

IPCRG - Medzinárodná respiračná skupina v primárnej starostlivosti: kto, čo a prečo s nami spolupracovať ?

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IPCRG

- Založená v júni 2000 v Cambridgi medzinárodnou komunitou praktických lekárov, ktorí sa snažia o rovnováhu tak, aby aj primárna sféra mala svoj výskum a vzdelávanie
- Škótska charitatívna organizácia pracujúca medzinárodne
- Poskytuje zastrešenie národným respirologickým záujmovým skupinám v primárnej sfére
- Slovensko sa stalo členom v apríli 2009 prostredníctvom našej skupiny respirologických nadšencov z radov VLD

IPCRG

JEDINÁ medzinárodná respiračná skupina v primárnej starostlivosti;

JEDINÁ medzinárodná organizácia v primárnej zdravotnej starostlivosti s poslaním respiračného výskumu

www.theipcr.org

Zaväzujeme sa

Zlepšovať starostlivosť o ľudí s respiračnými ťažkosťami vyskytujúcimi sa bežne v komunite, ako sú astma, CHOCHP, alergická nádcha, fajčiarska závislosť a infekcie dýchacieho traktu

www.theipcr.org

Veríme,

Že najlepšie *miesto* na diagnostiku a liečbu väčšiny týchto ľudí je ich komunita, kde žijú a pracujú a že najlepším *spôsobom* ako to urobiť, je zabezpečenie vysokej kvality primárnej a komunitnej starostlivosti

www.theipcr.org

Našou ambíciou je

preskúmať najefektívnejšie spôsoby v „reálnom živote“, aby bola starostlivosť o týchto ľudí bezpečná a spoľahlivá vo všetkých participujúcich krajinách a naše závery šíriť pomocou vzdelávania, publikovania a networkingu

www.theipcr.org

Peer-reviewed Medline listed journal: Primary Care Respiratory Journal (PCRJ)

Primary Care RESPIRATORY JOURNAL

www.thepcrj.org



PUBLISHER'S UPDATE AUGUST 2008

The ONLY fully indexed, international primary care journal specifically devoted to the care of patients with respiratory diseases

International recognition of the importance of the *Primary Care Respiratory Journal* significantly increases

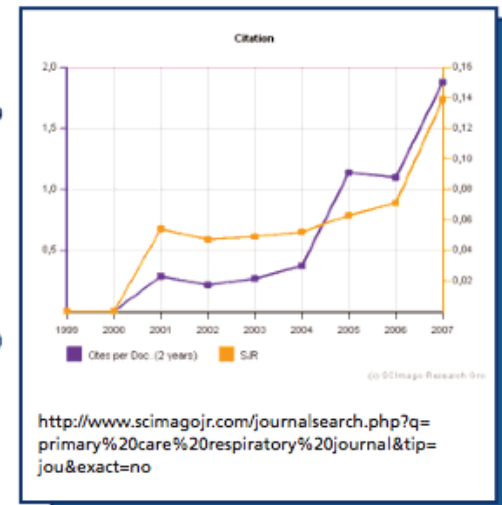
Citation rate doubles in a year

The citation rate of the *Primary Care Respiratory Journal* has almost doubled in the last year.

According to the latest figures produced by SCImago – an independent academic research organisation ranking journal citation rates – the citation index (SJR) of the *Primary Care Respiratory Journal* has risen from 0.071 to 0.139 (SCImago (2007) – SCImago Journal & Country Rank. (Retrieved August 01, 2008, from <http://www.scimagojr.com>)

This 51% increase in the citation rate reflects the significant increase in the importance of the title amongst the respiratory community worldwide.

Data produced by SCImago (www.scimagojr.com) is widely recognised as an independent measure of a journal's academic importance. It uses citation data captured in the SCOPUS (www.scopus.com) database which includes 14,000 peer-reviewed scientific journals (including 4614 medical journals) from > 4000 publishers worldwide.



