# EFFORTS

***Emphysema Foundation For Our Right To Survive***

Emphysema Takes Your Breath Away August 2007


## COACHING FOR DOCTOR OFFICE VISITS HELPS PATIENTS ASK RIGHT QUESTIONS

Asking more questions during a visit to the doctor might help patients get care that is more satisfactory, but many patients are not sure where to start.

A new review of 33 studies found that giving patients question checklists or providing in-office coaching can help them ask more questions of their health care provider and get more information that is useful — often extending the length of the consultation as well.

"For outcomes like satisfaction, the patient's response is likely to cover the whole experience in the clinic — coaching and consultation — and thus the patients will feel like they got a better deal than usual as they had a nice time with the coach," said lead review author Paul Kinnersley.

When interventions took place immediately before a consultation, they resulted in a small but significant increase in the duration of the office visit. Interventions that occurred some time before the consultation had no effect.

In general, interventions produced small increases in patient satisfaction, plus a possible reduction in patient anxiety before and after visits. Coaching had a slightly larger benefit in patient satisfaction than providing question checklists.

"Coaching is a more intensive intervention and may have some therapeutic impact," said Kinnersley, co-director of the Communications Skills Unit at Cardiff University in Wales.

At the very least, coaching helps patients voice and rehearse their concerns. "Patients need to have the courage and confidence to ask questions," said Sherrie Kaplan, Ph.D., co-director of the Center for Health Policy at the University of California, Irvine. "Many patients don't want to look stupid. Studies have shown that even doctors find that when they are patients, they don't want to ask questions that will make them look stupid."

The review also looked at the value of refresher courses in communication skills for doctors. Doctors can underestimate their patients' information needs for a variety of reasons, according to the review authors. When treating patients with serious or life-threatening illnesses, doctors might be reluctant to dispense information that they feel could be harmful or disturbing. Alternatively, they sometimes focus so hard on confirming a diagnosis that they do not take the time to encourage patient involvement in constructing more individualized treatment approaches.

"Doctors are prepared to ask questions, to formulate what's wrong, find it and fix it," Kaplan said. "In studies we've done, the patient will talk for about 30 seconds before the doctor interrupts with more questions and takes over." Kaplan was not involved with the Cochrane review.

According to Kinnersley, doctors do benefit from refresher courses in communication, even if they are not always eager to go. "Pretty much every medical school will teach communication skills and assess them before qualification, but we still have evidence that patients are dissatisfied with doctors' communication skills," Kinnersley said. "I think the problem is that after qualification, doctors learn a lot more clinical knowledge and they get more enveloped by medical culture. Thus, their communication skills often deteriorate. They focus on curing the patient rather than caring for them."

The review found small increases in consultation time when doctors received training, but found no significant increase in patient satisfaction. Ultimately, the review recommended more studies to compare methods of intervention, intervention timing and the possible benefits of additional training for health care providers.

The review studies covered a variety of settings and diagnoses, including primary care, cancer, diabetes, women's issues, heart problems, peptic ulcers and mental illness. It is possible that the more serious the illness, the greater the level of anxiety might be and the more intimidated a patient will feel about asking questions, Kinnersley suggested. "If patients are anxious or the answer to a question might be frightening, you're going to need more encouragement to ask questions," he said.

For Kaplan, the key to getting the most out of any doctor visit and reducing anxiety is preparation. She compares preparing for a doctor visit to studying for a test. "Anxiety can affect your memory but if you haven't prepared to take a test, whether you're anxious or not, you are not going to do well," said Kaplan. "You need to prepare so you can be cool, calm and collected. Patients need to meet the doctor halfway and doctors need to give patients the sense that there is some way they can get involved in their own treatment."

Source: cfah.org

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## ONE BILLION PEOPLE DON'T GET ENOUGH VITAMIN D

Vitamin D deficiency is a common problem that can lead to a number of serious health conditions, but it can be prevented, says one expert.

People get vitamin D from sun exposure, diet and supplements. Yet vitamin D deficiency is all too common. In utero and in childhood, not getting enough vitamin D can cause growth retardation, skeletal deformities and increase the risk of future hip fractures. In adults, too little vitamin D can lead to or exacerbate osteopenia, osteoporosis, muscle weakness, fractures, common cancers, autoimmune diseases, infectious diseases and cardiovascular diseases.

