

# Asthma and older people in general practice

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Recognising and managing asthma in older people is an area where the complexities of general practice are thrown into sharp relief. What a plethora of diagnostic possibilities is raised by shortness of breath in an older person! Add to this the multiple roles of the general practitioner (GP) — sorter of undifferentiated symptoms, coordinator of multiple chronic problems and comorbidities, interpreter of specialist advice, manager of polypharmacy, link with allied health professionals, liaison with family, and advocate for patients — and the complexity of general practice care becomes evident. How do GPs address the challenges of diagnosing asthma in the face of multiple diagnostic possibilities?

And once asthma is identified, management in the older patient is influenced by factors that include the effects of comorbidities, of ageing itself and of its social consequences. There are also concerns about polypharmacy and the usefulness of current tools and management orthodoxies in older age groups, as well as organisational and structural barriers that limit best care.

## Asthma in the older person

Asthma and respiratory symptoms are common in older age,<sup>1,2</sup> and there is considerable overlap between asthma and chronic obstructive pulmonary disease (COPD).<sup>3</sup> Shortness of breath is one of the most common respiratory symptoms — it was reported by 25% of adults aged 49–65 years in a community-based study in Melbourne.<sup>3</sup> A Welsh study found the prevalence of dyspnoea to be 32.3% in people over 70 years of age living at home.<sup>4</sup> Those with breathlessness had poorer functional status and poorer physical and mental health, and were more likely to be anxious and depressed. In older patients, several respiratory and non-respiratory causes of breathlessness may be present in the same person. Symptoms are not specific for a specific diagnosis, and lung function testing does not always help clarify the underlying cause.

Community studies have shown that asthma is underdiagnosed. An Adelaide community study found asthma had not been diagnosed in 27% of those who had the condition, representing about 3% of that population.<sup>5</sup> People with undiagnosed asthma were more likely to be older, immigrants, retired or undertaking home duties, and to have a lower income. A British study has shown the prevalence of untreated asthma in a general practice population to be 1.75% in people aged over 65 years (2.4% for men and 1.2% for women), most of whom had moderate or severe disease, with the highest prevalence in those reporting a previous diagnosis of asthma by a doctor but not currently being treated.<sup>6</sup>

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## ABSTRACT

### *What we need to know*

- Why is there undiagnosed and untreated asthma in older people in the community and in general practice?
- What patient, general practitioner and organisational factors contribute to this?
- Are current best practice guidelines appropriate for older people with asthma?

### *What we need to do*

- Undertake broad community and general practice screening to identify characteristics of older people with undiagnosed asthma.
- Analyse GPs' perspectives and decision-making processes for older people with dyspnoea.
- Undertake targeted research in general practice, trialling decision-making frameworks for older patients with dyspnoea.
- Undertake appropriate and relevant community and GP awareness campaigns about the prevalence of asthma in older people.
- Analyse current best practice management of asthma, including self-management and the Asthma 3+ Visit Plan, in older people.

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The Adelaide study found that those with undiagnosed asthma visited their GP and hospital outpatient clinics as often as those diagnosed with asthma. This raises the question, why are they being missed?

## The Australian general practice context

The BEACH (Bettering the Evaluation and Care of Health) study is an Australia-wide paper-based collection of data on GP–patient encounters. It gathers information from about 1000 randomly sampled GPs each year.<sup>1</sup> These data reveal that GPs in Australia see older patients presenting often with general and unspecified reasons for the encounter, and with multiple and chronic health problems that impose further challenges for GPs in uncovering undiagnosed problems.

People aged 65 years and over use twice as many general practice services (9654 services per 1000 patients) as younger people, but significantly more patients in the older age group have general and unspecified reasons for their encounter with the GP (34.7% of encounters in the 65–74 age group, and 40.3% of encounters in the 75+ age group).<sup>2</sup>

Asthma itself is not a common reason for GP encounters in older people — it is not one of the top 16. But older people commonly present with a number of problems that may include shortness of breath as a symptom<sup>2</sup> (Box).

Nevertheless, GPs reported managing asthma in 2.6 per 100 encounters in the 64–75-year age group, and 1.7 per 100 in the

**Reasons for general practice encounters that may include shortness of breath as a symptom, Australia, 2000–2002\***

Reason for encounter	Rate per 100 encounters	
	65–74 years	75+ years
Shortness of breath	1.5	2.3
Chronic obstructive pulmonary disease	2.2	2.3
Heart failure	1.5	3.8
Acute bronchitis	2.5	2.6

\*Derived from the BEACH (Bettering the Evaluation and Care of Health) study.<sup>2</sup>

75+ age group. GPs manage the problem more often than patients give it as the reason for their encounter, in part because older people are more likely to present one of their more troubling comorbidities as the problem they want dealt with.

A subsample of the BEACH study examined the prevalence of chronic conditions in the older age group.<sup>2</sup> Participating GPs reported that in 49% of encounters in the 65+ age group, more than one condition was managed. As the number of conditions managed rose, so did the number which were chronic. The sheer scope and number of problems to be managed in a single encounter in this population mitigates against the uncovering of hidden problems.

