

THE NZ JOURNAL OF RESPIRATORY HEALTH
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on the cover:

From Left: Dean Barker, Dennis Conner, Sir Michael Fay
An Evening with America's Cup Yachting Legends at The Langham,
Auckland in aid of Asthma New Zealand

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Asthma and COPD Nursing Course Information

Applications are now invited from registered nurses wanting to enrol in the Asthma New Zealand/Unitec Asthma Nursing Course for July 2011. The programme is offered by distance learning. The primary aim of the Asthma Nursing Course is to provide nursing health professionals with a high level of evidence-based asthma knowledge that promotes best practice and is consistent with national policy.

Many applicants had not undertaken any additional study since completing their nursing training, which may have been years before. However, most find the courses to be challenging but thoroughly enjoyable learning experience that is within the grasp of any competent nurse practitioner.

Asthma New Zealand in association with Unitec New Zealand offers this course within the Bachelor of Nursing Programme. Asthma Nursing Course is a level 7 course and attracts 24 credits. **A grant towards the cost available for registered nurses.**

For an enrolment form for the 2nd Semester please contact:

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The closing date for 2nd Semester enrolment is 30th June 2011

Upcoming events and courses

ASTHMA NEAT COURSE

15 June 2011
21 September 2011

HALF DAY COPD COURSE

20 April 2011
20 July 2011
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Asthma Control Test™

message to readers

An open letter to healthcare professionals – put asthma to the test

Asthma New Zealand is on a mission to change the way asthma is managed in our country and we need your help.

This chronic disease affects more than 600,000 Kiwis and we have the second highest prevalence of asthma in the world (after the UK).

Many people with asthma falsely believe they have control of their asthma. Research tells a different story – more than half (54%) of New Zealand do not meet international best-practice (GINA) guidelines for asthma control.

As part of Asthma Awareness Week, which runs from April 27 to May 3, we urge you to put asthma to the test at your practice.

A simple, yet effective tool called the Asthma Control Test (www.asthmacontrol.co.nz) has been developed which enables you to quickly determine whether patients are managing their asthma effectively. It provides useful insights so you can help your patients to achieve better asthma control.

We strongly encourage you to use the Asthma Control Test with patients who have existing appointments and to target those patients with asthma you may not have seen for a while.

Together, we have the ability to change what a life with asthma means. Patients who have lived with the symptoms of asthma for a long time

and have accepted them as part of life can, with proper asthma control, achieve a near normal quality of life. It is our responsibility to help them get there.

Gerry A. Hanna
CEO
Asthma New Zealand



peak flow monitoring

Compiled by Murray Webb

– Asthma and Respiratory Devices New Zealand

Just over 50 years ago British bioengineer Martin Wright invented the mechanical peak flow meter, a simple device to aid in the diagnosis and management of asthma. It is designed to measure maximal airflow during forced expiration – or, in simple terms, how fast air can be expelled from the lungs. This gives the person with asthma an objective assessment of how well their condition is under control. In New Zealand, PHARMAC subsidises up to 40,000 peak flow meters every year, suggesting the ongoing importance of the device in asthma management.



Specific reasons to use a peak flow meter and a written diary of daily readings include:

- To assist in the diagnosis of asthma and its severity
- To determine how well current asthma medication is working
- To assess response to changes in asthma therapy
- To help identify triggers (such as allergens in occupational settings)
- To help avoid asthma exacerbations by detecting decreasing lung function early, and potentially altering treatment

It should be noted that symptom assessment is equally important when making the above appraisals. However, one study indicated that up to 20% of people are unable to gauge the severity of their asthma symptoms despite significant deterioration in their lung function. Another study showed that children exhibited inaccurate symptom perception one-third of the time. Objective surveillance with peak flow meters would thus seem especially important to these groups.

Unfortunately, however, peak flow monitoring is not always possible for some people. The very young and very old may have trouble coordinating a breath in order to register a reproducible result. Furthermore, care should be taken by people with the following health conditions should they wish to undertake monitoring:

- Current painful ear infection
- Eye surgery in the last 3 months
- Chest/abdominal surgery in the last 3 months
- History of aneurysm or collapsed lung
- History of detached retina
- Stroke or heart attack in the last 3 months
- History of coughing up blood in the last month

Other issues include patient compliance – using a mechanical peak flow meter necessitates the keeping of a written peak flow diary. Two separate studies have found that only 50% of children's peak flow diary entries were accurate after 3 weeks of recording – mainly because the children began making up readings, possibly out of sheer boredom. Dr Glenn Twentyman, a GP working in Manurewa, makes the observation, "Keeping a peak flow diary is just like homework for a child, sometimes they just don't want to do it. Unfortunately, fabricated diary entries can lead to under- or over-dosing of asthma medication for that child". Readings that are missing altogether from diaries are another common compliance issue, even with adults.

Much better compliance is achieved using electronic peak flow meters that record every reading automatically, thus removing the need to continuously update a diary. One study that used the nSpire Piko-1 electronic peak flow meter (which is now available in New Zealand) found that people used it as directed up to 93% of the time, only rarely forgetting times that they were meant to blow into it. An added benefit of an electronic peak flow meter is that data falsification - and related asthma treatment errors - are eliminated.

In summary, peak flow monitoring remains an important aspect of a broader asthma management plan. The advent in New Zealand of user-friendly electronic peak flow meters will certainly contribute convenience and reliability to the process, especially with children.

The nSpire Piko-1 electronic peak flow meter is available from Asthma New Zealand, pharmacies, and via the online shop at www.allergy.org.nz

Selected references:

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are women more likely to have asthma than men?

Compiled by Ann Wheat RN, BN

It is known that in children boys have worse asthma than girls. But by the time girls reach adulthood the opposite is in fact true, and women do have worse asthma than men. According to McCallister & Mastronarde (2008) this could be because women experience asthma symptoms differently to men with more asthma symptoms and poorer quality of life. They go on to say that females have greater healthcare utilization, more frequent use of oral steroids and a greater use of rescue medication. They also have more anxiety than men. McCallister & Mastronarde (2008) also says that sex related differences exist in hospitalizations and mortality as well. Women are more likely to be admitted to hospital than men and this is despite having better lung function on arrival at emergency departments. There are often more asthma deaths in women than men (McCallister & Mastronarde, 2008).

