANADA
l'Association canadienne des médecoms de famille contre l'asthme

Chairman's Report September 2002

The FPAGC continues its mandate to improve management of respiratory disorders in primary care. This is done by educational programs and our newsletter. The editorial staff hopes that you enjoy the newsletter and learn from it. We would love to hear from you with questions or issues that you would like to have answered. We will certainly attempt to publish your questions (named if you like) and the answers. We can be contacted through the website www.fpagc.com

There are currently two available Mainpro C programs; one in spirometry and one in asthma. Preparations are being done to assist in the formation of a Mainpro C program in COPD also. Let your executive know if you would like to get these programs in your locale; we'll try to come to you!

I had the occasion to represent Canada at the first annual International Primary Care Respiratory Group meeting in Amsterdam in June 2002. It was a compilation of primary care physicians from around the world with an interest in respiratory illness. I will report further in the issue on the meeting, but I wanted to bring up one issue that I feel was highlighted by the meeting. Primary care research is being done all over the world successfully. There is an excellent forum for it to be published in the Primary Care Respiratory Journal.

I would like to expand the mandate of the FPAGC to include research. If there are those of you with any interest in this, please let me know. There may be opportunities to have members assist you in patient recruitment for observational studies. There are pharmaceutical companies who are looking for interested Family Physicians to assist them in phase 3–4

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Chairmans Report (*Continued From Cover Page)*

studies. Please contact me through the website ("Ask us" section) if you have any interest or ideas with respect to research.

I look forward to continuing to strengthen the practice of primary care respiratory medicine in Canada.

Alan Kaplan MD CCFP(EM)
Chair, FPAGC

NOTICE

Annual Meeting FPAGC

The annual meeting of the FPAGC will be held in conjunction with the annual Scientific Assembly of the Ontario College of Family Physicians at the Marriott hotel in Toronto in November 2002.

If you would like to attend this meeting and meet some of the executive of the FPAGC please contact our chairperson Dr. Alan Kaplan or e-mail me at docrob@telusplanet.net. We would love to see you in Toronto!!

Rob Hauptman
Secretary Treasurer FPAGC

THE COPD AWARD

COPD is a major cause of death and disability throughout the world; being the sixth leading cause of death in the world, ranking fifth in Europe and fourth in the USA. Approximately 600 million people worldwide suffer currently from COPD. About 2.75 million deaths around the world are attributable to COPD. With all this, it is still underdiagnosed, with an estimate that only 25% of all COPD cases in Europe being properly diagnosed.

The IPCRG (International Primary Care Respiratory Group) works to improve respiratory care in general practice through research education and development in collaboration with others interested in respiratory care. In addition, the IPCRG aims to stimulate respiratory care research in primary care; improve international collaboration between respiratory groups and raise the awareness of respiratory issues worldwide. The IPCRG is an independent organization of Primary Care Physicians, which receives educational grants from several pharmaceutical companies. Canada, through the FPAGC, is one of the members of the IPCRG. Personally, I am an international board member of the IPCRG.

The COPD award values are to:

-reward, encourage, develop and share best practice management of COPD

-recognize high standards in prac tices – regardless of size or experience in COPD

-reward new initiatives which focus on management of patients with COPD

-share best practice as a valuable tool in improving our work in COPD

-heighten the awareness of COPD

Entries are encouraged from physicians working with COPD patients at the primary care level. A manuscript of 1000 words, in English, is to be submitted outlining their own best practice relating to COPD diagnosis, treatment or management. Implementation of the GOLD guidelines would be encouraged.

Include the following details in your submission

- Background information on your initiative, including details of your patient population
- Achievements in accurate and timely diagnosis of COPD
- Methods of COPD treatment and management
- Results of your initiative
- Demonstration of excellence in one or more areas of COPD management

You may also wish to add some of the following

- Any initiatives encouraging patients to present for consultation or treatment
- Involving patients in their own care – increasing patient compliance
- Any focus on improving patients' quality of life through successful treatment and management
- Staff and team development
- Future plans to implement best practice care

Three awards will be chosen by an international panel (no, I am not on it). Three winners will be invited to attend the 2003 European Respiratory Society meeting in Vienna, Austria.

