PAEDIATRIC ASTHMA CARE MASTERCLASS: PRACTICAL ENGAGEMENT STRATEGIES

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Welcome and introductions

Cathryn Berry 00:00

We're really delighted to welcome you today to our webinar, a paediatric asthma care master class on practical engagement strategies. My name's Cathryn, and my role at asthma Australia is to look at how we can support healthcare professionals in the delivery of that best-practice, person-centred care for people with asthma. With my colleagues, I've been working to deliver on some grant funding that we received from the Department of Health under the quality use of diagnostics, therapeutics and pathology program. And we're delivering this quality use of medicines healthcare professional education package in asthma, in collaboration with partners from the Lung Foundation and the Thoracic Society. So, this webinar forms part of this package of work. And after the event, we'll send you some periodic updates when you know we've got more content available and so on. Before we go any further, I'd like to acknowledge the traditional custodians of the lands on which we meet today. I'm speaking to you from Cammeraygal Country, and I pay respect to the continued cultural, spiritual and educational practices of the Aboriginal and Torres Strait Islander peoples. I'll hand over now to Dr Chris Pearce, who is our moderator for this evening. Chris described himself the other day as a rural generalist, and in his spare time, he's also been a leader in health informatics for over 20 years. Chris has an important connection to Asthma Australia, as he's a member of our Board and our Professional Advisory Council. Thank you for starting our meeting today.

Chris Pearce 01:46

Thank you very much, Cathryn for the introduction. And I'd really like to welcome you all here today. We've got an excellent panel gathered here today to help you with this masterclass. As you can see, we've got Tim Senior, who is a general practitioner from the Tharawal Aboriginal Corporation in South West Sydney, New South Wales, and has a long history in helping Asthma Australia with its with its work. Kirsty Porteous is an Asthma Educator Asthma Australia, based in Queensland, and has been working a lot with us in terms of personalising treatment measures for people with asthma. Gaylene Bassett is a nurse practitioner in Paediatric Respiratory and Allergy at the Northwest Regional Hospital in Tasmania And we also have Rebecca Smith, also from Tasmania, who is a parent of a child, and a lot of experience in how the personalisation of asthma care, if you like. We will be starting also with Dr Shivanthan Shanthikumar who's a Paediatric Respiratory Specialist at the Royal Children's Hospital and the MCRI here in Victoria. He will be giving us a background on some of the specialty aspects of the management of asthma. So, I think with any further ado, we'll move on to Shiv's section of the talk. Shiv. Thank you very much.

Presentation - It's time to reassess the management of paediatric asthma

Shivanthan Shanthikumar 03:29

Thanks so much, Chris. And thanks for the opportunity to speak tonight. Over the next bit under 10 minutes, I'm just going to discuss the current state of paediatric asthma care in Australia. And I think the idea is that we can kind of set the scene for where we are at the moment. And what I think that's going to show us is that, unfortunately, outcomes and quality of care across the health system, including at hospitals like the one I work at, in specialist centres like where I work, just isn't good enough for our children and families. And as a result, across the health system, we all need to work together to work better, to improve things. Hopefully, with that kind of data and information, it will kind of motivate us to really take on the learnings from the rest of tonight's session. Starting with some kind of overall statistics, we know that one in nine Australians have asthma, so that makes it one of the most common chronic diseases across the lifespan, and that equates to nearly 3 million Australians. If we look specifically at the paediatric population, that's about 385,000 children, and with slightly more boys affected than girls. If we just focus rather than numbers of people affected, if we think about the impact that has, well, asthma is the leading cause of disease burden for children in the preschool and primary school age groups, and it's the second leading cause for the early adolescent period. As a result, you know, it's not just that many people have asthma, it causes a large disease burden for our children's and therefore our health system. In terms of the burden on the health care system, that results in presentations to our emergency departments with about 26,000 visits, and also many hospital admissions per year, being one of the leading causes of hospital admissions in the paediatric age group. And this disproportionately affects children, so even though many, more than half of many more adults have asthma than there are children that with asthma, if you just look at the raw numbers, nearly half of all admissions are in children under the age of 15. It's really children disproportionately hospitalized with asthma. So that we've got our children who present to hospital are kind of even more disproportionately affected. And what I mean by that is the rate of readmissions to hospital of very high. A recent study that was done in Victoria, spanning metropolitan and region hospitals showed that one in three children are readmitted to hospital within 12 months of their index presentations. So that means if they come to hospital and admitted to the wards, then one in three of them will be back on the wards within 12 months. And that

compares poorly to similar studies done internationally. There are lower rates of readmission in places like America and China and also compares poorly to historical data - a similar study done in Victoria a decade ago showed that only one in five children were readmitted. The numbers in our emergency departments are even more concerning. When we looked at Victorian wide data, 45% of presentations to the emergency department of children with asthma were, in fact, re-presentations. So that means that when child kind of comes to ED once, there's a one and two chance that they'll be back in the emergency department within 12 months, which is a very high number, and something that we need to do something about. Interestingly, it's not just the hospital system that's affected. GP utilization for asthma care is very high. So, when we looked at children admitted to Victorian hospitals, the median number of GP visits for asthma in the previous 12 months was nine visits. So that's a lot of GP utilization. But interestingly, most of those seem to be for acute care, so management of an exacerbation, as opposed to for management of asthma as a chronic disease with a preventative focus, and also people went to different GPs. There was a median of five different GPs used across four different practices, so no continuity of care in terms of some other metrics of quality of care. Well, we know that overuse of relievers, such as Ventolin, is not good asthma care. So that reflects a reliance on rescue therapy rather than preventative medication. And one in four children overuse their reliever, reliever, and that's from Australia wide data. And correlating with that, we know that inhaled corticosteroids are very effective preventative measure in all age groups, and less than 1/3 of those children who have been prescribed inhaled corticosteroid actually take a reasonable amount to equate to prevent, like A good amount of coverage from their inhaled corticosteroids. And similarly, there's lots of data that many children aren't even prescribed their inhaled corticosteroids. So again, in the study that was done in my hospital and a few others in Victoria, a minority of children who were admitted to the wards were actually even prescribed inhaled corticosteroids. So inhaled corticosteroids are under prescribed. And even when they are prescribed, they're underutilized. There are some other key tenants, non-pharmacological, and we're going to talk concentrate on these tonight that represent good asthma care, such as, you know, every asthmatic patient should have an Asthma Action Plan. That should be 100% of people, whereas Australia wide data would suggest that only about two and three children have an Asthma Action Plan. And there are some other deficits we know, such as a lack of asthma education and a lack of kind of coordinated care. So, as I mentioned before, the hospital admission emergency department presentation is very common a median of five different GPs visited. But unfortunately, care is often not coordinated across all those different healthcare professionals. But to end on a more optimistic note, I've highlighted a lot of deficits in asthma care, but we also know what works, and we also know that there's really high quality evidence about what can help asthma care to be excellent and to improve the outcome, and that includes things like provision of an Asthma Action Plan, coordinated care across the primary and tertiary centred centres, person centred approach to making decisions and environmental assessments. And when we can provide these to our patients, we do improve the outcomes. I think the aim of these webinars is to try to promote that sort of high-quality asthma care and hope. Hopefully, if we can all do that together, we're going to see that asthma outcomes improve for the children of Australia.

