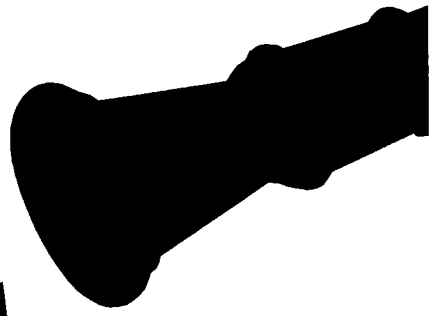


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Presentation and Basic NHS cost Flixotide Accuhaler: 60 inhalations. 50 micrograms - £8.23. 100 micrograms - £12.80. 250 micrograms - £24.23. 500 micrograms - £40.23. Flixotide Inhaler: 120 actuations. 25 micrograms - £6.86. 50 micrograms - £11.43. 125 micrograms - £22.86. 250 micrograms - £38.86. Flixotide Diskhaler: 14 four-place disks with Flixotide Diskhaler. 50 micrograms - £8.23. 100 micrograms - £12.80. 250 micrograms - £24.23. 500 micrograms - £40.23. Refill pack: 14 four-place disks. 50 micrograms - £7.66. 100 micrograms - £12.23. 250 micrograms - £23.66. 500 micrograms - £39.66. Diskhaler and Inhaler Hospital packs also available. Product licence numbers 10949/0226-0229, 10949/0001-0008. Product licence holder Allen & Hanburys, Stockley Park West, Uxbridge UB11 1BT.

POM

References 1. Price JF, Russell G, Hindmarsh P, Weller PH, Heaf DP. Am J Resp Crit Care Med 1996; 153 (4): A409. 2. Price JF, Weller PH. Resp Med 1995; 89: 363-368.



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June 1996



BRITISH LUNG FOUNDATION

British Gas TransCo



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Closing date for applications – 26th February 1997

Application forms are available from

**The Research Grants Administrator
British Lung Foundation
78 Hatton Garden, London EC1N 8JR
Tel: 0171 831 5831**

Please quote reference APRH/THX/96

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BRITISH LUNG FOUNDATION



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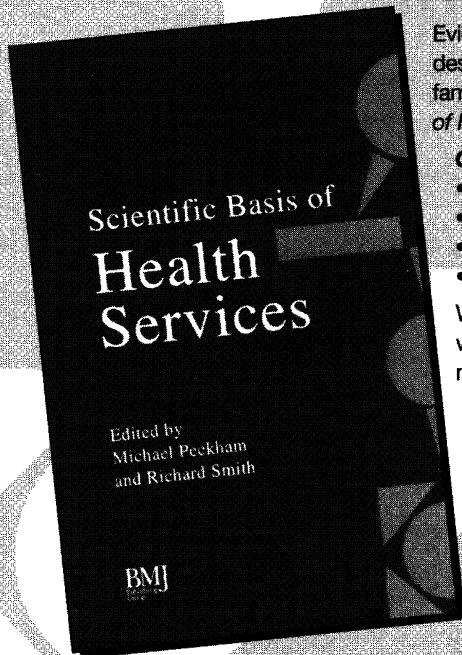
Application forms are available from

**The Research Grants Administrator
British Lung Foundation
78 Hatton Garden, London EC1N 8JR
Tel: 0171 831 5831**

Please quote reference ANN/THX/96

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Edited by Michael Peckham and Richard Smith

