The following full text is a publisher's version.

For additional information about this publication click this link.
http://hdl.handle.net/2066/24534

Please be advised that this information was generated on 2019-01-28 and may be subject to change.
**P1286**

**Under-treatment in asthma outpatients with mild bronchial obstruction**

B. Farbollini, M.S. Gattianini, S. Pucci, M.B. Bilb, L. Antonicelli, F. Bonifazi.
Allergy Respiratory Unit, Hospital Umberto I, Ancona, Italy

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.

The aim of our study was to evaluate, in asthmatics with mild bronchial obstruction, the difference between the domiciliary treatments carried out by outpatients (Ops) and that prescribed by the specialists (Sps) based on the severity of symptoms referred.

A retrospective study of 12 consecutive Ops (51 males, 61 females; mean age: 29 yrs, range: 13-63) with % FEV1 > 70 (mean: 98%, range: 70-125%) 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 Ops and prescribed by the Sps was compared.

 Spearman’s rank correlation was used for non-parametric data.

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

We found a significant difference between the therapy used by Ops at home and that prescribed by the Sps (median: home therapy: 0.5; Sps: 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 Ops, unlike that of the Sps (r = 0.24, p < 0.001).

In conclusion, asthmatics with mild bronchial obstruction referred to our Respiratory Unit, Hospital Umberto I, performed a domiciliary therapy different from that prescribed by the specialists even if they were treated in the same institution.

The difference between domiciliary therapy and day symptoms only (r = 0.20, p < 0.03) and shortness of breath due to exertion (r = 0.19, p < 0.03) was found to be significant, so that domiciliary therapy was not used regularly.

Therefore, the proper therapy is 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`**

M.L. van Gerven, C.P. Sturkenboom, P.J. Schayek, H.J.M. van Kollenburg, K. van Bascheide, H.J.M. van den Hogen, J. Molenaar, C. van Weel, Dept. of General Practice and Social Medicine, University of Nijmegen, The Netherlands, Department of Pulmonology, University of Nijmegen, The Netherlands

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 Dutch, national, 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 241 patients (15 %pred) visited the chest physician, every 3 months during 2 yrs. Prior to each visit, methacholine PC20 (baseline: geom: mean ± SD: 0.63 mg/ml ± 2.11 DD) was assessed and the subjects received asthma symptoms, %FEV1 and peak flow variability (PEF-variability).

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

In conclusion, in asthmatics with mild bronchial obstruction: 1) the treatment and day symptoms only (r = 0.20, p < 0.03) and shortness of breath due to exertion (r = 0.19, p < 0.03) were smaller in strategy (B) on top of improving symptoms, FEV1 and peak flow (PEF) variability (strategy A) levels; no steroids, 400, 800, 1600 ¿ig/day (baseline: geom: mean ± SD: 0.63 mg/ml ± 2.11 DD) was assessed and the subjects received asthma symptoms, %FEV1 and peak flow variability (PEF-variability) levels; no steroids, 400, 800, 1600 ¿ig/day (baseline: geom: mean ± SD: 0.63 mg/ml ± 2.11 DD) was assessed and the subjects received asthma symptoms, %FEV1 and peak flow variability (PEF-variability) levels; no steroids. 400, 800, 1600 ¿ig/day (baseline: geom: mean ± SD: 0.63 mg/ml ± 2.11 DD) was assessed and the subjects received asthma symptoms, %FEV1 and peak flow variability (PEF-variability) levels; no steroids.

We conclude that a treatment strategy aimed at reducing BHR 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.

This abstract is funded by: The Netherlands Asthma Foundation

**P1289**

**Use of a simple patient focused asthma morbidity score**

L.D. Rimington, L. Acroosfiksy, A. Mowatt, E. Wharburton, I. Ryland, M.G. Pearson. Aintree Chest Centre, Liverpool and Dept Rehabilitation, Univ of Salford, UK

Established and validated questionnaires have been shown to be useful research tools with which to assess asthma morbidity (Juniper 1993), but they too time consuming for routine clinical practice. We have used four questions that the docuter would usually ask in each consultation (covering nights waking, reliever inhaler use, daytime bronchospasm and disruption of activities) to produce an 8 point score that requires no extra time from the clinician. We have assessed this short questionnaire score (Q score) with the Juniper morbidity score (total score and symptom score), with levels of PEF, and with the UK asthma guidelines treatment step (B vs A (MANOVA: p < 0.05)). We conclude that a treatment strategy aimed at reducing BHR 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.

This abstract is funded by: The Netherlands Asthma Foundation

**P1290**

**Effects of patient education to the life quality in asthma patients: 3 years experience**

E. Akkaya, A. Yilmaz, F. Ece, B. Bayramgül, A. Baran, A. Akalp. SSK Şirineyapapa Center for Chest Diseases and Thoracic Surgery, Istanbul, Turkey

Acceptance and application of the International Asthma Report by most countries made asthma therapy more than a simple prescription. It may be expected that patient education in addition to drug treatment will improve the life quality and prognosis of patients. For this reason, we studied randomly selected 25 cases (group I) that gave special education for 1 year and randomly selected 27 cases (group II) that received usual care. Both groups were followed over 3 years.

**Group I**

- **change in life quality at the end of education**
  - PEF 205 (138), FEV1 2.4 (1.0)
  - Qscore 0.8 (0.5)
  - A (MANOVA: p < 0.05)

- **change in life quality at the end of education**
  - PEF 205 (138), FEV1 2.4 (1.0)
  - Qscore 0.8 (0.5)
  - A (MANOVA: p < 0.05)

- **change in life quality at the end of education**
  - PEF 205 (138), FEV1 2.4 (1.0)
  - Qscore 0.8 (0.5)
  - A (MANOVA: p < 0.05)

- **change in life quality at the end of education**
  - PEF 205 (138), FEV1 2.4 (1.0)
  - Qscore 0.8 (0.5)
  - A (MANOVA: p < 0.05)