In the July 19 issue of the New England Journal of Medicine, Michael Holick, director of the General Clinical Research Center at Boston University School of Medicine and director of the Bone Healthcare Clinic at Boston Medical Center, published an overview of his work on vitamin D. According to Holick, it has been estimated that one billion people in the world are vitamin D deficient or insufficient.

Without vitamin D, only 10 percent to 15 percent of dietary calcium and about 60 percent of phosphorus is absorbed by the body. This can have a direct effect on bone mineral density.

There is evidence that people who live at higher latitudes -- where the angle of the sun's rays is not sufficient to produce adequate amounts of vitamin D in the skin -- are more likely to develop and die of Hodgkin's lymphoma, colon, pancreatic, prostate, ovarian, breast and other cancers. And there is an association between low levels of vitamin D and increased risk for type 1 diabetes, multiple sclerosis, Crohn's disease, hypertension and cardiovascular disease.

Holick says that the current recommended adequate intake for vitamin D needs to be increased to 800 to 1,000 international units (IU) of vitamin D3 per day.

"However, one can not obtain these amounts from most dietary sources unless one is eating oily fish frequently. Thus, sensible sun exposure (or UVB radiation) and/or supplements are required to satisfy the body's vitamin D requirement," Holick said in a prepared statement.

Holick added, "The goal of this paper is to make physicians aware of the medical problems associated with vitamin D deficiency. Physicians will then be able to impart this knowledge to their patients so they, too, will know how to recognize, treat and most importantly, maintain adequate levels of this important vitamin."

Source: HealthDay News

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## SOME SMOKERS HAVE GENETIC PREDISPOSITION TO DEVELOP COPD, RESEARCH SHOWS

Some people have a genetic variation that makes them more susceptible to chronic obstructive pulmonary disease (COPD) if they smoke tobacco, according to new research from Wake Forest University School of Medicine and colleagues.

"The genetic variant we studied seemed harmless on its own," said Alireza Sadeghnejad, M.D., Ph.D., lead author. "But when someone has this variant, there is more of an adverse effect of smoking on lung function. Therefore, in combination with smoking, this genetic variant represents a risk factor for COPD."

Emphysema and chronic bronchitis are components of COPD, which is the fourth leading cause of death in the U.S. and the only top-10 killer that is increasing in frequency. The World Health Organization predicts that by 2020, COPD will be the third-leading cause of death worldwide.

The study is published online and will appear in a future print issue of the American Journal of Respiratory and Critical Care Medicine. The researchers studied two variations (–1112C and –1112T) of the interleukin-13 (IL-13) gene. The gene is responsible for the production of the IL-13 protein that is involved in pulmonary inflammation and susceptibility to COPD.

Everyone has two copies of the gene, one inherited from each parent. The investigation suggests that having two copies of –1112T in the IL-13 gene is linked with a more profound adverse effect of cigarette smoking on lung function.

Study participants were 1,073 men at least 40 years old who had smoked 20 or more pack-years. One pack-year is equivalent to smoking one pack a day for a year. Participants underwent genetic testing and a pulmonary function test known as Forced Expiratory Volume, which is the volume of air that can be forced out in one second after taking a deep breath.

Jill Ohar, M.D., senior researcher and a professor of internal medicine-pulmonary, said it's likely that –1112C/T is one of several genetic variants that influence the risk of a smoker developing COPD. About 25 percent of smokers develop the disease, suggesting that genetic factors, in addition to environmental exposure (in this case cigarette smoking), play a role.

"This finding may help us to understand why some smokers develop COPD and improve our understanding of how the disease develops," said Ohar. "It shows us that it's likely the gene/environment interaction sets you up for this disease."

Sadeghnejad said that by understanding more about the role of IL-13 in COPD, the protein may one day be a target for new drugs for the disease.

The variant has been shown to be associated with asthma, which may help explain why COPD and asthma tend to cluster in families, Ohar said.

Source: Wake Forest University Baptist Medical Center

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## STEROIDS AND COPD LINKED TO PNEUMONIA

A Canadian study finds chronic obstructive pulmonary disease patients taking inhaled steroids are at greater risk for severe pneumonia.