BMJ

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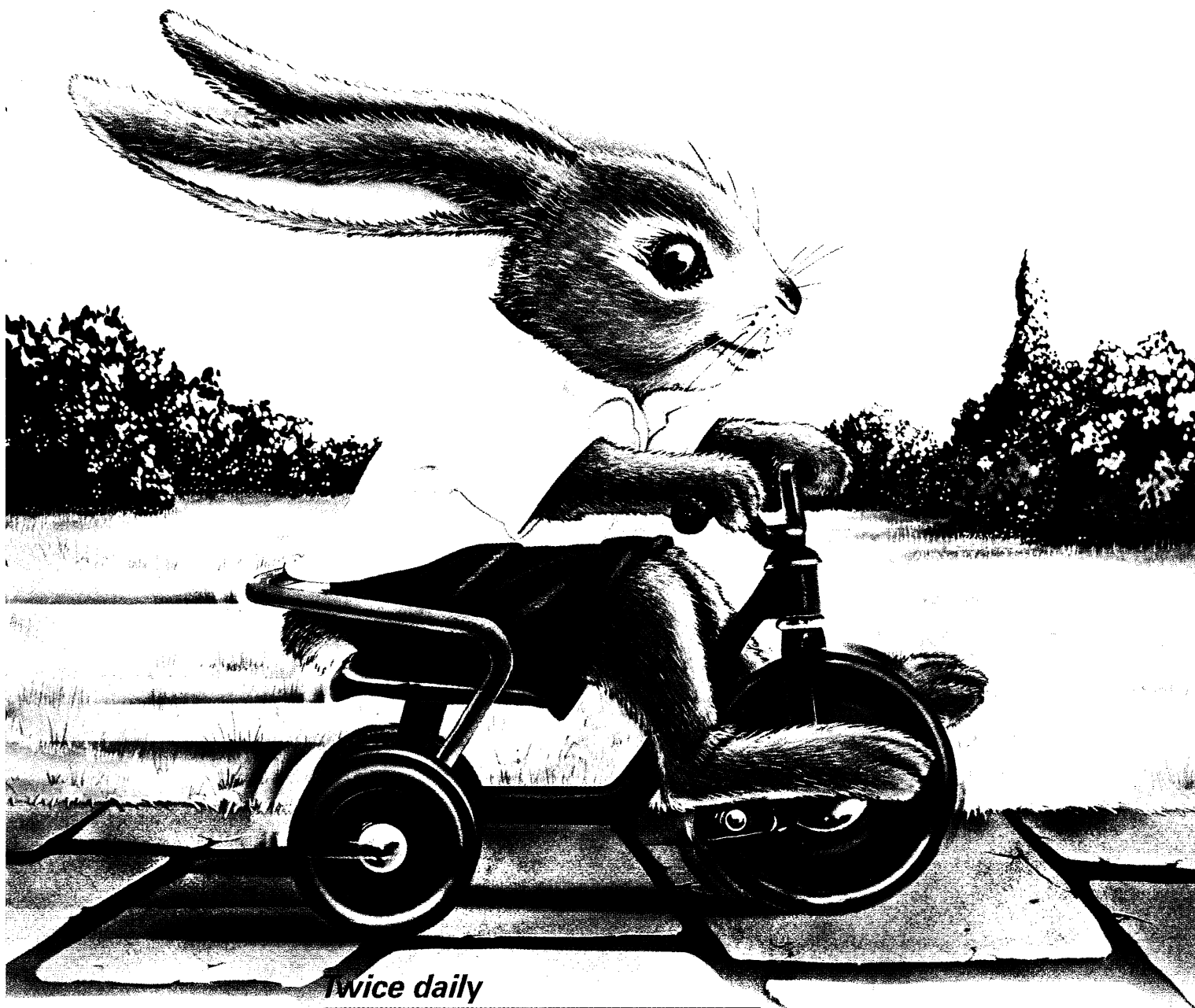
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Precautions Do not initiate in significantly worsening or acutely deteriorating asthma. *Steroid therapy:* Serevent is not a replacement for corticosteroids and/or, in children, sodium cromoglycate. Warn patients with asthma not to stop or reduce

such therapy. *Severe or unstable asthma:* Bronchodilators should not be the only or main treatment. Consider using oral steroids and/or maximum doses of inhaled corticosteroids. Warn patients to seek medical advice if short-acting bronchodilator use increases or becomes less effective. Treat severe exacerbations in the normal way. *Acute symptoms:* Serevent is not for relief of acute symptoms. A short-acting inhaled bronchodilator is required. *Thyrotoxicosis:* Use with caution. *Drug interactions:* Avoid beta-blockers. *Hypokalaemia:* May occur, particularly in acute severe asthma. It may be potentiated by xanthine derivatives, steroids, diuretics and hypoxia. Monitor serum potassium levels in these situations. *Pregnancy and lactation:* Experience is limited. Balance risks against benefits.

Side effects Tremor, subjective palpitations and headaches have been reported, but are usually mild and transient. Tachycardia, skin reactions, muscle cramps, non-specific chest pain, local irritation and arthralgia have been reported. Potentially serious hypokalaemia may result from K₂-agonist therapy. *Paradoxical bronchospasm:* Substitute alternative therapy.