A multidisciplinary childhood asthma consult

Chris Pearce 10:09

Thank you very much for that. That's actually really interesting. For someone like me, who's generally following stuff, I would have thought there's a lot of interesting information there. Look,

there's no specific questions have been asked of you at this point in time, although I'm sure there will be some later. So we will now just move on. As I said, although the science and the stats are all very interesting, the thing that really gets people thinking is, of course, having a case to work on, especially general practice always works on the on the person-centred narrative. So, with that in mind, we have a case to present tonight, and I will hand over to Tim senior, who's going to take us through it.

Case study background and patient history

Tim Senior 11:00

Thank you very much indeed. Lovely to see you all this evening, I'm coming to you from Dharawal, country where I live and work the so this is Tommy, our case study. And as we go through this, it's worth everyone just thinking what sort of approaches they might take with Tommy and his mother, Sandra, in terms of his asthma management, particularly in the light of what we've heard as to what we know quality asthma management is and what we know is often missed. So, Tommy Chen is a 10-year-old boy who has had asthma since the age of four. He's attending with his mother, Sandra, and they've booked the appointment as his school have asked for an updated Asthma Action Plan. So, it's worth thinking what sort of things are going through our mind at that point. So, a bit more detail. This is current treatment, Fluticasone, 50 micrograms via oral inhalation, twice a day, as low dose inhaled corticosteroid, and salbutamol as needed. His last review was eight months ago. He's had two emergency department visits in the past year for asthma exacerbations. So those are the sort of the basics of thinking about Tommy and thinking about his mother, Sandra. And I think it's worth this. Certainly, I've got some thoughts about that, my sort of approach that would take to that, and I think it's interesting to go through all the panel and see how we might do that. Chris, do you want to take us through a discussion of how we might work with Tommy and Sandra?

Chris Pearce 12:37

Yeah, you're very happy to so. So, I'd be interested in, in perhaps the initial thoughts from the other members of the panel about what's going through your mind when you know what the sort of questions and things are you might want to ask with a case like this at this point, might start, perhaps with Gaylene.

Gaylene Bassett 13:02

Thank you, Chris. My concerns would be, how is his asthma being controlled on a daily basis? And so, asking the individual questions the asthma, the childhood asthma control test, can help us guide the questions there. So how has the asthma impacted on daily life? I'd be trying to understand, if he'd been using his salbutamol, how often, what is, what his current rate of taking his medication is while he's been prescribed the Fluticasone 50 daily. Has he actually been taking it as prescribed? And how does he take it? Doing a review of his of his medication inhaler technique at that time, and that would be my first points, okay,

Chris Pearce 14:06

Kirsty your comments.

Kirsty Porteous 14:13

Yeah, so I'm, I'm intrigued that this child needed to go to, yeah, hospital a few times, and we it's probably helpful if I talk a little bit about the process, we take in engaging with the family. So, I'm, I'm very much going to focus on building a relationship and a connection with them, if I can, and remain very curious. I want to validate them for coming in. And I'll often say I'm really glad that you called, or you came. You've done the right thing. Because the family obviously hold the clues, and therefore the answers, and my job is to elicit those clues and gaps which tell us what might help this family and then support the family to take those actions. So, I'll be asking them questions, and I'll often say that that's really important clue, or Wow, that would be really important for your doctor to know about. And I want the parent to feel like the expert in their life, so that they're bringing important information to the table, and this is a working partnership, so I'm going to find out from this family what their priorities are, what they value, what their concerns are, and we've my education around that. So, I'm coming from that angle, and that might be, that might be about their concerns with medications, or it might be about feeling a bit more safe and confident, and it might be making sure that their child's keeping up with friends and that sort of thing. So certainly, looking at how often this child's taking preventer? What's happening with that reliever? How often are they using that? How they're using their devices, that sort of thing, but weaving it around their story and their priorities.

Chris Pearce 16:37

Okay, that sounds good. Sorry, I've just we had introduced Rebecca Smith as a consumer representative here. Unfortunately, I've just been told she's not able to join so we will be going on without that perspective, which is unfortunate, because I think we've all talked about the importance of personalizing the care and having the consumer perspective would be fairly crucial. Never mind, we shall just barrel on Shiv, any your general comments here?

Shivanthan Shanthikumar 17:18

Yeah. I mean, kind of to echo what Gaylene and Kirsty have already said. But probably one other bigger thing that I think is useful is just trying to highlight what is good asthma control like. As in our aim for asthma is this, and I have an idea of what that is, but often just making sure that that aligns with families, because I think sometimes along the way, families get the message that asthma - like presenting to ED is normal for a child with asthma - is unavoidable. And so actually two ED presentations is no big deal, because we go in, we get it like, you know, that's just what's to be expected, but actually just trying to reset people's expectations that no we can manage asthma well, and that if we work together, my aim is that you have zero emergency department presentations, zero uses, use of prednisolone. You know you're not missing any school. You're doing whatever you want. Because I think that that patients and families knowing that that's a real, realistic expectation is helpful, and then it means that you're working towards the same goals.

Chris Pearce 18:28

Yeah, Tim, you have any comments or before? Yeah, move on to the next.

Tim Senior 18:32

Yes, certainly. We've had some interesting comments come through in the in the chat as well, about approaches to this case. There are a few things that strike me. One is that they're coming in asking for an updated Asthma Action Plan: that's a really good opportunity to make sure they get an effective Asthma Action Plan. This is an opportunity to talk about preventive care for asthma, not just acute care and so and we can make sure that the Asthma Action Plan is really useful for them, not just a piece of paper that they take away. And I think schools are generally pretty familiar now with aspect action plans. And so, to make sure that it's useful, both for school and for them, the other thing that really struck me in the first statistics and that we're presented with about the importance of continuity of care and the relationship that that actually improves asthma care in itself. So, I'm going to be really intentional in developing a relationship with Tommy and developing a relationship with Sandra. And I think the in a sense, I don't think of this as an asthma consultation. I think of this as a series of asthma consultations lasting several years that takes part in 15 minute blocks, and so that way we can talk about the things that are relevant to them today, but we're really intentional in making a relationship so that they will be confident in in coming in to talk with, with me, maybe colleagues at the same practice about their asthma care and how to manage it, not just expecting asthma care at times of being acutely unwell. And so, I think that's got to be laying those foundations are really important for that, that everything arises from in terms of the trust for managing their asthma. There are some really good comments and some questions coming through on the chat as well. And I'd agree with some of those about the points about what's triggering them, the details about what time of year the emergency presentations are coming, and whether they're far apart or near together. Had some questions about management of with oral or inhaled steroid, which we will certainly come to, I think, because they're important questions.

