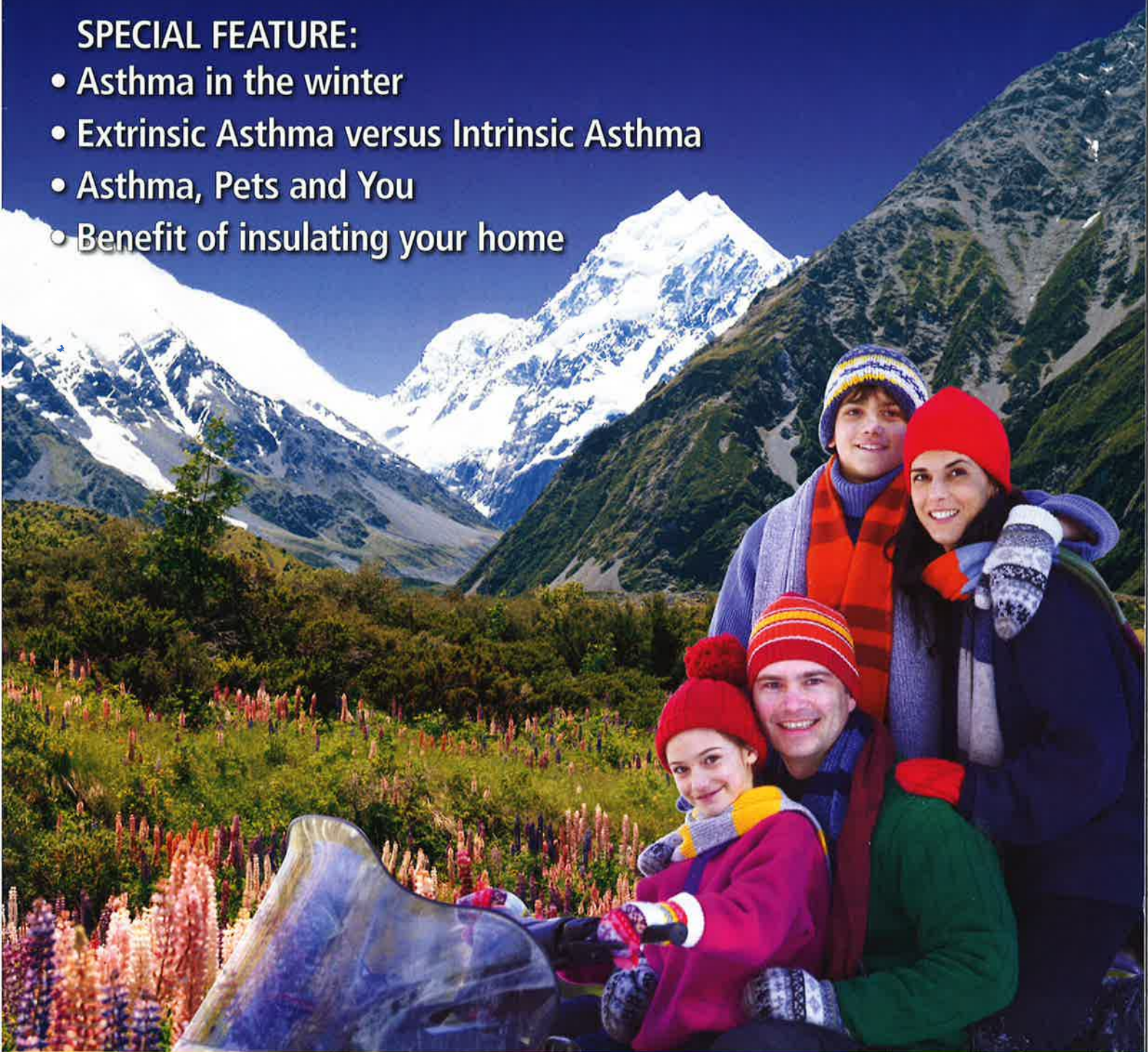


SPECIAL FEATURE:

- Asthma in the winter
- Extrinsic Asthma versus Intrinsic Asthma
- Asthma, Pets and You
- Benefit of insulating your home



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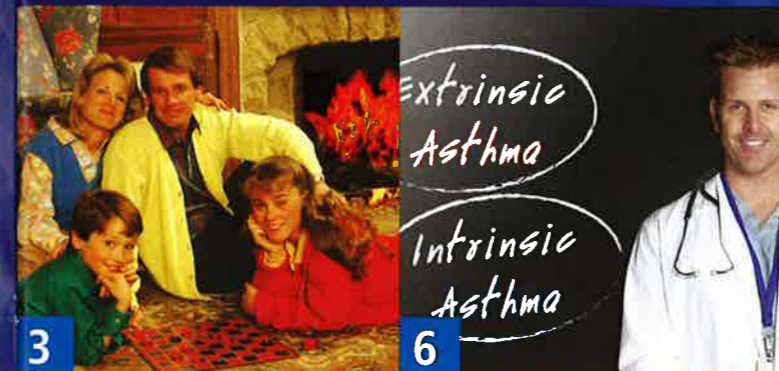
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editorial

The following letter from Dr Geraldine King highlights an issue with the Asthma & Respiratory Foundation's reliever product, Salamol. Salamol contains alcohol and many medical groups have opposed it being used by children; now, we see another vulnerable group being exposed to a product it doesn't wish to use because of the exposure to alcohol.

Vulnerable groups should be able to use a product that meets their needs and doesn't financially penalize them.

G. A. Hanna / Executive Director

Dear Editor,

I am a medical practitioner who has recently had it brought to my attention that the lack of full subsidy to the Ventolin brand of inhaled Salbutamol may serve to discriminate against a hitherto unrecognized group of New Zealanders. I refer to those alcoholics in recovery who, as a deep conscience issue imperative to their abstinence, choose to avoid taking alcohol into their systems by any route. And being able to maintain this total abstinence they believe is vital to maintaining physical health as well as functioning within their relationships at home, at work indeed as members of society in general.

I support and wish to validate, as a doctor, such a decision, indeed a right, to avoid alcohol in

the inhaled form as well as the ingested, even in the relatively small quantity as the propellant in the Salamol inhaler. As a General Practitioner who has worked in the field of Drug and Alcohol medicine with many alcohol dependent patients over the years, I attest to the importance for the alcoholic in recovery being absolutely respected should they make such a determination: to not knowingly take into his or her system by any means alcohol in any form or quantity. I would further offer that those affected by alcohol dependency (and it is within this group those patients who are seeking to absolutely avoid alcohol) have also, by the very definition of this condition, so often have had their finances adversely affected as well. A part charge of

\$4 or more for each inhaler is, in my opinion, a significant cost issue for many of these folk.

I thus wish to strongly add my opinion and advocacy for this hitherto unheard group of New Zealanders: those alcoholics seeking to maintain abstinence who also suffer from asthma and/or chronic pulmonary disease for whom the preferential funding of Salamol has been discriminatory and therefore potentially detrimental to their respiratory health.

Yours faithfully,
Dr Geraldine King, FRNZCGP
Remuera, Auckland



Asthma in the winter

There are certain weather patterns that are known to cause problems for people with asthma. Winter is one of them. Cold air is a major trigger of asthma. Obviously, you can't change the weather, but you can take steps to avoid exposure to it.

A warm, cozy house may seem like an asthma friendly place, but it can be a breeding place for dust mites, mold and pet dander. These asthma triggers, along with germs, accumulate in an insulated house, so people should keep their homes extra clean when all the doors and windows are closed for the winter. The use of dehumidifiers can avoid dust mite & mold growth. Air in a heated room can be dry and release irritants that bother the airways of people with asthma. Autumn and winter fires can be a real problem for some people with asthma who are sensitive to smoke. Make sure to clean the chimney before lighting your first fire. Doors on

fire places should be closed while a fire is burning to eliminate as much smoke as possible from entering the house. Not only be aware of smoke in your own home and also chimney smoke from your neighbor's homes. There is an increased incidence of colds and viruses which can put increased pressure on the respiratory system and cause airway inflammation and trigger symptoms.

Second hand smoke can aggravate asthma, so try to keep your home and motor vehicle smoke free zones. It is very important to protect the body from the cold air if people with asthma want

to participate in out door winter sports. Wrap a scarf around the face to make sure the air that is entering the nose and mouth is warm and moist. Asthma may be a condition that can become life threatening if not managed correctly. Research shows allergens play a large role in triggering airway inflammation and asthma symptoms, leading to episodes of breathing difficulty such as wheezing and shortness of breath.