The deadline for submissions is December 31, 2002.

The COPD Award is supported by Boehringer Ingelheim. For further information visit

www.boehringer-ingelheim.com

Alan Kaplan MD CCFP(EM)
Chair, FPAGC

Reduction in use of Antibiotics in Children

We all recognize the need to limit antibiotic usage to decrease the increasing levels of antibiotic resistance. This is especially true for children, and upper respiratory infections are a common culprit. As an example, antibiotics can often be held for 48 hours and patients reassessed to see if their otitis media has resolved or was likely viral.

The 'common cold' is a frequent reason for physician visits and still results in frequent antibiotic prescriptions. Patient and parent expectations are commonly the reason for this. I will review a paper that dealt with parent expectations and a method to decrease this problem in children.

Mangione-Smith R,et al. Parent expectations for antibiotics, physician-parent communication and satisfaction. Arch Pediatric Adolescent Medicine July 2001;155:800-6

These investigators studied

(1) how parents communicate their desire for antibiotics to physicians

(2) which parent communication behaviors make physicians feel pressured to prescribe antibiotics

(3) which physician communication behaviors enhance parental satisfaction with the visit

The results were quite interesting.

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Reduction in use of Antibiotics in Children *(Continued From Page 3)*

Fifty percent of the parents expected an antibiotic before the office visit; one percent actually made a verbal request to the physician. Physicians said they felt pressured 38% of the time. Parents of children who did not receive antibiotics for their children, but were given a contingency plan were much more likely to voice satisfaction with the office visit than those not given a contingency plan. This contingency plan offered the possibility of an antibiotic prescription if the child did not get better.

By giving parents of an ill child a contingency plan, we can improve the parent's satisfaction with the visit while reducing the use of antibiotics for viral URIs. This is an easy workable strategy that we can all use daily.

Alan Kaplan MD CCFP(EM)
Chair, FPAGC

Pediatric Asthma control;

are we looking for the right stuff?

Recent studies such as the Landmark Asthma in Canada study have shown recurrently that physicians over-estimate the level of control that their patients have over their Asthma. Are we sure that we are even looking at the correct parameters for control? The landmark study very reasonably looked at control with respect to the Canadian Guidelines. I would like to review some of the findings of the AIR Study (The Asthma Journal, 1999; 4(2);74-78). This study may show that we may not be asking the correct questions.

This study was a questionnaire study of 687 parents of asthmatics aged 0-14, 579 asthmatic children aged 9-14 and 1210 health care professionals (HCP) who treat asthma.

Initial results were very similar to the Landmark Study. 25% of patients received a reliever without a preventer. 60% of patients reported difficulty breathing at least once a month; dry cough, nocturnal awakenings, inability to talk. 29% suffered at least once weekly. HCP estimated 24% of patients had symptoms once monthly.

The major issues that I wanted to bring out from the paper are the impact of Asthma on activities. Half of children reported that they could not do everything those without asthma could (GPs estimated 41%). Specific issues were even less well correlated; 53% of kids estimated they had to avoid contact with animals cf. 25% of GPs.

HCPs tend to define 'health' with a medical model of an absence of symptoms or illness. Patients tend to focus on concepts of being able to look after themselves and measure their control in activity limitation. Perhaps the best question to ask our pediatric patients is **about their ability to take part in activities that they want to include in their daily lives** such as exercise and playing with friends.

Thus, in summary, a patient centered approach will include measures such as limitation of activities. This would encourage an even more effective therapeutic relationship.

Alan Kaplan MD CCFP(EM)
Chair, FPAGC

Vocal Cord Dysfunction

You just cannot figure out what is going on with the patient sitting in front of you. She has chronic cough, stridor, an abnormal voice, complaints of a tight chest and recurrent throat clearing. Her spirometry is normal, her methacholine challenge is normal. A Chest X Ray and CT scan of her chest and sinuses are normal. A trial of PPI for GERD has done nothing. A trial of inhaled steroids has not helped. It is intermittent with fairly abrupt onset and termination. What have you missed?

