



Good news for people with Asthma

SPECIAL FEATURE:

- Count on good asthma control
- More frequently asked questions about asthma
- Occupational asthma
- Managing it: A mother's perspective
- The Cook Strait swim
- Asthma study wins award
- COPD medications

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August 2006



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Count On Good Asthma Control

For the first time in New Zealand your metered dose inhaler (MDI) or puffer will tell you when you need a new one! Don't worry, it's not going to start talking to you, the new fully funded Seretide puffers are now equipped with a dose counter that shows you when you are running out of puff!

The counters start at 120 doses and every time you take a dose, it counts down – 120, 119, 118...until you get to zero. This is a simple yet crucial innovation which gives you a clear warning of when you need another puffer. No more shaking the puffer to see what's left and hoping it keeps doing its job.

The puffers also come with a couple of other innovations that make life easier. The dust cap covering the mouthpiece of the puffer now clips into the main part of the puffer and stays securely in place. No more lost dust caps or fluff in your inhaler. The other change is the ergonomic design of the puffer. It now has

an indent on the underside of the puffer where your thumb holds it. The indent has prominent grooves to stop your thumb from slipping when you depress the canister to take a puff.

These design changes are simple but smart changes to make the use of puffers easier and safer. The dose counter is a huge advancement which helps to manage your asthma and make sure you are never without an inhaler with medicine inside. It also has the potential to help you manage a child's asthma better as you can see if they have taken a dose or not by checking the changes on the counter.

How to get the new puffers
From August new Seretide inhalers are fully funded for people with asthma who are still struggling with their symptom control despite the use of a long acting beta-agonist (controller or LABA). Your doctor will tell you whether you are eligible for the new puffers.

Seretide is a combination inhaler with two active medicines in one inhaler. It reduces inflammation of the airways using an inhaled cortico-steroid (preventer or ICS) and constriction of the airways using a LABA that dilates them for twelve hours or more.



editorial

Good news for people with asthma

At last, some excellent news! For years, Asthma New Zealand – The Lung Association has been lobbying Government for better access to drugs for people with asthma, drugs the rest of world has been using to great effect for several years. It looks like finally our wishes have come true – well almost!

From August, people most in need will be able to access these therapies free. Funded Symbicort combination turbuhalers have been available for some time but at a highly restrictive level of access. Seretide has been available for a few years, but without funding the uptake has been very small. Now both are finally to be funded and available to those already on a LABA but without good control.

New Zealand has done a great job over the years of reducing the deaths of people with asthma to a level around that of other OECD countries even with the limited medications available. That said, just because people with asthma aren't dying as often doesn't mean they have their asthma under control or are able to fully enjoy their life without asthma symptoms holding them back. These combination products can

potentially make this difference to people's lives and anecdotal feedback from our members who use them is extremely supportive (not to mention the enormous volume of high quality research supporting their use).

We strongly support their appropriate use as they not only control asthma, they ensure people take both medicines they need in each puff rather than constantly using relievers or LABAs for the 'feel good' factor.

Asthma New Zealand would ideally like these therapies to be made available to everyone who can benefit without having to jump through hoops to get there. As usual Government control of the public health dollar may make this a while off yet. Right now, we're delighted with what we've got. We suggest people with asthma make

the best of the opportunity and use it as a good reason to review your control and your current medication.

Hope the winter asthma season isn't holding you back. Keep well.

Kind Regards

Gerry Hanna
Executive Director
Asthma New Zealand – The Lung Association



NOW FUNDED!



Seretide puffer with new dose counter

Aim to live symptom free

- Do you have asthma?
- Have you been using a preventer puffer for more than 3 months?
- Have you been using a symptom controller puffer for more than 3 months?
or
- Are you currently using a combination (red) inhaler?

Seretide
Fluticasone propionate/Salmeterol xinafoate

Seretide is the World's most prescribed combination Asthma inhaler² and is now fully funded with Special Authority in NZ.¹ If you have answered yes to the above questions, ask your doctor if Seretide is right for you.

For a free trial of a Seretide puffer speak to your doctor. For more information on Seretide visit www.gsk.co.nz/seretide

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

Seretide (fluticasone propionate/salmeterol xinafoate; available as a 50/25 or 125/25mcg per actuation inhaler, or as a 100/50 or 250/50mcg per actuation Accuhaler) is a Prescription Medicine for the treatment of reversible obstructive airway disease (ROAD) including asthma, and for the treatment of chronic obstructive pulmonary disease (COPD). Seretide is a fully funded medicine; Special Authority criteria apply. Seretide 250/25mcg inhaler is a private purchase medicine that you will need to pay for. Use strictly as directed. Seretide is not for relief of acute symptoms. Always carry your reliever inhaler. Do not discontinue Seretide abruptly. Tell your doctor if: you are taking any other medicines or herbal remedies; you have pulmonary tuberculosis (TB), a thyroid problem or a heart problem; or you are having treatment for high blood pressure; Side Effects may include: 'shaky' feeling; headache; fast heart rate; irritation in the nose and throat. If symptoms continue or you have side effects, see your doctor, pharmacist or health professional. For more information, see Seretide Consumer Medicine Information at www.medsafe.govt.nz. Normal doctor's office visit fees apply. Ask your doctor if Seretide is right for you. Seretide and Accuhaler are trade marks of the GlaxoSmithKline group of companies. Marketed by GlaxoSmithKline NZ Limited, Auckland. TAPS No. NA1502-06AU GLANZ0725



MORE FREQUENTLY ASKED QUESTIONS ABOUT ASTHMA

COMPILED BY CHRISTINA VERCOE

In this issue the questions and answers covered are related to winter. Winter is a time of year that can be troublesome for people with asthma.

Why does the cold weather make me wheeze?

Breathing in cold air often makes people wheeze and cough and can sometimes trigger their asthma symptoms. This is more likely to happen if the air is dry as well as cold.

Cold air is one of the inhaled triggers which can sometimes irritate the airways and makes them "twitchy".

You can decrease your wheezing in cold weather by keeping good control of your asthma with regular treatment.

If necessary by taking extra reliever treatment before you go out into cold air.

I always get attacks in winter. Why is this?

There are several possible reasons but there are three main ones:

1. Your attacks probably result from a cold

which then irritates your airways. An upper respiratory infection (common cold) is responsible and is a common asthma trigger. In the winter months there are more of these viral infections around than at any other time of year.

2. Cold air is an important trigger factor and, of course, this will affect your chest more in the winter than at other times of the year. When anyone has a cold their nose becomes blocked. This forces them to mouth breathe, the air is no longer warmed and filtered two important processes that the nose does so efficiently. The unwarmed /unfiltered air then irritates the airway and in some individuals will result in an acute episode of asthma.

3. Finally house dust mite numbers are at their highest in the early part of the winter, when the heating is switched on and moisture

levels are increased due to condensation inside.

My son coughs often at night how do I tell if it is asthma – or something else.

This is a question we get asked frequently. Without a proper medical evaluation, you as a parent can't always tell what the cough is caused by. A persistent night-time cough is one of the most common symptoms of asthma but even doctors find it difficult to diagnose asthma when its only presenting symptom is a night-time cough. Other reasons for a night-time cough could be nasal allergies or chronic sinus infections. A "habit" cough usually disappears with sleep.

In general, an asthma cough is a non productive cough – one that doesn't bring up any mucus. The cough may sound as if something is rattling, or have a wheezing sound at the end of the cough.

MORE FREQUENTLY ASKED QUESTIONS ABOUT ASTHMA



More often than not, there's a spasmodic quality to the cough it may continue until the child is completely out of breath and gagging, or even until they actually vomit.

Asthma coughs are mostly dry coughs caused by irritable airways. The cause of an asthma cough is an irritant or allergen of some kind that starts an inflammatory response. Part of this response is a tightening of those airways with mucus production.

An asthma cough should be treated with asthma medication not with cough suppressants.

What is the difference between wheezy and quiet types of asthma?

When your airways are slightly narrowed, they produce a wheezing or whistling sound during breathing in and out.

The breathing in this type of asthma is noisy and it is very easy to tell that you are having an asthma episode. When your asthma is severe some airways are almost closed and very little air

can move in and out of the lungs.

If this happens your breathing becomes very quiet and it may not be so obvious that your asthma is bad. You may have difficulty in breathing or speaking and you may even be a blue colour around your lips and tongue.

A very low peak flow reading is the best way to confirm that your asthma is indeed very bad.

This can be a very dangerous condition, especially in an acute attack when you need urgent medical help.

Are breathing exercises, and relaxation techniques beneficial? If so why are they never recommended by doctors?

Nowadays most doctors feel there is only a limited place for breathing exercises for people with asthma.

Generally, they are useful only for those people with the most severe asthma. During an acute asthma episode the muscles around the airways tighten up, and it is more important to get these

muscles to relax and open up the airways. We have no conscious control over these muscles and the best way to relax them quickly is by giving reliever treatment. Fortunately this is usually very effective and works rapidly.

Although breathing exercises are not recommended, general relaxation exercises and controlled breathing can be extremely helpful.

When an acute asthma episode begins it is easy for someone to become distressed and to "over breathe" (hyperventilate)

In the panic of an acute asthma episode your breathing becomes rapid and shallow

This can irritate your airways and actually make matters worse.

It is very helpful to learn how to breathe in a slow relaxed way to prevent over breathing from happening.

You should practice these techniques between acute episodes, when you are symptom free. Instruction on this can be obtained from your GP, physiotherapist, asthma nurse or breathing specialist.



What is Occupational Asthma?

