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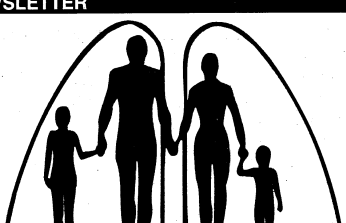

FPAGC

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

MESSAGE FROM THE CHAIR

This spring and summer have brought many asthma issues to the fore. Members of the FPAGC have been busy across the country with asthma- related work. The Asthma Consensus Group met in May at Niagara-on-the-Lake. The FPAGC was well represented by Mervyn Dean, Tony D'Urzo, Andrew Cave, Gordon Dyck, and me. The group, co-ordinated by the Canadian Thoracic Society (CTS) (the medical divsion of the Canadian Lung Association) reviewed and updated the 1995 guidelines, led by Dr. Louis Phillip Boulet, chair of the Asthma sub-committee of the CTS. We hope that the document will be released in the fall of 1998.

Our membership is now over 500 strong and continues to increase. I would like to welcome and introduce to you Dr. Josiah Lowery of Orillia, Ontario who has joined the FPAGC executive. He has recently written a guide to office spirometry for family physicians, which I had the opportunity to peer review for the College of Family Physicians. It is an excellent piece of work which I recommend to all. It is available through Boehringer Ingelheim or the College of Family Physicians of Canada.

The CFC transition period issue will be discussed later in the newsletter. I have been appointed to the national steering committee on education regarding this issue and we are meeting in September. Mervyn Dean and Tony D'Urzo are involved with this issue on College of Family Physician committees.

Representation of the FPAGC continues on CNAC and the National Task Force for Asthma. I currently sit on a CNAC subcommittee which is evaluating written asthma education materials that are currently available for the office of the Family Doctor. Please send me anything you have developed if you feel it has merit and the potential to be distributed nationally.

As has been previously mentioned the FPAGC is currently trialing an ACTION PLAN form to attempt to make a user-friendly tool to help with office asthma management.

This summer will also herald the release of a new asthma product called *Singulair* produced by Merck Frosst. Montelukast (the generic name) is the second Leukotriene Receptor Antagonist (LTRA) to come to market in Canada (The first was *Accolate* (zafirlukast) from Zeneca). I expect you will all be hearing a lot about LT RA's over the next year.

Alan Kaplan MD CCFP(EM)
Chairperson FPAGC

HOW FAMILY PHYSICIANS MANAGE ASTHMA: Part of Canada's National Asthma Control Strategy.

Family physicians play an integral role in the management and care of people with asthma. Visits to family physicians/general practitioners (FP/GP's) comprise the most frequent "point of entry" into Canada's health care system. How family physicians manage patients with asthma is of major interest to the *Laboratory Centre for Disease Control* (LCDC) of Health Canada. Why is this so? LCDC is Canada's national public health agency. Its mandate encompasses human health conditions in Canada and the surveillance, investigation, prevention and control of major diseases. More than a decade ago, LCDC identified asthma as a chronic disease of concern in Canada. The increasing mortality and hospitalization rates during the 1970's and 1980's reflected trends in other western countries.[1]

Closely linked to the surveillance of asthma are the goals of prevention and control. Accordingly in 1994-95, LCDC brought together the major health organizations concerned with asthma in Canada in order to form the *National Asthma Control Task Force* (NACTF). Six national medical groups are on the NACTF: respirologists, pediatricians, allergists, emergency room physicians, and two groups representing family doctors: the College of Family Physicians of Canada and the Family Physicians Asthma Group of Canada (FPAGC). Other health professional groups represented are the respiratory nurses, respiratory therapists, physiotherapists and pharmacists. The voluntary "lay" organizations on the Task Force are the Asthma Society of Canada, the Canadian Lung Association, and the Allergy and Asthma Information Association. LCDC (specifically its Respiratory Disease Division in the Bureau of CRD - address at the end of this article) functions as the secretariat and funder of the Task Force.

The NACTF has developed a National Asthma Control Strategy with the overall goal of reducing asthma mortality and morbidity in Canada through 12 specific objectives.[2] Examples of specific objectives include "the appropriate asthma management by physicians", "the correct diagnosis of asthma", and "patient and family education". Separately, in 1995, the Canadian Thoracic Society organized the Canadian Asthma Consensus Conference in order to set recommended practices for managing asthma, often referred to as "the (Canadian) guidelines".[3] (The guidelines are being updated this year, 1998.)

With these issues in mind, LCDC in 1996-97 commissioned a national survey of physicians, in order to establish national baseline information on asthma management practices, and how these compared with the 1995 Consensus guidelines. Five groups of physicians were surveyed: family physicians (FP/GP's), respirologists, pediatricians, internists, and allergists/immunologists. (Emergency room physicians had their own national survey previously.[4]) A total of 2,180 physicians in all 10 provinces and the two territories completed the questionnaires. The initial results have been released,[5] and LCDC has conducted further data analysis. The overall results are being summarized for publication in one or more Canadian medical journals.