People with asthma are at a greater risk from influenza than others as asthma symptoms are often triggered by respiratory infections. A flu vaccine is an effective way to ward off the



virus during the winter season. If colds and flu make your asthma worse, prevention is the key to keeping your asthma under control. The flu vaccination offers protection from the virus for a year and is free to people with asthma. Before resigning yourself or your child to a life attached to an inhaler, first try improving your indoor air quality as a preventive measures.

Exercise is important even during the winter months so here are a few exercise tips for people with asthma during the winter season.

- Avoid strenuous exercise in cold dry air, as cooling and drying of the bronchial airways can trigger an asthma episode.
- Do not directly inhale a blast of cold air; breathe through your nose rather than your mouth whenever possible.
- Avoid winter sports, such as skiing, snowboarding, or ice skating, especially if your asthma is not under good control.
- Use your bronchodilator inhaler, 20 minutes prior to exercise.
- Keep your inhalers warm in order to avoid a cold aerosol spray.
- Be sure to "warm-up" before and "cool-down" after strenuous exercise.
- When exercising in cold air, wear a scarf or facemask over the nose and mouth to warm the air you are breathing.

- Be sure to drink plenty of liquids before and after exercise to prevent drying of the airways.
- Exercise indoors when outdoor temperatures drop.
- Run on an indoor track during the coldest winter months.

The best year-round exercise for people with asthma is swimming in an indoor heated pool. But Chlorine, when combined with organic substances (such as skin particles, hair follicles, water-borne bacteria, and even sweat and urine), forms Trihalomethanes (THMs). Although chloramines and Trihalomethanes (THMs) have long been known to be agitators of asthma and its symptoms, studies have now proven that these harmful chemicals may actually cause asthma. Two recent European studies deeply scrutinized these substances in order to determine their negative health effects. Researchers found that nitrogen trichloride, one of the many known THMs, was the main culprit in many forms of occupational asthma.

Here are a few further tips for people with asthma for the whole year

- Encase pillows and the mattress with special encasings that protect against dust mites. Place a barrier between you and the dust mites that live in the mattress and pillows.

- Every two to three weeks wash sheets in very hot water, at least 130 degrees Fahrenheit or 55 degrees Centigrade for at least 10 minutes to kill dust mites.
- Eliminate all sources of dust. Clear out the clutter. Look under the bed and on bookshelves.
- Wash the curtains.
- Be sure to clean window air-conditioning filters.
- Dust all surfaces such as picture frames, walls and floors with a slightly damp cloth.
- If possible, remove all carpeting. Carpets collect dust, crumbs, hairs, fluff from clothing and mold.
- No matter if your room is carpeted or not, vacuum the room thoroughly at least once a week, preferably using a HEPA filtered vacuum.
- Don't have a dirty wet clothes hamper in the bedroom. Dirty clothes are a breeding ground for mold and mildew.
- Keep pets outside whenever possible. Do not allow them into the bedroom.

Reference:

- ADVANCE for managers of respiratory care
- Dr. K. Thickett of the Occupational Lung Diseases Unit at the Birmingham Heartlands Hospital, Birmingham, England



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References: 1. PHARMAC. Notification of changes to the Pharmaceutical Schedule (Letter), 10 July 2006. 2. IMS Report May 2006.

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Extrinsic
Asthma

Intrinsic
Asthma



Extrinsic Asthma versus Intrinsic Asthma

Compiled by Ann Wheat

So what are Extrinsic (allergic) asthma and Intrinsic (non-allergic) asthma and how do they differ?

Allergic Asthma

The term Extrinsic (allergic) asthma was first introduced by RM Rackeman in 1947, in association with the triggering role of allergens in asthma (Romanet-Manent et al, 2002).

Air born allergens, such as dust mites, dog dander, cat dander, mould spores, pollens plus other air born allergen are the main causes of extrinsic or allergic asthma, and more frequently begins in childhood. In this form of asthma, the main finding in the lungs is eosinophilic inflammation (Green, Brightling & Bradding, 2007). Eosinophils infiltrate the lining of the airway causing

inflammation (redness, swelling and mucous production) and can be isolated from sputum to help with diagnosis. It is also well known that in allergic asthma there is an increase in Immunoglobulin E (IgE) antibody levels in the serum of people with asthma. IgE antibodies are produced in response to allergens encountered at mucosal surfaces (Jayaratnam, Corrigan & Lee, 2005). These people with asthma will have positive skin and RAST (radioallergosorbent) tests for air born allergens and according to Jayaratnam, Corrigan & Lee (2005), will have more exacerbations of asthma in summer. We also know that people with allergic asthma have higher levels of exhaled Nitric Oxide* (NO) (Baraldi & Zanconato, 2001). Nitric

Oxide is produced when inflammation is present in the lungs and can be measured in exhaled breath.

Non-allergic asthma

Intrinsic or non allergic asthma as it is known today was also first mentioned in 1947 by RM Rackeman when he discovered that not all people with asthma had an allergic component (Tedeschi, Comi, Lorini, Tosini & Miadonna, 2005). According to Kaplan (2005), this form of asthma affects 40% of adults and 10% of children.

It has been widely assumed over the years that non-allergic asthma occurs in much

Extrinsic Asthma versus Intrinsic Asthma

the same way as allergic asthma. Much research has been completed on this and in fact is still being undertaken, and it is only recently that the differences between the two have become more apparent. Clinically there is little difference in presentation and symptoms.

What is known about non-allergic asthma is that it has a later onset in life, is more common in women, is often found with nasal polyposis and has a more severe clinical course (Tedeschi et al, 2005). People with non-allergic asthma will have negative skin and RAST tests. They are less likely have a family history to allergic asthma and development of symptoms are often preceded by an upper respiratory infection (Jayaratnam, Corrigan & Lee, 2005). It is interesting to note that this group of people with asthma are more likely to have exacerbations in winter, possibly as a result of irritants such as cold air, wind and respiratory infections (Romanet-Manent et al, 2002).

What is becoming more obvious is that in this group, instead of having an eosinophilic base to the inflammation in the lungs, there is a neutrophilic reaction causing the inflammation in the lungs and these can also be isolated in sputum (O'Donnell & Frew, 2002). From the research papers, it is still not clear how this occurs but several hypotheses on this are still under investigation. Further studies have also shown that non-allergic people with asthma have lower exhaled Nitric Oxide* levels (Baraldi & Zanconato, (2001).

To confuse matters even further, it is now thought that there are a group of people with asthma who have a combination of both these two types of asthma (mixed eosinophilic and neutrophilic) as well as a group that have neither of these two (paucigranulocytic asthma), (Green, Brightling & Lee, 2007). As research continues, hopefully it will be possible in future to clarify all these types more clearly and as a result better treatments will

become available for each of them.

Further research has been carried out on the role that Basophils play in allergic and non-allergic asthma, and according to Abrahamsen, Haas, Schreiber & Schlaak (2001), basophils may play a role in non-allergic asthma more than in allergic asthma.

Management

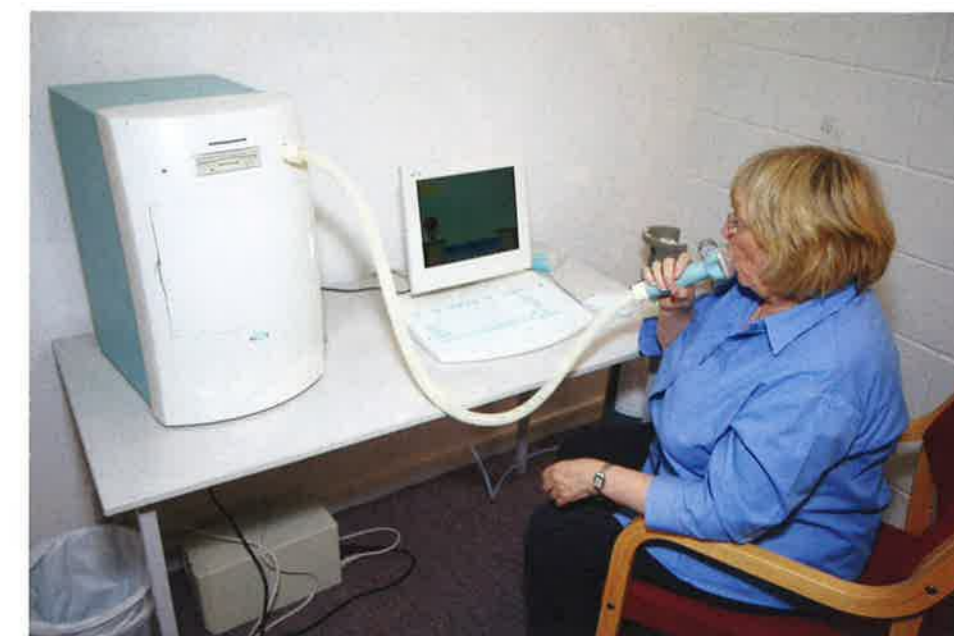
The mainstay of all asthma today, is the use of Corticosteroids. Corticosteroids are used to reduce inflammation in the airways. They can be taken mainly by the inhaled route directly into the lungs, where they work at the site of the inflammation or orally. In allergic asthma particularly, use of corticosteroids appears to be more efficacious. Use of short and long acting beta agonists have an important role in the control of asthma. Overseas more medications are being developed to be specific for the various phenotypes of asthma.