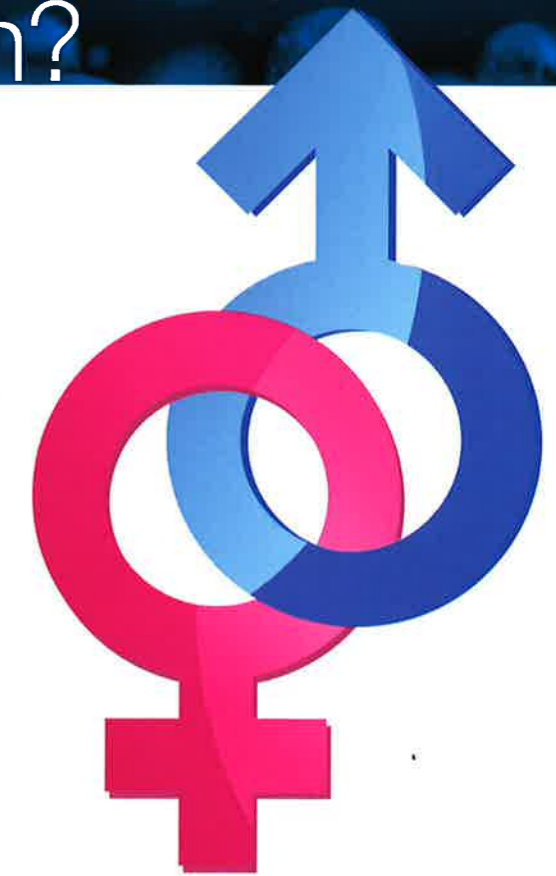
What can cause these variations between men and women?

Firstly women are more likely to have an increase in bronchial hyper responsiveness or as it is more commonly known broncho-spasm in the bronchioles. This is where there is an exaggerated response to asthma triggers such as cigarette smoking. Bronchial hyper responsiveness can persist even when people are thought to have excellent control of their asthma.

Female hormones may also play a part in asthma being worse in women than men. It has been reported by McCallister & Mastronade (2008) that between 20 and 40 percent of women of reproductive age will complain of worse asthma symptoms three days prior to and at the fourth day of the menstrual period. There are other times that asthma is worse for women and that is during pregnancy. This may not be true for all women as it is estimated that about a third of women with asthma will become worse during pregnancy and may require an increase in medication while a third remain the same and a third show improvement. The other time that can be problematic is at menopause especially for lean women according to Real, Svanes, Omenaas et al (2008). They say that women have lower spirometry lung function results even after only 6 months of menopause and more respiratory symptoms. Real et al (2008) say that the optimum weight for women at menopause is with a BMI of between 23 to 28 kg/m2.

Finally, a study by Hancox, Milne, Poulton et al (2005) identified that an increased body mass index is associated with asthma and atopy in women but not in men. They went on to say that 28% of asthma that develops after the age of nine is due to women being overweight.

Once identified, the importance is to find out how well controlled asthma is and if it is not well controlled, then an increase in medication may be required and it would be important to visit your doctor to have your asthma reassessed and then at least annually. To identify how well controlled your asthma may be then a simple tool to use is the Asthma Control Test which is included in this magazine. If one is not included then it is possible to go www.asthmacontrol.co.nz to take the test.



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managing asthma during school time

Compiled by Janet Delooze RN



As asthma nurse educators, we are frequently asked by parents how they can manage their child's asthma in the school environment. Parents need to know that when they leave their children at school that the staff are informed of any health issues, and can assist with the administration of medications and confidently deal with any emergencies that may arise. Apart from the health and safety aspects, one of the main problems is the number of school days lost due to asthma.

Studies in the US have shown that asthma is the leading cause of school absenteeism due to a chronic condition, accounting for nearly 13 million missed school days. Children who have had interrupted sleep due to night time asthma symptoms come to school tired and may fall asleep in the classroom. They can also be lethargic or irritable. Additionally, students who experience difficulty in breathing find it difficult to concentrate on schoolwork, and those who need breathing treatments during school hours miss class time. (Environmental Protection Agency, 2001).

To help support school staff in caring for children with asthma, we can provide the School Asthma Education and Emergency Kit. The kit contains an education folder of asthma information and record forms together with a belt bag with asthma emergency devices, medication and instruction card.

The folder is presented to school staff after an education session has been undertaken and aims to:

- Provide school staff with a better understanding of asthma and its management
- Assist schools to be able to deal confidently, correctly and effectively with an asthma emergency.

In the event of a child with asthma having an asthma attack the kit:

- Ensures the caregiver is able to competently administer the Ventolin treatment as instructed on the "Dealing with an Asthma Emergency" card
- Assists school staff to recognise worsening asthma and implement appropriate action (Asthma New Zealand, 2010)

Some of the information contained in the kit: New Zealand Asthma Statistics

- 1 in 4 children
- 1 in 6 adults

Facts & Myths; What is Asthma? What are Triggers?

- For example:
- Foods, such as nuts, eggs, dairy products, etc.
 - Animals – there may be school pets
 - House dust mites – some schools have carpeted floors and other dusty areas
 - Exercise – a daily part of the school curriculum. Teachers need to be aware of how to help children with Exercise Induced Asthma to enable their participation in all physical activities and to reduce the onset of asthma symptoms.

Worsening Signs of Asthma
A description of mild, moderate and severe asthma: the emergency card explains what should be done in each case.

Asthma Medications
The inhaler most likely to be in school will be the child's reliever unless for some reason the child takes their preventer during school hours. It is important for school staff to understand the difference between relievers, preventers and symptom controllers so the correct medication is used in an emergency.

10 Tips for Good Asthma Control Suggested Guidelines for a Policy on Asthma To maintain the safety of the child with asthma during school hours

Asthma Action Plan
This form can be photocopied and sent home with each child who has asthma at their enrolment, when a child is newly diagnosed, on an annual basis or when the child changes class or teacher. It should be completed and signed by a doctor, and includes what medication the child is on, what should be taken before exercise and what should be taken in an emergency. All forms can be kept together with the first aider or wherever the inhalers are kept.

Record Card and Expiry Date Form
This enables all people dealing with the child, be it school staff or the parents, to keep track of the number of doses given to each child. Parents may be unaware how frequently their child is using their inhaler in school.

Instructions for Looking After Your Spacer and Spacer Cleaning Record
Staff in charge of medications and spacers need to be aware of their use and care. Apart from the hygiene aspect, spacers need to be washed weekly in warm, soapy water and left to air dry without rinsing to reduce the static. If there is static in the spacer, this will reduce the amount of medication reaching the airways. Spacers improve the clinical effect of inhaled medications, especially in patients unable to use a Metered Dose Inhaler properly (Lavorini and Fontana, 2000).

Instructions for using various types of inhaler
We do not expect school staff to become experts in all things concerning asthma, however, these instructions may be helpful if a child has a different inhaler from the majority that are kept in school.

Many children with asthma symptoms are sent home when they could easily and safely be dealt with in school. Supporting school staff to care for children with asthma can help reduce the number of sick days taken due to asthma, and give parents the confidence to know that their children are in safe hands.

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some medications can make your asthma worse

Compiled by Karen Little RN

Any person with asthma who is started on any new medication for another health condition should be advised to carry their reliever with them and to watch for any deterioration in their asthma. Also remember to ask your Doctor or pharmacist about the effect a new medicine may have on your asthma.

The most common medications known to trigger symptoms of asthma are:

Aspirin and other painkillers.