Symptom control assessment

Chris Pearce 20:57

Okay, so you want to move on to the next part of the study there. Tim and I could Yeah one of the questions or come one of the questions in there will come to a bit later on. Absolutely.

Tim Senior 21:08

So, so we've already all, we've raised a little bit about what sort of symptoms of the having, what's the asthma control being like? And so, during this review, Sandra reports that Tommy has been waking up coughing two to three nights per week, gets breathless during his twice weekly soccer practice. He has been using his reliever inhaler at least once a day in the past month, and he does report difficulty keeping up with friends during play time. So those are some really important symptoms that for us to know.

Chris Pearce 21:44

They certainly are. Kirsty, would you like to comment on whether or not you think he's that his management is, you know, optimal or sub optimal?

Kirsty Porteous 21:58

So, it's disturbing to hear that he's using and needing his reliever every day, and that it sounds like he's having nighttime disturbance, which we don't like to see at all. He's obviously having trouble with exercise, keeping up with friends. So, it definitely doesn't sound like he's well controlled at this point in time. And it's interesting, that he's turned up for a routine action plan appointment, when, in fact, he's not controlled and clearly needs some assistance with the family self-management.

Chris Pearce 22:42

How would you any other questions you would ask about, you know, what is management like?

Kirsty Porteous 22:51

I'd be obviously finding out a little bit about his adherence and whether he's taking that preventer every day, I'd be curious to know a little bit about whether mum or dad are still in control of that, or whether he's sort of starting to take the reins himself. And also wanting to know a little bit about how he's using those devices as well, whether he's whether he's using a spacer or not, and I'd probably if I was talking to him - if he was there on speakerphone - I'd probably be trying to engage him a little bit around the sport, the soccer and perhaps coming a little bit at that angle.

Chris Pearce 23:39

Shiv, I also mentioned your perspective. But I think in doing also the couple of the questions in the chat. One is, you know, deciding which particular type of device you use. You know, he's on fluticasone. But you know, there's a couple of modes of how that might be delivered, and so on and so forth. And also, just a question here, sort of about, when you start on inhaled corticosteroids, how long for?

Shivanthan Shanthikumar 24:10

So, I'll just quickly say Tim made the point about it, this being a series of consults. Sometimes you can't get everything done on one consult. So it might be that you just pick one or two things to focus on the initial one. But let's just say that he sounds poorly controlled. He's on Flixotide 50, 1 puff twice a day, which is, you know, at 10 years of age, relatively, the lowest dose of inhaled corticosteroid. So, he's got lots of room to move. I would be thinking I'd be increasing it. I'd be thinking about a few different options - and this is where it could be helpful to work with him and his parents. The two things I think about are like drug class and device. Do we just want him on just inhaled corticosteroid, or do we want to go to inhaled corticosteroid plus LABA? So that's kind of the drug. And given he's on such a low dose of inhaled corticosteroid and he's in the primary school age

group; I probably keep him on just in the inhaled corticosteroid at a higher dose. And then if we talk about the device, well, you know, in general, in Australia, I think we've mainly used meter dose inhalers plus spacer in the primary school age group, but I think there's actually pretty good level evidence that we can use dry powder inhalers in the primary school age group, and kids have adequate technique, so that gets around the need for a spacer. I would be thinking that we could probably in the first visit, because you're just getting to know him, you don't want to change too much. I'd probably just bump him up to a higher strength puffer, meter dose inhaler inhaled corticosteroid. So, something like Flixotide 125, 1 puff twice a day. Or if adherence was a real issue and they can only manage something once a day, I'd think about ciclesonide, which is just one puff a day. That's what I'd be thinking. And then maybe at the next visit, I might be considering swapping them to a dry powder inhaler, if that's something you'd really want. Once I explained it to him, and I would give it like six to 12 weeks to work. You want to give at least six weeks, and practically it's hard to get people back in before three months. So that's I'd give it a while to work.

Chris Pearce 26:36

There's a question here. Do you give Flixotide only once a day? I thought they only work for 12 hours it should be given. BD?

Shivanthan Shanthikumar 26:43

Oh, sorry. I hope I might have misspoken. So yes, the idea in general is that you give Flixotide BD, there's one inhaled corticosteroid called ciclesonide, which the brand name is Alvesco, that is a 24-hourly preparation. And there is some reasonable, actually quite high-level evidence that budesonide, given once a day is as effective as budesonide given twice a day, so you can give two puffs in the morning rather than one puff twice a day. I think for an inhaled corticosteroid like budesonide or ciclesonide, I'm happy to give it once a day. Flixotide is generally one that I would give twice a day.

Chris Pearce 27:22

And Tim, in your mind, what, what success looks like here? Is it never using a reliever? Is it, you know, like, what's, what's the what's the goal?

Tim Senior 27:32

Yeah, it's a, is a really good question. And I think for me, it's really guided by what Tommy and Sandra want to achieve. I think it's really important that we that they recognize that recurrent symptoms on are not normal control and not good control. And the aim is that Tommy is able to keep up with his friends, that he is able to play football, that he's able to sleep through the night. And I think lots of our questioning can be, what? What's your day-to-day life like? What are the things you love doing? And using those to say, let's make it so you can keep doing the things you love doing without it being interrupted by your asthma symptoms. And so, I think that will be guided by what, with the goal of what to achieve. I would aim to achieve that. And if that requires some preventer before playing sport, then that's then, then that's fine, as long as they can keep doing the

sport. And I think, and my, my general principle about sort of inhalers is, is that it needs to make contact with the airways. So, the sort of the device and the drug is, is what's going to work for them, that they can actually do the inhalation and the technique at times they need to that. That means it actually makes contact with the airways to treat it. And so, I think we work towards that, and we'll work to engage both Tommy in doing that and Sandra in helping Tommy do that. Like there's almost two patients in this consultation that we need to engage both of them, so Tommy likes coming to visit the doctor as well, as well as Sandra feeling that it's useful. Okay, yep, I was just wondering as well. I think Kirsty and Gaylene, one of the things I'm aware of these of asthma symptoms scoring, that's quite widely used. GPs tend not to use them that much, but I know they can be quite useful in providing, like, a validated score that's good for comparing over time about what, what, how those symptoms might fit into the asthma score. And just when I think, Gaylene, you do you mentioned using those?