I guess this must just be nerves, right? Globus Hystericus? Well, here is another thought, a relatively new entity called vocal cord dysfunction (VCD). This syndrome refers to the inappropriate closure of the vocal cords. The closure occurs usually on inspiration and occasionally on expiration. It is restrictive enough to have patients complain of shortness of breath. This will mimic asthma, and just to make it really hard, is common in patients with a history of asthma.

Other terms include 'irritable larynx syndrome' and recurrent adult croup.

A structurally normal but functioning abnormal larynx characterizes VCD. It is seen in patients with asthma, GERD, psychologic concerns or highly achieving athletes. It can occur at any age but is seen predominantly in females.

Diagnosis is made by clinical history and examination, and subsequent ENT examination to rule out vocal cord nodules, cysts, tumors or lung tumors. Endoscopic evaluation of the function of the vocal cords is done by some interested ENT specialists.

Treatment is done by a team including the Otolaryngologist, respiratory therapist, speech therapist and other health care professionals as needed. The treatment focuses on substituting the appropriate vocal cord opening/relaxation during breathing.

Emergency department treatment of these patients can include sedatives such as Lorazepam to get relaxation of the vocal cords. Nebulized Lidocaine to anesthetize the cords or Heliox to bypass the 'obstruction' can also be of value.

So, there you are, something else for your differential diagnosis of cough!

Alan Kaplan MD CCFP(EM)
Chair, FPAGC

IPCRG report Amsterdam, June 2002

The International Primary Care Respiratory Group is a compilation of the primary care respiratory groups from many member companies. The first official meeting of this group was held in Amsterdam June 7-9, 2002. I had the pleasure of presenting at the conference on the issues of Asthma management, allergic rhinitis management and also taught a workshop on spirometry. The conference dealt with respiratory issues of Asthma, COPD, Allergic Rhinitis,

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IPCRG report *(Continued From Page 5)*

Infectious Diseases, Lung Function, Lung Cancer, Smoking Cessation, Organization of Care, Quality of Life measurements, and Tuberculosis. It was broken up into themes of clinical seminars, research symposia, and workshops.

Asthma

Delivery of care starts with the diagnosis by the physician. Diagnostic issues such as spirometry, peak flow, allergy testing, and clinical predictive values were discussed. The difficult diagnosis in pediatric asthma was discussed. While the initiation of therapy is done by the physician, it is often modified or reinforced by other health care professionals. In the UK, there are primary care nurses that work in the physician offices that often continue the patient's asthma care. They are specially trained in the management of Asthma, and in fact, many of them attended this conference. In Australia, there is a very strong presence of the National Asthma Society, which works in close relationship with the Family Physicians in providing support to the asthmatic patients.

In Canada there is the potential for similar relationships with Nurse Practitioners and lay organizations such as the Asthma Society and the Lung Association. Economic climates are of course different and will affect these relationships.

The reality of asthma care is disappointing everywhere. In Canada we have the Landmark Study which has shown that there continues to be significant morbidity from asthma and that physicians and patients overestimate the degree of control of the asthma. In UK, the Air Study (Asthma, June 1999; 4: 74-78) similar results were seen with physicians and practice nurses overestimating control and underestimating inhaled steroid use and short acting B2 use.The lack of control can be blamed on diagnostic insufficiency, lack of education for the health professional, lack of resources of the patient and lack of compliance.

The principle of early aggressive management of pediatric asthma was reviewed. A number of studies have shown that early aggressive treatment results in improved long term control; the theory being the prevention of long term remodeling. This must be balanced against the over-enthusiastic diagnosis of asthma in first time wheezers; the adage that all that wheezes is not asthma must be remembered.

Spirometry was dealt with in detail. As I mentioned, I did teach a workshop in spirometry. Basic skills were reviewed as well as indications and subsequent interpretation. I also chaired a symposium on research in spirometry which reviewed issues such as introduction of spirometry in a spirometry-naïve country (Spain), a look at reference values in Norway, a review of the reproducibility of results in a family practice setting vs. the pulmonary function laboratory in the Netherlands, and the use of handheld spirometers.

