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Asthma Auckland Charity Golf Day 2009

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asthma NEW ZEALAND THE LUNG ASSOCIATION

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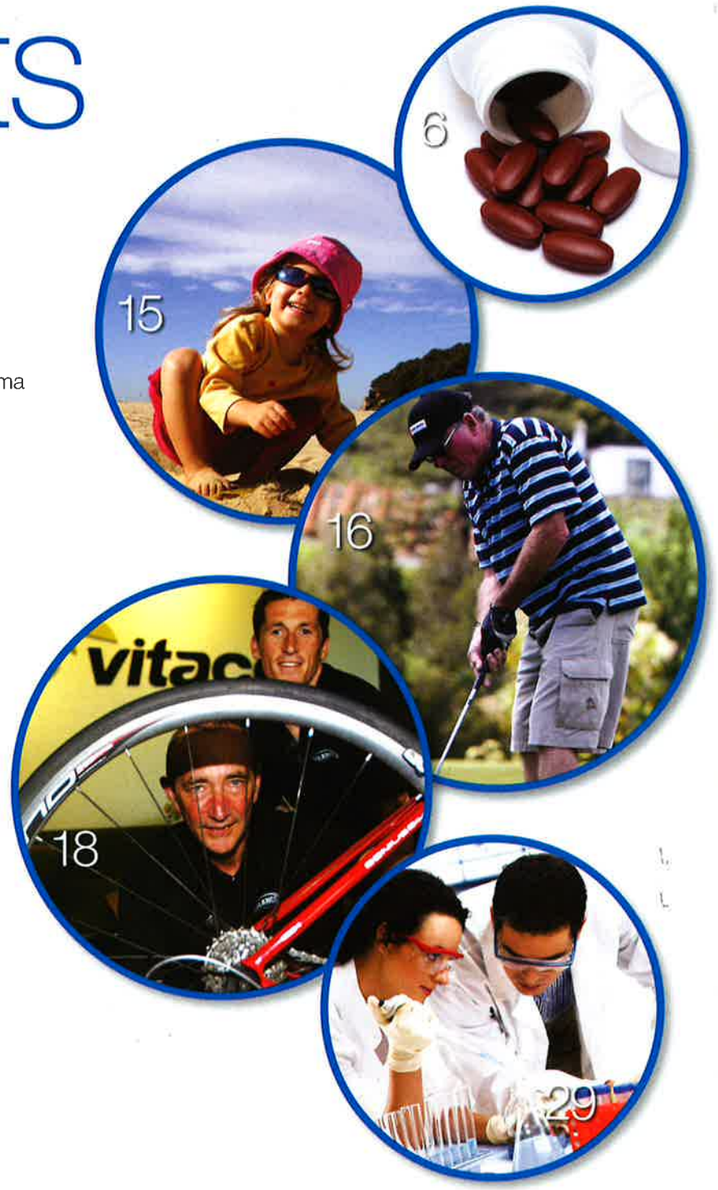
contents



on the cover:
An afternoon on the greens
… Asthma Auckland Charity Golf Day 2009
Photo by Steven Neville, ASP Photography.

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Unitec NEW ZEALAND
Te Whare Wānanga o Wairaka

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THE LUNG ASSOCIATION

Applications are now invited from registered nurses wanting to enrol in the Asthma New Zealand/Unitec Asthma Nursing Course for **February 2010** and COPD Nursing Course for **April 2010**. The programmes are offered by distance learning. The primary aim of the Asthma and COPD Nursing Courses are to provide nursing health professionals with a high level of evidence-based asthma and COPD knowledge that promotes best practice and is consistent with national policy.

Since the commencement of the Asthma and COPD Nursing Courses, 803 nurses have enrolled over 29 intakes. Many applicants had not undertaken any additional study since completing their nursing training, which may have been years before. However, most find the courses to be challenging but thoroughly enjoyable learning experience that is within the grasp of any competent nurse practitioner.

Asthma New Zealand in association with Unitec New Zealand offers these courses within the Bachelor of Nursing Programme. Asthma Nursing Course is a level 7 course and attracts 24 credits. COPD Nursing Course is a level 7 course with 12 credits. **A grant towards the cost is available for registered nurses.**

For an enrolment form for the 1st Semester please contact:

Ann or Swarna
Asthma New Zealand – the Lung Association
P O Box 67- 066, Mt Eden, Auckland 1349
Phone: 09 623 0236 - Ex 804
Fax: 09 623 0774

Email: annw@asthma-nz.org.nz or swarnah@asthma-nz.org.nz
The closing date for first Semester enrolment is
30 January 2010 for Asthma Nursing Course
15 March 2010 for COPD Nursing Course

Upcoming events and courses

1 DAY 'NEAT' ASTHMA COURSE FOR REGISTERED NURSES
3 March 2010
9 June 2010
8 September 2010

½ DAY COPD COURSE FOR REGISTERED NURSES
21 April 2010
21 July 2010
13 October 2010

Visit our Mobile Asthma Clinic for FREE Asthma Education at Bunnings stores between 10 and 2 as follows:

Saturday 13 March 2010	Christchurch
Sunday 14 March 2010	Nelson
Monday 15 March 2010	Wellington
Tuesday 16 March 2010	Palmerston North
Wednesday 17 March 2010	Wanganui
Thursday 18 March 2010	Taupo
Friday 19 March 2010	Rotorua
Saturday 20 March 2010	Hamilton
Sunday 21 March 2010	Auckland

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ONE MAN, ONE ROAD, ONE CYCLE
13-21 March 2010

Further enquiries for any of these events phone
09 630 2293

Message to Readers

Dear Readers

The rather bleak winter and spring did little for children and adults with asthma or COPD. October was the coldest October since 1945. This year has seen a massive increase in referrals from hospitals, GPs, and the community. To assist meeting the needs of the asthma family a further Asthma Nurse Educator was employed, bringing the total to five Asthma Nurse Educators for the Auckland region. The "3-Plus Plan" involves at least three visits to the family home to ensure that the education provided is effective.

I would like to thank the "asthma team" of Asthma Auckland for their commitment throughout the year. They work extremely hard to improve the quality of life for children and adults with asthma throughout the Auckland region.

I would also like to express my appreciation to the Asthma Auckland Board for their support throughout the year.

Asthma New Zealand – the Lung Association (Inc) continues to provide quality education courses for Asthma and COPD through the Unitec Institute of Technology, Auckland; over 850 nurses have tertiary qualifications in Asthma/COPD throughout New Zealand. I thank them for their commitment on behalf of their patients with asthma and COPD.

Asthma New Zealand faces many challenges next year with the commitment to developing a "branch-based" system across New Zealand. However, if we work together, we can achieve success.

I wish you all a very happy Christmas and New Year. I trust you will return revitalised for the challenges ahead.

Gerry A. Hanna
Executive Director
Asthma New Zealand – the Lung Association (Inc)

CAM Use and Vitamins/Supplements for asthma

Dr Shaun Holt & Iona MacDonald

Shaun Holt

Shaun holds Pharmacy and Medicine degrees, has been the Principal Investigator in over 50 clinical trials and has over 75 publications in the medical literature. He is an Honorary Research Fellow at Medical Research Institute of New Zealand, an Advisor to the Asthma & Respiratory Foundation of New Zealand, an Advisor to Natural Products NZ and a regular contributor on TVOne's Breakfast programme and national radio shows. His 2008 book Natural Remedies That Really Work was a bestseller.

Iona MacDonald

Iona is a medical writer for Research Review (New Zealand and Australia) and CardioPulse (European Heart Journal), with an avid interest in the interface between contemporary Western medicine, scientific research and CAM.

Use of CAM by patients with asthma

Increasingly, patients report the use of complementary and alternative medicine (CAM) therapies such as herbal therapy, acupuncture, yoga, chiropractic, relaxation techniques, nutrition and dietary supplements, in the management of their asthma. National surveys over the last decade have confirmed this trend across all age groups. In 1998, nearly 60% of 3837 members of the UK National Asthma Campaign reported that they had used CAM for asthma; 11% of therapies were herbal-based. Nearly 70% of never-users claimed they would consider using CAM in future. The extent of CAM use was 80% among US adolescents with asthma sampled in 2002; 21% of them reported using CAM instead of prescribed medications. The most commonly used CAMs included herbal teas (39%), a herbal preparation called Jarabe 7 syrup, comprising a mixture of sweet almond oil, castor oil, tolu, wild cherry, licorice, cocillana and honey (24%), and foods (24%).

