AIRWAYS

College of Respiratory Nurses NZNO

Hongihongi te rangi hou'
'Smell the fresh air'

Newsletter of the
College of Respiratory Nurses (NZNO)

November 2018

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Note from Chair KIA ORA KOUTOU

KIA ORA KOUTOU

Welcome to our November issue of AIRWAYS, our last edition for 2018. The committee for the College of Respiratory Nurses has had another extremely busy and successful year. The highlight was our biennial symposium in Wellington: Taking Respiratory Care Beyond the Rhetoric – Less Talk More Action. Carol George and her team, with the support of the Committee, organised a really thought provoking conference. Key note speaker Lance O'Sullivan challenged the way we practice and the role 'virtual health' may play in the future. During the Symposium the College held our annual general meeting (AGM). Our new committee was elected and all members have quickly settled into their new roles. Carol George and Marilyn Dyer are continuing the high standard with AIRWAYS to showcase, promote and reflect the diversity of how respiratory nurses deliver their practice around Aotearoa.

Two of our members Dawn Acker and Mary Cox attended the NZNO AGM in Wellington in September. Highlights from the conference were: Dr Karyn O'Keefe on 'Shift work and Fatigue: Nurses and Mental Health'. The focus of this presentation was on why we sleep and the effects of sleep of deprivation. The other presentation was on Communication, which was based on a presentation by Amy Scott: https://www.youtube.com/watch?v=Jp9b2Hf7QWg . Throughout the year the committee has commented and made submissions on draft guidelines and policies. We are continuing with SNIPS, which you will find on the website. We will continue to monitor this service to ensure it is meeting your needs.

It has been decided to reduce the number of scholarships offered by the College from ten to five, but to increase the amount offered from $250 to $500. It is hoped that the increased amount will result in members feeling more supported by the College and the barriers to accessing education reduced. Details are on the website.

Our College remains small, but numbers are growing. Our aim is to provide a voice for all those working with respiratory disease at a national level. The wider our base, the more representative our voice, and therefore the greater our impact. Please encourage colleagues to consider joining. Nurses can belong to three colleges/sections.

The Skills and Knowledge Framework review is due in the next year. The previous sub-committee who undertook a review in 2016 have been approached to consider undertaking this again. If there is anyone who would like to be on the sub-committee for the 2019 review, please contact any current College committee member.

Our next Symposium is in April 2020 in Whangarei. Mary Cox from Whangarei and Marilyn Dyer from Kaitaia have already begun planning and organising for what is shaping up to be a really outstanding symposium. This is the first time has been held in Whangarei, so please watch the space as information comes to hand. It will be really worthwhile travelling to the far north for this. When the date is confirmed make sure you enter it into your diary!

We have three committee members who are stepping aside in February 2019 at the next AGM which will be held at SIREF. Sharon Hancock, our treasurer has completed two outstanding terms. Sharon has ensured that all finances are sound, and has been pivotal in the transition to centralised banking. Sharon you have been amazing; thank you. Laura Campbell joined the

committee at the same time as I did, and has been extremely supportive as Secretary. Laura thank you so much for your assistance, commitment and expertise.

Finally I am standing down, having completed my term as Chair. This has been a really rewarding challenge. I could not have managed this position without the fantastic support from our PNA Annie Bradly-Ingle, and our extremely dedicated committee. I also acknowledge the support I have received from my manager, Jane Harnett at Ashburton Hospital with this role. Jane has been very facilitative and understanding of my position. Finally, and importantly, thank you to all members of the College of Respiratory Nurses, NZNO. As I have read your articles I am truly humbled by all the work you do, and often under extremely challenging circumstances.

When I joined the committee my personal goals were to increase linkages with respiratory nurses, and to advocate at a national level. Following writing to all the electoral parties, we were invited to parliament and met with the then Health Minister. I have always been aware of some of the challenges Northland faces, and hoped for a voice from this area. Thank you Marilyn for joining our committee.

I am totally committed to the Treaty of Waitangi, and reducing the inequities in respiratory disease. We are privileged to have Mary Cox on the committee, and her passion and knowledge is invaluable. I know that I leave the committee in strong hands with Carol George, Dawn Acker, Mary Cox and Nicola Corna. Marilyn will be our new Chair, and she brings much enthusiasm and passion to the role. It has truly been a privilege to know and work with you all.

There are some vacancies on the committee, and I urge you to take up this challenge. It is so rewarding. Please consider joining our committee; contact details for the current members are with this issue of AIRWAYS. Any one of us would gladly speak with you and answer any questions you may have.

The taxing winter months are behind us, not only for patients, but also for staff. I hope that you are able to have some down time during the summer months to relax and rebuild reserves. I especially thank all members for your continued support of the College, and the committee welcomes all comments and suggestions that you may have, so that we truly are reflecting your needs and experiences.

