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SPECIAL FEATURE:

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COMBINATION THERAPY
- ITS PLACE IN ASTHMA MANAGEMENT

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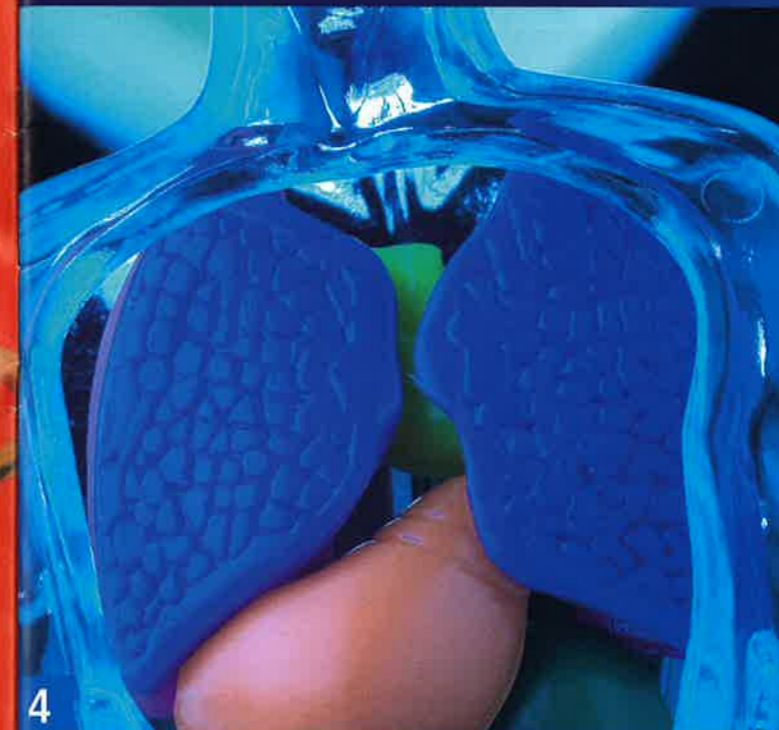


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Welcome to the very first O₂. We're really pleased with the new name. We hope you like it too. A big thank you to Andrew and Rod at J Walter Thompson who came up with the idea and the artwork to go with it.



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So why a new name? We were looking for a name that better reflects the wide range of respiratory conditions talked about in our magazine. So its off with the old and on with the new. Sit down, put your feet up and enjoy reading O₂. The New Zealand Journal of Respiratory Health.

editorial

The fight against asthma – it doesn't have to be fatal!

Asthma New Zealand the Lung Association (Inc) is the primary national advocate body for people with asthma in New Zealand. Our role is to provide the latest information on asthma to partner societies, health professionals and community workers to improve the quality of care provided for people with asthma.

As the national body representing the community, Asthma New Zealand takes on the role of a catalyst for change, to facilitate improvement in the standards of asthma care and management with key stakeholders. The role extends to make representations to, and consult with government, government bodies or other authorities regarding asthma, to encourage and coordinate communication, collaboration and cooperation with interested parties so we can support people with asthma.

The statistics on asthma in New Zealand are alarming. While there's no cure for asthma yet, in the majority of cases asthma can be controlled enabling people to be active. Asthma is not a terminal illness. People can enhance their quality of life with education, medication and proper care.

Sadly 1 in 3 kiwi kids are affected by Asthma. Current statistics for New Zealand indicate that 21% of children under the age of 14 years and 30% of children aged 14 years are affected by Asthma. Prevalence rates of Asthma in New Zealand for 14 year olds is the second highest in the world. 4 out of 10 children do not have their Asthma under control. 550,000 School Days are lost due to Asthma each year. Children are three times as likely to be hospitalized as a result of Asthma. Asthma is the most common cause of hospital admission in children. The statistics in adults are slightly different. 1 in 6 adults are affected by Asthma. 7 out of ten adults do not have their Asthma under control. The economic cost of Asthma has been conservatively estimated to be around \$825 million per year. The economic cost of indirect medical costs (including days off work, premature disability and death from Asthma) is estimated to reach \$700 million per year. 990,000 working days are lost due to Asthma each year. The mortality rate for Asthma is at present, one in every 200 deaths, (this includes both adults and children).

In recognition of the significant burden that asthma places on Kiwis, Asthma New Zealand launched yet another health initiative to improve health outcomes of people with moderate to severe asthma, with the 3+ plan. The 3+ programme is a planned asthma education and management initiative which involves three visits by asthma educators over a period six months for the purpose of improving the management of asthma. These visits will incorporate:

- diagnosis and assessment (including appropriate spirometry tests)
- development of a written asthma management plan, and
- patient education and review of asthma management plan.

The programme started off as a pilot project in Auckland and Asthma Auckland has had a great deal of success. During a 12 month period, 530 initial assessments were completed with 182 first visit reviews. The outcomes have been very encouraging. The reliever medication used, reduced by a 51% with a 55% reduction in the total number of times being woken up at night. The total number of days lost reduced by a 70% with 10 patients taking a reduced dosage of preventer medication. Total hospital stays reduced by 83% with a reduction of 8% in emergency treatment. The outcomes are positive and Asthma New Zealand urges people with Asthma to talk to Asthma Auckland about the 3+ plan and whether it would be of help to them.

In addition, Asthma New Zealand has set standards in Asthma education to healthcare providers, by producing leading edge educational courses in Asthma and COPD at tertiary levels. These courses support nurses to specialise in asthma care and management thereby providing a professional specialised service to the community.

We are thankful to Waitemata District Health Board, trusts and charitable organisation, corporates, members, donors and the public for their support. Together we can fight asthma.

With your continued support we can help Kiwis breathe easy. Together we can get on top of asthma in New Zealand.

Gerry Hanna
Executive Director
Asthma New Zealand

**ASTHMA NEW ZEALAND – HELPING
PEOPLE WITH ASTHMA LEAD A
BETTER QUALITY OF LIFE**





The Other Lung Disease

It's one of the world's leading killers, and early diagnosis could save lives. Why don't doctors test for COPD? By Michael D. Lemonick, TIME, APRIL 19, 2004

It used to take Bernard Regeth, 76, just 15 minutes to harness his two horses. "Now", says the retired mechanic from River Falls, Wisconsin, "it takes a good hour. I put the collar on, and I have to sit down and rest. I put the harness on, and I have to sit down and rest. I buckle the harness, and I have to sit down and rest".

If he exerts himself too much at a routine task like sweeping the kitchen floor, he feels as if he's suffocating. "I have to sit down and take a puff of one of my puffers until it goes away".

Regeth suffers from a disease most people never think about. Most haven't even heard of it, at least by the official name used by doctors, researchers and advocacy groups. A person might worry about getting heart disease or cancer or Alzheimers, but who sits around fretting about chronic obstructive pulmonary disease (COPD)?

In the U.S., lung cancer is deadlier (it killed 150,000 Americans in 2000, vs. 120,000 for COPD), but COPD is more common – by a long shot. Some 13 million Americans suffer from COPD, nearly 40 times as many as have lung cancer. In fact, this "other" lung disease – a condition that includes more familiar illnesses

such as chronic bronchitis and emphysema – is the fourth leading cause of death in the U.S., after cardiovascular disease, certain cancers and stroke. The number of deaths due to COPD has nearly doubled over the past two decades, and the most dramatic increase has occurred in women. In 2000, for the first time, COPD killed more females than males. By 2020, it may be the third leading cause of death in the U.S. and the fifth in the world.

That frustrates doctors to no end, because while COPD isn't curable, it's largely preventable. Although genes play a role in the disease, about 85% of all cases in the U.S. are triggered by smoking; in countries where cigarette and pipe smoking are commonplace, the disease is vastly more prevalent. When cells are exposed to toxic substances for prolonged periods, they tend to become inflamed and swollen. In COPD, cells lining the lungs swell to a point at which they restrict the flow of air. "It's like a sunburn of the air passages", says Dr. Thomas Petty, a pulmonologist at the University of Colorado Health Sciences Centre in Denver and at Chicago's Rush University. Swelling and inflammation trigger bronchospasm, a clenching of the muscles surrounding the air passages, further choking off the oxygen supply. Inadequate oxygen in turn damages the alveoli,

the sacs of cells that transfer oxygen into the bloodstream.

The best way to stop this vicious circle is to quit smoking. "If people stop smoking early on", says Petty, "their lung function actually goes up and stays up for five years". That's a lot easier said than done, considering how addictive tobacco is – and it's not an option for the 15% of COPD victims who don't smoke. But even for non-smokers, it's important to identify the disease as early as possible as that's when drugs are most effective. And because people with COPD are especially prone to lung infection, they need to be vigilant about antibiotics and flu shots.

But while early diagnosis is crucial, it rarely takes place. By the time symptoms like shortness of breath appear, the illness has usually been progressing for a decade or two. "It's like the brakes on a car", says Dr. Michael Stulbarg, chief of clinical pulmonary medicine at the University of California, San Francisco, Medical Centre. "You don't realise the damage they're enduring in normal use, and then at some point they just go out on you".

The only sure-fire way to identify COPD is with a C.T. scan, but few insurance companies cover such an expensive test for a symptom-free patient. There's another highly reliable technique, however, that's a lot cheaper: a \$1,000 cell-

phone-size device, known as a spirometer, that measures lung function. Unfortunately, says Petty, most doctors don't own a spirometer, and have probably never used one. "It's ridiculous", he says. "Doctors do bone scans and everything else, but no spirometry."

That could change if patients demand routine lung tests, but most are unfamiliar with COPD. "We've been our own worst enemies in the medical community – using so many different names for what we're talking about," says Sonia Buist, a pulmonologist at the Oregon Health Science University. Patients have heard of emphysema, the old-fashioned name for end-stage COPD, but it's stigmatised as a self-inflicted disease. "They feel guilty about it", says Dr. Stephen Rennard, a pulmonologist at the University of Nebraska Medical Centre in Omaha, "and so they don't complain much". They also don't generate the kind of sympathetic funding that goes to more presentable diseases. People with advanced COPD "aren't cute", he says. "They're suffering and miserable".

