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CHRISTMAS MESSAGE: ASTHMA AND PHARMAC

SPECIAL FEATURE: ANTIBIOTICS, PROBIOTICS, INFECTION AND DIRT EXPOSURE IN EARLY CHILDHOOD AND ASTHMA

FREQUENTLY ASKED QUESTIONS AND ANSWERS

FIRST AID FOR ASTHMA

COPD RESEARCH

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Christmas Message

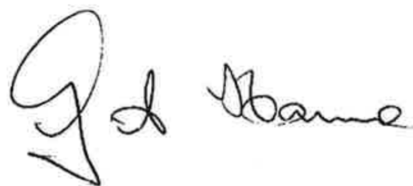
This year saw asthma become a major TV and newspaper issue due to Pharmac's decision to award sole supply of reliever medication (Salbutamol) to Airflow Limited, a wholly owned subsidiary of the Asthma & Respiratory Foundation of New Zealand (Inc). Ventolin, the well known, and used, reliever was set to disappear from New Zealand from May 2005. Asthma New Zealand strenuously opposed Pharmac and thousands of people with asthma supported us. The outcry was such that Pharmac revised its decision and people with asthma still have choice in reliever medication.

Here are a few points to ponder:-

- Airflow, as a wholly owned subsidiary of the Asthma & Respiratory Foundation of New Zealand (Inc), provided $561,860 to the ARFNZ this year (refer Annual Report ARFNZ 2005). This came from sales of Salamol (the ARFNZ brand of Salbutamol) etc. Had Salamol remained a "sole" supply item, then the ARFNZ was responsible for removing "choice" from people with asthma, and their families. Is it appropriate for the ARFNZ to be a pharmaceutical supplier, particularly in the area of asthma medications? Is the ARFNZ in a "conflict of interest" situation? Those who support the ARFNZ must ask themselves the same question.
- Salamol contains alcohol. Babies and children should not unnecessarily be exposed to alcohol.
- Reports are arising regarding numbers of people being taken by police for blood alcohol testing due to using Salamol prior to being breath tested. "If you use Salamol, and then within minutes blow into a standard Roadside Breath Testing Alcohol Device, you will fail that part of the test". This is incontestable and absolute fact. (Dr Shane Reti, Whangarei).
- Although, this battle has been won, be vigilant. The issue will rise again in 2007 and Pharmac does not like being beaten! Put pressure on your local Member of Parliament to advocate for "choice" in asthma medications.
- Comment has recently reinforced that there has been a "spike" in hospital admissions. Asthma New Zealand is trying to determine the time-lines involved in this increase. It is unfortunate that many in the lower socio-economic groupings cannot then afford the "part-charge" on Ventolin, therefore are forced to use Salamol. Taste is proving a problem for children in this situation.
- Pluses have occurred with the funding of Spiriva and Serevent. These will benefit people with asthma, and their families.

It has been a difficult, but rewarding year, working in the asthma field.

I wish you all best wishes for Christmas and the New Year.



Gerry Hanna
Executive Director

ASTHMA NEW ZEALAND
– THE LUNG ASSOCIATION
– HELPING PEOPLE WITH ASTHMA LEAD A BETTER QUALITY OF LIFE

Antibiotics, probiotics, infection and dirt exposure in early childhood and asthma

DR. ALLEN LIANG, CONSULTANT PAEDIATRICIAN

Over the last 30 years, detailed records regarding asthma have been kept in most developed and some developing countries. A disturbing trend is discovery of the prevalence of asthma almost doubling every ten years. Researchers are investigating the causes of such increases and subsequent methods of treatment in an attempt to stem the phenomenon.

As early as 1989, it was reported that allergy diseases were less common in large families. The fall of the Berlin Wall allowed the first significant study between the children of the poorer and more pollution-exposed Eastern Germans and their counter-parts in West Germany. At the time, many were surprised by the results of this investigation – East German children had fewer allergy problems! Furthermore, it was noted that the more older siblings the child had (especially brothers – presumably dirtier than sisters), the less likely the child was to develop asthma.

Another study done by Roland Leung and Allen Liang, of children from Canton, Hong Kong, Melbourne and Auckland produced interesting results for children of almost identical genetic background. The prevalence of asthma varied depending on the geographical location of birth, at 6%, 13%, 25% and 17% respectively! At first, we thought that this could be due to the difference of house dust mite and cat exposure

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ANTIBIOTICS, PROBIOTICS, INFECTION & DIRT EXPOSURE IN EARLY CHILDHOOLD & ASTHMA

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over the two geographical divides. Further studies of the house dust mite content, indoor and outdoor pollution indexes between Canton and Hong Kong actually showed very little difference. Looking from a different perspective, we saw that the difference could lie in the socio-economic status of these children, and perhaps the availability and accessibility of medical services in these countries.

Subsequent studies, especially those done in Eastern Europe, indicated that children brought up in farming environments, and those with increased exposure to endotoxins from birth had a lower risk of allergic diseases, especially asthma. Endotoxins are the components of the cell wall in animal faecal bacteria. It is now established that exposure to endotoxins in the first year of life (especially in the first six months), helps the immune response to develop and reduces the likelihood of allergic reaction.

Indeed, both viral and bacterial infections in the first two years of life appear to have similar beneficial effects on the establishment of natural immunity. The benefits of such "beneficial infections" start even before the birth of the child. There is beneficial bacterial flora in the gut of mothers and infants that promotes the rapid development of normal immunity in the infant. Destruction of such beneficial gut flora is related to abnormally skewed allergy responses. Pioneering studies were done on Swedish and Estonian mothers and infants. Increased antibiotic use in Sweden was implicated in the reduction of beneficial gut flora and an increase in the prevalence of allergy diseases in these two genetically similar peoples. Subsequent animal studies done in Perth, Australia have established that antibiotics deplete gastrointestinal bacteria which, at the critical time of immune maturation, is needed to suppress the allergy (TH2) response and promote the protective immune (TH1) response. Medical and other data available from Italian military recruits initially showed that the prevalence of allergy appeared to be directly related to the education level (and, by implication, the socio-economic status) of the recruit. Further studies indicated that evidence of childhood exposures to infections – parasitic, bacterial or viral – were likely sources of protection in the socially under-privileged.

The value of infections during the development of the child in preventing allergy diseases underpins the "Hygiene Hypothesis". Researchers are beginning to look for evidence that antibiotics prescribed for children may play a role in the current world-wide increase of allergic disease prevalence.

A recent New Zealand study has suggested that administering antibiotics during the first year of life increases the risk of asthma four-fold in allergy-prone children, while antibiotic use only after the first year of life increases the risk by only 1.6 times. A more recent study of children done in Detroit further confirms that antibiotic use in the first six months of the infant's life significantly increases the rate of asthma. This was reported in the 2003 European Respiratory Society meeting in Vienna. These studies indicate that antibiotic use should be minimised during the first year of life and only be used if a life threatening bacterial infection is present. The antibiotic not only stops the infant from having "contact" with the bacteria (the first process of immunity development), but also destroys many beneficial flora in the gastro intestinal tract. These are of primary importance in normal immunity development and maturation. In some communities, it is common for patients to take pro-biotics (a live culture of beneficial bacterial of the gut) after an illness or antibiotic use, to re-establish the good gut flora.

Many people believe that genetic makeup dictates everything. It is apparent that environment also plays an important role in establishing how and what a person is going to be.

Studies related to the currently hot topic of the Hygiene Hypothesis have brought some understanding to the concept of time in the

genetic-environmental interaction. Research in medical matters therefore has become more complicated, but at the same time, much more illuminating and exciting.

