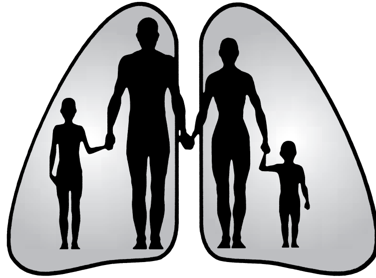
FPAGC NEWSLETTER



FPAGC

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

Chairman's Report

We have a new name!

In recognition of the fact that many of us have been very involved in the many facets of Respiratory care, we wanted to adjust our name to show what we do. We have paralleled our British colleagues who have made a similar change. Treating asthma definitely overlaps into the management of COPD, rhinitis, respiratory infections and other airway disorders. We are now the Family Physician **Airways** Group of Canada. We continue representation on CNAC, NACTF, IPCRG, Asthma Guidelines Group, and now also have representation in the COPD Alliance, and the PAACT (Program for Appropriate Antibiotic Therapy in the Community).

Some educational initiatives will include the running of a spirometry workshop at the Manitoba College meeting in April 2001, and another workshop at the Canadian College meeting in Vancouver in October 2001. Dr. Lowry and I have also been invited to teach a spirometry workshop at the American Academy of Family Physicians in Georgia in October 2001. ASED 5 will be held in Toronto in November 2001. If we can help you with a local educational initiative, please let us know!

Our website is now in the capable hands of Dr. David Cheah of Thornhill, Ontario. Our address is the same www.newcomm.net/fpagc . There has been a transition period, and if any of you have had difficulty with the site, we will

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Nasal Polyps, a review

In keeping with the change of our group to becoming the Family Physician **Airways** Group of Canada, I thought that this would be a good time to review a common medical disorder, nasal polyposis. This disorder affects about one percent of our population[1], with a male:female ratio of 1.5-2:1. Patients are typically between 30 and 50 years old, and are uncommon in those under 20. In fact, nasal polyps in a child must raise the suspicion of cystic fibrosis, as 30% of all nasal polyps in children are associated with cystic fibrosis[2].

Also, there is the well known triad of ASA sensitivity, nasal polyps and asthma which have been described in 2-28% of individuals with asthma. In this population it is not uncommon to also be sensitive to NSAIDs and tartrazine (yellow food dye).

The etiology of nasal polyps is not clear. Allergy, infection, trauma, chemicals, metabolic diseases (eg. diabetes), immunologic mechanisms and vasomotor instability have all been implicated. IgE mediated reactions are thought to play an important role, but allergic diseases are no more common in polyp patients than in the normal population 3. NARES, non-allergic rhinitis with eosinophilia syndrome, refers to patients with allergic rhinitis and abundant eosinophils in the nasal mucosa. These patients have negative skin tests and no identifiable IgE mediated hypersensitivity. These patients often get polyps that are quite recalcitrant to treatment.[4]

The most common complaints are nasal airway obstruction, hyposmia, anosmia (complete lack of smell),nasal discharge, post nasal drip, itchiness and sneezing.

Unilateral obstruction can occur due to asymmetric polyposis, but consider neoplasia in these patient as well as those presenting with epistaxis. Pain is unusual unless associated with a complication such as sinusitis. Ask your patient regarding the use of over the counter medications as

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Chairman's Report...

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have all the 'kinks' worked out real soon. Also please note, my Email address is changed to FOR4KIDS@sympatico.ca if you want to get hold of me.

We hope to have a link to the FPAGC Asthma Action Plan 'site' also real soon. Check out the site over the next number of months, and please download and utilize our action plan. Feel free to personalize it also.

Have a great end of the winter (hopefully soon!) and spring,

Dr. Alan Kaplan
Chairman

abuse of topical decongestants can lead to tachyphylaxis ('rhinitis medicanosum') another difficult to treat entity.

Polyps usually arise from the ethmoid sinuses or the mucosa of the turbinates and are most commonly seen in the upper lateral nasal wall. They are usually multiple, soft, movable, usually not tender, and do not bleed easily. They can grow to fill the entire nasal vestibule and may deform the internal architecture of the nasal cavity. Look in the nose with a rhinoscope, or if you can't find it in your office, use a standard otoscope and a large ear speculum.

Differential diagnoses include cystic fibrosis, antrochoanal polyp, juvenile nasopharyngeal angiofibroma, inverting papilloma, encephalocoeles, and carcinoma/sarcoma.

Not much is required for investigation. Allergy testing can be useful. Nasal smears for eosinophils are not usually helpful, although a predominance of neutrophils would suggest infection. Coronal CT Scans are useful for sinusitis and for planning surgical procedures. They also can demonstrate bony anatomy; bony expansion usually is caused by malignant neoplasms and not polyps.

Management.

