

Asthma New Zealand Health Warning

SPECIAL FEATURE:

- Asthma in the summer
- Let's take time to think about our lungs
- Should we have or not have? That is the question.
- Getting the most out of your medicines
- Impact of hay distribution
- 23 Pneumovax vaccine

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December 2006



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editorial

Asthma New Zealand Health Warning STOP PHARMAC NOW!!!

Sometimes you wake up in the morning and wonder why you bother! Unbelievable as it may seem, Pharmac is requesting proposals to supply a generic version of Ventolin and has stated in its tender document it will accept a sole supply contract – will they never learn!?

For those who can't remember the previous farce here's a quick summary:

- Not that long ago Pharmac introduced a sole supply contract with Salamol, a reliever inhaler meant to replace Ventolin (sole supply meaning Salamol would become the only subsidised version available)
- As the switch from Ventolin progressed, more and more patients reported their Salamol inhalers blocking or refused to take them because of the taste
- A Northland lady failed a roadside breath test because of the alcohol content of Salamol
- Pharmacists and GPs faced a patient revolt
- A & E doctors reported increased child admissions from kids refusing to use Salamol because of the taste
- After a media gun fight Ventolin was re-instated and people with asthma have moved in droves back to Ventolin

The current proposal is a stark example of how the current funding regime gives little regard to patient care and previous experience and absolutely no regard to common sense. Attempting to switch hundreds of thousands of people by forcing them onto a different medicine, when they are doing well enough with their current one, is plain stupidity. The financial

savings (probably quoted in millions over several years by Pharmac's propaganda machine) in reality will probably be 10-50 cents per inhaler.

Asthma New Zealand finds it astounding a Government organisation using public money supposedly for public benefit could be so callous, arrogant and shortsighted. Instead of spending our time helping people with asthma we are forced to once again go into bat with Pharmac and a new health minister (since the last battle) who should know better.

It's likely we will be told it's just a standard procedure and nothing will be done without consultation – excuse us while we laugh, remembering the last consultation which was sent out on the 24th December when everyone was at the beach! There are some things best left alone – this is one of them!

Once again the organisation is forced to unlock the arms cupboard, polish up the armour and sharpen our swords – as usual we will be taking no prisoners! If you or anyone you know relies on Ventolin, take arms with us. Arm yourself with a pen (to start with) and write to:

| | |
|--|--|
| Dr Peter Moodie Medical Director PHARMAC PO Box 10-254 Wellington | Hon Pete Hodgson Minister of Health Parliament Buildings PO Box 18-041 Wellington |
|--|--|

Note: The tender document is available for all to see on the Pharmac website – www.pharmac.govt.nz, under the tender documents section, suppliers tender, pg 45 of 97. 4

P.S. Hot off the press!!!! PHARMAC has just announced that it had a surplus of \$19MILLION in this financial year. I wonder how many people with cancer or asthma would have had a much improved quality of life if that surplus had been spent on them!

Kind Regards

Gerry Hanna
Executive Director
Asthma New Zealand – The Lung Association



FREQUENTLY ASKED QUESTIONS ABOUT ASTHMA

Asthma in the summer

COMPILED BY CHRISTINA VERCOE

The lovely long, warm, days of summer will soon be upon us. Unfortunately not everyone looks forward to summer. Why? Because those with allergies to pollens or grasses will be miserable. In this update on frequently asked questions, the topics will relate to the summer season and provide information on avoiding summer triggers.

Why is my asthma and hay fever worse in the summer?

Pollens are produced by plants for fertilization. Some pollens travel through the air in order to fertilize other plants while some pollens are carried by insects from plant to plant. It is the airborne pollens that mostly affect and cause allergy. The grass pollens (e.g. Rye, Couch, Veldt, Barley, Oats) are the most potent trigger for asthma and hay fever but certain weeds (e.g. plantain) and bushes (e.g. privet) or trees (e.g. silver birch) can present a problem.

TIPS FOR AVOIDING ALLERGENS IN THE POLLEN SEASON

- 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 usually rises 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.

Asthma in the summer



- 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-the Lung Association to help identify the pollen seasons of different trees, weeds and grasses.

My asthma gets worse in the summer; should I be allowed to alter my medication, or should a doctor always do this?

Nearly all doctors and nurses who have an interest in asthma aim to help their patients become experts in managing their asthma. In fact a major role of health professionals is developing a partnership in which together they work towards patient management at a level appropriate to what the patient wants. Ask your GP for a self management plan (see page 9) and discuss with her/him how you can manage your asthma.

DID YOU KNOW?

I received an interesting phone call requesting information regarding chlorine gas whilst showering. This was due to a child having asthma symptoms every time he had a shower. Symptoms were worse when the shower was hotter than when cooler water was used.

Upon researching information about chlorine gas I found that chlorine gas is more likely to be released in hot water. As it escapes from the hot water it is released in the confined shower recess, especially one with poor ventilation. The longer the shower, the greater the concentration of chlorine gas in the air we breathe. This may trigger asthma symptoms.

Up to two thirds of our exposure to chlorine is due to inhalation of steam and skin absorption while showering. A warm shower opens up the pores of the skin and allows for accelerated absorption of chlorine and other chemicals in water.

The steam we inhale while showering can contain up to 50 times the level of chemicals than tap water due to the fact that chlorine and most other contaminants vaporize much faster and at a lower temperature than water. Inhalation is a much more harmful means of exposure since the chlorine gas we inhale goes directly into our blood stream.

"Showering is suspected as the primary cause of elevated levels of chloroform in nearly every home because of chlorine in the water." Dr Lance Wallace, U.S. Environmental Protection Agency.

Using a filter system attached to your shower head can remove the chlorine from the water, therefore reducing exposure to chlorine gas while showering.

References: <http://www.aquacool.co.nz/chlorine>



NOW FUNDED



Seretide puffer with new dose counter

Aim to live symptom free

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

Seretide
Fluticasone propionate/Salmeterol xinafoate

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

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

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

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





Let's take time to think about our Lungs

Compiled by Debra Leutenegger

You have two lungs located in your chest. Each lung is between 27.5cm and 30cm (10 and 12 inches) long and therefore takes up most of the space there. Your left lung is a bit smaller than your right lung. The extra space on the left leaves room for your heart. The lungs are protected by the rib cage and beneath the lungs is a diaphragm, a muscle that works with your lungs to allow you to inhale (breathe in) and exhale (breathe out) air.

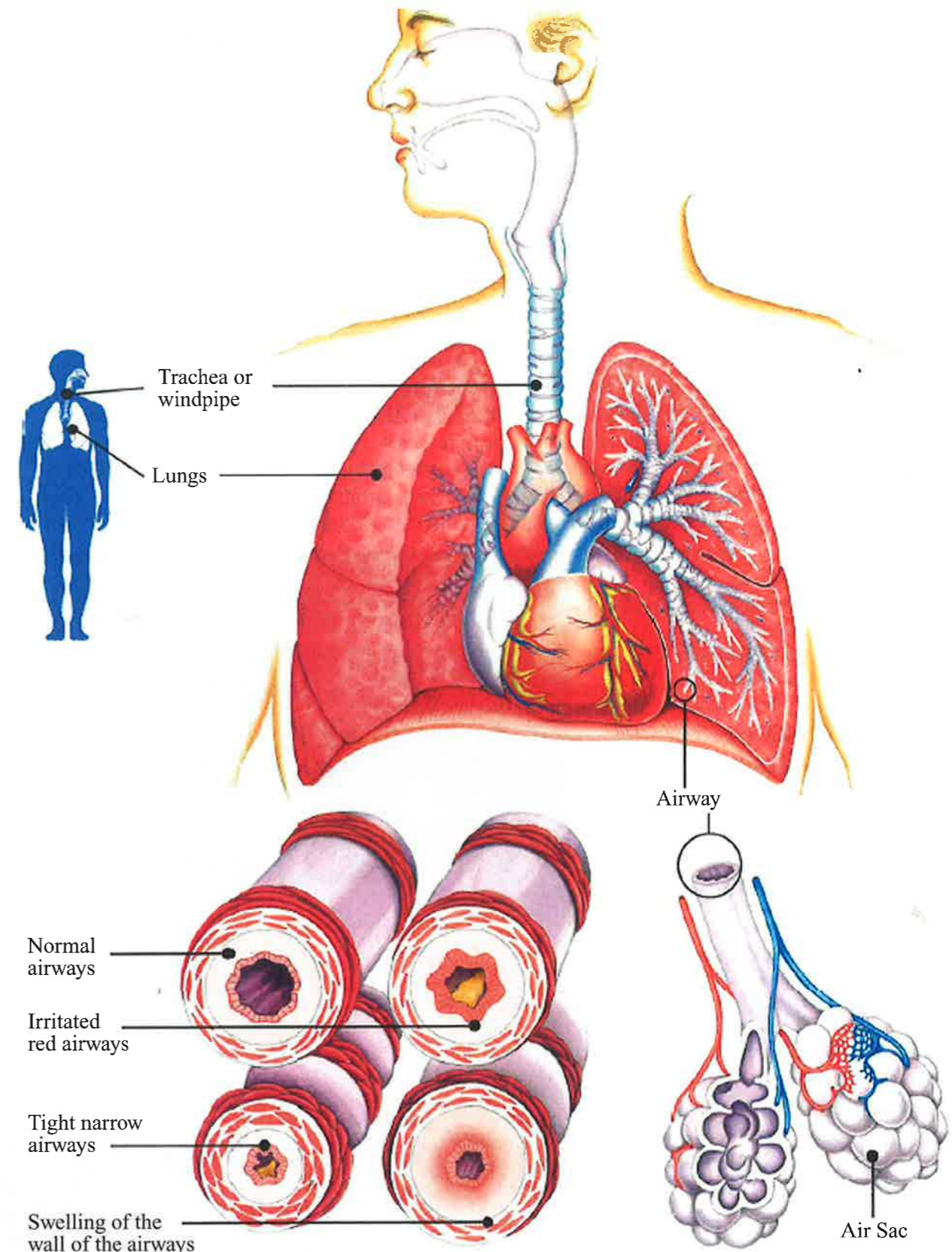
We all breathe in and out anywhere from 15 to 25 times per minute without even thinking about it. Because we breathe so regularly it's easy to take our lungs for granted. It is often not until we experience difficulty in breathing that we pay any attention to the work our lungs silently do for us.