COPD victims can do plenty to help themselves. These go beyond the traditional bronchodilator drugs, which are used to relax the bronchial tubes and increase airflow, and the more radical lung-volume-reduction surgery, which removes the most damaged tissue to give the rest a chance to work more effectively. Inhaled steroids, for example, can reduce inflammation. Even more promising is a new class of medications called PDE4 inhibitors, now in clinical trials, which not only appear to fight inflammation but also may slow the progress of the disease. Yet another group of compounds, called retinoids, may even help damaged lung tissue grow back.

Victims can do plenty to help themselves. "Because exercise makes COPD patients short of breath", says Stulbarg, "they turn into couch potatoes. And when they finally do exercise, the symptoms are even worse". Whether you have COPD or not, exercise is the best way to build endurance. "You push yourself", he says, "and gradually your limits increase".

Stulbarg showed in a recent study that even simple walking can help reduce COPD symptoms. Another study is looking at the possible benefits of yoga. Says co-investigator Virginia Carrieri-Kohlman of the University of California, San Francisco, School of Nursing: "We've got 70 year olds who are on oxygen, and they're able to get down on the floor and do some breathing and do the poses".

So while there's still no cure in sight for COPD and while folks like Bernard Regeth won't ever get back to their old selves, they have more options than ever for keeping the illness from completely destroying their lives. And if doctors and patients paid a little more attention to prevention and early treatment, the rates for this worldwide killer could start dropping, rather than rising, in the charts.

– Reported by Dan Cray/Los Angeles and Harlene Ellin/Chicago.

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NEW ASTHMA THERAPIES – A PATIENT'S GUIDE

WRITTEN BY: DR SHAUN HOLT – CLINICAL RESEARCH FELLOW

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Introduction

The prevalence of asthma is increasing in New Zealand and much of the rest of the world at an alarming rate. Although current asthma therapies, particularly inhaled steroids, have greatly helped to treat patients with asthma, there is a need for new and/or improved medications. Many researchers are currently working on the development of such medications and this article summarises the latest research.

Improvements on existing drugs and devices

There is a worldwide agreement to phase out the production of asthma inhalers containing CFC's over the next few years, due to their adverse effects on the environment. This means that new devices for delivering asthma drugs are being developed.

It is hoped that these new devices, as well as being environmentally friendly, will also be better at delivering asthma drugs to the place where they work – the airways of the lung. Only a small proportion of medicine from current devices gets down as far as the lungs, the rest being deposited in the mouth and throat. Better devices which deliver more drug to the target site will hopefully increase the effectiveness of current drugs.

Many people with asthma use more than one inhaler on a regular basis e.g. use a steroid and drug such as salmeterol (brand name Serevent) twice a day, every day. Several pharmaceutical companies are developing inhalers which contain two drugs. This would make life easier for people with asthma. The drawback with this approach is that such products contain fixed doses of the two drugs, which may not be suitable for everyone.

Preventer drugs, such as inhaled steroids, are usually taken twice a day. However, new research has shown that it may well be possible to get the same effect from taking a higher dose only once a day. Again, this would make life easier for patients with asthma.

Salbutamol (brand names include Ventolin, Airomir, Respolin) is one of the commonest reliever drugs i.e. for the relief of asthma symptoms. Recent work has shown that the drug actually consists of two very similar drugs, or isomers, in equal amounts. Tests show that only one of these isomers relieves symptoms of asthma and the other may actually be bad for

asthma. Therefore, work is underway to develop a product containing only the "good" part. It must be emphasised that it is recommended that asthmatics continue to use their salbutamol inhaler as normal.

New drugs

The most promising new drug in development is called "anti-IgE antibody". Many asthmatics react to allergens (particles that can trigger an allergic reaction such as house dust mites and pollens) by producing high levels of a blood protein called IgE. IgE can then start a chain of events leading to an asthma attack. Without IgE, the asthma attack is much less severe, if it occurs at all. The new drug removes excess IgE from the blood and therefore greatly improves the symptoms of asthma.

It is expected that the drug will be available in New Zealand in about two years. Results from early trials have been very promising, with many asthmatic patients able to greatly reduce the amount of steroid they take, or even stop it completely.

During an asthma attack, many chemicals are released and these chemicals are being targeted by new drugs which may help asthma. Targets include IL4, IL5, tryptase, PAF and neurokinin. Unfortunately, these drugs are still at a very early stage of development and it may be several years until a product is released. Anti-IgE is at a much more advanced stage and will be available in the not-too-distant future.

An asthma vaccine

Finally, work is underway here in New Zealand on a potential vaccine which could possibly prevent asthma from occurring in the first place. The vaccine is based on BCG, which is the vaccine used to prevent TB infection.

The basis for this vaccine is the fact that in Westernised countries, where asthma is increasing, we tend to have fewer infections than in the past due to vaccinations, having a more sterile environment and taking antibiotics. This lack of infection is believed to make the immune system more likely to produce allergy and asthma. Therefore, this vaccine may fool the immune system into thinking that infection is present and therefore may prevent the development of asthma. Many trials still need to be done to see if this exciting work will lead to a treatment or even cure for asthma.

Summary

There are many new asthma drugs in development, as well as research into improving current drugs and drug delivery devices. Unfortunately, many of these drugs will not be useful and the useful ones may not be available for some time. However, it is hoped that current and future patients with asthma will have better control of their condition due to the research being carried out.

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Study links allergies & asthma to antibiotics as a baby

Doctors already know excessive use of antibiotics in children is a bad idea. Now there's another reason to prescribe with caution: researchers have linked antibiotic prescriptions in infancy to the development of allergies and asthma later in life.

SUMMARY ARTICLE FROM HEALTH SCOUT

While it's not clear whether consumption of these antibacterial drugs directly causes allergies, experts are almost certain there's a connection. Babies who received antibiotics were at especially high risk for allergy problems if they lived in homes without at least two pets or had a family history of allergies.

But experts cautioned against antibiotic phobia. "This doesn't mean don't give your children antibiotics," says Dr Stanley Goldstein, a fellow of the American Academy of Allergy, Asthma and Immunology. According to Goldstein, an estimated 20% to 25% of American children suffer from allergies, while 5% to 7% have asthma. Both allergies and asthma are signs the body's immune system is overreacting to foreign invaders.

Over the past couple of decades, researchers have developed a theory that human immune systems are more likely to develop properly if exposed to germs and pet dander at a young age. "We now grow up in a more sterile environment," Goldstein says. "We're not stimulating that immune system with bacteria, and there's a higher incidence of allergies."

In Europe, research has shown that East Germans, who lived in a more rural environment

than their counterparts in the West, actually developed a higher rate of allergies after living standards rose in the wake of the unification of the two countries, Goldstein says.

Antibiotic use in infants, meanwhile, may contribute to allergies by killing off bacteria in the intestine that appear to play a role in the development of a healthy immune system, Goldstein says.

In the new study, researchers examined an earlier research project that followed 448 Michigan-area children from infancy to the age of about seven years in the late 1980s and early 1990s. At seven years of age, the children all had allergy testing. The results of the study were released on September 30 at a conference of the European Respiratory Society in Vienna.

The researchers, from the Henry Ford Health System, found that about 38% of the tested children showed signs of allergies to pets, ragweed, grass and dust mites and 5% had asthma. Those children who had taken antibiotics in the first six months of life – almost half of those surveyed – were 1.5 times more likely to develop allergies and 2.5 times more likely to develop asthma.

The allergy rates rose even higher for children

given antibiotics who didn't live in houses with at least two pets (cats or dogs), who had a mother with a history of allergies, and who were breastfed for more than four months.

Researchers don't know why the children took antibiotics as infants. "We didn't look at whether they were prescribed appropriately or inappropriately," says study researcher Dr Keoki Williams, a clinical epidemiologist at Henry Ford Health System.

Worries about the overuse of antibiotics, which appears to strengthen some bacterial disease, have risen in recent years. During the years of the study, however, the risk wasn't as well known as it is now. In light of the new research, "there's now potentially more than one reason to use antibiotics judiciously in young children," Williams says.

This is a summary article from Health Scout. Knowledgeable New Zealand health consumers may also find this article useful. This information is intended solely for New Zealand residents and is of a general nature only and no person should act in reliance on any statement contained in the information provided and at all times should obtain specific advice from a health professional. All rights reserved. © MediMedia (NZ) Ltd. This publication is copyright.



COMBINATION THERAPY: ITS PLACE IN ASTHMA MANAGEMENT



COMBINATION THERAPY: ITS PLACE IN ASTHMA MANAGEMENT

NATIONAL ASTHMA COUNCIL AUSTRALIA LTD. MARCH 2002.

Introduction

Experience with long-acting beta agonists (LABAs, or 'symptom controllers') over the last 10 years indicates that these drugs are potent and effective bronchodilators, capable of improving asthma control in those with moderate to severe disease. They are optimally used in combination with inhaled corticosteroids (ICS), these two classes thereby providing a dual anti-inflammatory and bronchodilator action.

Combination therapy with these agents is most appropriate in patients with moderate to severe asthma who remain symptomatic on ICS therapy, requiring frequent symptom relief with short-acting beta agonists.

The Rationale and Evidence for Combination Therapy

ICS have a vital role in gaining and maintaining control in mild, moderate and severe asthma. Their use is based primarily on the understanding that cellular mechanisms cause inflammatory mediator release, airway injury and remodelling, leading to poorer lung function and unstable disease. LABAs are potent bronchodilator drugs that are not suitable for use as monotherapy in asthma. Their use in combination with ICS has led to the rethinking of some important issues in asthma management.

Does the addition of a symptom controlling agent lead to any 'masking' of underlying airway inflammation?¹

This may seem possible, given that any worsening of disease would not necessarily be perceived by patients taking symptom-controlling LABAs. However, current evidence does not support this. In one study, symptomatic asthmatics taking ICS were given either more ICS or a LABA to gain effective symptom control. Bronchial biopsies were examined at the start of the study and after 3 months. Those taking a LABA had better symptom control and showed no evidence of masking of underlying airway inflammation.²

Is there any evidence of an anti-inflammatory effect of LABAs in addition to ICS?

