



# FPAGC

Family Physician Asthma Group of Canada  
l'Association canadienne des médecins de famille contre l'asthme

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## MESSAGE FROM THE CHAIR

Season's Greetings to the FPAGC! I wish you all a healthy and Happy New Year.

We have just completed the Third bi-ennial Canadian Conference on Asthma and Education (ASED III) in Vancouver. The weather was sunny (or so I saw from the window of the conference room) and the hospitality was outstanding. There were, however, some serious concerns about the quality of asthma education and follow-up given to patients, especially by family physicians. This should sound a wake-up call to all family physicians to look at their current asthma management.

Asthma continues to be a significant issue. The good news is that the mortality is decreasing, with the exception of asthma between the ages of 0-4 years. We don't yet know the reason why, but the National Asthma Task Force will review this important issue. The morbidity of asthma continues to escalate. Some 1993 numbers show the economic reality of a \$591,000,000 cost in Canada (\$393m direct cost and \$198m indirect costs). There were over 150,000 emergency room visits due to asthma, and over ten million prescriptions written for asthma care. Quality of life issues were also a significant concern throughout the conference.

The FPAGC held a meeting during the first evening of the conference. Mervyn Dean gave a presentation on the leukotriene receptor antagonists, after which a spirited discussion ensued. We were pleased to welcome some new members at this meeting. Later the FPAGC executive met with a representative from the Asthma Society with which we have formed a professional liaison.

We accepted with regret the resignation of Dr. Caroline Despard from the executive. She found the responsibilities of an active obstetrical/family practice and her four kids to be too much to allow her the time to carry on with her executive responsibilities. I would like to thank her for her major contribution over the years to the FPAGC. We will miss her sincerity, professionalism, and wit at the executive meetings, but we know she will continue to have an active role in the FPAGC.

Our membership is growing! Asthma is a very hot topic nationally, and we have the first new class of Asthma medications in decades! This will be a very exciting year for the FPAGC!

Alan Kaplan MD CCFP (EM)  
FPAGC Chairperson

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### PREVENTION OF ASTHMA

Asthma is known to be a disease of genetic predisposition. A child of one parent with asthma has a 40% risk of developing asthma, and a child of two parents with asthma a 65% risk. If the child has no asthmatic parents there is only a 10% risk of developing asthma. Monozygotic twins have a 59% risk of both having asthma, and dizygotic twins a 19% risk. These figures illustrate that risk factors for development of asthma are multifactorial, comprising both genetic and environmental factors.

There have been many attempts at mapping the genes responsible for asthma. It is known that the gene(s) for IgE receptors are located on chromosome 11. This and other findings will hopefully someday allow gene therapy, targeted pharmacological therapy, and/or screening and prevention.

Monozygotic twins who have grown up apart have a 60% risk of both having allergic rhinitis while monozygotic twins growing up together have a 62% risk. Similarly, dizygotic twins growing up apart have a 44% risk of both having rhinitis vs. a 43% risk if they grew up together. As monozygotic twins share 100% of their genes, and dizygotic twins share only 50%, there is obviously a strong genetic component, but it is not 100%. Therefore development of asthma/rhinitis must also be influenced by other factors, such as the environment. There is a higher likelihood of asthma in the child if the only the mother, as compared to only the father, has asthma. This would seem to indicate that the uterine environment may be a factor.

Prevention of exposure to a variety of substances has been studied. A study in the Lancet by Archad in 1992 showed that breast feeding, hypoallergenic formula feeding, and House Dust Mite (HDM) avoidance strategies started at birth led to a lower rate of asthma diagnosis. This was statistically significant until about the fourth year of age when it evened out. These measures also decreased significantly and continuously the risk of food allergies and

atopic dermatitis.

However, core blood T lymphocytes do react to various food products or HDM allergens in utero, which may explain why prophylactic measures after birth are not as successful as we would expect.

Children of smokers have an increased risk of asthma. Cotinine (a nicotine breakdown product) has been measured in smokers vs. non smokers and their babies. Cotinine is selectively concentrated in breast milk to three times blood levels. Cotinine levels are found to be higher in breast fed babies of smoking mothers than in babies of smoking non-breast-feeding moms. Therefore exposure in breast milk may also be significant.