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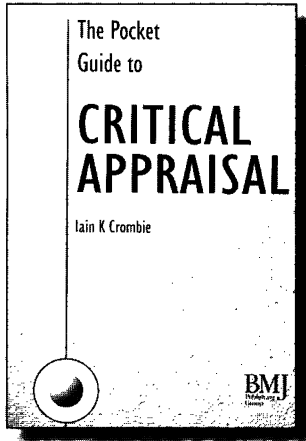
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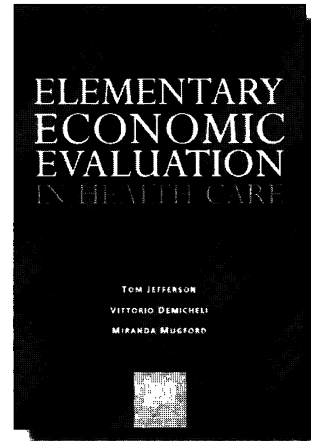
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Chronic obstructive lung diseases

This group of diseases includes chronic bronchitis, emphysema and chronic airways obstruction, the third being a new diagnostic category not used in the 1971-72 survey. The changes in patient consulting rates are shown in figure 2. Although there has been little change overall, there has been a decrease in consulting rates in adults aged 45-64, and an increase in those aged over 75. Within this group of diseases, it is likely that diagnostic transfer has occurred from chronic bronchitis to chronic airways obstruction, as has been seen with death certification (LAIA factsheet 92/1). It is unlikely that substantial net diagnostic transfer has occurred away from asthma in the elderly as consultation rates for asthma have also increased in this age-group. However, some of the decline in rates of consultation for chronic obstructive lung diseases in younger age-groups may reflect increased use of asthma as a diagnostic label.

Acute bronchitis & bronchiolitis

Figure 3 shows the changes in patient consultation rates for acute bronchitis & bronchiolitis. Rates overall were similar in 1971 and 1981, with a small increase in 1991. Among children, rates increased slightly in those aged 0-4, and decreased in the 5-14 age-group. Larger increases can be seen in the elderly, especially among those aged 75+ where rates almost doubled between 1971 and 1991.

Upper respiratory tract infections

Acute upper respiratory tract infections such as the common cold, sinusitis, tonsillitis and otitis media are the commonest respiratory complaints seen in general practice. Overall patient consultation rates were similar in the three surveys, the percentage of patients who consulted being 20%, 21% and 23% (figure 4). The highest consultation rates are seen among the youngest children (ages 0-4). In this age-group, 56% consulted in 1971, compared with 67% in 1981 and 70% in 1991. These respiratory infections also account for a sizeable proportion of all consultations with doctors - around 9% of all consultations in each of the three surveys.

Hay fever and allergic rhinitis

The percentage of patients consulting their doctor for hay fever and allergic rhinitis increased from 1.1% in 1971, to 2.0% in 1981 and 2.8% in 1991 (figure 5). An increase occurred in all age groups. In all three surveys, the highest rates are seen in older children and young adults, although the largest relative increases in patient consultation rates have occurred in the elderly.

Figure 4: Patients consulting a GP for upper respiratory tract infections, males & females combined, England & Wales 1971-1991.

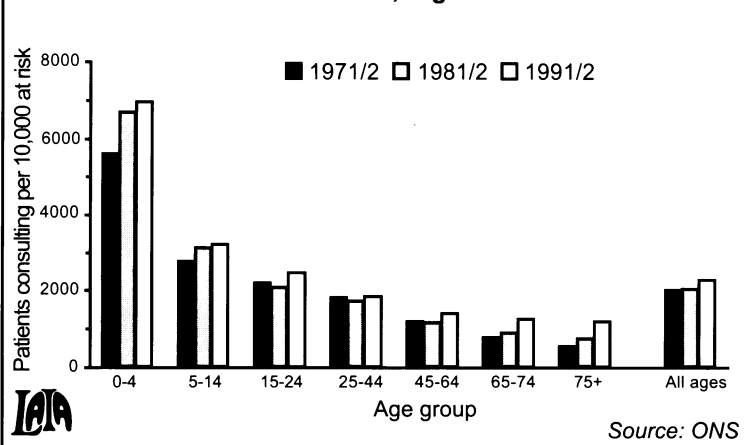
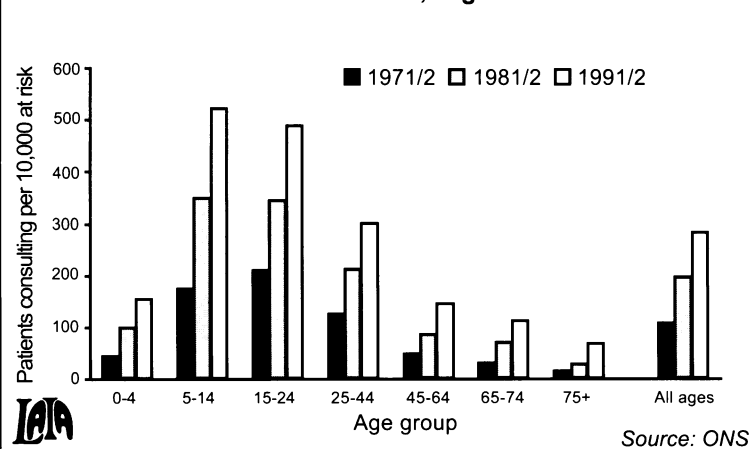