What do our lungs look like?

From the outside, the lungs are pink and a bit squishy, like a sponge. But the inside contains the real lowdown on the lungs! At the bottom of the trachea or windpipe, there are two large tubes. These tubes are called the main stem bronchi, and one heads left into the left lung, while the other heads right into the right lung. Each main stem bronchus (the name for just one of the bronchi) then branches off into tubes, or bronchi, that get smaller and even smaller still, like branches on a big tree. The tiniest tubes are called bronchioles, and there are about 30,000 of them in each lung. Each bronchiole is about the same thickness as a hair or less than 1mm in diameter. At the end of each bronchiole is a special area that leads into clumps of teeny tiny air sacs called alveoli. There are about 600 million alveoli in your lungs and if you stretched

them out, they would cover an entire tennis court. Each alveolus (the name for one of the alveoli) has a mesh-like covering of very small blood vessels called capillaries. These capillaries are so tiny that the cells in your blood need to line up single file just to march through them. The lungs are covered by a protective membrane called the pulmonary pleura.

Our two lungs hold about 2.5 litres of air. But when our body is active it needs much more oxygen. If you breathe deeply the lungs hold over 5 litres of air. In our lungs, in the course of a single day, an astonishing 8,000 to 9,000 litres of breathed-in air meet 8,000 to 10,000 litres of blood pumped in by the heart through the pulmonary artery. The lungs relieve the blood of its burden of waste and return a refreshed, oxygen-rich stream of blood to



Let's take time to think about our Lungs



the heart through the pulmonary vein.

Love Your Lungs

Your lungs are amazing: they allow you to breathe, talk to your friend, and shout at a game, sing, laugh, cry, and more! Your lungs work with your brain to help you inhale and exhale a larger amount of air and at a more rapid rate when you're running a mile - all without you even thinking about it once.

Keeping your lungs looking and feeling healthy is a good idea, and the best way to keep your lungs pink and healthy is **not to smoke**. Smoking isn't good for any part of your body, and your lungs especially hate it. Cigarette smoke damages the cilia in the airways so they can no longer move to keep dirt and other substances out of the lungs. Your alveoli say, "Ouch," too, because the chemicals in cigarette smoke can cause the

walls of the delicate alveoli to break down, making it much harder to breathe. Finally, cigarette smoke can damage the cells of the lungs so much that the healthy cells go away, only to be replaced by cancer cells. Lungs are normally tough and strong, but when it comes to cigarettes, they can be hurt easily - and it's often very difficult or impossible to make them better.

Young children have smaller, more delicate lungs and children who passively smoke are, therefore, more likely to develop sensitive airways, which make them more susceptible to a number of problems.

- chest illness including asthma attacks
- poor lung function and abnormally slow lung growth
- frequent coughs and more serious respiratory illnesses such as pneumonia and bronchitis

If you need to work with chemicals, be sure to wear a protective mask to keep chemical fumes from entering your lungs.

You can also show your love for your lungs by exercising! Exercise is good for every part of your body, and especially for your lungs and heart. When you take part in vigorous exercise (like cycling, running, or swimming, for example), your lungs require more air to give your cells the extra oxygen they need. As you breathe more deeply and take in more air, your lungs become stronger and better at supplying your body with the air it needs to succeed. Keep your lungs healthy and they will thank you for life!

References: Laura Inselman, MD
<http://www.lungusa.org>
<http://www.nhf.org.nz>
<http://www.cancernz.org.nz>

Should we have or not have?



That is the question.

Compiled by Ann Wheat RN BN

Susan Sawyer (2002) states that "Patient self-management improves asthma outcomes and that the key feature of self-management is having a written asthma action plan, monitoring symptoms and seeking regular review". Therefore using an action plan contributes to patients achieving optimal asthma self management.

Hand written asthma action plans are recommended the world over

What is an Action Plan?

An Action Plan provides written instructions to a person with asthma that detail when and how to take their medications, when to increase them, when to seek help or call an ambulance. An Action Plan needs to contain contact details of his/her medical practitioner for use in an emergency situation. It should also have a written goal for the person with asthma to strive for with their asthma control, as this encourages the patient to accept ownership of the plan.

What is the purpose of an Action Plan?

The purpose of an action plan is the provision of the action to take at the level of severity of asthma they are experiencing; early recognition of his/her asthma by either peak flow recordings or symptoms and then treating him/her self quickly to avoid the possibility of a severe

as a useful way of improving asthma control and improving health outcomes (Reddel, Marks, & Jenkins, 2004; Douglass, Aroni, Goeman, Stewart, Sawyer, Thien & Abramson, 2002; Adams, Boath, Homan, Campbell & Ruffin, 2001).

Asthma Auckland has found very few patients' use action plans nor have they been encouraged to use one. So what are they and why are they not used?

episode, which could require hospital admission, time off work and a decreased quality of life (Gibson, Włodarczyk, Hensley, Murree-Allen, Olson & Saltos, 1995).

What is an Action Plan based on?

An action plan is based on either peak flow monitoring, symptoms or both. Research demonstrates that both methods show similar benefits, especially when the patient's asthma is under good control (Adams et al, 2001). They go on to mention that people who are poor perceivers of asthma symptoms (around 15%) could benefit from the use of action plans that contain both peak flow monitoring and symptoms. In fact, in their action plans some people may be better advised to seek early professional help, rather than trying to deal with their asthma by him/her self (Adams et al, 2001).

Who should be involved in writing Action Plans?

General practitioners were at one time the main healthcare providers who could legally prescribe medications for asthma, but now the healthcare profession has Nurse Practitioners who have gained prescribing rights. Therefore the health profession has two groups who can complete an action plan. The most important factor is that the person with asthma ought to have input into the writing of the plan-it is her/his asthma after all. In fact, according to Douglass et al (2002), most patients with action plans modified them to suit their own asthma status and in some cases people who do not have action plans will manage their asthma to suit themselves by how they feel on any given day. In both cases, this means that the person with asthma is more likely to show ownership and use a plan. It is therefore important that doctors should check with their patients, not only that they are using their action plans once provided, but whether they have altered them to suit themselves. This will help to enhance the patient / doctor relationship.

What is the importance of an Action Plan?

When followed, action plans have been proven to reduce the number of visits to a hospital emergency department or an accident and medical clinic for acute episodes of asthma, to decrease the variability of peak flow readings and improve quality of life (Klein, van der Palen, Uil, Zielhuis, Seydel and van Herwaarden, 2001).