Of 802 adults treated for asthma in primary care in Singapore during 2003, almost 30% reported using CAM in the past year. Animal food products were used by 12% of patients and herbs by 10%. Chinese proprietary medicines, which are herbal-based products formulated as tablets or capsules, but sometimes containing Western prescription medicines such as steroids or antibiotics, were used by 3%. The list of animal food products used as traditional remedies for asthma included crocodile meat, fruit bat, camel heart, lamb or goat, snake, frog, monkey, bird's nest, horse, tiger, turtle, mice, iguana, rabbit, dog, blackskinned chicken, eel, fish roe, fish oil and cockroach. The common Chinese herbs used included Ma Huang, Cordycep, Ling Zhi, Ginseng, Herba Ajugae, Semen Armeniacae Amarum, Radix Glycyrrhizae, Vitex cannabifolia, Radix Codonopsis, Pinellia Tuber and Radix Atractylodis Macrocephalae. Other medicinal plants used included aloe vera and ginger.

A literature review in 2006 reported levels of CAM use for asthma ranging from 4–79% for adults and from 33–89% for children, with as many as 20–30% of adults and 50–60% of children with asthma using CAM at any one time. The most commonly used forms of CAM reported by adults with asthma included herbal remedies, homeopathy and naturopathy, animal food products, diet therapy, vitamins and minerals, teas and honey. During 2002, a 3-month survey of 174 Australian children receiving conventional care for asthma revealed that 90 (52%) of the children had ever supplemented conventional care with alternative measures, most commonly consisting of vitamins and minerals (53%) and herbal preparations (29%).

A brief overview below summarises vitamins and supplements that have evidence to support their use in people with asthma.

Omega-3

The impact of a medical food containing gammalinolenic and eicosapentaenoic acids on asthma management and the quality of life of adult asthma patients. Surette ME et al.
Curr Med Res Opin. 2008;24:559-67
http://www.ncbi.nlm.nih.gov/pubmed/18194593
Asthmatic adult subjects consuming a medical food emulsion containing the essential fatty acids gammalinolenic and epicosapentaenoic acids reported improved quality of life and decreased reliance on rescue medication after 4 weeks' treatment.

Low dietary nutrient intakes and respiratory health in adolescents. Burns JS et al.
Chest. 2007;132:238-45
http://www.ncbi.nlm.nih.gov/pubmed/17475634
Adolescents with low dietary intakes of omega-3 fatty acids had decreased respiratory symptoms (asthma, wheeze, chronic bronchitis symptoms) and increased pulmonary function.

Fat and fish intake and asthma in Japanese women: baseline data from the Osaka Maternal and Child Health Study. Miyamoto S et al.
Int J Tuberc Lung Dis. 2007;11:103-9.
http://www.ncbi.nlm.nih.gov/pubmed/17475634
In this study involving 1002 pregnant Japanese women, fish consumption was independently associated with a decreased prevalence of asthma after age 18 years and current asthma.

Antioxidants

Ascorbic acid supplementation attenuates exercise-induced bronchoconstriction in patients with asthma. Tecklenburg SL et al.
Respir Med. 2007;101:1770-8.
http://www.ncbi.nlm.nih.gov/pubmed/17412579
Two weeks of ascorbic acid supplementation (1500 mg/day) significantly modified the bronchoconstrictor response to exercise in asthmatic subjects and significantly improved asthma symptoms scores.

Coenzyme Q10 supplementation reduces corticosteroids dosage in patients with bronchial asthma. Gvozdjáková A et al.
Biofactors. 2005;25:235-40.
http://www.ncbi.nlm.nih.gov/pubmed/16873952
Antioxidant supplementation consisting of coenzyme Q10 as Q-Gel (120 mg) with 400 mg alpha-tocopherol and 250 mg vitamin C a day for 16 weeks reduced the dosage of corticosteroids in corticosteroid-dependent bronchial asthma patients

Vitamin C

Ascorbic acid supplementation attenuates exercise-induced bronchoconstriction in patients with asthma. Tecklenburg SL et al.
Respir Med. 2007; 101:1770-8.
http://www.ncbi.nlm.nih.gov/pubmed/16873952
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Gvozdjáková A et al. *Biofactors. 2005;25:235-40.*
Antioxidant supplementation consisting of coenzyme Q10 as Q-Gel (120 mg) with 400 mg alpha-tocopherol and 250 mg vitamin C a day for 16 weeks reduced the dosage of corticosteroids in corticosteroid-dependent bronchial asthma patients

Pycnogenol

Pycnogenol as an adjunct in the management of childhood asthma.
Lau BH et al.
J Asthma. 2004;41:825-32.
http://www.ncbi.nlm.nih.gov/pubmed/15641632
Compared with placebo, three months' treatment with Pycnogenol (a proprietary mixture of water-soluble bioflavonoids extracted from French maritime pine) in children and teenagers (aged 6-18 years) with mild-to-moderate asthma resulted in significantly greater improvement in pulmonary functions and asthma symptoms. The Pycnogenol group was also able to reduce or discontinue their use of rescue inhalers more often than the placebo group.

Pycnogenol® in the management of asthma.
Hosseini S et al.
J Med Food. 2001; 4:201-9.
http://www.ncbi.nlm.nih.gov/pubmed/15641632
Patients with varying asthma severity treated with Pycnogenol 1 mg/lb/day (maximum 200 mg/day) for 4 weeks experienced significant reductions in serum leukotrienes (naturally produced substances that promote asthma symptoms).

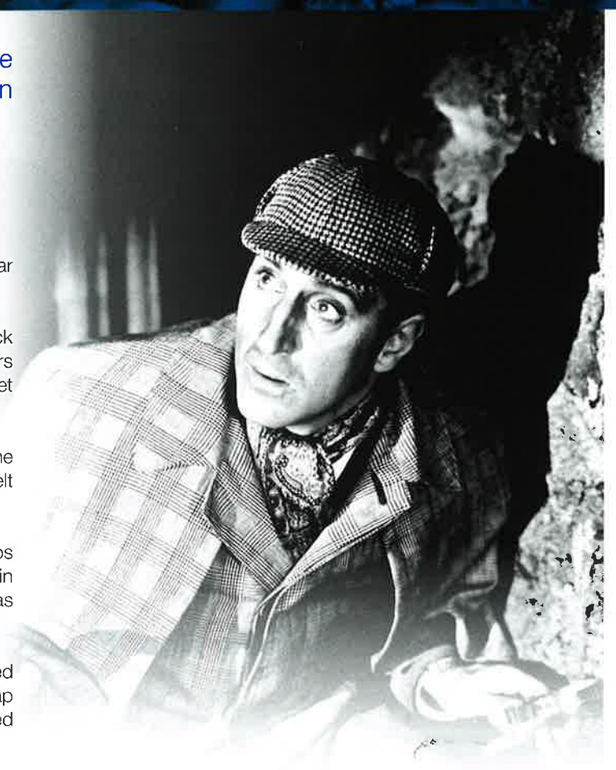
Magnesium

The role of magnesium sulfate in the acute and chronic management of asthma.
Rowe BH and Carmago CA Jr.
Curr Opin Pulm Med. 2008; 14:70-6.
http://www.ncbi.nlm.nih.gov/pubmed/15641632
In this review, substantial evidence suggests that intravenous magnesium sulfate is beneficial in the treatment of acute asthma in the emergency department, while a single bolus dose of intravenous magnesium sulphate reduces admissions and improves pulmonary functions in severe asthma exacerbations.

Oral magnesium supplementation in asthmatic children: a double-blind randomised placebo-controlled trial.
Gontijo-Amaral C et al.
Eur J Clin Nutr. 2007;61:54-60.
http:/www.ncbi.nlm.nih.gov/pubmed/16788707
Oral magnesium supplementation (300 mg/day for 2 months) reduced bronchial reactivity to methacholine, diminished allergen-induced skin responses and provided better symptom control in paediatric patients with moderate persistent asthma treated with inhaled fluticasone.

A meta-analysis on intravenous magnesium sulphate for treating acute asthma.
Cheuk DK.
Arch Dis Child. 2005;90:74-7.
http:/www.ncbi.nlm.nih.gov/pubmed/15613519
This meta-analysis of clinical trials demonstrates that intravenous magnesium sulphate provided additional benefit in moderate to severe acute asthma in children treated with bronchodilators and steroids.

Coroners report: "Cause of Death..."



Detective Sal Butamol sighed and picked up the phone receiver from his cluttered desk – the phone had been ringing incessantly for the last five minutes.

"Sal here...what is it now?"

"We got another one, Detective, down on precinct 9!"

'That's 5 this week!' Thought Sal – "I'll be right there – have the car wait for me at the entrance."