Patients with COPD are increasingly being prescribed inhaled corticosteroids to help control the disease. The study, published in the American Journal Journal of Respiratory and Critical Care Medicine, found that anti-inflammatory drugs may increase the chances these patients will be hospitalized for pneumonia.

Dr. Pierre Ernst, at McGill University, in Montreal, and other researches analyzed the hospitalization and drug prescription information from 1988 to 2003 of 175,906 patients with COPD living in the providence of Quebec. During that time, 23,942 of the patients were hospitalized for pneumonia. "In a large cohort of patients with COPD, we found that current inhaled corticosteroid use was associated with a significant 70 percent increase in the risk of being hospitalized for pneumonia," Ernst said in a statement. "Furthermore, for the severest pneumonias leading to death within 30 days of hospitalization, the risk with current inhaled corticosteroid use was also significantly increased."

The researchers noted that the admission rate for pneumonia increased with higher doses of inhaled steroids and that reduction in risk was observed once the medications were stopped. Source: USTINET Corporation

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## PEOPLE WITH ASTHMA IN WALES MOST CONCERNED ABOUT STEROID MEDICATION, UK

A survey by Asthma UK Cymru shows that over half (54%) of people with asthma prescribed steroid medication in Wales are 'very' or 'fairly' concerned about side effects and together form the nation with the strongest concerns.

The nation least likely to have strong concerns about the side effects of steroids is Scotland with 45%. People with asthma in Northern Ireland have also been found to be the least likely to allow their concerns to affect their use of steroid medication whereas people in England are the most likely to be non-compliant.

Of the 125,000 people with asthma prescribed steroid medication in Wales concerned about side effects, 19% do not take their steroid medication due to their concerns and 12% only take their medication when they have symptoms.

In the UK women were shown to be more likely than men to report their concerns, whereas men are more likely to allow their concerns to affect their use of steroid medication. The strongest concerns are expressed by the 45-54 age group with just over half (54%) of this group saying they are 'very' or 'fairly' concerned.

Patients are often concerned about the risk of developing osteoporosis caused by taking prolonged high doses of steroids. However, it is important to weigh up risks versus benefit and we know that inhaled steroids are the most effective preventer drug for adults and children for achieving good asthma control.

Inhaled steroid medicines are usually taken at low doses and the medication goes straight to the airways so very little is absorbed into the rest of the body. Those who encounter side effects such as hoarseness of voice, sore throat or mouth infection can help to avoid them by taking their inhaler via a spacer, brushing their teeth and rinsing their mouth afterwards.

Professor Martyn Partridge, Chief Medical Adviser to Asthma UK says: 'Good doctor patient communication is an essential component of asthma management and patients will understandably not take medicines about which they have concerns. Those with asthma should feel absolutely free to question doctors about their prescriptions and expect to be asked to express any concerns so that a balanced discussion regarding the facts may follow. Once reassured however people with asthma should do their best to take prescribed medicines as not doing so can have a profound effect on their health and well-being.'

Janet Pardue-Wood, National Director of Asthma UK Cymru says: 'Despite effective medication for the majority of people with asthma, Asthma UK Wales's data highlights that approximately 1 in 3 (36%) of people with asthma in Wales have not had a full discussion with a doctor or nurse about what asthma medicines, including side effects, are best for them. These results highlight the need to understand the concerns people with asthma have around their treatment, so that informed discussions can improve asthma control and reduce the number of emergency admissions.'

People with asthma concerned about side effects of steroids can call the Asthma UK Adviceline on 08457 01 02 03, which is a confidential service staffed by trained asthma nurses.

Source: www.asthma.org.uk

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## SMOKE-FREE ENGLAND A BREATH OF FRESH AIR FOR PEOPLE WITH ASTHMA

People with asthma across England can breathe a huge sigh of relief as the long-awaited smoke-free legislation comes into effect.

England has one of the highest rates of asthma in the world with 4.4 million people affected by this serious, widespread but controllable condition.

Mikis Euripides, Assistant Director of Policy & Public Affairs at Asthma UK says: 'For people with asthma the effects of smoking can be deadly. 82% of people with asthma in England tell us that cigarette smoke makes their symptoms worse and 15% of full and part-time workers with asthma have told us that they are exposed to other people's cigarette smoke at work.