Another important management tool is the identification of asthma triggers whether they are allergens or irritants. Knowing what triggers an asthma episode assists

with keeping asthma under good control by making it possible for people to minimise their exposure to the trigger that can exacerbate their asthma.

In conclusion, it is becoming apparent that asthma is made up of several different phenotypes. It is possible to identify by various tests such as sputum, biopsy or nitric oxide* measurement, which type of asthma a person may have. This can help in the management of the condition both by allergen avoidance and medication and lead to a better life for people with asthma.

* The significance of Fractional Exhaled Nitric Oxide (FENO) in exhaled air from humans is well known to the staff at the Asthma Centre in Mt Eden, Auckland. Elevated FENO values indicate airway inflammation or other pathological respiratory conditions. Asthma Educator Ann Wheat (below) demonstrates Asthma New Zealand's \$75,000 NIOX Nitric Oxide Monitoring System used in client assessments and clinical trials at the Centre. This System is considered to be the most accurate device for measuring FENO to the standard required for clinical trial data.





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Asthma, Pets and You

Christine Barry



Asthma Auckland receives many enquiries about pets. Pets are often regarded as family members and we can't imagine life without them. So what happens when we find out that our asthma is affected by our favorite pet! What can I do to control my asthma and enable me to still have my much loved pets?

The reaction to our pets is the result of our asthma being triggered (an allergy). Asthma can be triggered by substances in the air or substances which are taken by mouth causing an increase in irritation of the airways in the lungs. We can identify allergies that trigger asthma by having various tests including a skin prick test or RAST test.

How do animals trigger my asthma symptoms?

Animals produce allergens in the form of a protein. These proteins are produced from sebaceous glands on their skin, in their saliva and in their urine (Dr V, St A, Crump, personal communication, December 15, 2006). Animals that produce these proteins include; dogs, cats, horse, rabbits, mouse, rats and birds. Allergens produced from cats sebaceous glands include a protein called "Felis domesticus" or Fel D1 (Cat-World, n.d). In New Zealand there are tests for dogs and cats to detect allergens, but these tests are presently applied for research purposes and are not for practical use.

Poodles Safe for Asthma Sufferers - Just a Myth!

There is a common myth about poodles being a safe breed of dog for people with asthma. Pure bred poodles have been quoted as being the most hypoallergenic breed of dog for people who suffer with allergies to dog dander (FAQFarm, 2006). The term "hypo" means "less than," therefore hypoallergenic equates to a possible allergic reaction occurring, but the reaction is less than what may normally occur.

Some people with asthma find poodles to be a safe pet in regard to their asthma, but what must be emphasized is that the allergy is not provoked by the fur of animals but rather the proteins from oil glands in the skin, as mentioned above. These proteins are shed on the skin and form part of animal dander. The presence of hair or length of hair is not the issue.

I Love my Cat

There are also breeds of cat that are termed hypo-allergenic, Siberian and Rex are just two examples. Some people have no reaction to Rex cats, so why is this? There is no straight forward answer but there are two plausible reasons: (1) Rex cats may shed less hair and (2) they may deposit less allergen-laced hair around the home (Cat-world, n.d). In Australia up to 25% of Rex cats are in need of new homes as their original owners cannot cope with their allergic reaction to their Rex cat (Cat-world, n.d).

So if my asthma is triggered by my pet, what can I do?

There are several helpful hints and options available to you.

-If your dog has been identified as an asthma trigger for you, don't let the dog enter your bedroom and try to keep him/her out of main living areas like the lounge, dining room and kitchen. It is preferable to have your pets live outside, so ensure that they have comfortable and safe housing outside the home (CMPMedica [NZ] Ltd, 2006).

-Keep to a minimum other allergens in the house, for example smoke, scented candles, chemicals, mould and dust. Multiple allergens have been associated with the development of increased severity of allergic reactions (Cat-World, n.d).

-If you have pet birds, ensure the aviary is away from the house (CMPMedica [NZ] Ltd, 2006).

-Ask a family member or friend who is not allergic to brush your dog and/or cat outside (Lung Association 2000). This helps to loosen and remove hair and allergens from your pet therefore reducing the amount shed indoors (CMPMedica [NZ] Ltd, 2006). Pets leave allergens behind after they leave a room. Cat dander is known to be present up to six months after the cat has been in the area (Cat-World, n.d).

-Allergens are very small particles which can



accumulate in carpet and other furnishings. The particles can even move through fabric, therefore it is preferable to have suitable coverings on mattresses and cushions to help prevent the release of allergens when these furnishings are being used (CMPMedica [NZ] Ltd, 2006).

- Encourage your pets to sit on a washable sheet so that it can be changed very regularly and washed (CMPMedica [NZ] Ltd, 2006).

- Woolen knitted products can retain more allergens than cotton products even after washing (Cat-World, n.d)

- Wash your dog and your cat (cats can be washed). This can reduce the amount of allergen in the environment (CMPMedica [NZ] Ltd, 2006) and The Lung Association (2000).

-Allergens can settle in the lower level of carpet. Vacuuming with a HEPA filter may help prevent the release of the allergens, but the best approach is to have polished floor, tiles or linoleum (CMPMedica [NZ] Ltd, 2006).

- Wash your hands immediately after contact with your pet and ask other to do the same.

Pets of a Different Kind

Have you considered investing in a fish tank? Tropical fish are not only beautiful to look at but can help you relax and are great for stress relief. Loaches, cat fish and neon's all behave differently and are fascinating to watch. If you study closely you will see their different personalities. And then there is the good old goldfish that everyone knows, inexpensive and often happy, in a large fish bowl.

Reptiles such as turtles are also an option. A turtle tank will produce ammonia, so again find out what your asthma triggers are. What about a pet Iguana or newts? But wash your hands after handling any animal.

Asthma Auckland hope the above information is helpful and we trust you will continue to enjoy your pets.

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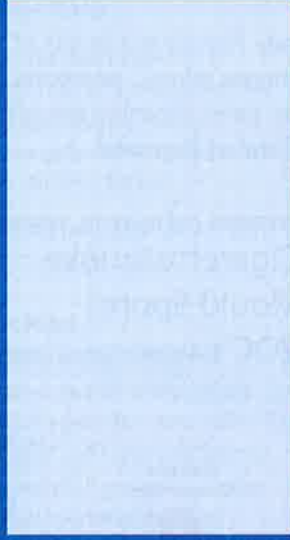
Care Plan Review Due

Date: ____/____/____

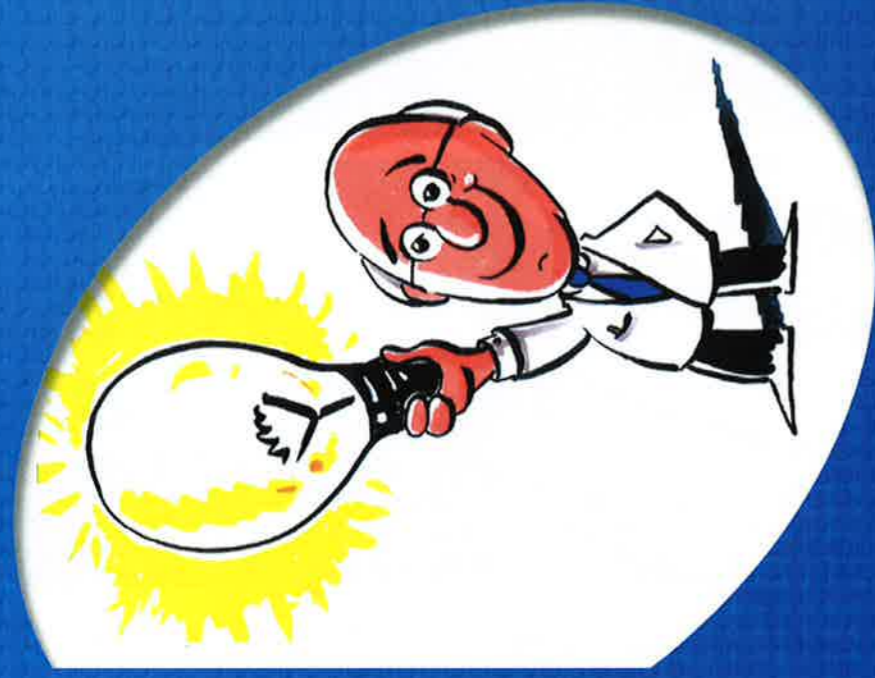
- Contact your practice nurse or GP if you are unsure or worried about what to do
- Please contact your practice nurse or GP if this plan is lost