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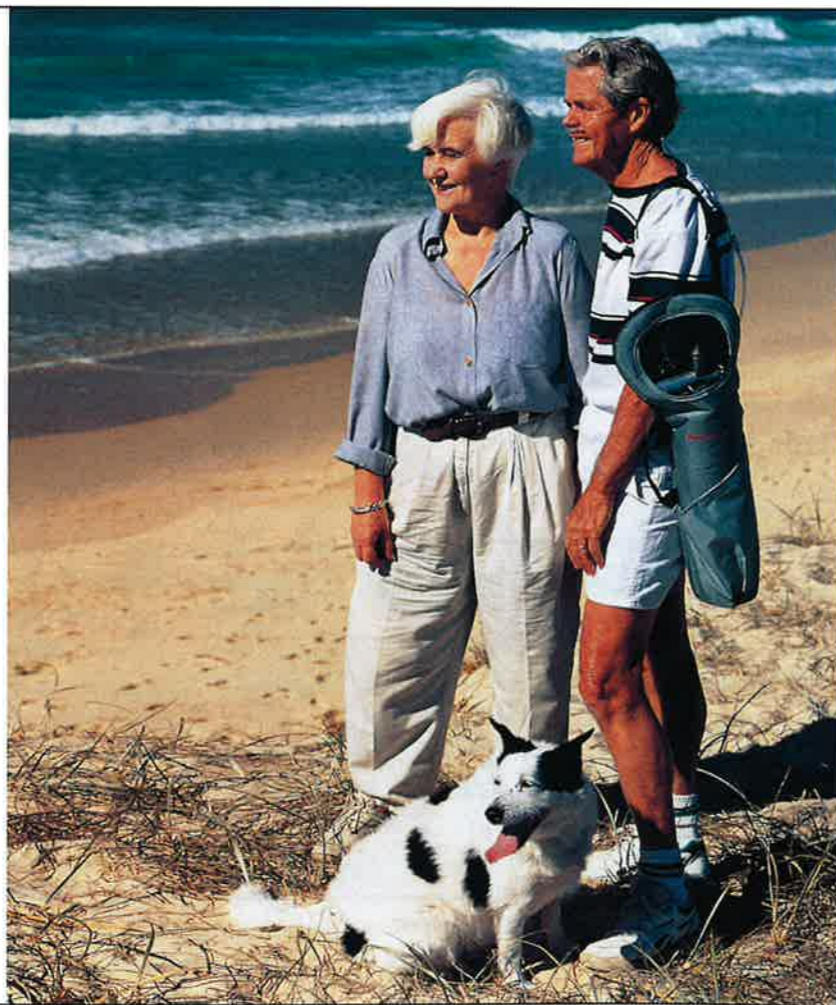
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Should we have or not have? That is the question.



Why are Action Plans not used?

Evidentially there appears to be several reasons why people with asthma do not use action plans. The most common reason according to Douglas et al (2002) is that people with asthma have never been given one by their doctor. There also appears to be certain occupational groups that are less likely to have an action plan, while those people who work in home situations and clerical workers are more likely to have an action plan (Douglas et al, 2002). Another reason is that people with asthma, although they have a plan, often do not use it as they have not been given definitive instructions or permission to use the plan by their health care provider (Adams, Smith & Ruffin, 2001). It would therefore seem obvious that when a plan is actually given to the patient that the health care provider makes sure that the person understands the plan and actually states that the person can use the plan to control their asthma. On the other hand, it is important for both patients and doctors alike to take a positive step in promoting the use of action plans by the doctor writing one for all patients. If an action plan is not suggested by the doctor, patients should feel able to initiate a discussion about obtaining one.

Conclusion

Action plans are an integral part of asthma management. They assist in the consistent improvement of health outcomes, reduce healthcare utilization by reducing asthma symptoms and acute exacerbations of asthma and reduce workplace and school absenteeism (Adams et al, 2001), thus reducing the burden of asthma in New Zealand, which at present stands at about \$825 million a year (Holt & Beasley, 2001) in both direct and indirect costs. It is therefore imperative that actions plans are offered to all people with asthma to encourage them to monitor their asthma and so that in the case of an asthma episode, they know what to do and how to treat it. Let us work together so that people with asthma can lead a healthy, normal life.

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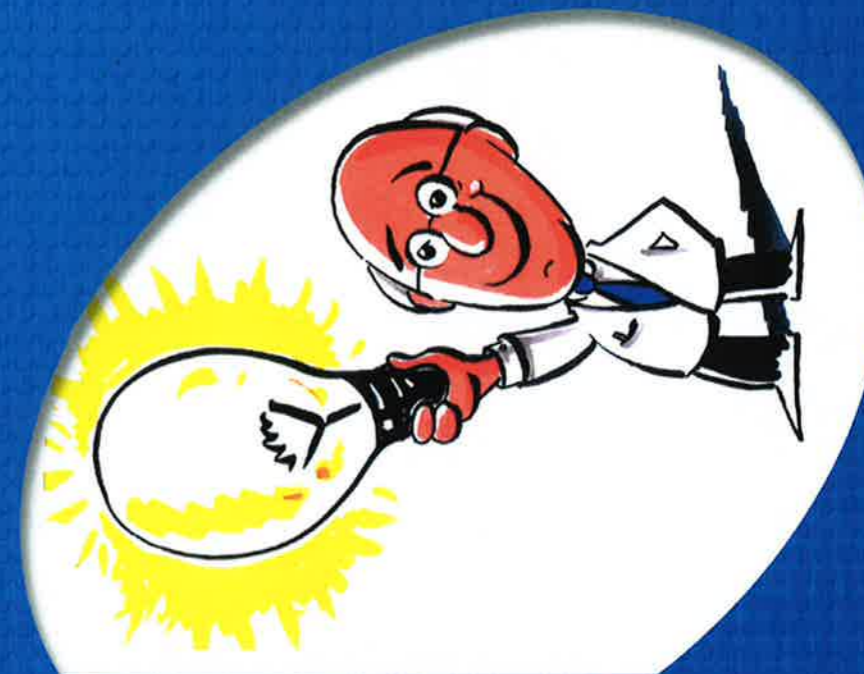
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Adult Management Plan to Control Your Asthma



For further information please contact your local asthma society



THE LUNG ASSOCIATION

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Website: www.asthma.org.nz

Asthma New Zealand/The Lung Association
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GP

Name: _____

Phone: _____

Date: ____/____/____

Practice Nurse:

Name: _____

Phone: _____

Care Plan Review Due

Date: ____/____/____

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

For further information please contact your local asthma society



Getting the most out of your medicines

(ASTHMA UPDATE FOR PEOPLE WITH AN INTEREST IN ASTHMA AND ALLERGY ISSUE 31 SEPTEMBER 2006 - ASTHMA FOUNDATIONS OF AUSTRALIA)

Adult Action Plan to Control Your Asthma

Your peak flow readings

Name: _____
Date: ____/____/____

My goal is: _____

100%

Green Zone-Go!
Asthma under control

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



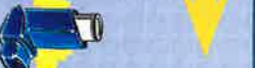
To control your asthma take

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

85%

Yellow Zone-Cautious!
Asthma getting worse

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



Increase preventer and reliever inhalers

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

60%

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

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



Sit upright and stay calm

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

40%

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

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

Dial 111 and ask for ambulance

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



Aerosol Inhalers

The most popular inhaler used in the management of asthma is a Metered Dose Inhaler (MDI) or puffer.

It is an aerosol canister that produces a fine mist of medication and transporter.

The medication and transporter separate when not in use hence the reason for shaking the puffer before use.



1.1 Puffer – press and breathe in. The only inhaler that delivers medication without having to suck it in.

Puffer

How to use your puffer

1. Remove the cover from the puffer mouthpiece (the mouthpiece prevents your inhaler from gathering fluff etc. which you might inhale.)
2. Hold the puffer upright and shake vigorously
3. Breathe out
4. Tilt your chin up
5. Put the puffer mouthpiece in your mouth and create a seal with your lips
6. Start to breathe in through your mouth, then



- fire one puff of medication and continue to breathe in gently and slowly
- 7. Remove the puffer from your mouth and hold your breath for 10 seconds (or as long as you are able)
- 8. Breathe out through your nose
- 9. Replace the cover
- 10. To take more medication repeat steps 2-8

Puffers require good coordination so it is important to press down on the canister and breathe in gently and slowly at the same time.

Did you know that more medication gets into the lungs when a puffer is used along with a spacer device? Researchers tell us you receive about 20% more.



Cleaning your puffer

1. Remove metal canister. Do not wash canister
2. Wash the plastic casing only. Rinse the mouthpiece through the top and bottom under warm running water for at least 30 seconds. Wash mouthpiece cover
3. Allow to air dry
4. Reassemble

Vicrom and Tilade inhalers should be cleaned every day.



Cleaning you spacer

About every one to two weeks the spacer should be washed in clean hot soapy water and allowed to drip dry. Do not rinse or wipe dry.

Using a spacer makes life easier because:

- There are fewer side effects from medication
- It is easier to use as it requires less coordination than a puffer alone
- More medication is inhaled into the lungs

Spacers come in many shapes and sizes. Your choice will depend on medication type, your age and ability. Children under four years of age will need a small volume spacer with facemask. Ask your doctor, pharmacist or local asthma society for information.