Approximately 10% to 20% of people with asthma have a sensitivity to aspirin or a group of painkillers called non-steroidal anti-inflammatory drugs – or NSAIDs – such as ibuprofen (Motrin, Nurofen, Advil) and naproxen (Aleve, Naprosyn). These drugs are frequently used to treat pain and reduce fevers. It is important that people with aspirin sensitivity read labels of all over the counter drugs used to treat pain, colds and coughs. Why a drug that normally decreases inflammation causes worsening asthma is not completely understood.

Beta-blockers.

Beta-blockers are commonly prescribed medications used to treat numerous conditions including heart conditions, high blood pressure, migraine headache, and, in eye form, glaucoma. These drugs can lead to problems because of the presence of beta receptors on respiratory passages. While blocking the action of beta receptors on blood vessels is a desired effect in treating high blood pressure (causing blood vessel dilatation), similar blockade of beta receptors on respiratory passages causes constriction, and can lead to dangerous consequences.

The beta blockers used to treat high blood pressure are not very selective, so they don't do a good job distinguishing between the different types of receptors on blood vessels and respiratory passages.



The commonly used non-selective betablockers are: carvedilol (Dilatrend), nadolol, pindolol, propranolol (Cardinol).

Because beta blockers are so effective at treating high blood pressure, an effort has been made to develop versions that do a better job of discriminating between blood vessels and respiratory passages. These drugs called selective beta-1-blockers, have been subjected to a variety of clinical tests in order to determine their safety in asthmatic patients. However even these medications are rarely prescribed to people with asthma. (Craig Weber).

The more selective B1 beta-blockers are metoprolol (Betaloc) and Atenolol.

Some betablockers are also present in eye-drops used to treat/control glaucoma – Timoptol contains timolol, Combigen contains brimonidine and timolol, Cosopt contains Dorzolamide and timolol, Betoptic contains betaxolol, Betagan contains levobunolol. These medicines are all either contraindicated in or cautioned in those people with asthma. They may cause respiratory failure, bronchospasm, dyspnoea and a cough. Your doctor will make the decision what medicine will be best for you.

Angiotensin-converting enzyme inhibitors (ACE inhibitors).

These are other types of medications used to treat heart disease and high blood pressure. These drugs can cause a persistent dry cough in about 10% of the patients who use them. (WebMD, 2009). This cough is not necessarily asthma. But, it can be confused with asthma or, in the

case of unstable airways, can actually trigger wheeze and chest tightness. If you are prescribed an ACE inhibitor and develop a cough speak to your doctor.

The commonly used ACE inhibitors in NZ are captopril (Capoten), cilazapril (Zapril), enalapril, lisinopril, quinapril (Accupril). Generally if a patient reports a dry cough while on an ACE inhibitor, they will be tried on another and if the cough persists they may be switched to an Angiotensin Receptor Blocker (ARB). Pregnant women cannot take ARB medication.

Safe Hypertension Drugs

Many drugs for treating hypertension are safe to use in patients with asthma, including:

- Angiotensin Receptor Blockers (ARBs)
- Diuretics
- Calcium Channel Blockers

One side effect of diuretic treatment in all patients, not just those with asthma, is low potassium (hypokalemia). Though all patients treated with diuretics have some risk of developing hypokalemia, this risk is somewhat higher in patients using inhaled asthma drugs. (Craig Weber). Asthma medications have a tendency to force potassium out of the blood and into cells, where it is not freely available. This tendency, combined with the potassium sapping nature of diuretics, means that asthmatic patients using these two types of drugs at the same time need to have their potassium levels monitored regularly.

Cough Suppressants

Cough suppressants are medications that prevent or stop coughing. They act on the centre in the brain that controls the cough reflex, and are meant to be used only to relieve dry, hacking coughs associated with colds and flu. They should not be used to treat coughs that bring up mucus or the chronic cough associated with asthma or

emphysema. Dextromethorphan is an ingredient in many cough medicines these medicines can come in capsule, tablet, lozenge, and liquid form and are available without a doctor's prescription. Dextromethorphan is not meant to be used for coughs associated with asthma. Some examples are Benadryl Dry Forte, Vicks Formula 44 and some Robitussin and Strepsils products.

The dye tartrazine is an ingredient in some cough suppressant products. This dye can cause allergic reaction in some people, especially those who are allergic to aspirin.

Contrast Dye for X-rays

Sometimes when you have an X-ray, you have to drink or get an injection of contrast dye to make the X-ray picture show up. Some contrast dyes may trigger an asthma attack. It's very important that you tell your doctor or X-ray technician that you have asthma. (FamilyDoctor.org). Sometimes they can give you another medicine before you get the contrast dye, so the dye won't cause any problems.

Summary

If you are doing everything your doctor and asthma nurse have recommended to control your asthma but are still experiencing bouts of severe or worsening asthma it could be caused by a medication you are taking for another health condition. While it's not clearly understood how this happens, doctors suspect it's due to an allergic reaction. Remember to discuss with your Doctor all the medications you are taking if your asthma appears to be worse, or even if you are coughing more frequently.

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bronchiolitis

Compiled by Elaine Murray RN
Asthma Nurse Educator.

What is bronchiolitis?

Bronchiolitis is a common illness usually caused by a viral respiratory infection which leads to breathing problems in babies and children less than one year of age. It affects the smallest airways (bronchioles) in the lungs and is most common in winter and spring. The most common virus is the respiratory syncytial virus (RSV) and is responsible for almost half of all the cases every winter, but other viruses can be involved.

Bronchiolitis is very contagious. It spreads by contact or in airborne droplets from the nose and mouth when a person sneezes, coughs or laughs.

Symptoms of bronchiolitis:

- Sneezing
- Mild cough
- Low grade fever
- Rapid respiratory rate
- Runny nose
- Stuffy nose
- Hyperinflation
- Wheeze
- Crackles
- Poor appetite or refusing to drink

Bronchiolitis can be mild, moderate or severe

Most babies do not require any special medical treatment and will get better by themselves. Because the illness is caused by a virus, there is no indication for antibiotics, systemic or inhaled corticosteroids or bronchodilators. Most babies can be looked after at home if they have no breathing problems and continue to feed well and are not dehydrated.

How to look after your baby at home

- Offer small feeds of breast milk, formula or sips of water.
- Keep your baby warm and not too hot
- Try to stay at home to avoid the temperature changes
- Try and get your baby to rest as much as possible
- Keep your baby's nose clear. If it is blocked or crusty you can use saline nose drops (these are available from the chemist). Use the drops before you feed baby as this will help to clear the nose and they will feed better.

Some babies with bronchiolitis may become very sick requiring hospital treatment. This can happen gradually or very quickly.

Signs to watch for:

- Rapid shallow breathing
- Heart beat is a lot faster than normal
- Sucking in of the neck muscle and the muscles below the rib cage and between the ribs
- Very restless, irritable and not sleeping
- Not feeding or taking fluids
- Exhaustion

A baby with severe bronchiolitis may tire from the work of breathing and have poor air movement in and out of the lungs, due to the tiny airways being blocked, causing blueness to the lips and fingernails (cyanosis). Babies with severe symptoms or who deteriorate may require oxygen, nasogastric feeding and intravenous fluids.

