



## FPAGC

FAMILY PHYSICIAN ASTHMA GROUP OF CANADA  
l'Association canadienne des médecins de famille contre l'asthme

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### Chairman's Report

**T**he Family Physician Asthma Group of Canada has had another busy season.

Representation for Family Physicians continues on the Canadian National Asthma Control Task Force (NACTF), CNAC (Canadian Network for Asthma Care), the Canadian Asthma Guidelines Implementation committee, and the newly formed International Primary Care Respiratory Group

We have a few new members of the Executive, Dr. John Li, of Moncton, New Brunswick, Dr. John Rea of Huntsville, Ontario, and Dr. Gordon Dyck of Steinbach, Manitoba. Dr. Alain Couet has been appointed the new representative to the Task Force in addition to myself.

We are continuing our mandate of educational initiatives. The Mainpro C accredited Asthma Workshop continues to run across Canada and has received rave reviews. Dr. Josiah Lowry, who is well known for his manual on interpretation of Spirometry, teamed up with myself and Boehringer Ingelheim to create a Mainpro C accredited workshop on Spirometry. We are only too delighted to run these educational events in your venues. Please contact me if you are interested in having one! We will be running the Spirometry Workshop at the combined OCFP/CCFP Family Medicine Forum 2000 in Ottawa this October.

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# Asthma Guidelines Implementation Committee Update

There has been two of four, mailings in total to 11,000 physicians across the country. The physicians targeted were family physicians, respirologists, and allergists. A personally addressed letter by one of seven key opinion leaders across the country was sent. The first letter was regarding objective measures and diagnoses. It was accompanied by a leave-behind piece that in this part was a mousepad with a pictorial overview of the guidelines. The second mailing should have reached you before this newsletter. It will deal with inhaled corticosteroids. The leave-behind piece will be a pocket slide rule which outlines adult peak flows. There will be two more letters on the other key issues of the guidelines, which are additional therapies and educational

and environmental control. There will be telephone follow up done by the guidelines implementation committee.

The guidelines and educational materials regarding them can be found at [www.AsthmaGuidelines.com](http://www.AsthmaGuidelines.com). Please visit the site and download anything you feel might be helpful. As of June 30, 2000, there were over 6000 hits to the site. Let em know if I can clarify anything for anyone.

The guidelines have been disseminated through the CMAJ as well as other paramedical journals such as a Nursing journal. The last part of the guidelines roll out is the public phase. The focus will be on Asthma Control. There will be public campaigns with media, infomercials and others.

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### Chairman's Report...

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Some good things have to come to an end. Dr. Mervyn Dean, who is one of the founders of the FPAGC, has been a Chair of our group, and the editor of our newsletter since its inception is resigning from our Executive as he is undergoing a career change. We will miss his expertise, his ability to keep us focused on issues, and his wit. He has helped me with my articles for years and has been the true "editor". Forgive me if I have a few too many run on sentences now that he is no longer checking up on me! He is a very important person to me and I am glad that I am only losing an editor and not a friend. Good luck!!

**Dr. Alan Kaplan**  
Chairman

# Canadian National Asthma Task Force Update

We have done a lot of work done including the completion of the Asthma Report, the National Asthma Prevention and Control Strategy, and indicators regarding further asthma surveillance.

**Asthma report:** This is a 140-page background document to the next report.

**National Asthma Prevention and Control Strategy:** This report outlines the current state of Asthma management in Canada and outlines future strategies in strategies to prevent, manage, and measure outcomes for our future asthma management.

Both of these reports will be distributed to the Department of Health. These reports are available if requested. With these we have developed indicators for Health Canada under the new name of "Centre for Chronic Disease prevention" Dr. Paula Stewart, who works for Health Canada, will be bringing these issues to the government to attempt to increase the awareness of respiratory disease which is relatively underfunded. These will be measured through population surveys, hospital statistics, billing statistics, and others. A presentation will be given to the provincial ministers meeting to try to initiate provincial plans which are all equi-efficacious

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## GINA (Global Initiative In Asthma Care)

You will be hearing more about this over the next while, so I thought I would explain what GINA is. In the UK, the use of decision support software and asthma audit materials has been linked to improvement in patient outcomes. GINA is a pilot project to assess the viability of the process to health professionals from throughout the world. Clinicians from various countries interested in improving asthma management have agreed to pilot the materials.

As of now, there are no pilots in Canada. The service offered to general practitioners provides for a patient sample randomly selected from the practice asthma register (this is not something most Canadian GPs have). A service incorporating a full repertoire of materials, will be developed and displayed on an Internet website. If there are those of you interested, E-mail me and I can hook you up with those more in the know about this.

