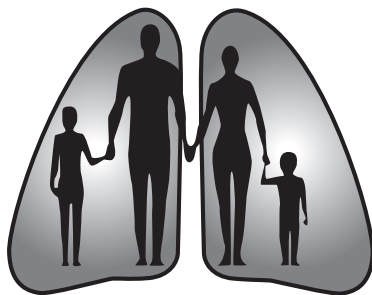


FPAGC NEWSLETTER



FPAGC

FAMILY PHYSICIAN AIRWAYS GROUP OF CANADA
l'Association canadienne des médecoms de famille contre l'asthme

Chairman's Report September 2003

The Canadian Asthma Guidelines group are getting together to revamp the adult guidelines. A new group under the auspices of CNAC are creating the second ever Canadian Pediatric Asthma Guidelines. In addition, the COPD guidelines group is also meeting in June.

We have been invited to each of these prestigious groups for a number of reasons. Members of the group have authored some parts. Critical review of the guidelines has been performed by other members. Our greatest strength has been in the fact that as Family Physicians, we are key stakeholders in the implementation plan of these guidelines. The College of Family Physicians of Canada have created a partnership with the FPAGC to represent Family Practice at these meetings.

I have created a document on Barriers to Asthma Guidelines in Practice which will become part of the new guidelines. These issues will be the principle areas of concern for the meetings of the various implementation groups. I would be very grateful to hear from all of you regarding the barriers that you see in the dissemination and implementation of guidelines in your practice. I value the feedback that I have received from many of you, but the process is still early and can be changed/improved upon. Send me a note at FOR4KIDS@sympatico.ca so that I can really feel that I am representing all of you!

SEPTEMBER 2003

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I am also attending a meeting to review the national strategy for Asthma management in the USA in June in Washington. I hope to be able to bring some of our experiences there and vice versa.

I feel that I have to at least mention SARS as it is so topical. We have had a recrudescence of cases in Toronto and it appears that outbreaks of this disease may continue. Yes, I dress in the ER with two gowns, gloves, N95 mask and face shields. This may be our new normal, time will tell. I have been appointed by the CFPC as the representative for Family Practice for

the clinical working group on SARS treatment. Steroids are in, Ribavirin appears not to work in the test tube, but is still being used in China. My best advice is WASH YOUR HANDS!

I hope this newsletter finds you well. For at least those of you in quarantine, feel free to check the website www.fpagc.com to read our past newsletters.

Alan Kaplan

Chairperson,

*Family Physician Airways Group
of Canada*

Avian influenza in the Netherlands

24 April 2003

World Health Organization report

Outbreaks of a of highly pathogenic strain of avian influenza virus A (H7N7) have been reported in various poultry farms in the Netherlands since February 2003. Recent cases of the disease in poultry have also been reported in Belgium.

While avian influenza strains normally infect exclusively poultry, Dutch authorities have reported that the H7N7 strain has now jumped the species barrier, causing one death and more than 80 cases of mild disease in humans.

A 57-year-old veterinarian who visited a poultry farm affected by the (H7N7)

strain died on 17 April of acute respiratory distress syndrome in the Netherlands. H7N7 influenza virus was isolated from the patient. No other respiratory pathogen was detected in a series of laboratory tests.

The detection of the H7N7 avian influenza strain in humans is the most recent case in which an avian influenza virus has crossed species to affect humans. In Hong Kong in 1997, the H5N1 strain of avian influenza caused its first outbreak in humans, with 18 cases and 6 deaths. In mid-February 2003, again in Hong Kong, the H5N1 strain infected two persons, causing one death.

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Since the beginning of the H7N7 outbreak in the Netherlands in late February, there have been 83 confirmed cases of human H7N7. The majority of these cases (79) exhibited conjunctivitis, and 13 of them displayed mild influenza-like illness. Three family members of 2 poultry worker have also fallen ill with a minor respiratory disease, suggesting a possible chain of human-to-human transmission. Affected poultry in the Netherlands are being slaughtered as a control measure. Mass culling of poultry proved effective, in both Hong Kong outbreaks, in preventing further cases in humans.