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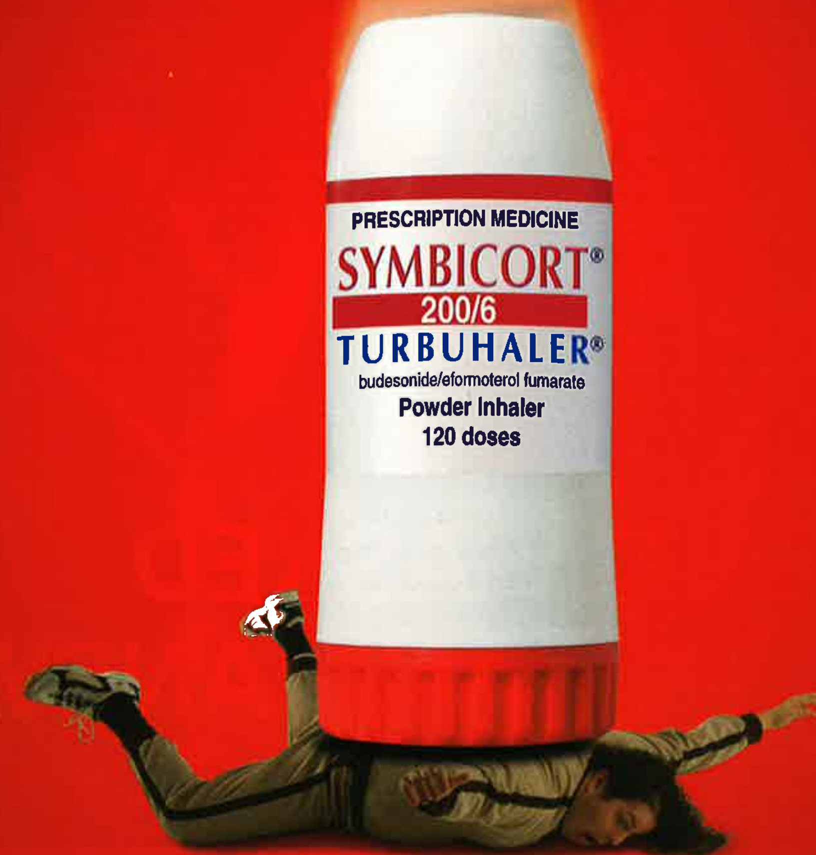

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FREQUENTLY ASKED QUESTIONS AND ANSWERS

COMPILED BY CHRISTINA VERCOE

Over the past ten years there has been an increase in the prevalence of asthma, especially children. *(ISSAC Steering Committee, 1998)*

In New Zealand alone the prevalence has increased. In 1996 there were 450,000 people with asthma and in 2001 the figure had increased to 700,000.

This can be shown as 1:3 children (32%) and 1:7 adults (14%).

Why is this happening? Many western countries are actively carrying out research into the causes and management of asthma to try to find the answer.

What ever the reason for the increased prevalence, it is important that people with asthma understand what is happening to their airways.

While there have been only one or two new medicines introduced in the past ten years, the general understanding of what happens in asthma and the effective use of existing medicines has become better understood.

As there are still many unknowns surrounding asthma as a chronic condition it important that for effective control and management people have to feel comfortable and confident about using their medication.

The aim of this article is to answer a few of the frequently asked questions we are asked in our role as Asthma Educators.

Frequently Asked Questions (FAQ):

1. What is asthma?

Asthma is a chronic condition that affects the lungs.

"Asthma is a condition of the airways causing bronchoconstriction often complicated by swelling and the production of mucus, which is reversible either spontaneously or with the intervention of medication." *(Asthma New Zealand and Lung Association 2000.)*

We all need oxygen to survive and the lungs are the part of the system that delivers oxygen to our body. Lungs are like giant natural sponges with connecting tubes throughout. The tubes known as airways are different sizes, starting off quite large and becoming smaller (the size of uncooked spaghetti).

The airways of a person who has asthma react to asthma "triggers". A trigger is the substance or situation that causes the airways to become irritated

The muscle around the walls of the airways become tight and the airway narrow. The airways then become inflamed, and start to swell. There is often sticky mucus or phlegm produced. This makes moving air in and out of the lungs very difficult.

As the airways become narrower and more irritated the symptoms of asthma appear.

The signs and symptoms of asthma are

- coughing that is dry and persistent especially at night
- wheezing or a whistling noise in the chest when breathing out
- shortness of breath (breathing is fast and shallow)
- a tight feeling in the chest. The chest is unable to expand freely

These symptoms vary from one person to another and also vary from time to time within the same person.

Some people may have all the symptoms, while some may only have a cough or wheeze.

Symptoms also vary in intensity.

It is important that you get to know your own symptoms and keeping a symptom diary may help you and your GP to understand your asthma symptoms and establish the correct action plan.

2. What causes asthma?

The cause of asthma is still largely unknown though scientists are beginning to understand what contributes to the development of asthma.

Research shows that it is more common in English speaking countries such as the UK, Australia and New Zealand. (Holt and Pearce, 2000.)

It is known that the allergic response which occurs is influenced by a combination of genetic predisposition and exposure to one or more allergens or triggers.

Asthma can begin at any age.

Asthma tends to run in families, which means that you are more likely to develop asthma if someone in your family already has it.

Children with eczema or food allergy are more likely than other children to develop asthma.

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It is unknown as to why in some individuals the allergic reaction is suppressed, and activated in others.

Some experts suggest that children are being exposed to more and more allergens such as dust, air pollution, and second-hand smoke. These allergens can trigger asthma episodes.

Other experts suspect that children are not exposed to enough childhood illnesses to build up their immune system. It appears that a disorder of the immune system where the body fails to make enough protective antibodies may play a role in causing asthma. *(Klienert, S. 2000)*

Still other experts suggest that decreasing rates of breastfeeding have prevented important substances important for development of the maternal immune system from being passed on to babies.

It does seem, however, that a reaction to an environmental allergen is the biggest risk factor for developing asthma, rather than just developing an allergy alone.

It is important to understand that triggers do not cause asthma. Triggers are the factors that precipitate the symptoms of asthma.

3. Will my child grow out of asthma?

Statistics do suggest that children grow out of asthma.

1:3 children are diagnosed with asthma and this drops to 1:7 in adult life. *(Sears et al 2003)*

When reviewing current data it appears that in general a child who has few episodes of wheezing, which is associated with respiratory tract infections or who has intermittent transient wheeze, the outlook is promising.

With clinical features which are more frequent and/or persistent the condition is more likely to continue in to adult life.

A New Zealand study supports this *(Holt and Pearce, 2000)*. It was found that approximately 50% children diagnosed with asthma may become symptom free by the time they reach adolescence or adulthood. As a rule, this usually occurs in children with mild asthma. Children with moderate to severe persistent asthma are more likely to have asthma all their lives.

The reasons for this are unclear but research is currently being carried out to answer questions such as these.

4. Can asthma be cured?

No, asthma cannot be cured but asthma can be controlled. Although there have been significant advances in the treatment and management of asthma there is, unfortunately, no cure.

However due to the nature of asthma there are times when some people may feel they are cured because they have no symptoms. This symptom free state (called remission) may continue for months or years but once a person has had asthma the tendency will always be there to have asthma again.

Effective control is vital.

The steps to gaining and maintaining effective control include:

1. Giving/taking asthma medications as directed
2. Monitoring you/your child's asthma
3. Staying active and healthy
4. Wherever possible avoid 'triggers'
5. Understand and have a written asthma plan
6. Visit the doctor regularly

With good management you/your child can lead an active life.

Good management equals good control.

What you want is to control your/your child's asthma not your/your child's asthma controlling you/your child.

Some people may have questions other than those addressed here. We hope up coming editions cover some of the questions we are frequently asked.

REFERENCES

Holt, S., & Pearce, N (2000) Asthma in New Zealand: Myths and realities. New Zealand Medical Journal 113, 39-41

ISSAC Steering Committee (1998). Worldwide variation in prevalence of symptoms of asthma allergic rhino conjunctivitis, and atopic eczema:ISAAC. Lancet 351,1225-31

Klienert, S. (2000)). The hygiene hypothesis gains further momentum in childhood asthma. Lancet 335.

Pearce, N., et al (1999) How much is asthma attributable to atopy? Thorax 54, 268-72

Sears,M. R. et al (2003). Descriptive epidemiology of asthma. Lancet 350 (suppl.II), 14.

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SPACERS VERSUS NEBULIZERS IN TREATING AN ACUTE ASTHMA EPISODE

COMPILED BY ANN WHEAT

There is still much discussion by both health professionals and individuals with asthma, on whether metered dose inhalers (MDI) with spacers are superior to nebulizers for treating episodes of asthma.