If the polyp is unilateral or otherwise suspicious, then ruling out neoplasia is your first step. If bilateral, then allergy assessment is usually warranted. In children, please rule out Cystic Fibrosis. A medical trial of dietary changes, desensitization, antihistamines, antibiotics, decongestants, and topical corticosteroids are your next steps. A salicylate and tartrazine free diet has been helpful in some patients, but is difficult to follow. Treatment of sinus infections with appropriate antibiotics, topical steroids and topical decongestants (make sure less than 5-10 days to prevent rhinitis medicanosum). Topical corticosteroids must reach the tissue to be effective; therefore, combination with decongestants is often useful. Warn your patients that it may take several weeks for improvement to occur.

For treatment failures, or for those with complications, surgery may be the answer. The polyps can be excised, cauterized, frozen or shaved off. Aggressive medical therapy must follow to ensure success. Functional Endoscopic Surgery(FESS) techniques have emerged as the preferred method of sinus drainage as they are least disruptive to normal sinus physiology.

For those waiting for, or declining surgery, a trial of systemic steroids is an attractive option. Short courses of less than two weeks can be used several times a year with reasonable safety and good effect. A typical course would be of Prednisone starting at 40-60 mg. per day tapering over two weeks. Make sure to start a topical steroid at the same time.[4]

Nasal polyps are common and an interesting condition to treat. We can help our patients, often asthmatic, with these and improve a lot of their morbidity.

Reference:

1 Busuttil A, Chandrachud H, Kerr AIG, et al: Simple nasal polyps and allergic manifestations. Journal of Laryngologyand Otology 1978; 92: 477-88

2 Schramm VL Jr., Effron MZ: Nasal Polyps in Children. Laryngoscope 1980: 90: 1488-95

3 Drake-Lee A, Lowe D, Swanton A, et al: Clincial Profile and recurrence of nasal polyps. Journal of Laryngology and Otology 1984: 98: 783-93

4 Wong D, Witterick I, Hawke M, Dealing with your patients nasal polyps. The Canadian Jopurnal of Diagnosis 1996: 13: 60-72

AK

Coroners Inquest.

The death of a Toronto teenager this last year highlighted some deficiencies in asthma management. These were highlighted in a coroner's report. There were a number of recommendations made; I will copy those of direct relevance to physicians.

Coroner's Inquest Recommendations (Joshua Fleuelling) Asthma Treatment and Management (Includes Prevention) November 2000

1. Physicians should advise all asthma patients that untreated, or improperly managed asthma can be life threatening.
2. Physicians should be trained to recognize the increased risk of death in asthma patients who have presented to hospital Emergency Departments for breathing problems, or have been hospitalized due to a poorly controlled disease. Long-term asthma management requires patient education, knowledge of environmental control and irritants, and the proper usage of medications.
3. Physicians should prepare in consultation with their patients a "self management action plan" in writing which details the appropriate use of medicine, a list of potential environmental irritants, and steps to be taken by the patients in the event breathing problems arise.
4. A generic "self management action plan" form should be developed by the College of Family Physicians to assist physicians and patients in the preparation of the action plan.
5. Hospitals should have asthma management educational materials readily available for any patient who presents to an Emergency Department with breathing difficulties due to asthma, in order that it may be brought to the attention of the patient prior to discharge that his/her illness is potentially life threatening if improperly controlled.
6. Hospitals should develop a protocol requiring notification to physicians that an asthma patient in their care has presented to an Emergency Department and has received treatment, as well as a prescription of medication, but who was not admitted for hospitalization, where a consent for notification has been obtained from the patient.

There are some very relevant recommendations that will occur due to this and they will and should impact on the medical care of asthma. Some of you may be approached to create a "hospital discharge asthma instruction sheet" as these recommendations are also being sent to hospitals. I am currently working with the asthma society on one of these, and hopefully these will be finished in the near future. E mail me through the website at *www.newcomm.net/fpagc/* if you are looking for this information.

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In addition, these recommendations make it perfectly clear that you need to tell your asthmatics that Asthma is a life threatening illness. Some would call this fear-mongering, BUT: There are a number of good studies that show that deaths in asthma happen to people categorized as mild-moderate asthmatics, and NOT just the severe asthmatics.

Lastly, the recommendations clearly state that all asthmatics need to have a written Asthma Action Plan. As many of you know, we are working on the final stages of a colored Asthma Action Plan, which we hope to have available to download from our website.

All clouds have a silver lining. Let us insure that the tragic death of this young man is used to improve the asthma management of all the people in this country!

AK

Practice Points: COPD vs. Asthma

Very often in clinical practice, clinicians are called upon to distinguish between COPD and asthma in patients with recurrent or ongoing respiratory symptoms. Distinguishing between these two entities can be challenging especially in patients who smoke. In clinical practice I find family physicians usually rely on the standard history and physical to distinguish between these two conditions. Unfortunately, this commonly leads to misdiagnosis and often the overdiagnosis of COPD especially in smokers (one needs to keep in mind that only about 10-20% of smokers will go on to develop COPD).