2. Dry powder inhalers

Dry powder inhalers require a deep inhalation to get the medication into your lungs. They include:

- 2.1 Turbuhaler**
- 2.2 Accuhaler**
- 2.3 Aerolizer**



Spacers

Asthma New Zealand-The Lung Association strongly recommends that all puffers are used with a spacer. A spacer is a special device shaped like a clear plastic football or tube. Puffer medications are fired into this device and then the medication is inhaled through a facemask or mouthpiece. Adults do not need to carry a spacer around with them as long as you use it in the morning and at night to take your medication

How to use your spacer

1. If required, assemble the spacer
2. Remove the cap from the puffer and shake the puffer well
3. Attach the puffer to the end of the spacer
4. Place the mouthpiece of the spacer in your mouth and close your lips around it. If using a spacer with a facemask, place the facemask over the mouth and nose to ensure a good seal
5. Press down on the puffer canister once to fire the medication into the spacer
6. Breathe in and out normally for 4 breaths, or breathe in for 5 seconds, hold for 10 seconds and breathe out
7. To take more medication, shake the puffer and repeat steps 3-6

Important points

- Always hold the devices upright when loading the medication. This stops the powder from falling out
- Always check the amount of medication left in your device. Doses may be indicated on the device
- Keep dry powder devices away from moisture and do not blow into them
- Correct inhaler use is very important. Have your technique checked regularly by your doctor, practice nurse, asthma educator or pharmacist

2.1 Turbuhaler

When using a Turbuhaler a deep inhaled breath is required to get the medication into the lungs. This may be difficult for young children and adults who are short of breath. It is wise to have a puffer and spacer available for emergencies.

The indicator on the side of the device will either highlight the doses left in the device (Symbicort) or it will appear red to indicate that it is nearly empty (Bricanyl, Pulmicort and Oxis)

Using your Turbuhaler

1. Unscrew and lift off the cap
2. Hold the Turbuhaler upright
3. Twist the coloured base to the right then the left, until it clicks
4. Breathe out gently away from the Turbuhaler. Do not blow into it.

5. Put the mouthpiece in the mouth ensuring a good seal is formed with the lips
6. Breathe in through your mouth forcefully and deeply for approximately 5 seconds
7. Remove the Turbuhaler from your mouth before breathing out
8. Replace the cap
9. To take more medication repeat steps 2 – 8

Cleaning your Turbuhaler

Wipe mouthpiece with clean dry tissue

2.2 Accuhaler

The indicator on the device shows how many doses are available in the device

How to use your Accuhaler

1. Hold the Accuhaler by its base in one hand

2. Place the thumb of the other hand in the thumb grip
3. Open the accuhaler by pushing the thumb grip around until it clicks
4. Slide the lever until it clicks
5. Breathe out away from the Accuhaler
6. Put the mouthpiece in the mouth ensuring a good seal is formed with the lips
7. Breathe in steadily through your mouth for approximately 5 seconds
8. Remove the Accuhaler from your mouth and hold for approximately 10 seconds
9. Breathe out slowly
10. Close Accuhaler
11. To take more medication repeat steps 2 – 9

Cleaning your Accuhaler

Wipe mouthpiece with clean dry tissue

2.3 Aerolizer

The Aerolizer (used only for Foradil) contains powdered medication in a capsule. The medication is released when the blue buttons on the base are pressed, piercing the capsule.

Using your Aerolizer

1. Lift off the blue cap
2. Hold the blue base with one hand and with

- the other grasp the white mouthpiece and turn in the direction of the arrow
3. Remove a capsule from the blister pack and place in the slot inside the blue base
4. Twist the mouthpiece back into place
5. Hold the Aerolizer upright and firmly squeeze the two blue buttons on the side until the capsule is pierced
6. Breathe out away from the mouthpiece
7. Place the mouthpiece in your mouth sealing the lips around it
8. Inhale deeply for approximately 5 seconds
9. Remove the mouthpiece from your mouth and hold your breath for approximately 10 seconds
10. Breathe out slowly
11. Remove the used capsule and replace blue cap
12. To take more medication repeat steps 2 – 11

When inhaling medication, you should be able to hear the capsule rattling inside the Aerolizer.

Cleaning your Aerolizer

Wipe mouthpiece with a clean dry tissue

Nebulisers

Nebulisers convert liquid medication into fine mist that is inhaled through a mask or

mouthpiece. The airflow and pressure of a nebuliser should be checked regularly (at least once a year). Depending on use, disposable nebuliser bowls may need replacing every three months. It is advisable to always have a spare bowl. Nebuliser filters should be changed and the machine serviced according to the manufacturer's instructions. Ask your doctor, nurse, pharmacist or asthma educator for advice on how to use a nebuliser if it is prescribed for you. Most people DO NOT need to have a nebuliser at home. Appropriate doses of medication given via a puffer and spacer are just as effective as using a nebuliser. For more information ask your practice nurse/doctor or local asthma society.

Managing your asthma effectively

- Find a doctor who has a keen interest in asthma and have regular reviews of your asthma.
- Ask your doctor for a written Asthma Action Plan
- Avoid things that make your asthma worse (triggers)
- Know your asthma symptoms and how to treat them
- Make sure you use asthma medications correctly





- Recognize signs of worsening asthma and follow your written Asthma Action Plan
- Know your Asthma First Aid Plan and how to use it
- Inform your family members about your asthma and how they can provide Asthma First Aid

What is a written Asthma Action Plan?

Your plan should help you to:

- Recognize worsening asthma symptoms
- Start treatment quickly
- Seek the right medical assistance

Early attention to worsening asthma may prevent you from having a serious attack.

See the article compiled by **Ann Wheat**
Why do we need an Asthma Action Plan?
Should we have or not have?
That is the question.



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NEWS FLASH

Ventolin to Salamol -- a crossover study in New Zealand.

Reti S. School of Population Health, Auckland University, Auckland. salamol@selectpost.com

AIMS:

To assess asthma stability in adults converted from Ventolin to Salamol.

METHODS:

Thirty-six general practice adults with documented asthma and using Ventolin at least weekly in the previous 12 months, changed their Ventolin for

Salamol for a period of 4 weeks. The validated Asthma Control Questionnaire was applied at the beginning and end of the study period.

RESULTS:

Of the 36 adults, 6/36 (17%; 95%CI 4-29%) prematurely withdrew mainly due to Salamol ineffectiveness. A further 15/36 (42%; 95%CI 25-58%) could not maintain Salamol alone and returned to Ventolin at some time during the study

period with 10/15 (67%; 95% CI 42-91%) citing Salamol ineffectiveness. Of the remaining 15/36 who maintained the study design, nearly all had worse asthma stability 14/15 (93%; 95%CI 80-100%).

CONCLUSIONS:

Asthma stability was significantly worse with Salamol compared to Ventolin. Psychological features related to changing inhalers, different

physical aspects of Salamol inhalers, and pharmacological ineffectiveness are possible explanations.

The recent research by Dr Shane Reti, Whangarei, concludes that "Asthma stability was significantly worse with Salamol compared to Ventolin".

Pharmac recently announced a surplus of \$19 million - what a shame that some of this massive surplus (planned or unplanned?) could not have been used to meet the needs of people with asthma, and their families.

It is appalling that those who are unable to afford the part-charge on Ventolin must use this alternative. Both should be fully subsidised in order that all children and adults with asthma can access the medication which provides the most effective and best control for them.

G. A. Hanna
Executive Director



IMPACT OF HAY DISTRIBUTION, AS A METHOD OF DE-STABILISATION ON ASTHMATICS



IMPACT OF HAY DISTRIBUTION, AS A METHOD OF DE-STABILISATION ON ASTHMATICS

A letter received at the Auckland Asthma Society from Vickie O'Connor, 6 Northcross Drive, Browns Bay, Northshore City

Back in March of this year, I suffered an asthma attack that I believe was a direct result of a particular hay distribution method used on land development sites. On Friday the 17th of March, I looked out my window across at an area of land being developed and saw they were using a large canon-like machine to distribute hay over the entire land development area. There must have been more than 20 massive hay bales, lined up, waiting to be distributed. It was a fairly windy morning and within minutes of this practice taking place, I was virtually unable to see out the window of my home.

Concerned with the effect this was going to have on my sons and my breathing, I called North Shore City Council, who informed me that somebody would look into it straight away. My objective at this point was to get someone from council to visit them on site and ask them to stop. I rang several times in the course of the morning to no avail. I continued to contact? over the next couple of days and due to the windy time of year asked if they would dampen down the subsequently laid hay; this did not happen. Having expressed my concern at this point that NSCC had not acted quickly in this matter I started to enquire as to how they go about this practice. It turns out that the ARC have certain land preparation methods that must be adhered to in order to avoid soil erosion. Whilst hay distribution is not the only option, it seems to be the one being used as it is quick, easy and inexpensive and requires less pre-planning.

I enquired with the Sediment Management Specialist at ARC whether there were any parameters around using this method and any responsibility given for informing the public of the possible effect of this method. They came

back to me, having checked with their legal people and said that ARC were not directly liable and that once consent is given to the Land Consent Holder, the responsibility is with them. So I contacted the Land Consent Holder, who said they were just following ARC guidelines and the practice they use is one stipulated by ARC.