Compiled by Debra Leutenegger

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Life Benefits

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The National Occupational Health and Safety Advisory Committee of New Zealand (NOHSAC) states that Occupational Asthma is a disorder characterized by bronchial hyper-responsiveness or variable airflow limitation related to workplace exposures. Occupational asthma is probably the most common work-related respiratory disorder in industrialized countries, and many hundreds of occupational agents, including some inorganic and organic dusts, have been associated with it. Biological agents include grains, flours, plants and gums, fur, feathers and other animal parts, insects and fungi, drugs and enzymes, and various types of wood. Chemical agents include chlorofluorocarbons, alcohols, metals and their salts, and welding fumes.

It is estimated that occupational asthma represents approximately 5% of all cases of asthma. Typically features of occupational asthma include a latency period of up to several years prior to onset of symptoms, worsening of symptoms shortly after the end of the shift or at night, and improvement in asthma symptoms on the weekends or when on annual holidays. (Auckland Allergy Clinic)

Several studies have considered occupational asthma in New Zealand. These studies found asthma was more common in farmers and farm workers, food processors (other than bakers) and laboratory technicians. Other studies of specific work groups found increased risks of occupational asthma in sawmill workers, plywood mill workers and some farmers. (NOHSAC).

Symptoms of Occupational Asthma

- Coughing
- Shortness of breath

- Wheezing
- Tight chest

Note: these symptoms occur during the working week, day by day and improve during absences from work, at weekends or when on annual leave.

Occupational history record is an important part in establishing the level of exposure to substances.

Asking questions such as:

How messy was the workplace?

Sometimes you must rely on anecdotal estimates ("I couldn't see across the workshop because of the dust"). Occasionally, environmental monitoring (i.e. dust concentration measurements) has been performed and can be used.

How many hours a week was the employee exposed?

Work out a time estimate for the exposure – so many hours, per week for so many years.

What is Occupational Asthma?



What protection was in place and was it working?

Personal protection (e.g. respiratory masks) is often ineffective because people find such protection uncomfortable and won't wear them. There needs to be an effort by management to ensure that protection is available and used.

How to prevent occupational asthma

Provide Information – Education in the workplace is important. Being knowledgeable about occupational asthma will help in recognizing and preventing the disease.

Employees also need clear information about sensitiser substances and respiratory irritants that may be encountered in the workplace.

Tobacco/cigarette smokers are at a higher risk to occupational asthma than non-smokers.

Control exposures at work

Workplaces can assist to prevent occupational

asthma by eliminating potential sensitisers or by minimizing exposure to them. This will not only prevent workers from developing asthma from exposures at work but can also provide a safe work environment for those who have pre-existing Asthma.

Possible approaches that can help in the control are:

- Provide well-maintained ventilation systems to remove dust and other inhalable hazards.
- Minimise exposure to dust particles, vapour or aerosol as well as exposure to excessive cold or hot temperatures that can trigger occupational asthma.
- If exposures cannot be minimized, provide adequate protection to workers with suitable respiratory protective equipment.

Treatment

Treatment of occupational asthma depends on how severe the asthma is.

Prevention is always the first choice of treatment. For some people, just avoiding exposure to the trigger is possible and is enough to prevent symptoms; for others, a combination of avoiding the trigger and medication can prevent symptoms.

The goals of treatment are:

- To prevent asthma episodes
- To be able to carry out normal activities
- To maintain normal or near-normal lung function
- To have as few medication side effects as possible

Only as a last resort people with severe occupational asthma may need to consider changing to a different job or a different line of work.

The New Zealand Department of Labour provides best practice information and guidance to assist New Zealand businesses with health and safety

What is Occupational Asthma?



in the workplace. The Department of Labour also inspects workplaces to check on safety and health arrangements and makes sure employers and employees comply with health and safety legislation.

Appropriate forms and information can be obtained from Occupational Safety and Health (OSH) from their website: www.osh.govt.nz

Diagnosis

The diagnosis can be inexact but relies on:

- a clinical history consistent with Asthma
- an exposure history to some potential causative agent
- evidence of reversible airways obstruction associated with the workplace exposure

The best measure of the occupational origin of the patient's asthmatic symptoms is obtained by peak flows.

A minimum of four peak flow measurements a

day for two weeks is recommended. These are taken before work commences, midway through working day, at end of work day and in the evening.

Conclusion:

Asthma is recognized as a major health problem in New Zealand. What is greatly unknown is the extent of occupational influences on the incidence of asthma amongst the New Zealand working population. Because of this lack of knowledge and because occupational influences are often overlooked, occupational asthma has been included in the Occupational Safety and Health Notifiable Occupational Disease System (NODS)

An occupational origin must be considered in any case of asthma arising for the first time in an adult.

References

Auckland Allergy Clinic: <http://www.allergyclinic.co.nz/guides/5.html>

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http://www.emedicinehealth.com/occupational_asthma/page6

New Zealand Occupational Safety and Health: A guide to the management of Occupational Asthma <http://www.osh.govt.nz>

New Zealand Council of Trade Unions: <http://www.worksafereps.org.nz/hazards>



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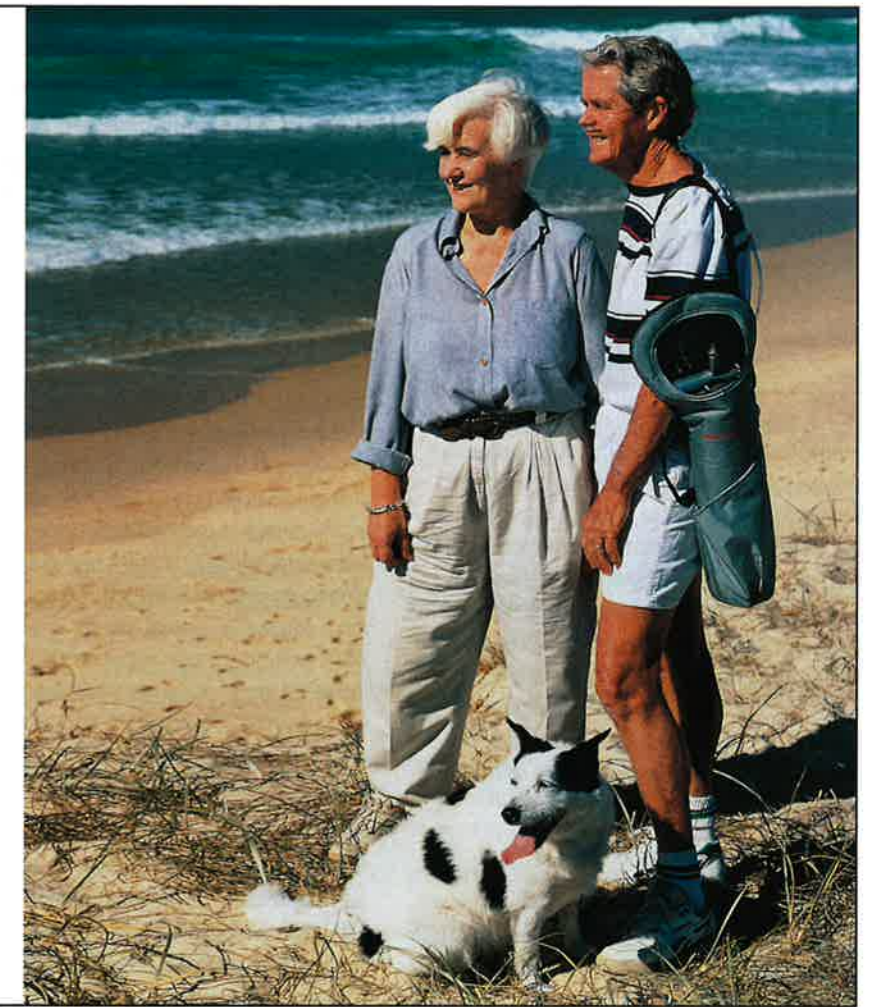
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Managing it: a mother's perspective of managing a pre-school child's acute asthma episode



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Abstract

Over the last decade asthma management strategies have required families to take increased responsibility for the assessment and treatment of their child's asthma. This exploratory descriptive study informed by grounded theory examines the experience of mothers in managing their pre-school child's acute asthma attack at home.

Introduction

Asthma is a common chronic illness of childhood which impacts significantly on the lives of pre-school children and their families. Over the last decade asthma management strategies have required families to take increasing responsibility for the assessment and treatment of their child's asthma. Education and self-management have become the 'catch cry' of health professionals, but rarely has the perspective of the caregiver been considered. This study, using a grounded theory approach, set out to describe the experience from a caregiver's perspective of managing a pre-school child's acute asthma episode.

Background to the study

In New Zealand during the early 1980's and 1990's a significant increase in paediatric hospital admissions for asthma occurred especially in the zero-four-year-old age group. This reflected

The study reveals that mothers perceive that they are responsible for the management of their pre-school child during an acute asthma episode, a process they described as 'managing it'. This process involves mother in 'working on treatment', 'making the call', 'watching' and 'calming', while the husband/partner, family, friends and health professionals are 'supporting

a worldwide trend of increasing admissions for childhood asthma (Horwood et al., 1991; Mitchell and Cutler, 1984; Mitchell and Dawson, 1989) and was postulated to reflect a small increase in severity and prevalence of asthma among children (Garrett et al., 1995; Peat et al., 1994). In an attempt to reverse this alarming trend of increasing morbidity, a number of more intensive strategies were implemented. These included a more aggressive approach to the treatment of acute asthma episodes with bronchodilators and increased use of preventer medication, especially inhaled steroids (Mitchell, 1992). The delivery of drug therapy to pre-school children was improved with the introduction of spacer devices.

These devices provide a more portable and user-friendly method of drug delivery compared to the previous reliance on oral medications or home nebulizers (Leversha and Asher, 1996). Another strategy was the use of Asthma Action Plans. These are individualized pre-written instructions

treatment'. This study suggests that nurses and doctors need to move away from the current paternalistic view of health care delivery in acute settings and embrace the concepts of support and partnership in the care of the pre-school child with asthma and their family.