If the baby is not feeding well or taking in enough fluids it will become dehydrated very quickly and this can be serious, and the baby must be admitted to hospital.

Signs of dehydration:

- The baby's skin feels hot and dry
- Dry mouth
- Not passing very much urine i.e. fewer wet nappies
- Not eating or drinking
- Irritable
- Crying a lot
- May be very sleepy or lethargic
- Temperature over 40°C

When should I take my baby to the doctor?

If your baby is unwell and coughing it is important to see your doctor for a check to see if it is bronchiolitis or if there is something else causing the cough.

What will my doctor do?

Your doctor will talk with you about your baby's symptoms and will use a stethoscope to listen to the breathing. The doctor will check your baby for signs of dehydration. He may ask you to come back in the next 24 hours for a check up to see if your baby is improving or getting sicker.

When should I get urgent help?

See your GP or go to an after-hours medical centre urgently if you are worried about your baby or if your baby:

- Is under three months
- Is breathing very fast, has noisy breathing and using the muscle in the neck and the muscles under the rib cage and between the ribs
- Looks unwell or very pale
- Is vomiting
- Is getting worse

When should I seek emergency help?

Dial 111 for urgent help if your child has any of the following;

- **Stops breathing**
- **Has severe difficulty breathing or has periods of stopping breathing**
- **Has blueness of the lips or fingertips**
- **Is very sleepy, difficult to rouse, is floppy and very pale.**

Re-infection is common.

Re-infection is very common. Advice should be given on how to reduce the risk of infection, and how to prevent the spread of infection to other infants in the family.

- **Remember that the virus is spread by contact, sneezing and coughing.**
- **Always wash your hands before and after handling your baby.**
- **People who have a cold or flu- like illness should try to avoid contact with infants.**
- **Keep the home or the room at a constant even temperature**
- **Make the home a smoke free environment.**

- **Seek help early if you are concerned about your baby's breathing or wellbeing.**

Situations that increase the risk of bronchiolitis include:

- Damp housing
- Inadequate heating
- Overcrowding
- Smoking
- Family or whanau who are unable to provide adequate clothing for warmth over the winter months
- Transport and access problems to health care resources

"Transient infant wheeze is thought to be due to smaller than normal airways and is associated with exposure to tobacco smoke and early viral infections. Acute attacks of wheezing tend to occur with viral upper respiratory tract infections" (Pattimore, 2009, p.40).

"Only a minority of infants who wheeze in the first year of life will have asthma. Some of these infants will have a strong risk factor, such as parental asthma or eczema. A definite response to bronchodilators and asthma can be recognised from an early age. In others, the trend towards a recurrent wheezy illness responsive to bronchodilator, is only apparent after a period of months or years. Risk factors for asthma include eczema in the infant, wheeze without a cold (interval symptoms), more than two episodes of wheezing with a cold and a family history of atopy"(Pattimore, 2009, p 40)

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Asthma and Respiratory Foundation of New Zealand (Inc)
What is Bronchiolitis?
Fact Sheet prepared by The Asthma Foundation 2010
Pattimore, Dr Philip, Associate Professor of Paediatrics, University of Otago, Christchurch, www.bpac.org.nz keyword: bronchiolitis
(BPJ) 2009 Issue 20 pages 38-43



Make your home smoke free!

HAVE YOU ASKED YOUR DOCTOR IF YOU OR YOUR CHILD ARE ELIGIBLE FOR A FREE FLU VACCINE?

This years flu vaccine includes SWINE FLU (H1N1)



SWINE FLU (H1N1) May cause more severe symptoms for people with asthma or other respiratory conditions.

ALERT: Ensure you are using your preventer, even when you feel well, as prescribed and have your asthma under control. Seek medical advice early if your inhalers are not helping!

Flu Vaccines are available from your GP and is **FREE** for people with a chronic condition which includes ASTHMA and COPD.



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Ventilating your home with fresher, drier air vastly improves the quality of air that you and your family breath. DVS® ventilation systems are approved by Asthma NZ and are proven to reduce the mould and fungal spores that can be triggers for people with asthma. A percentage of every unit sold is donated to Asthma NZ.

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A Central Vacuum Unit from DVS® is the healthier, easier way to vacuum, providing better air quality for you and your family. Portable vacuums can pollute more than they clean because they exhaust dirt, dust and allergens back into the room being cleaned. A Central Vacuum unit however, eliminates the re-circulation of dirty air inside your living areas, extracting the dust and debris into an out of the way dust collector. Suitable for both new and existing homes.

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Kid's Page

Which season has the most allergies in New Zealand?



A: Mostly Spring



Which are the preventer inhaler devices?



Flixotide Salamol Flixotide MDI Ventolin

A: Orange Flixotide Inhaler devices

Find your asthma triggers



- Pets
- Exercise
- Plants and trees
- Dust
- Cold air
- Perfume or hairspray
- Sprays
- Cold air
- Colds or flu
- Smoke
- Dampness
- Car Exhaust



Legends Panel: Dean Barker, Sir Michael Faye, Grant Dalton, Dennis Conner and Peter Lester

an evening with america's cup yachting legends in aid of asthma new zealand



Gerry Hanna (CEO – Asthma Auckland), Phil and Colette Cullen



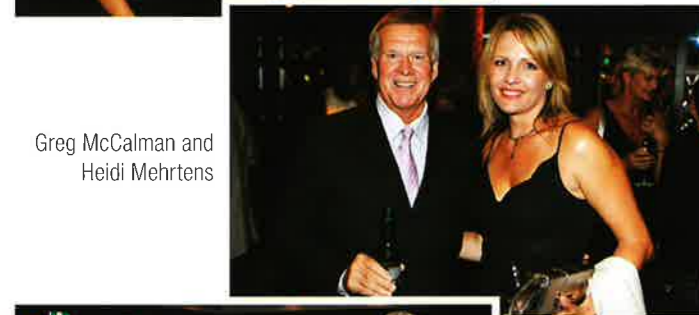
Kirsten Hartnoll, Jason and Alison Borland

'Mister America's Cup' himself, Dennis Conner or affectionately known as Dirty Den turned on the charm at Asthma New Zealand's gala dinner – An evening with America's Cup Yachting Legends held at The Langham, Auckland in December.

He shot from the hip on the ups and downs of his sailing career and took on Sir Michael Fay, Grant Dalton and Dean Barker in a panel discussion on all things yachting.

Dennis had asthma as a kid and thought it was time to give something back to New Zealand, his second home, he says "The America's cup is really New Zealand's cup. They are the dominant presence in sailing."

Sailing is his dream but didn't come without a sacrifice to his home life. He is also a businessman, artist and author and brought three of his own limited-edition watercolour prints to auction for Asthma New Zealand.



Greg McCalman and Heidi Mehrstens



Claire Brokken, Linda Thompson (PR/Marketing Manager – Asthma NZ), Frank Brokken, Vicki Currie



Dean and Mandy Barker

ASTHMA CAN KILL

- 1 in 4 children in New Zealand have asthma
- 1 in 7 adults in New Zealand have asthma

KNOW THE FACTS!



