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Poison Ivy, Asthma, Urgent consults

Allergy Shots For Poison Ivy – The Very Short Version Also Mold & Indoor Allergens

My abstract, *Successful Immunotherapy for Poison Ivy*, was accepted for presentation to the American Academy of Allergy Asthma & Immunology February 28, 2010.

One cannot present findings as “new” at a scientific meeting if they have previous public disclosure. I asked the Academy if describing our findings in an issue of *Wheeze 'n Sneeze* before I present them at its annual meeting would be considered public disclosure. They said it would. Their rules let me announce the title of

the presentation on Jan 1 when the same title is published in the program for the meeting. I can disclose exact text from the abstract when the abstracts are published on Feb 1, but I cannot give further details in any public forum until I present them to the Academy on Feb 28.



Feel free to call me to discuss management options for either individual patients or types of patients, which is not public disclosure. If your department, society or medical staff would like a scientific presentation on this topic, I'll be happy to give it after Feb. 28.

Managing asthma exacerbations

Traditional wisdom for the control of acute asthma exacerbations is that “A short course of corticosteroids following assessment for an asthma exacerbation significantly reduces the number of relapses to additional care, hospitalizations and use of short-acting beta(2)-agonist without an apparent increase in side effects. Intramuscular and oral corticosteroids are both effective.” (Cochrane Database Syst Rev 2007 July 18;(3):CD000195) The published literature contains “insufficient evidence” that inhaled corticosteroids alone are as effective as systemic steroids (Cochrane Database Syst Rev. 2003;(3):CD002308).

We treat many patients with severe persistent asthma who have historically been “frequent fliers” in hospitals and emergency departments. In contrast to the traditional wisdom cited above, it’s been our experience that with early increases in inhaled corticosteroid dose, usually combined with additions or increases in other non-steroid medications, these patients can achieve better control of their asthma with less disruption of work or school than when treated according to “traditional wisdom.”

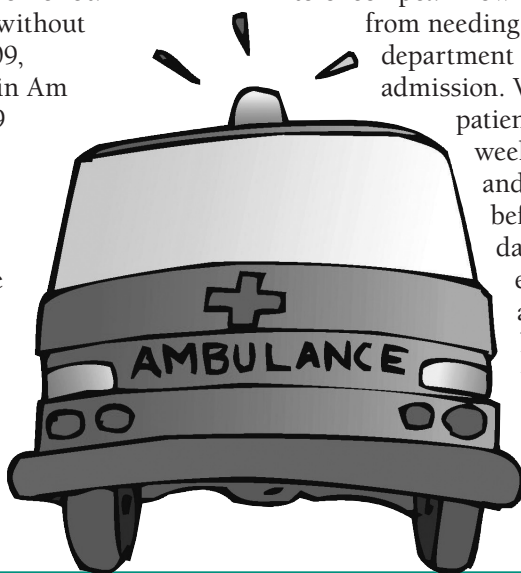
The first published validation of our approach of early treatment without systemic steroids was in 10/09, when Osborne et al reported in Am J Respir Crit Care Med. 2009 Oct 1;180(7):598-602 that “quadrupling the dose of inhaled corticosteroid when asthma control starts to deteriorate appears to reduce acute exacerbations of asthma and deserves further investigation.” The same group previously reported that doubling inhaled steroid dose under the same circumstance did

not reduce need for oral steroids (Lancet. 2004 Jan 24;363(9405):271-5). Correspondence about the 2004 article included discussion of whether addition or increase in other non-steroid meds, principally long acting bronchodilators (which we also do **prescribe** for exacerbations) could improve outcomes more than doubling steroid dose alone.

To translate these results into optimal community-based asthma care one must also teach and motivate patients to avoid avoidable asthma triggers. This often requires allergy evaluation and in many cases allergy treatment. Patients and parents must also learn to look for and respond to early increases in asthma activity with individualized management plans. Some patients can sense increases in asthma activity without home peak flow monitoring. Others need to measure peak expiratory flow rate to tell whether a little bit of cough or congestion is an early warning sign that requires action.

Patients who are well controlled between occasional asthma exacerbations tend to stop following PEFR when they’re feeling well. When symptoms recur they often don’t remember to check peak flow early enough to keep from needing oral steroids, emergency department care and occasionally hospital admission. We try to motivate such patients to choose one day of the week to be their peak flow day, and to record both AM and PM before-medicine PEFR on that day every week. Then, at the earliest symptom of a possible asthma exacerbation, they know where the meter is, they know that it works, and they know their recent “well” peak flow rate to compare with their

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Outcomes are better when education is a part of disease management

Our standard of care is to offer customized asthma management plans to all patients with severe exacerbations. When appropriate these include teaching environmental controls and other life-style measures to control triggers, risk factors and clinically relevant comorbidities.