Figure 5: Patients consulting a GP for hay fever/allergic rhinitis, males & females combined, England & Wales 1971-1991.



Summary

- The percentage of patients who visit their general practitioner in the course of a year has risen over the last twenty years.
- Respiratory diseases are the commonest reason for consultation with a family doctor.
- There has been a marked increase in the percentage of patients who have consulted their doctor for asthma. This has been most noticeable in children.
- Upper respiratory tract infections are the commonest respiratory complaint seen in general practice.

Footnote

Definitions Results from the studies are published as rates per 10,000 person-years at risk, which take into account patients moving into or out of the study practices during the study period. The data presented throughout this factsheet are patient consulting rates. This is based on the number of patients who consulted their doctor at least once during the study period, and can be thought of as a measure of the period prevalence. Data not presented in this factsheet are the total number of consultations with a doctor and the rate of new or first ever episodes. The total number of consultations is based on the number of consultations rather than the number of patients and gives an indication of the work-load associated with a particular condition or group of conditions. The rate of new episodes could be used as a measure of the incidence of a particular disease.

Factsheet 96/2 - Trends in hospital admissions for asthma This factsheet has been reprinted, as figures 2, 3 and 4 were insufficiently clear, due to a printer's error. The reprint will be circulated in Thorax and will also be available from the Lung & Asthma Information agency on request.



Lung & Asthma
Information Agency

Respiratory Morbidity in General Practice, 1971-1991

Lung & Asthma Information Agency, Department of Public Health Sciences, St. George's Hospital Medical School, Cranmer Terrace, London SW17 0RE

Introduction

Nationwide studies were carried out to record consultations with general practitioners in 1971-72, 1981-82 and in 1991-92. This factsheet looks at trends in respiratory morbidity over the three surveys. Information on the data collected is given in the footnote.

Changes in patient consultation rates

In 1971-2, 66% of the population registered with a doctor consulted at least once during the year. This increased to 71% in 1981-2 and to 78% in 1991-2. However, these increases may reflect increasing contact between doctors and patients, due to a shift towards more community-based care, the introduction of screening and a decrease in hospital follow-up for less serious conditions.

In all three surveys, diseases of the respiratory system were the most common reason for visiting a doctor. The percentage of patients who consulted for respiratory disease in each survey was 26%, 27% and 31% respectively. The major respiratory diseases for which patients consult are asthma, acute bronchitis & bronchiolitis, upper respiratory tract infections, chronic obstructive lung diseases (chronic bronchitis, emphysema and chronic airways obstruction) and allergic rhinitis (including hay fever).

Asthma

The changes in the patient consultation rates for asthma are shown in figure 1. It is clear that a large increase has taken place, most markedly between 1981 and 1991. In the 1971 survey, 1% of patients consulted for asthma during the year of study. In 1981 the figure was 1.8% and in 1991, 4.3%. In 1971, patient consultation rates were similar across the age-groups, but by 1991 there were larger variations by age-group. Although increases are seen in all age groups, it is most marked in the youngest children (ages 0-4), where the rate increased seven-fold between 1971 and 1991. Reasons for these changes may include increasing prevalence and severity of asthma, changes in the balance between primary and secondary care, changes in therapy and management practice, and increased concern about asthma, especially among parents of young children. Diagnostic transfer over time from acute bronchitis and bronchiolitis is unlikely as consultation rates for these conditions also show an increase (figure 3). However, asthma may more commonly have been applied as a label for symptoms and signs in more recent years.