Some studies have found that although LABAs alone do not act as anti-inflammatory agents³, they may enhance the anti-inflammatory effect of ICS. In studies examining airway inflammation in people with asthma who remain symptomatic on ICS, the addition of a LABA resulted in less airway inflammation.⁴ Eosinophils are sensitive indicators of corticosteroid activity and are readily suppressed by ICS. Studies on sputum⁵ and peripheral blood⁶ have indicated that LABAs in combination with ICS may exert an anti-eosinophilic effect. Recent evidence supports this view, showing that ICS have enhanced activity at glucocorticoid receptors after exposure to LABAs.⁷

Recent studies have also found a plateau effect with ICS. There is minimal clinical benefit of increasing doses above 250-500mcg/day of fluticasone propionate (FP). This has been observed with other ICS.⁸ This finding is a clear indication for the addition of a LABA to achieve better asthma control in symptomatic patients taking higher doses of ICS.

When these findings are taken together, evidence indicates that there is likely to be an interaction between the two drugs, manifesting as reduced airway inflammation with prolonged and enhanced bronchodilation, reflected in better clinical outcomes.

In studies of the combination given in a single versus two devices, statistically significant, but no clinically important differences have been shown in favour of one versus two devices.⁹ The reasons for these apparent small benefits may relate to the simultaneous delivery of ICS and LABAs.

ICS remain the mainstay of asthma treatment. LABAs do not replace them and should never be used as monotherapy. LABAs do not possess clinically important anti-inflammatory activity and therefore cannot control the underlying disease process. In combination with ICS they provide greater symptom control, morning and evening peak flow benefits and reduce mild and severe exacerbation rates, compared to ICS alone.

Combination Therapy : its place in asthma management Clinical Use of Combination Therapy

Many carefully conducted studies in symptomatic patients on ICS indicate that the addition of a LABA to ICS results in greater improvement in:

- symptoms,
- quality of life,
- lung function, and
- exacerbation rates

than would be achieved by doubling the dose of ICS.^{10, 11, 12, 13}

In symptomatic adult patients, there is Level 1 evidence indicating that adding a LABA is more effective than increasing the dose of ICS. Studies have shown this is true for dose ranges of ICS from 400-1000mcg daily budesonide (BUD)/ beclomethasone (BDP) or equivalent and 200-800mcg daily in children.¹³

LABAs achieve better control of asthma symptoms without the adverse effects that may occur with additional high doses of ICS.

As LABAs produce prolonged bronchodilation (up to 12 hours), they can be combined with ICS and given in a twice-daily dosing regimen. The combination can achieve improved asthma control in symptomatic patients when the total ICS dose is unchanged, or can maintain stability in well-controlled patients when the total ICS dose is reduced.^{14, 15, 16}

Adverse effects are pharmacologically predictable, based on the beta-adrenergic activity of LABAs (tremor, tachycardia, palpitations and headache) and are no different when the drugs are administered in separate devices or together in one device.^{9, 17} Similarly, there is no evidence that administration of a LABA and ICS in a single device alters the adverse effect profile of ICS, although long-term studies are awaited.

The combination of a LABA and ICS should be considered when:

- 1 Symptoms or sub-optimal lung function persist on ICS alone.
- 2 It is desirable to reduce the current dose of ICS while maintaining optimal asthma control.
- 3 Initiating asthma treatment in a patient in whom rapid symptom improvement is needed.

Combination Therapy : its place in asthma management Combination Therapy in Children

The advantages of combination therapy apply equally to children.¹⁸ Clinical trials

have demonstrated combination therapy to be as effective as component medications taken individually.¹⁹ However, before starting combination therapy, consider the indications for LABAs in children. Most children with persistent asthma should be adequately controlled on a dose of ICS equivalent to 250mcg/day of FP or BDP-hydrofluoro-alkanes (HFA) or less, and should not require LABAs. LABAs should only be prescribed for children with persistent asthma that is not adequately controlled on 200-250mcg/day of FP or BDP-HFA.

Other issues to consider are adequate adherence with previously prescribed ICS, and that the child has an appropriate delivery device and reasonable technique. If control has not been achieved on a combination of LABA and a dose of ICS equivalent to 500mcg/day of FP or BDP-HFA or 800-1000mcg/day BUD/BDP (chlorofluorocarbons (CFC)), seek a specialist paediatric respiratory physician opinion.

One further issue to consider in children is the variable natural history of asthma and the need to adjust the dose of ICS. During periods of adjustment it may be necessary to revert to single drug preparations to achieve appropriate flexibility of dosing.

There is no evidence to support dosage increases of combination therapy during acute exacerbations in children.

Combination Therapy : its place in asthma management Dosage and Administration of Combination Therapy

Combination therapy medications are available in both metered dose inhaler (MDI) and dry powder inhaler (DPI) forms. Comparison of the medication delivery between devices and resulting asthma control has produced similar results. However, individual variation in clinical response between devices may occur. Regardless of which type of device is considered to provide the best results, the choice of inhaler device for an individual should be based upon patient factors, e.g. the age, strength, dexterity, vision, cognition, inspiratory flow rate and personal preference of the person with asthma.

Combination medications are available in a range of strengths. The difference lies in the ICS dose; the LABA dose remains constant. Dosing guidelines matching a combination medication to a person's asthma severity have been developed for adults – these may change as our experience with the therapies increases.

- **Mild persistent asthma** – if a person is on

Continued on page 10



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a low dose of ICS (e.g. 200-250mcg/day of FP or BDP-HFA or 400-500 mcg/day BUD/BDP (CFC)) and has persistent symptoms, consider combination medication with low dose ICS or increase the dose of the ICS.

- **Moderate asthma** – try a moderate dose of ICS (e.g. 500mcg/day of FP or BDP-HFA or 800-1000mcg/day of BUD/BDP (CFC)) in combination medication as a first option before increasing the ICS dose.
- **Severe asthma** – use a higher strength ICS in combination with LABA (e.g. 500-1000mcg/day of FP/BDP-HFA or 1000-2000mcg/day BUD/BDP (CFC)) and consider referral for specialist assessment if this does not achieve optimal asthma control.

There is limited evidence supporting an increase in ICS for management of acute exacerbations of asthma, but there is no current evidence regarding increases in medication for those already using combination therapy. The traditional practice of increasing the patient's usual ICS dose would also increase the dose of the LABA. At present there is limited evidence to support this approach and it cannot be recommended. However, it is acknowledged that the most practical and cost-effective option for the patient may be to do this while seeking medical advice.

Combination Therapy : its place in asthma management Dose Titration and Patient Expectations

Effective use of combination therapy requires a few steps to ensure the patient is managed on the optimal dose for their age, disease severity and symptoms. To facilitate patients' appreciation of this process, and enhance their adherence, it is valuable to communicate these steps to them.

Gaining control

- The addition of a LABA leads to significant improvements in control in most patients.
- The initial dose of combination therapy used may be higher than the final maintenance dose. The aim will be to gradually reduce the dose of combination medication once control is achieved.
- 'Control' will be measured by improvements in lung function (PEF, FEV₁) and a decrease in the frequency and severity of symptoms. Good control is characterised by reliever use less than 3 times a week, as indicated in the Asthma Management Handbook.²⁰ This is an important goal of therapy.

NB. When commencing combination therapy,

advise patients to keep their ICS inhaler as it may be required when reducing the dose of combination therapy to a maintenance level.

Assessing control –

1-3 months after adding a LABA to ICS

- If patients are persistently symptomatic or continue to require reliever medication daily, consider other contributing causes/triggers and/or specialist referral. Further increases in doses may be beneficial, but current evidence does not support exceeding recommended maintenance doses (eformoterol 24mcg BD, salmeterol 50mcg BD).
- If stability is achieved with optimal lung function for the individual patient, consider a reduction in ICS.

Back titration –

reducing to a maintenance dose

- Once control is achieved, reduction of the daily dose to the lowest effective dose is the next aim.
- Back titrate by reducing to the next lowest dose of combination therapy. Some patients may require the addition of a separate ICS inhaler to facilitate gradual reduction of the corticosteroid component.

Maintenance

- Maintain at the lowest effective ICS dose and reinforce trigger factor avoidance and management

Schedule a follow-up appointment to assess the appropriate dose of each component (LABA and ICS).

Combination Therapy : its place in asthma management Combination Medications

Fluticasone and salmeterol (Seretide)

Fluticasone propionate and salmeterol xinafoate are available as a combination medication delivered by CFC-free MDI and **Accuhaler**. The **Accuhaler** is suitable for patients who have coordination difficulties when using MDIs.

Dosage:

MDI 50/25: 50mcg fluticasone and 25mcg salmeterol
MDI 125/25: 125mcg fluticasone and 25mcg salmeterol
MDI 250/25: 250mcg fluticasone and 25mcg salmeterol

Each MDI contains 120 doses.

Adults and children > 12 years: two inhalations bd of MDI 50, 125 or 250 depending on the patient's asthma severity
Children 4 years and over: two inhalations



bd of MDI 50

Accuhaler 100/50 : 100mcg fluticasone and 50mcg salmeterol

Accuhaler 250/50 : 250mcg fluticasone and 50mcg salmeterol

Accuhaler 500/50 : 500mcg fluticasone and 50mcg salmeterol

Each Accuhaler contains 60 doses.

Adults and children > 12 years: one inhalation bd of **Accuhaler** 100, 250 or 500, depending on the patient's asthma severity.

Children 4 years and over: one inhalation bd of **Accuhaler** 100

Budesonide and eformoterol (Symbicort)

Symbicort is a combination medication containing budesonide and eformoterol that is expected to be released in Australia in 2002. It is a dry powder delivered by **Turbuhaler**.

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Levels of Evidence
Level 1 – Systematic review of randomised controlled trials/ large multi-centre trial.

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SERETIDE
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Looking at Eczema

Eczema – that dreaded word. Oh no, my child has eczema. Parents often are quite distressed when their child is diagnosed with eczema. If it is your child with eczema, it is you and your family who will feel the effects. Sleepless nights with children waking and distressed, with their itchy inflamed skin affects the families.

Eczema can be a stressful condition. It accounts for a large proportion of skin diseases and is a common condition presenting to an Allergist or Dermatologist. Eczema can be red, blistering, oozing, scaly brown, or thickened, and usually itches. The dry scaly distinctive rash can occur at any age, but commonly begins in children under 5 years and frequently in babies under 6 months. The condition frequently improves with adolescence, but many patients are affected throughout life, although not as severely as in early childhood. It usually affects the face, behind the knees, arms and then other parts of the body. The itch can be so distressing that for relief the skin is scratched until bleeding

occurs. When the skin becomes broken in this way, there is a danger of secondary infection, which may need to be treated with antibiotics. Topical or oral antibiotics are used to kill the bacteria causing the infection.

