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Clinical Effectiveness Group

Asthma Course

Case Discussion: Asthma Case 1

Jane Jones, 62, has had asthma since childhood.
She attends surgery about x3 a year, usually for review of her chronic MSK pain (shoulders and neck) for which she has been seen (and discharged) by the local community pain clinic.

She has a phone consultation requesting a further course of steroids to have as a rescue pack. Her asthma is a bit worse, she has increased her use of salbutamol, but doesn't think you need to see her.

PMH

Choleystectomy, Longstanding neck and R shoulder pain, recurrent low mood
Hypothyroidism
BP 154/86, BMI 27, Non smoker

Current medication

pMDI salbutamol, pMDI Clenil 400mcg bd
Amitriptyline 50mg, co-codamol, diclofenac as needed
Thyroxine 150mcg
Last course of steroids for asthma 10 weeks ago (40mg a day for 10 days)

1. How would you respond to this telephone consultation?

3. What do you consider the three most important management interventions?

4. What coded entry would you make on the computer?

Case 1 Page 2……….
Three weeks later…

Jane Jones calls to say that her asthma did get worse and she went to AED a week after speaking to you. She was admitted for two days, and is still taking the course of steroids they gave her. She wants to see you as the asthma is better but she has a severe pain between her shoulder blades, which is not like her usual chronic pain.

Before seeing her you note that over the last year she has used:
12 x salbutamol inhalers
12 x clenil inhalers
Had x4 courses of steroid rescue medication. Attended an asthma review 15 months ago

1. What would you cover in the consultation?

2. What 3 management interventions would you prioritise?

3. Is a specialist referral indicated?

Case Discussion:

Asthma Case 2

Sarah Smith is 42, she has had mild asthma since childhood. She smokes intermittently, 2-3 a day. Her main problem has been related to physical abuse in childhood and chronic anxiety and depression related to this. For years she has tended to binge eat, and feels she has lost the battle with her weight.
She sees you because of increasing concern about breathlessness on activity and feels that her asthma is less well controlled, and the new inhaler has not helped.

PMH
Frequent attendance related to depression and weight problems. Is still seeing primary care psychology. OA both knees. Hypertension

Medications
Amlodipine, orlistat, co-codamol.
pMDI salbutamol, pMDI clenil 400 bd. She has recently had salmeterol bd added to her prescription.

Findings
Current BMI 40. (varied over ten years between 27-42)
Chest clear, no wheezes,
PEF 70% predicted

1. What would you cover in the consultation

2. What further investigations might you arrange?

3. How might you alter her prescription?

Case 2 Page 2…………..
One month later.

You see her for a review appointment following a spirometry test, and a review following your change of medication (pMDI fluticasone 400 bd – or similar) and her attendance at GUS in the local pharmacy.

She reports that she is on patches, her breathing is no better, and she is getting increasingly tired, with poor sleep because she is worrying about her chest.

Her spirometry results show
FVC of 68%, %predicted FEV1 64
FEV1/FVC ratio is within the normal range

1. How do you explain these spirometry results to her?

2. Would you make any further changes to her asthma prescription?

3. Would you refer this patient to a specialist respiratory physician?

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Case Discussion:

Asthma Case 3

Kamal Khan is 35, and has recently joined your list. He moved from Birmingham to work in a pharmaceutical firm in the City. He attends surgery requesting a further prescription of his salbutamol inhalers. He says that his asthma has been worse since coming to London, but is OK at present as he has been on holiday this week.

He also wants to know if he should take fish oil or selenium to improve asthma?
Should he invest in an ioniser to reduce indoor air pollution?

Medical history includes:
Non smoker, Mild asthma from childhood. Meniscus removal from the knee. Appendicectomy.

Current medication: pMDI salbutamol, pMDI Clenil 200mcg bd
Lansoprazole for indigestion.

Findings

Chest quiet
PEF 85% predicted value.

1. How would you respond to his queries?

2. Are there any further investigations/enquiries you might make?

3. Is there any further examination /tests you would do?

Case 3…….Page 2

You decide that he may be at risk from occupational asthma.
How would you explore this with him?

1. What are the common forms of occupational asthma?

2. Would you make any changes to his treatment?

3. He requests referral to an asthma specialist.
What might be gained from such a referral?

Case Discussion:

Asthma Case 4

Amina Khan 45, is a frequent attender at the surgery. She has diabetes, hypertension, CKD stage 3 and is taking methotrexate for her RA which was diagnosed two years ago, and which is fairly stable now. She also has asthma, as do four of her five children. Her English is poor and usually requires an interpreter in the consultation.
She has recently come back from a 6 week trip to Bangladesh, and has run out of her medications.
She attends with sore eyes and itchy nose and a dry cough, and you note that she has had hay fever in the past and usually had cetirizine for treatment.

Findings
Latest HbA 83, eGFR 52, no recent ACR. Latest BP 138/42
No recent monitoring BT for her methotrexate (shared care so monitoring managed by GP)
Chest quiet.

Medications
Metformin, simvastatin, amlodipine, co-codamol, pMDI salbutamol, pMDI clenil 400od

1. What are the management priorities in this consultation?

2. Would you make any changes to her medication

Case 4 Page 2………….
Two days later.

Amina attends as an emergency. Her asthma is worse with widespread wheeze and dry cough. She is nebulized in the surgery and given a stat dose of oral steroids.

Her PEFR improves to 85% of her predicted value.

1. How would you improve the management of her asthma?

2. This case is discussed at a clinical meeting. What areas would you highlight for discussion?