Comment:

SARS has been in the news, and rightly so, but this disease scares me even more! I remember 1997, when all the

poultry in Hong Kong had to be destroyed to prevent progression of this disease. Influenza has a significant mortality, even in 'healthy' patients. The fact that Oseltamivir may be effective prophylactically is somewhat reassuring.

The WHO Global Influenza Surveillance Network is currently assembling a test kit for H7N7. As a precautionary measure, the network is also working on the development of a vaccine for H7N7.

For those of you who are meat eaters, we may have no poultry (influenza) and no beef (mad cow disease)!

AK

Pneumonia in advanced age, and no, I do NOT mean SARS!

Kaplan V et al. Pneumonia: still the old man's friend? Arch Intern Med 2003 Feb 10; 163:317-23

The 1997 Medicare database was used to compare the in-hospital mortality and one-year mortality of 158,960 patients over 65 with CAP and among 794,333 patients hospitalized for other reasons (controls). The in-hospital mortality was 11% vs. 5.5% for controls. The one-year mortality was >40% vs. 29% in controls. If we look at patients

over 90 years old the one-year mortality was 57%!

Comments: Pneumonia is the 'old man's (and woman's) friend. The older you are and the greater the number of co-morbidities, the greater the risk of death. This has implications for the practical issue of things like advanced directives and patient and family expectations.

AK

Asthma Exacerbation due to infection, what are the bugs?

Lieberman D et al. Atypical pathogen infection in adults with acute exacerbation of bronchial asthma, Am J Respir Crit Care Med 2003 Feb 1; 167:406-10

Serology was measured on 100 adults admitted for asthma in a hospital in Israel compared with the control of 100 patients admitted to the hospital orthopedic ward. No patient was diagnosed with pneumonia. Convalescent serology was also drawn. Serology found infection with Strep pneumonia, Legionella, Coxiella burnetti, Chlamydia pneumonia, viruses

(Influenza A, B, adenovirus), and Mycoplasma. Thirty of the 100 showed serology for viral infection cf. 4 in controls. The only bacterial potential pathogen was 18 of 100 for Mycoplasma cf. 3 in control.

Comment:

This study puts doubt on the common myth of Chlamydia causing asthma exacerbations. 18 of 100 did have evidence of Mycoplasma, but this does not, in my opinion, justify the use of empiric antibiotics for all asthma exacerbations.

AK

Cystic Fibrosis in 2003

Cystic Fibrosis in 2003

This is a summary of the presentation done by Dr. Elizabeth Tullis, medical director of the Adult Cystic fibrosis Centre in Toronto at the Better Breathing meeting in Toronto in January 2003. Thirteen years ago the CFTR gene was discovered, identifying those people who are unable to absorb salt and form normal mucous.

There are five types of CFTR mutations. Type 1 is no CFTR protein made. Type 2 has the protein made, but not incorporated into the cell wall. Type 3 is the protein in the cell wall but does not

conduct electrolytes. Type 4 and 5 has the protein being normal, but it is produced in smaller amounts or has decreased conductivity.

Comment:

The median survival in 1940 was one year, in 1960 it was four years, and now the median survival is 35 years, and Canada has one of the best survival years in the world. Cystic Fibrosis is not just a childhood disease, look for it in adults presenting with sinusitis, malabsorption, or infertility by ordering a sweat chloride test!

AK

Asthma drugs in pregnancy

396 singleton births were studied between 1996 and 2002 by being placed into the Registry for Allergic and Asthmatic Pregnant Patients established by the AAAI (American Academy of Allergy, Asthma, and Immunology).

The concern of growth of the fetus being affected by inhaled steroids was shown to be not an issue. The incidence of small for gestational age infants was 7.1%, lower than the expected rate of 10%! The average birth weight of infants was 3000g. Beclomethasone and fluticasone were the commonest steroids used. Even those patients on the highest doses of ICS did not have a

statistical significant decrease in the incidence of small for gestational age newborns.

Comment:

The old adage of pregnancy and asthma is one-third get better, one-third get worse and one-third stay the same. The data is clear, bad outcomes do happen in asthmatic moms; eclampsia, SGA infants, prematurity and more. These things occur in asthmatics who are poorly controlled. My message is the same, inhaled steroids are safe; CONTROL THE ASTHMA!

