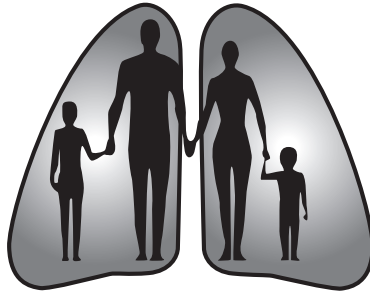


FPAGC NEWSLETTER



FPAGC

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

Chairman's Report April 2003

I have had a number of people contact me to ask clinical questions and to enquire regarding upcoming CMEs. I would like to thank you for your interest; I welcome the opportunity to help. The website has all of the events that we currently know about, but we are always planning others. In addition, we are willing to try to come to you; so let us know if there is a group of you needing help.

I have included a response to one question that I was asked and may continue to do so if the feedback is positive. Keep on asking! I can be reached at FOR4KIDS@sympatico.ca You can review past issues of the newsletter all the way back to the group's inception on line at www.fpagc.com

We are exploring partnerships to create a yearly FPAGC educational event in conjunction with another respiratory disease meeting, more to come. We do know that some of you still need Mainpro C credits.

Everyone stay warm and keep healthy. The good news is we seem to so far not have had a flu epidemic! Remember that the dryness caused by the heat being constantly on in our homes is good for something: dust mites like humidity!

Alan Kaplan MD CCFP(EM)
Chair, FPAGC

APRIL 2003

Severe acute respiratory syndrome (SARS)

My hospital, York Central Hospital in Richmond Hill, Ontario had one of the earlier cases reported in Canada. Of course, I was working in the ER at the time! This has been a fascinating story for those with an interest in epidemiology and respiratory medicine. However, some close contacts, including healthcare workers, have developed similar illnesses. Fortunately, I did not come down with anything! Our hospital is the second hospital to have closed down due to SARS. I am now out of quarantine!

I have been appointed as the College of Family Physicians of Canada's representative to the SARS clinical working group, a federal task force created to produce guidelines for the management of SARS. It is one of four groups that are federally working on SARS. The other groups are surveillance, public health measures and infection control.

Definition of SARS:

SARS is an illness associated with severe progressive respiratory symptoms suggestive of atypical pneumonia or acute respiratory distress syndrome with no known cause.

It is postulated that a sick Beijing professor stayed at the Metropole Hotel in Hong Kong and infected other patrons who spread it to Singapore, Vietnam and Canada. All of the cases in Canada can be traced back epidemiologically to people who also stayed in that hotel. In our hospital, we received a patient in transfer from

another hospital wherein the index patient had infected him.

The incubation period for SARS is typically 2--7 days; however, isolated reports have suggested an incubation period as long as 10 days. The illness begins generally with a prodrome of fever ($>100.4^{\circ}\text{F}$ [$>38.0^{\circ}\text{C}$]). Fever often is high, sometimes is associated with chills and rigors, and might be accompanied by other symptoms, including headache, malaise, and myalgia. At the onset of illness, some persons have mild respiratory symptoms. Typically, rash and neurologic or gastrointestinal findings are absent; however, some patients have reported diarrhea during the febrile prodrome.

After 3--7 days, a lower respiratory phase begins with the onset of a dry, nonproductive cough or dyspnea, which might be accompanied by or progress to hypoxemia. In 10%--20% of cases, the respiratory illness is severe enough to require intubation and mechanical ventilation. The case-fatality rate among persons with illness meeting the current WHO case definition of SARS is approximately 3%.

Chest radiographs might be normal during the febrile prodrome and throughout the course of illness. However, in a substantial proportion of patients, the respiratory phase is characterized by early focal interstitial infiltrates progressing to more generalized, patchy, interstitial infiltrates. Some chest radiographs from patients in the late stages of SARS also have shown areas of consolidation.

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Early in the course of disease, the absolute lymphocyte count is often decreased. Overall white blood cell counts have generally been normal or decreased. At the peak of the respiratory illness, approximately 50% of patients have leukopenia and thrombocytopenia or low-normal platelet counts (50,000--150,000/ μ L). Early in the respiratory phase, elevated creatine phosphokinase levels (as high as 3,000 IU/L) and hepatic transaminases (two to six times the upper limits of normal) have been noted. LDH seems to be another marker. In the majority of patients, renal function has remained normal.