The survey found that family physicians were less likely than respirologists and internists to order spirometry for making the diagnosis of asthma and for follow-up of patients. This is perhaps not surprising, given that FP/GP's are less likely to have the equipment, to be familiar with interpreting the results, or to see as severe asthmatic patients as the specialists. Still, it is worth investigating how family physicians may benefit from more education on the use of spirometry and/or better access to it. In the meantime, as the LCDC survey found, 75% of FP/GP's would choose "a trial course of inhaled β_2-agonists often or almost always" for diagnosing asthma in adults and children over the age of six.

The survey found that members of the College of Family Physicians of Canada were more likely to order spirometry and indeed, to manage asthma more in accordance with the Consensus guidelines, compared to non-members. This finding may suggest a positive effect from the continuing education programs of the CFPC. (The analysis controlled for other factors such as the physician's sex, age group, rural versus urban location, region of Canada, number of years in practice, and average number of asthma patients seen per month.)

In terms of treating asthma, the FP/GP respondents did not differ significantly from the specialists in how they ordered inhaled β_2-agonists for three patient "scenarios" in the survey.

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In prescribing corticosteroids, however, the family physicians tended to choose lower-potency drugs (inhaled instead of oral, low-dose instead of high-dose) than did the respirologists or pediatricians. Furthermore, the family doctors were more likely to select drugs not recommended for the scenarios, such as oral xanthines, antihistamines or antibiotics. On the "bright" side, however, only small percentages (7-14%) of FP/GP's chose these types of medications. (The survey was conducted before the leukotriene-receptor antagonists were approved in Canada.)

In terms of educational practices for asthma patients, almost all family doctors said that they gave verbal information and advice, and most said that they demonstrated how to use inhaler devices. Only a small minority (14%), however, developed written action plans for their patients, and only 12% would refer them to other health professionals, an asthma centre or a non-profit agency for education.

As a "barrier" to educating patients about asthma, many FP/GP respondents cited "a lack of time" during office visits (as did the specialists). About one-third of family physicians also cited a lack of "community resources" and "appropriate materials to use". The challenge, therefore, is to make family doctors aware of the educational materials and resources in their communities, and to facilitate their access to them. Moreover, educational materials should be adapted, where possible, to the typical time constraints of office practice.

The survey findings have been valuable not only in describing the current asthma management practices of physicians in Canada, but also in pinpointing the specific areas in which educational interventions are needed. In addition, the survey found that while a majority of family physicians reported being "aware" of the 1995 consensus guidelines, only a minority (37%) felt "knowledgeable" about them. Since the survey found that reported knowledge of the guidelines correlated with appropriate practices (controlling for other factors), medical organizations (such as the CPFC and the FPAGC) will be actively disseminating the currently-under-revision consensus guidelines (1998). Another national survey in 2 to 3 years may then gauge how effectively the updated guidelines will have been implemented in Canada.

In summary, the appropriate management of asthma by family physicians, and indeed by all health professionals, is an integral part of the National Asthma Control Strategy, and LCDC will continue to play facilitative and co-ordinating roles in partnership with the FPAGC and other national health organizations in Canada.

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THE GERRY ALEXANDER MEMORIAL LECUTRE 1997

In May 1997 this lecture was given by FPAGC founder member and former executive member Dr. Grahame Owen. He began by briefly reviewing the history of the Family Physician Asthma Group of Canada (FPAGC) and its mission statement, and went on to pay tribute to the time, effort and inspiration which Gerry Alexander had devoted to the foundation and support of the FPAGC until his untimely death. He was and is sorely missed and will continue to be missed in the years ahead.

Dr. Owen chose as his subject, a review of the management of asthma over the past 200 years:

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"The management of asthma is multi-factorial; it has been based on fashion, empiric formulations, enthusiasms and, above all, the physicians' art. Although the presence of inflammation in association with asthma has been recognized for over 100 years, it is only in the very recent past that it has been realised that this inflammation is the basis of the process and has to be addressed to prevent, treat and ameliorate the long term effects of the condition.

"In 1802, Herbenden recommended a bit of everything. In 1821, Lannec described asthma as rare and consisting of catarrhal and spasmodic modalities. Thirty years later, in 1851, Owen (not the present lecturer) wrote in the British Journal *Lancet* warning of the dangers of not treating asthma. Osler, in 1892, brought to the world's attention that inflammation was a factor in the disease, but in 1897 Holt, a pediatrician, though recognizing the place of allergies, still described asthma as a vaso-motor neurosis. The mainstays of treatment were barks, herbs, tobacco, emetics, stamonium, lobelia, strychnine, morphine, and cocaine among many others.