For further information please contact your local asthma society

For further information please contact your local asthma society



Adult Management Plan to Control Your Asthma



THE LUNG ASSOCIATION

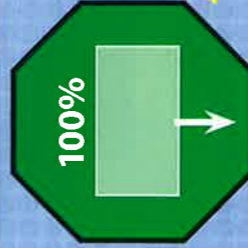
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Telephone 0-9-623 0236, Fax 0-9-623 0774
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Website: www.asthma.org.nz

Asthma New Zealand/The Lung Association
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Adult Action Plan to Control Your Asthma

Your peak flow readings



Green Zone-Go! Asthma under control

- Breathing is good
- Needing reliever less than 3 times a week
- Able to take part in activities
- Free of Night-time symptoms



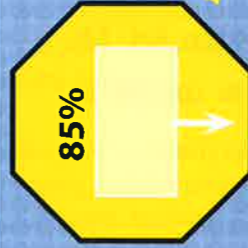
To control your asthma take

- Preventer: _____ puff(s) morning & night
- Reliever: _____ puff(s) when needed and 5-10 minutes before exercise
- Symptom controller _____ puff(s) morning & night
- Other medication: _____

Name: _____

Date: ____/____/____

My goal is: _____



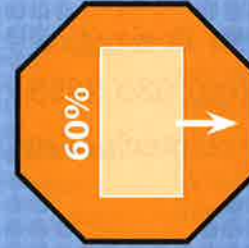
Yellow Zone-Caution! Asthma getting worse

- At first sign of a cold or flu
- Increasing breathlessness
- Coughing, wheezing or chest tightness during the day
- Waking at night because of asthma symptoms



Increase preventer and reliever inhalers

- Preventer: _____ puff(s) morning & night for _____ days after symptoms have improved, return to the dose you take to control your asthma (Green Zone)
- Reliever (blue inhaler) _____ puffs, 6hourly until symptoms improve
- Continue with symptom controller and any other medication as in Green Zone



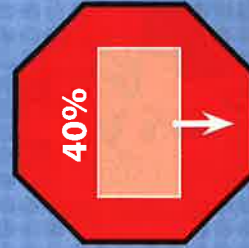
Orange Zone-Medical Alert! If you experience any of the following, action orange zone

- Very short of breath
- Difficult to breathe
- Cannot do usual activities
- Needing reliever every 2 to 3 hours
- Wheezing sound louder



Sit upright and stay calm

- Contact doctor and start prednisolone _____ mg, as prescribed.
- Use reliever (blue) Inhaler _____ puffs (one puff at a time to six breaths) through spacer, at 20 minute intervals for one hour.
- If symptoms continue to worsen and peak flow drops further follow Red Zone.
- If symptoms improve, follow Yellow Zone.



Red Zone-Emergency !!!! If you experience any of the following, action red zone

- Severe difficulty with breathing, walking or talking
- Blueness of lips or skin
- Exhausted due to the effort of breathing
- Wheezing stops suddenly



Dial 111 and ask for ambulance

- State your child/you are having a Severe Asthma Attack
- Give/Take 6 puffs of blue reliever inhaler through a spacer (one puff at a time to every 6 breaths) every 6 minutes until help arrives.
- If alone contact a support person to stay until help arrives.





Dust Mites? We've got a solution!



The first **natural** organic-based dust mite control agent which really works!

DUST MITES are one of the biggest triggers of asthma and other allergic reactions for an overwhelming 1 million New Zealanders.

They feed on dead skin and dander produced by humans and animals and then excrete their waste products in soft toys, bedding and carpets.

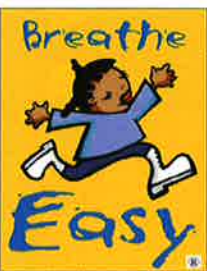
So **DUST MITES** are found in places that your family is in constant contact with!

Naturobiotech **Allerzero** is the safest way to protect them.

Allerzero kills dust mites simply and safely through the action of cinnamon. Where protective coverings offer some relief from the allergens produced by dust mites, peace of mind comes from **eliminating** them altogether.



Allerzero is proudly **recommended** and endorsed by **Asthma New Zealand**. Tested and approved by the worlds leading experts in Dust Mites, including the President of Asthma New Zealand, Microbiologist Richard Thorogood, we are proud to be able to offer you a natural solution to keeping your home safe from allergen-causing mites.



Allerzero Dust Mite Spray is available from :
Asthma New Zealand, 581 Mt Eden Rd, Mt Eden, Ph (09) 630 2293 or view online at www.naturobiotech.co.nz



North & South

NEWS FROM AROUND THE REGIONS

INTRODUCING: HEATHER McMILLAN



Heather McMillan is the new Auckland City Asthma Educator for the Auckland Asthma Society Inc. She is based at the Asthma Centre in Mt Eden.

Heather trained as a Comprehensive Nurse at Nelson Polytechnic.

She has worked in the fields of aged-care, practice nursing, school nursing and skin screening.

Heather's interests include tramping, photography, reading, cookery, music, gardening and, in particular, her family and grandchildren. She lives in Remuera.



WE HAVE MOVED!

Asthma South Canterbury has moved to their bright shiny new rooms. Great news for all in the South Canterbury Area. Asthma South Canterbury has moved to the newly renovated Community House at 27-29 Strathallan Street. The room is bright, clean and very convenient.

Asthma Nurse Jane Dunbar will be there every Tuesday with free advice for those who need it. There is a bus stop right at the door, and if you wish to drive then there are visitor car parks right beside the rooms.

We have more good news for you. Jane has just completed and passed her COPD course so well done Jane, we are all very pleased for you and of course for all in our region with COPD.

If you require any assistance or guidance on the use of your medication, spacers or peak flow please contact Jane as if you are unable to come and see her, she will visit you in your own home. To contact Jane please phone 687 7379 ext 121.

Congratulations!!!! - From Asthma New Zealand/ the Lung Association

INTRODUCING: ANNEMARIE DOBSON



Annemarie Dobson is the new South Auckland Asthma Educator for the Auckland Asthma Society Inc. She is based at the Asthma Centre in Mount Eden.

Annemarie is a New Zealand Registered General and Obstetric Nurse who originally trained at Thames Hospital. She has since also completed the Plunket Certificate and a Batchelor's Degree in Health Science at MIT.

Her clinical experience is extensive and includes work at Middlemore Hospital, National Womens, Lansdowne Hospital, District Plunket Nursing (Sth Auckland), Plunketline Telenursing and Kidz First Public Health Nursing.

Annemarie's interests include the outdoors, camping and tramping, fitness, nutrition, child health, reading, education and fashion.

What has happened to our health system?? What has happened to NZ??

The following letter has been received from a U.K. qualified asthma nurse highlighting her concerns over what she found to be happening in New Zealand on her return to New Zealand after 18 years in the UK.

The O2 Respiratory Journal would be interested in your comments.
G.A.Hanna / Executive Director

I was born in NZ but have been living in London for the past 18 years following my "OE". I worked in London as a Nurse Specialist working into Primary Care.

We worked with all the flaws, faults and constant frustrations of the Health System in the UK, the NHS, but nothing could've prepared me for my return "home" to the Health System that faces me now!

I am staggered by the lack of concern and, at times, blatant disregard for the poverty that obviously exists in New Zealand. Having only been in New Zealand for 16 months it seems to me that somehow NZ has lost sight of, not only the poverty and strife in its own country, but to a certain extent, world-wide. They seem oblivious to the poverty and recurring disasters that are happening world-wide. In the UK it seemed part of life – the constant news update of the world tragedies and calls for help as well as the concerns of the plight of the UK itself. Here in NZ it seems that New Zealanders themselves are unaware and unconcerned about what is happening world-wide, maybe they feel that they are not part of the wider world which seems so apparent in many facets of life.

As a nurse I find it exasperating and frustrating to see how far behind the UK nursing in NZ is, especially in Primary Care. The majority of nurses in the primary sector seem to be regarded as servants to doctors this is depicted in the amount they get paid and what makes it worse is that some of the nurses themselves see it no differently.

I recently went to get some medication from my GP, which I have been on for the last 5 years in the UK, and was told that it isn't available in NZ. My GPs words to the pharmacist were "Is this

a third world country?". Perhaps behind all the appearances of white middle-class houses and pretty shop fronts there is a third world country that is growing but no one wants to acknowledge this!? I'm sure like many New Zealanders I resorted to ordering the medication online. I mentioned this to a prominent businessman and friend in London his words were "I thought the supplier of your medication was a third world country not New Zealand". What has happened to NZ?