Thank you for allowing me the honour of being Chair of the College of Respiratory Nurses, NZNO. I wish you all a very happy and safe Christmas, and may 2019 bring you and your families' peace and good health.

Hongihongi te rangi hou
'Smell the fresh air'

Mary Gluyas
Chair
College of Respiratory Nurses NZNO

Editors Note

Welcome to the last edition of Airways for 2018. This year has flown passed and there have been some great achievements for 2018

For the respiratory College, the NZNO Respiratory Symposium was great fun and challenging. In addition, there have been a number of Registered Nurse prescribers through and several nurses near completion of Nurse Practitioner.

We would love to know what your achievements have been over this year and the year ahead. Have you completed projects, audits or been involved in national consultation? Have you become a prescriber, what was your journey?

It would be great if you could send in your highlights so we can celebrate with you.

Have an awesome run into 2019.

Regards
Marilyn Dyer and Carol George

Please forward articles for Airways, feedback, achievements to:
Email: respiratorycollege@gmail.com

"You all came down with the flu at the same time. Do you, by chance, all work together?"

brɒŋkɪˈɛktəsɪs - bronchy' what? Carol George NP

What is this bronchiectasis? The Thoracic Society defines bronchiectasis as a clinical syndrome with the symptoms of wet productive cough with or without features of airway hyper responsiveness, recurrent chest infections, growth failure, hyperinflation, chest wall deformity. Gold standard diagnosis of bronchiectasis is confirmed on HRCT (2015, Chang, Bell, Torzillo et al.). It seems that nothing about Bronchiectasis is simple. The word is complex, the definition is complex and the guideline name is even more complex - Chronic suppurative lung disease and bronchiectasis in children and adults in Australia and New Zealand! However, one thing stands out as been simple about Bronchiectasis and that is it is preventable. In 2005, Twiss stressed that the rate of Bronchiectasis in NZ was too high (Twiss, Metcalfe, Edwards, and Byrnes 2005). Fifteen years on, how have the trends of bronchiectasis in NZ changed?

The National Respiratory Strategy writes, that since 2000 to 2013 there has been a 30% increase in hospitalisation with deaths doubling (2015, Asthma and Respiratory Foundation of New Zealand). In addition, the strategy reports that Pacific Island people are 6.4 times more at risk, with Maori at 3.7 times and Asians at 2.3 times of being hospitalized with Bronchiectasis. Not only is there is ethnic disparity, bronchiectasis also has a significant socioeconomic inequality with deprived areas 3.2 times more likely to be hospitalised and 2.7 times likely to die (2015, Asthma and Respiratory Foundation of New Zealand). Therefore, not only has our incidence increased (Lutz, 2018), but as highlighted, people in lower decile, Māori and Pacific populations are over represented in NZ data.

Have we missed the boat in turning Bronchiectasis around in New Zealand? The strategy reinforces interventions that have made a difference including immunisations, antibiotic management and improved housing. The year 2018 has heralded the new "warrants of fitness" for rentals which should contribute towards warm dry housing. Moreover, increasing the age of free child GP/ NP visits to 12 years of age will hopefully reduce the frequency of chest infections. Lutz writes that Bronchiectasis may be starting to lose its orphan disease status, but the work ahead includes raising the awareness and management of bronchiectasis (Lutz, 2018). Our challenge is to reduce the incidence and significant health disparities associated with bronchiectasis in NZ. As nurses, our roles enable opportunities to advance the recommendations made in the Respiratory Strategy (Asthma and Respiratory Foundation of New Zealand (2015). Working towards prevention and diagnosis it is imperative that our practice includes optimising scheduled immunisation targets; identifying and treating chest infections early (utilising the new nurse prescribing and Nurse Practitioner roles); improving access to health care and lobbying for improved housing. In addition, our management of people with bronchiectasis should encompass self-management strategies including action plans and sputum clearance techniques. Here as nurses we can provides support and education the family and Whanau of people with bronchiectasis reinforcing the person centred multi team approach.

Therefore, as highlighted, the trends in bronchiectasis in NZ remain of significant concern and nurses are in a prime position to work towards reducing incidence and issues around bronchiectasis. Although seemingly complex, care of people with bronchiectasis has some clear strategies which nurses can advance including supporting early diagnosis and management, advocacy patient / Whanau centred care and education.

