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Specialist approach to childhood asthma: does it exist?

RICHARD L HENRY, ANTHONY D MILNER

Abstract

Twenty six paediatricians and 21 consultant physicians concerned in the care of children with asthma answered a postal questionnaire on various aspects of the management of asthma, attitudes to referral, and the nature of advice given to parents and children. The 47 specialists had considerable differences in opinion for more than half the questions, including the role of allergen skin tests and the use of "breathing exercises." In addition, the paediatricians disagreed with the responses of the non-paediatricians on common issues such as whether to useaminophylline suppositories and whether swimming helps children grow out of asthma.

These results have disturbing implications for the advice that specialists give to general practitioners, children, and parents.

Introduction

Despite the very effective drugs which are available for the treatment of childhood asthma, mortality remains unchanged and hospital admissions are actually increasing.1 Unfortunately, we have clear evidence that many children suffer from under-treatment and mistreatment of their asthma.2,3 One contributory factor may be poor communication between general practitioner and specialist, resulting in different recommendations for treatment by different doctors. Some specialists believe that the problems are at the community level, but we decided to see how uniform were the views held by a group of consultants who managed children with asthma.

Methods

We posted a questionnaire to 55 British specialists who were about to attend a symposium on communication in childhood asthma. A total of 47 (85%) replied. All the respondents managed children with asthma and were either paediatricians (n=20) or physicians with an interest in chest diseases (n=26). The 25 questions that we asked together with the answers that the doctors gave are tabulated below.

Asthma questionnaire and responses (expressed as percentage of all replies)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 7 year old boy, whose mother has asthma, has his first attack of wheezing. Would you tell his parents that he probably has asthma?</td>
<td>68</td>
<td>28</td>
<td>4</td>
</tr>
<tr>
<td>Do you arrange for every child you see with asthma to have a chest x ray on at least one occasion?</td>
<td>83</td>
<td>17</td>
<td>0</td>
</tr>
<tr>
<td>An 8 year old girl with asthma has no history of allergy to cats. Should she be allowed to keep a cat as a family pet?</td>
<td>60</td>
<td>32</td>
<td>9</td>
</tr>
<tr>
<td>Do you arrange for allergen skin tests (or IgE radioallergosorbent tests) for most children with asthma?</td>
<td>86</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>Do you think that all children with a nebuliser for home use should be seen by a specialist?</td>
<td>85</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Do you think that all children receiving inhaled or oral steroids should be seen by a specialist?</td>
<td>89</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>The parents of a 10 year old asthmatic ask you whether the asthma is likely to be cured by moving to a warm, dry climate. What is your answer?</td>
<td>17</td>
<td>74</td>
<td>9</td>
</tr>
<tr>
<td>Do you use rectal suppositories of aminophylline?</td>
<td>30</td>
<td>70</td>
<td>0</td>
</tr>
<tr>
<td>A 5 year old boy is seen at home by a general practitioner during an acute severe attack of asthma that requires admission to hospital. Should the general practitioner give intravenous steroids before referral?</td>
<td>66</td>
<td>30</td>
<td>4</td>
</tr>
<tr>
<td>Do you recommend that general practitioners should administer intravenous aminophylline at home?</td>
<td>43</td>
<td>55</td>
<td>2</td>
</tr>
</tbody>
</table>

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RICHARD L HENRY, FRCP, research fellow
ANTHONY D MILNER, MD, FRCP, professor of paediatric respiratory medicine

Correspondence to: Professor Anthony D Milner.
Discussion

This study suggests that specialists—both paediatricians and non-paediatricians—vary widely in their opinions about the appropriate management of childhood asthma. These differences are of great consequence to parents and children, who are very confused by problems such as the importance of allergy tests, whether the family cat should be destroyed, and the need for measures to control house dust mites. The results of the questionnaire indicate that specialists are also in conflict on these matters. If an individual general practice has children who are managed by more than one consultant, it is likely that two children with asthma of similar severity will have received different advice about common problems and philosophies of management.

Some people might argue that the variety of opinions has no effect on the individual doctor's ability to treat asthma. Clearly this is untrue. For example, if an ‘asthma specialist’ (question 4) is really of benefit then the 57% of specialists who do not use them are denying their patients a valuable form of treatment. On the other hand, if these exercises are unhelpful 40% of specialists should abandon them.

The questions that we asked were designed to explore current specialist practice rather than test knowledge on how to treat asthma. Roughly half of the questions were ones that parents commonly ask, and most of the rest were other problems which specialists encounter in an average outpatient clinic. We expected differences of opinion on some issues such as whether to use the term ‘wheezy bronchitis.’ Nevertheless, we were surprised and concerned that so few questions were answered the same by all specialists. Furthermore, the majority response for some questions was opposite to the view in the latest edition of an important respiratory textbook. For example, Phelan et al. believe that a chest radiograph is not essential in every child with asthma (question 2), do not support unproved manoeuvres aimed at the house dust mite (question 7), and do not recommend routine allergen tests (question 16).

Presumably each doctor believed that the answers he gave were sound medical practice, but for most questions only one response could be correct. Published work does not contain the factual information necessary to complete the questionnaire. This means that any suggested master copy of answers reflects the authors’ personal biases. In most cases we agreed with each other and with the majority specialist opinion. We do not, however, recommend vacuuming and dusting the bedroom of an asthmatic child at least three times a week (question 7) and believe that a therapeutic trial of a beta agonist is worth while in a 10 month old infant (question 9). The recommendation that general practitioners should give intravenous steroids before referral to hospital (question 21) is an untested hypothesis, and our view is that the emphasis should be on the use of nebulised bronchodilators before referral. We also regard 20 puffs of beta agonist as safe (question 25), although it may indicate poor control. The answers on which we could not agree were to questions 2, 16, and 18. The differences reflect degree of emphasis rather than basic philosophy. We both agree that a chest radiograph may be very useful, that skin tests do not often contribute to management, and that specialists should see all children taking oral steroids and most taking inhalational steroids.

What we need now is open debate among specialists to establish a consensus on all the subjects of dispute. Only then can we present balanced opinions to parents and children.

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References


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