# **Leukotriene Receptor Antagonists in clinical practice**

## *Review of Leukotriene 'Modifiers'*

by Alan Kaplan MD CCFP(EM)

I was asked to write a review article of the new class of drug for Asthma management, the Leukotriene Modifiers. This is a personal area of interest of mine and I was delighted to oblige.

In 1938 Kellaway and Feldberg discovered that challenging an animal lung with Cobra venom liberated a substance which caused sustained contraction of smooth muscle. Histamine causes a "rapid and twitch" contraction, the new substance caused a

longer more sustained contraction, hence the name Slow Reacting Substance. Upon evidence by Brocklehurst of the generation of this substance in the allergic challenge of human lung tissue, it was renamed the Slow Reacting Substance of Anaphylaxis.

OK! Enough history! Now for Biochemistry! Arachidonic Acid is metabolized by Cyclooxygenase to Prostaglandins and Thromboxane or by 5-Lipoxygenase to Leukotrienes (the

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new name for SRS-A). Without too much detail, Leukotrienes have been shown to be chemicals which are potent bronchoconstrictors (1000 times more so than Histamine). In the lung they cause microvascular leakage, edema, and enhanced mucus secretion. For more details of these issues, please refer to Dr. Anthony D'Urzo's excellent introductory article in the FPAGC newsletter No.11.

There are currently three Leukotriene modifiers. Zileuton is a 5-Lipoxygenase inhibitor. It is a potent Asthma therapy, but will never be released in Canada as it has been associated with elevated liver transaminases. We do have in Canada two medications which block the Leukotriene Receptors. Zeneca led the way with Accolate and Merck Frosst followed with Singulair.

We have lots of studies showing both of these drugs efficacies. They have been proven to improve FEV1 compared with placebo. They have been proven to improve FEV1 when added to steroid therapy. They have been proven to inhibit bronchoconstriction induced by cold, dry air, exercise and aspirin induced asthma.

One of the challenges we faced at the Canadian Consensus guidelines update meeting in May 1998 was where exactly to place these medications in the Asthma therapy armamentarium. There was great debate then, and there is. The following are my feel-

ings about potential uses for these medicines with my justifications and or potential concerns regarding them.

### **I) Mild Asthma as Monotherapy**

The potential of an oral treatment for first line therapy is very tempting. Compliance has shown to be excellent with these medications, whereas this is not the case with inhalers. We also have the ability to use another non-Chlorinated Fluorocarbon (CFC) product for Asthma management (See FPAGC Newsletter No. 12).

There are excellent studies showing FEV1 improvement with no tolerance developing BUT:

We have no long term studies to tell us that LTRAs (Leukotriene Receptor Antagonists) will affect the long term prognosis of Asthma. Proper, aggressive management with Steroids have been demonstrated to affect the Asthma condition at the cellular level with reversal/prevention of basement membrane thickening. It would be easy to use these medications first line, but I think longer term studies/experience will be needed to confirm if this is the correct route to go.

### **II) Addition to inhaled steroids to improve control**

Both companies have studies to prove this.

*Continued >*

## Leukotriene Receptor Antagonists...

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### III) Addition to steroids to allow steroid tapering

This has been successfully done and studied. It has done so well, in fact, that it has allowed some people to wean off oral steroids completely, which has unmasked a new disease called Churge Strauss syndrome. This is an Eosinophilic vasculitis which occurs in some patients when their Asthma is so much better that they can withdraw from their po steroids. This condition is exceedingly rare and is readily steroid responsive.

### IV) Exercise induced Asthma

Obviously this is not the fifteen minute pre-exercise situation, but could be useful the night before a full day ,for example, on the ski slope.

### V) Compliance issues

This has been discussed above. Technique issues are also a potential advantage here.

### VI) Allergic Rhinitis

The studies are coming, but there us good anecdotal evidence that these medications are of benefit to your asthmatic with allergic rhinitis as well.

### VII) Aspirin Induced Asthma

People with the classic Asthma Triad of Asthma, Nasal Polyps and Aspirin Allergy are felt to have extremely high levels of a prostaglandin which inhibits Leukotrienes.

Therefore, when Cyclooxygenase is inhibited by Aspirin, the inhibitory prostaglandins are not produced allowing the Leukotrienes to proliferate. Leukotriene receptor antagonists have been shown to be of particular benefit in this subset of asthmatics. I personally feel that all Aspirin Allergic Asthmatics should have at least a trial of one these medications.

You are now all excited about the first new class of Asthma drug in many years.

Which patients should you try them on? First of all, recognize that these medications probably will only work in 75-80 % of your patients. I feel (sorry, no evidence here) that these work well in patients with true eosinophilic bronchitis. Dr. Hargreave's work on induced sputum analysis may have a role here in predicting which patients will respond, in the meantime, allergic asthmatics deserve a trial.