Identifying triggers

People with eczema may also have asthma and allergies, such as hay fever. In some people with eczema, food allergies may bring on or worsen eczema. Allergies to animal dander, rough fabrics such as wool, which has an irritating effect on the skin, and partly due to the dust mites that it harbors. Hypersensitivity to house dust mite antigen is found in up to 90% of adolescents or adults suffering Atopic eczema.

In addition to mites, sensitisation to pollen or animal dander may be associated with eczematous skin reactions. Identifying food allergies is a means to avoiding foods that contribute to eczema. It may be obvious if an exacerbation occurs after ingesting certain foods e.g. peanuts, citrus fruits. Skin prick tests may identify these triggers. Removing or at least limiting all offending foods from the diet is essential to control eczema.

Avoiding triggers

- **Skin irritants**
If wearing woolen garments, use cotton vests or skivvies underneath. Take irritating labels out of clothes, which may scratch the skin. Use soap and detergents for clothes washing that are recommended for allergy sufferers. Ensure clothes are rinsed well and avoid bleach and fabric softeners. Avoid perfumed powders, soaps, bubble baths, detergents and contact with some cosmetics and toiletries. Wash all new clothes and bed sheets before using them to remove the chemicals used in the manufacturing process. Employ house dust mite reductions measures for example damp dusting, using a HEPA filter vacuum cleaner and house dust mite barrier bedding covers may be worth consideration.

- **Food**
It is best to breast feed baby if possible. Some foods may be worth delaying, such as eggs, cow's milk, peanuts and fish. Delaying the introduction of solids until six months is strongly suggested.

- **Allergies**
People with eczema often develop allergies to house dust mite, animal dander, grasses and pollens. It is often not possible to avoid these allergens.

Children with eczema should not have pets in their bedrooms and ideally pets should be kept outside. Hypersensitivity to house dust mite antigen is found in 5% of all people in Western nations, whereas it is found in up to 90% of adolescents or adults suffering from Atopic eczema. Exacerbations of Atopic dermatitis caused by dust mites are presumed to be related to both inhalation and skin contact. Several clinical studies have reported improvement of the skin condition after a reduction in the level of house dust mites. House dust mite allergy can be managed by: Weekly or more frequent vacuuming with a HEPA filter vacuum cleaner to reduce dust disturbance and distribution. Damp dusting frequently. Use non-wool blankets and bedspreads. Wash linen once a week in water temperature more than 50 degrees Celsius. Air bedding in the sunshine regularly. Vacuum mattresses regularly for dust mites,

and use house dust mite barrier covers for mattresses, duvets and pillows. Keep soft toys off the bed and wash or place them in freezer for 24hrs on a monthly basis.

- **Bathing and moisturising**
The key to reducing skin dryness and irritation is to keep the skin moisturised. Moisturisers should be used several times a day. They soothe and protect the skin from external irritants. There are several different moisturisers such as ointments, creams, lotions and combinations. They are best applied immediately after bathing to seal in the moisture. When bathing use tepid water. Use emollient or bath oil in the bath, e.g. Pine tar derivatives may be added to the bath to control itching.
- **Creams and Ointments**
The skin is one of the largest organs in the body. One of its functions is to protect us from environmental factors such as sunlight, bacteria, chemicals and detergents. The

skin also helps to control the body's water content. It is important to find a product which will suit your skin and not cause further irritation. Products that combine water and oil will apply easily like a cream and have the rehydrating properties of an ointment. Steroid creams help reduce inflammation and swelling. They should be used sparingly on the red itchy areas. Use as directed by your doctor as different strengths of steroid are used for the face and body. Some children benefit from an emollient wrap at night to keep their skin moisturised. Antihistamines can help reduce itching when eczema is severe. e.g. Phenergan Antibiotics are used when infection occurs and will help improve the skin condition. Sunscreens – Shop for a low irritant sunscreen. Ask your doctor or pharmacist which is right for you or your child.

- **Occupational eczema**



Some occupations are best avoided unless protective gloves or clothing can be worn. Contact with chemicals or irritants such as in hairdressing, cleaning or nursing may contribute to contact dermatitis. Once your skin has improved, don't stop using the emollients. Continue to moisturise your skin to maintain a healthy skin barrier, to help protect skin and prevent damage from drying factors like water detergents.

- **Hormonal and emotional factors**
Severity is frequently observed in women during pregnancy and menstruation. Stress during these times may be associated with an increase in itching, leading to scratching and deterioration of the skin.

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www.Allergyclinic.co.nz

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NEWS FROM AROUND THE REGIONS

Psst...it's on again... The Walk for Fun... Pass it on!

The Walk for Fun 2003 was such a great success, we're doing it again. This year the event will be held on **Wednesday 17 November (World C.O.P.D. Day) at Cornwall Park, Greenlane to raise awareness of Chronic Obstructive Pulmonary Disease, a serious respiratory condition affecting over 200,000 Kiwis.**

THANK YOU!



Rem Systems Limited supports Asthma Auckland in the fight against asthma.

Shirley Schollum, Director Rem Systems handing over a sponsorship cheque to Iyanthi Wijayanayake, PR & Fundraising Manager. Thank you Rem Systems for your continued support in our fight against Asthma.



A heartfelt Thank you to Rotary Club of New Lynn.

Christine North, Wife of the President of the Rotary Club of New Lynn handing over a donation to Iyanthi. The Rotary Club organised a charity fundraiser – Black and White Cocktail Evening in support of Asthma auckland.

Ever heard of it? Don't worry, not many people have, even though it is rated the fourth leading cause of death worldwide, and its on the rise.

The aim of the Walk for Fun is to raise awareness of COPD says Event Organiser Debbie Madden. Keeping active can help reduce symptoms, and that's why Asthma Auckland chose a walk. Whether you have C.O.P.D. or not walking is great activity for all of us. So call for an information pack, dust off your sneakers and join us. There will be a range of walks to choose from.

C.O.P.D. isn't curable, but it is largely preventable. Although genes play a role, 85% is triggered by smoking.

C.O.P.D. can be identified by a spirometry test, a simple breathing test. Although not many doctors have a spirometry machine, we do at Asthma Auckland. Answer the questions below and find out if there's a chance you may have C.O.P.D.

- Do you cough several times most days?
- Do you bring up phlegm or mucus most days?
- Do you get out of breath more easily than others your age?
- Are you older than 40 years?
- Are you a current or ex smoker?

If you answered yes to three or more of these questions you may have C.O.P.D. Ask your Doctor if you can undergo a spirometry test, or call Asthma Auckland and talk to one of our Nurse Educators on 630-2293.

Call 630-2293 for an information pack

New Zealand Management Academy helps Asthma

New Zealand Management Academy provides tertiary education courses, which include a call centre course. As a part of the practical training for the students. NZMA organised a database clean up for Asthma Auckland, with much enthusiasm and commitment. Thank you Marjorie and the team at New Zealand Management Academy. It was such a huge task for us. You are fantastic.



POPULARITY OF DEVICE TRAINING EVENING FOR PRACTICE NURSES

Two very popular device-training evenings for Practice Nurses were held on May 26th and July 7th 2004, at Asthma Auckland, 581 Mt Eden Road. The evenings were very well attended with 21 nurses present at each session. Nurses came from as far as Warkworth, 60 kms north of Auckland, to Papakura in the South.

The device evenings commenced with refreshments, followed by a welcome from National Asthma Educator, Janette Reid, from Asthma New Zealand The Lung Association. With so many attending, the nurses were divided into several groups. Auckland Asthma Educators, June

Bell and Ann Wheat facilitated the first evening and Marli Merhoye and Ann Wheat facilitated the second evening.

Devices were demonstrated by the educators and then practiced by the nurses present, included Turbuhaler, Accuhaler, Aerolizer, Autohaler and Metered Dosed Inhaler. The asthma educators also demonstrated spacers and the Handihaler.

To finish the evening, the nurse educators discussed important aspects of a nebuliser, nebuliser maintenance and the correct use.

Both evenings were a huge success with the Practice Nurses benefiting from evidence-based knowledge of devices. All agreed they enjoyed the evening tutorials and networking with other Practice Nurses.



Asthma educators Marli, June and Ann at Device Training

Our grateful thanks to Astra Zeneca for sponsoring the two evenings, providing the refreshments and nibbles. Each nurse was given a pack to take home by Astra Zeneca containing placebo devices, whistles and information on Symbicort the combination therapy.

Royal Oak Shopping Mall Health Week

Royal Oak Shopping Mall held their Health Week from Monday 21st June to Saturday 26th June. Asthma Auckland participated at the Health Week on two days. Asthma Nurse Educator Marli Merhoye provided education, advice and support from the Asthma Station to people who visited the Royal Oak Mall during the Health Week. The station was equipped with posters, leaflets, devices and teaching aids.



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NEWS FROM AROUND THE REGIONS CONTINUED...

BREATHE EASY KINDERGARTENS

JULY 2003 SAW THE INTRODUCTION OF ASTHMA AUCKLAND'S 3+ PLAN TO KINDERGARTENS WITHIN THE AUCKLAND AREA.

The programme was developed for parents/caregivers of pre school children who have asthma, and offers education, by a asthma educator. It is hoped by offering support and education caregivers will have the confidence and knowledge to manage their child's asthma.

The 3+ Plan includes:

- the initial consultation,
- a review within 4 weeks and
- at 6 months a final review (or a fourth if needed)

Asthma in the under 5's can be a very traumatic experience. Caregivers are often frightened, don't understand what is happening, or the need for continuing medications when the child is well. The prime aim is supporting and educating the caregiver so they understand the principles involved in caring for a child with asthma and answering any questions parents may have. It is hoped to reduce the burden of asthma and the incidence of acute asthma in the community.

At each education session discussion revolves

around symptoms, triggers, identification and management of and avoidance measures, medication, spacers and emergency action plans. Parents are requested to bring their child's medication and spacer with them so they can demonstrate how to use them.

Active teacher participation in this programme is essential for success. Teachers are requested to approach every parent and enquire if their child has asthma. When children are enrolled at kindergarten at the age of 2 years they may not have asthma, but have developed it since. Caregivers may not have admitted the child has asthma as the forms enquire if child has a "medical condition" which may sound onerous leading to denial. Therefore it is necessary to approach the topic with clarity.