References:

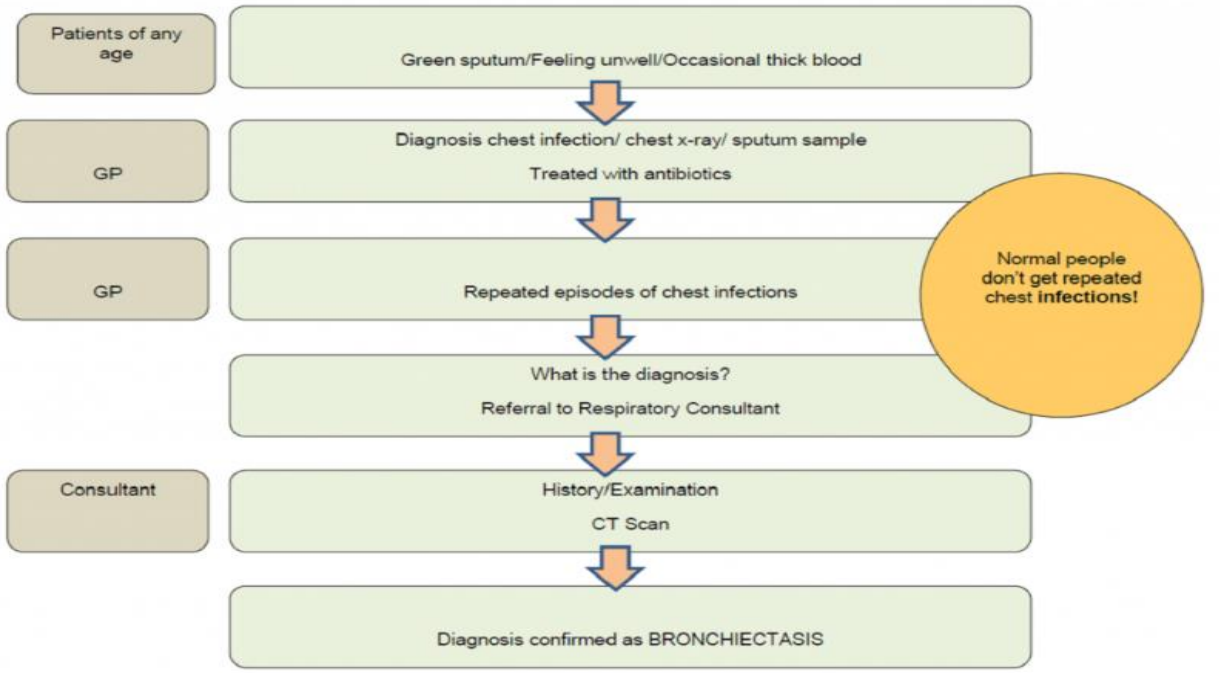
Asthma and Respiratory Foundation of New Zealand. (2015). *Te Hā Ora (The Breath of Life): National Respiratory Strategy*. Wellington, New Zealand: Author.

Chang, A. B., Bell, S. C., Torzillo, P. J., King, P. T., Maguire, G. P., Byrnes, C. A., . . . Grimwood, K. (2015). Chronic suppurative lung disease and bronchiectasis in children and adults in Australia and New Zealand Thoracic Society of Australia and New Zealand guidelines.(Report). *202*(1), 21-23.

Lutz, B. (2017). A focus on bronchiectasis and cystic fibrosis. *Respiratory Research Review, 142*. Retrieved from https://s3-ap-southeast-2.amazonaws.com/assets.asthmafoundation.org.nz/documents/Respiratory-Research-Review-Issue-142-Bronchiectasis-and-CF.pdf

Twiss, J., Metcalfe, R., Edwards, E., & Byrnes, C. (2005). New Zealand national incidence of bronchiectasis "too high" for a developed country. *Archives of Disease in Childhood, 90*(7), 737. 10.1136/adc.2004.066472

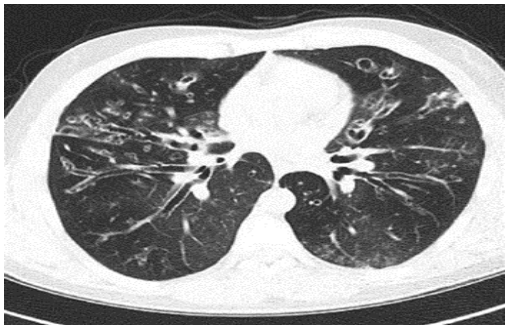
BRONCHIECTASIS DIAGNOSTIC PATHWAY



Used with permission from Professor Adam Hill
http://www.bronchiectasis.scot.nhs.uk/bronchiectasis-basic-facts/definition-and-diagnosis

Diagnosis includes clinical symptoms and radiographic features on chest CT.

