Results: This approach resulted in a significant enhancement of the quality of care.

Discussion and Conclusion: Implementation of locally developed guidelines with

P1286

Under treatment in asthmatic outpatients with mild bronchial obstruction

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Under treatment is one of the reasons for symptoms, sleep disturbance and limita­tion of activities in asthmatics. Inhaled anti-inflammatory drugs, in particular steroids, are very effective in controlling asthma symptoms in patients of all ages and severity.

This retrospective study was to evaluate, in asthmatics with mild bronchial obstruction, the difference between the domiciliary treatments carried out by outpatients (Opx) and that prescribed by the specialists (Sp) based on the severity of symptoms referred.

A retrospective study of 112 consecutive Opts (51 males, 61 females; mean age: 39 years; range: 13–63) with BMI %p FEV1 ≥ 70 (mean BMI, range: 70–132%) was performed.

The patients’ histories and disease severity score in the previous four weeks (DSS) were investigated and the therapy (level 0–4) used by the Opts and prescribed by the Sp was compared.

Sp’s rank correlation was used for nonparametric data.

Only 6 out of 112 (5%) Opts did not report symptoms of asthma (DSS equal to 0) after domiciliary treatment.

We found a significant difference between the therapy used by Opts at home and that prescribed by the Sps (median: home therapy = 0.5; Sp = 2; p < 0.0001, Wilcoxon test), even if a correlation did exist between them (r = 0.39, p < 0.0001).

The total DSS was not associated with the therapy used by the Opts, unlike that of the Sp’s (r = 0.24, p < 0.001).

We found a significant correlation between the domiciliary therapy and day symptoms only (r = 0.20, p < 0.03) and shortness of breath due to exertion (r = 0.19, p < 0.04); on the contrary there was significant correlation between Sp’s therapy and day symptoms (r = 0.22, p < 0.01), shortness of breath due to exertion (r = 0.23, p < 0.01) and also night symptoms (r = 0.21, p < 0.02).

In conclusion, in asthmatics with mild bronchial obstruction: 1) the treatment used by the Opts at home is different from that prescribed by the Sps and their treatment level is indicated by the severity of day symptoms and shortness of breath (r = 0.20, p < 0.03) and 2) the anti-inflammatory therapy is not used regularly, therefore the night symptoms are probably still present.

P1287

Non-participation in early intervention with inhaled steroids in asthma and chronic obstructive pulmonary disease (COPD): The role of ‘fear of steroids’.

Results of the ‘DIMCA’ study

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Treatment of chronic airflow obstruction with inhaled steroids at an early stage has shown to preserve the lung function. However, long-term treatment with inhaled steroids may cause local and systemic adverse effects. We tested the hypothesis that ‘fear of steroids’ may be an important reason of non-participation in the ‘DIMCA’ project, a Detection, early Intervention and Monitoring program on COPD and Asthma. 1749 Randomly selected adult subjects derived from 10 general practices were invited to a screening program to detect asthma or COPD. 604 Subjects were selected on the basis of the presence of bronchial obstruction, reversibility of obstruction and bronchial symptoms. After a two-year monitoring period, 24 patients with an increased lung function decline or bronchial hyperresponsiveness were invited to participate to an early intervention trial with inhaled steroids. Non-participants were sent a questionnaire about the reason(s) of non-participation. Together the screening, monitoring and intervention part of the study showed on average 29% non-participation. The most frequent reason for non-participation was a general resistance to take medication daily (50% of the non-participants of the intervention trial). Remarkably, a specific ‘fear of steroids’ was a reason for denial in only 6.8% of these non-participants. It was concluded that ‘fear of (inhaled) steroids’ seemed not to be an obstacle for early treatment of asthma and COPD.

P1288

The clinical control of asthma after adding airway hyperresponsiveness (AHR) to the policy of low symptom Asthma: A two-year randomized trial

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According to present guidelines (GINA), the level of anti-inflammatory treatment for asthma is solely based on symptoms and lung function. In a randomised parallel design we investigated whether a treatment strategy aimed at reducing AHR (strategy B) on top of improving symptoms, FEV1 and peak flow (PEF) variability (strategy A) leads to a more effective control of 35 non-smoking adults with mild to moderate asthmas (18–50 yr; 23 newly detected; FEV1; mean ± SD: 92 ± 15 %pred) visited the chest physician, every 3 months during 2 yrs. Prior to each visit, methacholine F20 (baseline: geom. mean ± SD: 0.63 mg/ml ± 2.11 DD) was assessed and the subjects received regular asthma, S2-agonist usage and morning and evening PEF on a diary card, during 14 days. At each visit, in both strategies, controller medication with inhaled corticosteroids and/or prednisone (4 levels: no steroids, 400, 800, 1600 µg/day+2 wk prednisone) was adjusted according to a stepwise approach similar to GINA, and to which 4 corresponding classes of AHR were added. In 62% of all instances, AHR-class indicated the need for an increased medication level, which was only applied in strategy B. Improvements in FEV1 and morning PEF (% personal best) were more pronounced in strategy B vs A (B: 5.0 %pred, 9.0% and A: 1.18%pred and 3.5 % respectively; p < 0.05).

In strategy B patients were two times lower in strategy B vs A (Cox regression; p < 0.05). Furthermore, individual standard deviations over the last 1.5 yr period for %pred, morning PEF, PEF-variability and PEF were smaller in strategy B vs A (MANOVA: p < 0.05). We conclude that a treatment strategy aimed at reducing AHR on top of improving symptoms, FEV1, and PEF-variability leads to more effective control of asthma, resulting in fewer exacerbations and less variable airflow limitation. This implicates a role for monitoring AHR in the long-term management of asthma.

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