Which one do you use? I will list the pros and cons of each medication. Singulair is approved in children down

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to four years old. (I have used even younger with excellent results) Accolate is approved down to 12 years old. Accolate is a twice daily drug, Singulair is designed once daily at bedtime. Accolate must be given on an empty stomach, Singulair has no such restriction. There are potential drug interactions with Accolate and Aspirin, Coumadin (raising the INR), Theophylline and Macrolide antibiotics. Cytochrome P450 metabolism may also be an issue here.

A side effect that has been much discussed is that of the Churge-Strauss syndrome. This is an eosinophilic vasculitis that occurred when people were removed from systemic steroids as their asthma got better with the LTRAs. It was initially thought to be a side effect of the LTRAs but has been recognized now as a condition that is unmasked by the removal of the systemic steroids, and also reported with Long Acting B2 agonists. I consider it a PLUS! Imagine all these patients being so improved with the LTRA that they are able to come off their Prednisone!!

Both have very few side effects with discontinuation rates as good as or better than placebo. Accolate is approximately 40% cheaper than the adult dose of Singulair. Singulair is dosed at 10 mg. qhs for adults and 5 mg. qhs for children. Accolate is dosed at 20 mg. BID. There is no dose response curve above 10 mg for Singulair. There may well be further improvement with increasing Accolate dosage. The chil-

drén's formulation of Singulair is a chewable cherry tasting tablet. In a patriotic vein, I should add that Singulair is a product discovered and developed entirely in Canada.

I look forward to our asthmatic patients having even more choices for treatment in the future, in the meantime here are some new ones to try!

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## CNAC Update

We also are represented on CNAC (Canadian Network for Asthma Care). CNAC has developed a certification exam for Asthma Educators, which has now been taken by hundreds of educators. There have been two sittings of the Certification Exam. The success rate was 87% in the first sitting and 88% in the second. The exam can be taken in French. The cost of the exam will now be \$300. This has now been recognized in the industry as the gold standard of Asthma education.

A recurrent question has been how Physicians can become eligible to write the CAE (certified asthma educator) exam. One must fulfil the criteria of a regional asthma education program of which there are currently six approved by CNAC. **If there were sufficient interest from physicians, a program like this could be developed by the FPAGC.**

The material that is required to be covered by the regional programs and is the content for the exam is being continually updated. The new Asthma Guidelines and new issues in behavioral learning require ongoing redefinition. It was previously called the Pre-study module. Now the module and the prestudy learning objectives have been combined to make a 280 page 'Asthma Educators Guide'. It is copyrighted to CNAC. It is tabbed and very user friendly. Each section is linked to learning objectives with pre

and post-test questions. It defines the minimum Asthma knowledge required to be an effective asthma educator.

ASED 5. This conference will occur in Toronto from November 29 to December 1, 2001 at the Sheraton Centre. Guest rooms will be at the special conference rate of \$149 s/d plus taxes and will apply for three days prior and three days after the convention dates (cut off date Oct. 29,2001). There will be a lot of interactive workshops at this meeting. It will be a very good conference for physicians who treat patients with asthma to attend.

PATIC Patient's Access to Treatment Initiative Committee. CNAC recognizes that there are barriers to patients receiving adequate medical care for their Asthma. There is a strategic plan to attempt to improve access to optimal pharmacotherapy, education, diagnostics and devices. As patient advocates, we must support these attempts to educate our government on decisions that may require looking at evidence-based medicine (such as our new guidelines) and not just the cost aspect!

A letter has been sent to the Health Minister by the Guidelines committee to try to optimize coverage of recent breakthrough medications for Asthma management.

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The Study of Asthma in Canada "A Landmark survey" is a GlaxoWellcome sponsored study on patient and physician perspectives of asthma care. The results were very interesting as to the disparity between perceived asthma control between physicians and patients. If you have not received a copy or would like an additional one, please contact your GlaxoWellcome representative or let me know and I will do that for you centrally.

GP's in Asthma Group (Great Britain) International Primary Care Respiratory Conference, Setting the Agenda for the New Century, June 9-11, 2000

I was fortunate to be the Canadian representative to this conference. It was an interesting conference that brought together Family Physicians from all over the world; Australia, New Zealand, Sweden, Norway, Denmark, Portugal, England, Scotland, Ireland, and Holland. I gave a talk there about Health Care in Canada.

The conference was very well organized. There were a number of main themes, some running concordantly. These included Allergy and Rhinitis, Organization of Care, COPD, International Perspectives, Respiratory Infections, prevention, research, and medication use (such as ICS in COPD and B2 use past, present, and future).

