

The Seven Minute Asthma Consult



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Asthma is a chronic disease which can vary over time between mild to severe, even in the same patient. Its management is made difficult by the fact that, in many cases, patients perceive their level of control to be adequate, but when asked key questions, it is found that their asthma is actually poorly controlled. Because of the chronic nature of asthma and in many cases, the perceived stigma associated with a chronic disease, patient acceptance of treatment is less than satisfactory.

The components of the consultation

There are three related components to the management of asthma in the context of the patient-physician interaction. Because of the complexity of diagnosing, initiating and continuing treatment, multiple consultations may be required to complete the diagnostic, therapeutic and asthma education continuum.

Diagnosis

The diagnosis of asthma may take a number of visits before it is established. It will be primarily based on a pattern of wheezy bronchitis in a patient with background of atopy. There may be a reluctance to label a patient as having asthma because of its long-term implications. The key questions related to the diagnosis of asthma are outlined in Table 1. The pattern may not always

Table 1

The key questions related to the diagnosis of asthma

When asthma is suspected, a physician should ask the following questions:

- Do you wheeze?
- Are your symptoms worse on exposure to cold or with exercise?
- Do you wake at night coughing?
- Do you have a history of allergies?
- Is there a family history of asthma?
- Are there any increase in symptoms when at work or in contact with pets and other allergens?

be typical, as in the case of cough-variant asthma with no wheeze. Symptoms suggestive of asthma may follow a viral infection, or be confused with reflux related symptoms. Rhinitis, with post nasal drip, may be suggestive of asthma, but only if found in association with a cough and no wheeze and may, in fact, not be due to asthma at all. Asthma-like symptoms in a smoker may be labeled erroneously as being due to chronic obstructive lung disease, but the use of objective measurements of airflow obstruction will be shown in fact to be due to asthma. Thus, at the time of diagnosis, an objective measurement of airflow is important, especially if coupled with a test of reversibility.

Initiation of treatment

All asthma guidelines recognize the primary role of inhaled corticosteroids (ICS) in the management of asthma. There is no evidence that starting at a high dose is better than starting at a lower dose and then adjusting the dosage depending on the level of control.

At the time of diagnosis, when the role of ICS is mentioned, patients will be struggling with the concept of a potentially lifelong diagnosis of asthma. Many patients will focus on the sometimes pejorative term of steroids in such a discussion. We know that patients have significant concerns about ICS and the potential for side-effects with these drugs. Although these concerns about systemic side-effects are largely unfounded, the well documented phobia about these treatments will likely affect adherence. Adherence may be affected positively if patients are asked open-ended questions, such as: "Are you comfortable taking ICS?" "Do you have concerns about the side-effects of ICS?" Or, "Are you worried about ICS losing its effect over time?" The ideal scenario will require minimal or no use of rescue medication.

Patients need to be educated on properly responding to a change, should they start needing rescue medication or should their symptoms (*i.e.*, nocturnal awakenings) start to worsen. The treatment needs of patients must be reviewed on an ongoing basis and their treatment must be adjusted accordingly. When control is achieved, dosage will be reduced accordingly. However, it is important that both physicians and patients be aware of the need to continue treatment, even in the presence of current good control. Patients should be mindful that although current day-to-day

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control is important, the additional importance of adequate maintenance of treatment is that it helps in the prevention of exacerbations. At the time of treatment initiation, it is crucial that patients are shown exactly how to use their inhaler. Add on therapy (*i.e.*, long-acting β -agonist) need to be considered if patients continue to be symptomatic, despite the following:

- adherence with treatment,
- proper use of their inhaler,
- ongoing allergen exposures,
- assessment of occupational exposures,
- management and treatment of comorbid conditions (*i.e.*, reflux and or rhinitis)

Educating patients about responding to worsening asthma

After the diagnosis of asthma is made and the maintenance regimen has been started, the next critical phase in the patient-physician interaction is the development of a written action plan (which has been shown to be a key element of successful education). A written plan can also help to prevent the development of an exacerbation. We have previously shown, in a primary care setting, a symptom-driven action plan is as good as a peak-flow, meter-driven action plan.

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Educating patients about their response to their worsening asthma is important. We have shown that doubling the dose of ICS is not adequate and based on other studies, it's likely that quadrupling the ICS dose is required. Patients on a combination of formoterol and budesonide can safely increase their maintenance therapy, most notably with a strategy called SMART which involves the use of this combination both as maintenance and as rescue medication.

In contrast, patients on a combination of salmeterol and fluticasone do not have a well defined strategy for responding in such a situation. The options include the use of an additional ICS canister, or the use of a short course of prednisone. These are not easy concepts to translate into a brief consultation in a primary care setting and are likely best achieved by the involvement of a certified asthma educator. There are now many recognized asthma education programs across Canada and the location of these centres can usually be obtained from provincial lung associations.

Ongoing consultations

Once the above goals of asthma management have been achieved, there needs to be ongoing monitoring of how well patients are controlling their asthma. Such consultations should reinforce the importance of patient adherence and review inhaler technique. If there has been a worsening in a patient's asthma, the physician should assess how the patient responded to the increased symptoms. At these ongoing visits some key questions need to be asked (Table 2).

Measurement of peak expiratory flow should be integrated into all patient visits. This is probably more important than auscultation of a patient's chest. Ongoing attempts should be made to get patients to stop smoking, especially because, in addition to all the known negative effects associated with smoking, it also reduces the efficacy of ICS.

Table 2

The key questions related to the worsening of a patient's asthma

When a patient's asthma symptoms become worse, a physician should ask the following questions:

- How well is your asthma controlled? (Note: a response that the asthma is great should not preclude the supplementary questions from being asked)
- Do you wake up at night?
- How often are you using rescue medication?
- Are any of your recreational activities limited?
- Show me how you are using your inhaler
- Are you concerned about the side-effects from inhaled corticosteroids?
- Do you suffer from any nasal symptoms?
- Are there any complicating features occurring (i.e., gastroesophageal reflux)?

In summary, asthma is a chronic disease that requires a structured approach to patient management, often spread over time and requires multiple consultations. We now have effective treatment strategies, which are not being translated into better clinical outcomes. This in part is due to a failure to address proper communication opportunities in the patient-physician interaction. This challenge is further accentuated by issues related to ethnicity, language and literacy, all of which have an impact on these interactions.

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References

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