So I enquired with OSH, who said their primary concern was for employees but if there was a nuisance being created to those in close vicinity they felt there was a moral obligation that should be undertaken. I contacted a public health officer at the Ministry of Health and spoke with an environmental officer at NSCC. Whilst most people empathised with the obvious problem this method can cause, no one was willing to take responsibility and my discussions lead me back to the ARC to ask if any health considerations were taken into account when deciding this was a viable way in which to mulch. The answer was no.

In response from the ARC to me, they say

"We can recommend that sites inform neighbours of when mulching is to occur

But can only recommend this be done as good-practice, but ultimately decisions are left with the consent holder and their representatives. Any discussions as to what is the best way to overcome any health issues, i.e. staying inside or moving offsite, would be discussed with the consent holder and those affected.

In raising this point with the Land Consent Holder, they informed me that they would not undertake the practice of informing local residents before mulching because they felt that would just be inviting problems they would obviously then have to deal with. So without some actual parameters being enforced, there is no reason why the Land Consent Holder should

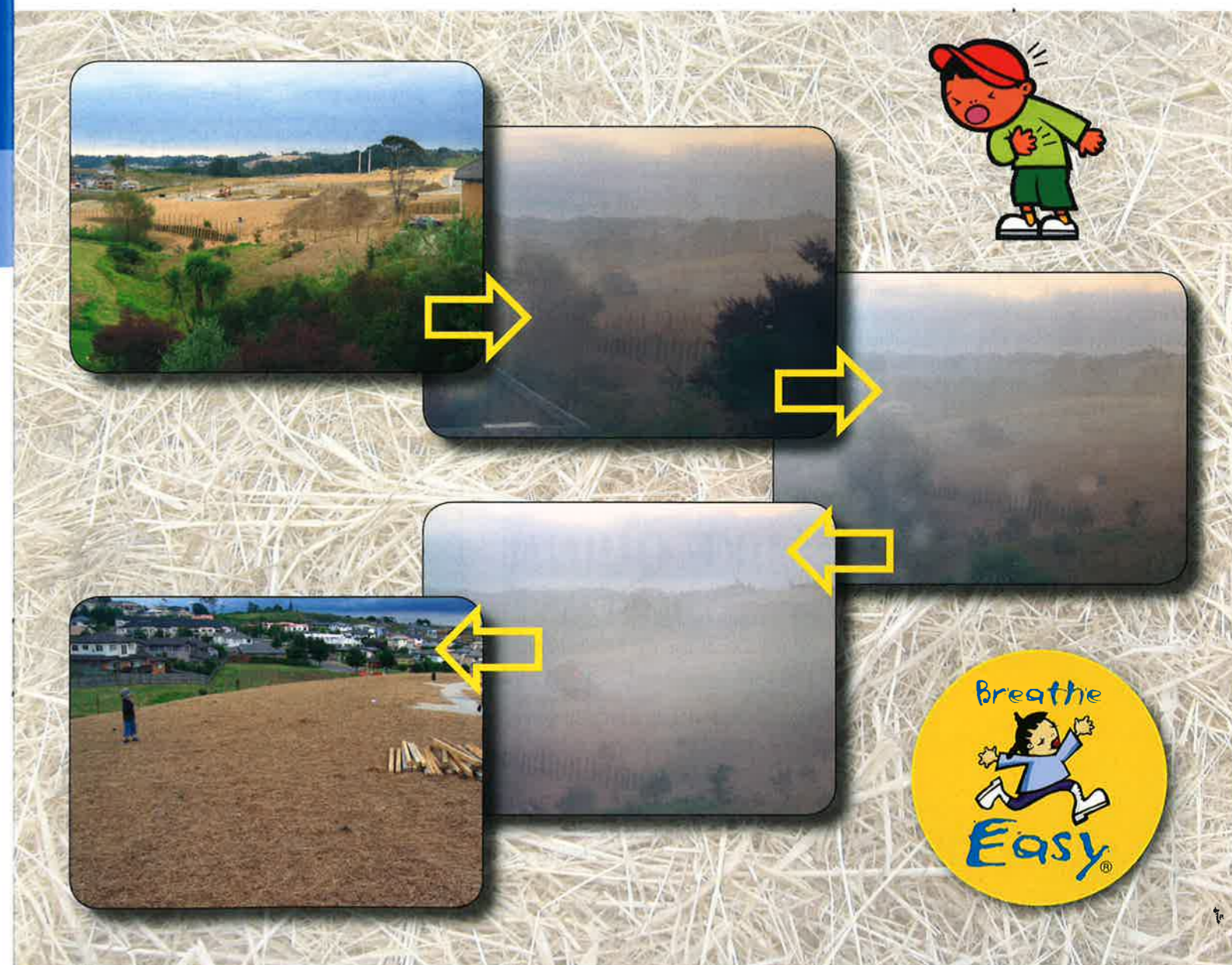
want to become involved in this issue.

So here we are; the Land Consent Holder is responsible from ARC's perspective, but the Land Consent Holder is just following ARC regulations and several other areas agreeing this is a problem but not under their jurisdictions or area of responsibility.

Shouldn't the body that imposes the regulations then be responsible for ensuring some parameters are put in place for using this method, once they realise that this could be causing a public health nuisance? My concern is looking around so many areas being developed currently, especially on the North Shore. Everywhere you

look there is hay covering the land where it is being developed. A further note; the hay is being distributed with grass seed in it also, which adds to the allergenic factor.

With the rising rates of asthma in Auckland and in our young children, surely this is worthy of further investigation by someone who cares enough to bother! Had it not happened on my door step, I am not sure I would have made the connection, but when you are faced with an acute asthma attack yourself and my then 4 year old son's asthma worsening at that time, it seemed fairly clear.



North & South

NEWS FROM AROUND THE REGIONS

ASTHMA SOUTH CANTERBURY



2005/2006 has been a mixed year for Asthma South Canterbury. Catherine our Asthma / Respiratory Nurse Educator was very busy visiting doctors rooms, schools, young mothers and talking to practice nurses throughout the district as well as helping to look after a very sick father and carry out her duties as a wife and mother. All of this has brought with it rather a lot of stress and tension that in today's busy society we can all do without. Catherine felt that she could not do justice to all that was happening and with a sad heart had to give

up her position with us. I say sad because her passion is really to help those with Asthma.

However she is not totally lost to us as she is willing to stay on the committee and to assist our new Asthma / Nurse in any way possible, which is really good for our Society.

Catherine went out to find us a new Nurse who we here in South Canterbury feel will fit in very well with us and starts on October 10th.

Jane Dunbar RN
Bachelor of Nursing

Jane began her career path in 1984 at Ashburton Hospital, where she trained as an Enrolled Nurse. After graduating worked for several years at Ashburton Hospital, gaining experience in many different areas of Nursing. During this time made the decision to bridge over to becoming a Registered Nurse as there was major restructuring within nursing and the scope for her to work as an Enrolled Nurse was becoming limited.

After receiving her Nursing degree, in

Wellington, she worked extensively in Coronary Care. While working in Wellington, Jane met her husband and they soon moved to Timaru. They have been here for 10 years and enjoy the area very much. Prior to having two children Jane worked at Timaru Hospital in the Medical Ward and in District Nursing. Jane then left the hospital and worked as a Practice Nurse for several years, leaving to have her family, but going back part time between children.

Recently Jane returned to nursing since her youngest has gone off to school and is doing casual work at Timaru Hospital, mainly in the outpatient setting.

Jane says "the nursing profession offers many opportunities and challenges that have provided me with a lifetime of rewards. I am looking forward to those that come about from working in the area of Asthma & Respiratory Health".

We as a committee are looking forward to working with Jane and look forward to a long association with her.

INTRODUCING: MIKE QUINN



Mike Quinn joined the societies in early September as the new PR/Fundraising Manager.

Mike had previously been with Arthritis New Zealand for two years as both a fundraiser and as an Arthritis Educator. He has fundraising and marketing experience in the not-for-profit sector with two other organizations going back a further three years. Prior to that, Mike spent nearly twenty years in the pharmaceutical industry and in nursing and he has further experience in the field of Special Needs. He feels his

paramedical background has been very useful in making the transition to Asthma as the service delivery model is very similar to that used by Arthritis New Zealand, and hopes his grasp of the issues involved in the field of asthma will serve him well in his new role.

Mike is married to Margaret who works in Special Education and they have an adult son and daughter who are both engineers. Mikes hobbies include photography, history and restoring and modifying classic Minis.