Treating Childhood Asthma

An international primary care response to Professor Ulrich Wahn's contention that there be discrete guidelines for managing children with asthma, and that there be more specific research on children



DISCUSSION GUIDE

Our discussion guide, developed by an international primary care panel, has elicited some fascinating information and could be used as the structure for a local meeting, or as an interviewing guide ▶

THE FULL SET OF QUESTIONS

The complete set of questions sent to the international panel ▶

THE RESPONSES

Some questions produced very practical responses. These are arranged by country and by subject

- ▶ Responses by country
- ▶ Responses by subject

Published by the International Primary Care Respiratory Group, London

OUR NEWSLETTER
DISCUSSION FORUM

USEFUL LINKS
QUESTIONS

ASTHMA GUIDELINES 2008

How useful to primary care professionals around the world are they?

This IPCRG Exchanges shares international primary care reflections on the use and impact of new and updated guidelines. Hailing from 11 countries on 4 continents, 11 PCPs and 2 patient representatives

participated in interviews, following a structured questionnaire. The aims were to understand how the latest guideline updates are being received and accepted in primary care globally, and to assess how useful they are to busy working PCPs.



OVERVIEW

A concise review of the GINA, ARIA and IPCRG guidelines and PRACTALL consensus – and PCPs views on how to use them and share them

GUIDELINE SUMMARY

A more detailed summary of the GINA, ARIA, and IPCRG guidelines and the PRACTALL consensus statement

THE QUESTIONS

The 16 questions we used to guide our discussion with our panel of experts

USEFUL LINKS

Spirometry

Spirometry is the gold standard for the diagnosis, assessment and monitoring of COPD,¹ and may assist the diagnosis of asthma.² It can also contribute to the diagnosis of other causes of dyspnoea.

Which Spirometer?

Ideally, a spirometer should have a graphical display to allow technical errors to be detected. It should be able to produce a hard copy.

Regular calibration is essential. Some spirometers need to be calibrated before each session using a calibration syringe. Others hold their calibration between annual services. Check manufacturers' instructions.

Three types of spirometer are commonly used in primary care:

- Small, hand held meters which provide digital readings. These are the cheapest option and small enough to fit into a medical bag, but the lack of graphs can make it difficult to judge when a blow is complete. Predicted charts and a calculator will be needed to interpret the results.
- Portable meters with integral printers. These are more expensive but they will undertake all the calculations, including reversibility. Small displays of the volume time graph help monitor the blow and the printout includes a flow volume loop.
- Systems designed to work with a computer which will display a graph, calculate predicted and reversibility and provide a print-out. Integral memories allow data to be recorded outside the practice and uploaded when convenient.

How is spirometry performed?

Starting with full inspiration the patient blows out as hard and fast as possible until the lungs are 'empty'.

Sit or stand? Sitting is safer for the elderly and infirm, though standing may give better readings.

Three satisfactory blows should be performed:

- The blow should continue until a volume plateau is reached. This may take more than 12 seconds in people with severe COPD (in whom a slow, unforced manoeuvre may give a more accurate assessment of vital capacity).
- FVC and FEV₁ readings should be within 5% or 100ml
- The expiratory volume-time graph should be smooth and free from irregularities.

Reversibility tests

Reversibility tests involve measuring spirometry before and after treatment and can help distinguish between COPD and asthma (but note that spirometry may be normal in stable asthma).

Preparation of the patient:

The patient's condition should be stable (ie at least 6 weeks since an exacerbation).

Before a bronchodilator reversibility test the patient should stop their short acting β₂ agonist for 6 hours, long acting bronchodilator for 12 hours and theophyllines for 24 hours.

Procedure

- Perform baseline spirometry
- **Bronchodilator reversibility:** Administer bronchodilator (at least 400mcg salbutamol, e.g. 5mg by nebuliser). Perform post bronchodilator spirometry after 15 minutes.
- **Steroid reversibility:** A steroid trial (30 - 40mg daily for 2 weeks or 1,000 µg of ICS for three months) may be appropriate. An increase in FEV₁ of >12% and >200mls is significant. An increase >20% and >400mls suggests a diagnosis of asthma.