AK

Priming

Do you know how many sprays it takes to prime your MDI? Are they all the same? Do you need to prime them?

I have investigated this and discovered that I was not informing my patients correctly! I hope this is of the same value to you. We do all recognize that you must wait 30-60 seconds between doses of the same inhaler, but what about when you have not used that inhaler for a while?

I will only deal with HFA inhalers as CFCs are rapidly going the way of the dinosaur.

Ventolin HFA, CFC Free Salbutamol, and Ratio-Salbutamol HFA all require 4 sprays after 28 days of non use. Airomir is 4 sprays after 14 days of non-use.

Flovent HFA is one spray after 7 days of non-use. Qvar is 4 sprays after 14 days of non-use.

Advair is 2 sprays after 7 days of non-use.

So, remember to tell patients to prime their inhalers after they haven't been used for a while!

AK

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CNAC

This is my report regarding issues of CNAC, Canadian Network for Asthma Care and its last meeting of May 30, 2003. This group has representation from respirologists, allergists, pediatricians, family physicians, respiratory therapists, nurses, patient advocacy groups and members of the pharmaceutical industry.

The major accomplishments of CNAC include the creation of a website, a list of asthma education programs across Canada, the first national certification of asthma educators in the world, and the creation of an asthma education conference ever two years.

The group has decided to continue its certification examination annually, despite the decrease in numbers taking the exam. We will continue to be advocates with the government for asthma educational issues. Research on issues of asthma education and information will be encouraged.

Surveillance of Asthma is being done by Health Canada under the auspices of CNAC. This will hopefully allow early availability of relevant asthma statistics.

The benefits of being a CAE (Certified Asthma Educator) to the participant and their employers needs to be highlighted. Having a CAE designation indicates that the health professional has gone through a certified training program and has passed a rigorous examination. For the patient and the health care employer this demon-

strates a good working knowledge on asthma issues and a continuing commitment to best practice, current standards, and knowledge. For the professional, this demonstrates professional accomplishment, professional growth, and gives formal recognition of a specialty practice.

The Canadian Pediatric Guidelines meeting will occur in June 2003, and the FPAGC will be represented there. Yes, that means more guidelines, but the group recognizes that implementation strategies must occur to make the guidelines applicable and utilizable.

As many of you know, there is also a similar group in COPD, called the CCA (Canadian COPD Alliance). Issues of certification of COPD educators being done in parallel to improve costs and efficiency of providing the exam (which is very expensive!) are being explored, especially as most educators teach both and THEY ARE NOT THE SAME CONDITION!! They also have a conference every two years also.

Can I be so bold as to suggest that there will be economies of scale to combine these two groups under an umbrella of respiratory disease to allow a greater potential impact in the political arena for patients and physicians? I think it is important to educate physicians and patients on these conditions and their differences, but they do share a lot of commonalities.

AK

Let's put the dentist out of business!

Aligne CA et al. Association of pediatric dental caries with passive smoking. JAMA 2003 Mar 12;289:1258-64

What do you think is the most common chronic condition in children. I would have said asthma, but in fact it is dental decay. This study measured the role of environmental tobacco smoke (ETS) in risk of dental caries. These children has dental exams and also had measurement of serum cotinine which is considered a marker of environmental tobacco smoke.

53% of kids had passive exposure to ETS. The odds ratio was 2.1 for development of cavities in deciduous but not

permanent teeth. The association was independent of age, race, family income, and blood lead level. There was an association to poor children and lower educational levels. One quarter of children had at least one unfilled carie and a third had at least one filling. The authors attributed 27% of unfilled caries and 13.7% of filled caries to ETS. Surprisingly, sugar intake was not associated with increased risk of caries.