Key words - asthma - partnership - pre-school children - support

on the detection and management of the child's asthma attack. Asthma Action Plans were widely promoted to enhance self-management of acute asthma episodes. Asthma education programmes were also introduced, often based on educational, psychosocial and behavioural programmes developed in North America (Becker et al., 1994). Nurses were recognized and used as the appropriate health professional to deliver such education (Garrett et al., 1995; Mitchell et al., 1986). The focus of both nursing and medical practice was therefore centred around optimizing medication and medication delivery, providing self-management tools and educating the families on asthma management. This placed increased responsibility on families for assessing and treating the child's asthma at home. Although several authors had noted the reciprocal and interactive nature of asthma on family functioning in older children (Baron et al., 1992; Deaves, 1993; Miller and Wood, 1991)

Managing it: a mother's perspective of managing a pre-school child's acute asthma episode

the impact on caregivers and families of pre-schoolers of these strategies and approach to management had not been studied (Clark et al., 1993).

Methodology

The aim of this study was to describe the experience of a caregiver in relation to the management of their child aged two to five years during an acute asthma episode. A small exploratory descriptive study was undertaken, informed by the method of grounded theory as described by Glaser (1978).

Ethical approval for the study was gained from both the Massey University Human Ethics Committee and the Northern Regional Health Authority Ethics Committee. Informed written consent was obtained from all participants, and confidentiality and anonymity were maintained by assigning identity codes to each family and using these in all data collected.

A purposive sample was obtained using a 'snowball' of networking sampling strategy as described by Lo-Biondo-Wood and Haber (1994). Inclusion criteria for the study were caregivers who had a child between the ages of two and five years, who had had a recent acute asthma episode which did not require admission as an inpatient, who had cared for the child during the acute asthma episode and who spoke English as a primary language (Glaser, 1978).

Five mothers agreed to participate in the study. They ranged in age from 24 to 40 years and were self-reported 'European New Zealanders'. Three of the mothers were employed in either part or full-time paid employment. Three of the families had a family history of asthma, and two of the mothers had older children also affected by the disease. There were five pre-schoolers with asthma in the study who ranged in age from two to four years of age and had been diagnosed as having asthma between 15' and 30 months of age. All the pre-schoolers were on regular preventer medications, and four of the children had been admitted to hospital in the last 12 months.

Data were collected from a number of sources. Each mother participated in one interview of approximately one hour in length. Interviews were conducted over a three-month period. The interview technique used was as described by Glaser and Strauss (1967) with the researcher initially asking open-ended questions and then listening to the respondent's stories. Interviews

began with the question "Tell me about an asthma attack your child has experienced?". The interviews were audiotaped, transcribed and typed. Field notes were also taken and typed. These field notes consisted of key words and phrases used and the researcher's observation of the participant's behaviour during the interview. Literature reviewed during the study was also considered as data. These data were then analysed using the constant comparative method of analysis as described by Glaser (1978).

Each interview was transcribed and then open-coded line by line. This involved reading through the data, with no preconceived codes, and coding each sentence to arrive at as many codes as possible. These codes were discovered by constantly asking four questions of the data: 'What are the data a study of?', 'What category does this incident fit into?', 'What is actually happening in the data?', and 'What are the basic social-psychological problems being faced by participants?' The codes were constantly compared and grouped into concepts that described the underlying meaning and pattern of the data. Throughout this coding concepts were compared with other concepts to see whether they could be grouped together into a core category. A core category, as described by Glaser (1978), represents a category that was central to the data, that re-occurred frequently, that related meaningfully and appeared to describe a dimension of the problem which could have a relationship to a formal theory. While the size of the sample in this study did not allow for theoretical saturation to occur, one core category, 'managing it', emerged.

Results

The study demonstrated that mothers perceive that they, as the central person caring for the child, manage the child through the acute asthma episode. This process was described by the mothers as 'managing it'. 'Managing it' is not merely coping with the management but is an active and dynamic process which involves 'working on treatment', 'making the call', 'supporting the treatment', 'watching' and 'calming'. Three of these concepts, 'working on treatment', 'watching' and 'calming', appeared to occur throughout the acute asthma episode, while 'making the call' and 'supporting the treatment' occurred on a much more intermittent basis, usually at the time of increasing severity of the asthma episode.

'Working on treatment' involved the mothers in

actively undertaking the work of administering medication as planned in response to symptoms and monitoring the response. 'Working on treatment' included the substantive codes of 'negotiating treatment', 'following a plan', 'treating', 'timing', and 'weaning off treatment'. The mothers described how they confidently and assertively negotiated with health professionals to get the best treatment plan for their child. In some instances this meant that recommended medical treatment be deferred in response to the mother's expert knowledge about her child. 'He (the doctor) says well I think we should (give a nebulizer)', and I will say 'no not this time..... If he needs it really on the point of going either way, he will get it.'

This work was a dynamic process as the mother adapted to the changing illness patterns and treatment regimes. While much of the time was taken up with treating the child with prescribed medication, alongside of this was the work of 'timing' the response to treatment. One mother described her timing this way:

Then I just get to a point where I sort of look at him and think that last lot of Ventolin two hours ago, you're worse or back to what you were two hours ago. I kind of use the two-hour mark when I think of it.

As the acute asthma episode resolves, 'working on treatment' now involves weaning the child off the added medication given to manage the asthma attack. It is an uncertain and stressful time.

You know there is this constant thing..... Now, shall I wean her down to one today, or shall I leave it till tomorrow? I tend to get a bit 'ansy' about whether today's the day to drop to one; or if she coughs, Oh, we better have three today, I find I tend to be a bit panicky.

Parents have previously described as 'work' the care of a child with a disability (Perkins, 1993); and the concept of a central person - usually described as the mother, primarily responsible for the care, treatment and planning of care for a child with a chronic illness - emerges as a theme in other studies (Eiser et al., 1991; Perkins, 1993; Stewart et al., 1994).

One of the more stressful and difficult aspects of 'managing it', described by all of the mothers, was the process of 'making the call'. This was the decision making process mothers went through to decide when a phone contact or visit to a

Managing it: a mother's perspective of managing a pre-school child's acute asthma episode



health professional was needed. This involves not only 'gauging the severity' of the child's illness that was frequently based on the experience of other asthma episodes, but also being able to 'justify' the call they made. It was extremely important for mothers that they could justify their choice even if, as one mother described, this choice may have resulted in the child's death:

And rightly or wrongly I could have justified that to myself. I think now looking back I would say, no, I didn't do all that I could have... But I didn't do that, so up until recently I could justify (child) dying. That's terrible isn't it?

This was an agonizing, uncertain and stressful time with the underlying worry that they might be making the call too early or too late, as one mother described:

I find personally the call is really hard to make, regarding 'has she reached that point where I need more help'. I find it a really hard thing to determine and I often think, Oh, I've left her too long. I find it really hard to sort of say at this point, this is enough, we go now.

As with 'working on treatment', 'making the call' was something that the mothers felt was their primary responsibility: 'So I think if I find it (the call) hard, there is no way I could ask anyone else to make it.' While some of the mothers described at length how they had attempted to instruct partners or husbands in 'gauging the severity' and 'making the call', all seemed resigned to the fact that they alone must take responsibility for this process.

While the interaction between mother and child was central to the process of 'managing it', partners/husbands, other family members, friends and health professionals were seen as 'supporting treatment'. The role of partners/husbands, family and friends was supportive in providing emotional and instrumental support in assisting with the care of the child, while health professionals' role was 'supporting the treatment' with affirmatory, informational and treatment support. From the mother's perspective an essential part of a doctor or nurse's role was to 'confirm the call' made by the mother and offer reassurance and affirmation that the mother was indeed 'managing it', as one mother described:

I am quite happy about my doctor because the first time I had to give it (Betnesol), this is what happened: I gave him Betnesol. I gave it at home. I had given it in the morning, and he (the doctor) said, 'well, you've done just the right thing'. You just need someone to say that to you, to reassure you exactly about what you need to do.

In 'supporting treatment' doctors and nurses were also called upon by mothers to instruct them in how to manage this and future attacks. All of the mothers described how they expected this instruction to be honest and decisive. This affirmational and instructional role of health professionals has also been noted in other studies (Perkins, 1993;

Cunningham-Burley, 1990; Stewart et al., 1994; Gibson, 1994).

'Managing it' also involved the mother vigilantly 'watching' the child during the acute asthma episode. This required advanced observational and clinical assessment skills and the development of an intuitive knowledge about the child's asthma signs. Each of the mothers could describe their child's signs of asthma, often referred to by them as 'the asthma look'. The mothers described the importance of 'staying with the child', frequently sleeping with them:

I find that when she has asthma I usually go and sleep in her bed with her because I am scared that I might not hear something if I go to bed.

They described how they were constantly 'checking and observing' the child for any changes in the illness pattern. The need to stay with the child often related to the underlying concern that the course of the asthma was difficult to predict with the mothers describing how they were constantly having to learn and relearn their child's asthma signs as asthma patterns changed over time. While all of the mothers described 'watching' as a very stressful and exhausting process, all felt that they were the best person to do the watching. It was something that they wished to remain responsible for even if the child was in hospital, believing that they ultimately knew the child and the child's asthma patterns best.

Burke et al. (1991) described 'vigilance, being just in case' (p.43) as a covert activity of parenting children with repeated hospitalizations. Cohen (1993) noted that a major strategy for containing illness was the need for 'constant vigilance' so that problems can be detected early and action taken (p.91). She described that early in the illness parents often do not know what to watch for and watch for everything, an unfocused vigil which generates a lot of anxiety. However, with the passage of time the parents learn specific assessment skills, begin to trust their judgement and use of data; and their 'constant vigilance' changes to 'central scanning' and periodic monitoring which is much more focused. It appeared in this study that the mothers described early in the acute asthma episode that 'watching' involved 'constant vigilance' because of the unpredictability of the asthma episode; however, as the illness resolved 'central scanning' was more frequently employed.