Once the children with asthma have been identified the teacher may encourage the parent to make an appointment with the nurse. All caregivers, whether the child has mild, moderate or severe asthma will benefit from education. Statistically 1-3 children in New Zealand have

asthma, it is therefore likely there will be a number of children with asthma attending the kindergarten.

The aim of education is to:

- Reduce the amount of reliever medication being used
 - Facilitate the child and their family having a good night's sleep
 - Reduce absence from kindergarten for the children and the necessity for parents to take time off work
 - Eliminate emergency visits to doctors, accident and medical centres and hospital
 - Have children participate in normal activities.
- So, teachers and parents, if your kindergarten is invited onto the programme, get right behind it. This a unique offer of specialised healthcare aimed at New Zealand children helping them to live healthy and happy lives, free from asthma symptoms.

For more information phone June on 09 630 2293.

CENTRAL COPD SUPPORT GROUP

At Asthma Auckland
581 Mt Eden Rd
Mt Eden

1.30-3 pm, 4th Wednesday of each month

- September 22nd
- October 27th
- November 24th
- Christmas Lunch December 8th

Join us for, tea/coffee, time to socialize plus interesting speakers.

For more details contact:
Ann Wheat
Asthma Educator
Asthma Auckland
Ph 09 630 2293

NORTH SHORE COPD SUPPORT GROUP

At Sunnynook Community Centre
148 Sycamore Drive
Sunnynook

10-12 pm, 2nd Thursday of each month.

- September 9th Acacia Room
- October 14th Acacia Room
- November 17th (3rd week of month) COPD Fun Walk at Cornwall Park
- December 9th Christmas Lunch venue to be confirmed

Join us for, tea/coffee, time to socialize plus interesting speakers.

For more details contact:
Marlinee Merhoye
Asthma Educator
Asthma Auckland
Ph 09 630 2293

WEST COPD SUPPORT GROUP

At Wai Physiotherapy Clinic, Wai Health,
13 - 15 Ratanui St Henderson
(Opposite "Pak & Save")

1-3 pm, 1st Monday of each month

- September 6th
- October 4th
- November 1st
- December 6th

Join us for tea/coffee, time to socialise, plus interesting speakers & supervised exercise

For more details contact:
June Bell
Asthma Educator
Asthma Auckland
Ph 09 630 2293

ROTORUA BACK IN ACTION

Great news for the Rotorua community is that Marinda Claassen, a Registered Nurse from Nelspruit, South Africa has been appointed as the new Asthma Educator. Prior to emigrating to New Zealand, Marinda worked as a Diabetes Educator and Medical Nurse. She will make a positive contribution to the community and hopes to use her experience as a medical educator to assist people with asthma, and their families.

Marinda and her family enjoy the country life and many tourist attractions in the area. She is married to Nico, a professional civil engineer and has four daughters, Carmen, Shani, Marna and Kim. She was five times National Martial Arts Champion and represented the South African Martial Arts team at 2 World Championships.

Please feel free to contact Marinda for information regarding asthma at the Rotorua Asthma Society (07-347 1012)



Marinda, Rotorua's Asthma Educator

Good News for People in Taupo

Annette Thomas has just been appointed the Community Asthma Educator for the Taupo area. She has lived and worked in Taupo for the past 17 years. Annette's aim is to provide educational resources and support people with asthma in the Taupo region

to help them manage their asthma and to be able to lead a normal life. Her work will include group education sessions, one to one education. Now you can look forward to some exciting and fun asthma promotions.

Annette is very excited about her new role and she is looking forward to developing the service to help the Taupo community. Her many years of experience in the local community and her wide network of contacts will help her to meet the needs of the community.



Annette Thomas - Asthma Educator in Taupo

GREAT NEWS FROM SOUTH CANTERBURY



Catherine Wills

South Canterbury Asthma Society launched a major project early this year to ensure that all schools in the area have at least one Asthma Emergency Kit. That's not all: Catherine Wills, the Asthma Educator for South Canterbury

educates teachers and caregivers to manage asthma, how to give the medication correctly and manage an acute asthma attack until emergency services arrive if needed.

Catherine visited Pleasant Point Primary School recently to provide them with an Asthma Emergency Kit and education sessions for staff members. Part of the education was on how to handle an asthma emergency at school.

Kids at Pleasant Point Primary were challenged to raise funds for a worthy cause. The kids responded by organising a coin trail. They organised the fundraiser to coincide with Catherine's visit to the school. The children raised a total of \$129.05 and donated the money to the South Canterbury Asthma Society. This donation will help the Society to put an Asthma Emergency Kits in 3 Schools.

Kids of Pleasant Point Primary - Thank you. We think you are Awesome!!!!



Team from Pleasant Point Primary who helped in support of the fight against Asthma

2 – MUCH IS TOO MUCH

Almost every New Zealander with asthma will have used a blue reliever inhaler at some point, that's one in every six people. Research shows New Zealanders use around one million reliever puffs a day, a staggering volume that indicates a widespread problem of overuse and poor control. So how much is too much?

Opinions differ but one thing is for sure, you should use it if you need to. It is far more dangerous to try and ride out the problem and not to take the reliever when you feel breathless – just keep a record of how often you need it and tell your doctor.

The problem with using too much is not about the safety or side effects of the medicine, they have been around since the 1970's and have an excellent safety record. The problem is if you use relievers a lot it indicates you have uncontrolled symptoms and likely airway inflammation that relievers don't tackle. Those who don't use adequate preventer medicine are twice as likely to end up in hospital with an asthma-related problem². It may even lead to permanent scarring inside the airways making them less flexible and less responsive to relievers³. So again – how much is too much?

Reducing reliever use – a world beating story

17-year-old Sarah-Jane Jones from Wellington competes in top-level sport and is rated as one of the top five junior artistic roller-skaters worldwide. The sport demands very fast, very high-energy activity for short periods that can be extremely hard for someone with exercise-induced asthma.

Sarah-Jane and her parents had a constant

and very stressful battle with her asthma. She normally trains for about three to four hours a day during the week and around six to seven hours a day at the weekend. She took up to 16 puffs of reliever a day just to get her through the training sessions. The sessions are very physically demanding as they are fast and high energy, probably the most difficult for people with asthma.

She often had to take oral steroids but tried to avoid it if at all possible because it precluded her from competition as a banned substance. This meant she was often left struggling on her blue reliever.

Her doctor advised if her peak flow dropped below 300 it could be very dangerous because of the physical demands and her inability to take on enough air to fuel the high-energy sport. It was a constant battle and they knew we weren't controlling her asthma but traded good control off against competing in the sport she loved.

About two years ago, Sarah-Jane's parents were talking about the high reliever use with their GP, they decided to try something different to reduce her reliever reliance. They were given the opportunity to try a puffer they had to pay for that contained a long acting controller and preventer in one inhaler.



Sarah-Jane says she has never looked back. She has not had to use oral steroids since and has used her reliever less and less.

During the two-year period on the new inhaler Sarah has maintained her position in the top five junior skaters in the world, most recently coming fourth in the world championships in Argentina. She also won five gold medals in the Oceania championships and seven golds at the New Zealand national championships.

Sarah-Jane's next big tournament will be representing New Zealand at the World Championships in California in November (funding support for flights would be helpful!)

Expert opinion

So how much reliever is too much? The World Health Organisation funded Global Initiative for Asthma (GINA) says people have well-controlled asthma if they meet a variety of measures. One measure is the use of reliever medication and GINA says up to two doses (four puffs) a week is acceptable⁴. New Zealand research has shown over half of people with asthma use their reliever more than once a day, seven or more times a week⁵.

Other expert groups like the British Thoracic Society more or less agree with GINA – some say twice a week others say three times a week. The difference is not hugely significant. The real point

2-MUCH IS TOO MUCH

if you use five, six or even as much ten doses a week you need to take action and see your doctor.

Rules of two™

As a general guide "2-much is too much" – in other words using more than two doses (four puffs) of reliever a week may be an indication of a greater problem. We can set some basic 'Rules of two'⁶ for identifying poor asthma control:

1. More than 2 doses (four puffs) of blue reliever a week
2. More than 2 night-time awakenings a month
3. More than 2 blue inhaler canisters a year (200 puffs per inhaler)

Take action

There are many sophisticated tests doctors can do to rate your asthma control but until you tell them otherwise they can only assume your asthma is under control.

The 'Rules of two' are a useful guide to identify if you may be at risk of developing more serious problems. It is a good idea to keep a record or diary, the chances of remembering how many times you woke up at night coughing over a month or how many canisters you used last year are fairly slim.

If you can't comply with the 'Rules of two' report your measurements to your doctor and work with them to take better control of your asthma.



REMEMBER: 2-MUCH IS TOO MUCH!

REFERENCES

- 1) IMS data: Reliever inhaler sales in the 12 months to September 03 were 1.58 million units – Each unit contains 200 puffs giving a total of 327 million puffs a year or 896,000 puffs a day. In July 03 reliever sales totalled 177,881 units – 35 million puffs or 1.15 million a day.
- 2) Blais L et al, Am J Respir Crit Care Med 1998;158:126-132
- 3) Ward C et al, Thorax 2002;57:309-316
- 4) Global Initiative for Asthma. Asthma management and prevention, NIH publication 1995
- 5) Holt, S Beasley R; A Study Assessing Health Outcomes For Patients With Asthma in New Zealand; ATS May 2002.
- 6) Rules of Two™ is a registered trademark of the Baylor Health Care System, USA.

FROGFI ASH

In the last issue of Asthma Update we turned up the heat under a pot of boiling frogs. For those who missed it this was not senseless animal cruelty but an attempt at showing how people with asthma commonly ignore their worsening symptoms until they reach a crisis point. Even those who don't reach crisis point often put up with serious symptoms and don't measure their frequency or report them to their doctors.

We had promised to share the results of a landmark worldwide study which has finally explored whether total control of asthma was possible – no reliever use, no night-time awakenings, no exacerbations, no hospital visits, and optimum peak flow. Unfortunately the full results are not available yet so we



will bring them to you as soon as possible – the frogs must simmer a little longer.