I know that there are many other medications that are available in the world that New Zealand doesn't have access to – some of these drugs are LIFE SAVING drugs.

As a Respiratory Nurse Specialist I have available to my patients in the UK thirteen different inhaler devices. Here I have two devices I can offer, unless, of course, the patient has money then there is another device available. I ask the question - Are we living in a western country where we have access to what is available in the western world?? It doesn't appear so.

Some of these inhalers are funded but there is still the prescription fee even with a community service card. For example if you have 3 children needing asthma medications on a regular basis, the cost would soon mount up. There is not a cure for asthma but we can abolish symptoms through asthma medications. This costs money. If asthma is not treated it causes long term damage which can lead to more serious chronic conditions which will cost even more money, not only for the individual but also for the government - the country. Asthma NZ and The Asthma Foundation research states it costs the NZ government \$825million per year for uncontrolled asthma – it would cost 100 times

less if asthma was controlled i.e. no symptoms. Control of asthma for the patient would mean a reduction in GP visits/emergency treatment/hospital visits/time off work or school and less money spent on medications. The amount of money would be greatly reduced. What financial incentive does the GP have to make patients well or educate patients about asthma (or any chronic condition)? They would lose money. Having networked with several PHOs in Auckland and chatted to key Nurses the comment remains the same – What incentive is there?

Unfortunately, to obtain asthma control as a nation it would mean a lot of money spent on education, asthma clinics being set up and would include improving equality of accessibility, but in the end it would save millions and reduce chronic disease.

The public transport isn't reliable and is almost non-existent. You would need a car to get to the hospital/medical centre but petrol is so expensive and you can't afford to pay for an ambulance so what happens in an asthma attack – no car or no petrol, no money for a taxi and certainly no money for an ambulance --- what is the answer? Of course there are those who have never had the experience of "not having money" so they could not understand the concept/dilemma but generally these individuals remain judgmental, cynical and ignorant. I have experienced this attitude several times in the last 16 months.

In Chronic Obstructive Pulmonary Disease there is a drug that improves quality of life and reduces hospital admissions – it is a drug that is easy to use and only needs to be taken once a day. It works best in moderate to severe COPD yet in New Zealand it is only available on Special Authority once the patient has lost 60% of their lung function!! It is still available by prescription but at about \$100 each prescription. People are dying yet we can't give them what they need because we live in NZ – what has happened? There are many more drugs like this – this is just one example.

Bronchiectasis is known as a "third world" disease in the medical profession and a rare condition in the rest of the developed world. Yet

bronchiectasis is thriving and increasing in this country.

I will quote from an article by Innes Asher, Dee Parks and Carolyn Dakin "Promoting Better Policies for Children. Backgrounder 20." * This covers in detail some of the issues which I am trying to highlight. It is important to highlight one paragraph: "New Zealand ranks 80th in WHO member states in health system performance on level of health well below Australia and most developed countries (The WHO Report 2000). In the same report, the disability adjusted life expectancy or level of health in New Zealand is ranked 31st compared with 2nd in Australia." "Health Care in Primary Health Care or General Practice which forms the majority of health care delivered in New Zealand is private with out the safety net of equitable access Even the theoretical free access of children under 6 is not always practiced and is inadequate. I am surprised that there is so little debate about this aspect of privatization of healthcare, since access to healthcare is considered to be a basic human right (World Health Organisation, WHO, Alma Ata declaration 1987)."

Primary Care itself seems second to Secondary Care, yet Secondary Care deals with a small percentage of the population compared to Primary care, which deals with the whole population. Twisted thinking somehow. Secondary Care manages all the funds yet doesn't deal with where the New Zealand Health is at on the ground level.

Pharmac holds back on medications making them unavailable or too expensive for New Zealanders, yet in the "NZ Journal of Respiratory Health - O2", December 2006, states Pharmac had a surplus of \$19 million this financial year. New Zealanders who suffered with their health last year, whose quality of life worsened and who had family or friends die of conditions that could have been avoided by medications available in other western countries. I wonder if those New Zealanders were celebrating Pharmac's success. I wonder if they feel it's all worth a government organization making money at their expense.

To top it all off, the Anti-smacking bill is in the

process of being passed by government – yet it is a fact that 80% of New Zealanders are against it. How does a government in a democratic country pass a bill that the majority of the country doesn't want?? How does something like Pharmac still function in this same democratic country?? Or are we a Third World country under Dictatorship Rule?

There are many more issues I can bring up in this letter but I believe I have generally expressed my concerns. The question still arises – What has happened?

I have returned home to a shambles in politics and health. I have come backward in time. I watch "grown" adults call themselves politicians yet bicker like children – I have never seen it so child like and THEY rule the country. Is there any hope for New Zealand to get back on its feet?

Signed: "once proud to be a kiwi but no more"

* "Promoting Better Policies for Children. Backgrounder 20. Published March 2002" by Assoc. Professor Innes Asher, Dee Parks and Dr Carolyn Dakin. Child Poverty Action Group.



WORLD COPD DAY – 15 NOV 2006

World COPD Day was held on the 15th November 2006.

The COPD Exercise Group had a lovely luncheon at the Redwood Lodge. The luncheon was sponsored by Di-Perry Knox Gore from Boehringer / Ingelheim.

Asthma Rotorua handed out gifts and certificates to the members. The group really enjoyed World COPD DAY and they invite all COPD sufferers to join the group next year for some exercise and a whole lot of laughter.

We would like to thank the exercise group for inspiring others to get up and go!

Remember..... The less exercise you do, the more your muscles become weak and the less you will then be able to do. When you exercise your muscles regularly, they are able to do more work on less oxygen!

COPD Exercise Group meets every Wednesday at the Redwood Retirement Village, Te Ngae Road, Rotorua from 01:00pm – 03:00 pm.

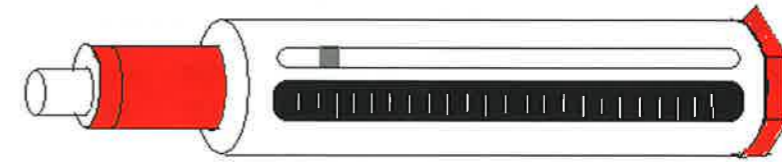
Rita Nieuwoudt
Community Asthma Educator

Kid's Challenge

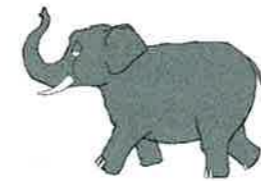
Kid's Challenge



Find the name for this device



This _____ Meter is a device that you blow through; it measures how hard you can blow air out. This measurement can tell you if there is any narrowing of the airways in your lungs. You can find the name of this device by writing the first letter of each animal picture below.



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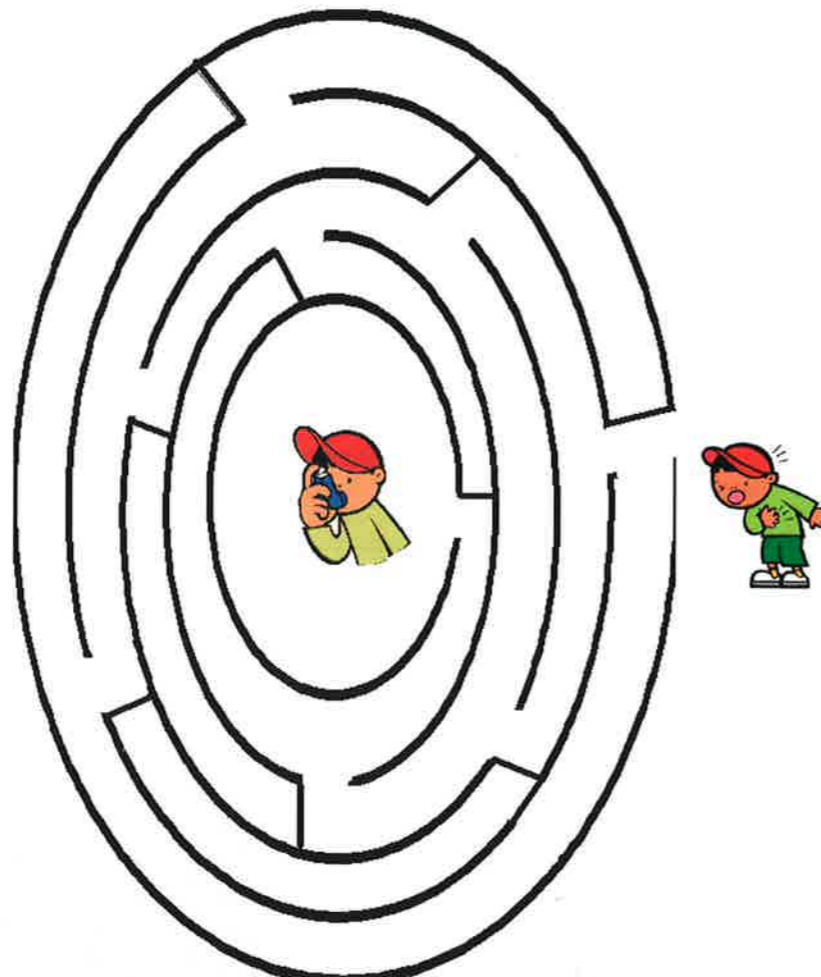