Gaylene Bassett 29:52

Yes, absolutely, I actually like to use a Childhood Asthma Control Test to start that initial conversation. Even with the with the children. So, the first question on a child with asthma control test is, what is your asthma? And that's a really good question to get them to be able to have their words to you, to for them to be able to understand in their language how to explain asthma to somebody external to their family, because occasionally they don't need to explain it to their school. And if you ask them, "What is asthma?" and then start to get them to think about it, then you can validate the fact that you know that they need to use their puffer that's asthma, and that needs to be what we need to get under control so they can play sport. So, the second question is about activity levels, and the third question is about cough, and the fourth questions about sleep at night. For the children, they're the specific questions for the children, and then the three questions for the adults are time limited. Around the last months, we don't put a time frame on it for the four to 12 year olds, that's just about any time in their recollection, whereas for an adult, because we know children, of course, haven't got that sort of capacity to understand time, but the adults have the time frame for the last month, and they are able to explain what the symptoms have been like in the last month. So, using that validated score helps the parents to understand the symptoms that we're interested in, to identify asthma control and then, you know, the penny might drop. If they're coughing lots, or they're not having a good ability to exercise, then that's what we are considering poor asthma control, and that's what we want to improve.

Tim Senior 31:55

Thank you. One of the other comments that I think is worth addressing as well is understanding the cultural impacts for the family and cultural understandings. And I think that can be really, really useful. I work in an Aboriginal medical service, and so that can be really important. And often questions like, 'Are there traditional understandings of these symptoms?', or 'Are there grandparents who have who have given you advice about what to do?', or 'Are there any traditional remedies that that are often useful for these symptoms?', that can be really useful at sort of raising those cross cultural understandings in in a nonjudgmental way. Many families will have been using them and might be a little bit nervous about telling us about that, for fear of being told off or judged. And so, I think the comment about understanding cultural influences on people's understanding and management of asthma is a point really well made.

Chris Pearce 32:52

There are two questions in the chat about montelukast, so perhaps we could deal with that now either Tim or Shiv?

Shivanthan Shanthikumar 33:01

Yes well, actually, kind of circuitously, to answer that question, as well someone asked about what's the role of LABA in children. So if someone's poorly controlled on low dose inhaled corticosteroids, your options are to go to high dose inhaled corticosteroids, to go to ICS plus LABA, or to go to ICS plus montelukast, and there's a really nice study that shows that you can't predict which one's going to work best for the child in front of you - some children will respond better to each one of those three treatments, sometimes you got to choose multiple options. And this is also where I think talking to families makes a lot of sense to try to find out what aligns with their beliefs best. So, speak specifically about montelukast, the advantage of is the tablet. Children like taking it. You don't have to worry about puffer technique. It'll also treat comorbid condition like allergic rhinitis, if that's a relevant comorbidity. So those are some of the pros. The two negatives, and I'm guessing this is part of what the questions are about, is the one is it doesn't work for everyone. And two, the rate of neuropsychiatric side effects is relatively high, so that can be things like irritability, nightmares, oppositional behaviour change in personality. I think you have to be very open with families about that, because, and that's just good practice. And two, they'll if they Google the medication, which everyone does these days, that's the first thing that will come up. And so, if you haven't been open with the family, of course they're not going to take it. So, I will regularly offer montelukast to families, and they will say - when I kind of explain those pros and cons, some families go, "that's definitely not for us". That's completely fine, I have alternates. And some families go, "Yep, thanks for that information, we'd like to give it a go. We know if the child's behaviour changes, I'm going to we'll stop it straight away.". I think that's perfectly fine, too. So, in general, I think it's montelukast should still be in our armoury of treatments, but we have to inform families appropriately. And if families choose not to start it, that's completely fine.

Reliever use

Chris Pearce 35:06

Okay, so yes, let's, let's move on with the case.

Tim Senior 35:13

Back to the case study. So, Tommy is using his Ventolin four to five times a week. Sometimes forgets to bring his inhaler to school, and he rarely uses his spacer device because he says it's embarrassing at school. So, I think this feels like really important information about the way we're going to engage in the management and the options that we have to help Tommy actually take his inhalers.

Chris Pearce 35:50

I think one of the questions here is, is the embarrassment on using the spacer and Gaylene, how would you approach this when it comes up in the work you do?

Gaylene Bassett 36:08

I guess you've got two options, and it depends on the child in front of you. So, you could consider if, if we were going to go to an ICS / LABA, then we could choose to use a device that doesn't require a spacer. If the child is able to inhale that it has the correct technique and inhale correctly. So, you need to do a check on his technique. And I always say to families, you know, we all start off well when we've been to see someone and you've got the information right in front of you, but you need, you need to revisit that spacer technique, or the inhaler technique, quite regularly. And particularly with a 10-year-old who may be transitioning to being able to manage some of his medication alone. I always suggest to families that they keep a bit of an eye on it, because we do slip in our in our habits. We will start to rush our treatment program process and not inhale correctly. So potentially changing the device, if we're going to go down the ICS / LABA to not a metred dose inhaler, but a breath-actuated device, so that they cannot carry a spacer at school. But the other thing I also say is to try and normalize asthma for this age group. You know, in in a primary school class, generally, you know there's going to be two, three or four other children that have asthma and just to explain to the child, 'If you feel shy and embarrassed about taking your medication, how does someone else feel like that? Would you want them to feel like you?' and just get them to understand that, that they're not alone in that group. And so, changing the device, normalizing the technique, and just, I think was it, Tim, you mentioned being able to participate in sport, so be making them finding a common goal that you can work through with the child, so that they will be happy to undertake their medication regime, so that they can participate in sports and life in general.

Kirsty Porteous 38:49

If I can just add something to one of the I think one of the things that's really helpful with kids, this age is to work with whatever sport or activities they're doing. So, in this case, Tommy's playing soccer. And I think it's really helpful to remind kids and their parents that there's a lot of elite sports people, soccer players, Olympians, that have asthma and can perform at that top level, because they're managing their asthma really well, and there, they're doing what's described. So, I think that's always, always worth sort of bringing into the conversation with kids too, because I think that's quite intriguing to them, to sort of think about all those celebrities, you know, people like, I think, I believe David Beckham, for example, is a soccer player with asthma. So yeah, giving, giving kids a sense that you can have asthma and, you know, use your devices and still perform. And giving parents a bit of. Hope and optimism that that things could be things could be good, could be normal.

Chris Pearce 40:04

And Kirsty, you're clearly not a fan of the world game, to describe David Beckham as a soccer player with asthma! Sorry, is there a role here for schools, for instance, to have some, you know, spare inhalers for kids in this in this space, is that something that's, that's, you would consider useful?