Cylindrical bronchiectasis on CT



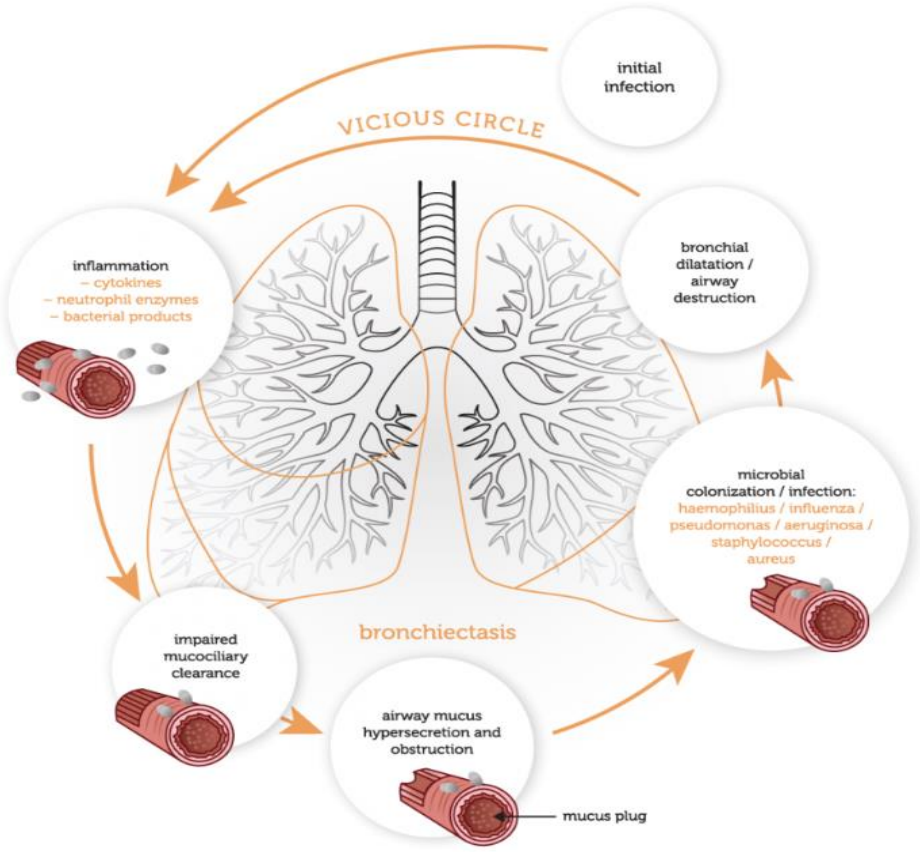
Bronchiectasis Pathophysiology:

Non cystic fibrosis Bronchiectasis pathophysiology is underlined by a combination of infection and a defective host response involving uncontrolled recruitment and activation of inflammatory cells within the lower airways. It is an acquired disorder characterised by infection, chronic inflammation and damage to the bronchi. The extent of destruction of airways can be localised or diffuse.

The initial infection triggers an immune response with mucociliary activation and release of inflammatory agents such as neutrophils, erythrocytes and macrophages. This activity occurs within the bronchial lumen. Neutrophil increase contributes to impaired mucociliary action and may increase adherence of bacteria in lungs.

Subsequent bacterial colonisation promotes a chronic inflammatory cycle resulting in further release of immune mediators leading to progressive and self-sustaining airway inflammation. Extended pulmonary destruction occurs with neutrophil initiated release of inflammatory cytokines, elastases and matrix proteinases. At this stage elasticity is reduced resulting in chronic dilatation of the airways. Cascading damage includes progressive airway fibrosis and destruction, neovascularisation and recurrent pneumonia with lung tissue damage.

The cycle of pooling secretions, infection and release of inflammatory mediators, which in turn contribute to airways damage progresses. Therefore, early recognition and treatment of pulmonary infections is vital to minimise the impact of infection, chronic inflammation and bronchial destruction.



Used with permission form: Bronchiectasis Toolbox:
http://bronchiectasis.com.au/bronchiectasis/bronchiectasis/pathophysiology

Bronchiectasis Aetiology: Cheat Sheet

Infectious

- Measles & pertussis
- Adenovirus & influenza virus.
- Bacterial virulent organism: Staphylococcus aureus; Klebsiella
- Atypical mycobacterium.
- HIV (human immunodeficiency virus)
- Tuberculosis
- Fungi (aspergillous)

Non Infectious

- Toxic substances: inhalation ammonia, aspiration gastric acid. (GERD) Gastroesophageal reflux disease
- Immune response triggering inflammation and destructive changes (ABPA: Allergic Bronchopulmoinary Aspergegillosis).
- Inflammatory Disease/ Autoimmune: ulcerative colitis; Sjogren; Rheumaotoid.
- α1-antitrypsin deficiency, A1AD.
- Yellow Nail Syndrome.

Impaired Host:

- Local Causes: Endotrachial obstruction.
    - Tumour.
- Hereditary conditions
    - Cystic fibrosis
    - Primary ciliary dyskinesia, including Kartagener's syndrome
    - Marfan syndrome
- Immunologic abnormalities
    - Immunoglobulin deficiency syndromes
    - White blood cell dysfunction
    - Complement deficiencies
    - Certain autoimmune or hyperimmune disorders, such as rheumatoid arthritis and ulcerative colitis
- Socioeconomic Factors:
    - Child in decile 1 (< 10%) x 15 developing Bronchiectasis.

The Bronchiectasis Foundation of New Zealand was launched on 7 April 2015 by the former Governor General Sir Jerry Mateparae and supporters of Whangarei woman Esther-Jordan Muriwai, who suffered the illness for most of her life. She passed at the age of 24, shortly before the foundation was created.