Sal pulled himself to his feet, grabbed his grey fedora hat and black long-coat and left his office heading towards the stairs (the elevators were broken again) – 'and here I am thinking it was going to be a quiet night', groaned Sal under his breath.

Slightly out of breath, and heavily overweight, Sal threw himself into the back of the squad car, closed the door, and scrambled for the seat belt as the car, sirens screaming, lurched out of the station car park.

There had been increasing numbers of them lately, poor Joe Soaps and Jane Does, always found alone in the same circumstances, in all districts, Sal suspected the same assailant in all cases – it was always the same weapon.

The street lights formed a kaleidoscopic blur through the rain streaked windows of the squad car they were passing through the cheap districts, now entering the middle class suburbs – the car crunched to a halt, like a cheap cigarette being ground into an ashtray.

'Here we go,' – thought Sal – the door of the car was grabbed open by an earnest faced officer – "first floor sir – it's not a pretty sight".

Barely glancing at the hastily manicured lawns and sparsely planted flower beds, Sal walked up to the yawning doorway of the modest detached house, threaded his way through the white suited forensic team busily photographing the crime scene and stepped up the staircase to the first floor, his jacket flapping and catching at the frozen smiles of the family pictures on the walls.

Always the same, he knew what to expect, it was like some bizarre repeated television soap, different actors and the same twisted script.

The body of the young man lay diagonally across the single bed, its face frozen into a look of surprise and despair, the telephone receiver still hanging limply in its right hand.

The operator had alerted the police to the crime whilst it was in progress, the assailant had set about business as usual, the victim was left struggling for breath, unable to finish his last sentence, a scream turned to a whispering wheeze – then, silence.

"Detective!" – a voice behind him startled Sal from his reverie of the waxwork tableau before him.

"We have looked everywhere sir, no sign of an adult action plan, no preventer either, just drawers of empty reliever inhalers."

Sal shook his head and idly picked at a fragment of bagel caught between his teeth.

"When will they ever learn?"

"What shall we put down as cause of death, detective?"

"Same as always, son," replied Sal, "Cause of death – complacency".

Sal turned on his heel, noting out the corner of his eye, the tell tale of the empty blue reliever puffer still gripped tightly in the victims cyanosed left hand.

'Now' – thought Sal – 'where was that coffee and donut shop he had spotted on the way over?'

(A true story from Bronchopolis – names have been changed to protect the ignorant).

There is no excuse for ignorance and complacency when it comes to asthma control – yet people suffer from daily assaults and accept it as part of daily life – we would not accept to be mugged every day on our way into work.

Do you have an action management plan?

Shouldn't you be taking your preventer twice daily?

When was the last time your doctor reviewed your asthma?

How much reliever are you using weekly?

David Halewood RN.
Asthma Nurse Educator.

Asthma and Pregnancy

Compiled by Ann Wheat

Asthma is a condition that has periods of wellness interspersed with periods of acute symptoms of breathlessness, wheeze, shortness of breath and cough. In pregnancy, asthma is an important condition that can affect not only the pregnant woman with asthma but can have devastating effects on the developing unborn child. Poorly controlled asthma can lead to perinatal mortality, preeclampsia, preterm birth and low birth weight infants (National Heart, Lung, and Blood Institute, (NHLBI), 2004). It is therefore essential that asthma is kept under excellent control before, during and after pregnancy.

Pre Pregnancy

The most important time to be aware of asthma control is before a woman becomes pregnant. If they have control prior to pregnancy or in the early stages of pregnancy, it is a good indicator of what kind of control they can expect during pregnancy (Kennedy, 2009). Asthma control should be discussed with the doctor if a woman is considering becoming pregnant and education given so that they are aware of what is required to keep not only themselves but their baby healthy. If asthma is well controlled during pregnancy there should be no problems with pregnancy or delivery. It is important to know that pregnancy itself can affect asthma in that one third of pregnant women will improve, one third will remain the same and one third will have deterioration of their asthma control but should return to pre-pregnancy state within three months of delivery (Prasad & Samuels, 2008; Becroft, Cochrane & Milburn, 1998). On the other hand asthma can also affect the pregnancy as stated above. The worst time for an acute asthma episode is between weeks 24 – 36 although acute episodes are rare during delivery (Kenney, 2009; British Thoracic Society & Scottish Intercollegiate Guidelines Network (SIGN, 2009). It has also been identified, that the sex of the unborn child can affect asthma episodes during pregnancy with female foetuses causing increased severity and male foetuses improving symptoms of asthma (Prasad & Samuels, 2008, Bakhireva, Schatz, Jones et al, 2008).

Management during Pregnancy

As the pregnant woman is providing oxygen for the unborn child via the placenta it is essential to maintain normal oxygen levels during pregnancy which means that asthma control has to be paramount.

Medication is the mainstay of asthma treatment. This is not only true for the non-pregnant woman but also for the pregnant woman. Many women worry about the consequences of medication on their unborn child but there is now a lot of well documented literature that covers the safety aspects of medications used in asthma treatment today (Kennedy, 2009; SIGN, 2009). It is essential though that medication use is monitored carefully during pregnancy especially if drugs such as Theophylline are used (SIGN, 2009). All medications should be continued throughout pregnancy and post partum even if breast feeding. These should be at the lowest level to maintain good control (NHLBI, 2004; Prasad & Samuels, 2008). It is also essential that inhaler technique is assessed and corrected to ensure that medications are being used correctly. Incorrect use of inhalers reduces the amount of medication that reaches the lungs and therefore can reduce asthma control. Use of spacers are a great way to increase the control of asthma as it increases the amount of medication received in the lungs and are much easier to use than a MDI alone. It has been stated that the amount of increase in medication reaching the lungs is 50% higher when using a spacer.

Asthma Action Plans should be given to every woman who is pregnant so that they know what to do if they have an acute episode of asthma and how much medication they can take safely. These should be individualized by the woman knowing what her personal best peak flow should be. It is worth noting that peak flows will decrease by as much as 0.65 l/min per week with advancing pregnancy (Prasad & Samuels, 2008). A personal best peak flow is reached by obtaining peak flow reading twice a day for three weeks and taking the highest of those readings.

Other Considerations during Pregnancy

It is also important to identify and control any factors that could have an adverse effect on asthma control. This includes allergens such as dust mites, animal dander and irritants such as tobacco smoke, perfumes and pollution so as to improve maternal well-being which may in fact lead to lower medication requirements (NHLBI, 2004). Asthma education can play an important part in helping a pregnant woman with asthma management during pregnancy so that they are aware of how to reduce triggers, assist with self monitoring of asthma both by symptoms and peak flows, ensure correct use of devices such as metered dose inhalers and spacers, how to handle worsening signs of asthma by having an action plan and may help overcome barriers and fears in adherence with use of medications.

Following Delivery

Again this is a time that medication dose needs to be monitored carefully as asthma control can change following delivery (Canadian Lung Association, 2009). It is also important that asthma is managed well due to tiredness and even the possibility of post natal depression which could all play a part in its management.

Breast feeding is safe for both mum and baby. Asthma medications do not seem to cause any side effects to the baby with the exception of Theophylline or antihistamines which can cause irritability and sleepiness (Rey & Boulet, 2007).

Conclusion

Pregnancy is a happy time for most women. For women with asthma it should also be a time of joy especially if asthma is managed well. It is important to see health care professionals regularly to ensure that asthma management is optimal and as a result there should be happy endings with the delivery of a healthy baby

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Beecroft, N., Cochrane, G.M. & Milburn, H.J. (1998). Effect of sex of fetus on asthma during pregnancy: blind prospective study. BJM. 317: 856-857 http://www.bmj.com/cgi/content/short/317/7162/856

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Rey, E. & Boulet L-P. (2007). Pregnancy Plus: Asthma in Pregnancy. British Medical Journal. http://www.bmj.com/cgi/reprint/334/7593/582

The winner of the clear jug competition is:
Anne Toft – Wellington

CLEAR$_2$O

Congratulations

Heartiest Congratulations on successfully completing Asthma Nursing Course 2009 – 1st semester

1. Alosi Tangi – Auckland
2. Sally Levie – Timaru
3. Anne Waugh – Napier
4. Eileen Quilty – Auckland
5. Luisa Qeisere – Auckland
6. Heather Thompson – Invercargill
7. Kay Harrington – Christchurch
8. Yvonne Sant – Kaitaia
9. Maree Lee – Palmerston North
10. Helen Markham – Queenstown
11. Patricia Williams – Auckland
12. Julie Price – Napier
13. Ruby Sekhon – Auckland
14. Robyn Kitchen – Upper Hutt

Chronic Obstructive Pulmonary Dieses Nursing Course 2009

1. Dianne Rosemary Webb – Chatswood
2. Julie Price –Te Awa
3. Santa Sahayam – Te Atatu Peninsula
4. Helen Cleary – Papakura
5. Jean Margaret Weary – Nelson
6. Agustilia Rodrigues – Johnsonville
7. Janice Ann Norman – Whakatane
8. Susan James – Kaiti

Bronchiectasis

Compiled by Elaine Murray RN

Rene` Laennec, inventor of the stethoscope first described Bronchiectasis in 1819 while observing patients with Tuberculosis and the sequelae of pneumonia in the pre antibiotic era. The term Bronchiectasis is derived from the Greek bronchion, meaning wind pipe and ektasis-meaning stretched.