The future is not quite here yet, but the research is starting and is exciting. We can now counsel our patients, pregnant mothers, and fathers on avoidance behaviours and preventative feeding behaviours.

Alan Kaplan CCFP(EM)  
FPAGC Chairperson

References: ASED III lecturers

- i) Dr. Peter Pare  
Professor of Medicine at UBC
- ii) Dr. Moira Chan Yeung  
Professor of Medicine at UBC
- iii) Dr. Alan Becker  
Associate Professor of Allergy and Immunology at the University of Manitoba

#### **Correction: A New Class of Asthma Medication: Leukotriene Modifiers (FPAGC Newsletter No. 11)**

The name of the author of this article was inadvertently omitted. The piece was written by Dr. Anthony D'Urzo, FPAGC Committee member. Our apologies to Dr. D'Urzo for this omission.

### CFC'S AND WHAT IS NEW IN DELIVERY SYSTEMS.

I introduced this issue to the membership in FPAGC Newsletter no.10. Chlorofluorocarbons (CFCs) are the propellants for the currently used metered dose inhalers (MDIs), but are toxic to the ozone layer. This is a significant issue in global health.

CFC propellant MDIs have not been manufactured since January '96 but there is still a stockpile which is being sold. The industry has committed to having them out of circulation by the year 2005, although I think they will be gone long before that.

There are options to use if you want to avoid these chemicals. Dry powder inhalers such as the Diskhalers (Glaxo), Turbuhalers (Astra), Rotacap-like devices (Novartis) are available. 3M pharmaceuticals is releasing both a salbutamol and a beclomethasone with an MDI using a different propellant called HFA 134a. It produces a smaller plume with smaller

particles. It is not temperature dependant and causes less reflex bronchospasm. The smaller particles allow deposition further into the alveoli. This does not change the dosage of salbutamol, but will possibly halve the effective dose of inhaled beclomethasone.

Glaxo is developing the Accuhaler. This is a breath actuated dry powder device with a dose counter. It will deliver albuterol/salbutamol, or fluticasone.

The CFC issue is topical and receiving world wide attention. Many countries of the world are enforcing non-CFC policies through the World Health Association. Look for a statement regarding this issue from Environment Canada in the near future.

Alan Kaplan MD CCFP(EM)  
FPAGC Chairperson

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### CANADIAN ASTHMA CONSENSUS GUIDELINES

Clinical Practice Guidelines (CPGs) are very much the "in" thing. Not only are there guidelines concerning asthma management, but also COPD, headache, and hypertension, to name the one's which have been brought to my notice in the last few weeks. I have been told that the Canadian Medical Association lists over 100 CPGs. With so many sets of CPGs it is no wonder that any one CPG is not familiar to a large number of physicians.

But CPGs are mostly aimed at family physicians. The FPAGC's interest is of course in asthma guidelines. At the end of May there will be a meeting of asthma experts to update the 1995 Canadian Asthma Consensus Guidelines. The FPAGC will be represented at that meeting by Alan Kaplan, and the College of Family Physicians of Canada will also have a representative there. Although the entire guidelines will be reviewed, the major changes will, I expect, be based on our further

experience with the long-acting beta-2 antagonists, and the fact that we now have a totally new class of drugs, the leukotriene receptor antagonists, in our armamentarium.

However, there are two other concerns. 1) What is the best way to present these guidelines, and 2) What is the best way to bring them to the attention of family physicians, and help them to remember the salient points? When asthma guidelines were first introduced they were modelled on the stepped-care approach, comparable to hypertension guidelines at the time. In 1995 the Canadian guidelines broke from this world-wide-adopted format and devised the asthma continuum. The guidelines were evidence-based, but the presentation format was not. (The evidence does not, to my knowledge, exist). We do not know which is the better format, nor do we know if we need a format that is different again.

