# Recent Advances in Asthma Care

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The buzz word in asthma circles today is 'control'. We speak fairly glibly about measuring control and getting patients to achieve good asthma control. Whilst this is an excellent and admirable sentiment, what is seldom discussed is what measuring control involves (just how reliable are our current measures of control), what control really means and finally what we can do to improve control. Some studies talk about using defined symptom-based questions to assess control, while others utilise spirometry and or biomarkers of disease activity. If one looks critically, however, at these studies and guidelines, the critical scientific tests for reliability and validity of these purported measures are sometimes not done or their interpretation misleading. This is most acute in children. I do believe that we are on the right track when we say we want our patients with asthma to be 'well controlled'. We certainly would like them to have a normal quality of life and be free of exacerbations. Quite possibly then we should state this as our goal and not use seemingly unclear tests to mark what it is we want.

Failure to find agreement in most studies between control measures; asthma symptoms, spirometry and biomarkers, may simply reflect the basic error in our understanding of asthma. This error stems from trying to lump a vast array of distinct disease phenotypes into a single clinical entity. Asthma is a complex syndrome. Some correlations may exist between various parameters used in clinical assessment, but no single parameter can describe and assess all individuals. This is because we know that some asthmatics are atopic, some not. Some have overt nasal disease, some not. Some asthmatics have significant airway inflammation while in some airway hyper-responsiveness drives symptoms. In some poor symptom control has been ongoing for some time, while in some drug therapy has been timeous and adequate. Multiple phenotypes may preclude finding one definitive test for control. Assessment of multiple parameters including physiologic measures, symptoms, and activity limitation may then be necessary to categorize asthma clinical status accurately, at least until we work out which patient has which type of asthma.[1]

Just as we have moved away from assessing asthma severity in known and treated asthmatics, it may be time to phrase the need to control asthma in terms that we and our patients can both understand and live up to. Expectations to meet pre-determined levels of spirometry or questionnaire recall may not be a useful guide to an asthmatic who feels that his or her life is good and that asthma does not trouble him or her. Likewise finding poor control in patients needs a clear plan for getting control back. This plan must not focus on changing or adding medication as the sole reactionary step. In fact this is the last thing that really needs revision.

New Asthma Guidelines are emerging every month. South Africa has had new Adult guidelines for 2 years and Paediatric Guidelines are about to be published. Let us use guidelines for the purpose for which they were intended, to help practitioners and thereby patients to meet certain goals. The goals don't change. Only our suggestions for getting to these goals change. We don't have any major new drugs for asthma and we don't have a cure in sight. However what we do have is a wonderful tool to achieve asthma control and yet we fail to utilise it. This tool is education. Every study ever done has shown that talking to patients in a goal-directed way improves asthma outcomes. This is not to negate the vital role that treating asthmatic inflammation has played. But anti-inflammatory treatment has saved lives, it has not, on its own, improved quality of life. Only by taking medication correctly and regularly will quality of life be improved. These are critical education messages. Showing patients how to use inhalers and checking that inhaler refills are made are critical steps to improving asthma end-points.

Today we realise that without education of both health care practitioners and patients no asthma control is possible. And yet most of us pay lip service to education. We don't talk to our patients, we don't ask them relevant questions and we sign off on the prescription even before the patient has undressed.

As World Asthma Day 2009 approaches may I ask that we get asthma care back on track. I encourage all practitioners to sign up with the National Asthma Education Programme and together let us help asthmatics live to their full potential. For further information about the National Asthma Education Programme (including free downloadable symptom / adherence diaries and action plans) please see www.asthma.co.za.

## References:

1. Fuhlbrigge AL. Asthma severity and asthma control: symptoms, pulmonary function, and inflammatory markers. Current Opinion in Pulmonary Medicine 2004;10:1-6.