Until then if you consider yourself a frog sitting in hot water (a person with signs of uncontrolled asthma) see your doctor and don't forget to take your 'thermometer' along with you (measure your symptoms and tell your GP). If you think your water is still cold try a thermometer anyway (if you think you have good control, test it anyway) – you might be surprised at the temperature.

HOW green IS RESENE?

Imagine using a vermilion paint coloured by pigments made from a mercury compound to paint your bathroom. Or choosing a green paint containing arsenic to finish the fence painting. Both scenarios are ridiculous to contemplate today, yet were commonplace in the past.

Resene is noted for its role in introducing waterbased paint to the New Zealand market in the 1950s and for its groundbreaking move to remove lead from its decorative paint products in the 1970s. Joining the Environmental Choice Programme in 1996 was another logical step, reaffirming Resene's commitment to the environment. Resene is green!



Resene's Environmental Choice range includes low odour paints. Ideal for areas such as children's bedrooms - when you need to use the room soon after painting - or for allergy sufferers, Resene Low Odour paints will clear the

air for you. Like all paints in the Resene Environmental Choice range, they have dramatically reduced solvent levels and are better for our environment.

See the range of Environmental Choice paints - including Low Odour paints - at your local Resene ColorShop. Visit www.resene.co.nz or call 0800 RESENE for a copy of the Resene Environmental Choice brochure.

Remember - Don't throw out leftover paint. Save it to use later or donate it.

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AUSSIE WORLD CHAMPION NEEDS NEW ZEALAND MUSSEL IN GOLD QUEST

Since publishing the research article 'Treatment of asthma with lipid extract of New Zealand green-lipped mussel:' in the May edition of the Asthma Update, Asthma New Zealand – the Lung Association has found some further interesting information about Lyprinol.

For example:

- Lyprinol is available over the counter in Pharmacies between \$60.00 and \$70.00. Lyprinol is available from Asthma New Zealand for \$45.
- Lyprinol is also used to help ease the pain of arthritis
- Some Australian athletes who have asthma, use Lyprinol to help them manage their disease.

Lyprinol has long been known for its' anti-inflammatory effect in treating arthritis. Made from New Zealand-grown mussels, it is now bringing new hope to people with asthma around Australia, including some top athletes. Here are 2 reports about these athletes, Sam Riley and Jana Pittman.

Sam Riley has struggled with asthma all her life.

Until 2002 Sam Riley found the strenuous training required in competitive swimming helped in controlling her asthma. But when the champion breaststroker retired two years ago, she was once again struggling to breathe. Sam said, "When I stopped swimming my asthma really went downhill and I was having to take several different types of medication twice a day – a bit of a cocktail".

"I started on Lyprinol in November last year and since then I've been able to cut my medications back to: Lyprinol, Ventolin and one preventative." Riley says she has more than halved the amount of medication she takes.

Having been on a lot of steroid medication for most of her life, the most important benefit for Sam was reducing the amount of steroids she had to take. "I think it's great because now I do not use so many steroids and it's nice to be able to supplement your medication with something that's natural."

Riley said the company marketing Lyprinol approached her to try it. She says she was initially sceptical but the thought that Lyprinol has no known side effects was enough to convince her.

"I thought there was no harm in trying it and as I said, it really worked," she said.

Jana Pittman has experienced chronic asthma for years.

Jana Pittman, the current Commonwealth and World 400 Metres Hurdles Champion and favourite for Olympic Gold this year in Greece has experienced chronic asthma for years. In fact she nearly had to give up athletics altogether due to frequent, and severe acute asthma episodes.

Due to asthma problems she almost did not qualify for the Manchester Commonwealth Games. Fortunately for her and Australia, about two years ago she discovered Lyprinol and started taking it. Within a few weeks, Jana noticed a dramatic improvement in her breathing

and recovery rate during and after exercise. Her inhaler usage dropped significantly and she was able to train without the impediment she previously had from the symptoms of asthma.

Before the Commonwealth Games in 2002 she told a reporter " I was always in and out of hospital during winter periods. You can have a really great day and train well and then it can completely turn around the next day. In fact sometimes you find it hard to breathe never mind exercise or train."

The current World Champion now says, "Before taking Lyprinol I was often concerned when competing that my breathing would let me down. I can now go into competitions knowing that I can breathe, easier."

New Zealand will watch Jana's Olympic progress with pride and interest.



RESEARCHERS CONFIRM FEATHER PILLOWS MORE SUITABLE FOR ASTHMATICS

If you're an allergy sufferer, you might want to think about throwing away your synthetic pillows.

23 June 2004

Research carried out at the University of Otago's Wellington School of Medicine and Health Sciences has confirmed previous suspicions that synthetic pillows contain more house dust mite allergen, known to affect asthma sufferers, because of the larger pores of the pillow covers.

The evidence is presented in a paper co-written by Rob Siebers a Senior Research Fellow from the University's Wellington Asthma Research Group, and published recently in an international leading allergy journal, Clinical and Experimental Allergy.

During the research, 20 live adult house dust mites were placed on each of the coverings of a feather, polyester and a newer polyester/cotton pillow. After 24 hours all of the house dust mites had penetrated the polyester pillow covering, but even after 48 hours none had penetrated the feather or the newer polyester/cotton pillows.

The differences in the permeability "are because of the smaller pore size of the feather and newer polyester/cotton pillow coverings compared to the synthetic pillow covering," says Siebers.

Electron microscopic measurements showed the pores of synthetic pillows to be an average size of 57mm, compared to the feather pillow pores which are 18mm. The average width of larval house dust mites is 20mm.

"Until now, asthmatics sensitised to house dust mites were advised to cover all their bedding with occlusive covers. However, these are expensive, so the next best advice would be to replace all synthetic bedding with feather bedding or with a new type of synthetic pillow."

The new synthetic polyester/cotton type pillow is manufactured by Auckland company NZ Merchants Ltd and has a pore size similar

to those of feather-filled pillows, which is why it remained free of dust mites.

The debate between synthetic and feather pillows for asthmatics has been ongoing for many years. The Wellington Asthma Research Group has already proven that synthetic pillows contain larger quantities of house dust mite allergens than feather pillows, but it was not understood why. Synthetic pillows have also repeatedly been linked to increased allergy symptoms shown by asthmatics.

"We believe these results provide a convincing explanation for our previous findings

of much higher house dust mite allergen levels in synthetic bedding material," Siebers concludes.

The research was funded by the Asthma Research Group.

For further information, please contact Rob Siebers Senior Research Fellow Wellington Asthma Research Group Wellington School of Medicine and Health Sciences Tel 64 4 385 5999 ext 6838 Cell 021 257 6462 Email rob@wnmeds.ac.nz



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Spring Season Looms

COMPILED BY MARLI MERHOYE

Are you rejoicing at the thought of spring arriving, knowing that summer will be here soon? If you don't share in the joys of spring and can't get past the worsening of your seasonal allergic rhinitis or hayfever symptoms, you are not alone.

What is Allergic Rhinitis

Allergic rhinitis is an inflammation of the mucous lining of the nose caused by airborne particles, called allergens, which trigger symptoms.

Prevalence

The prevalence of allergic rhinitis is similar to that of other allergic conditions, such as allergic conjunctivitis, asthma and eczema, in that it is highest in countries such as Canada, New Zealand, Australia, United States and the United Kingdom. It has increased steadily over the past 40-50 years, and around 15% of adults and 20% of children experience seasonal rhinitis, conjunctivitis or asthma symptoms.

Symptoms

A person may have any or all of the following symptoms:

- Watery discharge from the nose all the time, occasionally or during certain seasons of the year.
- Stuffy nose all the time or during specific seasons.
- Reddened lining in the lower eyelids.
- Frequent throat clearing.
- Breathing through the mouth.
- Snoring.

- Rabbit like twitching movements of the nose.
- A horizontal crease across the top of the nose as a result of constant rubbing.
- Bouts of sneezing, especially in the morning.
- Repeated nosebleeds.
- Headaches because of pressure from inside the nose.
- Frequent earaches, fullness in the ear, ear infections or hearing loss.
- Dizziness or nausea related to ear problems.
- Chronic cold without much fever.
- Nasal voice because of blocked nasal passages.
- Dark circles under the eyes ("allergic shiners") as a result of pressure on the small blood vessels from blocked nasal passages.

Pollens

Pollens are produced by plants for fertilisation. Some pollens travel through the air in order to fertilise other plants, and insects carry other pollens from plant to plant. It is the airborne pollens that mostly affect and cause allergy. The grass pollens, e.g. rye, couch, veldt, barley and oats, are the most potent triggers for asthma and hayfever, but certain weeds, e.g. plantain, certain bushes, e.g. privet and certain trees, e.g. silver birch, can present a problem.

Ways in which people with hayfever can reduce their exposure to pollen.

- Close windows in cars and use the car's air-conditioning or use re-circulated air.
- Close windows on windy days, or when humidity is high, and at night.
- Arrange outdoor activities for early afternoon when pollen levels are lowest. Pollen is usually emitted between 5.00am and 10.00am. Grass pollen is released when the weather is dry and sunny and has usually risen high into the atmosphere by noon, descending again when the air cools, towards the evening.
- Use wrap-around sunglasses when outdoors.
- Have a shower after spending time outside as pollen can collect on skin and hair.
- Avoid hanging sheets and clothes outside to dry, as they will collect pollen.
- Choose pretty, brightly coloured flowering plants, as these tend to attract bees and other insects to transfer the pollen rather than becoming airborne. A selection of recommended plants for the garden can be obtained from "Low Allergen" garden books.
- Holidays near the beach, at the height of the pollen season may be less symptomatic.
- Avoid freshly mown grass. Arrange to have lawns mown often to avoid flowering.
- Pollen calendars are available from Allergy New Zealand or Asthma New Zealand to help identify the pollen seasons of different trees, weeds and grasses.

Treatment

The symptoms of allergic rhinitis/hayfever should be managed depending on the severity of each individual symptom and if symptoms are confined to the eyes or nose. Treatment needs to be started at least 3 weeks before the pollen season.

If symptoms are only mild and intermittent then allergen avoidance measures can be helpful along with the newer non-sedating antihistamines.

Topical application of an antihistamine or sodium cromoglycate to the eyes (eye drops) or nose (nasal spray) may also be used to control symptoms.