Training

Poorly performed spirometry produces misleading results. Training for operators, with regular updates and quality audits are fundamental.

Training courses

- Spirometry manufacturers can provide training in the use of their equipment. Some run spirometry courses.
- Most COPD training courses include training in spirometry.

References:

1. Global Strategy for the diagnosis, management and prevention of chronic obstructive pulmonary disease. GOLD Workshop summary: updated 2003. Available from <http://www.goldcopd.com>
2. Global Strategy for Asthma Management and Prevention GINA Workshop Report: updated November 2003. Available on <http://ginasthma.com/>

Users' guide to asthma control tools

Date of preparation May 2006

KEY Very poor If this criterion is important, not good enough Good enough Recommended Highly recommended



CRITERIA / TOOL	Technically sound (reliable and valid)	Clinically meaningful	Practical for use in primary care consultations	Flexible administration (eg postal, telephone, self-completion, electronic)	Suitable for different age ranges: children and adults	Available in different languages (1)
RCP 3 Questions						
RCP 21 Questions						
Rules of two TM						
The 30 Second Asthma Test TM						
ACQ						
ACT						

Note 1

Availability in other languages does not necessarily mean that it is validated for use in that language. Check if the translation has been validated using appropriate methodology. Also, there may be cultural adaptations that are needed.

Description

RCP 3 Questions <http://www.brit-thoracic.org.uk/asthma-management-tools.html>. 3 items (not lung function) each with Y/N response; assessment of control over last week/month. 30 seconds to complete. Only validated for use in UK English. Only used in adults. Very good face validity. Has been used as paper self-completion, telephone and electronic.

RCP 21 Questions Fuller and newer version of the RCP 3 Questions. More items so interpretation is better than RCP 3 questions but validation less clear. Used by the GIPAG research unit in Aberdeen as its approved asthma template. Only validated for use in UK English. Only used in adults. Very good face validity. Has been used as paper self-completion, telephone and electronic.

Rules of two TM The "Rules of Two"™ is a registered service mark of the Baylor Health Care System and the tool is used widely in the USA <http://www.baylorhealth.com/medicalspecialties/asthma/asthmaprograms.htm#Ref2>. 3 items (not lung function) each with Y/N response; assesses control over different periods for various items. 30 seconds to complete. Reliability and validity problematic. No responsiveness measurement. Patient paper completion. Adult only. US English only.

The 30 Second Asthma Test TM Used and recommended in asthma guidelines in Canada for 5 years: <http://www.asthmaincanada.com/> Adapted from the Canadian Consensus Report, updated 2001. 6 items (not lung function) each with Y/N response and scored as poor control if Y to ≥1 item; assesses control over different periods for various items. 30 seconds to complete. Not validated. There is also a children's version. Patient completion on paper or website www.asthmaincanada.com. English and Canadian French.

ACQ Designed for research and regarded by researchers as the international gold standard. 6 items (not lung function) each with 7 possible responses; control level calculated from mean score; assesses control over past 1 week. See <http://www.goltech.co.uk/Asthma1.htm#acq>. Require permission from author Professor Elizabeth Juniper: juniper@goltech.co.uk; +44 (0) 1243 572124. Good validation: meets standards for responsiveness. Validated for paper and phone patient completion. 2-3 minutes to complete. Cannot be analysed by "eyeballing". Validated for age 16 and over. Children's version in development - abstract accepted for IPCRG conference June 2006. 60+ languages. Validated in all languages. Cultural adaptations made. Should be completed prior to the consultation.

ACT 5 items (not lung function) each with 5 possible responses; control level calculated from adding score for 5 items; assesses control over past 4 weeks. <http://www.asthmacontroltest.com/> Good validation. 2-3 minutes to complete. 80+ languages but only validated for use in some languages eg Spanish. Patient completion. Validated for paper completion although also available for completion on website: www.asthmacontroltest.com. Age 12 and over. A child ACT for ages 4-11 years is in development. Should be completed prior to the consultation.

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