PLEASANT POINT PRIMARY SCHOOL

Pleasant point primary school children decided that each house group collect the out going coins and donate to different community organisation's including Diabetes, Multiple Sclerosis and Asthma. Asthma South Canterbury was presented with a cheque for \$152.30, a great effort from the BLUE HOUSE group! The money will go towards the Asthma Nurse putting an Asthma Kit into schools around South Canterbury District.

Pictured below from left to right Emma Linton, Catherine Wills (Asthma / Respiratory Nurse) and Hayden Johnston



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Kid's Challenge



Kid's Challenge



Word find

Please find the words highlighted in the text in the word find

Asthma is a chronic condition affecting a person's **airways**, which can become irritated by **triggers**. Types of triggers include; **cold air**, **mould**, **dust mite**, **smoking**, **pollen** and **exercise** which can cause **inflammation** by activating the **mast cells** in the walls of the airways. Two common signs and symptoms of an asthma episode include a dry **cough** and **wheezing**. If the asthma episode progresses and becomes an **emergency**, call the **ambulance** immediately.

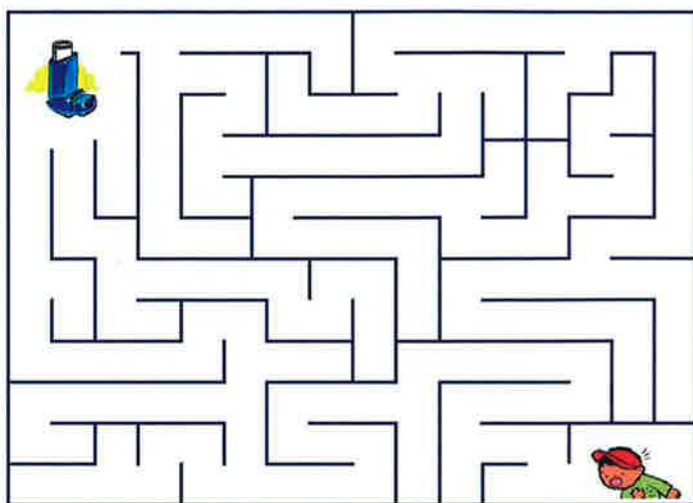
You can help manage your asthma by following your asthma **care plan**, which will tell you when to use your preventer (e.g. **flixotide**) and **blue reliever** (e.g. **ventolin**). You also should monitor your **peakflow** on a regular basis.

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Spot the triggers



Find the inhaler



Spot the triggers

1. Cat
2. Bird
3. Dog
4. Horse
5. Rabbit
6. Grass
7. Pollen
8. Horse
9. Exercise
10. Cold air
11. Smoke
 - Car
 - Factory
 - House Chimney
 - Barbecue
 - Cigarette



Dietary antioxidants and asthma in adults.

Patel BD, Welch AA, Bingham SA, Luben RN, Day NE, Khaw KT, Lomas DA, Wareham NJ.
Department of Public Health and Primary Care, Institute of Public Health, Cambridge, UK.

BACKGROUND: Several antioxidant nutrients have been reported to be inversely associated with asthma. A study was undertaken to assess the independent associations of these nutrients with asthma in adults.

METHODS: A nested case-control study was performed in 515 adults with physician diagnosed asthma and 515 matched controls using dietary data obtained from 7 day food diaries. The main outcome measures were physician diagnosed asthma and current symptomatic asthma (diagnosed asthma and self-reported wheeze within the previous 12 months).

RESULTS: Cases were similar to controls in age, sex, social class, and daily energy intake but had a lower median intake of fruit (132.1 v 149.1 g/day, $p < 0.05$). 51.5% of the population reported zero consumption of citrus fruit; relative to these individuals, people who consumed >46.3 g/day had a reduced risk of diagnosed and symptomatic asthma (OR adjusted for potential confounders 0.59 (95% CI 0.43 to 0.82) and 0.51 (95% CI 0.33 to 0.79), respectively). In nutrient analysis, dietary vitamin C and manganese were inversely and independently associated with symptomatic asthma (adjusted OR per quintile increase 0.88 (95% CI 0.77 to 1.00) for vitamin C

and 0.85 (95% CI 0.74 to 0.98) for manganese), but only manganese was independently associated with diagnosed asthma (OR 0.86 (95% CI 0.77 to 0.95)). Adjusted plasma levels of vitamin C were significantly lower in symptomatic cases than in controls (54.3 v 58.2 micromol/l, $p = 0.003$).

CONCLUSIONS: Symptomatic asthma in adults is associated with a low dietary intake of fruit, the antioxidant nutrients vitamin C and manganese, and low plasma vitamin C levels. These findings suggest that diet may be a potentially modifiable risk factor for the development of asthma.

Do the British Guidelines for Asthma Management facilitate concordance?

Steven K, Marsden W, Neville RG, Hoskins G, Sullivan FM, Drummond N.
Tayside Centre for General Practice, University of Dundee, Dundee, UK. k.steven@dundee.ac.uk

BACKGROUND: Asthma is an example of a common, chronic illness in which clinicians are encouraged to promote concordance and adhere to guidelines. Some existing research suggests that these aims may be incompatible.

OBJECTIVES: To describe patient goals for life and for asthma management in order to inform concordance with people with asthma. **DESIGN:** A cross-sectional, qualitative survey.

SETTING AND PARTICIPANTS: A purposive sample of 47 adults with asthma from Dundee, UK. The subjects were identified from general

practice asthma registers and had a range of ages and asthma severity but no significant comorbidity.

METHODS: Tape-recorded semi-structured interviews. The topic guide was based on the literature and had been piloted in a previous study.

RESULTS: The participants focussed on improving their lives, only aiming to improve their asthma as a means of improving their lives. Three aspects of asthma were reported to help or hinder improving life: the use of asthma medication, trigger avoidance and exercise.

People integrated these three aspects of asthma in order to maximize life.

CONCLUSIONS: The study supports the more individualized goals of the recently revised British Guidelines for Asthma Management but highlights the need to develop this further in future revisions. It also provides an explanation for patients' acceptance of less than 'perfect' asthma control and it suggests that shared goals may be achieved in practice by considering the advantages and disadvantages of medication and allergen avoidance on everyday life rather than on asthma.

An interdisciplinary intervention for under treated pediatric asthma.

Walders N, Kercksmar C, Schluchter M, Redline S, Kirchner HL, Drotar D.
Division of Psychosocial Medicine A109, National Jewish Medical and Research Center,
1400 Jackson St, Denver, CO 80206, USA. waldersn@njc.org

STUDY OBJECTIVES: To examine the effectiveness of an interdisciplinary intervention for pediatric asthma.

DESIGN: Randomized, controlled study.

SETTING: Urban tertiary-referral pediatric hospital.

PARTICIPANTS: One hundred seventy-five patients with asthma lacking written treatment plans and presenting with asthma-related emergency department visits (two or more) and/or hospitalizations (one or more) in the past year were randomized to a comparison group receiving medical care alone ($n = 86$) or to an interdisciplinary intervention group receiving

medical care, asthma education, and problem-solving therapy ($n = 89$)

INTERVENTION: All participants received written asthma management plans, peak flow meters, and spacer devices. The intervention group also received asthma education, an asthma risk profile assessment, brief problem-solving therapy, and access to a 24-h nurse advice line. The primary outcome measure was change in asthma symptoms, and secondary outcomes included health-care utilization and asthma-related quality of life.

RESULTS: Both groups demonstrated significant reductions in asthma symptoms and improvements in quality of life without any

between-group differences identified over the course of follow-up. In contrast, the intervention group demonstrated less frequent health-care utilization than the comparison group, with 28% of the intervention group requiring emergency department or inpatient services for asthma compared to 41% of the comparison group (adjusted odds ratio, 1.92; 95% confidence interval, 1.00 to 3.69) over the 12-month follow-up period.

CONCLUSIONS: This study examined the effectiveness of an interdisciplinary intervention for under treated asthma. The intervention did not result in improvements in asthma symptoms, but accomplished modest reductions in the utilization of acute medical care.

Breaking the access barrier: evaluating an asthma center's efforts to provide education to children with asthma in schools.

Cicutto L, Murphy S, Coutts D, O'Rourke J, Lang G, Chapman C, Coates P.
Faculty of Nursing, University of Toronto, 50 St. George St, Toronto, ON, M5S 3H4 Canada. lisa.cicutto@utoronto.ca

OBJECTIVE: To evaluate an asthma education program for children with asthma that is delivered in their school by certified asthma educators from a local hospital-based asthma center.

STUDY DESIGN: Randomized controlled trial.

SETTING: Twenty-six elementary schools located in a suburb of Toronto.

PARTICIPANTS: A total of 256 children in grades 2 to 5 with asthma and their parents were randomized to control and experimental groups. **INTERVENTION:** Children in the experimental group received the "Roaring Adventures of Puff" asthma education program over the course of six weekly 1-h sessions. Those in the control group continued receiving usual care.