Bronchiectasis is characterised by the dilation of bronchi with destruction of the elastic and muscular components of their walls. Also the tiny hairs called cilia have become damaged or destroyed. The cilia not only filter dust, germs and airborne pollens in the nose, but assist in the clearance of phlegm and mucous from the airways.

Due to the dilation and elasticity of the bronchial wall small pouches develop where the mucous can accumulate and act as a breeding ground for bacteria. With repeated infections the bronchial walls become chronically inflamed. This leads to a cycle of inflammation, infection and air way damage. Digital clubbing is reported in 30-50% of patients.

Bronchiectasis can develop at any age but begins often in childhood. It may be present at birth. Often developing gradually, symptoms of Bronchiectasis may not appear for months or years after the predisposing event that caused the Bronchiectasis to occur in the first place e.g. a child hood illness or disease such as pneumonia, measles, influenza or tuberculosis.

Bronchiectasis should be suspected in children with a recurrent bronchitis or pneumonia and when despite treatment symptoms persist.

Some common causes are:

- Severe pneumonia
- Measles, tuberculosis, pertussis
- Obstruction by foreign body or mass
- Chronic aspiration e.g. gastro esophageal reflux
- Congenital e.g. cystic fibrosis, ciliary dyskinesia
- Connective tissue disorder
- Allergic bronchopulmonary aspergillosis
- HIV

Smoking is not a significant cause of Bronchiectasis, in fact many patients with the condition have never smoked, but smoke is a major irritant to the lungs and will seriously aggravate the condition.

Doctors may suspect Bronchiectasis because of presenting symptoms but CT scan is the most sensitive test to identify and confirm the diagnosis and to determine the extent and severity of the disease. Bronchiectasis may affect a large area of the lung or it may only be in one or two smaller areas.

The main symptom of patients with Bronchiectasis is the chronic cough that is with them every day producing copious amounts of sputum. This can be very embarrassing for a lot of the patients as the cough often occurs at the most inappropriate time. The cough may be worse in the mornings and is often brought on by a change of posture.

Some of the sputum can be very odorous due to the chronic infection present. About one in three people also have chronic sinusitis which may cause loss of smell and taste.

Although chronic infection is present most of the time the patient is usually well but is prone to getting worse infections very easily, therefore they need to be aware of the first signs of worsening symptoms such as fever, chest pain and the change in the colour and amount of the sputum and to start treatment earlier than later i.e. the appropriate antibiotic to prevent further complications and to do regular postural drainage to assist in the coughing up of the sputum.

Fatigue, weight loss, shortness of breath and abnormal chest sounds can also occur. In more advanced Bronchiectasis the patient may also cough up blood.

Early identification and treatment of the conditions that tend to cause Bronchiectasis may prevent its development or reduce the severity. The incidence of Bronchiectasis declined after the introduction of immunisation and antibiotics. The prevalence is highest among persons in lower socioeconomic groups. Bronchiectasis is an important cause of morbidity in underdeveloped countries, it's incidence has diminished in developed countries but is still an important cause of morbidity, especially in children.

Hospital admissions for Bronchiectasis have increased dramatically in New Zealand during the past decade but deaths have declined. Hospital admissions were higher for those living in the most deprived areas and for Pacific and Maori and young people. In Counties Manukau during 1990-2004, hospital admissions for Bronchiectasis amongst children and young people also greatly increased, with rates being much higher than the New Zealand average, but it remains unclear if it represents an increase in the disease, an increase in access to hospitalisation, a change in the reporting in the A&E Dept. or the increase in the use of CT Scanning to accurately diagnose Broncheictasis.

Total daily sputum production has been used to characterise severity of Bronchiectasis, i.e. 10 mls of sputum-mild, 10-150mls of sputum-moderate and 150mls as severe. Many patients with mild Bronchiectasis may have no symptoms.

For patients living with Bronchiectasis they need to take steps to ensure they have a healthy diet and to be as physically active as possible. Activities, such as walking and swimming can help loosen the mucous so it can be coughed up.

It is important to stay well hydrated. Drink plenty of fluid, especially water, which helps to prevent the mucous from becoming too thick and sticky. The patient needs to take steps to protect themselves from further air way damage by avoiding contact with anyone with a cold or flu and from inhaling irritants such as smoking and second hand smoke, silica dust, and air pollution. If they do smoke patients must talk to their Doctor about programmes and products available to help them quit. They also need to have the annual influenza vaccination and the pneumococcal vaccine every five years. A major improvement in housing, nutrition and education in the lower socioeconomic group is also needed to prevent Bronchiectasis from developing in the first place and to keep these patients well after a diagnosis has been made.

For the most part, Bronchiectasis starts from damage to the lungs that is not necessarily ongoing or progressive. Although patients with Bronchiectasis sometimes fear that in the long term they will become quite debilitated, this is not necessarily the case, the majority of patients will remain stable for many years.

Prognosis for patients with Bronchiectasis depends on how well infections and other complications are prevented or controlled. Daily postural drainage, judicious use of antibiotics, with a back up of appropriate medical care can prevent most complications and allow these patients to live a relatively normal life.

References;

"The Health Status of Children and Young People in Counties Manukau", Counties Manukua DHB 2005.
Asthma and Respiratory Foundation of New Zealand; Bronchiectasis.
Bronchiectasis; Lung and Airways Disorders: Merck Manual Home Edition

How to clean your spacer...

Remember to wash your Spacer once a week.

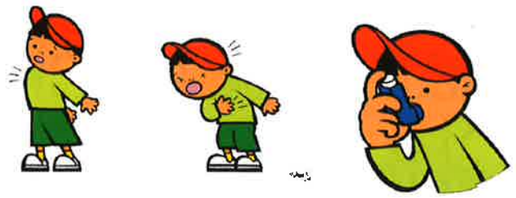
If the valve is sticky and needs washing, the spacer is not as effective and you obtain less medicine. In order to obtain maximum benefit from your spacer, you need to keep the spacer clean and primed. Always wash a new spacer as follows to prime it ready for use. If your spacer is used only occasionally, it will need priming again before use.

In an Emergency, you can quickly prime a rarely used spacer with 10 puffs of a blue inhaler.

1	**Take Apart** Take the spacer apart and undo all the removable parts.
2	**Wash** Gently move the parts back and forth in warm water using mild dish wash detergent to remove germs and medicine build-up. A soft cloth can be used but do not use brush or scrub it.
3	**Do Not Rinse** The detergent film left on the sides of the spacer when you do not rinse it, helps to reduce static.
4	**Let Your Spacer Drip Dry** Drip Dry overnight. Do not dry the inside of the spacer with a towel as it will re-introduce static. Static attracts the small medication particles to the spacer walls, thus preventing you obtaining the correct dose of medicine.
5	**Put Together Again** NB: If using a spacer with a removable rubber valve (e.g. Breath-a-Tech or Fisonair Spacer) ensure the valve remains flat when refitted to the spacer.
6	**Check for Cracks or Faulty Valves** Check the spacer and replace it when necessary, or every 6-12 months if used regularly.
7	**Store** Keep dust-free. Store in a bag (not plastic).

Kid's Page

The little boy is having an asthma attack



Can you name all the triggers...

F__d

S_____g

M__ld

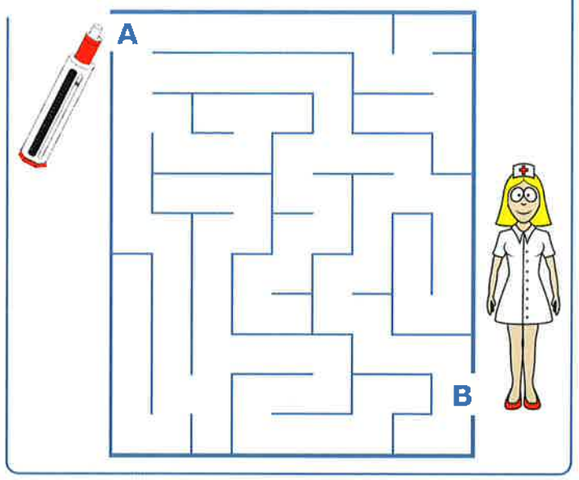
F_____s

Po__en

Ani___s

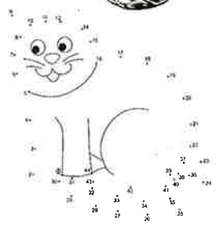
D___m__e

Please help our Asthma Nurse find the Peak Flow Metre.