Managing it: a mother's perspective of managing a pre-school child's acute asthma episode



'Calming' was the final concept of 'managing it' and involved the mothers not only in 'calming the child' but also in keeping themselves calm. One mother most succinctly described this as being 'resolutely calm':

To a certain extent you can put fear into it. If you're showing fear, they are going to pick up on it for sure, so I have tried to be resolutely calm.

This does not mean that the mothers were not frightened. All mothers in the study described the fear and panic of watching their child have an asthma attack, but all felt that an important part of 'managing it' was remaining sufficiently calm in order to avoid upsetting the child and potentially making the asthma worse. One mother described her experience:

Yes, I get frightened, and I think I find I get extremely stressed actually. Particularly by the time we get to the hospital it is invariably crisis point for me. I'll be sitting there and it is always 100 degrees; and I'm sitting there and I'm hot, and I can just feel like my heart rate is up and I feel stressed, and I'll be sitting there trying to read a story, and I will read the same page twice because I'm thinking, come on, come on, because you always wait for a while.

A variety of amusing or distracting activities for 'calming the child' including videos, taking a bath, riding the hospital lifts or reading stories were described.

As soon as I hear her start to speed up I would start to worry; and, you know, I'd get the books out and we would try to have lots of quiet time, and sitting and reading and things just so she didn't get wound up.

For all the mothers this process of 'calming the child' was often complicated by the fact that the bronchodilator medication being given to relieve the asthma has the side effect of 'hyping up' the child. 'Hyping up' was a term often used by the mothers to describe the increasing excitability of the child following the administration of bronchodilators, a recognized side-effect of the drugs. The paradox of trying to keep the child calm and giving a medication that potentially makes them more excitable is something that often influenced their decision about the timing of medication administration.

'Managing it' emerged as one of the key processes of parenting a pre-school child through

an acute asthma attack. The ever changing patterns of asthma in pre-school children made this process an uncertain, unpredictable and stressful time for mothers, however – one which they clearly indicated as their responsibility.

Discussion

The concept that the mother is managing the acute asthma episode has major implications for the practice of doctors and nurses. It challenges the traditional view of nurses and doctors who practise in ways that indicate that they are responsible for managing the treatment of the child with assistance from the family. Much of the literature in the field of asthma management emphasizes the paternalistic view of the health professional being an expert who instructs and educates the family in the management of the child (Becker et al., 1994; Clark et al., 1993). There has been an increasing call for co-management of asthma between health professionals and parents (Warner and IPAC Group, 1992), and this was supported in the interview data. However, the mothers in this study also indicated that this was not always evident in their interactions with nurses and doctors. The nursing literature also supports the concept of partnership between nurse, child and family and the creation of an environment that supports the partnership regardless of the clinical knowledge level of parents (Casey, 1988; Perkins, 1993; Shelton and Stepanek, 1995). This position involves a reversal of the traditional pattern of health-care delivery, with the health-care professional taking on an advisory and support role while the mother continues to take responsibility for managing the acute asthma episode.

From this study it emerged that the nurses' and doctors' involvement in the treatment of acute asthma episodes was primarily in 'supporting' the mother's management. The concept of support as it relates to health is well noted in the literature (Callaghan and Morrissey, 1993; Cohen and Syme, 1985; Dimmond and Jones, 1983; Keeling et al., 1996) and there has been studies in relation to the caregiver role (Norbeck et al., 1991). Norbeck et al. (1991) that identify four categories of support which closely follow those identified by the mothers in this study: informational, instrumental, feedback and emotional support.

Informational support refers to the provision of information regarding the illness, its management and coping and decision-making strategies. The mothers indicated in this study that this could

be provided by clear, honest individualized instruction to assist them in planning the management of future acute asthma episodes. This would suggest that although asthma information booklets might provide some background information, mothers clearly wanted individualized information pertinent to their child. Gibson (1994) noted that families learn through past experience of caring for the child. The frequency with which the mothers used past asthma episodes to assist them in managing the current episode suggests that informational support should not only be individualized but should also utilize the past experiences and observations of the caregiver.

The second category, instrumental support (Norbeck et al., 1991) involves those activities that help locate resources and provide direct assistance with care. The mothers in this study indicated that the support of nurses and doctors in the development of an asthma action plan – which integrated not only new treatments but also the new knowledge gained by the mother about the child's illness and treatment – was an essential component of this instrumental support.

Nurses and doctors also had an important role in supporting the mother in the work of managing the asthma episode. Doctors and nurses can support mothers by avoiding interventions and practices which might interfere with the watching and calming activities of the mother and utilize the mother's expertise in the ongoing assessment and care of the child.



Managing it: a mother's perspective of managing a pre-school child's acute asthma episode



Feedback support is the third support category (Norbeck et al., 1991). This involves active listening and the opportunity to talk and gain affirmation or validation of actions or feelings. All of the mothers emphasized the importance of such support. The importance of nurses and doctors supporting and reassuring the mother throughout each encounter cannot be overstated and was something frequently called for by the mothers in this study.

The final category described by Norbeck et al. (1991) is emotional support. Emotional support refers to the sharing of love, care, commitment and acceptance. In the study this type of support was frequently associated with close family members and friends; however, while acknowledging support from family and friends, the mothers in this study also expected a level of emotional support from nurses and doctors. This could be provided by supporting the calming activities of the mother, by maintaining a calm environment, and consulting the mother as to the best way to approach the child. Another significant aspect of emotional support was recognition of the stress and energy required by mothers to maintain calmness. This was often misinterpreted by the health professionals to mean that the mother was coping well with the illness episode, when in fact she may have

been very stressed. Useful emotional support by doctors and nurses included checking out with the mother how she was coping, ascertaining her needs and responding appropriately to them. This may mean relocating to a quiet private area, providing comfortable seating, refreshments or just sitting alongside and encouraging the mother as she supports her child through the illness episode.

The experience of mothers' managing a pre-schooler through an acute asthma episode has previously been largely unexplored. This study provides a glimpse into the experience of a small group of mothers. The grounded theory method of analysis provided a systematic and rigorous method of handling the data and developing the concepts. While it was not envisaged that data saturation would occur in this study, a larger sample-size and more data from each participant are needed to strengthen the conceptual development. The limitation of time to complete this study did not allow for more than one interview to be conducted with each participant or for any comparison to be made between groups. The use of other data sources, especially participant observation, would have given a greater understanding of the experience for mothers, as often the transcript did not capture the full experience of the mothers in managing

the acute asthma episode. The study findings are also limited by the fact that the mothers in the sample identified themselves as European New Zealanders and did not include other cultural groups or mothers of older children with asthma. Despite these limitations, the study did demonstrate that as a central person the mother clearly perceives that she is responsible for managing the asthma episode with support from family, friends and health professionals. In doing this the mother utilizes her expert perceptive knowledge about her child.

This study has important implications for the clinical practice of both nurses and doctors, particularly in regard to the issues surrounding the parent-professional partnership. Nurses and doctors need to reconsider their relationship and approach to parents of pre-school children with asthma and take up the challenge of a true partnership approach. Such a partnership would be based on mutual respect, acknowledgment of expertise, sharing of information, open communication, affirmation and reassurance. This study focused closely on the perception of the mother. Further research is needed which incorporates the views of fathers, siblings and other family members and care-givers. Attention should also be given to how care-givers managing pre-schoolers with asthma develop

Managing it: a mother's perspective of managing a pre-school child's acute asthma episode

their knowledge and skills and adapt this to the changing patterns of the illness.

Asthma continues to have a major impact on the lives of pre-schoolers and their families. This study recommends that a partnership approach between practitioners and families holds the key to improving the health outcomes for children and their families.

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NEWS FROM AROUND THE REGIONS

HEALTHFEST KAPITI COAST

In early March Kapiti Asthma participated in the Kapiti HealthFest at Whakarongatai Marae in Waikanae organised by Kapiti Community Health Trust.

It was a very cold day with a southerly wind keeping the temperature down and ensuring that the local op shop did a roaring trade in selling coats jackets and hats to those who didn't come prepared. Fortunately it only rained as we were setting up. The thermos of hot soup and the blankets we took proved most welcome.

There was a powhiri and speeches to start the day and the entertainment throughout had a healthy theme to it with displays of Tai Chi, Kapiti College Kapa Haka group, Line Dancing, as well as various speakers.

Some of the other displays were Arthritis, Diabetes, Disability Info, Parkinsons, Sport Kapiti, Falls Prevention etc etc

Our society had a variety of

information leaflets available and we were pleasantly surprised at the number of people who stopped by and availed themselves of our literature. One person from a drug and alcohol rehab centre took some of our Quit Smoking info saying that the people who were trying to give up said drink and drugs didn't realize that the effects of smoking cigarettes would probably kill them years down the track!!

A basket of lollipops for the young ones, of which there were very few, disappeared quickly once the local college performing Kapa Haka group found them!!

There is no way of knowing how successful we were, but we were most gratified with the interest shown in our display and will definitely attend another HealthFest.



DONATION FROM DIOCESAN SCHOOL FOR GIRLS

On Friday, 17th March 2006, the students at Diocesan School for Girls held a mufti day. Each girl was asked to bring a donation of a gold coin. They raised a total of \$1,200, which they most generously donated to the Asthma Society.

Well done girls, thank you most sincerely for helping us in the fight against asthma.



Jee Ho Rodriguez

joined the societies on June 12th as Finance Administrator taking over from Wendy Cathie who went into well earned retirement and who is now furthering her interest in decorating eggs. Jee Ho's first day was memorable as she was plunged into darkness by the Auckland power cut. Jee Ho is married to Romy and they have a teenage daughter, Jamie. Jee Ho is a Fijian born Chinese and

was educated in New Zealand. She has a Bachelor of Commerce from the University of Auckland. Prior to joining the societies, Jee Ho has been employed by Tertiary Education Institutes, AUT and Unitec in the International Student Department. Jee Ho enjoys travel, skiing and dining out. We hope that Jee Ho has a long and happy employment with Asthma Auckland.

