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Changes in Asthma Management in General Practice in Australia

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Description

Asthma is a chronic inflammatory lung disease with severe socioeconomic consequences for individuals and their families. The discovery that airway inflammation is the primary underlying cause of asthma has led to recommendations that inhaled corticosteroids be used early in the disease's treatment. Despite these standards and growing awareness, asthma morbidity remains high. Poor adherence to inhaled treatment is a major contributor to uncontrolled illness. Asthma control issues are linked to a lower quality of life and are estimated to account for three-quarters of the overall cost of asthma. As a result, it's expected that better medication adherence will lead to better asthma control and quality of life. Low compliance leads to medication misuse [1].

Overuse of inhaled steroids can lead to an increase in undesired side effects while providing no extra benefits. There is evidence that inhaled steroids can be weaned down or stopped during some periods or at the very least lowered to the smallest effective daily dose that maintains acceptable disease control. Individualizing treatment for each patient may help to balance advantages and dangers, resulting in a more efficient and cost-effective treatment. Patients with mild asthma who are being treated by their general practitioner may be eligible for intermittent treatment as long as their asthma is under control. It requires a lot of effort to implement guided self-management, and more research on its effectiveness and application in general practise is needed. Self-management has been demonstrated to be useful in patients with more severe asthma or frequent exacerbations in the majority of published studies but it is unknown if guided self-management is also effective in people with milder asthma. Asthma control loss is less common, and the impact on quality of life is less severe, leaving little possibility for improvement. The researchers wanted to see if guided self-management could be a safe therapy option for asthmatic patients in general practice [2].

The general practises came from two sources the first were practises in and around Eindhoven, and the second were practises from our department's academic research network. When a sufficient number of participating practises had been reached, recruitment was halted. To avoid contamination, practises rather than individual patients were randomly assigned. To avoid management bias, stratified cluster randomization was used depending on the kind of practise, the number of detected asthmatics and the type of practise used issue list coding, prescription data from practise records, the annual influenza vaccine campaign list, and prescription data provided by the local pharmacist to identify all asthma patients aged 16 to 60 years. Patients who were identified received a letter from their primary care physician inviting them to participate in the trial. Patients who agreed to participate were invited to a lung function laboratory for testing. Box summarises the inclusion and exclusion criteria. All patients lacking exclusion criteria had their inclusion criteria measured. Patients having a pre-bronchodilator forced expiratory volume in one second of 80% anticipated were treated with 800 mg budesonide twice daily for 6 weeks to achieve optimal asthma control at baseline and to allow thorough assessment of the personal asthma control [3].

The self-management programme began with four 30-minute, 20-minute, and 2-minute training visits to the GP's office over the course of three months. These sessions included individualised education as well as instructions on how to use a written self-treatment plan. Patients kept track of their morning and evening peak flow values, as well as the presence of asthma symptoms, on a weekly basis. Three warning symptoms were identified waking up at night due to asthma using a bronchodilator more than four times a day and increased dyspnoea without effort. Patients were instructed to begin daily measurements of peak flow and symptoms if they had alarm symptoms or if their peak flow values fell below 80%, 60%, or 40% of their personal best value. Box 2 summarises self-treatment guidelines for budesonide and oral steroids. Following the training sessions, biannual control visits were advised for a 21-month follow-up period. GPs examined the patients' compliance with the self-treatment instructions at each control visit. It was up to the GP and the patient to decide whether and when these control visits would take place. At each appointment, the breathing technique was taught again, as well as peak flow measurements. In the usual care group, GPs were told to treat all asthma patients as usual for the most part; this is in accordance with the Dutch College of Family Physicians guidelines, which recommend. Every 3–6 months is a good rule of thumb. These national recommendations are similar to most international guidelines, except they do not yet cover self-management. One visit to the GP's office was scheduled at the start of the programme to teach patients how to use and dose their inhaled steroids [4].

The goal of the self-treatment plan was to optimise treatment with inhaled corticosteroids on an individual basis. All trial patients were given budesonide 200 g/dose dry powder inhaler to see if it had any influence on the amount of inhaled steroids they utilised. The daily dosage in the group was decided by the patients' based on national asthma treatment standards. Inhalation instructions were given to both groups on a regular basis. Over the course of two years, patients attended the lung function laboratory every six months. The diary cards were gathered and double-checked for mistakes. FEV1 post-bronchodilator, reversibility, and asthma-specific quality of life were all measured at each visit. Histamine levels were tested at the start and after two years. The research group assignment was not hidden from the assessors. A week in which acceptable asthma control in terms of felt dyspnoea was maintained was classified as a satisfactorily treated week. Patients in both groups documented dyspnoea on a modified Borg scale ranging from to on a weekly basis. The median dyspnoea score of all individual recordings was used to determine which weeks were successfully treated and which were unsuccessfully treated [5].

Conflict of Interest

None.

References

1. Vicente, Tiago, José P.B. Mota, Cristina Peixoto and Paula M. Alves, et al. "Rational design and optimization of downstream processes of virus particles for biopharmaceutical applications: current advances." *Biotechnol Adv* 29 (2011): 869-878.

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2. Gunn, George R., David C.F Sealey, Fakhreddin Jamali and B. Meibohm, et al. "From the bench to clinical practice: understanding the challenges and uncertainties in immunogenicity testing for biopharmaceuticals." *Clin Exp Immunol* 184 (2016): 137-146.

3. Batchelor, Hannah K., Richard Kendall, Sabine Desset Brethes and Rainer Alex, et al. "Application of *in vitro* biopharmaceutical methods in development of immediate release oral dosage forms intended for paediatric patients." *Eu J Pharm Biopharm* 85 (2013): 833-842.

4. Orive, Gorka, Alicia R. Gascon, Rosa Ma Hernández and Alfonso DomínguezGil, et al. "Techniques: New approaches to the delivery of biopharmaceuticals." *Trends Pharmacol Sci* 25 (2004): 382-387.

5. Dong, Li Ming, Heng Li, Ram Tiwari and Lilly Q. Yue. "Subgroups in design and analysis of clinical trials, General considerations." *Design Analysis Subgroups Biopharm Appl*, Springer, United Kingdom.

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