For many years, patients admitted to accident and emergency departments in hospital or those visiting their own general practitioners or Accident and Medical (A & M) Clinics, have been treated with a nebulizer and compressor using salbutamol, and this is often still the preferred way of treating asthma, even for routine therapy *(Hewish, 2004)*. This allows for high doses of salbutamol to be given, either by facemask or by mouth piece, although up to 90% of the administered medication will be lost into the atmosphere while a small amount will remain in the nebulizer *(Rubilar, Castro-Rodriquez, & Girardi, 2000)*. Nebulizers are easier than MDI's with spacer for people with physical impairment of the hands to manage and this may be another reason that nebulizers are used.

Today research is proving that in fact using MDI's with spacers is as effective as using a nebulizer. This is true for both adults and children *(Buxton, Baldwin, Berry & Mandleco, 2002; Newman, Milne, Hamilton, & Hall, 2002)*. It is still important though, that severe episodes or life threatening asthma be treated quickly, so the use of nebulizers in this instance is the usual choice *(Hewish, 2005)*. This allows for the addition of oxygen, as oxygen levels are low in life threatening asthma *(Powell, Maskell, Marks, South & Robertson, 2001)*.

So why should a metered-dose inhaler with spacer be used rather than a nebulizer?

The use of nebulizers whether it is in hospitals, doctors rooms, A & M Clinics or in people's homes is expensive. Not only are the machines themselves costly to purchase, but most require annual servicing and the nebulizer

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bowls, tubing, masks and mouth pieces should only be used by one patient in the hospital, general practice and A & M settings. Home nebulizers can be used for as long as 6 – 12 months depending on the amount of use they receive. But there is still the constant cost to the user no matter where they are used. This includes regular replacement of mouthpiece, mask, tubing, filters and nebulizer chamber *(Hewish, 2005)* and electricity costs incurred with running the compressors. Nebulizers are noisy and often frighten very young children, making it difficult to keep the facemask in place, as children will fight and scream during nebulizations. This means that young children will receive a less than adequate dose of medication by nebulization, than when they sit quietly during the nebulization. Nebulizers are time consuming, taking up to ten minutes for each nebulization *(Ploin, Chapuis, Stamm, Robert, David, Chatelain, Dutau & Floret, 2000)*, which again means that it is more difficult to keep children still for this length of time.

For these reasons alone, using a MDI with spacer can be more effective. Newman et al (2002) state that "compared to an MDI/spacer combination, a nebulizer dispenses more medication but without added therapeutic benefit". This will mean that there are fewer side effects from medication use, such as tremor and anxiety *(Newman et al, 2002)*.

There are now many studies that have been undertaken for all ages, from the very young to adults, which show the usefulness and benefits of metered-dose inhalers with spacers. The consensus of these studies is that MDI's with spacers are as effective as nebulizers. They require less beta agonist medication, with fewer side effects, are cheaper and less time consuming *(Ploin et al, 2000; Epling, & Chang, 2003; Newman et al, 2002)*.

Other results that are of interest from the various studies about MDI's with spacers versus nebulizers suggest that patients have a greater improvement in their peak flow readings and spend less time in emergency departments when MDI's with spacers are used. They had a greater improvement in arterial oxygen saturation and relapse rates were significantly lower *(Newman et al, 2002)*.

One study mentioned that when using a MDI with spacer that the majority of children over the age of three are able to use a spacer without the necessity of using a facemask *(Dewar, Stewart, Cogswell & Connett, 1999)*. This can be beneficial for those children who do not like to use a facemask and become quite distressed when made to do so.

Conclusion:

From looking at the various studies, the common theme of findings is that MDI's with spacers are as efficacious as nebulizers when managing an acute episode of asthma in both children and adults. Not only do MDI's and spacers cost less than nebulizers with prescribed nebules, with fewer medication side effects, they are much cheaper to use in the long term due to secondary costs such as electricity and replacement parts. Patients spend less time in emergency departments, have better peak flows following treatment and have fewer relapses. When considering all these benefits, the use of MDI's with spacers are recommended over the use of nebulizers for asthma, whether it is at a medical practice, accident and emergency department or accident and medical clinic *(Hsu, 2004)*. The only exception is for severe asthma and life threatening asthma, where the use of intravenous treatment and rapid medication is essential.

REFERENCES

Buxton, L.J., Baldwin, J.H., Berry, J.A. & Mandleco, B.L. (2002). The Efficacy of Metered-Dose Inhalers with a Spacer Device in the Pediatric Setting. Journal of the American Academy of Nurse Practioners. 14(9), 390-397.

Dewar, A. L., Stewart, A., Cogswell, J. J. & Connett, G. J. (1999). A randomised controlled trial to assess the relative benefits of large volume spacers and nebuliser to treat acute asthma in hospital. Archives of Disease in Childhood. 80, 421-423.

Epling, J. & Chang, M. H. (2003). Are Metered-Dose Inhalers with Holding Chambers Better Than Nebulizers for Treating Acute Asthma? American Family Physician. 67(1), 62-64.

Hewish, P. (2004). Which device for asthma? – Patient UK. (WWW document).

Retrieved September 29, 2005 from the World Wide Web.

URL http://www.patient.co.uk/showdoc/40024500/

Hewish, P. (2005). Use of Nebulisers in General Practice. (WWW document). Retrieved September 29 2005 from the World Wide Web.

URL http://www.patient.co.uk/showdoc/40024617/

Hsu, J. T. (2004). Are Inhalers with spacers better than nebulizers for children with asthma? – Clinical Inquiries. (WWW document).

Retrieved September 29, 2005 from the World Wide Web.

URL http://www.findarticles.com/p/articles/mi_1_53/ai_112592270/print

Newman, K.B., Milne, S., Hamilton, C & Hall, K. (2002). A comparison of albuterol administered by metered-dose inhaler and spacer with albuterol by nebulizer in adults presenting to an urban emergency department with acute asthma. Chest. 121, 1036-1041

Ploin, D., Chapuis, F. R., Stamm, D., Robert, J., David, L., Chatelain, P.G., Datau, G., & Floret, D. (2000). High-Dose Albuterol by Metered-Dose Inhaler Plus a Spacer Device Versus Nebulization in Preschool Children With Recurrent Wheezing: a Double-Blind, Randomized Equivalence Trial. Pediatrics. 106(2), 311-317.

Powell, C. V. E., Maskell, G. R., Marks, M. K., South, M. & Robertson, C. F. (2001). Successful implementation of spacer treatment guideline for acute asthma. Archives of Disease in Childhood. 84, 142-146.

Rubilar, L., Castro-Rodriquez, J. A. & Girardi, G. (2000). Randomized Trial of Salbutamol via Metered-Dose Inhaler With Spacer Versus Nebulizer for Acute Wheezing in Children Less Than 2 Years of Age. Pedicatric Pulmonology, 29:264-269

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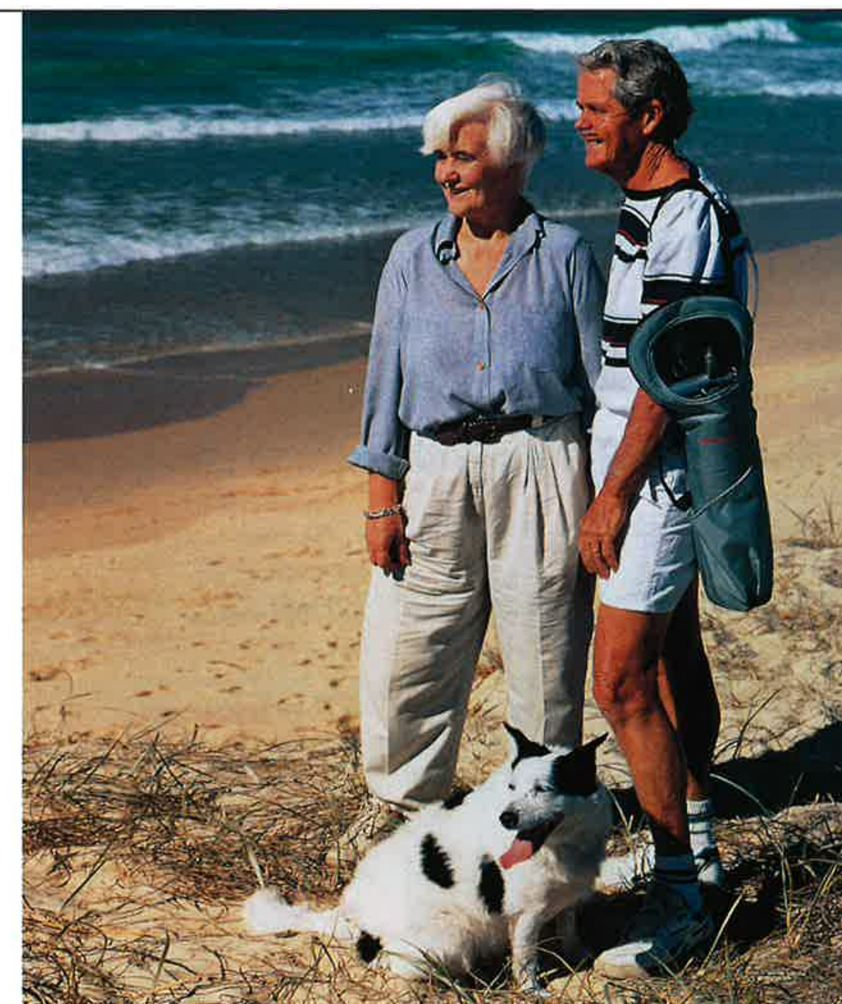