Currently care is supportive. Oseltamivir (Tamiflu) an antiviral for influenza has been shown to be ineffective. Ribavirin is another antiviral that may be effective, but even this is questionable. Steroids are useful when the patient deteriorates into ARDS (Acute Respiratory Distress Syndrome). Drug supply of the Ribavirin has been an issue, but there has been supply brought to Canada of both the IV and oral forms and this has relieved that concern currently.

The severity of illness might be highly variable, ranging from mild illness to death. Although a few close contacts of patients with SARS have developed a similar illness, the majority have remained well. Some close contacts have reported a mild, febrile illness without respiratory signs or symptoms, suggesting the illness might not always progress to the respiratory phase. Roughly 80-85% of patients do NOT develop the serious reaction.

The etiology had been postulated to be a parvomyxovirus. Recently it has been discovered that it is a coronavirus (this is the type of virus that causes the common cold). There is concern that it can live on fomites for three hours. The spread is felt to be with respiratory droplets. The spread is apparently increased by using nebulized medications, and therefore SARS patients requiring B2 Agonists etc. should be given them by MDI and aerochamber to decrease potential spread. This is not an airborne pathogen, or we would have had a lot more illness and death. It is spread by fairly direct contact only. It also appears that some patients are super-infectors and transmit much more virus than others.

This illness is potentially fatal, but seems to so far only have killed patients who are elderly or with significant co-morbidity. Respiratory protection and quarantine of the hospital workers or contacts who could have been in contact with sick index patients seem to have limited the spread. For more contact on infection control procedures check out the website: www.sars.gc.ca

If you see someone with this combination of symptoms and a history of travel to the above areas, or having treated a patient with SARS, or having been to one of the hospitals where SARS patients have been treated, wear a mask, gloves and wash your hands! You will need special masks (N95) and NOT just the routing surgical masks to filter the virus out properly. Remember the hallmark is

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SARS (severe acute respiratory syndrome) *(Continued From Page 3)*

high fever and myalgias, kind of like influenza; so do not fall victim to the current panic that everyone who coughs has SARS! It is important that we, as physicians, do not promote the hysteria that this illness has caused. This is a health worker disease primarily, and less so a community problem, now that we have done the proper

quarantine procedures. This will have far reaching ramifications, I am sure, on the way we provide acute care services for infectious illnesses in the future.

Alan Kaplan MD CCFP(EM)
Chair, FPAGC

Severe Acute Respiratory Syndrome (SARS) **Case Definitions**

Suspect Case:

A person presenting with a history of:

- Fever (over 38 degrees Celsius)

AND

- One or more respiratory symptoms including cough, shortness of breath, difficulty breathing

AND

One or more of the following:

- Close contact* with a probable case

- Recent history of travel (within 10 days) to Asia, especially in areas reporting cases of SARS (see below)

AND

- No other known cause of current illness
- *Close contact means having cared for, lived with or had face-to-face (within 1 metre) contact with, or having had direct contact with respiratory secretions and/or body fluids of a person with SARS.

A CASE FOR SPIROMETRY

The FPAGC in support of the Canadian Consensus Guidelines has always promoted the use of simple spirometry for the diagnosis and management of asthma specifically and airway disease in general. The FPAGC has developed a comprehensive 6 to 8 hour Main Pro C workshop dedicated to the understanding of the use of spirometry. The following case illustrates once again how basic spirometry can help us manage our asthma patients.

A 40 year old male presented after a 1 year absence for general review. He had a history of asthma dating back to adolescence. He had previously been well controlled on fluticasone 250 ug bid. His triggers included cat allergy and URTIs. He of course had had a cat since university and no amount of counseling had convinced him to find the cat another home. At this visit he announced that the cat had died 6 months prior and had not been replaced. As a result he had stopped his maintenance ICS and had used prn salbutamol for occasional wheezing. He was very impressed that since the cat died that he seemed "cured of his asthma"!

As outlined in the Guidelines I then asked him the 6 questions used to assess asthma control. He answered in the negative for all 6 questions. He had no daytime or nighttime symptoms. He had used his salbutamol only occasionally when he had been in contact with a cat or with extreme exercise. He was not limited by his normal activities. He had not missed work. He had experienced no exacerbations. (See Table 1). As mentioned above he was convinced

that his asthma was cured.