Dennis Conner

It was a great event, we enjoyed a sumptuous three course dinner, live music, first class entertainment and of course the live panel discussion and auction, in addition to raising over \$60,000 for Asthma we hope that we raised much needed awareness about poor asthma control in New Zealand.

Thank you

Linda Thompson
PR / Marketing Manager – Asthma New Zealand



Sir Michael Fay



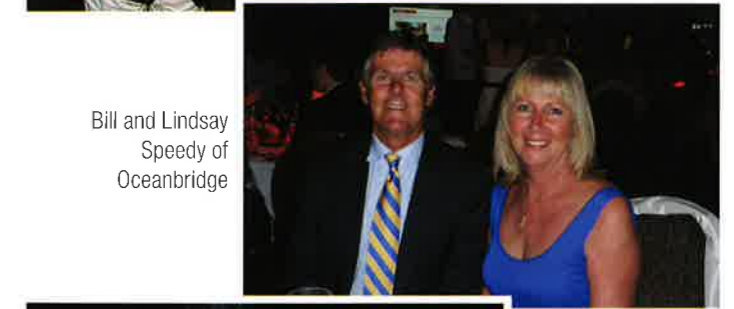
Grant Dalton and Peter Lester



Linda Thompson (PR / Marketing Manager – Asthma NZ)



Dennis Conner with Rachael Speedy – Auction winner of one of his signed prints



Bill and Lindsay Speedy of Oceanbridge



Margaret Hight, Gerry and Judy Hanna





a different view of normal – reflections from the asthma canterbury team post earthquake(s)

While the earthquake on Saturday 4th September rattled Christchurch and its residents many of us returned to near normal routines within a few weeks. Our office sustained no damage and reopened as normal on Monday 6th although things were quiet initially. There were a few road closures necessitating a slight change in the driving route to work and a few sad reflections seeing the damage to some buildings and areas of the city. By the time we assisted in hosting the South Island Respiratory Educator Forum here in Christchurch on 17th and 18th February we were pretty relaxed thinking the worst was over.

At 12.51pm on 22nd February 2011 that changed and what we thought of as normal will never be the same in Christchurch. We were very fortunate at Asthma Canterbury that all our staff and Board members were unhurt during the events of that day however many of them were in the central city when the quake hit and had an experience that they will never forget and never wish to repeat. Trying to check family were ok and negotiating the now badly damaged roads and associated hazards on the trip home was a harrowing

experience of up to 3 hours or more and, for many Christchurch residents, was worse than the quake itself. Central city, eastern and hill suburbs were worst hit but many areas to the west and south suffered little damage or disruption and therefore became an oasis where many would go to stay with family or friends. Others had or chose to tough it out without power, running water or sewage for days or weeks.



Our Asthma Canterbury office is located within the "four avenues" of the CBD and was not accessible for the first two weeks post quake. During that time we provided a mobile service for nebulisers and our Manager and nurses assisted at the hospital or in some of the relief centres in their local communities. The office did sustain some damage but was green stickered and deemed safe. The cordon moved enabling access to our office so on 10th March we reopened spending much of the first day restoring fallen items to their rightful place and supporting each other as we came to terms with the changes in the surrounding environment. As at 1st April the cordon is still about 10 meters from our door and the reassuring presence of armed forces personnel remains. Working in the Christchurch CBD however is quite a different experience. Most clients understandably cannot or do not wish to come into the central city and contact is by phone or home visit. It takes much longer to travel to and between visits, with many roads closed and others still badly damaged, so what we can fit into a day has also reduced. We have been quite busy with new referrals and education but there have also been a lot of cancellations of bookings made prior to 22nd February with people leaving the city and some aged care facilities now closed due to damage. We know when the cordons open that much of what was familiar will be gone, however we are fortunate in the resilience

and support of the people in our community, the amazing efforts of the civil defence, army, police, health, infrastructure services and volunteers that are working tirelessly fixing roads, making areas safe, restoring services and people to what will be a new normal.

There are now a lot less chimneys and as a consequence there will be fewer fires in Christchurch in the coming winter but new airborne irritants such as dust and liquefaction are present that may aggravate existing respiratory problems. It is important that anyone with a respiratory condition should take care to avoid exposure, wear protection where necessary and ensure they keep taking their preventer medication daily as prescribed. They should also carry their reliever inhalers with them at all times. Colds and flu are also a potential concern so keeping homes warm and dry and getting a flu vaccination are important preventative measures. Anyone in Canterbury wanting free information or advice regarding the management of asthma or COPD is welcome to contact Asthma Canterbury on 3665235 or email office@asthmacanty.org.nz.

Teresa Chalecki RN
Manager

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Carolyn Humphreys _____	Manukau City
Catherine Hellyer _____	Wellington
Sheridan Hattaway _____	Auckland



NEWS FROM AROUND THE REGIONS ...

Janette Whyte Reid RN BN

17 November 1944 – 10 February 2011

Coping with grief is a great challenge and it is also most challenging when faced with writing a fitting tribute. How do you sum up a person's life accomplishments in just a few sentences?

Janette Reid – colleague, friend, mentor, mother, wife and the list goes on... It is important to honour her with the respect she both deserved and commanded as due.

From the casualty departments in Scotland to paediatric nursing in Canada Janette Reid, after finally settling down in New Zealand in the late 90's and after many many years travelling the globe with her husband George and young family, George Jr., Martin and Stephen (pictured opposite), set about becoming an Asthma Nurse Educator with Asthma Auckland.

A self assured authoritarian, Janette soon became a force to be reckoned with she developed innovative asthma strategies and was always visionary in her approach with developing and furthering the education of nurses in asthma education in New Zealand; developing and implementing Asthma and COPD courses run alongside Unitec for Registered Nurses. Janette can be proud that hundreds of nurses are now qualified in asthma knowledge, promoting best practice in New Zealand.



Janette was a very passionate and warm hearted person, she loved her family, her friends, her dogs but most importantly she loved life and we will miss her bubbly larger than life personality, it has been both a pleasure and privilege to work alongside her and we thank her for her contribution to asthma in New Zealand and for her friendship for more than a decade.

Linda Thompson

On behalf of past and present staff of Asthma Auckland and Asthma New Zealand.

introducing amanda hirst

Hi I am Amanda Hirst the new Asthma Nurse Educator for the Rotorua Asthma Society.

I am a recent New Graduate Registered Nurse, whom is looking forward to the many challenges that are ahead of me in my role as asthma educator.

I was born and raised in Rotorua, although I have spent some years living in Tauranga once more I have returned to my whanau here in Rotorua.

I have three children, two girls and a boy. My mother is raising my son while I have my daughters at home with me. I have personal experience with asthma, I am an asthmatic and so is my son. My son also has Chronic Lung Disease due to being born at 25 weeks gestation in 1998. I feel that this personal experience will enhance my role as asthma educator, it will help me to understand where our clients are coming from and how asthma effects their everyday lives.