STARTING SCHOOL WITH ASTHMA

BY JUNE BELL

FACT ONE – One in three children in New Zealand have asthma, making it the most common chronic illness of school-aged children.

FACT TWO – It is responsible for more absenteeism from school than any other illness.

FACT THREE – Children with asthma commonly fail to participate fully in school athletic programs, and subsequent tiredness from uncontrolled asthma may affect their ability to learn. However, when effectively managed, children with asthma can participate fully in both academic and athletic aspects of school.

Children with asthma are unable to just leave their asthma at home, therefore they have to grow up quickly and learn to pay attention to their symptoms as they occur along with learning all about school life. Because children are in school for so much of their lives, the chances are high that they will experience an acute asthma episode sometime during school hours.

Because of medical confidentiality, it is up to the parent to inform the school if their child has asthma. When your child is due to start school, or starting at a new school, it is advisable to meet with your child's teacher, school principal and other school personnel who may need to be advised of the child's condition. They will need to know what medication your child will be taking to school, and you will need to know the school policy on administering and storing of medication. Ask if your child is able to keep their medication with them, or is medication to be kept at the school first aid station. If kept at the school first aid station, make sure your child knows this. Label your child's reliever and /or spacer with their name.

The staff will need to know:

- Any medication your child takes, including possible side effects
- What to do if it is to be used during school hours
- When to keep your child inside, or excuse him or her from outside activities
- When you would like to be called if your child appears unwell, and have alternative phones numbers so you may be contacted
- If your child is able to recognise their own symptoms
- Have a written copy of your child's treatment plan for asthma.

Important points:

- Meet with teachers and other relevant school staff to inform them about your child's asthma and special needs.
- Inform school personnel on your child's asthma medications and how to recognise symptoms and assist during an asthma episode if required.
- Ask staff to treat your child normally when the asthma is under control.
- Before starting a physical education class, ensure the teacher is informed of the possibility of exercise-induced asthma.
- Take steps to prevent asthma symptoms from starting that could hamper your child's energy level and learning ability.
- Ensure your child's emotional well being by reassuring that asthma does not have to slow him/her down or make him/her different from other children.

Participating in sport

Exercise, such as running, may trigger an asthma attack in some children with asthma. However, with good management of the child's asthma, children with asthma can participate fully in most sports. Aerobic exercise actually improves airway function by strengthening breathing muscles. Some tips for exercising successfully with asthma are:

- Teach your child to stretch before and after exercising, breathing through the nose and not the mouth. This will warm and humidify the air before it enters the airways. Taking time to warm up and cool down has been shown to reduce asthma symptoms occurring.
- If symptoms occur during exercise, encourage the child to rest, possibly use their reliever, and return to breathing normally before they resume exercise.
- Make sure your child knows to use their reliever medication before exercise, as recommended by their doctor. Ideally this is five to ten minutes before exercise.
- Have your child always carry their reliever medication, to be used if asthma symptoms occur.
- During cold weather, ask the child's teacher to consider your child's asthma, when taking children outside for exercise. A scarf over the mouth and nose, will aid to warm the air that is inhaled and make it easier to breathe.

With the variety of medication available, and awareness of exercise induced asthma, children with asthma are usually able to participate in any and all activities when asthma symptoms are under control.

Asthma aware schools

Here are some issues your may like to discuss with school personnel to support children with asthma and create an asthma friendly school.

- Keep schools smoke free, not only during school hours but also after school events.
- Maintain good air quality, reducing or eliminating allergens and irritants when possible.
- Classrooms have allergen control measure in place, for example, there are no carpets, walls and floors are of material easy to clean, and good house keeping is carried out.
- Good management of pollen. When are the school lawns mown? Are the windows closed when pollen count is

Continued on page 14

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.

Resene Apple

Resene
the paint the professionals use

...from page 13

high and is freely being blown about?

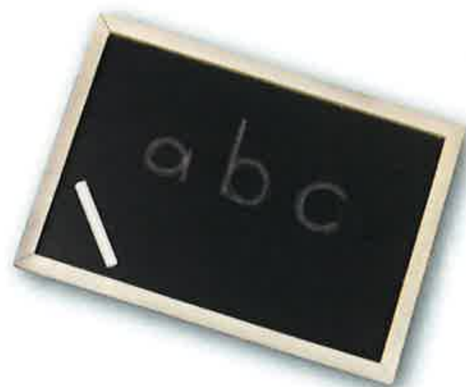
- Ask if there is at least one person with good skills in the management of an asthma episode in the school, and is able to administer medication when needed.
- Establish if the school has an emergency first aid kit which includes a spacer and reliever medication.
- Establish a policy which suits you and the school for keeping asthma medication at school, i.e. is your child able to take their mediation with them and use them freely as necessary.
- Ensure school staff has a copy of your child's individualised written action plan, which they understand, for assisting your child, and when and where to call you.
- Ensure that your child has an option for participating in physical education class, including access to their medication when necessary.
- When your child is going on an excursion outside the school boundaries, consider where they may be going, check out the environment if possible and ask if an emergency kit will be included.

Giving your child control of their asthma

It is important to be honest with your child about their asthma. New entrants have an ability to understand their disease and its impact. They need to be taught about their medications, how to use them independently, how to restrict exercise if needed, and how to avoid their triggers. Allow them to play with their peers and monitor their own symptoms. If possible ensure they know how to use their medication by the time they start school, and they know to ask for assistance when necessary. Always remember as they grow, independence is an important goal for them. They do not want to be different, and they will need guidance and supervision on any restriction they might have.

REFERENCES

www. teachereducation.wlu.edu/Asthma.htm
www. ynhh.org.healthlink/pediatraics
www. intelihealth.com
www. Childrenshospital.org
www. Respirar.org



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Source: American Academy of Allergy, Asthma and Immunology.

Allergic to dust mites? Find relief in this ad.

An astounding 1 in 6 adults and 1 in 3 children suffer from asthma. And for many of these people, the asthma is not under control.

Mattresses, pillows and bedding contain millions of dust mites that produce harmful allergens which trigger asthma and other allergic reactions.

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Asthma New Zealand recommends the use of allergy relief bedding covers for people with asthma and allergies.

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HealthLoom™ Anti Allergy Bedding products are available from:

Asthma Auckland, 581 Mt Eden Rd, Mt Eden, Ph (09) 630 2293 or phone HealthLoom™ direct on 0800 869 357 or view online at www.healthloom.co.nz - brochures available.

Premium Cotton

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COPD Patient Research

COMPILED BY JANETTE REID

In May 2003 Boehringer Ingelheim were about to launch Spiriva, a once a day medication for people who have Chronic Obstructive Pulmonary Disease (COPD). The company wanted an understanding on how COPD patients felt about the condition, how the patient and family coped with COPD, and how the condition was managed by the medical professionals. The reason why Boehringer Ingelheim was interested in the information was that Pharmac were refusing to subsidise Spiriva. This meant the consumer would be required to pay full price, therefore an insight into how the consumer managed her/his COPD would be beneficial. The market research company TNS became involved in the survey. Structured interviews were carried out with some interesting data obtained. The following article is based on a slide presentation by Boehringer Ingelheim

TNS's brief was to look at the following aspects and structure the questions accordingly.