Comment:

Add dental caries to asthma and otitis media that can perhaps be prevented/improved by avoidance of ETS. **AK**

Chairman's Report Asthma 2003 June 19-23, 2003 Washington DC

I had the pleasure of attending this conference as a representative of the Canadian College of Family Physicians. This meeting was supported by the government of the USA, in conjunction with its new initiative, Steps to a Healthier USA. Asthma was chosen as one target because of its debilitating effects and its responsiveness to preventative measures. The USA also has a goal of HP 2010, which is Healthy People in 2010 a goal of increasing quality and years of healthy life and eliminating health disparities. The goals of the meeting were:

- 1) Promote asthma awareness
- 2) Diagnose and manage asthma

- 3) Implement community asthma programs and policies
- 4) Prevent recurrent exacerbations of asthma

It was especially interesting to me to go to the meeting due to upcoming initiatives that I am involved with including implementation and dissemination of new asthma and COPD guidelines and the new Ontario ER project.

Dr. William Busse, a professor of Medicine, Allergy, and Immunology at the University of Wisconsin reviewed the change in focus of asthma management over the last few decades. In the 70s and 80s, asthma was consid-

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CHAIRMAN'S REPORT *(Continued From Page 7)*

ered a disease of bronchoconstriction. In the 80s and 90s inflammation was found to be key and measures of lung function were emphasized. In the year 2000, the issue of concern may well be remodeling. The hygiene hypothesis looks at the balance of Th1 vs. Th2. Children with older siblings (and thus exposure to URIs) early exposure to day care, exposure to other infections like TB, Hep A, and measles all invoke the Th1 cytokines. Th2 is stimulated by Western lifestyle, urban (vs. rural), diet of processed foods, and sensitization to House Dust Mite and cockroach. Th2 proliferation is associated with the spectrum of allergic diseases. That is, we should let our kids play in the sandbox and get URIs younger to stimulate the cell mediated immunity instead of the allergic pathway.

Dr. Noreen Clarke, Dean and professor of University of Michigan School of Public Health spent some time looking at the issues of social and behavioral factors on asthma control. Optimum control requires clinical knowledge, patient counseling, community involvement, and other measures of integrating community care. In her summation she felt that control of asthma lies at the intersection between clinical and community expertise.

Many examples of community integration were given. Coalitions in different communities showed good outcomes in multidisciplinary care. Special populations of Latino and African American patients require special interventions. Many school educa-

tion programs were presented. An abstract on education in the Girl Scouts was even presented. Starbright is a CD-Rom Asthma game distributed to asthmatic children free of charge; the game looks like lots of fun!

The rates of Emergency visits have fallen in the USA as has Asthma mortality, but there are still disturbing trends and these were presented by Dr. Carlos Camargo, Assistant Professor of Medicine, Harvard Medical School and Emergency Physician, Massachusetts General Hospital. The Marc data (which includes Canadian sites) showed that of patients that come to the ER with asthma 90% have been to ER that year, with 21% of them having been to ER more than six times! 15% have been intubated! The higher risk patients are non-Caucasian, lower socioeconomic status people, but surprisingly 65% did have primary care providers, which had been anticipated as a barrier.

Baren Ann Emerg Med 2001 showed that a simple inexpensive intervention of free Prednisone, a taxi chit and a 48 hour phone call increased follow-up with the primary care provider from 29% to 46%, but in this and other studies did not decrease recurrent ER visits. So, this means that even if patients do follow with their Family Physician, they do not get better. A study was reviewed wherein in a California HMO patients were randomized to direct referral to a specialist or routine care, and this intervention improved outcomes. Why?

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In my opinion this answer is multifactorial and may not apply in Canada quite the same. Physicians are less aware of the guidelines in USA and are felt to not follow them. I hope we will do better in Canada! Specialists have full clinics with social workers and psychologic testing in many centres, some of our specialists do have Asthma Educator Clinics in conjunction, but certainly only the minority! Patient behavioral issues are key to successful treatment and thus education which is interactive is necessary to effect behavioral change in patients.

Another interesting study was reviewed Jansen et al, J. Asthma 1996;35:427-435 in which patients were asked why they delayed receiving treatment in the ER. Uncertainty as to need (74%), minimization of symptoms(905), disruption of home (86%), fear of steroids (31%), avoidance of ER (34%, which is an underestimation of the Canadian scene now with SARS!), wanting to be self reliant (46%), and economic concerns (5%), not really a problem in our health care system) were reported. This provides some insights into the minds of our patients.