Introducing Asthma Auckland / Asthma New Zealand's newest staff member.

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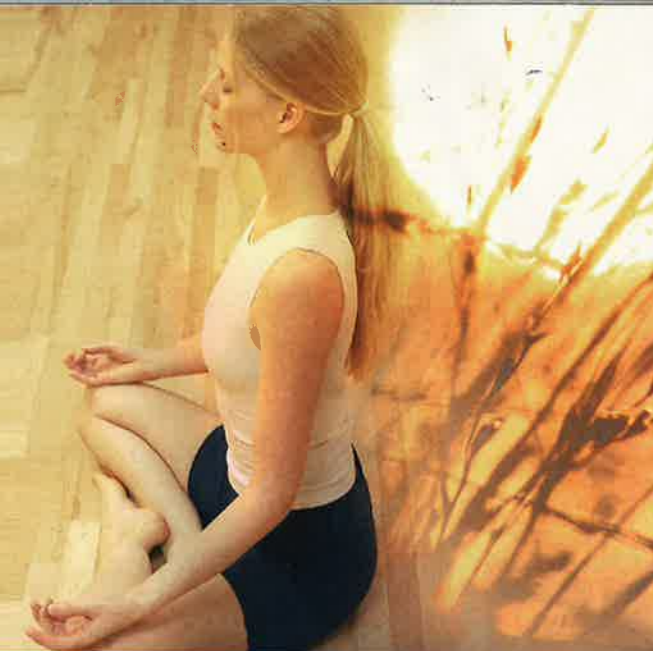
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Yoga for Children with Asthma



Yoga and yoga therapy for asthma has been scientifically validated since 1980, (Goyesche et al, 1980,1982). Studies have shown that yoga postures and pranayama (yogic breathing techniques) are beneficial for people with bronchial asthma (Singh et al, 1990, Nagendra & Nagarathna, 1985, 1986). Studies have also shown that yoga training results in increased lung function and exercise capacity in young asthmatics (Jain et al, 1991).

by Sharon Byron-McKay B.H. Sc (physiotherapy)
Director of The New Zealand School of Yoga

It is common for children who have asthma to develop postural habits that tend to close the chest, hampering diaphragmatic expansion. Yoga postures and breathing techniques help return the spine to its natural curvature, open the chest and shoulders to improve the proper use of the lungs.

Children can fall into a vicious cycle of doing little physical activity out of their fear or parents fear of provoking an asthma attack. This inactivity can result in the child becoming progressively weaker and sicker, making it more and more difficult for them to participate in any physical activity. Yoga exercises and postures can slowly strengthen bones and muscles due to its weight bearing nature. Bone density and muscle strength is improved in the arms, legs and trunk, along with this strengthening goes the ability to participate in other physical activity.

Often people see yoga as mainly flexibility exercises yet yoga is such a thorough form of exercise that flexibility, strengthening, aerobic conditioning go hand in hand and are perfectly in balance – unlike most forms of exercise. Simple yoga sequences can be gradually progressed so that heart rate and sweating is increased. Yoga however approaches cardiovascular fitness differently than the West, when practising yoga - blood flow to the heart

is increased without putting the heart under strain. This distinct difference is believed to be more beneficial for the heart. For children yoga provides a safe non-competitive environment where improvement in general fitness can be achieved in a simple and fun way.

Yoga ultimately is the art of regulating one breath to help keep relaxed in all situations. Initially yoga simply makes the student aware of how breathing slowly can be achieved in simple postures such as lying, sitting and standing. They can then be shown how to regulate and be relaxed in their breathing in postures that are directly beneficial for their asthma such as lying backwards over a bolster so that chest, diaphragm and abdomen are passively stretched, leaning forward over a chair so that their back spine is stretched and their diaphragm is rested. Gradually they are shown how to regulate the breath while remaining relaxed in more strenuous positions. As the students mature and learn to remain relaxed - through yoga techniques they are shown how to breath more slowly. A slower breath facilitates a deeper breath allowing less resistance in the airways. By breathing in a slower and more relaxed way during yoga practice helps to make it easier to deal with an asthma attack when slow breathing is only possible during the 'in' cycle of the breath.

Yoga is not merely a series of exercises practiced in a yoga studio, by learning the concept of doing more while exerting one self less, by practicing to remain as relaxed as possible during both passive and active poses. This is carried through in a functional way to everyday life in that the children are taught to remain relaxed in everyday activities and situations. This sows the seed for healthy management of stress. Stress being high on the list of precipitants of asthma. With regular practice children also find it easier to remain relaxed during an acute asthma attack and not panic, making breathing easier rather than more difficult.

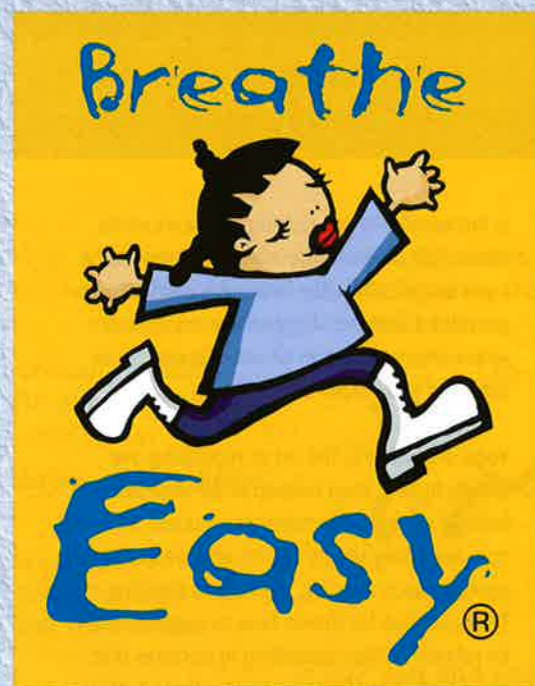
Studies have shown that exercise generally improves a child's self esteem, confidence, psychological and physical well being. Yoga is similar to a very gentle form of gymnastic which is known to be an exercise will tolerated by children with asthma. With yoga children who are not used to exercising can soon be doing a non-competitive physical activity with achievable postures and movements which does not compromise their breathing. If your child is interested in trying out yoga it is wise to take him/her to a qualified yoga teacher preferably with a medical background to learn in a supported and safe environment.

NEWS FLASH

Asthma New Zealand – The Lung Association (Inc)

would like to announce that it has taken Trade Mark Registration under Section 51 (a) of the Trade Marks Act 2002 on 22 June 2006, with a deemed registration of 16 December 2005.

The details of registration are as follows:-



The above Logo and the terms "Breathe Easy" is now owned by Asthma New Zealand – The Lung Association (Inc) under the Act, and cannot be used in any way, e.g., in publications, advertising etc., without the permission of Asthma New Zealand – The Lung Association (Inc). Anyone who uses the logo or term will be in breach of Copyright.

Asthma New Zealand – The Lung Association (Inc) will be using the above extensively in terms of branding. I would certainly appreciate your co-operation in this matter.

G.A. Hanna
Secretary/Treasurer



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

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Home

An asthmatic determined to swim the Cook Strait – A truly remarkable story

Hana Wolzak is one very determined lady who's well on her way to achieving this impressive challenge and she certainly hasn't let asthma stand in her way.

"It's been a goal of mine since 1976 to swim the Cook Strait. My first attempt was in 1999 but I had an asthma attack during the swim. It really knocked my confidence in my fitness and took me quite a while to get over it. During swim training in the pool I would always keep my Ventolin inhaler by the end of the lane because if I really pushed myself hard it sometimes triggered wheeziness or an attack.

I found I'd get to a certain level, have an asthma attack, rush to the after hours medical centre and then take two weeks off training to recover. I then found myself back at square one. It was so frustrating to feel that I'd never be able to excel past a certain level of fitness. This cycle went on for the following six or seven years since my first attempt. I then started using io's altitude simulation at the end of 2004 when it was recommended by an Ironman friend I met and trained with at the swimming pool. I'd had asthma all my life and by now, was willing to give anything a go.

When I started the io programme I noticed a difference within 10 days. I felt much stronger. Now, when I do my five-day booster programme I notice the benefits in my breathing even more quickly. My peak flow measurement jumped from 500 to 560 as a result of the io programme. Any asthmatic will know that's a huge, huge step up. Normally, over time, asthmatics' peak flow can worsen, but instead mine is getting better.

I didn't expect such dramatic changes but now, even if I wasn't going to swim, I'd still be a regular io programme user. As well as the significant and long-term boost to my asthma, other benefits from io include better recovery.

When I'm training for a Cook Strait attempt I swim 10 times a week, for up to two hours every session. My breathing is much more comfortable during training and at the end of a session I feel more in control than I ever did before. My coughing bouts are vastly reduced and I bounce back to form more quickly. io has really helped

me break the glass ceiling that has capped my performance up until now. Because of io I now breathe better, I can train harder and have increased my speed. I recently had another attempt to swim the Cook Strait in May 2006.

I was in good form, I'd put in the training time and had huge amounts of support, but unfortunately the water was just too cold on the day i.e 12 degrees. I swam 2.4km in the first 25 minutes – a strong start. After six hours it seemed to be getting colder though, and my core body temperature dropped by 2 degrees. The decision was made to abort the swim and within a flash it was over.

I'm really disappointed, but it goes without saying that I'll be swimming it again soon. What's a real bonus is that I didn't have an asthma attack at all this time, which has boosted my confidence hugely. I've not had a single serious attack since I started the io programme and my reliance for my inhaler has plummeted.