I attended the GPIAG annual general meeting as well. They currently have 870 members. They have two

members who will be Professors of Primary Care Respiratory Medicine which are University appointments; Dr. David Price, the recent chair of the GPIAG and Dr. Ron Neville. They have a much larger budget and are more involved in health policy and research than we (at the FPAGC) are.

One of the goals of the conference was to bring together international primary care physician leaders and to develop an ongoing relationship. To this end, the **International Primary Care Respiratory Group** was formed. Dr. Price reflected on how the conference had created and built momentum in the primary care respiratory arena and highlighted the excellent research and education work being carried out by the numerous primary care organizations. Positive international collaborative activities would continue the enthusiasm generated by the conference and drive it forward. It was agreed that we would continue the success of the GPIAG conference with a biannual conference, next in Europe. It will likely be the Netherlands in 2002 and Australia in 2004. The chairperson of this group will be from the country hosting the conference with the vice-chairman being from the country hosting the following international conference on a rotational basis. The conferences may be held in association with other meetings in the future. . When I know more about dates, I will let you know, as these will be outstanding respiratory care conferences to attend.

# Asthma Educational Initiatives of the Family Physician Asthma Group Of Canada

One of the mandates of the Family Physician Asthma Group of Canada is to educate family physicians on asthma. I would like to make the membership aware of current initiatives in this area.

Currently the Family Physician Asthma Group of Canada offers two MainPro-C programs in respiratory medicine. The first is a MainPro-C workshop on asthma. The second is a MainPro-C program on spirometry. Both of these programs have been well received by family physicians. They also offer participants a much coveted MainPro-C credit that is required by the College of Family Physicians.

The Family Physician Asthma Group of Canada also offers a website, which has posted relevant current asthma articles, as well as upcoming meetings. This website can be accessed at <http://www.newcomm.net/fpagc>.

The executive of the Family Physician Asthma Group of Canada also offers their services as speakers on asthma and other respiratory issues.

For any further information regarding these educational initiatives, please feel free to contact Dr. Alan Kaplan at (905)883-1100 or myself at (780) 458-1234.

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## What to do?

I am sure that many of you have had the experience of having a child in your office or ER who refuses to take Prednisone due to the taste. PediaPred is a cherry tasting liquid which has been a great benefit, but some kids still find it bitter and others throw it up. Well, here is an alternative. A study from Hawaii, reported in *Journal of Pediatrics* 2000;136:298-303, described a study of children from six months to seven years old. They were randomized into two groups. The first group were given Prednisone 2 mg/kg daily for five days. The second group was given a single IM injection of Dexamethasone 1.7 mg/kg.

There were no significant differences in any outcome measure, other than perhaps parental satisfaction in not having to fight to get the children to take the Prednisone in the injection group. This was a small study of only 32 children, which is a bit small. I also have the small concern regarding the five days of Prednisone use. This time frame is not universal and the duration of Prednisone should be individualized per each person's attack. Many of the specialists at the Consensus Guidelines meeting felt two weeks was the optimal duration! However, this gives you some more artillery for your armamentarium.

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## EDITOR'S NOTE

The current edition of the Family Physician Asthma Group of Canada Newsletter is our first newsletter for the year 2000 and marks my debut as editor for the newsletter. It has been a slow transition to get this current newsletter to printing and distribution and I personally apologize for the delay. It is my hope that this newsletter will continue to be published at least three to four times a year to keep Family Physician Asthma Group of Canada members aware of current developments in asthma, as well as other asthma initiatives.

I want to thank my predecessor, Dr. Mervyn Dean, for his assistance and information in preparing this newsletter. As editor for this newsletter, his shoes will be hard to fill. Nevertheless, I will strive to do so.

I would like to remind members that articles for the newsletter are graciously welcomed. Any contributions to this newsletter can be faxed to me at (780) 460-7941.

### **Dr. Robert Hauptman**

Secretary/Treasurer

Editor, FPAGC Newsletter

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# APPLICATION FOR MEMBERSHIP

If you are interested in a Membership to Family Physician Asthma Group of Canada  
please complete this form and mail to:

Family Physician Asthma Group of Canada  
25 St. Michael Street, St. Albert, AB T8N 1C7

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Special Interest:

(e.g. lecturing, research, writing, others)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## AFFILIATIONS:

University: \_\_\_\_\_

Hospitals: \_\_\_\_\_

Lung Association: \_\_\_\_\_

College of Family Physicians: \_\_\_\_\_

Other: \_\_\_\_\_

## MISSION STATEMENT

The Family Physician Asthma Group of Canada is committed to helping those with asthma lead a full life. The group is dedicated to helping all family physicians maintain and increase their skill in assisting those with asthma. 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 membres 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 de colliger des informations pratiques pour permettre aux médecins d'acquérir ces connaissances.

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