I went to a few different workshops on which I will report. Emergency management was reviewed from a number of different directions. Issues of defining severity and the need of standardized care reinforced the work that is being done on the Ontario provincial ER asthma project wherein we are currently looking at a number of asthma charts/caremaps to pilot in ERs across the province.

New treatment protocols for resistant asthma were reviewed. They include Magnesium IV, inhaled Heliox, IV Montelukast, and inhaled steroids on top of systemic steroids.

Implementation and dissemination strategies for the upcoming guidelines will be assisted by the review of the US strategies used for their guidelines. The involvement of multiple stakeholders is key. CME should be interactive and not didactic. Physician reminders, multifaceted office based initiatives such as review of outcomes and in-office education along with access to opinion leaders are all important.

Asthma is a disease of many phenotypes. The typical younger onset and atopic individual is one extreme; an eosinophilic disease. The older onset asthmatic tends to be non-atopic and is a neutrophilic disease and is also more steroid resistant and the lung function may not improve as much. The latter patient may have infectious etiologies and treatment in this group with antibiotics for presumed Chlamydia and Mycoplasma is being evaluated.

It was an honour for me to represent Canadian Family Physicians at the meeting. Canadian asthma research nurses were also at the meeting, so Canada was well represented. It is expected that this national USA meeting will be repeated in five years.

Alan Kaplan MD CCFP(EM)

*Chair, Family Physician Airways
Disease of Canada*

ER Rounds

Cydulka RK et al. Comparison of single 7.5 mg dose treatment vs. sequential 2.5 mg dose treatments with nebulized albuterol in the treatment of acute asthma. Chest December 2002;122:1982-7

This US trial looked at whether using sequential doses of Albuterol (their name for Salbutamol) is better or not to a single dose of the same amount of Albuterol. This randomized clinical trial enrolled patients with asthma as per ATS criteria who had FEV1 of less than 70% predicted presenting to their ER. Spirometry was performed 30, 60, and 100 minutes after treatment. The primary endpoint was improvement in lung function, with secondary endpoints being hospital admission and side effects. The mean presenting FEV1 was 46% predicted.

There was no difference in lung function or hospital admission. The single dose group had more side effects (40 vs. 22%), but this did not reach

statistical significance.

The authors conclude that a single dose of Albuterol 7.5 mg is equivalent to three sequential doses of Albuterol 2.5 mg delivered by nebulizer in the treatment of moderate to severe asthma. They also add that a single dose scheme may reduce the chance that subsequent doses could be delayed or missed.

My comment: The management of life-threatening asthma is steroids and enough B2 agonist to either break the spasm or keep the lungs open. My initial dose of Salbutamol is 5mg. It remains to be seen whether 3x5 mg doses are equivalent to 1x15 mg doses; these are the doses that I use in the ER. In addition, Atrovent is added as a routine to initial treatment doses as per CAEP and the effect of Atrovent and Steroid usage need to be controlled for in a study like this. Therefore, use a lot of B2 acutely and monitor closely!

Alan Kaplan

Discontinuing Inhaled Steroids in COPD

Van der Valk P, et al. Effect of discontinuation of inhaled corticosteroids in patients with chronic obstructive pulmonary disease. Am J Respir Crit Care Med November 15, 2002;166:1358-63

I wrote quite a detailed dissertation on the benefits of inhaled steroids in COPD a couple of newsletters ago. The authors here looked at it from the other direc-

tion, ie., what happens to patients with COPD if you stop their inhaled steroids?

This was a randomized, doubled-blind, placebo controlled trial to assess the effect of discontinuation of high dosage inhaled fluticasone on quality of life and exacerbations in patients with moderate to severe COPD.

506 patients with COPD were eligible,

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269 were randomized, and 263 completed the four month run in period where they received 500ug of inhaled Fluticasone propionate BID. 85% were men, 73% were former smokers and 83% had been on inhaled steroids prior to the study.

Outcomes measured were time to first and second exacerbations, recurrent exacerbations and quality of life. An exacerbation was defined as worsening of respiratory symptoms which required 10 day treatment with an antibiotic or oral corticosteroid.

The placebo group experienced an exacerbation 34.6 days sooner than the FP group. Rapid recurrent exacerbations occurred in 21.5% of the placebo group vs. 4.9% of the FP group. A statistically significant difference was noted between the placebo and FP treated groups in measurements of quality of life.