My next Cook Strait slot is booked up for the next season and I'm very determined to succeed."



About 'io' altitude simulation

io altitude simulators work by forcing the body to react as if at altitude. The result – boosted energy levels, feeling healthier, a stronger and fitter body.

Thinner air at altitude means it takes greatly increased effort just to breathe, let alone do anything else. That increased effort has proven beneficial effects on the body. The io programme delivers 'thinner' air, via a mask, inducing beneficial stress in the body and causing it to react by producing a higher proportion of red blood cells. The more red blood cells you have, the more efficient your body becomes at transporting and utilising oxygen.

This reaction is caused by the body having to adjust to alternately breathing high altitude (hypoxic) air and sea level (normal) air via your own mask every 5 minutes for an hour a day over a set number of days. All you have to do is visit an io centre, relax in a chair and read, listen to music, watch a movie, surf the internet, check your emails, work in peace or simply relax while your body does the work.

The io programme is natural and drug-free. It takes 50 hours over one year - one hour a day for 15 days, followed by one hour a day for a 5 day booster session every 6-8 weeks. The flagship io centre is located in Queenstown, and other centres will open soon in Wellington and Auckland. It costs between \$22 and \$30 per hour.

Asthma study wins ZONTA / Building Researching Award



She attended Hutt Valley High School before gaining a BSc in Zoology and Ecology and MSc in Ecology (Animal Behaviour) with first class honours from Victoria University of Wellington. She already acts as an ambassador in the Canterbury area for Futureintech, a government funded initiative, which aims to encourage young people into careers in science, engineering and technology. Caroline has a wide range of interests outside work including the Biomimetics Society of New Zealand, Civil Defence, dance, history classes, house design, rock climbing and abseiling.

Dr John Duncan of Building Research was delighted with the quality and number of applications for this year's Zonta/Building Research Award. He was equally impressed with the research topic and says, "Researching the air quality in our homes is particularly relevant to New Zealanders. Whilst it is estimated that one in twenty people worldwide are affected by asthma, the New Zealand statistics tell a very different story. Here it is estimated that as many as one in six are affected, and one in three preschoolers.

"This research will help us to understand the contribution of mould growth to these statistics, and give us reliable means of assessing levels of mould spores in household environments. It relates directly to Building Research's purpose to invest in research which delivers a built environment that is highly valued by New Zealanders and results in a better quality of life."

Dr Duncan acknowledged Zonta's contribution and went on to say, "Building Research is now investing some \$200,000 a year in scholarships and study awards to meet the needs of the building and construction sector. We are proud to sponsor and partner with the Zonta Club of Wellington. Helping students like Caroline complete their studies is an investment in the next generation of New Zealand scientists. We congratulate Caroline and look forward to following her progress."

For further information, please contact:

Sharon Nelson-Kelly Tel: 029 239 4874 (Mobile)
Convenor of Zonta Science Awards Zonta International Club of Wellington Inc.
Or
John Duncan Tel: 04 237 2053 (DDI)
Building Research 021 705 620 (Mobile)

BACKGROUND

Zonta International

Zonta is an international organisation of executive and professional women working together to advance the status of women. There are over 33,000 members in 1,246 clubs in 68 countries around the world.

Zonta International holds consultative status with United Nations' agencies – UNICEF, UNESCO, ECOSOC - and has permanent observers at the UN in New York, Paris and Geneva. It undertakes international funding projects to which all clubs throughout the world contribute. For example the Amelia Earhart Scholarship is awarded annually to 15 postgraduate students to pursue work in the aerospace science.

Over one million dollars has been contributed to the United Nations Unifem Fund to aid the economic development of women in ten of the world's poorest nations. In addition, the fund raising activities of local clubs support local organisations.

The Zonta Club of Wellington is one of 29 clubs in New Zealand. The original Zonta Science Award was initiated by the Wellington-based Club to fulfil one of Zonta's main objectives, to improve the economic, legal and political status of women. See <http://www.zonta.org.nz>

Building Research

BUILDING RESEARCH is the building and construction sector's leading research investment agency. Building Research invests in an extensive range of research, technology transfer and scholarship activities, with funds derived from the Building Research Levy, under the direction of a Board drawn widely from the building and construction industry. See www.buildingresearch.org.nz

Building Research should not be referred to as BRANZ, which is the trading name of the separate entity BRANZ Ltd (see www.branz.co.nz). BRANZ Ltd delivers research, testing, consultancy and educational services. While BRANZ Ltd has its own Board, it is owned by Building Research but draws only 40% of its income from investments by Building Research.

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Does an asthma education program improve quality of life? A two-year randomized trial.

Marabini A, Brugnami G, Curradi F, Siracusa A. *J Asthma*. 2005 Sep; 42(7):577-81

BACKGROUND: Asthma education programs result in clinical improvement. However, most studies involved programs of up to 1 year of follow-up, and their efficacy in improving quality of life (QoL) is still controversial. The aim of this study was to evaluate the effectiveness of a program of patient education in asthmatics over 2 years. Thirty-seven asthmatic patients were randomly allocated to group A (usual treatment) and 32 to group B (usual treatment plus patient education program). The effectiveness of the education program was evaluated by comparing

morbidity outcomes at baseline and 12 and 24 months afterwards.

CONCLUSIONS: At baseline, no intergroup difference emerged in age, sex, smoking, asthma severity, atopy, FEV1, symptom-free days, use of rescue salbutamol, and QoL. One year later, group B subjects had an improvement in the overall QoL (from 5.8 +/- 0.8 to 6.1 +/- 0.7, $p < 0.005$), and in "Activities" (from 5.3 +/- 0.9 to 5.7 +/- 0.8, $p < 0.05$) and "Environment" (from 6.4 +/- 1.0 to 6.8 +/- 0.4, $p < 0.05$) domains. Two years later

the "Activities" domain score increased in group B (from 5.3 +/- 0.9 to 5.7 +/- 1.1, $p < 0.05$). QoL did not vary in group A. The education program was ineffective in all other parameters at both follow-up time-points. In group A, a significant increase in medication expenses and a significant decrease in rescue salbutamol use was found 1 and 2 years after baseline, respectively. In conclusion, this education program improved QoL for 1 year, but the improvement was not sustained in the 2nd year.

Asthma prevalence in 1973, 1988 and 2003

M L Burr, D Wat, C Evans, F D J Dunstan, I J M Doull on behalf of the British Thoracic Society Research Committee *Thorax* 2006;61:296-299; doi:10.1136/thx.2005.045682

BACKGROUND: A study was undertaken to see whether the prevalence of asthma has changed since a survey was conducted in 1988, using the same methods that showed an increase during the previous 15 years.

Methods: A survey of 12 year old children was conducted in schools in South Wales where surveys had taken place in 1973 and 1988. The survey comprised a parentally completed questionnaire and an exercise challenge test, performed when no bronchodilator had been recently used.

Results: In 1973, 1988, and 2003, questionnaires

were obtained for 817, 965 and 1148 children, respectively; the exercise test was performed by 812, 960 and 1019 children, respectively. The prevalence of reported wheeze in the last year rose during each 15 year period (9.8%, 15.2%, 19.7%), with an even steeper rise in reported asthma ever (5.5%, 12.0%, 27.3%). There was a continued increase in wheeze attributed to running, in terms of all children (5.8%, 10.5%, 16.0%) and also as the proportion of those with a history of wheeze (34.1%, 47.0%, 57.3%). The use of inhaled corticosteroids (not available in 1973) increased fourfold between 1988 and 2003. The prevalence of exercise induced

bronchoconstriction rose between 1973 and 1988 but had declined by 2003.

CONCLUSIONS: The rise in the prevalence of asthmatic symptoms has continued since 1988. This appears to conflict with a reported recent decline, unless asthma prevalence peaked in the 1990s. The decline in exercise induced bronchoconstriction is probably attributable to better control of the disease as more children are now using inhaled corticosteroids as preventive treatment.

Predictors of primary care follow-up after a paediatric emergency visit for asthma.

Zorc JJ, Scarfone RJ, Li Y. *J Asthma*. 2005 Sep;42(7):571-6

BACKGROUND: Prior studies have reported low rates of follow-up with a primary care provider (PCP) after emergency department (ED) treatment for asthma. We sought to identify predictors associated with PCP follow-up.

METHODS: As part of a randomized trial we surveyed parents of children aged 2-18 years being discharged after ED asthma treatment. Parents described their child's asthma history and perceived benefits and barriers to making a PCP follow-up visit. Bivariate tests and multivariable logistic regression were used to determine association with completion of a follow-up visit

within 4 weeks of the ED visit.

RESULTS: A total of 278 subjects (N =278) were enrolled; 55% saw their PCP within 4 weeks of the ED visit. Baseline factors that were associated with an increased likelihood of follow-up included a recent hospitalization, more than one ED visit for asthma in the past year, the parent's assessment that the child has "very severe" asthma, and current daily use of a controller medication. Parental beliefs that taking daily asthma medications and finding out about the causes of asthma attacks were very important and were also associated with increased PCP

follow-up. Parents were less likely to follow up if they reported a lack of convenient appointments or prolonged waits in the PCP office. A multivariable model including clinical factors, parental beliefs, and the study intervention predicted the likelihood of follow-up.

CONCLUSIONS: Parental beliefs about asthma severity, the benefits of controlling asthma, and organizational barriers to seeing a PCP were associated with follow-up after a pediatric ED visit for asthma.

