Asthma and Allergy Associates of Florida
The Allergy Group
Diplomates, American Board of Allergy and Immunology

Adult and Pediatric Allergy and Immunology

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October 2007

Dear Doctor,

We would like to update you on the recently released **Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma.** EPR-3 was produced by the National Asthma Education and Prevention Program (NAEPP) and coordinated by the National Heart, Lung, and Blood Institute (NHLBI). This report represents the first comprehensive revision to the NAEPP's Asthma Guidelines in 10 years.

EPR-3 reminds us that asthma severity (e.g., the intrinsic intensity of the disease process) is best assessed on initial presentation of a patient who is not receiving long-term control treatment. Once therapy is initiated, the emphasis shifts from the classification of severity to the assessment of asthma control (e.g., symptoms, quality of life, functional impairment) and risk (e.g., likelihood of exacerbations, progressive decline in lung function, adverse effects of treatment). Control and risk are best monitored with periodic assessments at 1- to 6-month intervals.

Other highlights from EPR-3 which may be relevant to your practice are discussed below:

- Inhaled Corticosteroids (ICS): ICSs are the most potent and consistently effective long-term control medications for mild, moderate, or severe persistent asthma. In general, ICSs are well tolerated and safe at the recommended dosages. The lowest doses of ICS that maintain asthma control should be used.

- Long-Acting Beta2-Agonists (LABA): Of the adjunctive therapies available, LABAs are the preferred therapy to combine with low-dose ICSs alone in patients ≥ 12 years old, as well as in patients ≥ 5 years old with severe persistent asthma or poorly controlled asthma. LABAs should not be used as monotherapy for long-term control of asthma or for the treatment of acute symptoms or exacerbations.

- Comorbidities: Treating the following comorbid conditions may improve asthma management: allergic bronchopulmonary aspergillosis, gastroesophageal reflux, obesity, obstructive sleep apnea, rhinitis/sinusitis, chronic stress/depression, vocal cord dysfunction, or chronic exposure to allergens, industrial pollutants, or irritants such as tobacco smoke.

- Omalizumab (Xolair®): Omalizumab, a humanized monoclonal antibody to the Fc portion of the IgE antibody, binds to that portion preventing the binding of IgE to its high-affinity receptor (FcεRI) on mast cells and basophils. It is the only adjunctive therapy to demonstrate added efficacy to high-dose ICSs plus LABAs in patients with severe persistent allergic asthma.

- Immunotherapy: A meta-analysis of 75 randomized, placebo-controlled studies has confirmed the effectiveness of immunotherapy in asthma, with a significant reduction in asthma symptoms and medication and with improvement in bronchial hyperreactivity. All patients with persistent asthma should be evaluated for the role of allergens as possible contributing factors.

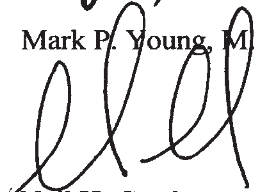
- Specialist Consultation: Referral for consultation to a specialist in asthma care (a fellowship-trained allergist or pulmonologist) is recommended when the asthmatic patient has had: a life-threatening asthma exacerbation, an exacerbation requiring hospitalization, two bursts of oral corticosteroids in one year, complicating comorbidities, atypical symptoms, unresponsiveness to therapy, or consideration for allergen skin testing or immunotherapy.

The complete 440-page EPR-3 can be downloaded from the NHLBI website at http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm.

Feel free to call us anytime with curbside questions on any topic.

Sincerely,

Mark P. Young, M.D.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