Colour me in!

Dot to Dot



The † CROSS † of coins

Move just two of the coins from their positions below in order to create a cross of equal length and height, containing all the coins.

The solution here involves placing one coin on top of the middle coin. Many people find this puzzle hard because they assume that all the coins have to placed side by side.

North & South
NEWS FROM AROUND THE REGIONS ...

Asthma Auckland Charity Golf Day 2009

in association with

Redwood Park Golf Club Inc.

An afternoon on the greens...

Asthma Auckland held their second annual golf day on 6th November at Redwood Park Golf Club Inc., Swanson and what a fantastic day it was; the sun was shining and again it was the only sunny day that week so we were incredibly lucky but then I wouldn't have had it any other way! A big "Thank You" to Fujitsu General for their sponsorship of the day and also the long list of companies who donated both money and prizes for the day, what would we do without companies like them prepared to go the extra mile to help out and make the day a successful one? Our shotgun start Stableford tournament got off to a great start with a sausage sizzle before sending the golfers, and those not so golf minded, out onto the course. Everyone was in great spirits and those involved made this fundraiser a fabulous fun filled day for everyone.

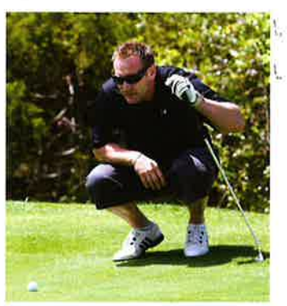
There were some interesting results but it was John Fellowes who took out first prize with an individual Stableford of 42, well done John.

The day came to a close with dinner, drinks and prize giving with everyone going home with something and by all accounts the day was a huge success raising some much needed revenue for Asthma Auckland.

Fundraising isn't an individual pursuit and although the day went very well none of it would be possible without the help of our tireless volunteers and Asthma Auckland wishes to thank Vicki Currie, Jan MacFarlane and Michaela MacFarlane for their time, we would also like to thank the staff of Redwood Park Golf Club for their support in making this day a successful one. We hope to continue this annual event so keep your calendars clear next November, I'll be in touch!

Thank you...
Linda Thompson
PR/Fundraising Manager

Winner – John Fellowes



One man, one road, one cycle

In December 2008, if you had told me that I was going to ride a Bike from Christchurch to Auckland, I would have said that you were mad. After all, I have been a runner and a jogger since 1972, and considered anybody who rode a bike as a bit of a sissy. I had done a marathon or two in the 1970s and 80s and was ok if not particularly spectacular, but had always jogged to keep fit.

In late 2007, I felt twinges of pain in my knees, and an ankle was also starting to feel a bit sensitive. I took the decision to stop jogging, buy a bike and give riding a go. After all it's a pastime which doesn't place high impact stresses on the joints, but gets the heart beating and the blood flowing. I hated it!! After a ride I would want to go for a run. It did not seem to be fun, what with having to find routes which seemed to go forever, bumpy roads and incredibly sore backside, I had to ask if it was worth it.

A colleague at work told me about her father who was 85 and who had been almost chair bound. He started on a course of Glucosamine, which within 3 months had him up and about and running up the stairs. That was good enough for me, and I bought a course. Three months later I decided to go for gentle jog and miraculously, it was completely pain free. I had been riding the cursed bike for all of this time and I kept it up as I gradually increased the days I was jogging and decreased the days riding. In about 3 weeks I found that I was not riding at all. The bike was pulleyed up into the roof and there it stayed. Yahoo, free again! No more sore butt: on its own a sufficient reason not to ride. But coupled with the fact that it can be done anywhere, needs only a pair of shorts, a T shirt and a pair of sneakers was irresistible to me; No helmet, no gloves, no windproofs, no waterproofs.

In March 2008 my wife Anita and I went to Christchurch to do the City to Surf run with my daughter, niece and her husband. It was great fun and after the run and over a beer, Kim my niece told us she wanted a bike. Whacko, I thought, an opportunity to get rid of the cursed bike. We could freight it down, and there you go a win win situation. However there was a problem, after a couple of beers, my family like an argument – how were we to get the bike to Christchurch? No airline would take it, no courier company would take it, accompanied baggage? Might as well buy a new one in Christchurch. Remember, as you well know, after three beers, a bloke is invincible. No sweat – I'll take a week off work and ride it down.

Anita said that if I was going to do that we should rattle a bucket and try to raise some money for Asthma; In January this year, my great nephew, Sean Hedley, the grandson of my late brother had an exacerbation of asthma which claimed his life. Sean, aged 9, had a life in front of him and his death was devastating to his family. In 2009, to have a young boy die from an asthma episode seemed incomprehensible to me. I have never suffered from this scourge which affects a quarter of the population of New Zealand, and his death triggered some degree of guilt in me for being healthy and reasonably fit at my age. When Anita suggested trying to use the ride to raise Asthma awareness, I was an enthusiastic convert.

Obviously it was necessary to ask the permission of the Asthma Society

North & South
NEWS FROM AROUND THE REGIONS ...

to raise money on their behalf, so heart in mouth. I picked up the phone and called. The lady who answered couldn't help, but put me through to the person who looks after fundraising for Asthma New Zealand. I had no idea what an upheaval that call was going to have on my life. Linda Thompson immediately took over the ride and my life. The ride was to be from Christchurch to Auckland, it would take 9 days – no more no less, it would start from Cathedral Square on Saturday, and end in a well known destination in Auckland the following Sunday.

Linda immediately took control! The bike which I had thought I could use, was completely unsuitable; it was a $500 job with 21 gears and would do no more than about 30kmh flat out – very suitable for city riding, but no good for doing 120km a day. Coincidentally, I took it for a 100km ride a little later, and it was a nightmare, but more of that later. Linda informed me that I was going to have a proper bike, I was going to do this properly and Asthma New Zealand was going to build an Asthma Awareness Campaign to run at the same time as the ride. She was also going to build a fundraising campaign and she expected me to get fit.

The first thing Linda did was organise a very generous sponsorship from Bike Barn; a fabulous road bike unlike anything I had ever ridden before. Not only that but the proper clip in shoes, spare tyres, tubes, tyre pump (for the numerically minded, the tyres have to be pumped up to 100psi) bike pants and T-shirts. Having not ridden the other hated bike for about 9 months, I had to start again. Terrified at being clipped to the bike, I set off for the first ride from Mangawhai to Kaiwaka 28km round trip. The road is winding and hilly. After what seemed at the time to be a long about 4 km, uphill, grind I reached the top of the first hill. Going down the other side was amazing!!! The bike just seemed to take over. Up to 60kmh and if I had the courage I could have gone faster.

Since then, with the support of Anita my adoring wife and Linda my slave driver, I have embarked on longer and longer rides. My Facebook page chronicles the rides with some very exciting rides notably one from Rotorua to The Bay of Plenty in the rain with huge logging trucks passing at 100kmh and spitting vast quantities of spray and woodchips, and another around Hawke's Bay; the first ride with other people.

In the meantime other generous sponsors have come on board, with nutritional supplements from Balance, Bunnings have offered the use of their premises during the ride for the use of the Mobile Asthma Clinic to provide FREE Asthma education throughout New Zealand.

In the last 6 months I have gone from a dedicated bike sceptic to a convert of the two wheeled mode of transport. I have taken to riding from Parnell to Manukau City and back two or three time a week to work. I love the rides through the beautiful countryside notwithstanding the fact that my behind starts to get a bit sore after about 80km. The Aussies may claim to live in the lucky country. Believe me they are wrong – WE live in the luckiest greenest country in the world.

Please support us during this campaign 13-21 March and help raise awareness and funds for Asthma – Asthma doesn't have to be a killer but it is!

Family Guide to Asthma

First Sovereign
www.firstsovereign.co.nz

gsk GlaxoSmithKline

It was great to finally receive our copies of a Family Guide to Asthma and as a large proportion of the funding for these books was from First Sovereign Trust it was decided the first copies should be given to schools in the Bay of Plenty. I met up with Rotorua Asthma Educator Rita Nieuwoudt and Taupo Asthma Educator Annette Thomas and spent two days visting schools in the area giving free copies of this great resource out. The book was well received and we have been receiving both repeat and new orders since.