Allergy and Rhinitis

A clinical symposium on this integrated the new ARIA guidelines (Allergic Rhinitis in Asthma). I reviewed the diagnosis and investigation; including allergy testing, Immunocap (specific IgE)

testing, as well as investigational tools. Management with antihistamines, nasal steroids and antileukotrienes were reviewed. The role of allergy testing and immunotherapy was reviewed; there are only FIVE allergists in all of the UK!!

The future

The meeting was an overwhelming success with almost 400 participants from physicians from USA, UK, Scotland, Ireland, Netherlands, Sweden, Norway, Iceland, Bangladesh, Egypt, Saudi Arabia, Spain, Portugal, Greece, Cyprus, Denmark, Germany, Australia, New Zealand, and Belgium.

The IPCRG also hosts a website and produces a journal. The journal has been submitted to Medline and we are awaiting acceptance.

Melboune, Australia will host the next meeting in February 2004. The 2006 meeting will be in Norway, likely in Oslo.

I am quite sure that there would be interest in the IPCRG to having the conference in North America. As you see, the preponderance of members are European. This has to be decided at least four years in advance; Norway is planning its conference now after deciding earlier this year to apply for hosting the 2006 conference. The hosting of the conference is not a small job. I will review the budgetary issues with my Australian colleagues if there is interest in a Canadian meeting. So I ask you, our members, if I build it, will you come?

Alan Kaplan MD CCFP(EM)

Chairperson, FPAGC

International Board Member, IPCRG

Member Canadian National Asthma Task Force

Member, Ontario Asthma Steering Committee

Member, Environment Canada CFC Transition committee

Tuberculosis

This disease continues to come up and confound us. It is certainly not the first thing we think of when we see patients with cough, but it needs to be considered. The classic symptoms of weight loss, upper lobe pneumonia and hemoptysis are certainly not the rule.

Canada is a multicultural country; almost everyone, it seems, originally comes from somewhere else. As the period of time from the infection to the onset of disease can be very long (even as long as 80 years!), it may not enter the differential diagnosis unless we think of it. A recent Alberta study revealed that half of the cases of immigrant Tuberculosis occurred more than seven years after their arrival to Canada. The HIV population is especially at risk, of course.

Most Tuberculosis in Canada occurs in the foreign-born; the disease is 10 times more common in the foreign-born compared with Canadian-born individuals. There are significant differences in the two populations.

Foreign-born patients with TB have a higher proportion of extra-pulmonary TB than native born. The common sites include the lymph nodes (most common in the neck), bones, gastrointestinal system, genitourinary

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Tuberculosis *(Continued From Page 7)*

system and the brain. Drug resistant strains of TB are three times more likely in foreign born vs. native born. This requires the uses of more toxic, less effective, and therefore more complex treatment regimens.

Not all that coughs is asthma; remember to include TB in your differential diagnosis, especially those who are from countries with high prevalence of the disease.

Alan Kaplan MD CCFP(EM)
Chair, FPAGC

Cat Exposure Increases Asthma Risk for Children of Asthmatic Mothers

One of the more potent triggers for asthmatic airway inflammation is cat allergen. For many of us, we would advise not only our asthmatic patients to get rid of household cats but also advise our high risk patients to do the same. Recent studies however challenged this approach and in fact suggested that exposure to cat allergen during infancy can actually protect children against developing asthma!

Now comes a report out of the Lancet that adds another twist to this issue. A new study supported by the NIH confirmed the protective effect of cat exposure for at-risk children in all but one situation – when the child's mother has asthma!

Dr. Celedon and his colleagues in Boston followed 448 children with a family history of allergic diseases from birth to age five. What they found was that children with non-asthmatic mothers were 40 percent less likely to wheeze as compared to those with no cat exposure. In the group of children with asthmatic mothers however, those exposed to a cat were significantly more likely to wheeze as compared to those with no cat exposure. In fact, by the fifth year of exposure the risk of wheezing tripled!

With this new evidence we should be much more able to counsel our high-risk families who have pets. Clearly the family cat should not be removed unless the mother has a history of asthma.

J. C. Celedon et al. Exposure to cat allergen, maternal history of asthma, and wheezing in the first five years of life. The Lancet 360(9335): 781-82(2002).

Rob Hauptman
Secretary Treasurer FPAGC

Did You Know?