Table 1:

Clearly from the subjective data

Asthma control criteria

- daytime symptoms < 3 days/wk
- nighttime symptoms < 1 night/wk
- physical activity normal
- exacerbations mild, infrequent
- no absenteeism
- β_2 -agonist needed < 3 doses/wk
- FEV₁, PEF 90% of personal best
- PEF diurnal variability < 10 - 15%

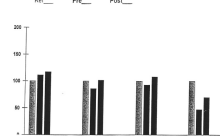
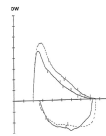
Canadian Consensus on Asthma 1999

given by this patient it would appear that his asthma is indeed under reasonable control and that perhaps no further investigation or treatment is indicated. However, as outlined in Table 1 the Guidelines suggest that the assessment of asthma control requires an objective measurement of airway flow. As a result spirometry was obtained.

Interpretation Of Spirometry

The FEV1/FVC ratio is less than 70% predicted at 63% which implies there is obstruction. The pre bronchodilator FEV1 is 86% predicted which implies the obstruction is mild. The post bronchodilator FEV1 is 102% predicted and

Ver: No	Pk/Yr:	Quit: Yrs.	Cigarettes: No	Cigars: No	Pipe: No
Spirometry					
	Ref	Pre	Pre	Post	Post
FVC	Litres	0.64	0.26	0.80	0.80
FEV1	Litres	0.42	0.17	0.48	0.48
FEV1/FVC %	%	62	63	71	71
PEF	L/sec	10.25	3.25	18.81	18.81
FEF25-75% L/sec		4.74	2.22	3.30	3.30
FEF50% L/sec		5.28	2.66	1.66	1.66
FEF75% L/sec		3.85	2.88	4.00	4.00
PEF75% L/sec		2.35	0.82	1.20	1.20
FET100% Sec			7.75		7.75



Continued on Page 6

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A Case of Spirometry *(Continued From Page 5)*

is an 18% improvement which implies the obstruction is reversible. The FVC is 111% predicted which implies there is no restrictive defect. This spirometry then is consistent with mild asthma.

As a result of the spirometry the patient was encouraged to resume the regular use of his fluticasone 250 ug bid. After a month he returned to the office to report that his breathing was much improved. He had become used to his mild obstructive defect after he had stopped his ICS and did not recognize that his asthma was indeed active.

A subsequent spirometry study was obtained at 3 months after resuming his ICS and showed flows consistent with the post bronchodilator readings above with no further reversibility.

This case illustrates that patients will often underestimate their asthma symptoms. Even when specific control questions are negative we need an objective measurement or airflow to document obstruction in some cases. Only with this information can appropriate diagnosis and management be addressed.

Novel Asthma Therapies: Omalizumab In the Management of Allergic Asthma

Omalizumab is a new drug that is currently being investigated in the management of asthma. It works by blocking IgE receptors in the body. Studies to date have shown the drug can reduce by up to 90 percent the circulating levels of IgE in the blood.

At the recent Annual Meeting of the American Academy of Allergy, Asthma and Immunology, Dr. Niven presented his study on the use of this novel drug in the management of asthma. Dr. Rob Niven is a respiratory consultant at the North West Lung Research Centre in Manchester, United Kingdom.

Dr. Niven's study enrolled 206 patients who received omalizumab in addition to their baseline medications and 106 patients who received only their baseline medication (an inhaled steroid – primarily beclomethasone).

Use of omalizumab was associated with a thirty percent decrease in unscheduled office visits and a fifty

percent reduction in time lost from work or school! Asthma exacerbation rates were also decreased by about fifty percent. Differences in the two treatment arms began to emerge after two months into the trial.

Lung function also improved more in the omalizumab group as compared to the placebo group.

Omalizumab was well tolerated and appeared quite safe over the course of the 12 month trial.

Dr. Niven's study was funded by Novartis Pharma and Genentech Inc., the developers of the drug.

Overall the results of this study are promising and may offer our patients a new and novel approach to the management of their asthma in the near future.

Robert Hauptman MD
Secretary Treasurer FPAGC

CFC issue revisited

I have been writing articles about the CFC (Chlorinated fluorocarbons) issue for the last year or so. Remember, the Montreal protocol banned CFCs as they were toxic to the Ozone layer and CFC MDIs were given an exemption for medical use, until alternatives could be created. I was involved in both Health Canada and Environment Canada working groups on the transition strategy.