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## FPAGC NEWSLETTER

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I suspect that the answer to the second part of the question is closely tied to the presentation format. If we can find the best way to present the guidelines, then the information they contain should be better retained and used by the practising physician. With this newsletter is a questionnaire on the subject of the guidelines. It is brief, so please

take a few minutes to complete it, and return it to the FPAGC. Your answer will go a little way towards starting to answer the above questions, and so to improve family physician asthma care in Canada.

Mervyn Dean  
Committee Member FPAGC

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### CNAC UPDATE

The Canadian Network for Asthma Care (CNAC) is an association of organizations which promotes asthma care and education. Now in its fourth year of existence, it was "born" at the first ASED conference, and has been the driving force for the two equally successful ensuing ASED conferences. The planning is already beginning for ASED IV which will be held in Halifax, Nova Scotia on Nov.11-14, 1999.

There are currently two large projects under development:

1. Directory of Asthma Teaching Programs in Canada. There is a directory of about 125 Asthma teaching programs available. Dr. Robert Cowie of Calgary has developed a tool to allow self evaluation of your asthma teaching program. It is called, 'How to evaluate your Asthma program'.
2. Educating the Educator. Dr. Alan Becker of Winnipeg has led this group in developing a standard for knowledge in asthma educators, and a certification exam is now being developed. Before being

eligible to sit a certification exam, it was agreed that candidates (health care workers or community educators) should possess a minimum core knowledge of asthma. This entry level knowledge could be acquired through a pre-study, self-directed learning module which is currently available and can be purchased from the CNAC office. We are hoping that the examination process will be available sometime in 1998.

The CNAC office is located at 6 Forest Laneway, Suite 1607, North York, Ontario, M2N 5X9. Phone (416) 224-9221 Fax (416) 224-9220 E-mail [ased@cnac.net](mailto:ased@cnac.net). The website is at [www.cnac.net](http://www.cnac.net), and contains information regarding the certification program, CNAC conferences, and links to member organizations (like us!!)

Currently, I am the FPAGC representative.

Alan Kaplan MD CCFP(EM)  
Chairperson FPAGC

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### MESSAGE FROM THE SECRETARY

Recently, I was asked to speak on asthma management to family physicians at a local hospital. While I was looking through my asthma slides to prepare for my talk, I was amazed to find the number of slides that were currently out of date. I have been speaking on asthma management to family physicians and

health professionals for over five years, but in just this short period of time our understanding of asthma and our therapeutic options in the management of this disease have changed considerably. Our knowledge of asthma as a disease of inflammation has remained of fundamental importance in our understanding

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of chronic management. But recent years have seen us focus on patient monitoring and action plans, and on newer therapeutic options, such as long acting beta-2 agonists and leukotriene inhibitors.

Through all these changes, I continue to firmly believe that the management of asthma is best undertaken by family physicians. As family physicians, we are in a unique position to not only understand and manage the disease appropriately, but also to see how this disease affects our patients and their families. We, on the executive of the Family Physician Asthma Group of Canada, remain committed to assisting family physicians in the management of their patients with asthma.

One of the newest initiatives that the executive at the Family Physician Asthma Group of Canada is particularly pleased with, is our association with the Asthma Society of Canada. We believe this will increase our ability to act as advocates for both family physicians and our patients. Through the work of our Chairperson, Alan Kaplan, our membership has been increasing. This gives us more weight at a

national level and an increased ability to act as advocates for family physicians in asthma management.

I am pleased to tell you that in May of this year the FPAGC will once again be holding a one day asthma workshop at the College of Family Physicians of Canada's Annual Scientific Assembly (ASA) in Halifax. This workshop was well received at last year's ASA and will be of interest to anyone who wants to further increase their skills and abilities in managing asthma patients in their practice. As well, at this year's ASA the FPAGC will be holding their Annual General Meeting. We invite any family physicians in the area to visit us at our meeting. During this meeting the annual Gerry Alexander Memorial Lecture will be delivered.

I would encourage anyone who is interested to send relevant articles for publication to Dr. Mervyn Dean (address, fax, and e-mail in the list of committee members elsewhere in this newsletter).

Robert S. Hauptman  
Secretary/Treasurer, FPAGC

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