The authors concluded that cessation of ICS in patients with moderate to severe COPD decreased health related quality of life, decreased the time to first and second exacerbations, and increased the risk of recurrent exacerbations.

Comment:

Forty percent of the study patients experienced no down side from discontinuing the ICS. I think we still must attempt to tease out which patients with COPD are the ones which benefit from steroids. These also were patients from a pulmonary clinic, thus perhaps not really mirroring what we see in primary care. In the meantime, I will continue using inhaled steroids in patients with COPD who have severe disease, recurrent exacerbations, or are steroid responders.

Alan Kaplan

LEVALBUTEROL

Comment:

Levalbuterol is the R isomer of Albuterol (salbutamol) and is available in the USA. The theory is that the S isomer is not effective for therapy, but does increase the side effects. One theory also is that the R isomer occupies the B2 receptor and causes up regulation of B2 receptors and even a paradoxical worsening of asthma. Levalbuterol lasts 8 hours, longer than the racemic Albuterol.

I can see the potential utility for this agent in COPD, wherein routine B2 use is necessary. I don't want my asthmatics using that much B2, so it probably does not matter which type you use when you need it. The exception might be in the ER, when patients come in having used lots of routine Albuterol and it has not been working! More to come (and it is not available in Canada yet anyhow).

Alan Kaplan

The role of the Family Physician in the management of COPD

The role of the Family Physician in the management of COPD

With the upcoming release of new Canadian COPD Guidelines, I thought it prudent to analyze the role for Family Physicians in the office management of this common disease. Its prevalence is increasing and Family Physicians have the ability to intervene in this disease to prevent morbidity and effectively manage their care.

COPD is currently the fifth commonest cause of death and will rise to third by 2020. It is a common cause of disability and lost years of productivity. The largest cost in COPD is in hospital admissions and emergency care.

Screening

Family physicians are in a prime position to identify and diagnose COPD. Cigarettes of course mostly cause it and screening smokers has been proven to be effective. Screening of the population has proven to be effective and cost effective. One active screening program cost \$564 per detected case. Contrast that to other screening programs like breast cancer screening which can cost from \$5700 to \$23,400 per detected case². If one can identify the smokers who are at highest risk of COPD, those who are losing lung function at an advanced rate (thought to be roughly 20% of smokers) and get them to stop smoking, the economic impact will be huge. You will also save many

years of morbidity and quality of life years lost, in addition to decreasing mortality later. You can't just wait until symptoms develop, as this may well occur later in the disease as patients often become accustomed to their symptoms.

Diagnosis

The diagnosis of COPD is made through spirometry, which shows chronic airflow obstruction. This is also, of course, how you screen your patient population. Rick Hodder in Ottawa has developed the thirty second COPD test as a tool to make you think of COPD in your patients. See Figure 1.

Guidelines for management

We currently have GOLD guidelines, British Thoracic guidelines and soon to be released Canadian COPD guidelines. I will review some basic tenants of the GOLD guidelines and I will update with the changes in our guidelines in a future newsletter. The goals³ of therapy are

- i) prevent disease progression
- ii) relieve symptoms
- iii) improve exercise tolerance
- iv) improve health status
- v) prevent and treat exacerbations
- vi) reduce mortality

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Prevent disease progression

Smoking cessation is the only intervention that has been proven to delay or halt COPD progression. This needs to be dealt with by multifactorial interventions by physicians, government and patient groups. In the day to day office practice that we have, I find the Prochaska model of readiness to change very useful. In it you identify people who are in different levels of readiness. Precontemplative, contemplative, preparation, action, and maintenance are the levels. I would suggest that you suggest smoking cessation to those who are not ready to change and keep your energies fresh for those who are more prepared to change.