Canada's transition strategy:

- **July 1, 2002:** Salbutamol MDIs will no longer be allowed to be produced or imported if they contain CFCs.

- **January 1, 2003:** Salbutamol MDIs will no longer be allowed to be sold if they contain CFCs.

- **January 1, 2004:** Corticosteroid MDIs will no longer be allowed to be produced or imported if they contain CFCs.

- **January 1, 2005:** All other MDIs will no longer be allowed to be produced or imported if they contain CFCs.

So now we have it, no more CFC B2 agonists currently and no more CFC inhaled steroids after January 2004. What options do we have, and are they safe?

The first option for inhaled steroids to avoid CFCs is to use dry powder inhalers which have no propellant at all to hurt the ozone layer. HFA (Hydrofluoroalkane) propellants are much safer for the ozone layer, but they still do affect it. Secondly, there was the creation of HFA Beclomethasone created by 3M and

called Qvar. The size of the particles is smaller than previous Beclomethasone that was in solution, not in suspension. This allows treatment of the 'whole lung' and allows the dose to be relatively twice as strong mg. per mg. compared to previous Beclomethasone. Budesonide (Astra Zeneca) is currently available as nebulizer or dry powder. Mometasone (Azmacort) is a USA brand that, last I heard, will not be made into an HFA product.

Fluticasone (GSK) is available currently in both HFA and CFC formulations, and flovent diskus although you must specify HFA or you will get CFC (go figure government rules!). Are they the same? Brian Lyttle et al authored the article Fluticasone propionate 100 ug bid using a non-CFC propellant, HFA 134a, in asthmatic children. Can Respir J Vol 10 No. 2 March 2003, 103-109. This article showed equivalence in the two forms of Flovent.

We can, therefore, say that HFA and CFC Fluticasone are equivalent and interchangeable from the point of view of effect and therefore feel free to start using the HFA form any time now; it is better for the environment. This is different than the change from CFC to HFA Beclomethasone, wherein they also changed the mode of delivery allowing the new product to be twice as potent. In addition, Altana is a new pharmaceutical company in the respiratory market that is also working on launching a new inhaled corticosteroid.

World Asthma Day May 6, 2003

Asthma is a serious global health problem, with increasing prevalence worldwide. This disease places a significant burden on many countries in terms of healthcare costs, lost work productivity, missed school, and results in unnecessary limitations on individuals' lives.

On World Asthma Day, GINA will release the initial results of its Burden of Asthma Report, with statistics that provide a global overview of the current asthma situation. In the months following World Asthma Day, these statistics will be expanded upon with country-specific data and regional analysis.

To ease the burden of asthma, it is vital that people with asthma, health professionals, and governments around the world work together. Over the last few years, many positive steps have been taken to change attitudes toward asthma and improve asthma care globally. However, the majority of patients have not yet benefited from treatment advances and many still lack access to medication.

To improve asthma care and reduce the burden of this disease, GINA has developed a set of global guidelines for the diagnosis and management of asthma. To view the guidelines in full, go to:

www.ginasthma.com/index_email2

However, while asthma causes a global burden, it needs local action. With this in mind, GINA has developed a set of 5 positive steps-based on the GINA guidelines-that people with asthma can take to help ease the burden of this disease.

To view 5 positive steps that people with asthma can take, see the site: www.ginasthma.com/index_email4

There are so many things you can do to help tackle your country's own asthma situation. Get involved on World Asthma Day and take this opportunity to educate and inform.

To find out what some countries are already planning for May 6th, go to: www.ginasthma.com/index_email6

Remember, May 6 is the day!

Alan Kaplan MD CCFP(EM)
Chair, FPAGC

ER Rounds

ACADEMIC EMERGENCY MEDICINE 2003; 10:16–21.