Kirsty Porteous 40:31

Schools generally do have spare inhalers and spaces and asthma emergency kits. And we have a very supportive school program that provides education for schools and training for all the staff and that sort of thing. And we make sure that schools are knowledgeable about the asthma first aid process and know how to deal with children who are presenting for the first time, or children who are having symptoms but don't have their devices, don't have their medications or how to deal with emergencies. So, I think the school is very important, and we certainly take that very seriously at Asthma Australia and have a very extensive program for schools. And sometimes it's helpful, actually, find it sometimes helpful to remind those anxious parents that that the school does have trained staff, and they do have equipment, and that they have got your back.

Chris Pearce 41:40

There's a question here in the chat about nebulisers, are they a thing of the past? I'd have to say I haven't seen one in use for, you know, 10 or so years. But interested in Tim, Shiv or anyone, any more comments on nebulizers.

Tim Senior 42:02

It's really, I think there should be a thing of the past, and I still come across patients who say, oh, no. Really need a nebulizer. And in those circumstances where they're insistent and they've got the machine, I will prescribe, but I'm always wary, because if they're using a nebulizer, then their asthma is probably not very well controlled if they're needing to do that. So, I sort of try and invite them into that sort of conversation about making it so that they don't actually need the nebulizer.

Chris Pearce 42:34

I think for a certain generation of physicians, when I started practice, having the nebulizer meant you were going to get better. And Shiv, I would presume, it's virtually disappeared from places like the Children's Hospital?

Shivanthan Shanthikumar 42:52

Yeah. So, the only, the only people that get a nebulizer are those who are so severe their mental state precludes the appropriate techniques. So, we're talking about people who are peri-arrest, that type of thing. I think in the past, people thought that that was a better treatment because it's what you got when you went to hospital. But now we don't even give that when you're in hospital. I try to explain to families that the dose of Ventolin and a puffer is 100 micrograms, the smallest Ventolin neubule is 2.5 milligrams. So, you're talking about giving my maths is bad, but, you know, like, lots, lots, lots more. Yeah, that's but this might be something that I leave to the second or third consult, because, you know, maybe there I've got bit more important things to deal with, like getting someone taking their preventer each day, and then we can kind of deal with that down the track.

Chris Pearce 43:46

Before we move on to the next bit of the case, which opens up a whole other area, there's been a few comments in the chat about spirometry, so I'd be interested in comments on the role of spirometry in general and specifically for Tommy, and I'm open to who, whoever wants to take that.

Shivanthan Shanthikumar 44:10

Yeah, I can, well, I can give my two cents and see what other people think. So, I think spirometry is a useful test when you're not sure of the diagnosis. So, spirometry in children is challenging, and I think it shouldn't really be done outside of paediatric pulmonary functional laboratories, which are obviously hard to access. So, I think that, yeah, it's a really helpful test if you're not sure of the diagnosis. If based on talking to the family and your observations in clinic, and/or, looking at ED discharge summaries, you're very confident that asthma is the right diagnosis, I don't think spirometry is that helpful. But I'd be interested. But I say that being someone who can access spirometry very easily, I'd be interested in what other people's thoughts are.

Chris Pearce 45:02

Well, Gaylene and Kirsty - do you see much spirometry? Because I know there's a there's interesting, but yeah, sure, they're pulmonary, but there are a lot of spirometers, spirometry units, in general practice. So, do you see much of that in your practice being presented to you?

Gaylene Bassett 45:19

I do, and I agree with Shiv, it really takes someone who's had fairly consistent exposure to paediatric spirometry to get good spirometry, to get accurate spirometry, or good quality spirometry. Is it wrong for general practice to attempt spirometry? I don't think so, in that it would be exposing children to the ability to learn how to do the technique. Is it useful information for a medical consultant on the first time that you see the spirometry? Potentially not, but I think exposing them to the technique is good. I'm spoiled. I do spirometry myself every day. I couldn't practice without it. I see so many patients that come in that have no clinical symptoms to note, but they have a massive bronchodilator response, and you cannot pick it with your stethoscope. You cannot pick it by listening to them. You can only pick it by doing spirometry. So, but, but that's coming from a passionate place of doing spirometry on a daily basis with paediatric patients. And I know that not everyone has that has that capacity, but it's something that certainly affects the way I prescribe, and it affects my consults with the patients.

Chris Pearce 47:06

Tim, what about the use of peak flow meters? Yeah,

Tim Senior 47:09

it's a quite a long time since I've used them. Actually, Tommy might be an age where he could possibly do it, but I do tend to be guided. I feel a bit guilty that I'm not using them as often, but I do tend to be guided by the by the symptoms as much as anything, I think, like Gaylene says, the symptoms are usually my main guide. When they're coming in to see me and I'm listening to the chest, it's, um, that's usually during the day off, in the afternoon, sort of warmest part of the day. And I know that the night before and the night coming up, they're going to be worse, but not, not when I'm there, that might be the time to hear the wheeze. And I think similarly, with sort of with peak flow, it can be useful, particularly where parents like to see a real measure, or the child can do it. But I do tend to be guided by parents, by symptoms, more than I'm guided by peak flow measures. I think I agree with you, Tim, that's good. I always worry about, you know, when people mentioned peak flow meters, because I haven't used one in practice for some time. Like, is everyone else using them? Yeah, but no, so that's good.

Shivanthan Shanthikumar 48:19

Yeah. I we don't use them at all. And I think most guidelines and things have gone away from recommending their use and to be more yet, basing off symptoms reliever use and severe exacerbations.

Chris Pearce 48:39

I will put the panel on a bit of notice for the end of this session. There's been some questions about Asthma Action Plans, particularly about examples of Asthma Action Plans across the ages, which, clearly, they're so personalized, you can't do that but, but I thought it would be a useful exercise at the end. We will construct an Asthma Action Plan for Tommy at the end of this, and so we can give an example of how we would do it and what it might look like. So okay, yeah, Tim, so the next, the next element of the case.

Risk factors for exacerbation

Tim Senior 49:15

So, this is where we start to consider the living circumstances of Tommy and Sandra. And it turns out that they've recently moved to a rental property, and there's visible mould in the bathroom. We've got a picture. They show us a picture on their phone of the of the mould, because they're not happy about this. His Tommy's father is does smoke, and he only smokes outside. Tommy has allergic rhinitis, which is particularly bad in spring, and there is a family history of asthma on the paternal side, on the father's side. So, what aspects of this are we able to sort of discuss, try and influence, even try and advocate?

Chris Pearce 50:03

Which is exactly right, you know, how do we influence things that at a certain level, some of them are not influenceable. We can't change the family history, but there are elements that we can do. Kirsty. I think we'll start off with you, because this, I mentioned, this is the sort of thing you'll get, you know, in your discussions with people.