'The legislation will be truly life-changing for these people. It will ensure that they are protected from second-hand smoke in the workplace and allow them to socialise in enclosed public places without the fear of a fatal asthma attack.'

Smoke-free legislation is a major triumph for Asthma UK, which has worked tirelessly to lobby the Government to pass this historic piece of legislation. The charity is now calling on the Government to maintain a strong smoking control strategy by continuing to highlight the dangers of smoking and ring-fencing funds for smoking cessation services.

Mikis adds: 'Whilst we welcome the new legislation, more work must be done to encourage people to give up this deadly habit. Over 800,000 people with asthma in England are smokers themselves, increasing their risk of asthma symptoms, asthma attacks and permanent damage to the airways. It is vital that adequate support services are available to these people following 1 July to help them kick the habit once and for all.'

Surce: www.asthma.org.uk

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## ASTHMA SUFFERERS NOW HAVE A NEW CHOICE OF COMBINATION THERAPY TO HELP ACHIEVE ASTHMA CONTROL

AstraZeneca announced that SYMBICORT® (budesonide/formoterol fumarate dihydrate) pressurized metered dose inhaler (pMDI) is now available in the United States for the long-term maintenance treatment of asthma in patients 12 years of age and older.

Administered twice daily, SYMBICORT is a combination of two proven asthma medications – budesonide, an inhaled corticosteroid (ICS), and formoterol, a rapid and long-acting beta2-agonist (LABA). For many patients, this combination treatment offers improved asthma control as early as day one that is sustained over 12 weeks. SYMBICORT also delivers improved lung function occurring within 15 minutes of beginning treatment. SYMBICORT does not replace fast-acting inhalers for sudden attacks.

SYMBICORT is available in two dose strengths, 80/4.5 and 160/4.5 g of budesonide and formoterol, respectively. SYMBICORT is approved for patients whose disease is not adequately controlled on another asthma-controller medication (e.g., low- to medium-dose inhaled corticosteroids) or whose disease severity clearly warrants initiation of treatment with two maintenance therapies.

"With the U.S. launch of SYMBICORT, millions of asthma sufferers will have a new choice of fixed combination therapy to help achieve control of their asthma," said Chris O'Brien, MD, PhD, senior director, Medical Science, AstraZeneca.

Asthma is one of the most serious chronic diseases in the U.S. It is estimated that more than 20 million Americans suffer from the condition and, if not properly managed, asthma can be life-threatening.

"The U.S. availability of SYMBICORT holds great promise for millions of Americans that suffer from asthma," said Tony Zook, president and chief executive officer, AstraZeneca U.S. "The addition of SYMBICORT to our respiratory portfolio reinforces AstraZeneca's commitment to developing new, effective treatments, and provides patients and physicians with a new treatment option to improve and maintain lung health."

SYMBICORT was approved by the U.S. Food and Drug Administration (FDA) on July 21, 2006. The SYMBICORT submission was based on 27 Phase I, II, and III trials designed to assess the efficacy and safety of SYMBICORT in a pMDI. The approved indication is largely based on data from two pivotal double blind, placebo-controlled, 12-week trials involving 1,076 patients in the U.S., age 12 and older. These studies showed that both dosage strengths of SYMBICORT produced a greater improvement in lung function compared to the same doses of budesonide or formoterol, administered alone, or placebo. In addition, these studies demonstrated a more rapid improvement in lung function compared to budesonide and placebo. Clinically significant improvement in bronchodilatory response, or opening of the lung airways, occurred within 15 minutes of beginning treatment with SYMBICORT.

The safety profile of SYMBICORT is based on a robust U.S. development program, which evaluated safety in over 6,000 patients treated with SYMBICORT in Phase I, II and III studies that were submitted to the FDA. SYMBICORT has safety data from long-term studies up to one year and a robust cardiac safety profile.

**About Asthma**

Asthma is a chronic inflammatory disease of the airways characterized by excessive sensitivity of the lungs, or increased reaction of the airways, to various environmental stimuli or triggers. The inflammation results in narrowed, swollen airways, increased mucus, and frequently is accompanied by tightening of the muscles in the airways, or bronchoconstriction, causing difficulty breathing and the familiar wheeze often associated with the disease.