- Who would participate in the survey?
- Patient terminology for COPD
- The diagnosis and impact of COPD
- Any gender differences
- Symptoms, treatments and GPs

Who participated? …

A total four focus groups were interviewed

- Three were identified via COPD support groups from Asthma Auckland
  - Central Auckland, Northshore, Middlemore
  - Aged between 62-83 years
- The fourth group was separately recruited from volunteers between 51-75 yrs.
- Gender – Male and female in each group were interviewed separately.
- All participants had moderate to severe COPD
  - Fieldwork conducted in Auckland between 18th June – 9th July 2003 by market research company TNS

Patient terminology

- Many of the participants were unable to relate to or had heard of the terminology COPD
  - Most either said emphysema or chronic bronchitis
  - Those in a COPD support group had heard of it and were able to relate to the terminology.
- There was some confusion by the participants between the terms COPD COLD, CORD and Asthma.
- There are signs that GPs aren't using the term COPD with patients. (This is of interest as the global initiative for Chronic Obstructive Pulmonary Disease or GOLD a worldwide recognised body of respiratory experts recommend we all use the same terminology COPD).
- When the questioner referred to COPD in isolation reactions by the participants to the term appeared to be confusion
  - The questioner translated this confusion as 'the term seems removed from the patient'.
- The use of Chronic Obstructive Pulmonary Disease, though a mouthful, made it medical, severe and did not relate to them.

What terminology did participants use?

- Participants called it:
  - Emphysema, chronic bronchitis, asthma-like, breathlessness, wheezing
- Terms for symptoms were:
  - Breathless, wheezing, gasping, huffing and puffing
  - Mucus, spit, green stuff, blockage, rattling, bounce
  - Coughing, tickle
  - Weakness, tiredness, lack of energy
  - Hunched shoulders

Diagnosis and Impact of COPD

- Participants viewed COPD as a gradual illness that they didn't notice until the symptoms were really badly affecting their lifestyle
- The GOLD guidelines recommend that COPD diagnosis should be multi stepped (a) History (b) Symptoms (c) Spirometry (d) Pack years smoked
  - The way diagnosis was made caused some confusion with the patient as there appeared to be no structure to the diagnosis and no explanation given.
  - Some participants believe the GP didn't know what is wrong with them.
- People with COPD are in the age group where they often have a multitude of other co-morbidities.
- Heart problems, diabetes, arthritis, asthma, osteoporosis, allergies, kidney problems, hypertension this caused further confusion to the participants.

How they felt once diagnosed …

- Uninformed
  - Most felt that the GP didn't explain things clearly.
- Possibly don't remember it all.
- Too embarrassed to ask again.
- Don't want to seem too 'dense'.
- Lacking in hope.
  - Once diagnosed they perceived not to be given positive messages or helpful advice, eg coping strategies, referral to pulmonary rehabilitation, or energy saving strategies.

Little information was provided on what caused their COPD…

- The participants appeared to have looked outwards for the cause of COPD. Very few attributed it directly to smoking. Reasons given were:
  - Viral
  - Pneumonia/Pleurisy/Infection/Cold
  - Work/industrial – mainly men
  - Generic drugs
  - Dampness
  - Parents smoking
  - Decreased immune system due to other diseases
  - Inherited.

Impact on daily lives …

The interviewer found that COPD has a huge effect on all aspects of daily life. A constant lack of energy along with a lowering of self image and the chronic symptoms of COPD overflows into the following:

- Affects how they relate to others.
- Impacts on others, i.e. their partner, family and friend relationships.
- The person builds an 'outer defence.'
- But underneath the surface they are resentful, embarrassed, vulnerable and fearful.

Gender Differences

Females felt:

- More self conscious than males.
- More likely to hide the severity of their symptoms than males.
- Embarrassed about others seeing them struggle.
- Don't want to worry family.
- More likely to put on a brave face than males.
- More likely to seek treatment earlier than males.

Males felt:

- More resentful than females of a multitude of things
  - Loss of energy
  - Being told to 'pace yourself' and to do tasks slowly
  - Having to continually revise their abilities downwards and still not being able to do them.
- More focused on their physical limitations than females
- Car is very important to males as it helps them to feel some independence
- Don't let their emotions/feelings show as much but did use 'grave' humour
- More likely to attribute causes to work related reasons than females
- Exhibited more severe symptoms than females

Symptom Treatment and GP

Most of the participants would like more information on treatment and management of triggers.

Because the participants are in the age group who previously seldom visited their GP they found it difficult to develop relationship with GP/medical practitioner.

- Majority have unquestioning trust in their GP to diagnose and treat correctly their condition.
- They look for advice on how to better manage their symptoms and reassurance that they are doing the right thing.
- People in Practices where the Practice Nurse provided advice on COPD felt more peace of mind from being seen more often.
  - They felt more in control.
- Patients may raise a question about a named product.
  - Several had asked their GP about Flixotide.
- But they are extremely unlikely to 'challenge' a GP in any way if the GP did not consider or suggest an alternative medication.
  - Very unlikely to demand they be switched to another medication if the GP doesn't think it is right for them.

This survey provided some very interesting points about how the person views COPD with some very powerful emotions described. The lack of knowledge they had about the condition was surprising so there is a need for education on COPD.

The good news is that Spiriva is now funded and available for those who have COPD and it is proving beneficial to 80% of those who have tried it. Also there is a COPD Nursing Course available so if there are any nurses out there who would like to have the knowledge to help their clients.

Asthma Components

Finally we're equipped to tackle both components of asthma.

At long last: from 1st November 2005 people with asthma have been able to access the long acting beta-agonist (LABA for short) Serevent (Salmeterol) at recommended levels. Internationally LABA's have been around for almost 12 years and recommended as part of the overall management of asthma. While in New Zealand the person with asthma had to wait until she/he was on fairly high doses of corticosteroids before her/his GP could prescribe this medication.

Why is this so important?

Asthma is a two-component disease one is airway inflammation (redness and swelling) the other is bronchoconstriction (tightening of the smooth muscle surrounding the airways). Most people with asthma are prescribed preventer medication for example Flixotide or Pulmicort (inhaled corticosteroids or ICS for short) to treat the airway inflammation. These medicines reduce the inflammation and swelling of the airways ensuring they remain as wide and clear as possible.[1,2]

This doesn't treat the other component of asthma – bronchoconstriction or tightening of the airways that causes breathlessness. People with asthma tackle this problem by using short acting beta-agonists (SABA's for short). Popularly known as reliever medication examples are Ventolin or Bricanyl. This medication works almost immediately and lasts up to four hours. LABA's undertake a similar action but last for up to 12 hours[3]. Important information is LABA's must never be used on their own only in conjunction with a corticosteroid and must never be used in place of relievers.

So how do we get it?

If you or your child has asthma you will need to ask your doctor about Serevent and if it can be prescribed. Here are some guidelines that will help you identify if you/your child can add a LABA to your treatment regime:

- For younger children (under 12 yrs) where asthma is poorly controlled despite using ICS for at least three months at total daily doses of 100mcg Flixotide (200mcg Beclozone/Pulmicort) – it can be used for children as young as 4 years old.
- For older children (12 yrs and over) and adults where asthma is poorly controlled despite using ICS for at least three months at total daily doses of 200mcg Flixotide (400mcg Beclozone/Pulmicort)[4].

Poorly controlled asthma is medically defined as using a reliever medication more than four times per week for symptoms.

The introduction of Serevent at these levels is endorsed by the British Thoracic Society[5] and the World Health Organisation Global Initiative for Asthma (GINA)[6].

How many people this could help?

In 2002 The New Zealand POMS study (Patient Outcomes Management Study) reported by Dr Shaun Holt showed that despite patients',

Continued on page 20

SCHOOL DAY?
OR ASTHMA DAY?

In a recent study of 3,421 people, in centres all around the world, most people showed they could markedly reduce their asthma symptoms. So if you are losing days off work or school to your asthma: ask your doctor if you can manage asthma better.

MAKE TOTAL CONTROL YOUR ASTHMA GOAL

AN ASTHMA HEALTH INITIATIVE FROM:

Reference:1. Bateman ED et al. Am J Resp Crit Care Med. 2004;170:836-844.