Kirsty Porteous 50:29

Yeah. So, there's obviously, there's obviously a few risk factors and triggers and that sort of thing involved there. So, I mean my general lens, on any given basis, is, I've got a safety thing in mind. So, I'm thinking, what's going to make this family safest today? What do I need to sort of focus on? But apart from those triggers, if I, certainly, if I look at the mould aspect, you know, the family sound like they're aware that moulds, moulds quite a big issue, and it can have quite an impact on lungs and asthma. So, I would certainly talk to them a little bit about that and guide them to our website, which has a lot of really good information on, on mould, cleaning, how to protect yourself, if you're, you know, if you're exposed to that or can't do a lot about it. With the with the smoking aspect, it's, it's really common that parents would say to us, I smoke, but it's okay. I do it outside. So, I gently inform parents that it's, it's really, a lot of parents don't realize that it's the chemicals that collect on the skin and the hair are also problems. So, I'll sometimes, I'll sometimes bring a little bit humour in and suggest that that parent might also need to wear a shower cap and some gloves and things like that and hang them at the door. But I also try to encourage them to have a chat with Quitline, even if they're not ready to quit smoking at the moment, but just to, just to make that connection and get that ball rolling. But yeah, when it comes to safety, I want to make sure that that those that those parents want, and want those parents know what to monitor how to distinguish between mild, moderate, severe asthma, when to ring an ambulance, how to do asthma first aid, that sort of thing as well, so that they can certainly keep themselves safe.

Chris Pearce 52:57

Tim, your comments here, what advocacy might you be able to do?

Tim Senior 53:03

Yeah, so one of the really common things I do is see people who have housing conditions that make their medical things worse and so regularly writing letters and filling out, if they're in Department of Housing houses in New South Wales, filling out the medical assessment forms for housing. There's a there's a quirk in New South Wales, maybe only in New South Wales. I don't know where they need a letter from a doctor for any health thing so they can. I've literally had the situation where they've walked into a house, Department housing see rats, and they need a letter from me to say that rats are bad for this particular person's health, as opposed to bad in general, and the same with mould. So, where someone has asthma, a child has asthma, it's an easy letter or form for me to do, to say, look that that needs to be treated. And if the patient can't do it themselves, the landlord needs to do it, Department of housing needs to do it. Sadly, always takes too long. The other thing that strikes me about this, obviously, we want to help the Tommy's father stop smoking as much as we can, and brief interventions there. One of the common things scenarios we might come across now is he's not

smoking, but he's vaping. And what, what would our advice be there about how safe that is for Tommy? And I think, as you say, we can't change the family history, but in in and the allergic run out is important just in terms of the timing of symptoms and warning people to watch out for that and particular things, we've had particularly bad bush fire smoke in our area and back burning as well, which set off a whole load of presentations of respiratory symptoms, including lots of people worsening asthma. So, I think keeping abreast of all of those, and I know asthma, Australia has been involved in the project of informing people locally about their air quality, and I think pollen quality and that can be really useful in anticipating when symptoms might be bad. So being sort of across all of the. Those, all of those sorts of things.

Chris Pearce 55:03

Galene, how much would you apply to the allergic rhinitis part of that story? How would that? How would you deal with that?

Gaylene Bassett 55:12

So, we have a little anecdote, I guess, that I often felt if you treat the nose, the chest often does better. And so, we know that you know if your nose forms part of your airway, and we need to ensure that it's working properly. So, the treatment for allergic rhinitis is important in managing asthma. And in fact, I've seen many cases where the asthma improves, but we continue to treat the allergic rhinitis, so we can, we actually end up not needing to treat asthma anymore. But it's the allergic rhinitis that that managed well. Can control a lot of symptoms too. So, it's it is an important thing to treat, usually with intranasal steroids and making sure you're checking back in to see what their symptom control is like after you've been you've treated them

Kirsty Porteous 56:23

Just adding to that too, Chris, hay fever is certainly probably the trigger that we speak most about with parents, and it's the most overlooked. So, it's certainly, it's certainly something that we want to make sure is on their radar. And we find that a lot of parents don't realize their children have hay fever, but when we talk about a blocked nose overnight, suddenly a penny drops. So, it is a conversation we're often having. And when it comes to technique, I find the nasal sprays are often the most challenging for families getting that right. So, we can often, in a phone call, quickly flick them via SMS, an animated video that shows them the angle they need to use and that that's a really important moment for a lot of families who haven't been getting that right either.

Chris Pearce 57:35

And to the panel, does it make a difference if Tommy lives in steamy Queensland versus bitterly cold Victoria?

Tim Senior 57:48

I've not lived in Queensland for any length of time.

Shivanthan Shanthikumar 57:53

I don't so people's asthma can definitely change when they move between environments and things like that. But I guess I think it was some another panel member, I think, was Tim, mentioned talking about what you can control, and you just end up managing what's in front of you. And so often the principles come back to the same things of you know, assessing symptoms, assessing if good controls being met, adherence technique, whether the right medications being used. And I think those principles are probably the same wherever you are.

Kirsty Porteous 58:33

I was just going to say if, if we're talking about allergic rhinitis, I'd be very interested to know what state they're in, because I'd be thinking, if they're in Victoria or South Australia, there might be that added risk of thunderstorm asthma, if it's a seasonal hay fever that they're experiencing, and a possible poll analogy. So that would I guess listening, listening for their status is one of the things that that we really keep an ear out for in relation to hay fever as well as asthma,

Tim Senior 59:06

I think you're right to raise thunderstorm asthma there that bad case a few years ago in Melbourne. There were many more presentations to the emergency department, but actually GPs were handling many more cases of asthma exacerbations. And individually, they didn't notice the sort of increase particularly, but across the city, there was a huge number of presentations managed in general practice that ended up not going to hospital, fortunately. So, I think that's a really important thing for us all to be aware of and looking out for the predictions of when that might happen.

Chris Pearce 59:46

Certainly, in Victoria, we now get notifications. There's been a couple of questions on the role of air purifiers. Any comments, does anyone recommend air purifiers? And under what circumstances? Certainly, I've been talking about air purifiers in the moment with bush fires, you know, and the smoke that's been seeping across western Victoria.

Kirsty Porteous 1:00:21

We often get asked about different devices like that. And traditionally, we've said it's really, it's really about medicines as frontline management, but probably since the bush fires a few years ago, and those really prolonged periods of exposure, and finding that a lot of people were getting quite flared up eventually, even if they were on preventer, more and more people are asking about them.

And I'll often, I'll often, I'll often talk to parents about, you know, making sure all everything else is lined up, making sure that that they're looking at other risk reductions and making sure they're on the right medicines and all that sort of thing. They've got a good plan. Everything else is in place. And then I'll explain how an air purifier will work, and we've got some very good information on our website about this. And I'll talk about where it can be useful and may not be useful. So, for example, on a polluted on a polluted road where the windows got to be open or the seals are bad, then a family might find that useful bus. Or in a polluted area where there's a lot of smoke and that sort of thing. Then, then it might be something that the family would invest in, but generally I would say it's not, um, it's not something that families should be thinking of first. It would be more last resort. And most families wouldn't, wouldn't need something like that.