Despite the availability of many treatments for adults with asthma and guidelines on how to use them, the disease is still poorly controlled. A retrospective claims database analysis of nearly 4,000 patients found that patients experienced asthma attacks (defined as asthma related emergency department visits, hospitalizations or oral corticosteroid bursts) at a steady rate over a four year period. Additionally, the study showed that asthma patients who had experienced an asthma attack were twice as likely to experience additional exacerbations as other patients. The annual direct healthcare cost of the disease in the U.S. is approximately $11.5 billion. Indirect costs (e.g., lost productivity due to missed days at school or work) add another $4.6 billion, for a total cost of $16.1 billion.

**Important Safety Information**

Long-acting beta2-adrenergic agonists may increase the risk of asthma-related death. Therefore, when treating patients with asthma, SYMBICORT should only be used for patients not adequately controlled on other asthma-controller medications (e.g., low-to-medium dose inhaled corticosteroids) or whose disease severity clearly warrants initiation of treatment with two maintenance therapies. Data from a large placebo-controlled US study that compared the safety of another long-acting beta2-adrenergic agonist (salmeterol) or placebo added to usual asthma therapy showed an increase in asthma-related deaths in patients receiving salmeterol. This finding with salmeterol may apply to formoterol (a long-acting beta2-adrenergic agonist), one of the active ingredients in SYMBICORT.

SYMBICORT is not indicated for the relief of acute bronchospasm.

SYMBICORT should not be initiated in patients during rapidly deteriorating or potentially life-threatening episodes of asthma.

Particular care is needed for patients who are transferred from systemically active corticosteroids. Death due to adrenal insufficiency have occurred in asthmatic patients during and after transfer from systemic corticosteroids to less systemically available inhaled corticosteroids.

Patients who are receiving SYMBICORT twice daily should not use additional formoterol or other long-acting inhaled beta2-agonists for any reason.

Common adverse events reported in clinical trials, occurring in >5% of patients, regardless of relationship to treatment, included nasopharyngitis, headache, upper respiratory tract infection, pharyngolaryngeal pain, sinusitis, and stomach discomfort.

AstraZeneca has offered drug assistance programs side by side with its medicines, and over the past five years, has provided over $3 billion in savings to more than 1 million patients throughout the U.S. and Puerto Rico. AstraZeneca has been named one of the "100 Best Companies for Working Mothers" by Working Mother magazine and is the only large pharmaceutical company named to FORTUNE magazine's 2007 list of "100 Best Companies to Work For." In 2006, for the fifth consecutive year, Science magazine named AstraZeneca a "Top Employer" on its ranking of the world's most respected biopharmaceutical employers.

Source: astrazeneca-us.com.

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## AS COSTS OF DRUGS SHIFT TO CONSUMERS, SPENDING DROPS

***For those with chronic illnesses, that can translate into worse outcomes, researchers say***

As employers and insurance companies shift more of the cost of prescription drugs onto consumers, actual spending on these medications declines, new research finds.

For people with certain chronic medical conditions, this means more money is probably spent on expensive medical services and health outcomes worsen down the line, the researchers add.

"Prescription drugs are just like apples or breakfast cereal. When they increase in price, patients use less of them, and that's true even of patients who have chronic illnesses," said Dana Goldman, lead author of a study appearing in the July 4 issue of the Journal of the American Medical Association. "Cost-sharing can have powerful effects on the way people fill their medications." Goldman is director of health economics at RAND Corp., in Santa Monica, Calif.

With more and better medications available, access to outpatient drugs has become "a cornerstone of an efficient health-care system," the study authors wrote. But increases in pharmacy spending have caused insurers and employers to try to move some of that cost onto the consumer.

"There's been a movement in the last few years . . . toward increased cost-sharing," Goldman said. "It's ironic, because if drugs are actually doing their job, as you spend more on drugs, you would expect to have less inpatient use and less use of emergency services. You would expect that if drugs are an increasing share of spending, that that means they're working. We were trying to see what is the evidence that can reconcile these positions, that was the motivation."