This not-for-profit organisation is dedicated to supporting those living with bronchiectasis, empowering them in managing their condition with good health information, healthy lifestyle changes and encouraging inspiring relationships with their health team. Raising community awareness is also a priority.

The Foundation has appointed Lisa Young as Coordinator for Northland. The Whangarei support group provides a place for parents and caregivers to share their journey, to learn and to support each other. Guest speakers are invited from the community to share relevant information.

The Foundation is currently working on a 'Bronchiectasis Information Pack' which will be gifted to children of families receiving treatment or who are newly diagnosed. The bronchiectasis information will also be available to preschool, school, adults, General Practitioners and clinics. It will be accessible in Māori, English, Samoan and Tongan translation and distributed throughout the community.

The Northland Bronchiectasis Support Group can be contacted at:
bronchiectasisnorthland@gmail.com

In November 2017, Whangarei paediatrician Dr Catherine Bremner said 40 children aged under 16 are known to be affected by bronchiectasis. The number of adults is harder to deduce because "some with mild bronchiectasis don't come into hospital." The prevalence of the disease in the population is 99.6 per 100,000 people, or roughly one in a thousand. Prevalence is highest in Pacific and Māori people.

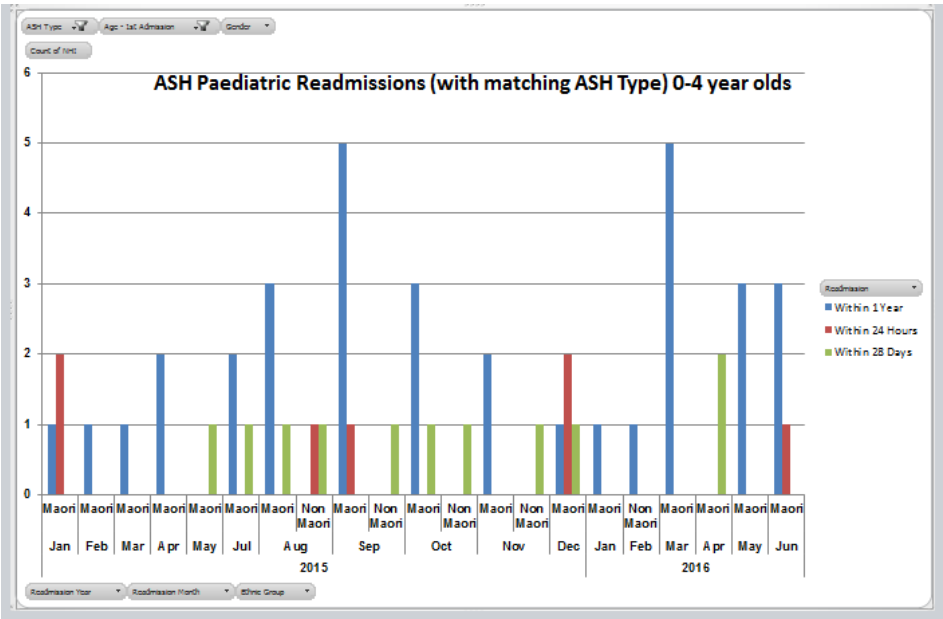
One approach taken by Northland DHB to address these rising rates is the Paediatric ASH Respiratory Events Readmissions Project. The aim of this project is that all tamariki aged 0–4 years in Northland will experience well managed respiratory illness, which will be evident in a 10 percent reduction in readmission within 24 hours, 28 days and one year post initial admission for the same coded respiratory ASH event.

This reduction will be the result of working collaboratively with key services across the primary and secondary care continuum, which is aligned with the Ministry of Health Systems Level Measures.

Overall, ASH admissions are mostly acute admissions that are considered potentially reducible through prophylactic or therapeutic interventions deliverable in a primary care setting.

Hospital admissions due to ASH are affected by various conditions such as social (housing quality and income), personal (age and ethnicity) and geographic factors (location and access to affordable health care).

To impact admission rates, an inter-disciplinary and across-sector approach to system improvement is required. When compared with similar profile DHBs, Northland has higher rates of admission and readmission within 24 hours and 28 days for paediatric respiratory ASH.



Multiple points of data collection influence the approach taken during this project. A literature review of related studies and models of care delivery from other areas in New Zealand and internationally helped to inform the group to identify and prioritise areas for service improvement. A large group representative of service providers and consumers was engaged.

Process mapping has identified significant issues and gaps in consistency and continuity of care, particularly at transition points between services and service providers. Some issues have already been addressed, others are works in progress. Some system and process improvements require a collaborative, interdisciplinary and across-sector approach. Areas that are known to impact well-managed respiratory illness are:

- access to warm and dry housing
- smoke-free pregnancy and environments
- standardised care
- early recognition and accessible care
- identification and management of high risk children
- better coordination of care at discharge for readmissions.