Thanks to First Sovereign Trust and GSK for their generous and continued support of Asthma in New Zealand.

Linda Thompson
PR / Fundraising Manager
Asthma New Zealand

Annette with Tauhara Primary School Secretary Lorna Pettigrew

Annette Thomas with Mt View Primary School Secretary Lynette Braithwaite

Asthma NZ PR Fundraising Manager Linda Thompson with Rotorua Asthma Life Member Peter Ludgate


Aorangi School Deputy Principal and School Secretary

Beryl Arnott of John Paul College with Rotorua Asthma Educator Rita Nieuwoudt

Jane, one of the school nurses, Lakes High School

Rotorua Girls High School nurse Shirley Tricklepenny

Val Honeyfield, Deputy Principal, Kawaha Point School

Asthma educator Annette Thomas with Wairaki Primary Deputy Principal Marie Woolnough

North & South
NEWS FROM AROUND THE REGIONS ...

ASG Parent and Child Show – Auckland

The Parent and Child Show was held over 3 days in Auckland allowing families to access asthma services and education at our stand. Education consisted of asthma management during pregnancy through all ages and stages of childhood and into adult life.

The stand was well attended and it was evident that education is the key to enable and empower people with asthma to self-manage their chronic condition.

Being able to see dust-mites via a power-point display held the interest of many of our visitors.

BNZ – Closed for Good!

bnz

Closed for Good is a unique way for New Zealand communities to get free help with projects. On Wednesday November 4th BNZ closed all stores and most support offices – "for good". On that day the staff weren't working for the BNZ, they were working for the community and Asthma Auckland benefited from this and were lucky enough to have smiley faced Carolyn Butland and Katharine Shanahan working with us for the day. They are a credit to the BNZ and we would like to thank them for choosing us!

Linda Thompson
PR / Fundraising Manager

North & South

NEWS FROM AROUND THE REGIONS ...

Hi Fellow Wellingtonians

Wellington Regional Asthma Society (Inc)

At our Special General Meeting in April 2009 it was agreed in principle that the Society would become a branch of Asthma New Zealand.

The background to the Special General Meeting was that the Society had been running a monthly deficit of around $10,000 which led to the depletion of virtually all the Society's reserves.

At the time your Management Committee was addressing the future of the Society it (along with other Societies) received an invitation to become a branch of Asthma New Zealand. The invitation was investigated by your Committee before it was accepted in principle by the Special General Meeting.

Since then Asthma New Zealand has assisted the Society in securing additional funding and has taken over our contract with the Capital Coast DHB. In essence this means a major change in how the Society will operate in future because while our legal name is still the Wellington Regional Asthma Society Inc. we will be trading as "Asthma Wellington".

The alignment of the missions of the Society and Asthma New Zealand to provide training, education and support for people with asthma and their families makes the merger sensible and appropriate. However it does mean a loss of autonomy which will be addressed by the continued operation of your Management Committee in an advisory capacity and by your President who will be a member of the Board of Asthma New Zealand.

The last few months has seen changes to the Society and it's sad to report that some familiar names are no longer with us. However we are pleased to welcome Liz Macdonald, Nurse Educator and Shaun Waugh, Administrator to the fold.

I regret it will not be possible to continue with the Society's newsletter "Hailer" but I hope we will be able to keep you up to date through space in this magazine and hopefully through the development of our website.

With consolidation over the next 12 months as a branch of Asthma New Zealand I am confident that we can continue and indeed expand upon our work in the Wellington Region.

John Kennedy-Good
President
Wellington Regional Asthma Society

Tribute to Martin Highgate

By Steve Tubb, Treasurer

Martin has been both Treasurer and President of the Society.

His ability as Treasurer became quickly apparent when the Committee was deluged with spreadsheets and budgets. This strange way of doing things however soon became the norm.

His elevation to President didn't bring any relief from new age high tech devices – indeed he even lectured at a Foundation AGM armed with all kinds of graphs and statistics.

Our relationship with the Foundation was never quite the same after that.

Martin was instrumental in bringing the Constitution up to date and in the Incorporation of the Society.

I believe Martin's true value to our organisation became more obvious after he left the Committee. Relationships within the Committee were worse for him not being there and relationships between the Committee and staff could also have been better.

Martin's abilities and industry left such a gap in the work force that we were eventually required to increase the staff of the Society by 2, namely a Business Manager and a Funding Officer.

We have been fortunate that he has continued his association with the Committee on a contractual basis for accounting and payroll services but it is typical of Martin that a large number of extra hours have been unpaid.

I believe Martin's contribution to the Society has meant that we became more businesslike in dealing with our main funder and lifeline the DHB and with other sponsors and clients.

Martin Highgate would be a worthy recipient of life membership of the Wellington Regional Asthma Society (Inc).

Are you frequently breathless? Do you have COPD?

Compiled by Debra Leutenegger (RN, Asthma Nurse Educator)

Chronic Obstructive Pulmonary Disease (COPD) is a largely preventable disease that affects the lungs however for many the symptoms of COPD develop slowly therefore go unnoticed in the mild (early) stage and diagnosis is often not made until the disease is in the moderate stage. The condition usually gets progressively worse over time and is now a major cause of disability.

COPD has previously been known by other names such as CORD (Chronic Obstructive Respiratory Disease) or COAD (Chronic Obstructive Airways Disease).

The most common risk factor for developing COPD is smoking (or a history of smoking) however there is also a genetic Alpha-1 Antitrypsin deficiency that may also lead to COPD. Other risk factors include prolonged exposure to chemicals/dust or fumes as well as indoor/outdoor air pollution. A history of childhood pneumonia or chronic uncontrolled asthma may also be relevant.

Symptoms may include shortness of breath (especially on exertion), a chronic cough and sputum production. These symptoms may occur in people over the age of 40 years and sometimes people think that the shortness of breath they are experiencing is due to being unfit or the ageing process. It is important if you have these symptoms and a history of other possible risk factors that you speak with your Doctor. COPD can be well managed and the reducing lung function can be slowed by early diagnosis and appropriate intervention/medication.

Often the first step in diagnosing COPD is to have a simple lung function test called Spirometry. This can be carried out by your doctor/nurse or by a respiratory physician. Some Asthma Societies throughout the country also perform these tests eg Auckland Asthma Society. Other tests may include a chest x-ray and blood test for Alpha-1 Antitrypsin deficiency especially if there is a family history.

COPD differs from asthma in that the airflow limitation is not fully reversible. Having a bronchodilator reversibility test using a reliever inhaler can also assist in obtaining the correct diagnosis since the management of asthma and COPD differs.

The goals in the management of COPD once diagnosed are to slow down the progression of the disease by stopping smoking if you are a current smoker, (is the most effective intervention), relieve current symptoms and seek early treatment for any acute exacerbations/complications.

Education and knowledge of COPD can help to improve skills in order to self-manage and to be able to recognise worsening symptoms. Symptoms can limit your ability to carry out normal daily activities such as walking or taking care of yourself. There are many techniques to learn including correct breathing techniques, spacing out activities to save your energy as well as regular exercise and a balanced diet. Ask about joining a COPD support group in your area to learn more and inquire about attending pulmonary rehabilitation sessions with a physiotherapist.

While there is no cure for COPD, treatment, good management and lifestyle changes can assist in maintaining independence, staying active and helping you to feel better. Don't feel that you are on your own since there are an ever increasing number of people being diagnosed with COPD.

World COPD Day 2009

World COPD (Chronic Obstructive Pulmonary Disease) day was celebrated at Asthma Auckland premises in Mt Eden on Wednesday November 18th. We had a great response from the advertisement in the "Aucklander" magazine asking these key questions:

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

Answering yes to three or more of these questions could indicate COPD, however, this needs to be confirmed with spirometry.

It was pleasing to see many of the participants of our Open Day bring in the advert and have their symptoms ticked off. Asthma Nurse Educators carried out education on COPD (and asthma), performed many spirometry tests, provided information brochures and referred several people back to their General Practitioners for diagnosis and management.

It was also a time for people to share their experiences and have their inhaler technique observed, spacer use and role discussed and to get answers to questions they had about current medications and management of COPD.

Breathless not Helpless!

World COPD Day 2009

November 18 2009

Congratulations to those people who attended for taking their health seriously, being self-motivated and interested in receiving advice and education. Remember if you missed the day but would like advice or information, please contact us as we are available and willing to assist everyone in the community at any time. Call 09-630-2293 and ask to speak with an educator.

Asthma Auckland
wishes to thank the generous support of the following businesses – please support them too.

Yes!

