Asthma: Awareness and Education

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Worldwide, an estimated 300 million people suffer from asthma and 255,000 people died of asthma in 2005. Asthma is a major public health problem worldwide. According to the 2006 National Health Interview Survey, approximately 11% of adults 18 years of age or older have been diagnosed with asthma in USA and the disease is not limited to age, ethnic origin, or socioeconomic status. The disease has been associated with familial, infectious, allergenic, socioeconomic, psychosocial, and environmental factors. Asthma is responsible for approximately 10 million physician office visits, over 100 million days of restricted activity, and total annual costs of over $11 billion. A paradox exists regarding asthma. Although we now have a better understanding of the pathophysiology of asthma than ever before, along with access to better medications for asthma treatment, we are seeing an increased incidence of asthma, an increase in hospitalizations, and higher rates of asthma related morbidity and mortality. This discrepancy between the scientific evidence and the reality scenario. Asthma education programme may be able to bridge the gap. Education in asthma care requires education for the patient about self-management of asthma and educations for the clinicians to enhance skills in teaching patients with self-management and provide support to implement guidelines recommended practice.

For the clinicians, potent interventional tools could change their practices and result in desirable patient outcome and it is very important for improving healthcare and reducing the cost. Whereas for patients various interventions for improving their knowledge about the disease in the form of asthma education programme comprising of information about disease, its long term effects, self-monitoring of disease, written management plan and correct inhalation technique significantly reduces asthma morbidity and mortality.

There is huge gap in the goals of asthma management and the reality scenario. Asthma education programme may be able to bridge the gap. Education in asthma care requires education for the patient about self-management of asthma and education for the clinicians to enhance skills in teaching patients with self-management and provide support to implement guidelines recommended practice.

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There is enough evidence now that asthma self-management education is effective in improving outcomes of chronic asthma, both in adults and children. The ultimate goal of this exercise is to reduce the impact of the disease on related morbidity, functional disability and quality of life. Educating patients about self-assessment and self-management to prevent or control exacerbations brings about reduction in emergency department visits and hospitalization resulting in reduced cost and ultimately improved health status. Associated benefits include reduction in symptoms, less limitation of activity, improved adherence to medicines and better control of asthma.

Patient education is the mechanism through which patients learn to accomplish various tasks like understanding and following complex pharmacological therapies, instituting environmental control strategies, monitoring asthma, to detect and self treat exacerbations, follows the right inhalations techniques and interacts with healthcare providers appropriately.

Asthma education can be delivered at various levels of care like clinics, emergency departments, hospitals, schools or community settings to both patient and family members. The clinic or office-based education requires clinicians to assess the disease, explain about asthma and the ways to monitor the disease and give tips to identify exacerbations and discuss the action plan before patients contact the doctor. Also at each reassessment visits the education is reinforced. This programme may be carried out at a clinic with single patient at a time or in small groups. Successfully treated patients can guide a new group and share their own experience.

Education may be provided in the emergency room or during hospital stay. It may be the best time to intervene as patients may be the most receptive at this time. A brief and focused interaction by clinicians with patients about their disease and importance of regular treatment and correct technique of aerosol therapy can be rewarding.

It is essential to have a partnership with the patient and involve him in decision making about disease management taking his social, financial and emotional needs into consideration. The written asthma education plan can provide a way to involve patient directly by writing down the treatment plan so that clinician and patient both agree upon and giving clear instruction that patient can use at home. It must include instructions both for daily actions to keep asthma under control and actions to adjust treatment when exacerbations or symptoms appear. It should be reviewed at each follow up visits and may be changes as per patient’s lifestyles and acceptance. The plan may be based on either symptoms or on the objective monitoring of disease with the help of peak flow meter. Peak flow meter is especially recommended for patients who have moderate to severe persistent asthma, those patients with poor perception of airflow obstruction or worsening of asthma and patient having environmental or occupational contributing factors.

In the current issue of the journal, the original article by Barthwal et al talks about the impact of asthma education programme on morbidity, inhalation technique and asthma knowledge. The study is the format in which the information about disease and the treatment part including the action plan given to the patients. A significant number of patients had satisfactory knowledge about the disease which resulted in better control of asthma. The limitation of the study is the absence of lung function study which were not
carried out. Disease like asthma with a lot of variation is best monitored with objective measurement like PEFR monitoring. Also, classification of asthma is based on objective assessment as mild, moderate and severe which is best assessed by peak flowmeter. It would have been interesting had PEFR monitoring been done and would have better proved the claim of the authors.

References