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Crossword

1	C									10	F									15	
16																					30
31																					45
47																					60
62																					75
77																					90
92																					105
107																					120
122																					135
139																					150
151																					165
173																					180
181																					195
207																					210
211																					225

Find my inhaler please



- Across**
- One of the signs and symptoms of asthma ----
 - This is a food allergy that can cause asthma ----
 - Short form of Exercise Induced Asthma ---
 - Your --- can be the trigger for your asthma
 - One easy non chemical method of killing dust mites -----
 - If you don't control your asthma, you feel ☹️
 - One of the allergens in spring is -----
 - Another trigger for asthma is ----
 - This is one breeding place for dust mites in your home -----
 - Flow Meter can tell if there is any narrowing of the airways in the lungs
 - An inhaled corticosteroid in a brown or orange inhaler is a-----
 - The trigger is not the Dust mite but its -----
 - One allergy test for allergens is the ----
- Down**
- The --- is the worst pet trigger
 - Recently found, an extract produced fromMussel helps Asthma
 - Control your asthma & be ☺️
 - MD Inhaler stands for ----- inhaler
 - Another symptom of asthma is ----
 - The O₂ Magazine is for the people who have ----
 - Young people from 13 to 19 ----
 - If your cat has asthma, who would it see? ---
 - The Blue inhaler is a -----
 - If you use your blue inhaler, you could --- the cross country

1. Cough	13. Metered dose
10. Fish	41. Wheeze
34. EIA	47. Asthma
43. Pet	69. Teen
62. Sun light	112. Vet
103. Sad	117. Reliever
144. Pollens	187. win
151. Cold	
173. Carpet	
181. Peak	
109. Preventer	
211. Droppings	
222. RAST	

Asthma as a Risk Factor for COPD in a Longitudinal Study

Graciela E. Silva, MPH; Duane L. Sherrill, PhD; Stefano Guerra, MD, PhD, MPH; Robert A. Barbee, MD, FCCP

ABSTRACT

BACKGROUND: For several years, asthma and COPD have been regarded as distinct entities, with distinct clinical courses. However, despite distinctive physiologic features at the time of diagnosis, and different risk factors, the two diseases over time may develop features that are quite similar.

STUDY OBJECTIVE: To evaluate the association between physician-diagnosed asthma and the subsequent development of COPD in a cohort of 3,099 adult subjects from Tucson, AZ.

DESIGN AND METHODS: A prospective observational study. Participants completed up to 12 standard respiratory questionnaires and 11 spirometry lung function measurements over a period of 20 years. Survival curves (with time to development of COPD as the dependent variable) were compared between subjects with asthma and subjects without asthma at the initial survey.

RESULTS: Subjects with active asthma ($n = 192$) had significantly higher hazard ratios than inactive ($n = 156$) or nonasthmatic subjects ($n = 2751$) for acquiring COPD. As compared with nonasthmatics, active asthmatics had a

10-times-higher risk for acquiring symptoms of chronic bronchitis (95% confidence interval [CI], 4.94 to 20.25), 17-times-higher risk of receiving a diagnosis of emphysema (95% CI, 8.31 to 34.83), and 12.5-times-higher risk of fulfilling COPD criteria (95% CI, 6.84 to 22.84), even after adjusting for smoking history and other potential confounders.

CONCLUSIONS: Physician-diagnosed asthma is significantly associated with an increased risk for CB, emphysema, and COPD.

Fish Oil Supplements Prevent Exercise Airway Constriction in Asthmatics

By Anthony J. Brown, MD

NEW YORK (Reuters Health) Jan 09 - Adding fish oil supplements to the diet can prevent exercise-induced bronchoconstriction (EIB) in asthmatics, a very common problem in this patient group, new research shows.

In an earlier study, Dr. Timothy D. Mickleborough, from Indiana University in Bloomington, and colleagues had shown that fish oil supplements can improve pulmonary function in elite athletes with EIB, but their use in asthmatics with the condition had not been well studied.

"The current findings suggest that fish oil supplements may be of value to asthmatics with EIB," Dr. Mickleborough told Reuters Health. "Our results support previous reports suggesting that the benefits are mediated through the

antiinflammatory effects of fish oil."

In a randomized, crossover study, the researchers assessed pre- and postexercise lung function and sputum inflammatory markers in 16 asthmatic patients with EIB who received a normal diet that was then supplemented with fish oil capsules or placebo for 3 weeks. After a 2-week washout, they switched to the other regimen, according to a report in the January issue of *Chest*. With the normal diet as well as the placebo-supplemented diet, the participants exhibited EIB. By contrast, with fish oil supplementation, the drop in FEV1 that occurred with exercise was smaller and did not reach the threshold needed for an EIB diagnosis. In addition, with this diet, the subjects were able to cut back on

bronchodilator usage.

Compared with the other diets, the fish oil-supplemented diet was associated with a significant drop in a number of sputum inflammatory mediators, such as leukotriene C4 and tumor necrosis factor-alpha. This was noted both before and after exercise.

Dr. Mickleborough said that subjects in the present study received 20 capsules of fish oil per day, in keeping with the dose his team had used in their earlier study. He agreed that this large amount could raise compliance issues and said that he hopes to conduct a dose-finding study in the future, which could result in the use of a much smaller dose. *Chest* 2006;129:39-49.

Endotoxin and indoor allergen levels in kindergartens and daycare centres in Wellington, New Zealand

Karen Oldfield, Rob Siebers, Julian Crane

ABSTRACT

AIMS: A large majority of children in New Zealand attend daycare centres and kindergartens early in life. Overseas studies have demonstrated a possible protective effect of daycare attendance against asthma and allergy later in life. One hypothesised agent for this protection is high levels of endotoxin, which have not previously been measured in New Zealand childcare facilities. The purpose of this study was to measure endotoxin and indoor allergens in

kindergartens and daycare centres in the Wellington region.

METHODS: Dust samples were collected from 18 kindergartens and 18 daycare centres and analysed for endotoxin by the kinetic limulus amoebocyte lysate assay and for indoor allergens by double monoclonal/polyclonal antibody ELISA.

RESULTS: The geometric mean level (95% CI) was 29,206 EU/g (19,410–43,950) for endotoxin, 0.25 µg/g (0.04–2.28) for Der p 1, 1.24 µg/g

(0.80–1.90) for Fel d 1, 0.43 µg/g (0.26–0.71) for Can f 1, and 0.028 µg/g (0.020–0.039) for Bla g 2.

CONCLUSIONS: Endotoxin levels in daycare centres and kindergartens in Wellington, New Zealand are similar to domestic dwellings in Wellington, however indoor allergen levels are much lower. The low indoor allergens in the daycare centres and kindergartens are unlikely to be problematic for sensitised infants, although some individual childcare facilities had very high Der p 1 levels.

Lower inhaled steroid requirement with a fluticasone/salmeterol combination in family practice patients with asthma or COPD

TRJ Schermer^a, JMC Albers^a, HWJ Verblact^b, RJMG Costongs^c and P Westers^d

ABSTRACT

BACKGROUND: Previous studies on inhaled steroid and long-acting beta2-agonist combination products may not be representative for the asthma and chronic obstructive pulmonary disease (COPD) patients in family practice.

OBJECTIVES: To compare in a group of doctor-diagnosed patients with asthma or COPD, the effects of a lower dose of fluticasone in a combination product with salmeterol with conventional treatment (i.e. a higher dose of fluticasone), both supplemented with as-needed use of a short-acting bronchodilator.

METHODS: The study was a 12-week multicentre, randomized controlled, double-blind trial. In all, 41 family practices recruited 137 patients diagnosed with asthma and 40 patients diagnosed with COPD. Primary outcome was the forced expiratory volume in 1 second (FEV1) as percentage of predicted. Morning peak expiratory flow (PEF), symptom-free days, health status [Asthma Quality of Life Questionnaire (AQLQ) and St. George's Respiratory Questionnaire (SGRQ)], exacerbations, use of short-acting bronchodilators and adverse events were secondary outcomes.