The Adult Incidence of Asthma and Respiratory Symptoms by Passive Smoking in Uterus or in Childhood

Trude Duelien Skorge, Tomas M. L. Eagan, Geir Egil Eide, Amund Gulsvik and Per S. Bakke *American Journal of Respiratory and Critical Care Medicine* Vol 172. pp. 61-66, (2005)

BACKGROUND: The effects of pre- or postnatal passive smoking on the adult incidence of asthma have not been reported previously. Between 1985 and 1996/1997, we conducted an 11-year community cohort study on the incidence of asthma and respiratory symptoms in Western Norway. The cohort included 3,786 subjects aged 15 to 70 years, of which 2,819 were responders at both baseline and follow-up. The incidence of asthma and five respiratory symptoms by self-

reported exposure to maternal smoking in uterus and in childhood, as well as smoking by other household members in childhood, was examined.

CONCLUSION: After adjustment for sex, age, education, hay fever, personal smoking, and occupational exposure, maternal smoking was associated with asthma, phlegm cough, chronic cough, dyspnea grade 2, attacks of dyspnea, and wheezing, with odds ratios (95% confidence intervals [CI]) of 3.0 (1.6, 5.6), 1.7 (1.1, 2.6), 1.9

(1.2, 3.0), 1.9 (1.2, 3.0), 2.0 (1.3, 3.0), and 1.4 (0.9, 2.2), respectively. The adjusted attributable fractions (95% CI) of the adult incidence of asthma were 17.3% (5.2, 27.9) caused by maternal smoking and 9.3% (95% CI, -23.2, 33.2) caused by smoking by other household members. Exposure to pre- and postnatal smoking carries a substantial risk for developing adult asthma and respiratory symptoms.

Predictors of body dissatisfaction in boys and girls with asthma.

Kelsay K, Hazel NA, Wamboldt MZ. *J Pediatr Psychol*. 2005 Sep;30(6):522-31. Epub 2005 Mar 3. *National Jewish Medical and Research Center, 1400 Jackson St. Suite*

BACKGROUND: Body satisfaction is an important issue for youth. Youth with more severe asthma may have experiences and emotions associated with less body satisfaction; however, this has not been studied.

OBJECTIVE: To identify correlates of body dissatisfaction in youth with asthma. **METHODS:** 63 females and 60 males, ages 8-18 years

with asthma, completed measures of body dissatisfaction, anxiety, depression, asthma symptoms, and behaviors. Parents completed measures of asthma limitations; clinicians rated asthma severity. **RESULTS:** Anxiety, depression, and body mass index (BMI) accounted for 21 and 15% of the variance in body dissatisfaction for females and males, respectively. Physical

activity added 13% variance to the above model for females. Asthma symptoms added 14% for males. Of note, neither parent ratings of asthma limitations nor clinician ratings of asthma severity contributed additional variance.

CONCLUSION: This study increases our understanding of youth with asthma and provides future research directions.

Understanding Participation in an Asthma Self-Management Program*

(Chest. 2005;128:3133-3139.)

Valentine Lemaigre, MA; Omer Van den Bergh, PhD; Katrien Van Hasselt, MA; Steven De Peuter, PhD; An Victoir, MA and Geert Verleden, MD, PhD

BACKGROUND: Asthma education programs improve asthma treatment results significantly. Low participation rate is a recurrent problem that impedes the efficiency of those programs. The purpose of this study was to investigate social cognitive determinants of the intention to participate in an asthma self-management program.

Design: Structured interview.

Setting: Outpatient clinic, University Hospital Gasthuisberg, Leuven, Belgium.

Patients: One hundred seven asthmatic outpatients (mean age 42 years; 35% male).

Interventions: Patients received a standard explanation about the asthma program, were

invited to participate, and were questioned about their beliefs about the program offered. Measurements and results: A social cognitive framework (attitude, social influence, and self-efficacy model) was used to compose a structured interview that was administered to assess the patients' attitude toward the program (perceived benefits), their social influence, and self-efficacy expectations to participate (perceived barriers). Asthma-related health behavior and clinical and demographic characteristics were evaluated by means of questionnaires. Fifty-nine percent of the patients expressed the intention to participate. Logistic regression analysis resulted in a model explaining 72% of the variance of intentions (Nagelkerke R² = 0.72). Having few structural

barriers to participate was a significant predictor of participation (odds ratio [OR], 12.5; 95% confidence interval, 5.2 to 19.3), next to believing in the personal benefits of the program (OR, 7.6; 95% confidence interval, 2.4 to 12.5), social influence (OR, 3.3; 95% confidence interval, 1.3 to 8.4), and education level (OR, 2.7; 95% confidence interval, 1.3 to 5.6).

CONCLUSIONS: Recruitment of patients with asthma for an educational program should emphasize personal benefits of the program, should include patients' social network, and should consider the impact of structural barriers on participation behavior.

Internet-based monitoring of asthma: a long-term, randomized clinical study of 300 asthmatic subjects.

Rasmussen LM, Phanareth K, Nolte H, Backer V. *J Allergy Clin Immunol.* 2005 Jun;115(6):1137-42.

Respiratory and Allergy Research Unit, Department of University Medicine 1, University Hospital of Copenhagen, H:S Bispebjerg Hospital, Bispebjerg Bakke 23, 2400 Copenhagen NV, Denmark. makowska@dadlnet.dk

BACKGROUND: Experience from other fields of internal medicine shows that Internet-based technology can be used to monitor various diseases. The new technology handles complex calculation programs easily, and it is a unique way of communicating. These advantages might be used in optimizing the treatment for asthmatic subjects because undertreatment is a common problem found in European asthmatic subjects. **OBJECTIVE:** We sought to investigate the

outcome of monitoring and treatment using a physician-managed online interactive asthma monitoring tool and to assess whether the outcome differs from that of monitoring and treatment in an outpatient respiratory clinic or in primary care. **METHODS:** Three hundred asthmatic subjects were randomized to 3 parallel groups in a 6-month prospective study: (1) Internet-based monitoring (n = 100); (2) specialist monitoring (n = 100); and (3) general practitioner (GP) monitoring (n = 100). All the patients were examined on entry into the study and after 6 months of treatment. **RESULTS:** The treatment and monitoring with the Internet-based management tool lead to

significantly better improvement in the Internet group than in the other 2 groups regarding asthma symptoms (Internet vs specialist: odds ratio of 2.64, P = .002; Internet vs GP: odds ratio of 3.26; P < .001), quality of life (Internet vs specialist: odds ratio of 2.21, P = .03; Internet vs GP: odds ratio of 2.10, P = .04), lung function (Internet vs specialist: odds ratio of 3.26, P = .002; Internet vs GP: odds ratio of 4.86, P < .001), and airway responsiveness (Internet vs GP: odds ratio of 3.06, P = .02).

CONCLUSION: When physicians and patients used an interactive Internet-based asthma monitoring tool, better asthma control was achieved.

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References: 1. Zetterstrom O et al. *Eur Respir J* 2001; 18:262-268. 2. Bateman ED, et al. *Am J Respir Med* 2003; 2(3):275-281. **Symbicort* Turbuhaler.* Abridged Information for Consumers.** Symbicort Turbuhaler is a combination product containing equivalent to budesonide 100µg or 200µg and formoterol fumarate dihydrate 6 µg/dose. **Uses:** For the regular treatment of asthma (preventer and symptom controller). **Do not use if:** Allergy to Budesonide, formoterol or inhaled lactose. **Cautions:** Thyroid or heart problems, diabetes, problems with potassium levels, pregnancy, breastfeeding. **Possible side effects:** Mild irritation in the throat, coughing, hoarseness, thrush (fungal infection in the mouth and throat), headache, trembling, fast or irregular heartbeat. Rarely, allergic reactions. **Medicine Classification:** Symbicort is a prescription medicine. Use strictly as directed. If symptoms continue or you have side effects consult your doctor, pharmacist or health professional. Consult your doctor to see if Symbicort is right for you. **Symbicort is fully funded under certain criteria. Your doctor's fee and prescription fee will still apply.** For full consumer information please refer to the manufacturer's Consumer Medicine Sheet available at www.medsafe.govt.nz. 29 October 2003. Trademarks herein are the property of the AstraZeneca Group. AstraZeneca Limited, PO Box 1301, Auckland. Tel (09) 623 6300 or Freephone 0800 363 200 Facsimile (09) 623 6301. TAPS NA9328. GREY AZC25612/02 AstraZeneca



What are the Medications for C.O.P.D.?

Compiled by Ann Wheat

Chronic Obstructive Pulmonary Disease (COPD) is one of the fastest growing diseases in the world (Sin, Johnson, Gan, Man, 2004). COPD is characterized by a progressive, irreversible limitation of airflow associated with an abnormal inflammatory response to noxious particles or gases (Gartlehner, Hansen, Carson & Lohr, 2006).

Town, Taylor, Garrett and Patterson (2003) advise that COPD in New Zealand is ranked 2nd in men and 5th in women with regards to its health impact. It is the 4th leading cause of death after cancer, heart disease and stroke and costs the country an estimated \$192m in direct health care costs each year. It is also worth noting that throughout the world it is the fourth leading cause of death and it is projected that by 2020, it will be the third leading cause of death (Ferguson, Funck-Brentano, Fischer, Darken & Reisner, 2003, Sin et al, 2004) and 5th leading cause of disability (Sin et al, 2004).

According to The Thoracic Society of Australia and New Zealand and The Australian Lung Foundation, (TSANZ, 2006), the major risk factor for COPD is cigarette smoking with approximately one half of all smokers having some airflow limitation and 15% - 20% will go on to develop clinically significant disability. They go on to

state that other factors that can also contribute to the development of COPD include:

- Occupational dust and fume exposure;
- Outdoor and indoor air pollution (including environmental tobacco smoke);
- Alpha-1-antitrypsin deficiency
- Genetic predisposition
- Recurrent respiratory infections in childhood; and
- Bronchial hyper-responsiveness.

Goals of Treatment

Nguyen (2004) states that "Although there is no cure for COPD, it is important to "prevent disease progression, reduce symptoms, improve exercise performance, prevent/treat exacerbations, improve health status and reduce mortality". She goes on to say that "even in those with advanced disease, it is still possible to relieve shortness of breath and improve exercise capacity".