Figure 1: Patients consulting a General Practitioner for asthma, males & females combined, England & Wales, 1971-1991.

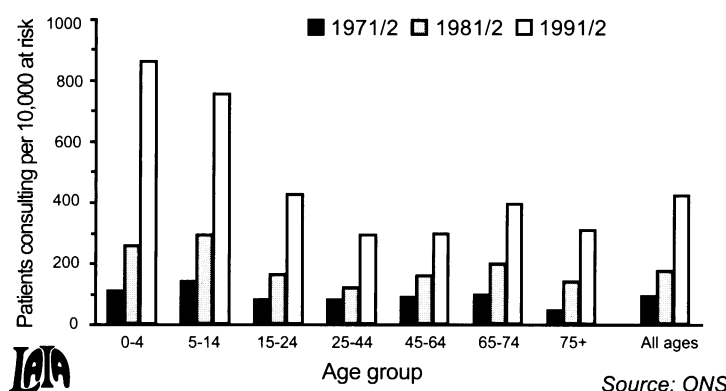


Figure 2: Patients consulting a GP for chronic obstructive lung diseases, males & females combined, England & Wales 1971-1991.

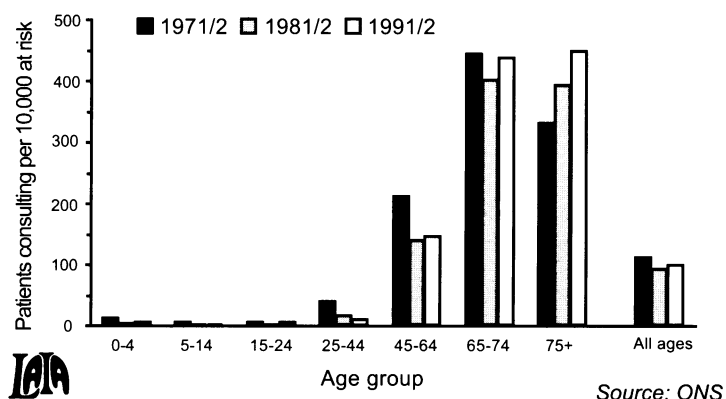
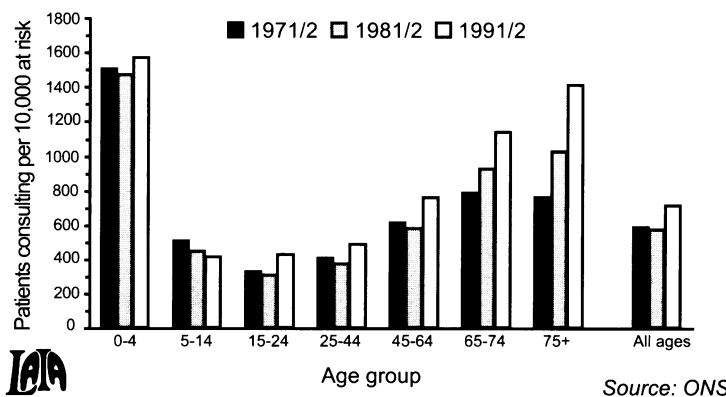


Figure 3: Patients consulting a GP for acute bronchitis & bronchiolitis, males & females combined, England & Wales 1971-1991.



In Scotland, similar patterns are seen. The admission rates in pre-school children currently seem to be fairly stable at around 95 per 10,000 per year. In the 5-14 age-group the rates may still be increasing, and are currently about 30 per 10,000 per year.

