EDITORIAL

Managing Asthma in the Caribbean

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The Caribbean Health Research Council (CHRC) has completed the revision of the clinical guidelines on *Managing Asthma in the Caribbean*. This is timely as it has been 12 years since the publication of the original Caribbean Asthma Guidelines by the CHRC then known as the Commonwealth Caribbean Medical Research Council (CCMRC) in collaboration with the Global Initiative for Asthma (GINA). The recent launch of the Guidelines marks the culmination of a partnership that included the CHRC, The University of the West Indies, St Augustine and Mona Campuses, the Chief Medical Officers of the 18 English-speaking Caribbean countries, regional professional associations as well as representatives from the private sector. The Pan American Health Organization supported the initiative.

The CHRC has a mandate to promote evidence-based practice in the Caribbean. Together with its partners, the team has ensured that the Guidelines are based on cutting-edge research findings. At least 21 of the 64 references cited detail research conducted in the Caribbean.

So how do the revised Guidelines differ from the 1997 edition?

The revised guidelines, *Managing Asthma in the Caribbean*, have been developed in 4 sections:

- Core Information Regarding Asthma and its Management
- Asthma in Young Children (< 6 years)
- Asthma in Children (6–13years)
- Asthma in the Adult Patient

In each of the above categories, there is clear differentiation for disease management for the community, emergency and in hospital care. For those familiar with the previous guidelines, there are more user friendly tables and algorithms that organize and highlight various management strategies. The CHRC is also committed to developing a pocket edition of the guidelines to facilitate the increased application of these revised guidelines.

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There are some key messages that form the major change from the 1997 edition. There is emphasis on assessing, treating and monitoring patients based on the level of asthma control rather than on disease severity. In the 1997 guideline, decreasing the severity of asthma was the characteristic feature of efficacy of management.

The classification of Intermittent severity was the best one could achieve, meaning there would be:

- Symptoms < once a week
- Brief exacerbations
- Nocturnal symptoms not > twice a month
- Forced Expiratory Volume in the first second (FEV_1) or Peak Expiratory Flow Rate (PEFR) > 80% predicted
- PEFR or FEV_1 variability of < 20%

In the revised Guidelines, achieving asthma control means that a person has:

- No or minimal asthma symptoms
- No waking at night
- No or minimal need to use quick-relief medication
- No Emergency Room visits
- The ability to do normal physical activity and exercise
- Normal or near-normal lung function test results (PEFR and FEV_1).

For persons 6 years and older, a 5-step management approach is recommended based on the level of control. Before a step up, one is advised to check for correct inhaler technique, adherence to recommended treatment and control of allergic rhinitis and the presence of environmental triggers. A short course of 7 to 10 days of oral corticosteroids may be needed to establish prompt control at any step. One new feature is the addition of leukotriene modifiers to Step 2. In addition, there is emphasis that long-acting beta-agonists must be accompanied by inhaled corticosteroids.

Specialists should be consulted when there is co-morbidity, failure of optimal response or if the patient progresses to treatment requirement at Step 4 or 5.

The Emergency Room doctor and other health professionals are reminded that patients with severe asthma and one or more risk factors, including psychosocial challenges and obesity, are at increased risk of

death. Indeed, admissions to hospital should include those in whom the presence of psychological problems, social isolation or compliance problems have been determined.

Although these points are emphasized, there is other valuable information not to be dismissed. Paediatricians tell cautionary tales of children in whom other diagnoses were missed while the child's asthma medication was persistently increased. Physicians are encouraged to seek an alternative diagnosis for recurrent wheeze in both children and adults. More frequently, internists give reports of adults being prescribed mucolytic agents or sedatives for persistent night cough. Health professionals are strongly reminded that these two classes of medications should be avoided in the asthmatic patient.

There is considerable emphasis on involving the patient and his or her relative in achieving the goal of asthma control by using an Asthma Management Plan. There is an appropriate analogy that compares blood pressure monitoring in the hypertensive patient with the Peak Expiratory Flow Rate (PEFR) monitoring in the patient with asthma. Physicians are encouraged to train patients to record their PEFR and to discuss with them how to overcome any identified barriers in following their Asthma Management Plan.

Implementing locally developed or international evidence-based guidelines has improved asthma treatment and decreased the burden of asthma. This is supported by the declining asthma mortality rates over the last 10 years. We therefore expect that these revised guidelines would allow that trend to emerge in Caribbean territories. In addition, it is critical that even more essential asthma research is conducted in the Caribbean to further guide evidence-based practice and form the foundation for future revisions of these Asthma Management Guidelines.

The guidelines are available on the website of The Caribbean Health Research Council. It is hoped that caregivers of patients with asthma and those with an interest in the disease will find them useful. The Caribbean Health Research Council welcomes feedback.
Website: www.chrc-caribbean.org