

Asthma Control – Is there a problem?

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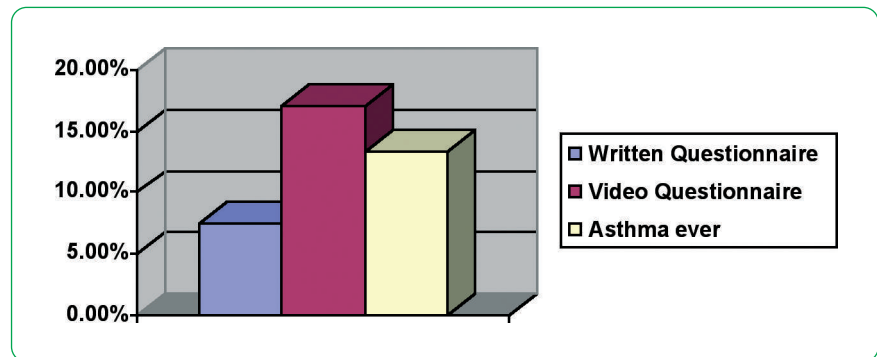
In 1998 the ISAAC Study reported a 12 month prevalence of self-reported asthma symptoms ranging from 7.5% to 17%.¹ The prevalence of “asthma ever” was 13.3% in this group of children (Figure 1). The International Study of Asthma and Allergies in Childhood (ISAAC) Programme was designed to compare the global prevalence of childhood asthma.¹

A subsequent ISAAC follow-up study conducted in the same region revealed a rise in the prevalence of asthma, with an increase in more severe asthma. What was of concern in this audit was that a diagnosis of asthma was seemingly less often made (H Zar personal communication).

The prevalence of asthma in Cape Town is thus high and asthma is a common condition. We should expect then that it would be familiar to the medical profession and well managed and controlled.

In addition to this being a common disease there are well defined end-points for asthma control. Both International and local asthma guidelines have suggested that there are ‘Goals’ for managing asthma² (Table I). These goals state that the only acceptable outcome for a diagnosed and treated asthmatic is return to normal life. Normal life implies a normal quality of life, free from symptoms and exacerbations. Quality of life is significantly impaired by night-

Figure 1: Asthma in Cape Town children (12 month prevalence of asthma) (ISAAC)



time and exercise-induced symptoms.

In a recent review on asthma morbidity from around the world (five studies in all) Professor Rabie has commented on the disappointing lack of asthma control as reflected by ongoing asthma morbidity.³ Many surveys of asthma care have been published from around the world.⁴⁻⁷ They suggest that in total only 5% of asthmatics are meeting the ‘Goals of asthma management’ as set out in Guidelines.⁶ He has listed 3 important reasons for this phenomenon including:

- Asthma is a subtle disease
- Patients have low expectations &

accept limitation

- “Patient and doctors consistently under-estimate severity & control”

It is my belief that 2 important additional reasons for poor asthma control are that:

- Patients are often non-adherent to chronic long-term therapy
- Patients ability to use MDI’s is usually limited

Altana Pharma commissioned Harris Interactive to conduct a 16-country survey among physicians, adults diagnosed with asthma and parents of children with asthma (the GAPP

Table I: Goals of asthma management

<p>The long-term aims of asthma management are to:</p> <ul style="list-style-type: none"> • abolish symptoms • maintain best lung function at all times • prevent development of permanently impaired lung function • reduce the risk of death from an acute attack • avoid unnecessary adverse effects from medication.

Figure 2

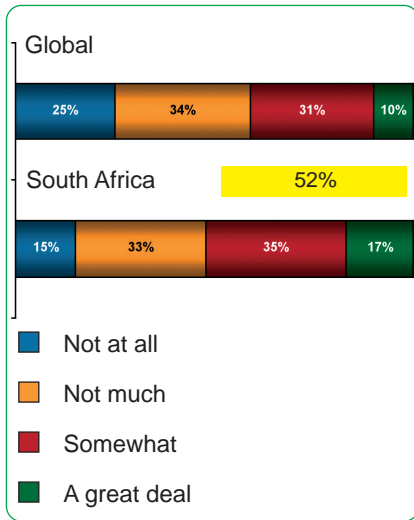
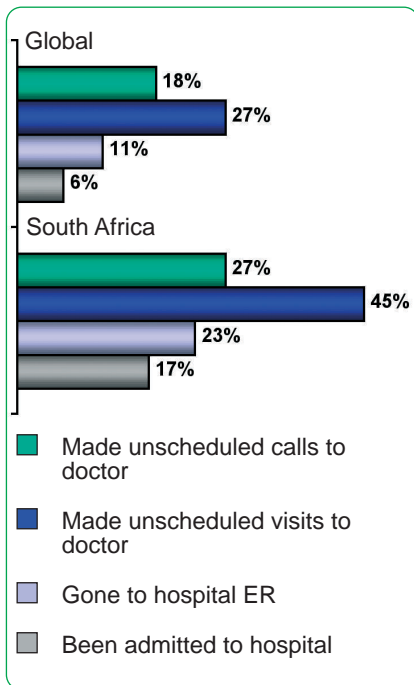