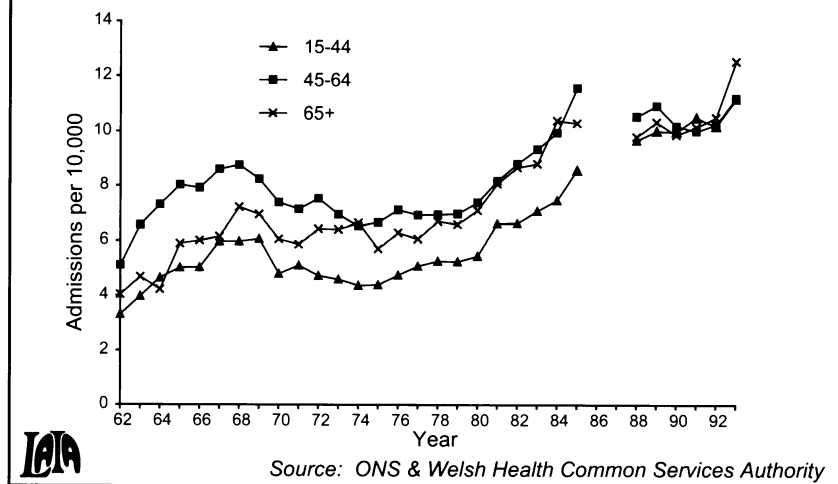
Special studies have established that these increases cannot be completely explained by an increase in re-admissions, diagnostic transfer from related categories such as acute bronchitis, bronchiolitis and pneumonia, or changes in the threshold of admission. A variety of medical care factors have been suggested, including more self-referral to accident and emergency departments during acute attacks, and an increase in referral by general practitioners of acute asthma to hospital. These would tend to increase the likelihood of children with acute asthma being admitted to hospital, regardless of any change in the occurrence of these acute attacks.

There have been changes in the reported prevalence of asthma and asthma-markers such as severe wheezing. Serial prevalence studies suggest a 50% increase in the prevalence of asthma in children over this time. Less is known about trends in the incidence of severe attacks not resulting in hospital admission.

Adults

Admission rates in adults in England & Wales increased slightly through the 1960s, but then declined during the 1970s before beginning to rise again from 1980 (figure 4). Rates increased in 1993 in all three groups after a period of relative stability from 1988 to 1992.

Figure 4: Age-specific hospital admission rates for asthma among adults. Males and females combined, England and Wales 1962 - 93.



In Scotland, rates still appear to be increasing among the younger adults (figure 3).

Pattern of admissions by age and sex

33% of admissions occur among children aged 0-4, and a further 18% among 5-14 year olds. Boys are twice as commonly admitted as girls. After the age of 15, this pattern reverses and women have a higher admission rate than men.

Summary

- **The rate of hospital admissions coded as due to asthma rose considerably through the 1970s and 1980s, but has levelled off since 1990.**
- **The increase was most noticeable among children.**
- **In England and Wales, rates among children now appear to have stabilised but among adults they increased from 1992 to 1993.**
- **In Scotland, there has been a continuing rise in admission rates among young adults but rates among children have levelled off.**

Footnote

Data sources Until 1982, data on hospital admissions for England and Wales were available in the form of a random 10% sample of all discharges and deaths (Hospital In-Patient Enquiry - HIPE). These were collected under the Hospital Activity Analysis system (HAA). In 1982, Wales started collecting their data separately with a 100% sample. The 10% sampling continued in England until 1985. In April 1987, changes were implemented in the NHS information systems in England following recommendations made by the Körner committee and the English data are now collected under the Hospital Episode Statistics system (HES). The published data are based on a 25% sample, aggregated by financial years. Wales continued collecting data under the HAA system until 1991, when they too changed to the HES system in April 1991. Under the HES system, discharges and deaths are identified as "finished consultant episodes". A consultant episode is a period of care spent under one consultant, and patients may experience more than one episode of care in an admission. The HES figures for England presented in this factsheet are based on a re-analysis by calendar year of unpublished 100% HES data, using first consultant episodes only, which represent the admitting diagnosis. As diagnostic coverage was incomplete in the earlier years, the numbers of admissions have been adjusted using the published multiplying factors. The HES data for Wales was obtained from the Welsh Health Common Services Authority.

Scottish data on admissions is more complete. The numbers have been based on a 100% sample since 1968, and there has been no break or change in the data collection system. The data is also published in calendar years, rather than financial years.

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Lung & Asthma
Information Agency

Trends in hospital admissions for asthma

Lung & Asthma Information Agency, Department of Public Health Sciences, St. George's Hospital Medical School, Cranmer Terrace, London SW17 0RE

Introduction

This factsheet updates LAIA factsheet 95/1 on hospital admissions for asthma which included data up to 1991.

The total number of hospital admissions in England and Wales with a discharge diagnosis of asthma rose considerably through the 1970s and 1980s (figure 1), increasing from just under 20,000 per year in the early 1960s to 80,000 per year by the mid 1980s. Data from the early 1990s show that numbers have stabilised at around 100,000 per year. Children account for about half of all asthma admissions.