I want to support Asthma Auckland

Breathe Easy®

Mr/Mrs/Miss/Ms _____

Address: _____

_____

_____

Phone: _____ Date Of Birth: (optional) / /

Benefits

- Magazine subscription (The NZ Journal Of Respiratory Health)
- Advice and support from Asthma educators
- Networking opportunities/support groups
- Access to information and medical research
- Your donation will also help provide education and support for other people with asthma and their families

Annual Membership $25
Donation (tax deductible)

☐ Cheque enclosed $_____

☐ Please debit my credit card $_____

☐ Visa ☐ MasterCard ☐ Amex

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Cardholder's Name: _____

Signature: _____ Expiry date / /

☐ I would like information about making a bequest.

Asthma info line:
Phone: 09 630 2293
Fax: 09 623 0774
Email: aas@asthma-nz.org.nz
Web: www.asthma-nz.org.nz
Information collected for Asthma Auckland use only. Under the Privacy Act members have the right to access and correct any information by contacting Asthma Auckland

Breathe Easy®

asthma NEW ZEALAND THE LUNG ASSOCIATION

Return this form to:
Asthma Auckland, PO Box 67 066
Mt Eden 1349, Auckland
New Zealand Regional Office:
581 Mt Eden Rd, Mt Eden, Auckland 1024 NZ

Let's fight Asthma together

"We need your help"

Our family and friends may have asthma, but let's not let asthma have them. Your support to help our community breathe easy has always made a difference in thousands of people who fight to breathe.

Please support generously

☐ Yes, I would like to help New Zealanders breathe easy! Here's my gift to support your work

☐ $25 ☐ $50 ☐ $100 ☐ Other:

My gift marked above is to be charged to my credit card

☐ Visa ☐ American Express ☐ MasterCard

Card Number

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Name of Card Holder: _____

Signature: _____ Expiry Date: _____

☐ Cheque for the above value is enclosed
Your gifts can attract a tax rebate. We will send you a receipt shortly for your donation.

Mr/Mrs/Miss/Ms _____

Address: _____

_____

_____

Telephone: _____ Email: _____

☐ 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-the Lung Association
581 Mt Eden Rd, PO Box 67-066
Mt Eden, Auckland 1024, NZ.
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 ASTHMA SOCIETY (INC)
581 Mt Eden Road, Auckland 1024
Ph (09) 630 2293

CANTERBURY ASTHMA SOCIETY
275 Cashel Street, Christchurch 8013
Ph (03) 366 5235

RESPIRATORY SUPPORT GROUP
22 Manawa Avenue
Raumati, Kapiti Coast 5032

ROTORUA ASTHMA SOCIETY
Community House
1115 Haupapa Street, Rotorua 3010
Ph (07) 347 1012

SOUTH CANTERBURY ASTHMA SOCIETY
PO Box 267
Timaru 7940
Ph (03) 687 7379

SOUTHLAND ASTHMA SOCIETY
70 Forth Street, Invercargill 9810
Ph (03) 214 2356

WAIRARAPA ASTHMA SOCIETY
Wairarapa Community House
170 Dixon Street, Masterton 5810
PO Box 2097, Kuripuni, Masterton 5810
Ph (06) 377 1175

WELLINGTON REGIONAL ASTHMA SOCIETY
Level 4 Pember House
16 Hagley Street, Porirua 5022
Ph (04) 237 4520

WHAKATANE ASTHMA AND COPD GROUP
141-143 King Street, Whakatane 3120
Ph (07) 307 1447

NORTH OTAGO ASTHMA SOCIETY INC
Community House
100 Thames Street, Oamaru 9400
Ph (03) 434 3202

Questions, Letters, Articles, Advertisements

O_2 Journal 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
PO Box 67-066, Mt Eden
Phone (09) 623 0236
Email editor@asthma-nz.org.nz

newstream

Management of chronic obstructive pulmonary disease: moving beyond the asthma algorithm.

Gordon E, Lazarus SC.

For many years, chronic obstructive pulmonary disease (COPD) was considered a disease of fixed airflow obstruction for which there was no good treatment. Out of desperation and frustration, health care providers extrapolated from asthma to COPD, and standard asthma therapy was adopted without evidence for efficacy. In recent years, we have gained a better understanding of the pathophysiologic differences between asthma and COPD, and prospective controlled trials have provided a rationale for therapy. Smoking cessation is critically important, both as primary prevention and as an effective way to slow the decrease in lung function in patients with established disease. beta(2)-Adrenergic and anticholinergic agonists improve lung function and relieve symptoms in most patients. Tiotropium improves exercise tolerance and quality of life and reduces exacerbations and hospitalizations. The increase in lung function seen with tiotropium is sustained with continued use over at least 3 to 4 years. Inhaled corticosteroids decrease exacerbations and improve quality of life, and their effect seems greatest in patients with lower lung function and in exacerbation-prone patients. There is no evidence that inhaled corticosteroids alone affect mortality, despite the reduction in exacerbations and increased risk of pneumonia. In some patient populations, inhaled fluticasone, salmeterol, or the combination might slow the rate of loss of lung function. Rather than reflexively using effective asthma therapy in the patient with COPD, current and future therapy for COPD is increasingly evidence based and targeted to specific inflammatory pathways that are important in patients with COPD.

Add-on salmeterol compared to double dose fluticasone in pediatric asthma: a double-blind, randomized trial (VIAPAED).

Gappa M, Zachgo W, von Berg A, Kamin W, Stern-Sträter C, Steinkamp G; VIAPAED Study Group.

RATIONALE: In asthmatic children whose symptoms are uncontrolled on standard doses of inhaled corticosteroids (ICS), guidelines recommend to either increase the ICS dose or to add further controller medication, e.g. a long acting ss2-agonist (LABA). The aim of this study was to compare the efficacy and safety of doubling the dose of ICS (fluticasone proprionate FP 200 microg twice daily) with adding a long-acting beta-2 agonist to the ICS (SFC, salmeterol 50 microg/FP 100 microg twice daily) in children with uncontrolled asthma. METHODS: Children between 4 and 16 years of age were eligible for this multicenter, randomized, double blind, double dummy, parallel-group study. During a 14-day run-in phase, all children inhaled FP 100 microg b.i.d. Patients with persistent symptoms on > or =7 of 14 days were randomized to 8 weeks treatment with a Diskus(R) containing either SFC 50 microg/100 microg b.i.d. or FP 200 microg b.i.d.. The primary endpoint was the mean change in morning (a.m.) PEF from baseline. The initial statistical hypothesis of non-inferiority of SFC vs. FP was confirmed in an adaptive interim analysis, so that the study was terminated prematurely. RESULTS: 441 patients from 39 centers entered the run-in phase, and 64% of these were randomized to treatment (N = 138 to SFC and N = 145 to FP). After 8 weeks, patients on SFC had significantly better results for primary and secondary endpoints: The mean increase in morning PEF was 30.4 +/- 34.1 L/min in the SFC group and 16.7 +/- 35.8 L/min in the fluticasone group, and the mean (95% CI) improvement from baseline a.m. PEF in the ITT group was significantly larger after SFC (+8.6 L/min, CI: [1.3; infinity]). Patients in the SFC group experienced 8.7% (CI: [1.2;16.3]) more days without asthma symptoms and 8.0% (CI: [0.6;15.3]) more days without salbutamol than patients receiving FP. Good asthma control was achieved for a longer period in the SFC (3.4 +/- 2.7 weeks) group than in the FP group (2.7 +/- 2.7, P = 0.02). Both treatments were generally well tolerated. Asthma exacerbations were recorded in 3 and 6 and SAEs in 2 and 1 patients from the SFC and FP groups, respectively. CONCLUSIONS: In children with persistent asthma inadequately controlled on low dose ICS alone, adding a long acting beta-2-agonist to ICS in a single inhaler was more effective than doubling the ICS dose. These results support recommendations of adding LABA to low-dose ICS as the preferred controller option for children older than 4 years with symptomatic asthma.

Safety of budesonide/formoterol maintenance and reliever therapy in asthma trials.

Sears MR, Radner F.