Tim Senior 1:02:03

Excellent. There has been a question come through; a comment come through about vaccination. I think that's an important one. We're coming up towards the release of the 2025, flu vaccine. Tommy would probably be eligible based on his asthma symptoms for a flu vaccine under the National Immunization program. And so, I think that's going to be important for all our patients with asthma that we're recommending and giving flu vaccine. COVID vaccines are still available and the other and there's lots of respiratory illness at the time. So, for certain people, there's even RSV vaccine. And I think that's going to be really important. And usually, general practice is the place where those will be given, particularly for children with asthma, a reminder as well for children - not quite Tommy - but for children under nine, if it's their first vaccination for influenza, they have two vaccines, as opposed to just one. And then after that, they have one vaccine.

Chris Pearce 1:03:02

So, what would be your advice if someone asked you about RSV vaccine, which is not on any schedule at the moment for a child like this, but you know they've heard about it. You know some someone in their families, the pregnant woman's got it in Queensland or whatever. So what? What advice would you give them? Perhaps, Shiv?

Shivanthan Shanthikumar 1:03:26

Yeah, to be honest. So, I'm very pro vaccination and very excited about the RSV vaccine, but in this situation, I would actually say it's not required. The rationale being, that to my knowledge, and if anyone is aware of studies that contradicts this, please let me know that this, the RSV vaccine has been tested primarily for use in the elderly and or, you know, there's one vaccine that's been used for pregnant women with the idea of covering the babies for the first year of life, or in newborns to cover them for the first RSV season. So, it actually hasn't been tested in this population, and also in general, like RSV definitely can trigger an asthma exacerbation, but once you are past your first year of life, in general RSV doesn't cause severe exacerbations that land you in hospital, unlike something like influenza. So, my advice would be, definitely get the influenza vaccine. Unfortunately, the RSV vaccine, at this current point in time, hasn't been tested for you.

Barriers to self-management

Chris Pearce 1:04:35

Tim, more of the case?

Tim Senior 1:04:39

Yeah. So, we've so we've identified some, but not all, of these barriers to effective self-management. Already, we've talked about social embarrassment that Tommy has about using space for a school. There may be a language barrier. Sandra sometimes struggles with written English instructions, and I think that's clearly important for us to elicit and understand cost concerns. Father recently reduced his work hours, and so there's concerns about cost. There's some confusion about when to increase the preventer medication, and Tommy is starting to manage his own medication, but he's inconsistent with his morning preventer. So, there's a lot in there for in terms of sort of discussion around his effective Asthma Prevention.

Chris Pearce 1:05:27

Who would like to kick us off?

Kirsty Porteous 1:05:31

So, yeah, looking at that, as I was saying earlier, we we'd often, we'd often talk, I guess, talking to Tommy about, you know, what's going on at school? You know, if he, if he knows what difference the spacer makes, is it going to make a difference? Is he going to use it? And if he's, if he's, if he's really reluctant, then it's probably worth talking to his parents about alternative options and give them something they can take to their doctor, send them some videos of alternatives and get a sense if, if they think they'd be able to use alternative devices that don't need a spacer. I'll always mentioned to parents that there's, there's cardboard spacers they can take on school excursions and that sort of thing, if it's just, if it's just the odd, the odd instance that that kids don't want to carry a spacer, but in this instance, it sounds like he's probably not going to. So yeah, I'd be thinking about talking, talking to the doctor about a different device, but the language barrier, it's, it's, it's certainly tricky, but some we, you know, we have a lot of we try to make sure that the information that we send in parents has a lot of pictures and a lot of animated videos and that sort of thing, which are easier to follow. I'd be thinking an Asthma Action Plan, which a lot of people, a lot of parents contact us, struggling to understand the instructions, not sure how to follow them. So, it's really important that their GPs providing a very detailed plan that's very clear about what to take, when, how much, and to make sure that the parent actually understands and can follow that plan before they before they leave. So, so that's generally what we see on the plans and what we'd be explaining to the parents, but it's ideal if, if the doctor can explain that really thoroughly before, before the patient leaves.

Chris Pearce 1:07:52

Gaylene, any other comments from you?

Gaylene Bassett 1:07:54

I think Kristy has covered that quite well. And other than to think about assisting with translation translator services, if necessary, for the family and medication costs. Just, I think she mentioned, you know, going from a 50-microgram puffer to a 125-microgram puffer, so that rather than having to use a puffer twice as much, you'll use half as much like so, rather than using two puffs twice a day to get to you're still not going to quite get as much doses to as a 250 dose. But thinking about puffer sizes and, and cost is important as well, for cost concerns. But also reiterating the fact that if we're using the preventer therapy correctly, we should be using less reliever so it'll cost less eventually as well .And costing less if you've got if you've got better asthma control, families are less likely to need to take leave from work so that they can that, so that they have to look after their child. So, there are a lot of pro actions that you can undertake or discuss to help with, you know, some of those goals for managing asthma well.

Chris Pearce 1:09:27

There's a question there about and it's a very general practice-based question, do you book for a long consult? What do you charge? Bulk bill and extras? I don't know about you, Tim, but it depends. Is the answer. Sometimes it's a comeback and look a long consult. Sometimes you have to deal with it at the time, and what you charge is up to your policy and your personal preference.

Tim Senior 1:10:18

And I think this is where, where quality care bumps up against system issues, because, as we know Medicare, you get paid less per unit of time - you get a smaller Medicare rebate for units of time, for longer consultations than for shorter consultations, and practices really struggle on the rebates through bulk billing, and they have to keep the doors open. So, there's a real squeeze there between family cost of living and affordability and practice viability. And I think that's a really difficult problem at the moment. We do bulk bill all our patients, so I don't. So that's not so much an issue, and I think individual practitioners will make those decisions based on what works for their them, their practice, and their patients. But it's it that's really hard. It causes more moral injury for GPs, I know. Make sure that you get medications on the PBS where possible, if you can source of supply of spaces - the funding for those is often not, not easy, but sometimes it's possible to get, get those funded and get a supply. But the cost, the cost issues, are real, and there's actually and often very difficult to get by. I think Gaylene's points are all are all valid. If somehow we can use the cost of Tommy's father's smoking, put the money aside from stopping smoking, we'll get that may be an additional motivation? I mean, it's easier said than done, because it is addictive, but that that may well help the visible increase of affordability. And I think Tommy's taking his own medication. That's sort of, I like the idea of that, but it's hard for a 10-year-old to do well, and so I think we'd be encouraging that with support. And I think, again, the Asthma Action Plan is crucial in being and it feels like Asthma Action Plans can only work if they're useful documents to the patients and to schools like, if it's a useless document, I don't think they'd be that helpful. And so, I think that's going to be a crucial point, that actually it does explain to the family what to do and when to do it, and it's and it's clear and unambiguous.