So how can this be achieved?

The most significant intervention is to stop smoking. Not only can cessation of smoking reduce the risk of COPD, but also it has been shown to slow the progression of the disease by decreasing the accelerated loss of lung function caused by smoking (Nguyen, 2004).

Medications

Currently the commonest medications that are used for COPD in New Zealand are; Short Acting Beta Agonists (Ventolin, Salamol, Bricanyl), Anti Cholinergics (Atrovent, Spireva), Combination (Atrovent/Ventolin = Combivent), Long Acting

Beta Agonists (Serevent, Oxis, Foradil), and Corticosteroids (Flixotide, Pulmicort, Beclazone). It is worth noting, that overseas the use of Combination medications of a corticosteroid and a long acting beta agonist (Seretide, Symbicort), are being used more often as research is proving more benefit in the long-term treatment of moderate to severe COPD (Sin et al, 2004).

Other medications that are used for people with COPD

Antibiotics can be used for purulent sputum to cover for typical and atypical organisms (TSANZ & ALF, 2006).

TSANZ (2006) also mention that the use of oxygen therapy is also indicated for patients with hypoxia (low levels of oxygen in the body). This aims to increase their oxygen saturations to over 90%. Oxygen therapy has to be given carefully to minimize excessive oxygen administration that can worsen hypercapnia (unusually high levels of carbon dioxide in the blood caused by hypoventilation).

Expectorants and Mucolytics may help with mucous clearance from the lungs by liquefying and thinning mucus or by helping to break the mucous down (University of Pittsburgh Medical Centre (UPMC), 2005).

Bronchodilators

Bronchodilators are first line treatment in COPD. Bronchodilators consist of Short Acting Beta Agonists (SABAs), Anti Cholinergic medications

What are the Medications for C.O.P.D.?

(both short and long acting) and Long Acting Beta Agonists (LABAs) and Combination medication using a SABA and Anti Cholinergic.

SABAs work on the Beta-receptors in the airways. These medications stimulate the receptors causing the smooth muscles around the airways to relax allowing the airways to open and thereby increasing airflow in the lungs. These medications are fast acting working within minutes of taking and last for 4 to 6 hours.

SABAs help by increasing exercise capacity, shortness of breath, providing symptom relief for people with intermittent symptoms and helping to clear airways of mucous, all of which mean a better quality of life.

Irritants such as cigarette smoke cause the body to produce Acetylcholine. Acetylcholine triggers the Muscarinic receptors in the airways causing the airways to tighten up (contract). Anti Cholinergic medications work by blocking the effects of Acetylcholine on the Muscarinic receptors thereby keeping the airways open (Rotech Medical Corporation, 1999).

Short acting Anti Cholinergics (Atrovent/ Ipratropium) provide relief within 5 – 15 minutes and the effects last for 4 – 6 hours (UPMC, 2005). According to Searle (2003), the maximum response occurs 1.5 – 2.0 hours after inhalation. Anti Cholinergics are used when symptoms occur every day. They are also used to relieve breathlessness and improve exercise performance.

The combination SABA/Anti Cholinergic medication Combivent, has been shown to produce greater bronchodilation than either drug alone (Searle, 2003). They work via the part of the nervous system that controls airway size and the part that controls muscle tissue around the airways.

The long acting Anti Cholinergic drug, Tiotropium/ Spireva, works over a 24 hour period and is used for severe COPD only. This medication reduces breathlessness, exacerbation rates and improves health status (TRANS, 2006). They also mention that Tiotropium improves exertional dyspnoea and exercise endurance by reducing hyperinflation. It is important to note that if

using Spireva, then a short acting anti cholinergic medication should not be used at the same time. Long Acting Bronchodilators (LABAs) last for approximately 12 hours and are used on a regular basis instead of as needed (UPMC, 2005). They work like SABAs by relaxing the smooth muscles around the airways. Usually LABAs are slower to work and it is therefore important to always have a SABA for acute breathing problems. One benefit of using a LABA is for night-time breathing problems as they provide up to 12 hours of relief (American Association for Respiratory Care, n.d.). It has shown that by using LABAs, there are clinically significant increases in lung function and decreased symptoms, associated with improvement in health status (Johnson & Rennard, 2001). They go on to say that LABAs may reduce the number of exacerbations and particularly decrease severity.

Corticosteroids

Although the role of Corticosteroids, (steroids), is well documented in asthma, its use in COPD is not quite as clear cut. Steroids, both inhaled and oral, are used to reduce swelling and inflammation in the airways as well as reducing



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mucous production (UPMC, 2005). The general consensus (TRANZ, 2006, Gartlehner et al, 2006, Nguyen, 2004) appears to be that the most benefit from steroids are obtained with moderate to severe COPD by reducing the number and severity of exacerbations, hospitalizations and thus improving health status.

Conclusion

Although most medications discussed have benefits for the treatment of COPD, it is essential that treatments options are discussed with a health professional, as not all medications are suitable for every person with COPD.

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Chronic Obstructive Pulmonary Disease (COPD) Nursing Course

Dear Nurse,

Did you know that Chronic Obstructive Pulmonary Disease (COPD) is estimated to affect over 200,000 New Zealanders, yet few New Zealanders have heard of it? Health professionals know it is a progressive respiratory disease caused mainly by years of smoking. The disease results in a major deterioration in quality of life by destroying the lungs and affecting the rest of the body.

As a health professional are you playing a proactive role in the treatment and management of this debilitating disease? If not do you want to? How about setting up early intervention programmes – i.e. all smokers are screened from age 40 for early signs of this disease.

The primary aim of Chronic Obstructive Pulmonary Disease (COPD) Nursing Course is to provide nursing health professionals with a high level of COPD knowledge that promotes best practice, based on available evidence, and is consistent with national policy. The programme is offered by distance learning with support from Janette Reid Asthma New Zealand's National Educator. The COPD Nursing Course is accredited with 12 credits, which can be used towards gaining your Bachelor of Nursing degree. The cost of a level 7, 12-credit course, which is done through a tertiary education establishment, is \$ 400.00 but a grant of \$200.00 is available to practice nurses/community nurses from Asthma New Zealand/The Lung Association. In the second year of commencement of the COPD Nursing Course 90 nurses enrolled over six intakes.

The society has decided to make the course available at such a low cost to benefit nurses with a special interest in COPD, and increase the knowledge of nurses throughout New Zealand. Applications are now invited from nurses wanting to enrol on the COPD Nursing Course in October 2006. The closing date is 30th September 2006. For information regarding COPD Nursing Course please

Email: janetter@asthma-nz.org.nz
swarnah@asthma-nz.org.nz
 Phone: 09 623 0236 ex 809 Janette
 or ex 804 Swarna

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



**Is your child between 7- 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 (in some participants only) slight itching. Allergic reactions are therefore not anticipated. Children with moderate to severe 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.

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.

**To find out more or to enrol please contact Rochelle at
 Asthma New Zealand/the Lung Association ph 09 623 0236,
 or email christinav@asthma-nz.org.nz**



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Congratulations

Asthma New Zealand, in conjunction with Unitec is proud to announce further successful students from the distance learning Asthma Nursing Course.

- | | |
|-------------------|-------------|
| Gabrielle Allen | Wellington |
| Jennifer Boles | Rotorua |
| Lynelle Dagley | Warkworth |
| Keli Dean | North Shore |
| Debra Leutenegger | Auckland |
| Heather McCaughan | Putaruru |
| Tracy McKee-Body | Auckland |
| Xin Jin | Auckland |



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

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Telephone: E-Mail:

- I want to become a member of Asthma New Zealand
- 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

581 Mt Eden Road, Auckland, Phone (09) 623 0236, 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

581 Mt Eden Rd, Mt Eden, Auckland.
Ph. (09) 630 2293

CANTERBURY

267 Madras St, Christchurch.
Ph. (03) 366 5235

GISBORNE/EAST COAST

PO Box 797, Gisborne. Ph. (06) 867 6732

KAPITI

19 Rifleman Lane, Paraparaumu.
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Ph. (07) 315 6151

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Ph. (06) 377 1175

WELLINGTON

16 Hagley St, Porirua, Wellington.
Ph. (04) 237 4520

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
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Email anz@asthma-nz.org.nz

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or
- Are you currently using a combination (red) inhaler?

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For a free trial of a Seretide puffer speak to your doctor. For more information on Seretide visit www.gsk.co.nz/seretide

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

Seretide (fluticasone propionate/salmeterol xinafoate; available as a 50/25 or 125/25mcg per actuation inhaler, or as a 100/50 or 250/50mcg per actuation Accuhaler) is a Prescription Medicine for the treatment of reversible obstructive airway disease (ROAD) including asthma, and for the treatment of chronic obstructive pulmonary disease (COPD). Seretide is a fully funded medicine; Special Authority criteria apply. Seretide 250/25mcg inhaler is a private purchase medicine that you will need to pay for. Use strictly as directed. Seretide is not for relief of acute symptoms. Always carry your reliever inhaler. Do not discontinue Seretide abruptly. Tell your doctor if: you are taking any other medicines or herbal remedies; you have pulmonary tuberculosis (TB), a thyroid problem or a heart problem; or you are having treatment for high blood pressure; Side Effects may include: 'shaky' feeling; headache; fast heart rate; irritation in the nose and throat. If symptoms continue or you have side effects, see your doctor, pharmacist or health professional. For more information, see Seretide Consumer Medicine Information at www.medsafe.govt.nz. Normal doctor's office visit fees apply. Ask your doctor if Seretide is right for you. Seretide and Accuhaler are trade marks of the GlaxoSmithKline group of companies. Marketed by GlaxoSmithKline NZ Limited, Auckland. TAPS No. NA1502-06AU GLANZ0725



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