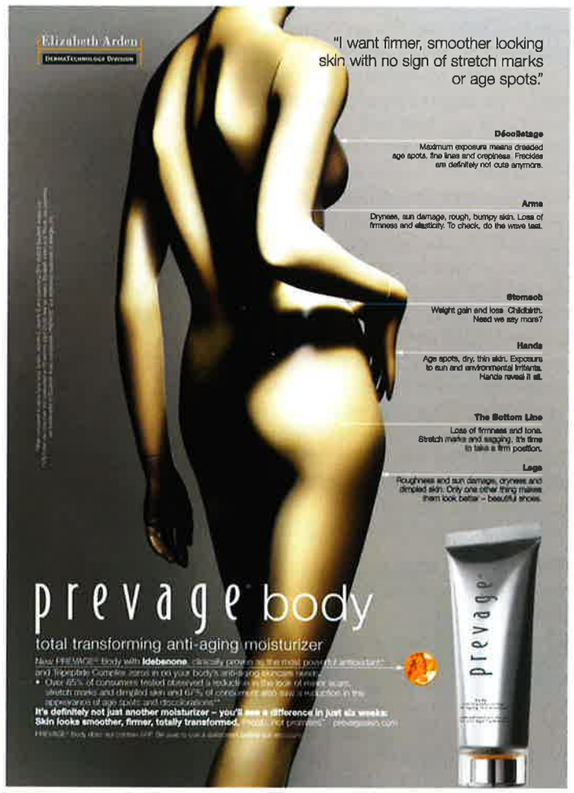
BACKGROUND: The safety of long-acting beta(2)-agonists (LABAs) in asthma is debated. This study examined the safety of the inhaled corticosteroid (ICS)/LABA combination budesonide/formoterol dry powder inhaler used as maintenance and reliever therapy versus combination treatments based on guideline recommendations. METHODS: Safety data from six double-blind, randomised clinical trials (RCTs) in asthma where budesonide/formoterol was used as maintenance and reliever therapy for at least 6 months were reviewed (N=14 346). All-cause mortality and asthma-related serious adverse events (SAEs) (co-primary endpoints), overall and cardiac SAEs, and discontinuations due to adverse events (DAEs) were assessed. Estimated Mantel-Haenszel (MH) relative risks (RR) with this regimen versus comparators were calculated. RESULTS: There was no increase in all-cause mortality with budesonide/formoterol maintenance and reliever therapy (four deaths [0.07%] versus nine [0.10%]; pooled MH RR 0.70, 95% confidence interval [CI] 0.21-2.30). Asthma-related SAEs were reduced with budesonide/formoterol maintenance and reliever therapy: 41 (0.73%) versus 121 (1.38%); pooled MH RR 0.59, 95% CI 0.42-0.85. All-cause and asthma-related DAEs were also reduced with budesonide/formoterol maintenance and reliever therapy: pooled MH RR 0.60 (95% CI 0.46-0.79) and 0.43 (0.28-0.68), respectively. Overall and cardiac-related SAEs were comparable between treatment groups: pooled MH RR 0.96 (95% CI 0.82-1.14) and 1.26 (0.72-2.22), respectively. CONCLUSION: Budesonide/formoterol dry powder inhaler maintenance and reliever therapy was well tolerated in RCTs versus fixed-dose alternatives and not associated with increased risk of death or cardiac-related SAEs and DAEs, and asthma-related SAEs and DAEs were significantly reduced. Given the limitations of RCTs, particularly exclusion of patients with co-morbidities, ongoing surveillance is appropriate.

Benefits of low-dose inhaled fluticasone on airway response and inflammation in mild asthma.

Boulet LP, Turcotte H, Prince P, Lemière C, Olivenstein R, Laprise C, Larivée P, Bégin P, Laviolette M.

RATIONALE: Current guidelines suggest that asthma should be controlled with the lowest dose of maintenance medication required. OBJECTIVES: To evaluate the effects of a low dose of inhaled corticosteroid compared to a placebo, on airway inflammation and responsiveness in patients with mild symptomatic asthma. METHODS:

In this randomized double-blind, placebo-controlled, parallel group study, we looked at the influence of inhaled fluticasone propionate 250 microg/day for 3 months followed by 100 microg/day for 9 months on airway inflammation and methacholine responsiveness in non-smoking subjects with mild allergic asthma. Subjects were evaluated at baseline and 3, 6, 9 and 12 months after treatments; a 2-week evaluation of respiratory symptoms and peak expiratory flow measurements was done before each visit. RESULTS: Fifty-seven subjects completed the 3-month study period. Airway responsiveness, expressed as the PC20 methacholine, increased by 0.27 and 1.14 doubling concentrations, respectively, in placebo-treated (n=33) and in fluticasone-treated (n=24) asthmatic subjects (p=0.03). An additional improvement in PC20 up to 2.16 doubling concentrations was observed in the fluticasone-treated group during the 9-month lower-dose treatment (p=0.0004, end of low-dose period compared with placebo). Sputum eosinophil counts decreased after 3 months of fluticasone 250 microg/day compared with placebo (p<0.0001) and remained in the normal range during the 9-month lower-dose treatment. Respiratory symptoms and peak expiratory flows did not change significantly throughout the study in both groups. CONCLUSION: In mild asthma, keeping a regular minimal dose of ICS after asthma control has been achieved, may lead to a further reduction in airway responsiveness and keep sputum eosinophil count within the normal range.



Abnormal Swallowing reflex and Chronic Obstructive Pulmonary Disease Exacerbations.

Terada K, Muro S, Ohara T, Kudo M, Ogawa E, Hoshino Y, Hirai T, Niimi A, Chin K, Mishima M.

BACKGROUND: It is unclear whether an abnormal swallowing reflex affects chronic obstructive pulmonary disease (COPD) exacerbations. This study investigated the prevalence of abnormal swallowing reflexes, and its relationship with COPD exacerbation prospectively. We also clarified its association with gastro-esophageal reflux disease (GERD) and airway bacterial colonization. METHODS: Swallowing reflex and serum C-reactive protein (CRP) levels were examined in stable COPD and control subjects. Concurrently, GERD symptoms were assessed using a self-reported questionnaire, and sputum bacterial cultures were investigated in the same subjects. Exacerbations were counted prospectively during the following 12 months. RESULTS: The study group comprised 67 COPD subjects and 19 controls. The prevalence of abnormal swallowing reflex was significantly higher in COPD subjects (22/67) than controls (1/19; p = 0 0.02). Among COPD subjects, the serum CRP level, GERD symptoms, isolation of sputum bacteria, and the frequency of exacerbations were significantly increased in those with abnormal swallowing reflexes compared to controls (2.72 vs. 1.04 mg/L, p = 0.04, for serum CRP level; 6.75 vs. 4.10 points, p = 0.04, for GERD symptoms; 5/11 vs. 3/22, p = 0.04, for the isolation of sputum bacteria; and 2.82 vs. 1.56/year, p = 0.007, for the annual frequency of exacerbations). Multivariable analysis confirmed that abnormal swallowing reflex was significantly associated with frequent exacerbations (>/= 3 per year; p = 0.01). CONCLUSIONS: Abnormal swallowing reflexes frequently occurred in COPD subjects and predisposed them to exacerbations. Abnormal swallowing reflexes in COPD might be affected by the comorbidity of GERD, and cause bacterial colonization.

Therapeutic conversion of the combination of ipratropium and albuterol to tiotropium in patients with chronic obstructive pulmonary disease.

Niewoehner DE, Lapidus R, Cote C, Sharafkhaneh A, Plautz M, Johnson P, Kesten S.

BACKGROUND: Ipratropium and albuterol, combined in a single formulation, is widely used as three to four times daily maintenance therapy in COPD. This trial compared tiotropium, once daily, as a potential alternative to patients already taking the ipratropium/albuterol combination. METHODS: 676 patients with moderate to very severe stable COPD (mean FEV(1)=39% of predicted) maintained on ipratropium/albuterol were randomized to receive over an 84 day period either tiotropium (18 mcg) each morning, or continue with ipratropium (26 mcg)/albuterol (206 mcg), 2 actuations 4 times daily, using a parallel group, double-blind, double-dummy design. Six-hour spirometry was assessed on study days 1, 22, and 84, along with safety assessments and other efficacy measures. RESULTS: In terms of primary outcomes, mean trough FEV(1) at 84 days was larger in the tiotropium arm, as compared with the ipratropium/albuterol arm (difference=86 ml; 95% CI, 49 to 123 ml, p<0.0001). The mean FEV(1) AUC(0-6) at 84 days was also larger in the tiotropium arm (difference=17 ml; 95% CI, -21 to 56 ml), this difference being statistically non-inferior to the ipratropium/albuterol arm (p<0.001), but not statistically superior (p=0.37). Other efficacy measures were similar in the two groups. Lower respiratory adverse events were reported in 40 tiotropium patients vs. 52 ipratropium/albuterol patients. Safety reporting was otherwise similar. CONCLUSION: Patients previously maintained on the ipratropium/albuterol combination taken four times daily can be switched to tiotropium once daily with the reasonable expectation of at least equivalent bronchodilation during daytime hours and superior bronchodilation during early morning hours.

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