Intramuscular versus Oral
Dexamethasone for the treatment of
Moderate-to-severe Croup: a
Randomized, Double-blind Trial
David Donaldson, DO, David Poleski, MD,
Eric Knipple, MD,

Kurt Filipis, DO, Linda Reetz, RN,
Rebecca G. Pascual, RN,

Raymond E. Jackson, MD, MS

Glucocorticoids are an effective treatment for croup, although the most beneficial route of administration remains unclear. For mild croup it has been shown that nebulized Budesonide decreases croup ER visits and admissions. Both intramuscular dexamethasone and oral dexamethasone are effective treatments for more severe croup; this study was designed to compare the two for moderate-to-severe croup.

Design: The authors performed a prospective, randomized, double blind trial involving children aged 3–84 months with moderate-to-severe croup, presenting to a suburban teaching emergency department (ED). Patients were eligible for enrollment if they had inspiratory stridor or a barking cough and a croup score of 2 or greater after 10–15 minutes of cool mist therapy. The patients were randomized to one of two intervention groups. In both groups, the parents were not present in the treatment room during study drug administration. One group received 0.6 mg/kg of intramuscular dexamethasone and an oral

placebo, while the other group received 0.6 mg/kg of oral dexamethasone and direct pressure on their thigh with the hub of a syringe. A nurse placed a Band-Aid on the site of the real or mock injection. Parents were contacted by telephone approximately 1 and 10 days after the index visit to ask about their child's symptoms using a standardized questionnaire.

Results: The groups were similar in all baseline characteristics, treatments received in the ED, and disposition. At 24 hours and 10 days after the visit, there were no statistical differences between the groups for the proportion with stridor, expiratory sounds, barking cough, sleep pattern, the degree of improvement, or the proportion with complete resolution of symptoms at one day.

Conclusions: No statistical differences for any parameters were observed between intramuscular and oral dexamethasone treatments for children with moderate to severe croup at 24 hours or at any time the week after treatment. The durations of symptoms were similar between the treatment groups. So why stick these poor kids? The evidence is clear that po Dexamethasone is as good as IM. Here's the rub; this did not look at Prednisolone, which is the po steroid of choice in the kid friendly PediaPrep form. I personally think the results would be the same, but if you want to be certain, your pharmacist can make up liquid dexamethasone suspension for you. Just let them know that you will want to do this so that he/she can stock the correct stuff!

ER Rounds

Does O2 saturation predict admission? (Ann Emerg Med 2002;40:300-307.)

Dr. Laine Keahey from Winnipeg Children's Hospital in Winnipeg, Manitoba and colleagues examined whether initial room air oxygen saturation measured by pulse oximetry in 1040 children presenting to the emergency department with acute asthma would reliably predict hospital admission.

Nearly a quarter of the children (23%) required hospital admission for their asthma exacerbations, the authors report.

The mean initial oxygen saturation for admitted children was 93%, whereas the mean initial saturation was 96% for children discharged home from the emergency room

The admission rate declined with

increasing oxygen saturation, the researchers note, and patients with an initial oxygen saturation of 88% or less were 32 times more likely to be admitted than those with an initial oxygen saturation of 100%. But, nine hundred ten of the 1040 children (88%) presented with initial oxygen saturation values of 91% or greater.

From this study we see that there is a statistically significant difference between the initial room air oxygen saturation value in children who are admitted and those who are discharged, but because of the large amount of overlap between the 2 groups, low oxygen saturation value is not sensitive enough to be used as a predictor of admission. "Pulse ox" is a measure of oxygenation and not ventilation and thus is only one of the tools we use in making the clinical decision of hospital admission.

Question:

What do you do with the child that only gets "viral respiratory tract infection induced asthma"?

Do they have asthma? How do you treat them?

Viral upper respiratory infections are very common, and represent a significant number of visits to family physicians and pediatricians. Patients and parents worry about the worsening of the illness, the risk of pneumonia, sinusitis and meningitis. Some just think that antibiotics will make their 'cold' better.

A typical 'cold' is a respiratory virus that causes nasal congestion and

clear rhinorrhea, secondary cough due to irritation of the bronchi or through post-nasal drip with throat irritation, and often fever. Myalgias may occur due to viremia. It is common for these infections to last up to two weeks. It is not uncommon for there to be a second phase. In this phase, the swollen epithelium gets colonized with bacteria and the secondary bacterial infection in the sinuses or lungs occurs. Typically this occurs a week or two

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after the initial illness, the fever has resolved and things are improving, and then things get worse again with increased mucus production, often coloured. This second phase will get better with antibiotics, the first will NOT. We have a responsibility as health care workers to make the proper diagnosis of our patients' illness and prescribe antibiotics ONLY when necessary. For instance, most bronchitis is viral and even the cough of green sputum is due to a viral infection. Enough proselytizing!