Flixotide (fluticasone propionate Inhaler; 25, 50, 125 or 250 micrograms per actuation and Accuhaler 50, 100, 250 microgram per actuation). **Prescription Medicine for the prevention of asthma. Do not use:** if you have ever had an allergic reaction to fluticasone or lactose; for sudden attacks of breathlessness. Always carry your reliever inhaler for use during acute attacks. **Tell your doctor if you:** are taking other medicines or herbal remedies; have had to stop taking other asthma medicines; you have tuberculosis (TB) or other long-term lung infection. **Do not discontinue Flixotide suddenly** without consulting with your doctor. **Common side effects:** sore throat or tongue, hoarseness or throat irritation, skin reactions, shortness of breath and wheezing. Tell your doctor or pharmacist immediately if you have any concerns. **Use Strictly as directed Ask your doctor if Flixotide is right for you. Normal Doctors visit fees apply. Flixotide inhalers are fully funded medicines, normal chemists fees apply. Flixotide Accuhaler is not fully funded. A part charge will apply to Flixotide Accuhaler. If symptoms continue or you have side effects see your doctor or pharmacist.** Flixotide is a trademark of the GlaxoSmithKline group of companies and is marketed in New Zealand by GlaxoSmithKline NZ Ltd, Auckland. **Additional product information is available from GlaxoSmithKline on 0800 808 500; Consumer Medical Information on Flixotide is available at the Medsafe website: www.medsafe.govt.nz under Consumer Information.**

GlaxoSmithKline

INSIGHT 0329002

TAPS NA 9294-05JA

...from page 18

nurses' and doctors' efforts 70% of adults and 40% of children did not have their asthma well controlled[7]. (i.e. were using relievers every day.)

An interesting aspect that the educators at Asthma Auckland have found is referred to as 'patient coping mechanisms.' Those who have asthma become accustomed to living with symptoms and have developed methods to avoid too much discomfort, like walking round the hill instead of up it.

The following questions may be indicative of suitability of a LABA medication being included into a medical regime.

1. Do I/my child use reliever medication more than four times a week for symptoms?
2. Do I/my child wake up at night with asthma symptoms?
3. Have I/my child reduced the amount we exercise?
4. Have I/my child had any days off work/ school because of asthma?
5. Have I/my child had any acute exacerbations of asthma within the previous six months.

It is estimated an additional 15,000 people with asthma can now benefit from taking LABAs. So if you are using a preventer, odds are you are now eligible for Serevent.

Some more good reasons to consider LABAs

Apart from the obvious benefits of LABAs – long-term symptom control, restful nights, no tight chest or wheezing and generally feeling better – what other reason is there? Well, recent evidence published in the British Scientific Journal - Thorax reports that using Serevent with a preventer provides significantly better results than increasing the preventer dose by twofold or more[8].

What this means is you can maintain preventer doses at a minimal amount, possibly well below your current dose, and using it together with Serevent can still give you a better outcome with reduced adverse effects. It's known as the 'Steroid sparing effect' because it allows the reduction of inhaled steroids to a minimum level that can maintain control. This is always good for you or your child as although ICS medicines have an excellent safety record, the use of high doses over a long period is not generally recommended due to side effects.

On a less scientific level Serevent comes in a puffer, the same device as Ventolin and Flixotide. If you're used to using these medicines, you'll know how to use Serevent. Most importantly it's fully subsidised so there is no cost.

Take action!

Asthma New Zealand has been asking for better availability of LABAs for many years and now that it has happened we need to grab the opportunity. From our contact with people with asthma and medical professionals we know there are a huge number of people who could benefit from LABAs.

The staff has met some people who already use LABAs and have benefited from them but some are using them in isolation without regular ICS. In the same way as ICS asthma management doesn't tackle both components of asthma neither does isolated LABA use. Most importantly this has the danger that airway inflammation when left unchecked can lead to very severe exacerbations of asthma that can't always be resolved quickly. So no matter which LABA has been prescribed it must be used with an inhaled corticosteroid.

Health professionals need to make every effort to help people understand asthma and the benefits to be gained from living symptom free. Adding LABA's into treatment regimes is taking asthma management to a higher level.

REFERENCES

1. Flixotide data sheet www.medsafe.govt.nz
2. Pulmicort data sheet www.medsafe.govt.nz
3. Serevent data sheet www.medsafe.govt.nz
4. PHARMAC guidelines for use of salmeterol; Pharmaceutical schedule update 1st November 2005; http://www.pharmac.govt.nz/pdf/SU.pdf
5. British Guideline on the management of asthma; British Thoracic Society
6. Global Initiative for asthma; Global strategy for asthma management and prevention; Chapter 6; A six-part asthma management program
7. Holt S et al. Asthma morbidity, control and treatment in New Zealand: results of the Patient Outcomes Management Survey (POMS),2001.NZ Med J 2003;116-1174/436
8. Masoli M et al, Moderate dose inhaled corticosteroids plus salmeterol versus higher doses of inhaled corticosteroids in symptomatic asthma; Thorax 2005; 60:730-734.

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NEW PRODUCT Breakthrough

20th January 2005

Re: Respiratory Guard

I have suffered from asthma and lung infections all my life. Over the years I have persevered with lengthy courses of antibiotics, prednisone, inhaler etc. I have regulated my diet, been conscious of my weight (I dropped several weight classes at one stage), changed my training patterns and only had limited relief.

The only product that has worked for me is Respiratory Guard. This has been a real breakthrough for me in the management of my problem, and has allowed me to train more for my sport without having so much time off recovering from infections and asthma.

I would highly recommend this product to athletes or everyday people who suffer from the same problems that I have.

Kind Regards

Steve Oliver

Powerlifting World Champ (Junior) 1994
Pancreation Wrestling World Champ 2004

Dr Hossam Mahmoud MBBCh, BHSc
16 Altair Place, Mairangi Bay, Auckland

29th October 2004

To: Health Beyond 2000 Ltd

Re: Respiratory Guard

I'm very pleased to provide this testimony for a great product by your company, Respiratory Guard. Being a medical doctor myself I deal with alternative medicine and natural health products with great cautions, particularly when it comes to serious diseases like bronchial asthma.

I tried Respiratory Guard personally out of desperation because I was on maximum medical therapy with frequent short courses of oral steroids for my asthma without achieving good control, particularly in the last few months. To my very pleasant surprise I started to feel a lot better shortly after starting the Respiratory Guard. In fact I started to reduce all my steroid inhalers to be less than third of my previous use. Also, since starting the Respiratory Guard I did not use any oral steroids and hardly used any bronchodilators, such as ventolin. On the other hand I did not experience any adverse effects from using Respiratory Guard.

More recently, I started my daughter who also suffers from bronchial asthma on Respiratory Guard. She already started to feel better and I'm hoping she will come off her steroid inhalers soon.

I understand that the company (Beyond 2000) is working hard to complete clinical trials in order to provide the medical evidence to support Respiratory Guard. By achieving the evidence I believe Respiratory Guard will be a significant milestone in the treatment and possibly cure of bronchial asthma.

Kind Regards

Dr Hossam Mahmoud
NZ Registered Medical Practitioner

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North & South

NEWS FROM AROUND THE REGIONS

Breathe Easy Family Fun Run Sunday November 13th 2005

BY SAMANTHA MEAGHER

Another year and another Breathe Easy Family Fun Run! This year we had a complete change of venue which did provoke some reaction from the public. However on the day, the comments were only positive about the wonderful Tahaki Reserve. Asthma Auckland is based in Mt Eden and it made a lot of sense to make the event a Mt Eden community event. We had tremendous support from Mt Eden Rotary and the Mt Eden Village Business and Mainstreet Association and from many local business's. We had 412 participants, many of whom were not local and had never before considered Mt Eden as a shopping or dining destination!

The event organisation started back in February with a mass of letters sent to everyone and everybody asking for their support. You would think that to organise a Fun Run would take a few phone calls, a quick look at a map, organise the printing of a few posters and that would be it. People would just turn up on the day, have fun and go home. Only it doesn't quite work like that! The event organiser needs to contact the Council and fill out forms, and have a health and safety report covering every eventuality that could occur. The funniest conversation that I had was with the O.S.H man who said that I had identified too many hazards! There needs to be a traffic management report and license for a sausage sizzle.