I have a very interesting and varied past. I spent five years as a volunteer fire fighter, back in the days where female fire fighters were not that common within the New Zealand Fire Service. I was lucky enough to spend three months on ambulances as a voluntary ambulance officer before my oldest daughter was born.



Asthma Rotorua has a new educator, Amanda Hirst. She is pictured here with her children. From left: Bailey, 13, Amanda, Sarah-Louise, 14 and Aimee Rose, 7.

I have been a girl guide leader for a couple of years, this was a very challenging and rewarding role.

I look forward to my future with the Rotorua Asthma Society in the role of Asthma Nurse Educator.

I have many ideas and visions for our future that I can't wait to put into place to help promote, educate and work alongside people with asthma and other respiratory conditions in the Rotorua area.

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GEORGE FOREMAN

To enter send your name, address, phone number and email address on the back of an envelope to Asthma NZ / George Foreman Food Steamer Competition, PO Box 67066, Mt Eden, Auckland before 28 February 2011.

copd and women

Compiled by Ann Wheat RN, BN

According to the Thoracic Society of Australia and New Zealand in 2003, there were approximately 220,000 New Zealanders affected with COPD (Chronic Obstructive Pulmonary Disease) and according to the World Health Organization data New Zealand also has one of the highest rates of mortality in the world. It is also worth noting that the prevalence of COPD in women is growing faster than in men worldwide. As well over the last two decades mortality rates are growing faster and since the year 2000 there have been more deaths from COPD in women than in men (Cote & Chapman, 2009).

Smoking is still considered the major cause of COPD throughout the world. But other causes can be occupational dust exposure, biological dust (more so in women), smoke from biomass fuels used for cooking especially in developing countries but uncommon in developed countries, outdoor air pollution and genetic abnormalities as in Alpha1 Antitrypsin deficiency. In New Zealand currently there is still a large discrepancy in the rates of smoking between the different ethnic groups with Maori men and women having the highest rate of smoking and Asian men and women the lowest rates (Ministry of Health, 2010). Pacific Island people have the second highest level of smoking. This means that there will be a higher burden of COPD among Maori and Pacific peoples. To add to this, women's rates of smoking has increased over the last few decades and according to McKenzie, Abramson, Crockett et al (2010), 2003 estimates suggest that the prevalence of COPD in New Zealand women had increased substantially and maybe the leading cause of death and disability. In fact the rate of mortality in Maori women is the highest of any women's group in the world (Boehringer Ingelheim (NZ) Ltd (2003). It is also worth noting that the detrimental effects of smoking are more pronounced in women than in men (Cote & Chapman, 2009). Cote & Chapman (2009), also state that women have more chronic bronchitis but that the rate of emphysema is much the same as in men.

Apart from the fact that more women now have COPD than men, are there any other significant differences and why? The answer is yes and unfortunately experts are unsure of why this is the case.

The first difference is that in women the disease severity is worse. They report more severe shortness of breath, more anxiety and depression for a similar severity of COPD. There have also been reports of lower quality of life (Science Daily, 2007). Women are less likely to be correctly diagnosed with COPD and offered the appropriate diagnostic tests such as spirometry (MacNaughton, 2010).

Female smokers have a greater risk of lung damage even if using smaller amounts of cigarettes and this damage can occur at a younger age because women's lungs are much more susceptible to the toxins from cigarette smoke. To make matters worse, women have a harder time stopping smoking than men (MacNaughton, 2010). The effects of smoking also have a greater effect on women's lung health. This is due to smaller lung capacity, airways, ventilatory muscle mass and the fact that women use a higher fraction of their lung capacity causing increased effort and shortness of breath (The Lung Association, 2006).

Finally COPD in women tends to progress much more quickly and

they become sicker earlier (MacNaughton, 2010). Cote (2006) as stated in an article by the American Thoracic Society (2006), advised that as women live on an average 7 years longer than men, women will carry a heavier burden of disease.

So what can be done to assist women with COPD?

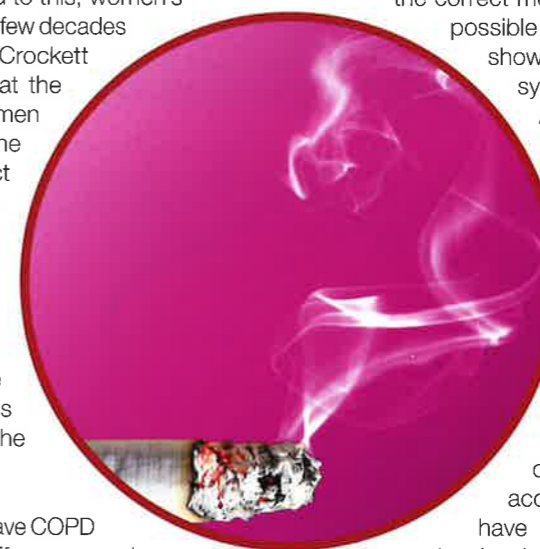
The most important point is that there is a major need for the correct diagnosis of COPD at the earliest stage possible. Spirometry testing is essential for all people suspected of having COPD especially women. Once diagnosed, it is essential that they are treated with the correct medications to ensure that they have the best possible outcomes. Correct medication has been shown to improve lung function, exercise capacity, symptoms and health status according to the American Thoracic Society (2006). It is also important that diet, exercise capacity and symptoms are discussed and acted upon if a problem is found, which will assist in better outcomes.

Secondly it is vital that there is reduction or elimination of risk factors including cigarette smoking, occupational dusts and chemicals and indoor and outdoor air pollution. Quitting smoking is still the most effective way of reducing the continual damage caused by smoking. Unfortunately according to MacNaughton (2010), women have a harder time quitting smoking plus a harder time staying quit. It is therefore essential that women have support from family and health professionals at this difficult time.

In conclusion, COPD is a major health concern for both men and women but it is becoming clear that women have a much harder time not only with the conditions but also with measures needed to assist them with managing their condition. It is imperative therefore that they are diagnosed early and given every support with this most debilitating condition.

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copd asthma and natural disasters

Management of Respiratory Conditions following Natural Disasters.

For most people living in the aftermath of a natural disaster is tough enough, but for people with a chronic condition it can become much more difficult. Living with a respiratory condition in an environment such as Christchurch following the earthquakes has potential for asthma or COPD to be triggered into an acute episode. It is not only the obvious triggers such as an increase in airborne irritants which has occurred because of the falling buildings and liquefaction but also there may be minute particles or fibres from the damaged buildings, road works, or building demolition and repairs. This is also compounded by the potential for **stress** from the loss of loved ones and/or homes and possessions plus the continuing aftershocks.

For children in particular, their safe and well known environment may have been changed for a short period or even forever. Parents need to be aware that moving into a new situation may lead to many possible new or different triggers, such as old mattresses and bedding which may precipitate an asthma episode.