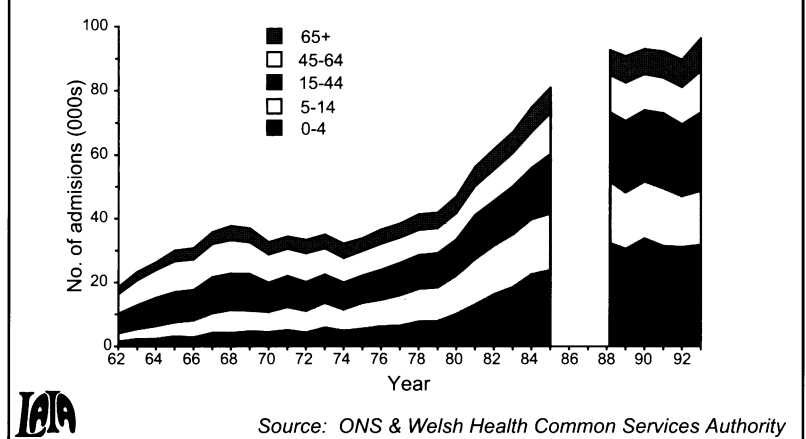
This increase in asthma admissions could have arisen for a variety of reasons, including changes in any or all of the following:

- Prevalence of asthma (LAIA factsheet 93/6);
- Disease severity or chronicity;
- Behaviour of patients (or their parents) during asthma attacks;
- Medical care, affecting the threshold of admission or the number of re-admissions;
- Information systems (see footnote);
- Diagnosis and coding of disease (LAIA factsheet 92/1).

Children

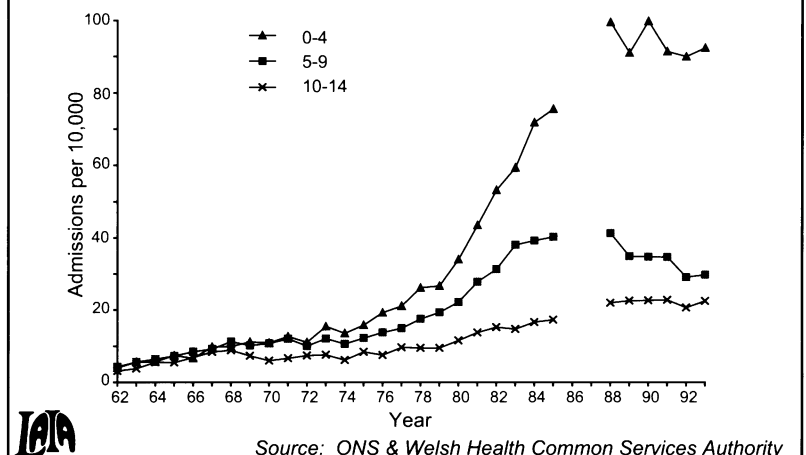
The largest increases in admission rates occurred in children, most notably in the youngest age-group (figures 2 and 3). In England and Wales among pre-school children, admissions went up from 4 per 10,000 in 1962 to almost 80 per 10,000 by 1985. Rates are currently level at about 90 per 10,000 per year in this age-group. A similar pattern is seen in children aged 5-9; rates increased six-fold to 40 per 10,000 in the mid-1980s, although they now appear to be decreasing, and are currently about 30 per 10,000 per year. Rates in the older children have increased more slowly and are now around 22 per 10,000 per year.

Figure 1: Hospital admissions for asthma, both sexes, England & Wales 1962-1993.



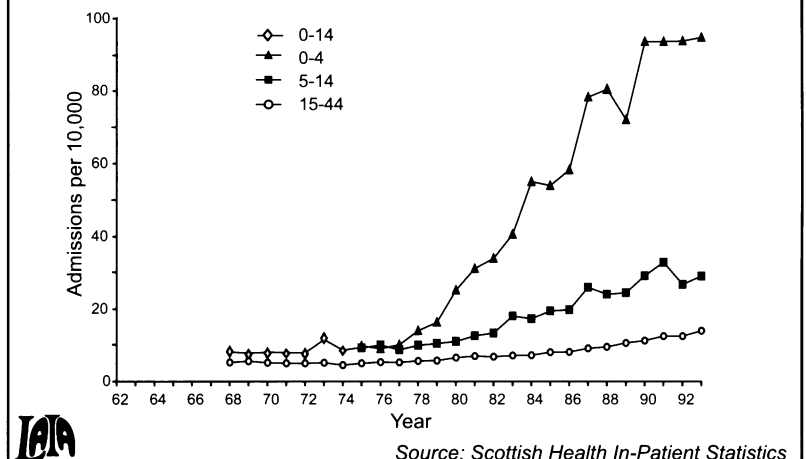
Source: ONS & Welsh Health Common Services Authority

