

ABS007: Scoring system-a guide for general practitioners enabling proper selection of drugs in step care management of asthma

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Introduction: In a population of 7 million asthma patients in Bangladesh, a maximum of only 0.1 million patients are receiving treatment from respiratory experts in the secondary or tertiary care setting. The remaining 6.9 million patients are receiving their treatment from general practitioners (GPs) in the primary care setting. The aim of this paper was to formulate a score by which primary care physicians can select the appropriate step for the patient. **Methods:** An extensive search together with personal experience was gathered to formulate a score system. Effectiveness of these criteria were assessed practically in 5 asthma orientation courses, where a total of 100 GPs applied these criteria on 200 different patients. **Results:** More than 90% GPs applied scoring successfully. **Conclusion:** This scoring system is found to be effective and cost effective in a PHC setting in developing countries.

Criteria scoring yes (1) no (0)

1. Do you have dyspnoea everyday?
2. Do you have nocturnal attacks of dyspnoea more than two times per month?
3. Have you suffered from dyspnoea, which was severe enough to necessitate steroid tablets, Nebulizer therapy, and Aminophylline Injection or hospital admission?
4. Do you have persistent dyspnoea for last six months or more? OR are you taking steroid tablets for one year or more?
5. Is the patient's baseline (during asymptomatic stage) PEFR <60% of predicted value? (Not applicable for <T 5 yrs).

Score wise recommendation for step care management:

Children ≤ 5 Years	>5 Years to Adults
Score → Recommended Step	Score → Recommended Step
0 Step-I	0 Step-I
1 Step-II	1 Step-II
2 Step-III	2 Step-III
3–6 Step-IV	3 Step-IV A
4 Step-IV B	
5–7 Step-V	

Conflict of interest and funding

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ABS008: Asthma management and the PCP: Findings of the global asthma physician and patient (GAPP) survey

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The GAPP Survey is the first global quantitative survey to uncover asthma attitudes and treatment practices among physicians and patients to identify factors that may affect

compliance. A total of 1,733 physicians, 1,726 adult asthma patients were surveyed in 16 countries. Results showed that PCPs are at the front line of asthma management: 54% of patients reporting that they usually see a PCP. A review of treatment used did not demonstrate application of current treatment guidelines. Survey showed that treatment compliance increases with the level of patient education, which is suboptimal at this point. Patient report having experienced short-term side effects in 34%, long-term side effects in 19%, decreased cortisol production in 4%. Patients who experience side effects, although they may not discuss them with physicians are less likely to be adherent, which impacts quality of life, and resource utilization. **Conclusion:** Effective communication may improve patient treatment compliance and proper asthma management. Patients and physicians do not adequately discuss the potential for medication-related side effects. In addition, the availability of new ICS treatment options with comparable efficacy and improved safety and tolerability might enhance patient outcomes.

Conflict of interest and funding

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ABS009: Impact on asthma morbidity and patient enablement of providing a telephone option for primary care asthma reviews: Phase IV controlled implementation study

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Introduction: Our recent randomised trial showed that telephone consultations can improve access to asthma reviews without clinical disadvantage. (Pinnock et al, BMJ 2003; 326:477–9) However, concerns have been expressed that telephone consultations in a routine setting may clinically disadvantage patients. **Aims and objectives:** To compare the effect on asthma morbidity, patient enablement and confidence in asthma management of routinely providing a telephone review service vs. a face-to-face review service. **Subjects and methods:** All registered patients with active asthma ($n = 1,213$) in a large ($n = 31,000$) UK practice were included. Existing practice groups were randomised to a review service including a telephone option (TC-option) vs. face-to-face consultations only (FtF-only). Morbidity and enablement questionnaires were sent to all adults and teenagers at 12 months. **Results:** Questionnaire response rate was 52% (536/1,038). The mini Asthma-related Quality-of-Life and Asthma Control Questionnaires scores were equivalent in both groups: [miniAQLQ: TC-option: 5.29 (SD 1.21) vs. FtF-only: 5.31 (SD 1.24) mean difference 0.02 (95% CI -0.21 to 0.24) $p = 0.87$] [ACQ: TC-option: 1.20 (SD 1.00) vs. FtF-only: 1.33 (SD 1.13), mean difference 0.12 (95% CI -0.06 to 0.31) $p = 0.19$]. However, the modified Patient Enablement Instrument and Asthma Bother Profile (management) scores were both significantly improved in the TC-option group: [mPEI: TC-option: 7.29 (SD 4.26) vs. FtF-only: 6.43 (SD 4.30) mean difference -0.83 (95% CI -1.56 to -0.10) $p = 0.03$] [ABP(m): TC-option: 3.99 (SD 0.84) vs. FtF-only: 3.78 (SD 0.89), mean difference -0.21 (95% CI -0.36 to -0.06) $p = 0.007$]. **Conclusions:** In a routine setting, providing a telephone option for asthma reviews is equally clinically effective as face-to-face reviews. Average enablement and confidence with asthma management was greater in the TC-option group, perhaps reflecting the increased overall review rate.

Conflict of interest and funding

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