Primary Care Respiratory Society UK - Opinion No.23

# Opinion

# Asthma review

## Reviewing people with asthma

Asthma continues to represent a significant disease burden with surveys consistently showing unacceptably poor control associated with low expectations on the part of patients.[1] There is good evidence that the provision of proactive care, including regular reviews incorporating self-management education, can significantly reduce morbidity.[2] Regular review of people with asthma is recommended by guidelines,[3] and is a standard within the UK Quality and Outcome Framework (QOF).[4]

## Key components of an asthma review

This Opinion sheet echoes the Quality Standards for asthma[5] and describes a practical approach to the provision of asthma reviews in primary care incorporating three key components:

- Assessment of control in order to target care
- Management to improve control
- Guiding self-management to facilitate ongoing control

## 1. Assessment of control

Patients under-report symptoms and both patients and clinicians overestimate asthma control.[1,6]

Standard morbidity questions should therefore be asked at every asthma consultation and recorded to provide an objective assessment of control.

The British Asthma Guideline, recommend the use of the, 'Royal College of Physicians three questions' (RCP 3Qs)[7] which have been used successfully to detect poor control and target care.[8] Validated alternatives include the Asthma Control Questionnaire,[9] or the Asthma Control Test.[10] Patients with controlled asthma should have no nocturnal waking or activity limitation, and symptoms should not occur on more than three days per week.[3]

**Data collection**

Computer coding (e.g. Read Codes) can be used to define and record clinical parameters. The QOF guidance and PCRS-UK publications include specific coding details. Templates can facilitate accurate coding of morbidity data e.g. the PCRS-UK asthma research template available from http://www.iharp.org/ (EMIS LV, Vision and ISOFT Torex systems only)

**Other indicators of control**

The prescribing record of relief medication and oral steroid courses provides evidence of poor control.

## 2. Management

If asthma is well controlled, discuss any issues of importance to the patient, check inhaler technique, consider reduction of preventer medication and reinforce self-management so that the patient is aware when and how to seek further help.

If, however, there is evidence of poorly controlled asthma the following should be considered and addressed appropriately:

**Review the diagnosis**

Deterioration, or persistence of symptoms despite adequate asthma treatment may be due to another disease.

**Inhaler technique**

Poor inhaler technique may be responsible for inadequate control. Three-quarters of patients make mistakes when using a pressurised metered dose inhaler, while only half can use dry powder devices or breath-actuated metered dose inhalers without errors.[11]

Similarly, poor inhaler technique can significantly reduce the amount of drug delivered to the lungs and result in poor asthma control.[12]

Simply observing inhaler technique, however is not enough: poor technique needs to be corrected and, if necessary, a device more suited to the patients ability should be prescribed.[3]

**Adherence**

Poor adherence to medical advice may explain failure to control asthma symptoms.[3] In primary care, computer repeat prescribing systems may provide an indication of adherence to prescribed asthma regimens.

Strategies for improving adherence include providing simple, verbal and written instructions with information on drug treatment for patients (and carers if appropriate) and asking the patient about barriers to using medication. Achieving concordance by listening and responding to the patient's concerns and goals is likely to improve (though not guarantee) adherence to advice.[3]

**Link with rhinitis**

Asthma and rhinitis co-exist in the majority of patients.[13,14] Diagnosis of co-morbid rhinitis should be actively pursued in all patients with uncontrolled asthma. Treatment of the concomitant allergic rhinitis, particularly with intranasal steroids, has been demonstrated to improve asthma morbidity.[13,14]

**Occupational asthma**

Occupational exposure is an important cause of uncontrolled asthma and should be considered in patients with adult onset allergic rhinitis or asthma, or reappearance of childhood asthma. Positive answers to the questions, "Is your asthma better on days away from work?" and "Is your asthma better on holiday?", are suggestive of work-related asthma. Serial peak flow measurements (at least four readings per day) may provide suggestive evidence indicating the need for referral to a specialist in occupational medicine.[3]

**Smoking status**

It is important to enquire about smoking status and offer cessation advice in patients with asthma, and the parents of children with asthma.[3] Smoking reduces the effect of inhaled steroids, and increased doses may be needed in current and ex-smokers.[3]

**Adjusting therapy**

After consideration of diagnosis, adherence, inhaler technique, smoking status, triggers and concommitant rhinitis, patients with poorly controlled asthma should be advised to step-up their medication.[3] It is equally important to consider stepping down treatment in patients who are consistently well controlled.[3]

## 3. Guiding self-management

A large body of evidence underpins the guideline recommendation that "All people with asthma (and/or their parents or carers) should be offered self-management education which should include a written personalised asthma action plan and be supported by regular professional review".[3] There is growing understanding of the inter-relationship of professional reviews and patient self-management.[15] Asthma guidelines explicitly recommend that asthma reviews should incorporate self-management education and provision of a written action plan.[3]

### Organisation of asthma review services

Asthma reviews should be undertaken by a healthcare professional with appropriate training.[3,16]

Not all patients are willing to attend for a regular asthma review.[3] Attendance may be improved by a range of strategies, including:

- Reminder letters, possibly including action plans for completion during the consultation,[17]
- Controls on repeat prescribing may enhance good practice and ensure regular reviews of patients prescribed medication.
- Flexible arrangements for providing reviews, rather than 'clinics' arranged at fixed times during the week may facilitate uptake.

### Telephone reviews

Providing an asthma review by telephone is recommended in the current BTS SIGN guideline for asthma as an effective option in some situations. Using the RCP 3Qs may identify those in whom a face-to-face review would be more appropriate.[3,18] Opportunistic telephone calls may be used to provide reviews for non-attenders, thus reducing QoF exception reports.[19]

A suggested model of care incorporates this evidence:

- Offer patients a choice of mode of review, expecting that most patients will make a choice appropriate to the severity of their asthma.[20]
- Call patients not responding to invitations or defaulting their appointment, and provide a telephone asthma review.
- Patients identified during a telephone review as having poorly controlled asthma (positive responses to standard morbidity questions, frequent requests for reliever medication and/or a history of acute attacks) should be invited for a face-to-face review.

## QOF and asthma reviews

The prevalence of 'active' asthma in the UK reported to QOF is 6%. In 2012/13 90% of practices achieved the 70% target for an review including an assessment of the RCP3Qs. The median 'exception reporting' rate was only 2.8% for the asthma review indicator, though a minority of practices had considerably higher rates than this.

A key change in recent years has been the inclusion of the requirement to assess asthma control during a review with the RCP3Qs. The rationale is that having assessed control, the clinician will take appropriate action to gain or maintain control and provide supported self-management tailored to individual needs.

**Table 1. The Royal College of Physicians three questions (RCP3Qs)[5]**

| In the last month: | Read Code |
|---|---|
| Have you had difficulty sleeping because of asthma symptoms (including cough)? | #663P |
| Have you had your usual asthma symptoms during the day (cough, wheeze, chest tightness or breathlessness)? | #663q |
| Has your asthma interfered with your usual activities (e.g. housework, work, school etc.)? | #663N |

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**Date of Preparation:** August 2008, **Revised** April 2014 **Author**: Dr Hilary Pinnock, Whitstable, Kent **Conflict of interest**: None
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