RESULTS: FEV1% predicted increased 2.6% (SD 8.3) in fluticasone/salmeterol- and 0.01% (SD 6.6) in fluticasone-treated patients (overall: $P =$

0.036, asthma: $P = 0.025$ and COPD: $P = 0.700$). PEF increased in favour of fluticasone/salmeterol in asthma patients only ($P = 0.016$). Fluticasone/salmeterol-treated asthma patients had 1.1 more symptom-free days per week ($P = 0.044$); no such effect was observed for COPD ($P = 0.769$). There were no differences in total AQLQ and SGRQ scores, exacerbations, use of reliever puffs or adverse effects.

CONCLUSIONS: In family practice patients diagnosed with asthma, several treatment goals were better achieved with a lower dose of fluticasone and salmeterol in a combination product than with a higher dose of fluticasone. We found no differences between the two approaches for patients with COPD.

Spacer inhalation technique and deposition of extrafine aerosol in asthmatic children

C. M. Roller¹, G. Zhang¹, R. G. Troedson², C. L. Leach³, P. N. Le Souëf¹ and S. G. Devadason¹

The aim of the present study was to measure airway, oropharyngeal and gastrointestinal deposition of ^{99m}Tc-labelled hydrofluoroalkane-beclomethasone dipropionate after inhalation via a pressurised metered-dose inhaler and spacer (Aerochamber Plus™) in asthmatic children.

A group of 24 children (aged 5–17 yrs) with mild asthma inhaled the labelled drug. A total of 12 children took five tidal breaths after each actuation (tidal group). The other 12 children used a slow maximal inhalation followed by a 5–10-s breath-hold (breath-hold group). Simultaneous

anterior and posterior planar ^{99m}Tc-scintigraphic scans (120-s acquisition) were recorded.

For the tidal group, mean±SD lung deposition (% ex-actuator, attenuation corrected) was 35.4±18.3, 47.5±13.0 and 54.9±11.2 in patients aged 5–7 (n = 4), 8–10 (n = 4) and 11–17 yrs (n = 4), respectively. Oropharyngeal and gastrointestinal deposition was 24.0±10.5, 10.3±4.4 and 10.1±6.2. With the breath-hold technique, lung deposition was 58.1±6.7, 56.6±5.2 and 58.4±9.2. Oropharyngeal and gastrointestinal deposition was 12.9±3.2,

20.1±9.5 and 20.8±8.8.

Inhalation of the extrafine formulation with the breath-hold technique showed significantly improved lung deposition compared with tidal breathing across all ages. Oropharyngeal and gastrointestinal deposition was markedly decreased, regardless of which inhalation technique was applied, compared with a previous paediatric study using the same formulation delivered via a breath-actuated metered-dose inhaler.

Effect of primary-care spirometry on the diagnosis and management of COPD

P. P. Walker¹, P. Mitchell², F. Diamantea¹, C. J. Warburton² and L. Davies²

Primary-care spirometry has been promoted as a method of facilitating accurate diagnosis of chronic obstructive pulmonary disease (COPD). The present study examined whether improving rates of diagnosis lead to improvements in pharmacological and nonpharmacological management.

From 1999 to 2003, the current authors provided an open-access spirometry and reversibility service to a local primary-care area, to which 1,508 subjects were referred. A total of 797 (53%) had pre-bronchodilator airflow obstruction (AFO).

Of the subjects who underwent reversibility testing, 19.3% were no longer obstructed post-bronchodilator. The results and records of a subgroup of 235 subjects with post-bronchodilator AFO were examined.

Of the 235 subjects, 130 received a new diagnosis, most commonly COPD. The patients with COPD were significantly undertreated before spirometry and testing led to a significant increase in the use of anticholinergics (37 versus 18%), long-acting β-agonists (25 versus 8%) and inhaled steroids (71 versus 52%). More than three

quarters of smokers received smoking cessation advice but very few were referred for pulmonary rehabilitation.

In conclusion, primary-care spirometry not only increases rates of chronic obstructive pulmonary disease diagnosis, but it also leads to improvements in chronic obstructive pulmonary disease treatment. The use of bronchodilator reversibility testing in this setting may be important to avoid misdiagnosis.

www.asthma.org.nz

Asthma New Zealand / The Lung Association has been caught in the WEB!

The "Breathe Easy" Website was launched on the 17th February 2006.

To access the services of Asthma New Zealand/the Lung Association, Asthma Auckland and partner societies go to:

www.asthma.org.nz

This exciting innovation from Asthma New Zealand has been quite some time in the production, but when you view it you will see it has been worthwhile. The web site developers have kept the site colourful, interesting, simple and direct so that up to date information can be accessed by a simple click of the mouse. If you do not have internet access, remember that most libraries have computers with internet access available to the public, so why not have a look and explore our website

The home page displays our "Breathe Easy" logo and has an EMERGENCY Signal so you can quickly access steps on "What to do in an asthma emergency".

There is also an A-Z asthma glossary, providing definitions for the most common words used in association with asthma and Chronic Obstructive Pulmonary Disease (COPD). Some examples of these: spacers, triggers, wheezing etc.

The asthma question section covers frequently asked questions. Many people have similar questions and concerns about their asthma – the answer you want may be here.

The website will promote current news and events. This will be regularly updated to keep you informed. This will include our COPD monthly meeting dates for the year.

From within the website, you will be able to move easily from the Breathe-Easy homepage to the

will endeavor to achieve this.

Of further interest is the ability to download copies of some of our pamphlets and in time we hope to be able to include a download of our quarterly journal "The NZ Journal of Respiratory Health" O2.

So it's now time for everyone to **GO SURFING** and experience the Breathe-Easy Site.



Asthma New Zealand- the Lung Association or to the Asthma Auckland homepages and back again.

We welcome any feedback you have regarding our website, including anything you think we should add. As you can understand, a website is a living document and requires maintenance to keep the information relevant and up to date. We

ALLERGEN BARRIER BEDDING COVERS PROVEN EFFECTIVE PROTECTION FROM DUST MITE ALLERGEN



MiteGuard²

RECOMMENDED FOR MITE-ALLERGIC SUFFERERS OF ASTHMA, ECZEMA AND CHRONIC RHINITIS

- PROVEN EFFECTIVE - Independently tested by Allergy Specialists
 - COMFORTABLE - Precision microweave polyester-cotton fabric
 - QUALITY - Made in NZ, 5 year manufacturer's warranty
- *NEW... 100% cotton **Cotton Natural** covers now available... *NEW*

Available from Asthma Societies
phone: (09) 817 4669 for information, e-mail: info@allergencontrol.co.nz



Benefit of insulating your home

ecoinsulation www.ecoinsulation.co.nz

Eco Insulation has been engaged on the Snug Homes program for the last 12 months. This initiative was created in partnership with ASB Community Trust, Auckland City Council, Manukau City Council, Procure Networks Auckland and Manukau, Auckland DHB and the Starship Foundation. These funding partners support the Energy Efficiency and Conservation Authority to assist in the retrofitting of insulation measures to over 1400 homes in the greater Auckland area.

The programme targets low-income families with young children who have a history of respiratory illnesses, housed in pre-1977 homes, and for the aged.

The value of applying insulation measures, including to the ceiling and under-floor, hotwater cylinder wrap, energy efficient light bulbs and front and rear door draft seals, can be measured in a number of ways.

So far over 800 homes have benefited from this program and it has dramatically improved the well being of hundreds of low-income families across Auckland. They report huge improvements in their health, lower power bills, fewer doctors' visits, reduced medication costs, and less time off work and school.

Overall, the project has been a huge success and has made a real difference to the lives of the householders and the community as a whole.

Background

In 1977 Standards New Zealand introduced a national standard on house insulation, which became effective in 1978, and remained the relevant standard for almost 20 years. A new standard was published in 1996, although it did not replace the former as minimum requirements until just recently. This study measures the levels of mainly ceiling insulation found against both standards.

Why Insulate

- Energy Efficiency
Less energy costs to increase warmth or reduce heat add up to savings in the power usage and subsequent costs.
- Comfort
A warmer dryer house is a healthier home.

- Health
Insulation can reduce dampness, mildew and improve living standards and health.
- Legal Requirement
The minimum standard requirements must be met, but the better the insulation, the bigger the savings, the more efficient your house is and the longer the benefits will last.