We sent out thousands and thousands of entry forms and many posters. They were designed for us by J. Walter Thompson Company and involved many, many emails to get them just right. In the end they were eye catching and used the Breathe Easy child logo to promote the event. Eventually the aim of promoting the logo all the time is to get the public to associate the Breathe Easy child with asthma.

Rem Systems Ltd had very kindly sponsored us with caps so the race packs contained a cap, number and letter and on the day the participants were recognisable with their black caps. All the volunteers and marshals had red caps and with their yellow safety jackets were certainly visible.

The actual day came around quickly. The weather was changeable to say the least. It was a wonderful sight to be standing on the stage watching the runners and walkers set off at the sound of the start gun. The skies opened just as the first of the runners got to the summit of Mt Eden, and continued to drizzle for most of the duration of the run. However back at the reserve there was Nescafe and Milo as well as a sausage sizzle from the Aussie Butcher. Entertainment was provided by Club Physical and Classic Hits and for the children there was a bouncy castle, face painting and balloon making.

The new location was a complete hit for our 412 participants, the sun shone for prize giving and the day really was a marvellous occasion. We use the Fun Run as a fundraising event but its main use is as an asthma awareness campaign, and to this end it was also highly successful!

Asthma Auckland Educators' with their new uniforms

Asthma Auckland New Appointments

Asthma Auckland takes great pleasure in welcoming our new recruits Debra Leutenegger and Christina Vercoe to the asthma nurse educator team.

Debra Leutenegger RN

In August Debra Leutenegger joined the team of Asthma Nurse Educators at Asthma Auckland.

Debra has had nursing experience across the spectrum from Neo-natal to Aged Care, including managing quality improvement systems. She completed her Registered Nurse training at Middlemore Hospital. Debra, with her husband has lived and worked in Switzerland while spending time with relatives. They now have a teenage daughter and son. Debra has always had an interest in educating and is excited about her new role. She will be working in the North Shore Area and will also focus on the Early Intervention Programme.

Christina Vercoe RN BN

The newest member to Asthma Auckland is Christina Vercoe.

Christina has joined our staff as an Asthma Nurse Educator.

Christina is a Registered Nurse who trained at MIT, with 15years Practice Nurse experience. Christina has traveled and worked in the UK and Europe before settling down in the Mt Eden area with her husband and three children. Christina has always had a keen interest in asthma education and is looking forward to her involvement at Asthma Auckland.

Christina will be involved in the forthcoming Lyprinol study. She will be focusing on health professional education as well as community education in the South Auckland area.

Debra

Christina

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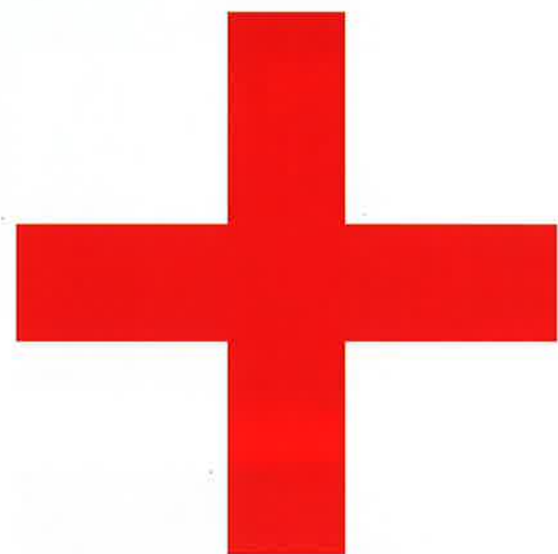
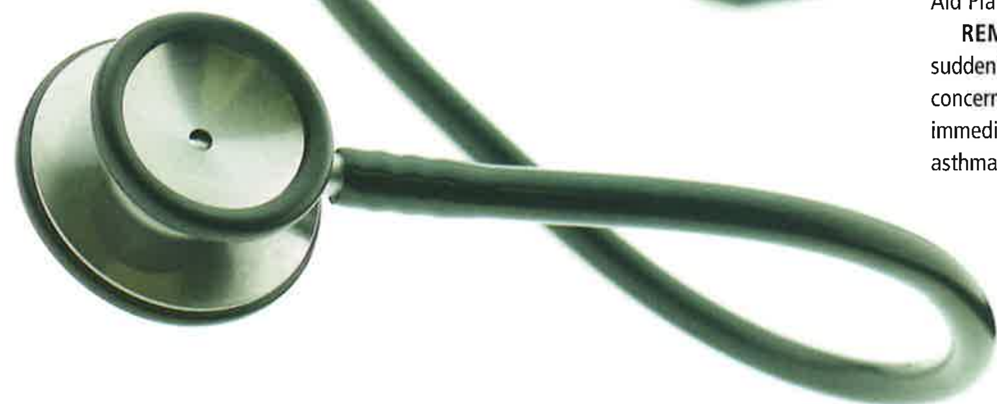


First aid for Asthma

BY JANETTE REID

Asthma is one of the most common persistent childhood diseases in New Zealand and also occurs in adults. One in three children and one in seven adults have asthma and many of these will require long term medication. An asthma attack can take anything from a few minutes to a few days to develop. During an asthma attack coughing, wheezing or breathlessness can quickly worsen.



People with asthma have extra-sensitive airways. Triggers vary from person to person. Dust, pollens, animals, tobacco smoke and exercise may make their airways swell and narrow, causing wheeze, cough and difficulty breathing. In severe cases, the patient is unable to speak whole sentences because of difficulty in breathing. In some severe cases, there may be blueness (cyanosis) of the lips, hands and feet.

It may be difficult to assess the seriousness of an asthma attack if the person first on the scene has never seen an asthma attack before. To help here is some advice.

In the event of an acute asthma episode (asthma attack,) follow this 4 Step Asthma First Aid Plan.

REMEMBER -if the person's condition suddenly deteriorates or if at any time you are concerned – Dial 111 and ask for an ambulance immediately. State the person is having an asthma attack.

ASTHMA FIRST AID	
1st step	If possible have the patient sit and lean slightly forward. Remain calm and assure the person you won't leave and help is on the way if no medication available. Assess the person's breathing rate every ten minutes for any increase until help arrives.
2nd step	When medication available: Give 4 puffs of a blue Reliever inhaler (puffer) – Ventolin – Relievers are best given through a spacer, if available. Use 1 puff at a time and ask the person to take 4 breaths from the spacer after each puff. Use the person's own inhaler if possible. If not, borrow one from someone else.
3rd step	Wait 4 minutes. If there is no improvement in respiration rate i.e. person is less breathless, give another 4 puffs.
4th step	If acute episode is prolonged and not relieved by medication. **CALL AN AMBULANCE IMMEDIATELY (DIAL 111)** and state that the person is having an asthma attack. Keep giving 4 puffs every 4 minutes until the ambulance arrives. Children: 4 puffs each time is a safe dose. Adults: up to 6 - 8 puffs every 10 minutes may be given for a severe attack while waiting for the ambulance.

WITH SPACER

- Shake inhaler and insert mouthpiece into spacer.
- Place spacer mouthpiece in person's mouth and fire 1puff
- Ask the person to breathe in and out normally for about 4 breaths.
- Repeat in quick succession until 4 puffs have been given

WITHOUT SPACER

- Shake inhaler.
- Place mouthpiece in the person's mouth.
- Fire 1 puff as the person inhales slowly and regularly.
- Repeat until 4 puffs have been given

What if it is the first attack of Asthma?

If someone collapses and appears to be very breathless, follow step one and

CALL AN AMBULANCE IMMEDIATELY, even if it is unknown whether the person has asthma or not.

Most ambulances carry medication to treat asthma.

No harm is likely to result from giving reliever medication to someone who does not have asthma.

Give four puffs of a Reliever and repeat if no progress.

Keep giving 4 puffs every 4 minutes until the ambulance arrives.

For more information on asthma, contact your local asthma Society.

REFERENCES

National Asthma Council Australia (NAC)

Summer Fun for People with Asthma

COMPILED BY DEBRA LEUTENEGGER

As the warmest season of the year approaches, it brings a smile to everyone's face. There is new found energy, with an urge to go outside, walk, go to the beach have barbeques and socialise. With the better weather children spend longer periods outside having fun instead of sitting in front of computers or televisions

Summer can be a time of the year that is wonderful for some people who have asthma and miserable for others depending on the area of New Zealand they live in. For some the drier and less humid air of summer makes their asthma less problematic. For others, the dry heat makes the lining of the airway less moist, which can be a very potent asthma trigger. While in Auckland the more humid air can affect the person with asthma either way.