This leads to the major challenges of asthma in the older person in general practice — diagnosis in the context of comorbidities and management of multiple chronic problems. In a Dutch study, nearly three-quarters of older people with a diagnosis of asthma or chronic bronchitis had at least one other chronic condition.<sup>7</sup> Social functioning and health perceptions are strongly affected by asthma and COPD in older people.<sup>7</sup> These factors, particularly depression, will affect if and how patients present to doctors, how GPs view their problems, and how they are managed.

**Decision-making in general practice**

For GPs, the doctor–patient relationship and the problems that patients bring to each encounter define their work. Flexibility, the ability to adapt to different circumstances and tolerance of uncertainty, are necessary. All clinicians need to tailor best evidence to the circumstances and values of the patient. And it is mostly impossible for GPs to keep up-to-date with best evidence in all areas of medicine. Clinical practice guidelines can help, but there is evidence that guidelines for asthma may be less well adhered to than others. A study of Dutch GPs showed there was only 48% adherence to guidelines for asthma, yet 100% for micturition in older men, and 93% for diagnosis of heart failure.<sup>8</sup> GPs express negative views about complex decision-support systems for chronic disease, with key issues being the relevance and accuracy of messages, and the flexibility to respond to the other factors that influence decision-making in general practice.<sup>9</sup> There is still much to learn about best practice in guideline dissemination and implementation.<sup>10</sup>

**Management of asthma in older people**

Multiple morbidity usually means polypharmacy, and both patients' and doctors' concerns about this may affect decisions about treatment. GPs are concerned about drug interactions, and

also about the effects of long-term inhaled corticosteroids on bone density, as reflected by the high prescribing of anti-osteoporotic medications in the UK for patients using inhaled corticosteroids.<sup>11</sup>

Older patients with multiple morbidities may have an aversion to taking multiple drugs, which may account for the strategy of taking some medications regularly (eg, for hypertension), while being more flexible with others, depending on symptoms.<sup>12</sup> This strategy particularly affects asthma management. Medication cost may also be a problem for older people. The older person may also assess and weight their asthma symptoms differently to GPs, which may affect both initial presentation and then adherence. In a study of patients with moderately severe asthma, people over the age of 65 weighted breathlessness as a less troublesome symptom than did younger people.<sup>13</sup> Doctors often know little about the self-management practices of their patients, even those with severe asthma.<sup>14</sup>

Comorbidities and ageing factors can also affect self-management. Cognitive and sensory impairment compound the task of effective education and self-management. Spirometry is often more difficult in older people, and access to spirometry is an issue in rural areas and in residential care.

Added to the complexity of diagnosing and managing multiple morbidities are the wider issues affecting the older members of our community — access to transport and health services, especially in rural areas, carer support, and financial considerations in an era of declining “bulkbilling”.

**Organisational and structural barriers to good GP care**

GPs are interested in asthma and the problems of older people. A limited review of Australian government-funded GP projects shows that 6% of the Divisions and Projects Grant Programs were awarded to asthma projects, and 14.8% to programs concerning the older person; 4% of the General Practice Evaluation Program project summaries were for asthma, and most Divisions of General Practice currently list an asthma project or education activity in their business plans (<<http://www.phcric.org.au>>).<sup>15</sup> Many projects were of local benefit, but were limited in time and scope.

**What are the barriers to delivery of best practice care?**

Organisation of general practice for effective delivery of chronic and complex care is the subject of ongoing and broad discussion. However, in terms of asthma management we know little about how some of the successful strategies work specifically in older people. Initiatives such as the Asthma 3+ Visit Plan, with planned proactive care, improves outcomes in some groups.<sup>16</sup> The barriers to completing such programs, which centre around the difficulty of encouraging patients to return for the third visit when they are well, may be less important for older people. Nurse-run asthma clinics have been a feature of many divisional projects, but there is still doubt as to the outcomes, with one of the most recent Australian studies showing no difference in terms of patient quality of life and lung function testing.<sup>17</sup> Are outcomes different for older people? Pharmacists can successfully deliver asthma self-management programs that lead to improved asthma control<sup>18</sup> and can be trained to perform competent screening and monitoring with spirometry,<sup>19</sup> but these moves have not been embraced by the GP

community. Is there potential for an enhanced role for pharmacy in team care of the elderly person with asthma?

### Conclusion

Two issues are critical for general practice care of the older person with asthma. First is the issue of recognising asthma as a possible cause for the common problem of breathlessness, and the second is management in the context of the complex health care needs and concerns of older people. We need to know more about the characteristics of those Australians who have undiagnosed asthma, to raise community and GP awareness, and to develop appropriate targeted screening and educational tools. We also need to find out how GPs go about making specific diagnoses in the face of multiple problems and comorbidities. How are standard asthma management guidelines and strategies applied to this group and should they be? And what are the structural and organisational barriers that may impede this?

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