Goldman and his colleagues looked at 132 articles published between 1985 and 2006 that examined the association between prescription drug plan cost-containment measures (including co-payments and pharmacy benefit caps). Increased cost-sharing was associated with lower rates of drug treatment, lower adherence rates and more frequent discontinuation of therapy. For each 10 percent increase in cost-sharing, prescription drug spending went down by 2 percent to 6 percent.

For patients with congestive heart failure, lipid disorders, diabetes and schizophrenia, higher cost-sharing meant more use of medical services. The long-term consequences were less clear.

"The evidence is somewhat underwhelming. There is some evidence, and we think it points to the fact that, ultimately, there are costs associated with this strategy, but the evidence is not as definitive," Goldman said. "For certain chronic illnesses, we do see that when you increase cost-sharing, you also increase the use of inpatient and emergency services which are expensive, and that suggests there are some trade-offs."

"There is some evidence that cost-sharing costs insurers more down the road, suggesting that the best strategy is to give people their medicine for free," Goldman continued. "Some insurers are actually moving toward that for certain chronic diseases."

**Some experts felt the study didn't go far enough.**

"It is meaningless to correlate "cost-sharing" with "compliance" without delving deeper into patient education, patient investment, alternative treatments, lifestyle changes, etc." said Greg Scandlen, president and founder of Consumers for Health Care Choices.

"Not all 'cost-sharing' is the same. The study appears to conflate co-payments and co-insurance, but they have very different effects," Scandlen continued. "A co-payment acts as a fine for using a medication. It conveys no information about the underlying costs. . . . A co-pay reduces the knowledge of the consumer, while co-insurance increases the knowledge of underlying costs. Once the consumer knows what the cost is, she can have a conversation with her physician about costs versus benefits. This gets her more invested in her own course of treatment, which will promote greater compliance with the entire gamut of treatment." Source: ScoutNews

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## GLAXOSMITHKLINE RECEIVES EXTENDED LICENCE INDICATION FOR SERETIDE IN EUROPE FOLLOWING SUBMISSION OF TORCH DATA FOR COPD

GSK announced that it has been granted a licence extension in Europefor Seretide™ 50/500 g(salmeterol/fluticasone propionate) for use in a broader population of patients with the lung disease COPD. This follows a regulatory review of the TORCH (TOwards a Revolution in COPD Health) study data by the European Regulatory authorities.

Darrell Baker, SVP Respiratory Medicines Development Centre said, "We are delighted that the European Agencies have extended the licence for Seretide to a broader patient population. We hope, and expect, that this will mean that patients presenting to their healthcare professional start to use Seretide earlier and benefit from improvements in quality of life and in their lung function, before they have reached the severe stage of the disease."

Seretide is now indicated for the symptomatic treatment of patients with COPD, FEV1 <60% predicted normal (pre-bronchodilator) and a history of repeated exacerbations, who have significant symptoms despite regular bronchodilator therapy. Forced expiratory volume in one second (FEV1), is a way of measuring the lung function of patients with COPD. A higher percentage indicates better lung function.

Prior to the label update, it was only when a patient's lung function had deteriorated to an FEV1 of <50% predicted, that Seretide was indicated for use. This new indication means that more COPD patients may be able to use Seretide earlier in the course of the disease and benefit from improvements in quality of life and in lung function, before they reach the more severe stage of the disease. This label captures a broader range of COPD patients eligible for treatment with this type of combination therapy.

The application was approved following consideration of the results of the landmark TORCH study; the largest prospective, randomised, placebo-controlled pharmacotherapy study ever carried out in COPD. In addition to a relative risk reduction in mortality of 17.5% (p=0.052), which was just outside the predetermined level of statistical significance of p<0.05, TORCH showed that Seretide reduced the rate of exacerbations by 25% (p<0.001) compared to placebo and that patients treated with Seretide showed an improvement in health related quality of life (HRQoL) and FEV1, when compared with patients receiving placebo, over the three years of the study (p<0.001).

The typical COPD patient experiences a decline in health status over time. Patients receiving Seretide in the TORCH study showed an improvement in their health status over the three years and at the end of the study remained above the baseline that they started from at the beginning of the study.

The Seretide label will also include additional advice to healthcare professionals about undesirable effects including upper respiratory tract infections and increased risk of lower respiratory tract infections, including pneumonia.