Typical heat loss in houses



Insulation	Annual savings
Ceiling insulation	\$140 to \$390
Underfloor insulation	\$50 to \$250
Hot water cylinder wrap & lagging	\$80+

ecoinsulation
www.ecoinsulation.co.nz



Laura's story about her Asthma

Asthma, one of the strangest things one could come across. One minute you are as happy as you could get and the next you have a horrible cough and it is hard to breath. My name is Laura and I have just, last year, found out that I myself have asthma. It was getting really hard to breath and I started to cough a lot, and that's when I found out I have hay-fever induced asthma. My chest went all tight, and I could no longer just breathe out of my nose. I had to take really deep breaths every time I opened my mouth to get just enough air. I got a prescription for an inhaler and a medicine called claratine. It was hard for me to use the inhaler correctly but I soon got used to it. I still have asthma although it's not that bad now, but I still sometimes get really puffed out and end up gasping for air.

How I got asthma is simple. Most of it was really the dust mites I think, they made me cough a lot and made me wheeze. I still have all my allergies and have to be careful around things like: dogs, cats, and lots of dust. I live with asthma and have learnt to deal with it. So for those who have asthma you will learn to deal with it too and I wish you **good luck!**

Laura McMahon aged 10
Auckland

asthma
AUCKLAND



Yes! I want to support Asthma Auckland

Name: _____
Title First Name Surname

Address: _____

Phone: _____ Date Of Birth: (optional) ____/____/____

Benefits

- Magazine subscription (The NZ Journal Of Respiratory Health)
- Advice & support from Asthma educators
- Networking opportunities/support groups
- Access to information & medical research

Your donation will also help provide education & support for other people with asthma and their families

Annual Membership \$25
Donation (tax deductible)

- Cheque enclosed \$ _____
 Please debit my credit card \$ _____

- Visa MasterCard Diners Amex
[Card number grid]

Cardholder's name: _____

Signature: _____ Expiry date ____/____/____

- I would like information about making a bequest.

Asthma info line:
Phone: 09 630 2293
Fax: 09 623 0774
Email: aas@asthma-nz.org.nz
Web: www.asthma-nz.org.nz
Information collected for Asthma Auckland use only. Under the Privacy Act members have the right to access and correct any information by contacting Asthma Auckland

Return this form to:
Asthma Auckland
P O Box 67 066
Mt Eden 1349
Auckland
New Zealand
Regional Office:
581 Mt Eden Rd
Mt Eden
Auckland, 1024 NZ

Asthma Nursing Course

(COPD) Nursing Course

Congratulations!

Asthma New Zealand/
The Lung Association
congratulate the following
nurses who successfully
completed the Certificate
in Asthma Nursing Course
in 2006 - 2nd Semester.

- | | |
|--|-------------------------------------|
| 1. Julie Beare - Pukekohe | 9. Andrea Johnson - Nelson |
| 2. Anna Carter - Bucklands Beach | 10. Heather Kellas - Maraetai Beach |
| 3. Anna Dunne - Massey | 11. Pirihiira Maxwell - Papatoetoe |
| 4. Drina Fletcher - Weymouth | 12. Melissa Miles - Henderson |
| 5. Elizabeth Frew - Te Atatu Peninsula | 13. Bridget Quigan - Miramar |
| 6. Elizabeth Graham - Bombay | 14. Karen Tidey - Drummond |
| 7. Bryony Hales - Wellington | 15. Maree Tonks - Carterton |
| 8. Deborah Hogan - Albany | 16. Jacque Webber - Rotorua |

Congratulations!

Asthma New Zealand/
The Lung Association
congratulate the following
nurses who successfully
completed the Certificate
in Chronic Obstructive
Pulmonary Disease Nursing
Course in 2007

- | | |
|--------------------------------------|---|
| 1. Diane Albao - Auckland | 12. Michael McGivern - Okaihau |
| 2. Pauline Frances Ansley - Westport | 13. Joanne Meinung - Palmerston North |
| 3. Catherine Clark - Whakatane | 14. Christine Rothman - Wanganui |
| 4. Jane Dunbar - Timaru | 15. Barbara Stirling - Limehills |
| 5. Darryl Francis - Kawakawa | 16. Susan Taylor - Westport |
| 6. Marla Hill - Westport | 17. Rittu Thomas - Waitakere |
| 7. Denise Hunt - Otorohanga | 18. Jennifer Wikeepa - Palmerston North |
| 8. Joanne Hunter - Bluff | 19. Judy Po Fong Wong - Auckland |
| 9. Elsa Lally - Motueka | |
| 10. Hye Lan Lee - Auckland | |
| 11. Debra Leutenegger - Auckland | |

Attention: All Children In Auckland Who Have Asthma
Breathe Easy!!!



Is your child between 6- 13 years?
Does your child have asthma?
Do you live in the Auckland area?



If the answer to these questions is "yes" read on

Why?

Asthma New Zealand needs **volunteers** to participate in a study which is investigating the benefits obtained from taking a natural product made from a marine substance, on children who have asthma. The only known side effect of taking this natural product is

Taking part in this study may help reduce the participants' use of asthma medication and the knowledge gained may help other children gain better control of their asthma.

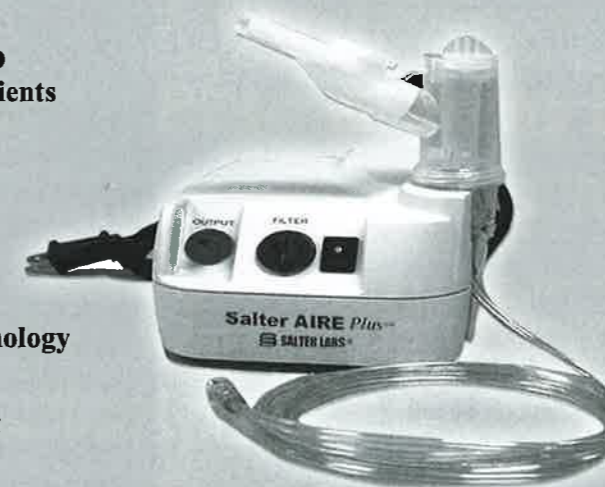
(in some participants only) slight itching. Allergic reactions are therefore not anticipated. Children with asthma who are taking inhaled corticosteroids are required. Children must be able to swallow capsules in order to participate, as there is no alternative form of medication. As the child's parent or guardian you will be asked to provide written informed consent before enrolling in the trial.

To find out more or to enrol please contact Ann or Heather at
Asthma New Zealand/the Lung Association ph 09 623 0236



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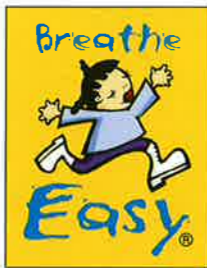
For enquiries, please contact Customer Services:
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email: customerservice@remsystems.co.nz

For Information regarding Asthma &
COPD nursing courses please email
swarnah@asthma-nz.org.nz





LET'S FIGHT ASTHMA TOGETHER



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Your gifts can attract a Tax rebate. We will send you a receipt shortly for your donation.

Mr/Mrs/Miss/Ms

Address:

Telephone: E-Mail:

- Please send me information on how I can help Asthma New Zealand through my will
- I have already left a bequest for the Asthma Society through my will
- I would love to do some voluntary work to fight asthma

Asthma New Zealand - the Lung Association

581 Mt Eden Road, PO Box 67-066, Mt Eden, Auckland 1024 NZ
Phone (09) 623 0236, Fax (09) 623 0774, Email anz@asthma-nz.org.nz

Thank you for helping us to fight asthma and make New Zealand breathe easy

Asthma New Zealand's partner societies around New Zealand:

AUCKLAND ASTHMA SOCIETY (INC.)

P O Box 67 066,
581 Mt Eden Rd, Auckland 1024
Ph (09) 630 2293

CANTERBURY ASTHMA SOCIETY (INC)

275 Cashel Street,
P O Box 13091 Christchurch 8013
Ph (03) 366 5235

ROTORUA ASTHMA SOCIETY

2/285 Vaughan Road,
P O Box 472 Rotorua 3010
Ph (07) 347 1012

SOUTH CANTERBURY ASTHMA SOCIETY

23 Aviemore Street,
P O Box 267, Timaru 7910
Ph (03) 688 5571

SOUTHLAND ASTHMA SOCIETY

70 Forth Street,
P O Box 1793, Invercargill 9810
Ph (03) 214 2356

WELLINGTON ASTHMA SOCIETY

Level 4, Pember House, 16 Hagley St,
Porirua, Wellington 5022
Ph (04) 237 4520

WHAKATANE ASTHMA AND COPD GROUP

P O Box 528,
141 - 143 King St, Whakatane 3120
Ph (07) 307 1447

Questions, Letters, Articles, Advertisements

Asthma Update welcomes dialogue with readers. Whether you are a person with asthma, a company involved in the sector, or a potential advertiser, we welcome your enquiries and communication.

Contact:
Asthma New Zealand
581 Mt Eden Road, Auckland
Phone (09) 623 0236
Email anz@asthma-nz.org.nz



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