Pharmacologic therapy

The therapy depends on the symptoms and the disease severity. Bronchodilators are begun with SAB2 prn and once being used regularly, long acting bronchodilators should be added. Salmeterol, Formoterol and Tiotropium are your current choices. (See newsletter # ? for an update on Spiriva)

Inhaled steroids are indicated if patients are steroid responders or have poor lung function and have frequent exacerbations. To be defined as a steroid responder, one must test for it. A patient who is not smoking and optimally bronchodilated with continued symptoms are challenged with two weeks of 30 mg per day Prednisone or three months of

Fluticasone or equivalent at 500 ug BID. If the repeat FEV1 shows a 20% improvement with at least 180 cc, you have defined a responder. The Isolde4 trial showed that people with moderate to severe COPD who used Fluticasone at 500 ug BID had decreased number and severity of exacerbations.

Non-pharmacologic therapy

Nutritional support of those who are undernourished, pulmonary rehabilitation and exercise training are other key factors in improving outcomes. The only drug that has shown to decrease mortality in COPD is Oxygen. Evaluation for need of Oxygen will be covered in an upcoming article.

Prevention and treatment of exacerbations

I have mentioned the role of ICS in potentially decreasing exacerbations. There is good data for Tiotropium also in decreasing exacerbations. Influenza and Pneumococcal vaccination are key strategies for prevention.

Once they occur, this is not the population to be stingy with antibiotics in. If they have increased sputum, sputum purulence and fever with increased shortness of breath, they likely have a bacterial etiology. Your choice of antibiotics will depend on severity of illness, co-morbidities and antibiotic exposure. Increase the bronchodilator, assess oxygenation and treat with systemic steroids for a short course as well in all but the mildest exacerbation.

Conclusion

Suspect COPD, screen for it with spirometry and make the diagnosis. Step up your efforts for smoking cessation with the identified patient. Ensure adequate immunization, nutrition and rehabilitation. Medication can help and the treatment regimens are much better with our long acting bronchodilators. Family physicians are the cornerstone of the Canadian health care system; we can make the difference for these patients.

Figure 1.

The Thirty Second COPD test

- Do you smoke currently, or have you smoked cigarettes?
- Do you cough regularly?
- Do you bring up mucous regularly?
- Do even simple chores make you breathless?
- Do you get frequent colds that persist longer than those of other people you know?

1. Murray CJL, Lopez AD. Alternate projections of mortality and disability by cause 1990-2020: Global burden of disease study Lancet 1997;349:1498-1504

2. Van den BoomG, van Schank CP, Rutten-vanMolen MPMH et al. Active Detection of chronic obstructive pulmonary disease and asthma in the general population. Results and economic consequences of the DIMCA program Am J Resp Crit Care Med 1998;158:1730-8

3. Pauwels RA, Buist AS, Calverley PMA et al. Global strategy for the diagnosis, management, and prevention of chronic obstructive lung disease. NHLBI/WHO Global Initiative for Chronic Obstructive Lung /disease (GOLD) Workshop summary. Am J Resp Crit Care Med 2001;163:1256-76

4. Burge PS, Calverley PMA, Jones PW, et al. Randomised, double blind, placebo controlled study of fluticasone propionate in patients with moderate to severe chronic obstructive pulmonary disease: the ISOLDE trial. BMJ 2000; 320: 1297-1303

Alan Kaplan

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MISSION STATEMENT

The Family Physicians Airways Group of Canada is committed to helping those with airway diseases lead a full life. The group is dedicated to helping all family physicians maintain and increase their skill in assisting those with asthma and COPD. The strategy of the Group is to maintain a speaker bank, a data base, and practical tools to help physicians attain these skills.

*"A group of family physicians
with a special interest in asthma."*

The opinions expressed in this newsletter are those of the authors, and not necessarily those of the Family Physician Airway Group of Canada.

Website www.fpagc.com

DÉCLARATION DE PRINCIPES.

L'Association canadienne des médecins de famille contre l'asthme. Un groupe de médecins de famille ayant un intérêt particulier pour le traitement de l'asthme. Les membres de l'Association canadienne des médecins de famille contre l'asthme s'engagent à aider les personnes atteintes d'asthme à jour pleinement de leur vie. L'Association veut aider tous les médecins de famille à entretenir et améliorer leurs connaissances dans le traitement de l'asthme. L'Association se propose de maintenir une liste de conférenciers et une banque de références, et colliger des informations pratiques pour permettre aux médecins d'acquérir ces connaissances.