Source: www.gsk.com

sis of COPD, the COPD Foundation says that close to 40% of primary-care doctors don't have spirometers in their practice. Among those who do have the devices, a third don't use them routinely, even though Medicare and most private insurers cover the use of spirometry when COPD is suspected.

"Though we'd like to believe everyone is following the standard of care and is up-to-date on the guidelines, there are millions of patients in rural areas and small towns where it is difficult for the general practitioners to keep up with everything," says Frank Quijano, a pulmonary and critical-care physician at the University of Kansas who treated Mr. Miller's COPD. There are several drugs commonly used to treat COPD, which though incurable can be prevented from worsening. Many drugs come in the form of puffers or inhalers; among the most commonly used are tiotropium (known by the brand name Spiriva), which dilates the bronchial tubes, and a combination of the steroid drugs fluticasone and salmeterol (known by the brand name Advair), which can also fight inflammation.

While a host of new treatments and drug dosages are being studied in large-scale trials, there has as yet been no major breakthrough. A study in the May issue of the American Journal of Respiratory and Critical Care Medicine found that a promising anti-inflammatory drug, infliximab, failed to improve symptoms of moderate to severe COPD. Moreover, because the conditions of COPD patients can often worsen dramatically, it has been difficult to conduct conclusive research. In one large study, known as the Towards a Revolution in COPD Health Trial, 40% or more of the subjects didn't continue to receive the assigned treatment throughout the study, because they either died, dropped out or sought other treatment. According to an American Lung Association survey, about half of COPD patients say their condition limits their ability to work, sleep, do household chores, and enjoy social and family activities, while 70% say it limits them in normal physical exertion. Mr. Miller, for example, has found it hard to exert himself, and his hospitalizations have forced him to miss out on a treasured pastime: riding his three-wheeled "trike" motorcycle with the Patriot Guard, a group that escorts military funerals.

Need for Early Treatment

Though oxygen therapy and surgery to reduce the size of the lungs can help prolong the life of severely ill COPD patients, at present, half die within 10 years of diagnosis -- a toll experts say could be sharply reduced if patients are diagnosed and treated early. The National Committee for Quality Assurance, which accredits health plans, is pressuring plans to encourage doctors to conduct screening for COPD. And the Center for Medicare and Medicaid Services is evaluating whether it can cover rehabilitation services, according to Steve Phurrough, director of the coverage and analysis group.

For patients like Mr. Miller, who suffer from other diseases along with COPD, proper treatment can dramatically improve the quality of life. His doctors at the University of Kansas treated his lungs with inhaled breathing treatments and antibiotics. And rather than perform open heart surgery that would have required a ventilator that might have done more damage to the airways, they performed angioplasty to open his blocked arteries. For now, the COPD is under control. Says Dr. Quijano, "He walked out of here ready to ride his motorcycle."

Source: Wall Street Journal

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## HERB COMBO FOR ASTHMA?

The popularity of herbal medicine is on the rise. Now, American researchers are testing herbs from China that may provide a natural solution to a problem that still stumps doctors: how to treat people with asthma safely and effectively.

Teo Hoke needs an inhaler to help her breathe and depends on steroids for survival. "When you have an asthma attack, you feel like someone is sitting on your chest," says Teodorina.

Either oral or inhaled, steroids are often the frontline treatment for asthma, but Neil Schachter, M.D., from Mount Sinai Hospital in New York, says they're dangerous. "There's the chance of bone damage, there's the chance of infection because

of lower immune system, chance of triggering diabetes," explains Dr. Schachter.

Researchers are studying an herbal alternative. "The goal of our clinical study is to reduce, or eventually replace, the corticosteroids," says Xiu-Min Li, Ph.D., from Mount Sinai Hospital. A Chinese study revealed a three-herb combo -- Ling-Zhi (Ganoderma lucidum), Ku-Shen (Radix Sophora flavescentis), and Gan Cao (Radix Glycyrrhiza uralensis) -- improves lung function in asthmatics.

"This would offer a significant alternative to using steroids, and it would be a lot safer," says Dr. Schachter.

If the results from the Mount Sinai study confirm the herbs are safe and effective, the botanical drug could be a welcomed new option for Tao and the 15 million Americans who suffer from asthma.

