

Asthma myth busting

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As asthma management becomes more routine in general practice, it can be easy for certain beliefs to become ingrained, even if these beliefs are based on misconceptions and are not supported by current evidence. Let's look at five common asthma management myths.

1. Don't double the dose

The old thinking that 'doubling the dose improves control' is no longer considered best practice for routine management. In adults with asthma that is not controlled despite low dose inhaled corticosteroids (ICS) treatment, a long acting beta agonist (LABA) should be the first choice for add on therapy once poor adherence and poor technique have been ruled out.¹ For day-to-day management, adding a LABA to ICS (usually via combination therapy) improves lung function and symptoms and reduces exacerbations to a greater degree than simply increasing the ICS dose.¹

2. Milk + mucous = myth

The 'milk myth' – the notion that milk makes mucous or that dairy triggers asthma – has now been debunked by several studies.² Indeed, findings from one group suggest that there may be an association between increased milk intake and reduced incidence of asthma symptoms in children.³ This misconception is widespread, however, and has led to some people with asthma (or their carers) limiting dairy intake, which can have significant health and nutrition consequences.¹ Most people with asthma can regularly include dairy in their diet, unless an allergy to cow's milk is proven.

3. Spacer over nebuliser

A growing number of systematic reviews have found that a metered dose inhaler (MDI) plus a large volume spacer is equally as effective as nebulisation for treating asthma in almost all circumstances.^{4,5} Not only is an MDI plus spacer more convenient and cost effective than a nebuliser, it is also easier to maintain and has fewer side effects.

Nebulisation should be reserved for patients with severe or life threatening asthma requiring continuous salbutamol and oxygen.¹

4. Rhinitis is nothing to sneeze at

Rhinitis can be more than just a minor irritation for the 75–80% of patients with asthma who have both conditions. Effective treatment of allergic rhinitis can improve asthma control and lung function, while effective treatment of asthma may also improve rhinitis.⁶ This connection is reflected in the 'one airway, one disease' hypothesis – that the hypersensitive lungs in asthma and the hypersensitive nose in rhinitis share the same mucosal susceptibility.⁶

Dispelling common asthma misconceptions in general practice



Patient with MDI and large volume spacer

5. Peak flow is not spirometry

Peak expiratory flow meters have been in use for many years; however they have significant shortcomings when it comes to assessing airway limitation, including the wide range of 'normal' values, a high degree of variability and a dependence on patient effort. In contrast, high quality spirometry provides detailed, accurate and reliable measurement of lung function. Spirometry is now the lung function test of choice for diagnosing asthma and assessing asthma control in response to treatment.¹ Peak flow is not an acceptable substitute.

For a range of asthma information, including spirometry resources, visit the National Asthma Council Australia website at www.NationalAsthma.org.au. ♦

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