"In the late 19th and early 20th centuries, despite enormous progress in our understanding and ability to treat medical conditions (largely as a result of the various wars that were taking place at that time) asthma did not benefit from these advances.

"In the 1917 "*Family Physician*", or "*Every Man His Own Doctor*," asthma is discussed as occurring in paroxysms at irregular intervals, there being internal and external triggers. It further says that attacks may come without warning, but that most persons who have had asthma in the past can predict some hours in advance the approach of a paroxysm and that the paroxysm usually occurs at night or in the early morning. The treatment of asthma at that time was described in two parts. For the acute attacks - stramonium cigarettes, tobacco leaves or cigars, nitrate of potassium, or tincture of lobelia, iodide of ammonia, bromide of ammonia, and syrup of Tolue. For prevention and/or maintenance - bromide or potassium in large doses, three times a day for weeks, and where practical, change of climate was suggested as the surest remedy which often relieved the symptoms permanently.

"In 1925 Hutchinson, a paediatrician, described asthma epidemiologically much as we would describe it today, but thought of it as occurring in gouty, neurotic, migrainous families and suggested not treating or under-treating it could lead to emphysema. He used the time honoured treatments as mentioned in the previous paragraphs, which had been the basis of treatment over the previous 120 years.

"From the late 30's into the late 50's, the same medicines being used in the 19th century persisted, and, in fact, the prescriptions that I wrote in those early days had 15 to 21 ingredients: those already mentioned, plus strychnine, arsenic, barbiturates, ephedrines, theophylline and alcohol.

"In 1953, compound E (cortisone) was available, but denied dying asthma patients because it was too dangerous. This attitude persisted into the mid-60's. In the 50's and 60's, one of our staple drugs was Tedral and other similar preparations. These were variations on a theme consisting of a sedative mixed with ephedrine and theophylline. In the late 50's and early 60's, atomized Isopril and other mixtures became available. Adrenaline came into vogue as a rescue medicine and intravenous aminophylline if that failed. Theophylline was often given intravenously for many days until the attack abated. In Canada we were spared the first epidemic of asthma deaths as the Isuprel inhalers did not appear in Canada and were, thus not available for misuse.

"The 1964 edition of "*Davidson's Textbook of Medicine*" recommended that bronchospasm be relieved by sympathomimetic drugs such as ephedrine and isoprenaline first, by mouth or by nebulizers. These nebulizers were efficient, but expensive. Adrenaline subcutaneously or aminophylline could be used for more severe cases, and now, for the first time, in desperate situations steroids could be given orally or intravenously.

"The 1970's saw the beginning of the modern era: In 1970, Oxyprenaline (Alupent) and Salbutamol (Ventolin) became available; in 1975, Terbutaline (Bricanyl), Beclomethasone (Beclovent) and cromoglycate (Intal); in 1983, Ipratropium (Atrovent); In 1988 Ketotifen (Zaditen) and Nedocromil (Tilade). Other alpha-adrenergic drugs and steroid agents became available over the next years, but as of 1997 no new class of asthma medication had become available for some 20 years. However, the drugs that became available to the public between 1970

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and 1997, revolutionized our understanding and treatment of asthma. They made it possible, in most instances, for persons with asthma to lead a full and active life within the individual tolerance of the various medications.

"Having dealt with a historical overview, the beginnings of change and the golden years (Bre-X gold?), I now look to the future. The only new medication class in the short term is likely to be the anti-leukotrienes, which should be available within the next 12 months. The place of these medications in the management of asthma will become apparent after they are released. In the long term, there are other investigational drugs, including smooth muscle relaxers, interleukins, phosphordiesterases and furosemide.

"The one thing we can be sure about in this polluted world of ours, asthma will continue to be a challenge with more children and more adults affected. There will be more refinement of present medications and delivery systems, improvement in our understanding of the disease, and as a result perhaps(?) a magic bullet, such as a pill once a day, for most sufferers.

Dr. Grahame Owen,
FPAGC Member

ASTHMA GUIDELINES SURVEY

I am delighted to say that for once I have a surfeit of contributions to the newsletter. Because of this I am holding over the results of the survey that was sent out with the last newsletter. Thanks to all who replied. Several respondents asked where they could obtain a copy of the guidelines. They were published in 1996 in the Canadian Respiratory Journal (1996;3(2):89-100) - I would hope your local medical library has a copy. Two of FPAGC's corporate members, Glaxo Wellcome & Astra Pharma have provided summaries or copies of the Guidelines for FPAGC workshops, and the Canadian Lung Association has a summary card of the guidelines.

For those who requested more information on the leukotriene receptor antagonists I would refer you to either FPAGC newsletter #11 for Tony D'Urzo's article, or to our website - http://www.newcomm.net/fpagc. If you don't have newsletter #11, write to me for a copy. If you don't have a computer and/or Internet access, I can't help you there.

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