Drug benefit plans affect corticosteroid prescriptions in children with asthma.

A Manitoba study showed that the change in provincial drug benefit policy from a fixed deductible and co-payment plan to an income based deductible system reduced the use of inhaled corticosteroids in higher income children. The study by A. Kozyrskyj used address data to define the income of the patients. Severity of asthma was based on hospital visits, MD visits, and a number of prescriptions for asthma medications.

Comparison was made to non-Pharmacare children who received 100% coverage of the medications.

One-year prior to the change and two years after were compared. Lower income families filled fewer prescriptions before and after the change, as the out of pocket costs did not change much. The out of pocket cost to the higher income family was greater after the policy change, which resulted in children being denied anti-inflammatory therapy.

The additional system costs in terms of hospital admissions, return visits, as well as absenteeism from school, and possibly parents from work, need to be taken into account when considering a Pharmacare program.

AL Kozyrskyj, AC mustard, MS Cheang, FER Simons, Income-based drug benefit policy: impact on receipt of inhaled corticosteroid prescriptions by Manitoba children with asthma. CMAJ, OCT 2, 2001;;165(7).

Gord Dyck MD

Did You Know?

IM vs. PO to prevent relapse in acute asthma, either or is equivalent.

John Chan et al compared 12 mg IM Betamethasone to 50 mg PO Prednisone in acute exacerbations of asthma who were suitable for discharge from ER. The study was randomized and double blind placebo controlled.

Patients were contacted by phone at 7, and 21 days to determine relapse (unscheduled visit to MD for treatment of continuing or worsening symptoms). Peak flow and symptoms were also recorded.

The study was able to recruit 6% of all ER visits for asthma in the two hospitals used for 171 patients enrolled were more frequent ER attendees who had been on oral steroids previously.

No differences in all the measured parameters were found. There was a slight trend at 7 days for improvement in the IM group, which would take a larger study to confirm.

The IM route provides an option for asthma exacerbations that is safe and effective.

JS Chan, RL Cowie, GC Lazerenko, C Little S Scott, GT Ford. Comparison of intramuscular betamethasone and oral prednisone in the prevention of relapse of acute asthma. Can Respir J 2001;8(3):147-152.

Gord Dyck MD

UPCOMING CME
MAINPRO C ASTHMA PROGRAM

Do you need some extra Mainpro C credits? Are you interested in an exciting and informative program that is guaranteed to improve your skills in the assessment and management of patients with asthma? Are you in the Toronto area in November of this year?

The FPAGC is pleased to be offering their very successful Mainpro C asthma program as a preconference workshop at the annual Scientific Assembly of the Ontario College of Family Physicians. This program will be offered on Wednesday November 13th, 2002 at the Marriott hotel in Toronto. For more information on this exciting opportunity please contact the Ontario College of Family Physicians or Dr. Alan Kaplan Chairperson FPAGC.

Rob Hauptman
Secretary Treasurer FPAGC

**Have you visited
our website yet?**

For more information

on the FPAGC and CME opportunities

**visit us on-line at
www.fpagc.com**

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MISSION STATEMENT

The Family Physicians Airways Group of Canada is committed to helping those with airway diseases lead a full life. The group is dedicated to helping all family physicians maintain and increase their skill in assisting those with asthma and COPD. The strategy of the Group is to maintain a speaker bank, a data base, and practical tools to help physicians attain these skills.

"A group of family physicians with a special interest in asthma."

DÉCLARATION DE PRINCIPES.

L'Association canadienne des médecins de famille contre l'asthme. Un groupe de médecins de famille ayant un intérêt particulier pour le traitement de l'asthme. Les members de l'Association canadienne des médecins de famille contre l'asthme s'engagent à aider les personnes atteintes d'asthme à jour pleinement de leur vie. L'Association veut aider tous les médecins de famille à entretenir et améliorer leurs connaissances dans le traitement de L'asthme. L'Association se propose de maintenir une liste de conférenciers et une banque de références, et colliger des informations practiques pour permettre aux médecins d'accquérir ces connaissances.

The opinions expressed in this newsletter are those of the authors, and not necessaritly those of the Family Physician Airway Group of Canada.

Website www.fpagc.com