The role of consumers is essential in informing the approach and critiquing options, hence consumers were included in the working group from the start of the project. All actions considered need to be patient and whānau centred.

-**Lisa Young** RN Child Health Services Northland District Health Board

-**Ronel White** RN Child Health Services Northland District Health Board

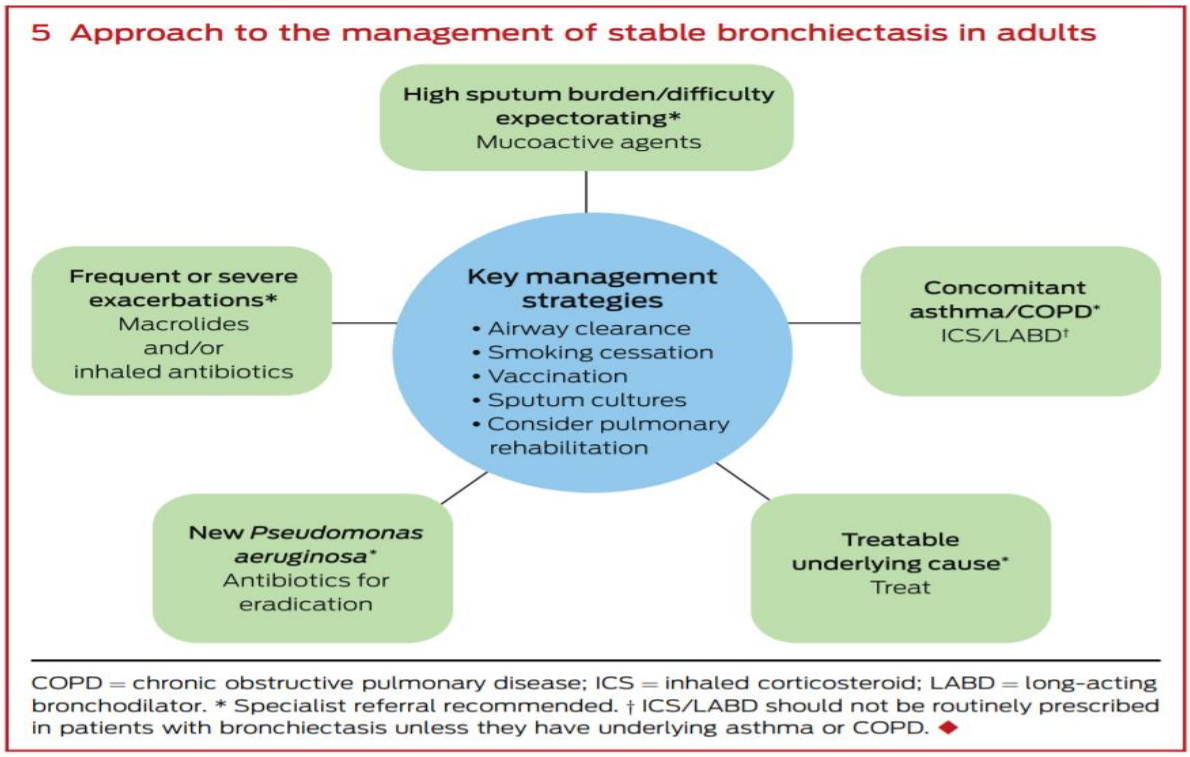
-**Camron Muriwai** Bronchiectasis Foundation

-**Martina Ackermann** Quality Facilitator, RN Child Health Services Northland District Health Board

Child Health Centre
Te Whare Hauora Mo Nga Tamariki

Top Tips Management of Stable Bronchiectasis

- **Airway clearance**
- **Action Plans**
- Smoking cessation
- Vaccination (influenza, childhood immunisations)
- Sputum cultures
- Pulmonary rehabilitation



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https://www.mja.com.au/system/files/issues/209_04/10.5694mja17.01195.pdf

It is always good to know who your support team is when managing people with any Chronic Respiratory conditions: This is your and your patient's support team

- GP / Nurse Practitioner
- Practice nurse/respiratory educator/respiratory specialist nurse
- Physiotherapist
- Occupational therapist
- Social worker
- Clinical psychologist
- Pharmacist
- Dietitian
- COPD support/exercise group
- Palliative care for end of life issues

Self - Management is a key strategy for managing bronchiectasis and includes Sputum Clearance techniques and Action Plans. Examples of Action Plans attached.

Sputum Clearance

Because mucocilary impairment is a hallmark of bronchiectasis, maximising sputum clearance a fundamental therapy for people with bronchiectasis. Essential components for sputum clearance include: Optimising ciliary function, effective techniques and Self - management.

Airway Clearance Techniques (ACT) are safe for people with stable bronchiectasis and may improve outcomes in including sputum expectoration, selected lung measures and quality of life (Lee, Burge and Holland, 2015). Sputum clearance will be based on sputum production, age, motivation, cost and time. Referral to physiotherapists for assessment and education is useful for initiating sputum clearance for people with bronchiectasis.

