



Editorial

Asthma Control: A Distant Objective

Control del asma: un objetivo lejano

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It is clear that significant progress has been made in the management of asthma: asthmatics die less often,¹ are not normally found in the emergency department with severe crises,² are hospitalised less often, sick leave and disability due to asthma have also declined^{3,4} and, finally, the quality of life of patients as related to the disease is better than in previous years. However, all populational studies aimed at determining how many patients have good control over their illness report disappointing results. Control of asthma refers to the degree in which the symptoms of the illness are absent or reduced to their minimal expression; it is a broad concept but reflects the adequacy of its treatment. Despite differences among countries, data indicates that approximately 70% of asthmatics poorly control their disease, with average figures of 72% in the European multicentre INSPIRE⁵ study. In a large Spanish study published in 2008 on 6518 asthmatic patients treated in primary care,⁶ 71.6% of cases had poor control of the disease. In the recent MAGIC study (Measuring Asthma GINA Control Study) on 1363 stable asthmatics attended in Spanish primary care, pulmonology and allergy settings, only 12.7% were well controlled (according to control criteria defined in the GINA 2006). In this issue of *Archivos de Bronconeumología* an interesting study was published,⁷ carried out in the field of Spanish primary care, with a transversal design and involving 2159 patients. Its results are still discouraging, since they confirm that 63.9% of patients currently attended in primary care are poorly controlled (using the ACQ questionnaire about asthma control).

Studies that analyse asthma control attempt to identify variables that are associated with deficient control, with the aim of changing them if possible. Therefore, in a number of publications, clinical, demographic, socioeconomic, and anthropometric variables that may affect asthma control are described, such as gender, race, body mass index, smoking, education level, physical activity, treatment and illness severity.⁸ Including all variables that may affect control of asthma in a study would make the studies impossible to carry out, so in each study certain variables are emphasized to the detriment of others. In the current study,⁷ a new factor is added that the authors find to be associated with poor control of the disease: a recent,

stressful event, based on the opinion of the patient himself. When asthmatics suffer a stressful event, the probability that their asthma is poorly controlled increases two-fold (OR: 2.44). In this study no psychological questionnaires were used to evaluate the emotional state of patients, but this simple consideration gives us an idea of the important consequences that emotional equilibrium has on the control of asthma. In this sense, an Italian study was recently published linking anxiety and depression in patients with asthma.⁹ Both are independent factors predicting poorly controlled asthma (anxiety with an OR of 3.76 and depression with an OR of 2.45). In my opinion, all of these reasons are enough to get us accustomed to assess the emotional state of our asthmatics and to think that its modification may be the reason the disease is not adequately controlled.

Another circumstance that deserves mention regarding the data collected from our study is the importance of patient treatment compliance. Asthma is a chronic disease with a higher level of non-compliance (reaching up to 70% in some series). We know that when the patient does not take the medication correctly, the degree of airway inflammation increases, which produces limitations in function, quality of life, medical resource use and, finally, poor asthma control.¹⁰ Thus, all the current recommendations for asthma management emphasize the essential role of education for asthmatic patients.¹¹ Education aims to provide the patient with the knowledge and skills to improve their self-care and compliance. Logically, education in asthma is not an easy task, but in this study it is shown that if patients have little confidence in the prescribed therapy, their asthma worsens (OR 1.66). To develop effective educational plans it is essential to jointly discuss treatment decisions, since the patients have to "believe in it" and demonstrate their compliance with the treatment we prescribe as the first step towards achieving better compliance.¹² Wilson et al.¹³ have published a clinical trial that shows that poorly controlled asthmatics who follow a program which includes negotiation with the patient in making treatment decisions report more favourable outcomes in terms of adherence and clinical disease control, compared to those who follow a standard education program. This demonstrates the importance of creating individualized and negotiated educational plans with the patients to achieve good asthma control. Primary care professionals play an important role in

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educating asthmatic patients. We will surely achieve improved asthma control in our society if educational seminars were conducted in primary care setting, similarly to those conducted for diabetes or reducing cardiovascular risk.

Finally, although in this series obese and smoker asthmatics have not proved to have more poorly controlled asthma, they are modifiable circumstances in which doctors should take part. In other Spanish and international studies,^{6,14} a significant relationship is observed between body mass index and asthma control. Some studies even show clinical and functional benefits that asthmatics obtain when they lose weight.¹⁵ On the other hand, smoking worsens the therapeutic response to corticosteroids as well as the natural evolution of asthma; however in various studies asthmatic smokers are not shown to have worse quality of life or poorer control of the disease. This apparent discrepancy is partially due to the fact that smokers minimize the symptoms or attributes them to tobacco and not to asthma. Therefore, we must not forget that quit smoking is a fundamental pillar for treatment.

Summing up, while all evidence shows that we are still far from having well-controlled asthmatic patients, it seems that the solution may be to develop plans for health education on asthma in primary care, discuss treatment guidelines with the patient to encourage confidence and compliance, without neglecting the emotional balance of asthmatics nor other behavioural factors such as smoking, obesity and exercise.

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