The number of colds one gets a year depends on your environment and your immunity. If you work in a day care setting or a pediatrician's office, you are being exposed to viruses all day! If your little Johnny is home with you all day, and rarely plays with other kids, he will not get much exposure. It is felt that by exposure to these mild viruses, your immune system makes antibodies against these viruses and protects you with future exposure. This is why doctors seem to not get sick that often despite how many sick kids they see! (Thank God!) If you have never been exposed to a particular virus or a close cousin with similar antigenicity, you will get sick when you 'meet' it. This is the principle of immunization; expose your body to a killed vaccine that has the same antigenicity, but not the ability to actually infect you. Thus it is normal to get a 'cold' every month if you have entered an area with lots of viruses that your immune system has not met before.

The infection in the lungs in a non-asthmatic may cause wheeze and

often does respond to bronchodilators such as Salbutamol. This does not mean that they are asthmatic, unless they have an objective diagnosis made through spirometry or PFR readings with recurrent illness. Most colds stay as head colds and do not move into the lungs.

Viral infection is the most common reason that I see for asthma exacerbation. However, it is unusual for the lungs to have been completely perfect prior to a virus if that virus then causes an exacerbation. If I see a child wheezing with no past history or family history one must consider bronchiolitis in the infant or pneumonia in older kids/people. In an asthmatic, the effect of the viral URI is to cause an increase in inflammation. If there is very little inflammation to start, there will likely not be acute severe bronchospasm. If there is significant inflammation present, the virus acts as the "straw that breaks the camel's back" by adding inflammation and swelling to the airway.

A common question from patients and parents is how long to continue the inhaled corticosteroids if the patient only seems to wheeze with the URI. I think this answer depends (don't most!) on a number of factors. These include the history of previous episodes; how long did it take to get better before?, the number of exacerbations per year, and the severity of the previous exacerbations. Our goal is to prevent exacerbations and the key is to control the inflammation.

If there are multiple exacerbations,

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A Case of Spirometry *(Continued From Page 11)*

then there is likely underlying inflammation (maybe the cat is to blame after all!). Similarly, if there are sudden severe exacerbations, thought to more prolonged treatment should be considered.

Another possible tool in making the decision is spirometry. Repeating spirometry to show that the obstruction is gone and the best possible lung function has been attained can allow us to make a reasonable argument for tapering and even discontinuing the ICS.

There are some studies from Hahtela Finland in NEJM which showed that early aggressive treatment with ICS showed sustained improvement in lung function with actually improved lung function compared with those treated with B2 agonists alone and switched to ICS later. It is

felt that the issue of airway remodeling is at play here. In other words, the lung inflammation causes a 'burn' to the airway basement membrane and scarring will prevent the return to normal lung function. This concept should be explained to those patients who stop their medication as soon as they feel better and have frequent exacerbations.

It is felt that the full effect of the ICS may take as much as three months to manifest. So, once you have decided it is asthma, treat aggressively with inhaled corticosteroids for all but the mildest intermittent asthmatic, and treat for long enough to reduce the inflammation.

Alan Kaplan

*Chair, Family Physician Airways
Group of Canada*

Kids are pricey!

Prospective Study of the Patient-Level Cost of Asthma Care in Children. *Pediatric Pulmonology* 2001; 32:101-108

This is a study of the cost of asthma of Ontario children. Direct costs (hospitalization costs of 43%, medications at 31%, visits to healthcare providers, ER visits, PFTs, devices and out of

pocket expenses) and indirect costs (parental productivity costs 12%, absences from work/usual activities, travel and wait times) were measured.

The costs in 1995 dollars (worth even more now!) was \$1,122 per child 4-14 years, and \$1366 per child under 4 years of age.

Warming up to new treatment ideas

Bronchial thermoplasty attacks smooth muscle, prevents contraction of airway (Medical Post March 2003)

Bronchial thermoplasty is a new technique being researched in Hamilton which involves delivery of heat to the airway wall so the airway smooth muscle's ability to contract is damaged. It is the narrowing of the airway, caused by contraction of the airway smooth muscle, which brings about many asthma symptoms. As flow is related to the radius of the airway squared (R^2), increasing the radius of the airway therefore exponentially increases flow.