Visit our offices or our web site at www.AASJ.com for current information and management strategies for Allergic Diseases and Asthma.

Managing asthma

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current reading. Most importantly these patients remember that they have a meter and what it's for, and they usually use it appropriately. We designed a home peak flow rate & medication tracking form that we and our patients both find simpler to use and interpret than anything we've seen on the internet or that comes from a meter manufacturer.

These patients' asthma plans typically include increasing or adding other meds in addition to increased doses of inhaled corticosteroids. These plans are effective for patients of all ages with recurrent severe exacerbations, even if they're well enough between episodes to need no meds at all. Of historical interest, this reflects the approach I first published in 1983, (Dynamic approach to asthma. *J. Asthma* 1983; 20(1):45-52), reducing hospital & emergency department use in a population of 32 former "frequent fliers" by 99%, achieving satisfactory and uncomplicated clinical control allowing full return to work, school and a full range of other activities in 97%, and reducing total direct costs of care by more than 50%.

SAFE, EFFECTIVE, SIMPLE, CHEAP

Whether it's poison ivy allergy, asthma or anything else in our specialty we look forward to offering your patients treatment according to our longstanding mantra: **SAFE, EFFECTIVE, SIMPLE, CHEAP.**

Disease Management and Education for Asthma and Sports Asthma

Allergies of the Eye, Ear, Nose & Throat

Chronic/Recurrent Sinus and Ear Infections

Skin Allergies, Eczema & Hives

Food Allergy, Latex Allergy

Antibiotic Desensitization

Customized Allergy Testing & Serum

Occupational & Environmental Allergy & Asthma

Do you have associates (partners, NP's, PA's) who didn't get this mailing but would like it?

We try to keep a complete mailing list but many groups are listed by group and not by individuals. If you have associates who'd like their own copy of these mailings, please send names & contact information by fax (206.202.2105), email aasj@aasj.com or call (856.825.4100).

Health Effects of Mold & Dampness

Exposure to indoor dampness and to molds that grow in damp places can cause respiratory irritation and aggravate respiratory allergies. However, these problems almost always resolve when exposure stops. There is no evidence that these exposures can cause fatigue or neurologic symptoms. Outdoor molds can aggravate allergies but don't usually cause irritant symptoms because irritant levels can't build up

outdoors as they do in closed indoor spaces. Molds are nature's recyclers of dead vegetation, and in South Jersey's humid climate with lots of dead vegetation, there's lots of mold.

The National Academy of Sciences 2004 review of *Damp Indoor Spaces and Health*, which I find to be the definitive review of the topic, is available for both reading and purchase online, at <http://books.nap.edu/catalog/11011.html>.

Avoiding Winter Allergens in the Home

Cold outside temperatures have forced most of us inside for the winter, increasing exposure to such common indoor allergens as dust mite, mold and pets. Symptoms of respiratory allergy can mimic many symptoms of viral respiratory infection. Each can increase the congestion caused by the other, increasing the risk of bacterial complications. Think of allergy if symptoms last longer than expected for a cold or if they recur in a seasonal pattern.

Simple environmental control measures are often helpful:

DUST MITE—The bed is almost always the most important source of dust mite exposure in the home. Modern dust-proof mattress and pillow covers are tightly woven fabric that breathes, unlike older covers made of plastic. In addition to covering mattresses and pillows, all bedding must be washed at least once per month with a technique that both kills and removes dust mites. There are separate methods for hot and cold wash but either can be expensive if you depend on coin-operated washers and driers. A child using a bed as a trampoline will blow out a dust proof cover in one jump; homes at risk for bouncing should use other control methods.

Box springs generally don't need dust-proof covers. Hard floors trap less dust mite than

carpet but it usually isn't worth the cost of replacing it except on concrete slab floors. Carpeted slab floors are common in split level homes.

If you want to keep knick-knacks, collectibles, stuffed animals, and other "dust collectors," put them in cabinets with glass or plastic doors.

MOLDS have three requirements for growth: moisture, a substrate (usually cellulose) and oxygen. For leaks or seepage of rainwater or groundwater, stop the leaks or seepage and remove all mold-damaged material without an easily cleaned hard surface. Scrubbing with a 1:10 dilution of household bleach with hand dishwasher detergent will both kill and remove mold from most contaminated hard surfaces. We also teach other simple mold control measures.

AIR FILTERS AND CLEANERS may reduce dust and make air seem fresher but they generally don't reduce exposure to dust mite allergen. Vacuum cleaners with HEPA filters or double layer dust bags (one bag inside another) will reduce exposure.

PETS—Sometimes pet exposures can desensitize as well as sensitize but for already sensitized individuals complete avoidance offers the best control. When this isn't practical, allergy shots almost always help.