The key points that should be followed at these times are:

1. Use of medications as prescribed by a doctor. It is imperative that preventer medications are used as prescribed twice daily, morning and night, even when well. If you rely on a nebuliser or home oxygen ensure your power supplier is aware and that you have a contingency plan of what to do if your power supply is interrupted.
2. Remember your emergency action plan. If you develop symptoms, use your blue reliever as directed and if symptoms do not settle, seek medical assistance quickly. Carry your reliever with you at all times and ensure that the cap is on when not being used.

3. If you have lost your medication, obtain new medications and spacer as quickly as you can. Do not be without it. If seeing a different GP, it is essential to advise what current medication you are on.
4. Use a face mask when outside at all times. This will help to reduce the amount of dust being breathed in.
5. Anxiety and stress can often cause hyperventilation. Try to reduce stress by limiting exposure to pictures, places or activities that may be upsetting, especially for children. Ensure that you get enough rest and try not to do too much at a time. Returning to old, or developing new, routines is also important. If you do start to hyperventilate try to stay calm and breathe deeply and slowly. Also seek help from a GP or counsellor if you cannot sleep or you feel you are unable to cope.

The staff of Asthma New Zealand would like to offer our deepest sympathy to those who have been affected by the Christchurch quake.



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References: 1. Price A, Clissold S. *Drugs*. 1989;38(1):77-122. 2. Gillies J et al. *N Z Med J*. 2005;118(1220):79-83. 3. N Z Guidelines Group. *The diagnosis and treatment of adult asthma*. Wellington: NZGG; 2002. 4. Ventolin Data Sheet, GSK New Zealand.

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LOGAN HARTNOLL
10 April 2005 – 20 February 2010



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newstream

Exposure to environmental microorganisms and childhood asthma;

Ege MJ, Mayer M, Normand AC, Genuneit J, Cookson WO, Braun-Fahrlander C, Heederik D, Piarroux R, von Mutius E, GABRIELA Transregio 22 Study Group; *New England Journal of Medicine (NEJM) 364 (8), 701-9 (Feb 2011)*

BACKGROUND Children who grow up in environments that afford them a wide range of microbial exposures, such as traditional farms, are protected from childhood asthma and atopy. In previous studies, markers of microbial exposure have been inversely related to these conditions. **METHODS** In two cross-sectional studies, we compared children living on farms with those in a reference group with respect to the prevalence of asthma and atopy and to the diversity of microbial exposure. In one study--PARSIFAL (Prevention of Allergy-Risk Factors for Sensitization in Children Related to Farming and Anthroposophic Lifestyle)--samples of mattress dust were screened for bacterial DNA with the use of single-strand conformation polymorphism (SSCP) analyses to detect environmental bacteria that cannot be measured by means of culture techniques. In the other study--GABRIELA (Multidisciplinary Study to Identify the Genetic and Environmental Causes of Asthma in the European Community [GABRIELA] Advanced Study)--samples of settled dust from children's rooms were evaluated for bacterial and fungal taxa with the use of culture techniques. **RESULTS** In both studies, children who lived on farms had lower prevalences of asthma and atopy and were exposed to a greater variety of environmental microorganisms than the children in the reference group. In turn, diversity of microbial exposure was inversely related to the risk of asthma (odds ratio for PARSIFAL, 0.62; 95% confidence interval [CI], 0.44 to 0.89; odds ratio for GABRIELA, 0.86; 95% CI, 0.75 to 0.99). In addition, the presence of certain more circumscribed exposures was also inversely related to the risk of asthma; this included exposure to species in the fungal taxon eurotium (adjusted odds ratio, 0.37; 95% CI, 0.18 to 0.76) and to a variety of bacterial species, including *Listeria monocytogenes*, bacillus species, corynebacterium species, and others (adjusted odds ratio, 0.57; 95% CI, 0.38 to 0.86). **CONCLUSIONS** Children living on farms were exposed to a wider range of microbes than were children in the reference group, and this exposure explains a substantial fraction of the inverse relation between asthma and growing up on a farm.

Source: *Pediatr Int*

Pneumonia during the first 2 years of life and asthma in preschool-age children;

Santos JC, Zhang L, Menegatti PK, Guasselli CS, Filho CC, Maito LR, Ferreira MF, Mariani MC, Wainwright C; *Pediatrics International (Feb 2011)*

Background: The relationship between viral bronchiolitis in early infancy and subsequent wheezing and asthma has been well established. This cross-sectional study aimed to test the hypothesis that pneumonia severe enough to require hospitalization during the first two years of life could also be associated with asthma or asthma like symptoms in pre-school children. **Methods:** We conducted structured interviews with parents of children who were classified as exposed (n = 36) or non-exposed group (n = 84), based on whether they were hospitalized with radiologically confirmed pneumonia during the first two years of life. The main outcomes were ever physician-diagnosed asthma, asthma-like symptoms and use of anti-asthmatic medications during the last 2 and during the last 12 months. **Results:** The prevalence of ever physician-diagnosed asthma was higher in the exposed group compared with the non-exposed group (41.6% vs. 22.6%, p = 0.01), with an adjusted prevalence ratio of 2.03 (95% CI: 1.10-3.62). The exposed group had a trend toward a higher prevalence of asthma-like symptoms and use of anti-asthmatic medications during the last 2 months and during the last 12 months. **Conclusions:** Radiologically



confirmed pneumonia in the first two years of life may be associated with asthma or asthma-like symptoms in pre-school children.

Source: *Pediatr Int*

No effect of fluticasone propionate on linear growth in preschool children with asthma;

Stefanovic IM, Verona E, Cicak B, Vrsalovic R; *Pediatrics International (Feb 2011)*

BACKGROUND: Eighty percent asthmatic children develop asthma symptoms by the age of five years. Inhaled corticosteroids (ICS), depending on dosage, may cause linear growth reduction and adrenal gland suppression. There are few studies about linear growth of preschool children with asthma. Aim of this investigation was to evaluate if there is any effect of fluticasone propionate (FP) on linear growth and adrenal gland function. **METHODS:** Twenty eight children aged 18 to 52 months with persistent asthma receiving ICS fluticasone propionate 100-200 mcg daily were studied over a year. By clinical parameters patients were divided into group of well (group 1) and poorly controlled (group 2). Height was measured every 3 months and expressed as height standard deviation score (SDS). Cumulative dose of FP expressed in mg was calculated for every patient. Early morning levels of serum ACTH and cortisol were assessed at the beginning and at the end of the study. **RESULTS:** Patients were taking FP for average of 11 months in group 1 and 16 months in group 2, which was not statistically significant difference. At the end of the study height SDS difference was - 0.0143 in group 1 and - 0.2000 in group 2 which was not statistically significant difference (t = 0.6072, p = 0.5489). There was also no statistically significant difference for average cortisol (p = 0.4381) and ACTH (p = 0.5845) concentration at the end of the study. **CONCLUSION:** FP 100 - 200 mcg daily had no effect on linear growth and hypothalamic- pituitary-adrenal gland axis but further follow up is necessary.