Two small clinical trials have shown that bronchial thermoplasty reduces the severity and frequency of asthma attacks in patients with severe asthma.

This treatment is likely not anti-inflammatory, and works on smooth muscle. With every muscle having to be complete to contract properly, severing one section of the muscle is enough to stop the constriction in the

airways. Bronchial thermoplasty uses the Alair Catheter System made by Broncus. It is a 1.8 mm flexible tube with an expandable wire basket at the tip. The basket opens, delivers heat to the muscle, and then can be closed again. The temperature of heat used to destroy the muscle is about the same temperature as a cup of coffee. Smooth muscle is very sensitive to heat and does not regenerate; all other tissues recover and it just leaves you with poorly differentiated connective tissue instead of smooth muscle," said Dr. Cox

Dr. Gerry Cox, a respirologists in Hamilton said that this procedure "is a mechanical solution as opposed to a pharmacological solution," My personal postulation is that airway smooth muscle is a defense mechanism that we have to prevent exposure to noxious gases(no evidence!) and this technique may be an effective treatment in the future for those needing bronchodilation. More to come.

Dr. Karan

ASED 6

Don't forget to register for ASED 6, to be held in Montreal November 27-29, 2003. It is being presented by the Canadian Network for Asthma Care (CNAC) and hosted by the Quebec Asthma and COPD Network.

It looks like an excellent line-up of speakers covering important topics such as asthma diagnosis in young children, differential diagnosis, new medications, and improving asthma management compliance. Visit www.cnac.net for more information.

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Events

Canadian Asthma Consensus Guidelines Continuing Education Program - Ontario Thoracic Association and Ministry of Health and Long Term Care various locations and dates can be accessed at our website www.fpagc.com and click on [events](#)

World Asthma Day
May 6, 2003

For further information:
www.ginasthma.com

Cochrane Airway Symposium
May 14-15, 2003
Edmonton, Alberta

For further information:
www.med.ualberta.ca/cag2003/

American Thoracic Society
(ATS) 2003 Seattle, Washington
May 16-21, 2003

For further information: www.thoracic.org

Canadian Society of Respiratory
May 30-June 1, 2003
Ottawa, Ontario

For further information: www.csrt.com

National Congress on Asthma 2003
June 19-21, 2003

For further information: www.asthma2003.net/

General Practice Airways Group (GPIAG) Annual Scientific Meeting St. Neots, England
June 20-21, 2003

For further information:
www.gpiag.org/news/sci-mtg-2003.php

XVII World Asthma Congress St. Petersburg, Russia
July 5-8, 2003

For further information:
Congress Secretariat, XVII World Asthma Congress,
16/10 Miklukho-Maklaya Street, 117997 Moscow,
Russia. Tel: +7 095 336 5000 or 429 9620
Fax: +7 095 336 5000
E-mail: acicis@ibch.ru (registration,
accommodation, tours etc.) E-mail:
abstract@ibch.ru (electronic submission of
abstracts) www.isir.ru

World Allergy Organization Congress XVIII
Vancouver, BC
September 7-12, 2003

ICACI.
For further information: www.worldallergy.org

European Respiratory Society -
13th Annual Congress Vienna, Austria
September 27-October 1, 2003

For further information: www.ersnet.org/2/7/7_1.asp

CHEST 2003
Orlando, Florida
October 25-30, 2003

For further information: www.chestnet.org

ASED 6 -

Canada's Sixth National Conference on Asthma and Education presented by the Canadian Network For Asthma Care (CNAC) Montreal, Quebec
November 27-29, 2003.

For full information, please see ASED 6 on the CNAC website at: www.cnac.net

AARC International Respiratory Congress
Las Vegas, Nevada
December 8-11, 2003

For further information: www.aarc.org

International Primary Care Respiratory Group -
2nd World Conference Melbourne, Australia
February 19-22, 2004

For further information: www.ipcrg-melbourne.org/

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THE COMMITTEE

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Hospitals:

Lung Association:

College of Family Physicians:

Other:

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."*

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

Website www.fpagc.com

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 colliger des informations pratiques pour permettre aux médecins d'acquérir ces connaissances.