- Active cycle breathing.
- Oscillating positive expiratory devices.
- Postural drainage.
- Forced expiration technique.

- Adjuncts to airway clearance.
  - Nebulised saline.
  - Nebulised Beta 2 agonist.
- Pulmonary Rehabilitation.
- Inspiratory muscle training

Pharmacology:

- Bronchodilators as indicated from B agonist response with spirometry.
- Anticholinergics.
  - Ipratropium bromide.
  - Tiotropium.
  - Nebulised normal saline and/ or hypertonic saline:
  - increase sputum yield, reduce sputum viscosity & improve ease of expectoration.
- Antibiotics:

Management of airway clearance

- Take medications correctly
- Drink adequate fluids. Unless on fluid restrictions
- Daily aerobic exercise at an appropriate intensity (Exercise Prescription)
- Daily airway clearance routine (Choosing an AC Technique)
- Bronchiectasis Action Plan

Health Navigator Bronchiectasis Action Plan

Action plans are recommended for people with bronchiectasis to support self-management.

My Blue Card

Action plan to stay well and keep out of hospital

1. When I'm well - I will make sure I have a good supply of all my medicines and take as directed

- ✓ I can do my usual activities
- ✓ Sleep as usual /eating as usual
- ✓ Taking usual medicines
- ✓ Usual amount of sputum

My usual medicines	Strength	Colour of device	How much?	How often?

2. When I'm becoming unwell or it is harder to breathe, I will watch out for

- More wheeze, coughing and/or short of breath
- Less energy and/or poor sleep
- Eating less

THEN:

- **I follow the plan below for extra medicines and keep taking my usual medicines.**
- **Start taking prednisone (if prescribed)**
- **Contact your GP Practice team.**

Signs of an infection can include:

- A change in colour and/or volume of sputum/spit
- Fever or feeling unwell
- Little energy

THEN:

- **Start antibiotics (if prescribed)**
- **Start prednisone, (if prescribed) and you are using your reliever 3-4 hourly but not getting good relief**
- **Contact your GP Practice team.**

ALSO:

- **Plan my day. Get rest. Relax. Use breathing techniques, huff and cough to clear sputum as needed.**
- **If I keep needing extra meds but I'm no worse I need to see my GP practice team to consider changing my usual meds.**
- **If you have bronchiectasis, increase sputum clearance exercises to three times per day**

My extra medicines	Strength	Colour of device	How much?	How often?

Prednisone: (strength & instructions)

Antibiotics: (strength & instructions)

EMERGENCY: If I am very short of breath when sitting or lying down, OR if I am feeling unusually restless, confused, drowsy or have chest pain – **call 111**

While waiting:

- **Keep taking your ..... inhaler via spacer every .....**
- **If you have an Advance Care Plan, show this to all healthcare providers**

Place magnet here

Your information

(Ask your doctor or nurse to help you fill this in)

Name: Address: NHI: Date of birth: / / Next of kin:	GP Name: Practice: Phone: **CO2 retainer:** Yes ☐ No ☐ Unknown ☐ **Home oxygen:** Yes ☐ No ☐ Flow rate: .....

Baseline for me:

- O2 sat. (%) .....
- Exercise tolerance .....
- Sleep .....
- Sputum .....
- Appetite .....

Special notes or requirements:

Allergies/alerts:

After-hours: When my GP Practice is closed, I should contact:

What to do to stay well:

- ✓ The number one treatment for any lung disease is to be smoke free and avoid smoke exposure
- ✓ Check I am using my inhaler correctly with my GP Practice team so I get the most benefit from my medicines
- ✓ Walk daily and keep active
- ✓ Ask your GP Practice team about attending lung rehabilitation (also called pulmonary rehabilitation)
- ✓ Get a flu vaccination each year
- ✓ Ask about pneumonia vaccination
- ✓ Your nearest lung support group is .....
- ✓ Find out more about lung disease at www.healthnavigator.org.nz
- ✓ Find out more about advance care planning www.advancecareplanning.org.nz

https://www.healthnavigator.org.nz/media/1629/bluecard-regionalcopdactionplanv-final-jan-2017.pdf

BRONCHIECTASIS
ACTION PLAN

Patient name: _____

Physiotherapist name: _____

Nurse name: _____

WELL

- Sleeping well
- Eating well

PHYSIO: _____

MEDICATIONS: _____

SICK

- Coughing more
- Tired
- Not eating
- More phlegm/mucous

PHYSIO: _____

MEDICATIONS: _____

Considering reducing sports/active play if they are out of puff

See your family doctor to get two weeks of antibiotics

VERY SICK

- Coughing lots
- Sore chest
- Lots of phlegm/mucous
- Out of puff/breath
- Fever

PHYSIO: _____

MEDICATIONS: _____

Let your child rest from sports

Go to your nearest emergency department

Consider taking a break from sports until they are well

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

Bronchiectasis Foundation

Starship Foundation

www.bronchiectasisfoundation.org.nz

NORTHLAND DISTRICT HEALTH BOARD

Bronchiectasis Resources:

Asthma and Respiratory Foundation of New Zealand 2015. Te Hā Ora (The Breath of Life): National Respiratory Strategy. Wellington: The Asthma Foundation.