Sodium cromoglycate is a non-steroidal alternative to other anti-inflammatory corticosteroids and is useful in the treatment of young children.

If it is not possible to avoid the allergen or symptoms are not controlled then further medications are needed.

To relieve nasal blockage, topical nasal steroids will be used, as antihistamines tend not to be very effective. Correct use of nasal sprays should be explained carefully by a health professional to obtain maximum benefit. If nasal sprays are sniffed hard into the nose the result will be that most of the drug is swallowed rather than remaining in the nose.

For runny nose, itching and sneezing symptoms, it is found that a combination of a

daily topical nasal steroid and a non-sedating antihistamine works best. Alternatively, a topical anticholinergic drug may be useful in controlling a runny nose.

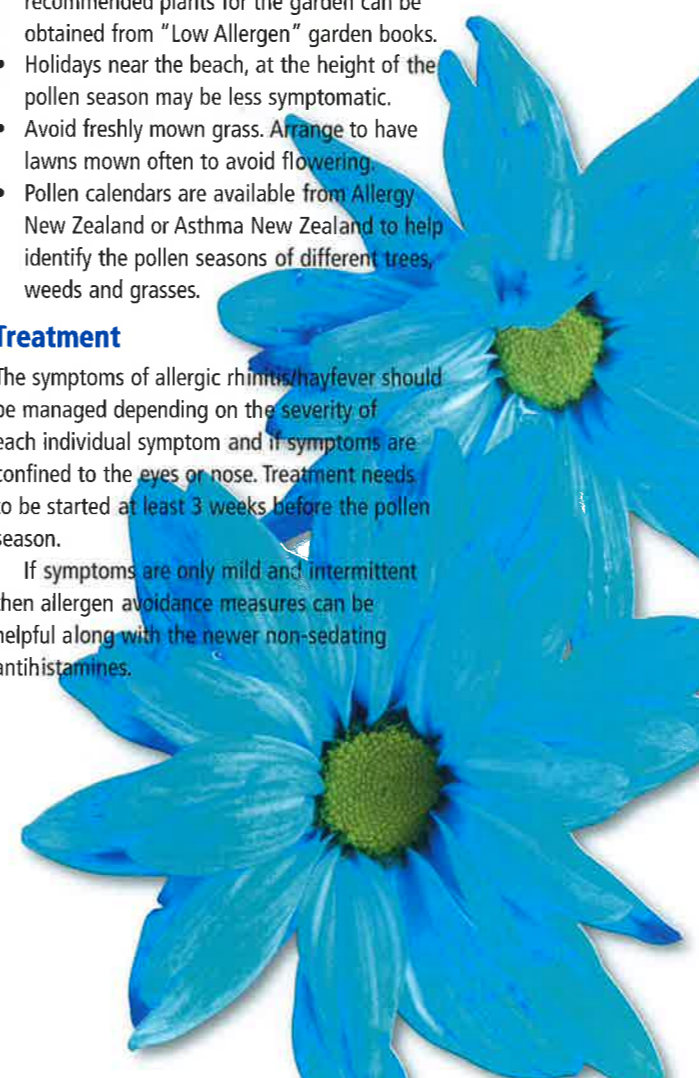
If topical decongestants are used, remember that these can only be used for up to 5 days at any one time because of rebound congestion.

If symptoms are severe and are unresponsive to treatment then referral to an allergist or ENT/eye specialist should be considered.

Armed with some knowledge of how to manage your allergies, you can hopefully embrace the joys of spring, instead of dreading the event of every unfolding flower.

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- Walker, S. Management of hayfever: a practical guide. The Asthma Journal, 2001; Vol 6: 2; 106-108.
 Malone, T. More than sneezes and wheezles Allergytoday. 2003; 106: 13-15.



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That's it! It's all about breathing easy. Something as natural as breathing to most of us may not be as easy for others. Imagine how it must feel when it is difficult to breathe. Some people with asthma tell us it is like trying to breathe through a straw.

Breathe Easy is about the fight against asthma and getting on top of it. It's about being able to do everything the person with asthma wants to do and not having asthma place limits on their lives.

Asthma affects not only the individual, but the whole family and may impact on family life. Breathing difficulties affect many aspects of daily life, such as playing your favourite instrument, sleeping all night, laughing, taking a simple test or participating in an important meeting.

The Breathe Easy logo was designed to illustrate the lifestyle achieved when asthma is beaten. Vibrant yellow was used to bring out the sunshine in people. The illustration indicates an active lifestyle combined with happiness and being free.

The figure does not indicate a particular gender or culture, because asthma affects everyone in all walks of life.

The Good News is – people with asthma can have a better quality of life with the right

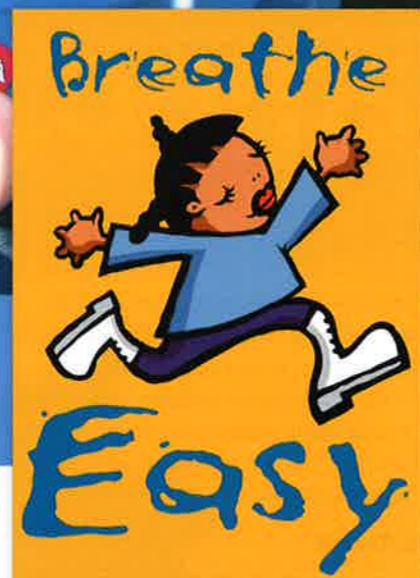


ILLUSTRATION BY ALI TEO
LOGO DEVELOPED BY JWT

medication and education about asthma and knowing how to manage it. Asthma doesn't have to restrict anyone's lifestyle, so why not give us a call and find out how you can get active again.

Lets win the fight against Asthma! Together.

A big "Thank You" to Andrew, Rod, Mal and the Team at J Walter Thompson International NZ Ltd. You are Awesome! JWT has supported us in many ways in our fight against asthma and getting the message across to the community.

The illustration was the creation of Ali Teo, a freelance Illustrator. She has done some exciting work and it's all there on her website www.aliteo.co.nz. Ali is very interested in environmental and humane issues. Hence her support towards asthma. Thank you Ali.

Inhaled steroids for asthma in pregnancy are safe: new study

ORIGINALLY POSTED WEEK BEGINNING 8 MARCH 2004
www.everybody.co.nz-Asthma Centre



Pregnant women prescribed inhaled steroids to control their asthma don't have to worry that the medications will limit their baby's growth in the womb, a new study says.

While pregnant women with asthma often are anxious about continuing to use their medication, the new research in the March issue of the *Journal of Allergy and Clinical Immunology* found the inhaled steroids did not lead to smaller-than-average babies in the nearly 400 women studied.

"None of our data points to adverse effects on intrauterine growth," says study author Dr Michael Schatz, chief of the allergy department at Kaiser Permanente in San Diego.

The topic is important because up to 8% of pregnant women now have asthma, Schatz says. Going off the medications during pregnancy could result in abnormally low levels of oxygen in the mother-to-be, and that lack of oxygen could actually hurt the fetus, he adds.

Schatz's group evaluated 396 pregnant women from 99 different allergists' practices in 35 states, noting the type of medication each was taking, the dose and then their babies' birth weights.

They found the incidence of infants with low birth weight, early births and birth defects was not greater than what is statistically expected in the general population, regardless of the dose used.

In the study, 7.1% of the babies were born at a low birth weight, below the 10% expected in the general population.

Schatz's team defined low birth weight as those babies who were in the lowest 10% of weight for their age, compared to other infants the same gestational age.

Babies who are low birth weight are at increased risk for other health problems, Schatz says, including early death while still a newborn.

Previous studies evaluating asthma medications' effects on birth weight have

produced mixed findings. And some studies have found pregnant women with asthma have an increased risk of giving birth early and of having infants with a low birth weight, compared to women without asthma.

Schatz's study looked at five inhaled steroids - beclomethasone, budesonide, flunisolide, fluticasone and triamcinolone. Other experts endorse the new study.

"This study should, in fact, ease the worry of pregnant women," says Dr Sheldon Spector, a clinical professor of medicine at UCLA's David Geffen School of Medicine. He was one of the 99 physicians who referred patients for the study.

The timing of the study is excellent, Spector adds, because inhaled steroids such as those evaluated in the study are now the "mainstay" therapy for persistent asthma.

It's also reassuring, Spector says, that a variety of inhaled steroids were evaluated, and no association was found between any of them and low birth weight babies.

Dr Frank Virant, a clinical professor of paediatrics at the University of Washington, says, "I'd view this as a relatively positive study."

He advises pregnant women to choose budesonide and fluticasone because they are metabolised more rapidly than some of the other medications, so overall exposure is lower.

Schatz advises pregnant women with asthma to work with their allergy and asthma specialists and follow their advice about whether they need to take inhaled steroid medications.

This is a summary article from Health Scout. Knowledgeable New Zealand health consumers may also find this article useful. This information is intended solely for New Zealand residents and is of a general nature only and no person should act in reliance on any statement contained in the information provided and at all times should obtain specific advice from a health professional. All rights reserved. © MediMedia (NZ) Ltd. This publication is copyright.



INHALED CORTICOSTEROIDS "PREVENTERS"

The symptoms you may experience with asthma, such as breathlessness, chest tightness, wheezing and coughing, occur because the small airways in your lungs are over sensitive to a variety of triggers, and react by becoming red and swollen producing extra mucus. This narrows the space through which air travels making it harder for air to move in and out of your airways

Corticosteroids, commonly in brown and orange inhalers, are preventers. They are the most effective agents for treating the swelling and inflammation in airways.

Inhaled corticosteroid medications have a key role in reducing symptoms, improving lung function, slowing the rate of decline of lung function, and reducing hospital admissions and mortality rate.