Source: *Clin Exp Allergy*

Paracetamol in pregnancy and the risk of wheezing in offspring: a systematic review and meta-analysis;

Eyers S, Weatherall M, Jefferies S, Beasley R; *Clinical and Experimental Allergy (Feb 2011)*

Background There is evidence to suggest that the risk of asthma might be increased with exposure to paracetamol in the intrauterine environment, infancy, later childhood and adult life. **Objective** To review the evidence from studies investigating the association between paracetamol use in pregnancy and childhood asthma. **Methods** A systematic review and meta-analysis was undertaken of studies reporting the association between paracetamol use in pregnancy and subsequent asthma in childhood. The primary outcome variable was wheeze in the last 12 months. For tabulated raw data, not adjusted

for confounders, random effects odds ratios (OR) were pooled by the inverse variance weighted method. Results There were six studies identified that were included in the meta-analysis. The age of children studied ranged from 30 to 84 months. The pooled random effects OR for the risk of current wheeze in the children of women who were exposed to any paracetamol during any stage of pregnancy was 1.21 (95% confidence interval 1.02-1.44). Features of the studies variably included an association with paracetamol use during all trimesters of pregnancy and an association with persistent asthma, severe asthma, and with atopy. Conclusion and clinical relevance The use of paracetamol during pregnancy is associated with an increased risk of childhood asthma. More research is urgently required to determine the impact of paracetamol during pregnancy on the risk of wheezing in offspring so that appropriate public health recommendations can be made.

Source: Chest

Effects of Body Mass Index on Static Lung Volumes in Patients with Airway Obstruction;

O'Donnell DE, Deesomchok A, Lam YM, Guenette JA, Amornputtisathaporn N, Forkert L, Webb KA; Chest (Feb 2011)

ABSTRACT BACKGROUND: Both chronic airway obstruction and obesity are increasing in prevalence but the effect of their combination on pulmonary function parameters across the range of airway obstruction is unknown. **METHODS:** We studied the impact of increasing body mass index (BMI) on static lung volumes and airway function in a cohort of 2,265 subjects from a large pulmonary function laboratory database who were 40-80 years of age and met GOLD spirometric criteria for COPD (post-bronchodilator FEV₁/FVC < 0.7). We also evaluated the influence of severity of airway obstruction (by GOLD criteria) on these relationships. **RESULTS:** With increasing BMI in the group as a whole: functional residual capacity (FRC), residual volume (RV), expiratory reserve volume (ERV) and specific airway resistance (sRaw) decreased exponentially (all p < 0.001); total lung capacity (TLC) decreased linearly (p < 0.001); inspiratory capacity (IC) and IC/TLC increased linearly (p < 0.001); whereas vital capacity (VC) was not significantly influenced. The effects of increasing BMI on FEV₁/FVC and sRaw were greatest in GOLD stage III/IV (p < 0.05), while increasing BMI had greater effects on IC in GOLD stage I (p < 0.001). **CONCLUSION:** With increasing BMI, subjects with airway obstruction had consistent reductions in lung hyperinflation, with significant improvements in IC and the FEV₁/FVC ratio; this effect was greatest in patients with the most severe airway obstruction. These results have important implications for the clinical assessment of patients with combined obesity and airway obstruction.

Source: J Heart Lung Transplant

Advanced chronic obstructive pulmonary disease is associated with high levels of high-density lipoprotein cholesterol;

Reed RM, Iacono A, Defilippis A, Eberlein M, Gargis RE, Jones S; Journal of Heart and Lung Transplantation (Feb 2011)

BACKGROUND: Chronic obstructive pulmonary disease (COPD) is an inflammatory systemic disease associated with numerous extrapulmonary manifestations. Amongst these is an increased risk for cardiovascular disease. The mechanisms for this association remain unclear. We sought to examine lipid trends in a well-characterized cohort of patients with severe COPD. **METHODS:** We conducted a retrospective prospective analysis of 126 consecutive individuals evaluated for lung transplantation with a diagnosis of COPD in whom lipid values were available. Observed lipid values were compared with

a reference population without severe COPD. **RESULTS:** Compared with the reference population, mean low-density lipoprotein cholesterol (LDL-C) levels were slightly reduced at 108 ± 44 vs 117 ± 29.5 mg/dl (p = 0.02) in men but were no different in women. Mean high-density lipoprotein cholesterol (HDL-C) levels were significantly elevated at 62 ± 24 vs 45 ± 12 mg/dl (p < 0.0001) in men and at 83 ± 27 vs 59 ± 16 mg/dl in women (p < 0.0001). Prednisone use correlated with higher HDL-C levels but did not fully explain the extent of elevation. Angiographically proven coronary artery disease was found in 61% of individuals and was unrelated to HDL-C levels. **CONCLUSIONS:** Severe COPD is associated with increased levels of HDL-C, which is partially attributable to oral steroid use. HDL-C in this population is not associated with reduced risk of angiographically proven coronary artery disease.

Source: Dig Dis Sci

Poorly Treated or Unrecognized GERD Reduces Quality of Life in Patients with COPD

Rascon-Aguilar IE, Pamer M, Wludyka P, Cury J, Vega KJ; Digestive Diseases and Sciences (Jan 2011)

BACKGROUND: The effect of gastroesophageal reflux disease (GERD) on health-related quality of life (HRQL) in COPD has never been assessed. **AIM:** To evaluate HRQL in patients with COPD alone compared with those with both COPD and continuing GERD symptoms. **METHODS:** A questionnaire-based, cross-sectional survey was performed. Subjects were recruited from the outpatient pulmonary clinics at the University of Florida Health Science Center/Jacksonville. Included patients had an established diagnosis of COPD. Exclusion criteria were respiratory disorders other than COPD, known esophageal disease, active peptic ulcer disease, Zollinger-Ellison syndrome, mastocytosis, scleroderma, and current alcohol abuse. Those meeting the criteria and agreeing to participate were asked to complete the Mayo Clinic GERQ and SF-36 questionnaires, by either personal or telephone interview. Clinically significant reflux was defined as heartburn and/or acid regurgitation weekly. Study patients were divided into two groups for HRQL analysis based on the GERQ response: COPD+/GERD+ and COPD only. Statistical analysis was performed using the Mann-Whitney-Wilcoxon T test for unequal variables and linear regression was performed using ANOVA. All data are expressed as mean and standard deviation. **RESULTS:** Eighty-six patients completed both questionnaires. Males were 55% and COPD+/GERD+ patients comprised 37% of the study group. Compared with COPD only, HRQL was reduced across all measures for the COPD+ GERD+ patients and achieved significance for bodily pain (P < 0.02), mental health (P < 0.05), and physical component score (P < 0.05). **CONCLUSION:** Patients with COPD and continuing GERD symptoms have reduced HRQL in comparison with those with COPD alone.

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References: 1. Global Initiative for Asthma; Global Strategy for Asthma Management and Prevention. Updated 2009. 2. Woodcock AA et al. *Prim Care Respir J.* 2007;16(3):155-161. 3. Bateman ED et al. *Am J Respir Crit Care Med.* 2004;170:836-844

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