

Asthma Training Module (ATM), Asthma by Consensus (ABC) and Asthma Education

T U S U K U M A R A N

National IAP President, 2011 and Professor of Pediatrics, PIMS, Thiruvalla, Kerala. Correspondence to: Sreeshylam, Ettumanoor P.O., Kottayam 686631, Kerala. tusukumaran@gmail.com

It is my pleasure and privilege to present one of my action plans for this year, revised Asthma Training Module (ATM) and a book on Asthma By Consensus (ABC). The prevalence of bronchial asthma varies from country to country and in the same country varies from state to state. The largest study group who conducted a study on prevalence of bronchial asthma is the ISAAC study group [1]. They studied the prevalence of bronchial asthma in 56 countries with the study population of 4.5 lakhs. As the principal investigator of this study from the state of Kerala, the data from Ettumanoor block area of Kottayam district showed the prevalence of 32.2% in children 13 – 14 years and 25 % in children 6 – 7 yrs (ISAAC Phase 1). Bronchial asthma is an iceberg disease [2]. Classical presentation with cough, wheeze, dyspnea and chest tightness is the tip of the iceberg and is seen only in 30% and remaining 70% present with atypical features. Patient education, along with pharmacotherapy is an integral part of asthma management [3].

WHY EDUCATION IS IMPORTANT IN MANAGEMENT OF ASTHMA?

Education helps children and their families to develop the necessary knowledge, attitudes, beliefs and skills to manage asthma effectively. No treatment regime is likely to be effective unless it is followed properly, so patient education is central component in current asthma guidelines. It starts from the basic communication skills. The lack of attention paid to parents' fears and concerns about their child's illness results in dissatisfaction with the consultation. Clear-cut explanations about the disease avoiding medical jargon are always valued by patients. It is

recommended that clinicians teach patients and their families, essential information concerning the disease process, medication skills, self-monitoring techniques and environmental controls [4-11]. The major goals of communication to the family of a child with asthma include the following:

1. Make them accept the diagnosis
2. Understand the trigger factors and avoid them
3. Drug therapy
 - (a) Concept of controllers and relievers
 - (b) Proper use of the drug delivery system
4. Likely prognosis in individual cases
5. Adjuvant
 - (a) Lifestyle modification
 - (b) Weight reduction
6. Consider the psychosocial aspects of asthma

MAKE THEM ACCEPT THE DIAGNOSIS

When there is family history of asthma and when child gets recurrent episodes of wheezing and breathlessness, it is probably easy for them to understand the concept of asthma. This is not the case when child presents only with nocturnal or exercise induced symptoms or has a cough variant asthma. Many people do not want their child to be labeled as 'asthmatic.' It will be easier for them to understand and accept the diagnosis if we do a bit of explanation on the pathophysiology, of course, in non-medical terms. They may understand better if explanation is done with the help of a few drawings.

Explain the following questions – What is asthma? What causes asthma? Why my child got asthma? Is asthma same as allergy?

UNDERSTAND TRIGGER FACTORS AND AVOID THEM

The importance of environmental control should be explained in great deal. Triggers may be different in different individuals. We can make the parents aware of the common allergens which may act as trigger in asthmatic children and instruct them to observe and find out the specific precipitants in the individual child. It is found that food is the least important trigger for asthma, but food restriction is the easiest to implement on the child, so many people practice various food restrictions. The important and avoidable triggers are tobacco smoke, smoke from fire wood in kitchen, incense sticks, mosquito coils, perfumes, body sprays, talc, odor of cleaning agents, house dustmites, cockroach debris, moulds, stuffed dolls, pets at home, pollens around certain food items, and additives.

DRUG THERAPY

Make the parents understand at least the following facts regarding medications. There are two kinds of medications in the treatment of asthma. (a) controllers - for prevention of future attacks (b) relievers - for relief of present attack.

Controller medications: These medicines are for long term control of asthma. They help to reduce the inflammation in the lungs that is behind each asthma attack. These medications should be administered daily irrespective of whether the child is having asthma symptoms or not. The commonly used controllers are inhaled corticosteroids and monteleukast. It is rather easy to start monteleukast which is an orally administered drug, but we may have to spend a little more time discussing about the need of inhaled corticosteroids. This is because many people are prejudiced against corticosteroids as well as use of inhaled devices use. The common belief is once a child is started on an inhaled medication, he becomes dependent on it. We should make them understand that some patients need these medicines for a longer duration due to the chronic or continuing nature of the disease. Also you can tell them that since child has problem only in his lungs,

medicines administered directly to that part will be more effective than a medicine given orally which will be distributed throughout the body and hence likely to produce unwanted side effects in other parts of body. Another point which we can explain is the reduction in dose of drug when you use the inhalation route. It comes to a few micrograms whereas orally given drugs are in milligrams.

Reliever medications: These are medications, to be administered once asthma symptoms like cough and wheeze begin. These stop the current attack only. They have no effect in the inflammatory changes of airways and also they won't prevent future attacks. Long term use of relievers do more harm than good as they can reduce the perception of bronchospasm by the patient and can lead to more severe and difficult to treat attacks.

ASTHMA TRAINING MODULE (ATM)

The concept and idea of ATM was started in 2000 by the Respiratory chapter of IAP under the Chairmanship of Dr TU Sukumaran, Dr SS Kamath, Secretary; Dr Swati Y Bhave, Advisor; and Dr RP Khubchandani, Convener. The first TOT on ATM was conducted at Hyderabad and trained 100 pediatricians as master trainers all over the country. The first revision of ATM was conducted at Bangalore by Dr Suresh Babu, Dr Mahesh Babu and Dr Nagabhushana in 2005. Now we are launching the 3rd revised ATM. With this aim, a national level TOT was conducted successfully at Bangalore on 7th and 8th of May. We are planning to conduct 35 workshops on ATM throughout the country this year.

ASTHMA BY CONSENSUS (ABC OF ASTHMA)

Respiratory chapter of IAP published the first edition of ABC of Asthma in 2003 under the chairmanship of Dr RP Khubchandani. Even though the revision of ABC started in 2005 by Dr Suresh Babu, Dr Mahesh Babu and later on 2008 by Dr Gautam Ghosh and Dr KK Ghosh it could not be materialized. This year we are publishing the second edition of ABC and are planning to distribute one copy of this book to all IAP members. We had a successful national consultative meeting on ABC at Hyderabad on 26th & 27th March 2011. My thanks to Dr YK Amdekar, Dr Swati Bhave, Dr Krishan Chugh, Dr H Paramesh, Dr N

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