Asthma Action Plan

Chris Pearce 1:12:42

And probably also mentioning the 60-day prescription initiative this year. So that's made a lot easier. Okay, in the last few minutes, let's talk about Asthma Action Plan. And I thought I might start with you, Gaylene, what does the Asthma Action Plan look like? Ah, we've got one popping up. What does the Asthma Action Plan look like in your mind for Tommy, or what might look like? Clearly, you do it in conjunction with the family, based on their feedback, etc. But you know, what do you think it might look like?

Gaylene Bassett 1:13:19

Yeah, so I do like the Asthma Action Plan from asthma Australia, the National Asthma Council of Australia also have an action plan that's very similar. And so, using the one that's that schools are happy to accept is important. So, making sure you've got the details on the plan of the child's name and the date and the review date and the doctor's details and the emergency contacts, like we you can see there on the top. When we talk about the preventer, we will decide, I think Shiv had decided that we were going to increase the preventer, the inhaled corticosteroid in the first instance, to see if that would make a difference and get away from the need to have an ICS / LABA. The preventer that we might choose in this place if we wanted to ensure that we were using a breath-actuated device rather than a metered dose inhaler, would need to be not, not fluticasone zone. Or maybe we could actually, I think there's a 125 fluticasone. So, you'd have the preventer listed there. At this point, we'd be using the 125 fluticasone as an Acuhaler morning and night, ticking the boxes. And then the reliever is his salbutamol for this point in time. And so, the reliever and I work in a hospital situation. So, it's a bit different than a GP practice. Often, I see in a hospital situation that the reliever, at this point in time, has 12 puffs written in it when I see it, but that's not what we'd expect in community practice. So in in this place, in the green section of the Asthma Action Plan, where he's well controlled, and he needs to take his relief for wheezing, coughing or shortness of breath, the recommendation would be to normally take two puffs at 10 years of age, and if he requires it, because exercises made him short of breath - we understand this from his story - then he would take two puffs of salbutamol 15 minutes prior to exercise. You happy with that? To start with, everyone in agreement?

Chris Pearce 1:16:02

Yes.

Tim Senior 1:16:08

Yeah, very much. So, the other thing I always do on my Asthma Action Plans, I write in the colour of the inhaler as well, so that people are really clear about what their Flixotide colour is, what their salbutamol colour is, put it in brackets and use that throughout the Action Plan, so that it so that's just not ambiguous at all.

Gaylene Bassett 1:16:31

Thanks, Tim for reminding me. I do the same, and I think it originally come from, was it Mike South Royal Children's Hospital action plans where you could actually choose the drop-down box and pop the colour. I try to use one Asthma Action Plan for our community, so that they're to the schools rather than switching around Asthma Action Plans, but that I do the same. I write orange inhaler, blue inhaler, next to the preventer and the reliever. Does someone else want to take it from here?

Chris Pearce 1:17:14

Yeah, okay, Tim. Tim, do you want to do the flare up?

Tim Senior 1:17:18

So that for the flare up, I think going over what the symptoms are of a flare up is really, really important, and sometimes I'm guided by how severe the patient's symptoms have been and how confident they feel about managing that. So first up, I would increase the reliever dose, and so for that, I'd go to four or even six puffs, and I'd specify, if it's a metred-dose inhaler by a spacer. And I'd be suggesting that they that it's worth coming in for a GP review during that flare up as well, just to see that things aren't going to get worse. And there's nothing else we need to do.

Shivanthan Shanthikumar 1:17:59

In general, in paediatrics, I'd say the evidence for increasing your inhaled corticosteroid dose during an exacerbation is lacking. So, for example, there's a study in primary school aged children where people quintupled, so it took five times the dose, and it didn't make a difference on asthma outcomes, but it did that group did have less vertical growth. So, in fact, I think paediatric Asthma Action Plans are very simple in that the preventer dose should always stay the same, and we shouldn't manipulate that during exacerbations.

Tim Senior 1:18:31

Thank you. That's really good to know.

Shivanthan Shanthikumar 1:18:34

I know what you've seen practice is a bit different, but, but that's kind of what I would say.

Kirsty Porteous 1:18:42

While we're writing this, but one of the points I'd make is while we, while we're doing this with the family, to make sure that they, the family, really understands that the preventer is actually slow acting, not fast acting like the reliever, but slow acting. Because we do find a lot of parents think it hasn't worked initially, and they so they stop taking it, or they misunderstand things and wait for

their child to be sick before they start on that preventer. So really explaining that it is a slow-acting medicine, they won't see immediate change, and they can look for improvement week-by-week or month-by-month, rather than day-by-day, which is what they're expecting.

Chris Pearce 1:19:32

So, Shiv, I might give you the severe.

Shivanthan Shanthikumar 1:19:35

So, in fact, I think it looks very similar. So, preventer is the same dose. Reliever I would keep it the same, and then definitely tick the make an appointment to see my doctor today. And then the last question is just whether you would, for some cases, I would give them parent-initiated prednisolone. So that's the one option we have up our sleeves, is if parents can have a supply to start themselves, or whether you want them to always seek medical attention, and I think that's kind of a case-by-case decision.

Chris Pearce 1:20:11

Excellent. Thank you very much for that. So that that gives us an example of what an estimate plan will look like. We have just a couple of minutes left, and I'm a big stickler on you know, if we say we're going to finish at nine, we turn off at nine. So, are there any final comments from the panel, any messages that they'd like to get across at this point in time?

Tim Senior 1:20:44

I can't emphasize enough the importance of relationship. That if you think about the advice you take from people, you take advice from people that you trust and that you think have your best interests at heart, and so all of our asthma advice and education falls on deaf ears if they don't feel that we've understood their circumstances and heard what they've got to say, and we've intentionally developed rapport with them, and we've all come across circumstances where that hasn't happened, but I think the whole management depends on doing that effectively, because then that's what will make people listen to our advice.

Chris Pearce 1:21:24

I personally would like to thank the panel for their time and insight, and I think it's been excellent. Every time I do these things, I learn something, even though, you know, I would have thought I was reasonably up to speed before I start. But there you go. Catherine, do you want to close us out?

Cathryn Berry 1:21:42

Yeah, really, I would just like to echo the thanks for the panel and your open sharing of your expertise and for such high engagement from the participants and all the great questions and discussions in in the chat. Thank very much. And as always, there's the call out for a little evaluation to help us deliver more events that work for your needs. So, thanks very much everyone.

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