editorial

Asthma Action Plans

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The article by Kable et al (page 470 this issue) demonstrates that general practitioners are not totally comfortable with writing Asthma Action Plans (AAPs) for patient's with asthma. The evidence from a Cochrane review[1] has demonstrated that written AAPs, regular medical review and self management education improves the outcome for adults with asthma.

The numbers needed to treat are: for every eight patient's with asthma given a written AAP, regular medical review and education about self management, one after hours emergency presentation will be prevented. For every 20 patients with asthma given these three elements, one admission to hospital will be prevented.

General practitioners do not write AAPs for all their patients with asthma: only about 40% of the population have a written AAP.[2,3] Why? Qualitative research in the UK found that doctors were unenthusiastic about standardised plans for individual patients, preferring to monitor them individually.[4] Similarly, patients thought that self management plans may be useful to other patients, but not relevant for themselves.[5]

So who needs an AAP and how can these patients be identified? This question has not been addressed. Perhaps it is the more severe and most unpredictable. Approximately 17% of patients with asthma will come under the 'moderate to severe' classification and therefore be appropriate for the '3+ Visit Plan'.

The current Asthma Management Handbook states: 'Formulate and provide a written Asthma Action Plan so that all people with asthma will be able to recognise deterioration promptly and respond appropriately...'[6]

What is not clear is whether this should be for 100% of general practice patients with asthma. The published evidence tends only to address more serious asthma, while most patients have mild asthma – although they too can develop emergencies.[7] Until more research addresses mild disease, GPs need to provide patients with potentially unstable or serious asthma with a written AAP about how to act if their asthma changes.

Any patient on asthma preventive medication should be given a written AAP. This has the benefit of linking to prescribing. As a script for a preventive medication is being written, we should enquire whether the patient has a written AAP; if they know where it is; if they use it; and what they think of the plan?[8]

There are two final issues. First, is the need to develop a systems approach that enables updating, eg. a 10 year old's AAP will need review at puberty.

Second, we must provide for the back titration of inhaled corticosteroids as control of asthma is achieved and consider the introduction or modification of other medications as the situation changes.

Once a patient's airways have stabilised and asthma control has been achieved, they may need a lower dose of inhaled corticosteroids to maintain that control. The introduction of a long acting beta-2 agonist may enable the patient to maintain control of their asthma with an even lower dose of inhaled corticosteroids. Therefore, AAPs need to be reviewed often so the information is current.

So, think about each patient with asthma and decide whether they need to have a written AAP (they probably do) and how you are going to provide it and keep it up-to-date.

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