Figure 2: Age-specific hospital admission rates for asthma in children. Males & females combined, England & Wales 1962-93.



Source: ONS & Welsh Health Common Services Authority

Figure 3: Age-specific hospital admission rates for asthma, ages 0-44, males & females combined. Scotland 1968-93.



Source: Scottish Health In-Patient Statistics

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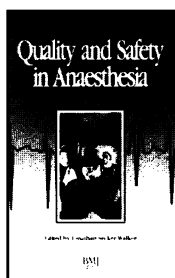
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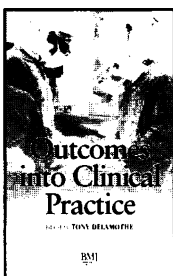


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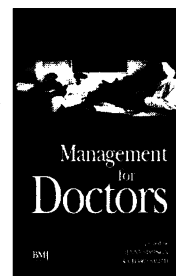
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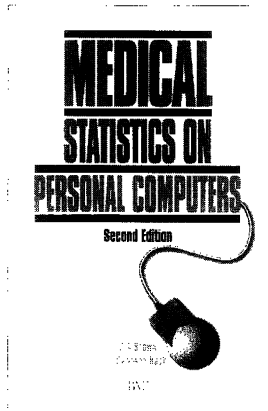
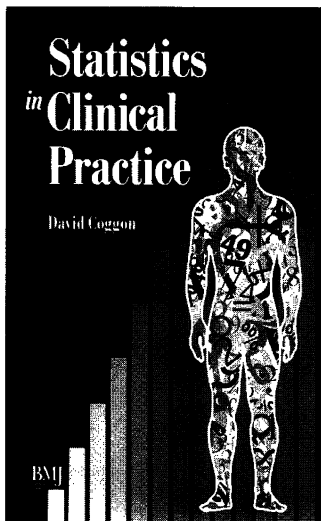
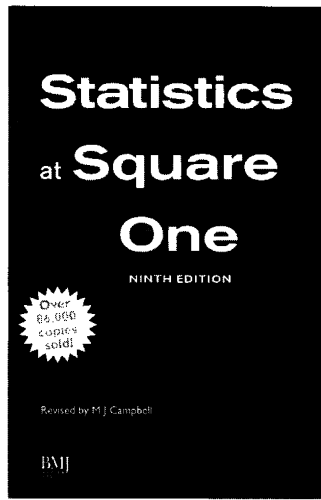
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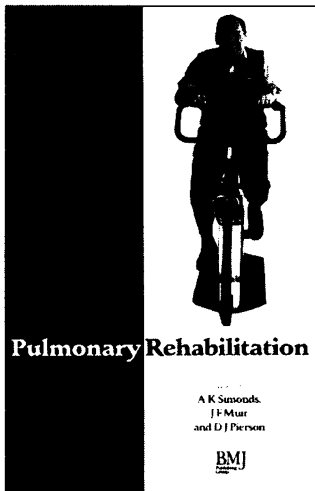
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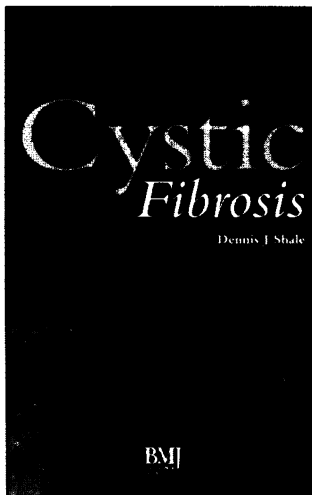
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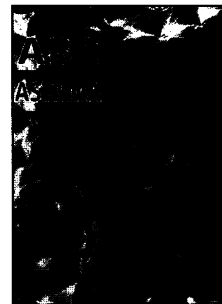
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