Figure 3

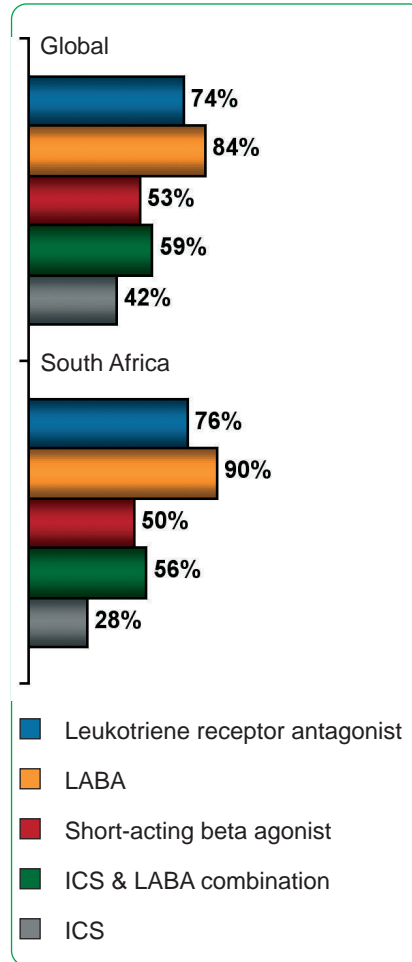


Survey⁷), to explore the following:

- Physicians' beliefs and prescribing habits
- Patients' experiences with asthma
- Doctor-patient communication
- Satisfaction with asthma medications
- Asthma and allergies
- Interest in new asthma treatment

16 countries participated in this research including South Africa. Throughout this report, the term "Global" refers to the combined totals for all study countries. In South Africa,

Figure 4: First-line treatments identified by Doctors for Mild Persistent Asthma



two groups of respondents were recruited for this study:

-100 adults age 18+ diagnosed with asthma were recruited and screened via physician referrals and existing sample lists

-101 physicians who treat adults (50 generalists*, 51 specialists) were recruited and screened from existing national databases.

Some of the important results presented are:

1. Many patients with asthma have daily activity limitation
2. Many patients with asthma continue to have asthma exacerbations
3. There is a disparity between treatment identification and use

1. The extent to which asthma has limited patients' daily activities.

Figure 2 reveals the fact that 52% of asthmatics, receiving therapy, are still limited in daily activities by asthma.

2. The prevalence of unanticipated medical issues among patients

Patients revealed a number of significant episodes of asthma requiring medical intervention (Figure 3).

This means that morbidity from asthma is still significant. Morbidity can be thought of as the ongoing suffering and problems caused by the disease. Despite availability of useful asthma therapies and treatment strategies the morbidity from asthma remains a problem in South Africa.

3. A disparity between ICS identification as the gold standard anti-inflammatory drug by doctors and actual use reported by patients.

The GAPP Survey highlights an important problem in asthma care, namely the disparity between identification of the value of ICS use for asthma and actual use reported by patients. Most South African Practitioners recognise the importance of ICS use for mild persistent asthma but only 38% of patients report using one (Table 2). There may be many confounding factors explaining this result but clearly ICS use is limited.

One additional reason for such dismal asthma control in South Africa is the apparent lack of use of adequate anti-inflammatory therapy for this chronic condition. There is published evidence that asthma therapy is dominated by short acting reliever medication in South Africa and that SABA prescriptions in the respiratory market outweigh inhaled corticosteroid use by a factor of 3.6.⁸

There is mounting evidence that a compounding factor to poor asthma control is under-diagnosis of the condition. Many surveys from South Africa have suggested delay in asthma diagnosis⁹ and recently Davis

Table 2. Asthma Medications Patients Report Currently Taking

	Global Total (%)	South Africa Total (%)
ICS	36	38
Xanthine	5	15
LABA	16	5
Anticholinergics	6	5
Anticholinergics	5	5
+ Combi		
Combi	27	3
LTRA	9	2
Cromoglycates	4	-
+ Combi		
Cromoglycates	1	-
Xanthine + Combi	-	-
Other	44	71

and colleagues¹⁰ found that part of the explanation for this phenomenon is failure to recognise asthma and atopy in parents of children with chest symptoms, since family history has always been suggested as an important screening question for asthma. If parents do not get diagnosed with asthma clearly a family history is useless or requires a more detailed screen of parental symptoms, rather than seeking asthma.

Conclusion

We are still far from achieving control over asthma in South Africa, despite our access to effective treatments. We need to empower asthmatics in order to achieve a normal life despite their asthma and we need to address some ongoing concerns in asthma care amongst our colleagues. This can be done only through a partnership of all role players in the asthma arena. Finally we must stress the importance of assessment of asthma control. Each asthmatic treated is only well if his symptoms resolve, his quality of life returns to normal, exacerbations cease and use of reliever therapy stops. 🙏

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