Summer is the time some of us like to spend outside, in the garden, planting flowers, mowing lawns, going on picnics, swimming in the sea and camping in the great outdoors. While all of these activities are great fun they also carry a high risk of exposure to asthma triggers, and can result in an acute episode of asthma.

People with asthma are just as likely to have acute episodes during summer as they are in winter, but by following a few simple steps you can have summer fun and keep asthma well controlled.

- Have your GP or practice nurse check your asthma before you go on holiday. You don't need to be unwell to have your asthma checked.
- Visit your doctor 2 or 3 weeks prior to departure. Get a letter from your doctor listing the medications you are taking and why. This is useful for an emergency and for customs if traveling overseas.
- Have your doctor or practice nurse prepare or update a written Asthma Action Plan. This tells you about your regular daily medications as well as how to increase or decrease your medications should you experience changes in your asthma.
- Continue on all your medications, especially preventer medication.
- Take a peak flow meter to provide you with a regular indication of how well your asthma is being controlled.
- Along with sunscreen, swimwear and cool drinks don't forget to carry your asthma medications with you at all times so you are prepared for any trigger that may cross your path.
- Minimise early morning outdoor activities when pollen is at it highest count, and avoid freshly cut lawns.
- If you are traveling or camping, remember to obtain spare inhalers before you leave so you don't run out while camping in a remote area.
- Before camping ensure the tents and sleeping equipment such as sleeping bags/liners are well aired and free from mould/dampness.
- Smoke is a harmful irritant to people with asthma. It makes it hard to breathe and can trigger acute asthma. A good idea is for the person with asthma to sit further away and upwind from a campfire to minimise smoke inhalation.
- Avoid outdoor activities on high pollen counts days or when ozone levels are high.
- If traveling by car and possibly caught up in traffic jams, close the windows and use the air conditioning, rather than bringing in air from outside which can contain the fumes of other vehicles.
- If flying, ensure that your medications are kept in your hand luggage as baggage can go astray and you don't want to be caught out.
- If staying with friends be aware of your asthma triggers like cat, dog or horse allergens. Also, dust mite numbers are often higher in coastal areas and humid environments.
- Check the fine print before you take out travel insurance. Not all companies provide cover for pre-existing conditions, such as asthma.
- For children whose asthma is triggered by exercise, pretreatment may be necessary before hiking, swimming or other strenuous activities. Ensure you warm up before you start exercising and cool down afterwards. Also very important is to ensure you drink adequate amounts of fluid to prevent dehydration.
- If you are staying somewhere unfamiliar find out where the nearest doctors and/or emergency services are and their contact phone numbers. It's better to be prepared in advance. Ensure that you have your cell phone fully charged. You can recharge your phone using the cigarette lighter port in your car with adaptor if necessary.

Remember! you cannot leave your asthma at home when you are on vacation. Don't ignore early symptoms, if medication is taken early and symptoms relieved you will be quicker in returning to the outdoors to continue your Summer Fun!

REFERENCES

www.asthma.about.com
www.sciencedaily.com
www.vanderbiltowc.wellsource.com
www.everybody.co.nz
medibank.com.au

CONGRATULATIONS

Asthma New Zealand/The Lung Association & Unitec School Of Health & Community Studies congratulates the following nurses who successfully completed the certificate in **Asthma Nursing Course** in 2005 February.

1. Hillary Rosanna Alexander ,Hamilton
2. Barbara Ann Bowring, Auckland
3. Kaye Marie Buckthought, Rotorua
4. Rosemary Gilbert, Christchurch
5. David Halewood, Helensville
6. Sheryl Rose Harding, Christchurch
7. Tamara Hollis, Waitakere City
8. Tracy Hudson, Waikato
9. Queenie Komene, Hamilton
10. Karoline Nodder, New Plymouth
11. Christine Rothman, Wanganui
12. Rosalind Rowarth, Rotorua
13. Helen Van Houtte, Papakura
14. Mark John Wade, Auckland
15. Marjorie Wood, Nelson
16. Maureen Wood, Auckland

Asthma New Zealand/The Lung Association & Unitec School Of Health & Community Studies congratulates the following nurses who successfully completed the certificate in **COPD Nursing Course** in 2005 February.

1. Karen Anne Davison, Gore
2. Elizabeth Fellerhoff, Masterton
3. Jacqueline Hill, Picton
4. Mark John Wade, Auckland

Asthma Nursing Course and Chronic Pulmonary Disease Nursing Course (COPD) Information

The primary aims of Asthma and Chronic Obstructive Pulmonary Disease (COPD) Nursing Courses are to provide nursing health professionals with a high level of Asthma and/or COPD knowledge that promotes best practice, based on available evidence, and is consistent with national policy. Both courses are Unitec School of Health & Social Science Courses in the Bachelor Of Nursing Degree. The Courses are offered by distance learning with support from Frances Dower Unitec lecturer and Janette Reid Asthma New Zealand's National Educator. The 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 $800.00. At present Asthma New Zealand/ The Lung Association is providing grants of $550.00 for each student towards the cost of the course, as a result students will be asked to contribute $250.00. Cost of the COPD Nursing course is $400.00 but a grant of $200.00 is available to practice nurses/ community nurses from Asthma New Zealand/ The Lung Association. In the four years since commencement of the Asthma Nursing Course 525 nurses have enrolled over 12 Intakes. In the second year of commencement of the COPD Nursing Course 90 nurses enrolled over six intakes.

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

Applications are now invited from nurses wanting to enrol on the Asthma and COPD Nursing Courses in January 2006.

The closing date is 14th January 2006.

For information regarding Asthma and COPD Nursing Courses please contact:

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

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

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

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

Asthma New Zealand's partner societies around New Zealand:

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

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

GISBORNE/EAST COAST
PO Box 797, Gisborne. Ph. (06) 867 6732

KAPITI
19 Rifleman Lane, Paraparaumu.
Ph. (04) 902 6855

ROTORUA
Haupapa St, Rotorua. Ph. (07) 347 1012

SOUTH CANTERBURY
PO Box 267 Timaru. Ph. (03) 688 0106

SOUTHLAND
184 Est St, Invercargill.
Ph. (03) 214 2356

TARANAKI
28 Young St, New Plymouth.
Ph. (06) 757 9080

TU KOTAHI
22 Barnes St, Seaview, Lower Hutt.
Ph. (04) 568 4629

WANGANUI
PO Box 790, Wanganui.
Ph. (06) 344 2023

WHAKATANE
105 Woodland Rd, Opotiki.
Ph. (07) 315 6151

WAIRARAPA
36 Harley St, Masterton.
Ph. (06) 377 1175

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

Questions, Letters, Articles, Advertisements

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

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

There's no need to switch from Ventolin™.

New Zealand's number one asthma reliever is still available from your local pharmacy. So, you can choose to stay with Ventolin but now you will be asked to pay a part charge on top of the normal dispensing fee. Prices may vary from pharmacy to pharmacy. Always seek your doctor's advice about the best way to manage your asthma.

Ventolin (salbutamol) is available as an alcohol-free and CFC-free Inhaler, 100mcg per actuation. Ventolin is a partially funded **Prescription Medicine. You will need to pay a part charge for this medicine**. It is a short-acting bronchodilator **used for the relief of asthma symptoms. Use strictly as directed. Do not use if** you are sensitive to any of the ingredients in the preparation. **Tell your doctor if:** you feel that the medicine has become less effective or you are using more than usual; you have hyperthyroidism, high blood pressure, cardiovascular disease, diabetes; are taking any other medicine or herbal remedy including those you buy from a supermarket, pharmacy or health food shop. **Common Side Effects include** headache, nausea, shaky or tense feeling, fast or irregular heart beat, "warm" feeling (caused by blood vessels expanding under the skin), mouth or throat irritation, shortness of breath or wheezing. **If symptoms continue or you have side effects, see your doctor or pharmacist**. Additional Consumer Medicine Information for Ventolin is available at www.medsafe.govt.nz. Prices for Ventolin may vary across pharmacies. Normal doctor's office visit fees apply. Ask your doctor if Ventolin is right for you.

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