The aim of the treatment is to

- Abolish symptoms
- Prevent acute asthma episodes
- Reduce the amount of reliever medication required
- Prevent long term damage to the airways due to inflammation
- Restore normal or as near normal airway function as is achievable

- Encourage normal growth and development
 - Reduce the amount of time lost at school or work
 - Reduce emergency visits for treatment and hospital admissions
- Indications for initiating or increase of inhaled corticosteroids:
- Using your reliever more than 3 times weekly for symptoms
 - Frequent acute episodes including the need to use oral steroids
 - Ongoing symptomatic disability (school absence, work absence)
 - Signs of chronicity (eg chest deformity in children)

Benefits of using Inhaled Corticosteroids

- Decreased symptoms
- Reduction in use of reliever medication

INHALED CORTICOSTEROIDS "PREVENTERS"

- Improved lung function
- Decreased exacerbations
- Reduced hospital admissions
- Reduced mortality

The benefits of using inhaled preventers effectively over oral preparations are less side effects. With inhaled preparations the side effects are mainly local, for example the most common are:

- Oral thrush
- Hoarseness
- Throat irritation
- Cough

These side effects can be minimised by using a spacer to reduce the amount of preventer medication deposited in your mouth and throat, or by mouth washing to discard the remnants of medication and prevent swallowing it. (Rinse, gargle, spit)

Systemic side effects are found mainly in association with the use of oral preparations or the long-term use of high amounts of inhaled steroids. Together with your doctor you can decide on the dosage of steroid to be used. Some patients are commonly commenced on a slightly higher dose to rapidly improve their asthma. It is therefore important to return to your doctor for a review pertaining to possible reduction to a smaller dose. The aim of your healthcare worker is to have patients on the least amount of inhaled steroid, which will keep them well and symptom free.

Many people express concern about the side effects of oral and inhaled steroids. The medical profession is aware of the side effects of oral steroids such as, growth suppression, moon face, brittle hair, thinning of the skin and bones and weight gain. Therefore, oral steroids are only prescribed sparingly or in the event of an emergency. The majority of patients use inhaled corticosteroids, although prolonged use of high doses may have the same side effects as oral steroids. These should not occur when safely administered within the recommended dose. Lifestyle choices which may help reduce your steroid use are no smoking, avoiding smoky atmospheres, regular exercise, avoidance of triggers and a healthy diet.

Preventers take 3 – 21 days to take effect, so do keep taking them even if you feel no improvement immediately. For them to be effective in decreasing inflammation in the airways, they need to be taken twice every day as prescribed by your doctor. Long-term treatment with inhaled corticosteroids is necessary for total asthma control. This may be

a period of time ranging from several weeks to years. Some people only need a preventer in the pollen season, or in the winter when they get colds. Like any other medicine, the higher the dose of medication the higher the chance you will have of some side effects. Many studies have shown using inhaled corticosteroids prevents many asthma symptoms and that the risk of side effects is small compared to the benefits of using them to control your asthma.

INHALED CORTICOSTEROIDS ARE NOT EFFECTIVE WHEN TAKEN . INTERMITTENTLY SUCH AS WHEN ASTHMA SYMPTOMS ARE PRESENT

They need to be taken every day!

Recent health research indicates that the use of inhaled steroids for asthma in pregnancy is safe. While pregnant women with asthma often are anxious about continuing to use their medication, the research in the March issue of the Journal of Allergy and Clinical Immunology, found inhaled steroids did not lead to smaller-than-average babies. They also found the incidence of infants with low birth weight, early births and birth defects was not greater than what is statistically expected in the general population, regardless of the dose used. Budesonide (Pulmicort) and Fluticasone (Flixotide) are advised because they are metabolised more rapidly than Beclamethazone, so overall exposure is lower.

Remember inhaled corticosteroids are of no benefit during an asthma attack. Always carry your blue reliever with you.

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- The Diagnosis and Treatment of Adult Asthma (New Zealand Guidelines Group) September 2002
- Asthma Clinical Guideline for Children and Young People (Procure, Starship, Kidz First and The University of Auckland) September 2002
- The Journal of Allergy-Clinical Immunology (Use of inhaled steroids by pregnant asthma women does not reduce intrauterine growth) March 2004 – Volume 113 – Number 3



Congratulations!

Asthma New Zealand/The Lung Association & Unitec School Of Health & Community Studies congratulates the following registered nurses who successfully completed the certificate in Asthma Nursing Course in 2004 July.

1. Fiona Michelle Evans - New Plymouth
2. Pauline Flynn - New Plymouth
3. Robyn Hewitt - Auckland
4. Mary Jones - Auckland
5. Cheryl-Alice Löser - Auckland
6. Jacinta McGovern - Wellington
7. Jacqueline Mitchell - Auckland
8. Louise O'Leary - Te Aroha
9. Samdra O'Shea - Napier
10. Margaret Simcox - Wellington
11. Judith Townsend- Whangaporoa
12. Janine Winchester - Auckland

The programmes are offered by distance learning. The primary aim of Asthma/COPD Nursing Courses is to provide nursing health professionals with a high level of Asthma/ COPD knowledge that promotes best practice, based on available evidence, and is consistent with national policy. Asthma Nursing Course is accredited with 24 credits, COPD Nursing Course is accredited with 12 credits, which can be used towards gaining your Bachelor of Nursing degree. The value of a level 7, 24-credit course, which is done through a tertiary education establishment, is \$699.00. At present Asthma New Zealand/The Lung Association is providing grants of \$500.00 for each student towards the cost of the course, as a result students will be asked to contribute \$200.00. Cost of the COPD Nursing course is \$350.00 but a grant of \$200.00 is available to practice nurses/community nurses from Asthma New Zealand/The Lung Association.

The society has decided to make the course available at such a low cost to benefit nurses with a special interest in asthma, and increase the knowledge of nurses throughout New Zealand.

For information regarding Asthma & COPD Nursing Courses please email swarnah@asthma-nz.org.nz

Phone 09 623 0236 ex 809 - Janette or Swarna



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

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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.

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This treatment, Symbicort, comes in a red inhaler. It's a completely new kind of treatment which combines two medicines that work in different ways. The first, a preventer, works like a brown or orange inhaler by reducing and preventing swelling in your airways. The second, a symptom controller, widens the airways, making it easier for you to breathe.

Symbicort provides fast relief from asthma symptoms (within 1-3 minutes after inhaling the medicine) as well as long-lasting control¹. That means fewer symptoms during the day and night, allowing you to do more activities without getting breathless.

Over half of New Zealanders with asthma are putting up with avoidable symptoms¹. **Are You?**

Take the simple test below to find out.



IS YOUR ASTHMA AS WELL CONTROLLED AS IT COULD BE?

- Do you avoid some activities because you might get asthma symptoms?
- Do you use your blue inhaler (reliever) three times a week or more?
- Do you wake at night coughing, wheezing and feeling breathless or tight in the chest?
- Do you take days off work or school due to asthma symptoms?

If you answered "yes" to one or more of the questions, your asthma may not be as well controlled as it could be. Take this checklist when you see your doctor. Your doctor will decide if you are eligible[#] for Symbicort.

0800 KICK ASTHMA

0800 542 527

www.kickasthma.co.nz

For a free Symbicort information pack, complete this coupon and send it (no stamp required) to Freepost 4251, SYMBICORT, PO Box 37 012, Parnell, Auckland.

Mr Mrs Ms Other (tick one)

First name: _____

Surname: _____

Address: _____

Email (optional): _____

QUESTIONS:

1. Do you have a: Brown inhaler Orange inhaler
2. Do you use a: Puffer Turbuhaler
3. How often do you use your blue inhaler?
 - less than once per day
 - more than once per day

Note: Your personal details will remain strictly confidential

Note: Symbicort is fully funded under certain criteria. Your doctor's fee and prescription fee will still apply.

SYMBICORT IS NOT MEANT TO REPLACE YOUR BLUE INHALER - A RELIEVER, WHICH IS A 'RESCUE' TREATMENT THAT YOU SHOULD ONLY NEED VERY RARELY.

All medicines have benefits and some may have risks. Use strictly as directed. If symptoms continue or you have side effects please contact your doctor. ABRIDGED CONSUMER MEDICINE INFORMATION: Symbicort® Turbuhaler® is a combination product containing equivalent to budesonide 100 µg or 200 µg and eformoterol fumarate dehydrate 6 µg per dose. Use: For the regular treatment of asthma (preventer and symptom controller). Do not use: Allergy to budesonide, eformoterol or inhaled lactose. Precautions: Thyroid problems, heart problems, diabetes, problems with potassium levels. Pregnancy, breast-feeding. Side effects: The most common side effects are: 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-Prescription Medicine. Consult your doctor to see if Symbicort is right for you. For full consumer information please refer to the manufacturer's Consumer Medicine Information Sheet available on www.medsafe.govt.nz. References: 1. AC Nielsen Asthma Survey 2001 2. Zetterstrom O, et al. Eur Respir J 2001;18(2):262-268. 3. Bateman ED, et al. ATS 2001; Abstract 1. 4. Symbicort Turbuhaler Data Sheet. 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 8535 McCann AZL8829 10-03.





If you are:

- ▲ *Over 50 years of age*
- ▲ *Using an inhaler everyday*
- ▲ *Coughing up mucus or spit most days*
- ▲ *Getting breathless more easily*

There is a product available called SPIRIVA®

- ▲ SPIRIVA® is a ONCE-A-DAY inhaled medicine for people with COPD (chronic obstructive pulmonary disease) which includes breathing conditions such as **chronic bronchitis** or **emphysema**.
- ▲ SPIRIVA® is an unfunded prescription medicine and a pharmacy charge will apply along with usual doctors visit fees.
- ▲ Free trial packs are being offered to your doctor so that they can assess whether SPIRIVA® is the right medication for you.
- ▲ For further information on COPD (including chronic bronchitis and emphysema) or SPIRIVA®, visit www.spiriva.co.nz or ask your doctor.

SPIRIVA® (tiotropium 18mcg) is a PRESCRIPTION MEDICINE. A charge applies. It is used for making breathing easier in chronic obstructive pulmonary disease (COPD) including chronic bronchitis and emphysema. SPIRIVA® should not be used for acute episodes or rescue treatment of bronchospasm. Cautions are high pressure in the eye (glaucoma), kidney problems, problems with your prostate gland or passing urine. Do not allow the powder into your eyes. SPIRIVA® like all medicines can cause unwanted side effects in some people. These may include dry mouth, dry throat, cough, fast heart beat, blurred vision and high pressure in the eye (glaucoma). If symptoms persist or you have side effects talk to your doctor. Use strictly as directed. DO NOT SWALLOW THE CAPSULES but administer with the HandiHaler® device. Boehringer Ingelheim NZ Ltd, Auckland. EP/03/20. TAPS PP798

Once Daily
 **SPIRIVA®**
 (tiotropium)