I have found that to improve my diagnostic accuracy, objective testing of airway obstruction using spirometry is invaluable. Spirometry as a diagnostic tool is now widely available in most communities, and also through many family practitioners' offices. By objectively testing airway function one can definitively know if a patient has COPD. NORMAL SPIROMETRY RULES OUT COPD. Spirometry that demonstrates airway obstruction may indicate asthma or COPD. The demonstration of reversibility of the airway obstruction either with a B2-agonist or with a course of either systemic or topical steroids is diagnostic of asthma. Irreversible airway obstruction is diagnostic of COPD.

An excellent resource for family physicians that are interested about learning more about spirometry is the book, "A Guide to Spirometry for Primary Care Physicians" by Dr. Josiah Lowry. This excellent resource is a concise yet brief review of spirometry, which will give you the confidence to use and interpret this diagnostic test. Copies can be obtained for free from your local Boehringer Ingelheim pharmaceutical representative.

Rob Hauptman MD
Secretary Treasurer FPAGC

Chronic Cough: Sorting out the Causes

Chronic cough is a frequent presenting complaint to family practitioners. Unfortunately, very little time is given to this topic in medical training. As a result many clinicians approach this problem with some degree of trepidation. The fact remains however that sorting out a chronic cough in the majority of patients is not as difficult as it seems. In this article I will attempt to outline a simplified approach to this common problem.

Not to suprisingly, I have found that the most important tool in sorting out the cause of a chronic cough is a thorough history. This history should focus primarily on the character of the cough. For example, is the cough worse at night or during the day, what does the cough sound like, and what makes the cough worse? Between the ages of 3 and 65 years of age, 90% of chronic coughs are either due to asthma, post-natal drip, or GERD. These entities can clearly be sorted out by focusing on the character of the cough (Table1).

If from history the cause of a chronic cough fits nicely into one of the above categories, I personally feel a trial of the appropriate treatment outlined would be reasonable. If investigations are deemed necessary the most important tests to consider would be a CXR, sinus Xray, upper GI series, and/or spirometry. Optional tests would include allergy skin tests and peak expiratory flow monitoring.

Referral to a specialist should be considered for the very young or the very old, especially when the history is not all that clear or the patient is not responding to interventions. Bronchoscopy may be necessary in these cases to sort out the cause of the ongoing cough.

In summary, I feel that the majority of chronic coughs that present to a family physicians office can be easily sorted out and managed by taking a thorough history. By focusing on the character of the cough the cause of the cough should be apparent in most cases.

Robert Hauptman MD
Secretary Treasurer FPAGC

Character of Cough	**ASTHMA**	**POST-NATAL DRIP**	**GERD**
Type of Cough	Dry, nonproductive, hacky, croupy.	Wet, productive, phlegmy, clearing throat.	Often dry but may be productive. Tickle in throat
Triggers	Environmental, allergens, exercise, smoke.	Environmental, allergens, exercise, smoke.	Meals.
Time of Day	Worse between 0200-0400hrs in the morning.	Worse as the day goes on. Worse when lying down to go to bed at night and first thing in the AM.	Worse after eating large meals and when lying down to go to bed.
Associated features	History of atopy.	History of atopy or recurrent sinusitis.	History of obesity or recent weight gain
Treatment	B2-agonist or inhaled steroids.	Nasal steroids or antihistamines. Antibiotics if associated sinusitis.	Proton pump inhibitors.

Mouse Allergen and Asthma

The list of culprits that contribute to asthma has a new member: mouse allergen. Highly prevalent in inner-city homes, mouse allergen exposure contributes to increasing sensitivity in children, according to two studies in the December issue of *Journal of Allergy and Clinical Immunology.*

One study showed that mice turned out to be even more important in inner-city asthma than cats, dogs, or dust mites. While cockroach is the most important inner-city allergen, mouse is second in line.

The researchers examined house dust samples from 608 inner-city homes and discovered that the mouse allergen is widely distributed. Overall, 95% of the homes had detectable mouse allergen. Particularly high mouse allergen levels were also associated with another inner-city asthma offender, cockroach infestation.

The second study showed that in their study there were significantly positive mouse sensitization rate (23% overall), especially in atopics (53%). It did NOT show a statistically significant link between mouse hypersensitivity and severity of asthma.

More studies are needed to see if these results can be extrapolated to other housing environments, but the treatment, eradication of mice, is likely a desirable outcome irregardless. So, those of you that work in inner cities, beware of mice!

AK

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APPLICATION FOR MEMBERSHIP

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

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

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FULL ADDRESS (NO., STREET, APT., SUITE)

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CITY PROVINCE POSTAL CODE

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Fax ______________________________

Special Interest:
(e.g. lecturing, research, writing, others)

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College of Family Physicians: ______________________________

Other: ______________________________

MISSION STATEMENT

The Family Physician Airways 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 Airways Group of Canada.