MEASUREMENTS AND RESULTS: Data collection involved measuring asthma quality of life, self-efficacy for managing asthma, school absenteeism, days of interrupted activity, health services use, and parental loss of time from work. Quality of life and self-efficacy data were collected from the children at baseline and 2 months. Telephone parental interviews conducted over 1 year were used to collect data on the remaining variables. Unpaired t test, analysis of variance, and χ^2 test were used to determine whether differences existed between the groups. The results are reported as the mean \pm SD. The experimental group demonstrated higher scores than the control group for self-efficacy (3.6 \pm 0.7 vs 3.8 \pm 0.9, respectively; $p < 0.05$) and quality of life (5.0 \pm 1.4 vs 5.5 \pm 1.4, respectively; $p < 0.05$). At

1 year, the experimental group demonstrated fewer mean urgent health-care visits (2.5 \pm 2.5 vs 1.7 \pm 1.9 visits per year, respectively; $p < 0.01$), days of missed school (4.3 \pm 5.7 vs 3.0 \pm 4.4 days per year, respectively; $p > 0.05$), and days of interrupted activity (9.1 \pm 10.5 vs 6.2 \pm 7.3 days per year; $p < 0.01$) related to asthma than the control group. There were no differences between the groups for parental work absenteeism or scheduled asthma visits.

CONCLUSION: Providing an asthma education program to children in their school can significantly improve quality of life and reduce the burden of childhood asthma.

The September epidemic of asthma hospitalization: school children as disease vectors.

Johnston NW, Johnston SL, Norman GR, Dai J, Sears MR.

Firestone Institute for Respiratory Health, St Joseph's Healthcare and McMaster University, Hamilton, Ontario, Canada. njohnsto@sympatico.ca

BACKGROUND: Viral infections are associated with the majority of asthma exacerbations in children and adults. Increased asthma hospitalization rates of children and adults, particularly in the early fall, have been observed to follow school vacations. **OBJECTIVE:** We sought to determine the sequence of timing of September asthma hospitalization epidemics in children and adults and to determine whether school-age children are the primary source of transmission of agents that cause them.

METHODS: By using Canadian asthma hospital admission data from 1990 to 2002, we examined

geographic variation in the timing of fall asthma epidemics and applied mathematical modeling to estimate their exact timing and magnitude in school-age children, preschool children, and adults, and relation to school return.

RESULTS: The September asthma hospitalization epidemic peak occurred in school-age children each year on average 17.7 (95% CI, 16.8-18.5) days after Labor Day. Similar epidemics of lesser magnitude were observed in preschool children peaking 1.7 (95% CI, 0.9-2.5; $P < .001$) days later, and in adults 6.3 (95% CI, 4.7-7.9; $P < .001$) days later than in school-age children. The epidemics

peaked 4.2 (95% CI, 1.2-7.1; $P < .001$) days earlier in school-age children in northernmost compared with southernmost latitudes.

CONCLUSION: September epidemics of asthma hospitalizations in Canada have a precise relationship to school return after the summer vacation. It may be speculated that school-age children transmit the agents responsible for the epidemic to adults. Measures to improve asthma control and reduce transmission of infections should be directed at children with asthma before school return.

Changes in active and passive smoking in the European Community Respiratory Health Survey.

Janson C, Kunzli N, de Marco R, Chinn S, Jarvis D, Svanes C, Heinrich J, Jogi R, Gislason T, Sunyer J, Ackermann-Liebrich U, Anto JM, Cerveri I, Kerhof M, Leynaert B, Luczynska C, Neukirch F, Vermeire P, Wjst M, Burney P.

Dept of Medical Sciences, Respiratory Medicine and Allergology, Akademiska sjukhuset, SE 751 85 University of Uppsala, Sweden, and Department of Thoracic Medicine, Haukeland Hospital, Bergen, Norway. christer.janson@medsci.uu.se

The aim of the present investigation was to study changes and determinants for changes in active and passive smoking. The present study included 9,053 adults from 14 countries that participated in the European Community Respiratory Health Survey II. The mean follow-up period was 8.8 yrs. Change in the prevalence of active and passive smoking was expressed as absolute net change (95% confidence interval) standardised to a 10-yr period.

Determinants of change were analysed and the results expressed as adjusted hazard risk ratio (HRR) or odds ratio (OR). The prevalence of active smoking declined by 5.9% (5.1-6.8) and exposure to passive smoking in nonsmokers declined

by 18.4% (16.8-20.0). Subjects with a lower educational level (HRR: 0.73 (0.54-0.98) and subjects living with a smoker (HRR: 0.45 (0.34-0.59)) or with workplace smoking (HRR: 0.69 (0.50-0.95)) were less likely to quit. Low socio-economic groups were more likely to become exposed (OR: 2.21 (1.61-3.03)) and less likely to cease being exposed to passive smoking (OR: 0.48 (0.37-0.61)). In conclusion, the quitting rate was lower and the risk of exposure to passive smoking higher among subjects with lower socio-economic status. Exposure to other peoples smoking decreased quitting rates and increased the risk of starting to smoke.



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

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

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

www.asthma.org.nz

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

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

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

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

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

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

will endeavor to achieve this.

Of further interest is the ability to download copies of some of our pamphlets and in time we hope to be able to include a download of our quarterly journal "The NZ Journal of Respiratory Health" 02.

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



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

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

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23-valent Polysaccharide Vaccine effectiveness in reducing bacterial pneumonia infections!

Compiled by Christine Barry

Clinical Bottom Line: The effectiveness of 23 Pneumovax vaccine in reducing hospital admissions of pneumonia in Chronic Obstructive Pulmonary Disease (COPD) clients over 65 years of age.

Scenario

As an Asthma Nurse Educator working in the community, I was asked by a concerned client diagnosed with COPD who had suffered repeated bouts of pneumonia and other chest infections about the effectiveness of the Pneumovax vaccine.

Question

Will the application of 23-Pneumovax vaccine every 5 years reduce the likelihood of hospital admission of streptococcus pneumoniae in people over 65 years of age with Chronic Obstructive Pulmonary Disease?

Search strategy

A computerised data base search was conducted on Medline (in process and other non-indexed citations), applying combined search terms of: pneumonia, Pneumovax 23 vaccine, COPD and elderly. These search terms were broadly applied as original title, abstract, mesh headings and keywords giving the results of 127 articles. Articles with small sample sizes less than one thousand participants were rejected. The search was then limited to recent articles from 2004 to present day and an article of choice was selected. A wide internet search via Google search engine was applied to locate full computerised version of chosen article.

Summary of Study

A large-scale programme of vaccination against Streptococcus pneumoniae was completed in Genoa Province of Italy. It involved a cohort of 9170 individuals from 1st Jan 1998 until 31st Dec 2002. The study included all individuals over the age of 64 or individuals with increased likelihood of acquiring pneumococcal infection or presenting with a serious risk of complication which included individuals diagnosed with

COPD. Officials/representatives from vaccination centres and nursing homes, along with general practitioners, invited individuals to receive the pneumococcal vaccine during an influenza vaccination campaign. Individuals were vaccinated with polysaccharide vaccine (Pneumo 23, Aventis Pasteur MSD, Lyon, France) between 1 January 2000 and 1st December 2002 at Department of Prevention Vaccination Centres or at Nursing homes where they lived. At vaccination each individual's name and identification code was recorded and transferred to a database at the Department of Prevention ('Genovese', Liguria Region, Italy). Vaccination data was matched with hospital discharge diagnoses according to International Classification of Disease (ICD-9-CM) from all hospitals in the Genoa Province. 9170 individuals were observed for a period of 547139 person-months (incidence/ 104), 392036 (71.7%) person-months before vaccination and 155103 (28.3%) person-months after pneumococcal vaccination. 8592 (93.7%) individuals also received influenza vaccine annually during the follow-up period. 452 individuals died in the follow-up period of after vaccination.

23-valent Polysaccharide Vaccine effectiveness in reducing bacterial pneumonia infections!

This retrospective study's main outcome was to compare the incidence of hospital admissions of pneumonia before and after vaccination with 23-valent pneumococcal polysaccharide vaccine, but also addressed reduction in other respiratory infections and decreased occurrence of COPD exacerbations. How effective the vaccine was in reducing pneumonia, other respiratory infections and COPD hospital admissions was addressed by comparing a lack of protective effect for hospitalisations from all illnesses that were not directly related to pneumococcal disease.

Summarised Results

The incidence of hospital admissions due to illness, was applied to calculate a relative risk (RR) value to attain if the vaccine had a beneficial effect of reducing likelihood of illness. A decrease in the incidence of individuals hospitalised with pneumonia (1/10000 person months) lead to a relative risk reduction of 38% in the vaccinated individuals compared with the non-vaccinated individuals.