The clinical trial investigator at Mount Sinai says the three phases of the clinical trial could take a couple of years to complete. Source: Ivanhoe.com

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## HOT WATER REMOVES ALLERGENS BEST

***Hot, Not Warm, Water Is Needed to Kill Dust Mites, Remove Animal Dander. Hotter is better when it comes to killing dust mites and other allergens in your laundry***.

A new study shows washing laundry in hot water (140 degrees Fahrenheit) kills 100% of dust mites. But turn the dial down just 36 degrees to a warm, 104 degree Fahrenheit wash and only 6.5% of dust mites are killed in the laundry. Hotter water was also better at removing dog dander and pollen.

But if your delicate laundry can't take the heat, researchers also suggest another way to reduce dust mites and allergens in the laundry: wash at a lower temperature (between 86-104 degrees Fahrenheit) and then rinse the laundry twice with cold water for at least three minutes each

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**Killing Allergens in the Laundry**

In the study, presented at the American Thoracic Society's 103rd International Conference in San Francisco, researchers compared the effectiveness of washing cotton sheets with regular laundry detergent at various temperatures in removing dust mites, dog dander, and pollen allergens.

The results showed that washing laundry at hotter temperatures was significantly more effective than warm water at killing dust mites as well as other allergens. For example:

- Washing laundry in warm, 86- to 104-degree Fahrenheit water killed only about 6% of dust mites.
- Hot water washing (at 140 degrees Fahrenheit) killed 100% of dust mites.
- Washing in hot water also removed nearly 90% of dog dander compared with about 60% removed in warm water washing.
- Hot water washing removed nearly 97% of pollen in the laundry compared with 69% at 86 degrees Fahrenheit and 95% at 104 degrees Fahrenheit.

The study also showed that steam cleaning of the sheets was equally effective as hot water (140 degrees Fahrenheit) washing at killing dust mites and removing dog dander and pollen.

In addition, researcher Jung-Won Park, MD, PhD, of Yonsei University in Seoul, South Korea, and colleagues found rinsing laundry twice in cold water was also effective at removing all traces of dog dander in laundry washed at any temperatures.

Source: WebMD

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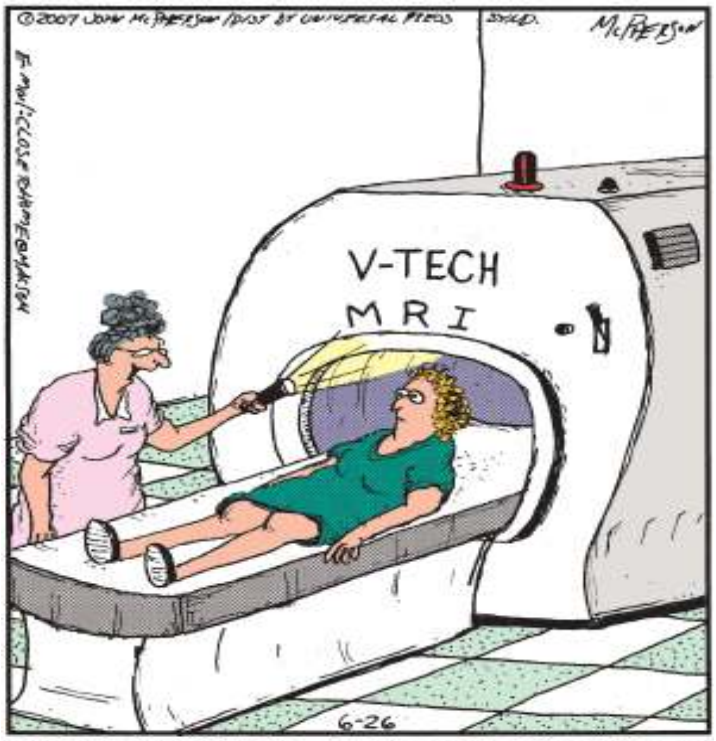
Information in this newsletter is for educational purposes only. Always consult with your doctor first about your specific condition, treatment options and other health concerns you may have.




"While you're in there, could you do me a favor and look around for a silver earring? The patient before you thinks that's where she lost it."

EFFORTS
Suite D
239 NE US HWY 69
Claycomo, Mo. 64119