ABS31: AKL1, a herbal treatment for asthma: a randomised controlled cross-over trial

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Introduction: Despite effective treatments, asthma outcomes remain suboptimal. Interest exists in herbal remedies. *Aims:* To evaluate AKL 1, an herbal mixture, in a randomised double blinded placebo controlled cross-over trial. *Methods:* 32 asthmatics (8 male, median (range) age 40.5 (22—73) yrs., median (range) FEV1% predicted 87.5 (33—126)%, median (range) daily ICS dose 800 (0—4000) mcg beclomethasone) completed a 36 week trial consisting of; four week baseline, twelve-week treatment with AKL or identical placebo, eight week washout and further twelve-week cross-over treatment period. The change occurring over treatment periods was observed for lung function, Asthma Control Questionnaire (ACQ), Asthma Quality of Life Questionnaire (AQLQ), Leicester Cough Questionnaire (LCQ) scores. The mean (95% Confidence Interval) individual patient changes between active minus placebo periods was calculated. *Results:* No significant differences in lung function (active—placebo) were found (FEV1: mean (95% CI) difference = 0.01 (−0.12 to 0.14)L, $p = 0.9$. PEF: −4.08 (−35.03 to 26.89) L/min, $p = 0.8$). Trends to clinical improvements favouring active treatment were however consistently seen in the patient-centred outcomes: ACQ mean difference (active − placebo) = −0.35 (−0.78 to 0.07, $p = 0.10$, AQLQ difference 0.42 (−0.08 to 0.93, $p = 0.09$), LCQ difference 0.49, (−0.18 to 1.16, $p = 0.15$). With a change in ACQ and AQLQ score of 0.5 signifying a clinically relevant changes in control or health status, on the ACQ, 28% were unchanged, 22% better on placebo and 50% better on AKL, and on the AQLQ 29% had no change, 29% were better on placebo and 42% better on AKL. Nine exacerbations occurred during placebo treatment and five whilst on AKL. No significant adverse events were noted. *Conclusions:* AKL1 treatment was well tolerated. Consistent trends to symptom and quality of life improvements were observed, although no improvements in lung function seen. Further studies

Conflict of interest and funding

None. Funding: The study was funded by Bridgehead Technologies Ltd.

doi:10.1016/j.pcrj.2006.04.131

ABS33: The care of asthmatic children in Aragon: what is the actual position in primary care?

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Background: In 2004, the Servicio Aragonés de Salud (SALUD) elaborated, by means of consensus, the Care of Asthmatic Children Document. Since that year, the care of asthmatic children has been included in the services provided [1]. *Objective:* To know the human and material resources that are available for care of asthmatic children and adolescents in Aragon' Health Centres, the asthma training received by professionals as well as the way in which the asthmatic children are treated. *Material and methods:* A survey was sent to the 138 paediatricians working in Primary Care of SALUD. *Results:* 71% of paediatricians surveyed replied. 90% have spirometers and 41% have paediatric mouthpieces. 75% have inhaled bronchodilators and spacers. 85% have hand held inhalers with placebo, 42% hand out information about triggers and 17% of paediatricians prepare a written asthma action plan for their patients. Asthmatic children are seen in surgery hours (82%). Spirometry is carried out by 40% of professionals. 36% have a register of all their asthmatic patients and 23% have the patients classified according to the severity of their asthma. *Conclusions:* The primary care paediatricians should strive both, to receive proper training in asthma and provide asthmatic children with suitable care. The Institutions should supply the necessary human resources and equipment, and there should be complete coordination with specialist care.

Conflict of interest and funding

There is no conflict of interest.

Reference

[1] García Marcos L, Castro Rodriguez JA, Montaner AE, et al., for the Spanish Pediatric Asthma Study Group. The use of spirometers and peak flow meters in the diagnosis and management of asthma among Spanish pediatricians. Results from the TRAP study. Pediatr Allergy Immunol 2004;15:365—71.

doi:10.1016/j.pcrj.2006.04.132

ABS34: Could interchangeable use of dry powder inhaler compromise quality of care? An international study of physicians and pharmacists

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Introduction: In the future there is greater potential for switching devices without physician and patient involvement at the pharmacy as more devices containing common products become available. *Aims:* To explore the opinion of physicians and pharmacists of switching DPI devices without physician and patient involvement. *Subjects and methods:* A Delphi process was undertaken with respiratory leaders to identify themes. These were developed into structured questionnaires for physicians and pharmacists. *Results:* 502 general practitioners (GPs) and 254 pharmacists from Australia, Canada, France, Germany and the UK completed the questionnaires spring 2005. Over half GPs and pharmacists considered patient involvement in selection of DPI to be important, 91% GPs noting involvement improves adherence. Majority GPs expressed concerns about possibility of receiving different inhalers with each prescription, particularly patient confusion and negative impact on asthma control (90% and 79% of GPs respectively). Pharmacists particularly concerned about patient confusion (77%). Both GPs and pharmacists anticipated a negative impact on adherence, device handling, therapeutic effect and workload if patients were switched from usual DPI. Majority GPs and half pharmacists thought DPIs should be prescribed by brand name, and there should be official recognition that DPIs are not interchangeable. *Conclusions:* This study suggests that indiscriminate switching of DPIs could result in patient confusion, device misuse and loss of asthma control. Interchangeable use of DPIs could compromise quality of care. DPIs should only be switched with physician and patient agreement, and patient training.

Conflict of interest and funding

D. Price has no shares in pharmaceutical companies. He has received speaker's honoraria for speaking at sponsored meetings from the following companies marketing respiratory products: 3M, Altana, Astra Zeneca, BI, GSK, MSD, Novartis, Pfizer, Schering-Plough. He has received honoraria for advisory panels with; 3M, Altana, Astra Zeneca, BI, GSK, MSD, Novartis, Pfizer, Schering-Plough. He or his research team have received funding for research projects from: 3M, Altana, Astra Zeneca, BI, GSK, MSD, Novartis, Pfizer, Schering-Plough, Viatris.

doi:10.1016/j.pcrj.2006.04.133