Fall 2007 Newsletter

Volume 4, Issue 1

# COPD & Asthma Network of Alberta

***Mission: To develop and implement a comprehensive provincial strategy which promotes and supports excellence in the prevention, promotion, and management of COPD & asthma in Alberta.***

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## Present Projects...Future Focus

2007 has been yet another productive year for CANA. Having secured a $200,000 grant from Alberta Health and Wellness, we are now active with a number of initiatives that honor our mission:

- **Alberta Provincial Respiratory Strategy (APRS)** – a collaboration with our allied partners and Alberta's Health Regions devising a 20-year plan to address respiratory health in Alberta. In the first 2 years, we will focus on COPD, Asthma, and Sleep Apnea.
- **Alberta's Asthma Action Plan (AAAP)** – a new standardized provincial asthma action plan developed in response to your expressed needs. The AAAP is now readily available for Calgary, Capital, DTHR, and Chinook Health Regions and will soon be studied in the other Health Regions. Triplicate color NCR pads and fillable PDF versions are available.
- **HealthLink Alberta's Protocols** – under review by our cross province teams.
- **Alberta Asthma Visits to Emergency Report** – communications plan in development.
- **COPD/Smoking Cessation Campaign** – training, targeting and awareness.
- **AB Gov't Allergy/Anaphylaxis/Asthma School Package** – consulting and facilitating.

CANA now services 180 members and invites you to help drive its activity. We are seeking new Advisors for a 2-yr term to begin Apr.1. There are also ongoing opportunities for Task Force and Development Committee involvement. Designed for professionals, our website (www.canahome.org) may be used to access useful links, download our Asthma Guideline Summary and COPD/Asthma services catalogue (both under 'key resources'), or keep abreast of coming events. We remind you that all CANA members are connected via our Listserve. Please use this avenue to communicate with other Alberta professionals as the need arises. Simply create an email using the address cana-L@mailman.ucalgary.ca, or contact us to facilitate on your behalf.

## Chronic Disease Management Conference – 2007

*Calgary* – Over 700 delegates were welcomed with presentations by Hon. Minster Hancock and Actor/Singer Tom Jackson at the 2nd global conference on Chronic Disease Management. Visit www.cdmcalgary.ca to view presentations and other details.

Highlights
Some suggestions from Australia's experience about monitoring our effectiveness with complex chronic disease patients:

1. The intellectual property of 'failures' is worth much more than that of 'successes' – we learn best from exploring various efforts' results.
2. Even a modest increase in services saves more health system costs than simply reducing the number of services to conserve budgets.
3. Decide on health outcome measures prior to initiating efforts, to maximize the evaluation's utility.
4. Engage comorbidity managers as priority over risk management experts.
5. Try to centralize the care of chronic disease patients in places other than an acute care venue.
6. Regardless of the diseases, ALL patients need a care plan.
7. Skill sharing has been shown to overcome manpower shortages while also improving care.
8. A care coordinator is vital in order to maximize the compliance with patients showing up for their appointments.
9. Success in reducing acute care costs depends on having the highest proportion of target patients taking up the most appropriate intervention; otherwise, even a 5% reduction in acute service uptake is unlikely.
10. Where possible, tap into the expertise of RNs and Nurse Practitioners, especially to provide virtual care and remote monitoring services.
11. To service the most appropriate patients in a CD program, quarantine 'frequent flyers' and comorbid patients from tertiary and other clinics. Any others can best be managed through other established services.

## New Product Review

### VARENICLINE TARTRATE (Champix) – submitted by Warren Davidson, MD

***NOTE:*** *This article is for information only, and should not be considered as prescriptive advice nor used for prescriptive purposes.*

*Smoking increases the risk of cancer, heart disease, stroke, complications of pregnancy, and chronic obstructive pulmonary disease [1]. In Canada, second-hand smoke will contribute to over 300 lung cancer deaths and approximately 700 deaths from coronary artery disease [2]. Nicotine dependence is recognized as a chronic clinical disorder [1]. Criteria for nicotine dependence include unsuccessful attempts to reduce or stop nicotine use, difficulty controlling tobacco use, and previous experience of withdrawal symptoms during a period of abstinence. Of the 35% of patients that attempt to quit smoking each year, only 5% are successful in unaided attempts to quit [3]. On average, smokers make an average of 6-9 attempts before remaining smoke free [4].*

Nicotine effects are mediated by nicotinic acetylcholine receptors (nAChRs). There are many subtypes distributed throughout the central nervous system. The subtype of nAChRs with two α4 and three β2 subunits form the high-affinity binding sites in the brain and are can be found in the nucleus accumbens (the brain's "reward center") [5]. Varenicline has partial agonist activity at the α4β2 nicotinic acetylcholine receptor and prevents nicotine binding (antagonist activity). In the absence of nicotine, varenicline's agonist activity is lower than nicotine, but sufficient to activate the central nervous mesolimbic dopamine system. Given its higher affinity for the α4β2 nAChR binding site, varenicline prevents nicotine from activating the receptor, thereby preventing full stimulation of the mesolimbic dopamine system. It is recommended that the dose be titrated up to the maximum recommended dose of 1 mg twice daily.

The efficacy and safety of varenicline has been evaluated in 6 randomized, double-blind, placebo-controlled studies [6-11] in cigarette smokers who were motivated to stop smoking. Each trial had a noticeable drop-out rate. Three of the trials included comparative arms versus bupropion sustained release [6-8]. Varenicline was found to have a higher continuous quit rate during the dosing phase (range 7-12 weeks) and during the followup period (week 9-52) compared with placebo or bupropion. Data is available on approximately 2300 patients treated for at least 12 weeks, approximately 700 for 6 months, and approximately 100 for one year. The most commonly observed side effects associated with varenicline (>5% and twice the rate seen in placebo-treated patients) were nausea, vomiting, abnormal dreams, constipation, and flatulence. In those patients given the maximum recommended dose of 1 mg twice daily following dose titration, the incidence of nausea was 30% compared with 16% in 0.5 mg twice daily and approximately 10% in placebo-treated patients.

No clinical trials of the combination treatment of varenicline and nicotine replacement therapy have been performed. **The safety and efficacy of the combination treatment with varenicline and nicotine replacement therapy have not been studied. The safety and efficacy of varenicline in pediatric patients (<18 years of age) have not been established and its use in this patient population is not recommended. There are no adequate data from the use of varenicline in pregnant women. It is not known whether varenicline is excreted in human milk. There is insufficient clinical experience with varenicline in patients with end-stage renal disease and treatment is not recommended in this patient population.**

## Coming Events...

**6th Alberta Respiratory Disease Symposium (ARDS) –** April 17-20, 2008 in Banff. Details: www.ards2008.com

**1st Canadian Respiratory Conference** – June 19-21, 2008 in Montreal. Details: www.lung.ca/crc

## CANA's Supporters

CANA is a not-for-profit Society with no ongoing source of funding. It is with the support from the following agencies that our activities are currently made possible:

Alberta Health and Wellness Population Health Strategies Branch, Alberta Asthma Centre (AAC), Alberta Strategy to Help Manage Asthma and COPD (A.S.T.H.M.A. C), AstraZeneca, GlaxoSmithKline, Novartis, Nycomed, Pfizer, SmartCare and The Lung Association of AB/NWT.

*Alberta's respiratory professionals tremendously appreciate your support!*