For those individuals diagnosed with COPD, a decrease in the risk of hospital admission due to exacerbation of COPD was noticed when the researchers compared before vaccination to after vaccination. Lack of vaccination was associated with increased risk of hospitalisation in 23% COPD, 38% pneumonia and 87% other respiratory infection. Unfortunately the reductions for pneumonia and other respiratory infections were found to be non-significant statistically, but realistically any reduction in occurrence of respiratory illness for individuals with COPD is of benefit.

The Incidence (/10 4 person-months) of Hospital Admission

| | Before Vaccination | After Vaccination |
|-------------------|--------------------|-------------------|
| | Number | Number |
| All Causes | 21,255 | 8,909 |
| Pneumonia | 342 | 123 |
| COPD | 636 | 262 |
| Other Respiratory | 74 | 18 |
| Infections | | |

Comments:

Individuals were not followed for the approximate same number of person months before and after the pneumococcal vaccination. Vaccination of 23 Pneumococcal polysaccharide with influenza vaccine may have had an additive protective effect.

Applicability

There is currently an on going debate regarding the effectiveness for pneumonia vaccination for people over 65 years of age. The COPD-X Plan: Australian and New Zealand Guidelines for the management of Chronic Obstructive Pulmonary Disease currently recommends 23-pneumovax for individuals over the age of 65 diagnosed with COPD in New Zealand.

So what is the approximate cost of Streptococcus pneumonia hospitalisations in New Zealand if we are to address the effectiveness of vaccination? Scott, Scott, Turley and Baker (2004) study addressing the economic cost of Streptococcus pneumoniae and found 26, 826 estimated hospitalised episodes of pneumonia in adults during the year 2003. They stated this as equivalent to a rate of 859 per 100,000 people with an annual estimated cost of 63 million dollars. The direct medical costs being 29 million dollars, with indirect medical costs of 1 million dollars and 33 million dollars in lost productivity. Scott et al... (2004) also found the number of hospitalisation were greater in the 65 year and older age group, citing pronounced loss of productivity and suggesting an intensified prevention and effective community treatment

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23-valent Polysaccharide Vaccine effectiveness in reducing bacterial pneumonia infections!



programmes focussing on the 65 years and older age group.

Conclusion

Scott et al... (2004) study outlines the huge cost of hospitalised pneumonia (from Streptococcus pneumoniae) and strongly advocates for primary health prevent strategy for vaccination in New Zealand. The 23 Pneumococcal polysaccharide vaccination of individuals over the age of 64 years (or at risk of infection/complication) improved their health by reducing hospital admissions for pneumonia, COPD and other respiratory infections.

In addressing the effectiveness for pneumonia vaccination for people over 65 years of age the following issues must also be considered;

- An individual's immune system decreases with age.
- Vaccines effectiveness may be impaired if individuals continue to smoke cigarettes. Nuorti et al... (2000) found pneumococcal disease

(Streptococcus pneumoniae) not only associated with cigarette smoking, but as the strongest independent risk factor for pneumococcal disease.

- People with COPD have a decreased ability to clear mucus (phylum) from their lungs therefore creating an ideal environment, warm and moist for bacteria to flourish. Nuorti et al... (2000) state pneumococcal disease is high among individuals with COPD probably because of defective clearance mechanisms.

In conclusion we at Asthma Auckland are strong advocates for the continued application of pneumovac in helping immune-suppressed COPD individuals.

Citations

Ansald et al... (2005). Effectiveness of 23-valent Polysaccharide vaccine in preventing Pneumonia and non invasive Pneumonia infection in Elderly People: a Large scale Retrospective Cohort Study. Journal of international Medical Research 33(5), 490-500. Retrieved October 4, 2006 from

Medline in process and other non-indexed citations database.

Scott G, Scott H, Turley M & Baker M (2004). Economic cost of community-acquired pneumonia in New Zealand adults. New Zealand Medical Journal 117(1196). Retrieved October 27, 2006 from Medline in process and other non-indexed citations database.

Nuorti et al... (2000). Cigarette Smoking and Invasive Pneumococcal Disease. The New England Journal of Medicine. Retrieved from <http://content.nejm.org/cgi/content/full/342/10/681?andorexactitleabs=&SEARCH...>

Appendix

Cohort members were followed for 5 years from 1st Jan 1998 until 31st Dec 2002.

F Ansald, V Turello, P Lai, S De Luca, R Rosselli, P Durando, L Sticchi, R Gasparini, E Delfino, G, Icardi.

Chronic Obstructive Pulmonary Disease (COPD) Nursing Course

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

As a health professional are you playing a proactive role in the treatment and management of this debilitating disease?

If not do you want to? How about setting up early intervention programmes – i.e. all smokers are screened from age 40 for early warning signs of this disease.

The primary aim of **Chronic Obstructive Pulmonary Disease (COPD) Nursing Course** is to provide nursing health professionals with a high level of COPD knowledge that promotes

best practice, based on available evidence, and is consistent with national policy. The programme is offered by distance learning with support from **Janette Reid, Asthma New Zealand's National Educator**. The COPD Nursing Course is accredited with 12 credits, which can be used towards gaining your Bachelor of Nursing degree. The monetary value of a level 7, 12-credit course, which is done through a tertiary education establishment, is \$ 400.00 but a grant of \$200.00 is available to practice nurses/ community nurses from **Asthma New Zealand/ The Lung Association**. In the second year of commencement of the COPD Nursing Course 110 nurses enrolled over seven intakes. The society has decided to make the course available at such a low cost to benefit nurses with a special interest in COPD, and increase the knowledge base of nurses throughout New Zealand.

For information regarding COPD Nursing Course, please
Email: janetter@asthma-nz.org.nz
swarnah@asthma-nz.org.nz
Phone: 09 623 0236 ex 809 Janette
or ex 804 Swarna

Asthma Nursing Course

Applications are now invited from nurses wanting to enrol on the Asthma Nursing Courses in February 2007. The programme is offered by distance learning. The primary aim of Asthma Nursing Course is to provide nursing health professionals with a high level of Asthma knowledge that promotes best practice, based on available evidence, and is consistent with national policy.

In the six years since commencement of the Asthma Nursing Course 545 nurses have enrolled over 14 Intakes. Of the many nurses who have enrolled in the Asthma Nursing Course, most had not undertaken any academic learning & students found the Asthma course to be very challenging, but thoroughly enjoyable experience of learning.

Asthma Nursing Course is accredited with 24 credits, which can be used towards gaining your Bachelor of Nursing degree.

Could you please phone/fax or email for an enrolment form.

**1st Semester
Asthma Nursing Course closing date -
30th January 2007**

**For information contact: Janette /Swarna
Asthma New Zealand/The Lung Association
P O Box 67-066, Mt Eden, Auckland**

Phone 09 623 0236- Ex 809 Fax 09 623 0774
Email: janetter@asthma-nz.org.nz
swarnah@asthma-nz.org.nz

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

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Asthma New Zealand - the Lung Association
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Phone (09) 623 0236, Fax (09) 623 0774, Email anz@asthma-nz.org.nz

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

Asthma New Zealand's partner societies around New Zealand:

- AUCKLAND**
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 197, Gisborne, Ph. (06) 867 6782
- KAITI**
19 Riffeman Lane, Paraparaumu.
Ph. (04) 907 6855
- ROTORUA**
Haupapa St, Rotorua. Ph. (07) 347 1012
- SOUTH CANTERBURY**
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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.

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Reference: 1. PHARMAC. Notification of changes to the Pharmaceutical Schedule (Letter), 10 July 2006. 2. IMS Report May 2006.
Seretide (fluticasone propionate/salmeterol xinafoate; available as a 50/25 or 125/25mcg per actuation inhaler, or as a 100/50 or 250/50mcg per actuation Accuhaler) is a Prescription Medicine for the treatment of reversible obstructive airway disease (ROAD) including asthma, and for the treatment of chronic obstructive pulmonary disease (COPD). Seretide is a fully funded medicine; Special Authority criteria apply. Seretide 250/25mcg inhaler is a private purchase medicine that you will need to pay for. Use strictly as directed. Seretide is not for relief of acute symptoms. Always carry your reliever inhaler. Do not discontinue Seretide abruptly. Tell your doctor if you are taking any other medicines or herbal remedies; you have pulmonary tuberculosis (TB), a thyroid problem or a heart problem; or you are having treatment for high blood pressure; Side Effects may include: 'shaky' feeling; headache; fast heart rate; irritation in the nose and throat. If symptoms continue or you have side effects, see your doctor, pharmacist or health professional. For more information, see Seretide Consumer Medicine Information at www.medsafe.govt.nz. Normal doctor's office visit fees apply. Ask your doctor if Seretide is right for you. Seretide and Accuhaler are trade marks of the GlaxoSmithKline group of companies. Marketed by GlaxoSmithKline NZ Limited, Auckland. TAPS No. NA1502-06AU GLANZ0725



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