Bronchiectasis Foundation Te Tupapa Mate Rukahukahu O Aoteroa

http://www.bronchiectasisfoundation.org.nz/

Bronchiectasis Tool Box info@bronchiectasis.com.au

Chang A., Bell S., Torzillo, P., King, P., Maquire, G., Byrnes, C., Holland, A., O'Mara,P., Grimwood, K., et al. Chronic suppurative lung disease and bronchiectasis in children and adults in Australia and New Zealand Thoracic Society of Australia and New Zealand guidelines. Med J Aust 2015; 202: 21–23.

https://www.mja.com.au/system/files/issues/cha00287.pdf

Lee AL, Burge AT, Holland AE. Airway clearance techniques for bronchiectasis. Cochrane Database of Systematic Reviews2015, Issue 11. Art. No.: CD008351. DOI: 10.1002/14651858.CD008351.pub3

Respiratory Review: Focus on Bronchiectasis: Lutz Editor Retrieved:

https://s3-ap-southeast-2.amazonaws.com/assets.asthmafoundation.org.nz/documents/Respiratory-Research-Review-Issue-142-Bronchiectasis-and-CF.pdf

Twiss, J., Metcalfe, R., Edwards, E., & Byrnes, C. (2005). New Zealand national incidence of bronchiectasis "too high" for a developed country. *Archives of Disease in Childhood*, *90*(7), 737–740. http://doi.org/10.1136/adc.2004.066472

Western Australian Government 2018. Diagnostic Imaging Pathways. Retrieved http://www.imagingpathways.health.wa.gov.au/index.php/image-galleries/medical-images/respiratory?id=132#pathway

Fresh from the ERS

Laura Campbell

This year I had the privilege and pleasure of attending the European Respiratory Society conference in Paris. With thanks to Asthma NZ and GSK I was awarded one of two scholarships to attend. It was an incredible experience with approximately 22,000 delegates in attendance and 10 concurrent sessions running each hour. It was a chance to hear ground-breaking research presented by the top respiratory researchers and physicians from around the world. It was difficult to decide what sessions to attend but I focused mainly on airway disease – Asthma and COPD.

ASTHMA

The big buzz in asthma was the results from the SYGMA (SYmbicort Given as needed in Mild Asthma) trials[1] looking at prn symbicort as a new treatment step for mild asthma. What was unusual about this research was that it was done by a pharmaceutical company (Astra Zeneca) at the request of the GINA (Global initiative for Asthma) to fulfil a gap in evidence. For many years now we have had a paradox in asthma where the guidelines recommend SABA (short acting beta agonist) monotherapy but advise against LABA(long acting beta agonist) monotherapy[2]. It is well known that both SABA and LABA can have negative consequences when used without an ICS, because of their pro-inflammatory effects, particularly where there is excessive use[3]. It is also well documented that patients are poorly adherence to their ICS (inhaled corticosteroid) treatment and by default may end up using SABA monotherapy[4]. Recent studies have also demonstrated that there is benefit for patients with few symptoms (i.e. fulfilling criteria for step one GINA) to be prescribed an ICS to reduce exacerbation rates but again adherence in this situation would be challenging[5].

The SIGMA trials compared SABA monotherapy (step one GINA) with symbicort (LABA/ICS) prn and maintenance ICS plus SABA (step two GINA). The results are interesting as the symbicort prn arm outperformed SABA monotherapy in both symptom control and exacerbation rate and showed statistically similar results in terms of reducing exacerbations as maintenance ICS but were inferior to maintenance ICS in controlling symptoms[1]. This then raises the question is it more important to control inflammation and manage symptoms or reduce risk by preventing exacerbations? Going forward how might this change guidelines? Will this signal the end of an era for SABA monotherapy? Can only symbicort be used in this way or is there potential to develop a SABA/ICS (again) to replace step 1 in GINA? And what type of patient would prn fast acting beta agonist/ICS suit?

On the opposite end of the spectrum was the new GINA pocket guide under development for difficult to treat and severe asthma. This guide was predominantly a series of flow charts taking the practitioner through step-by-step management from confirming the diagnosing to using the new biologicals. It was colour coded for primary care physicians and respiratory specialists showing the delineation of the workflow and clearly at what point referral was needed. This document is still being finalised but appeared to be a helpful and usable document for health professionals and we can look forward to this being released sometime in 2019.

COPD

In COPD again there was a look at the role of ICS with the IMPACT study[6] in this study there were three treatment arms triple therapy (ICS/LABA/LAMA – long acting muscarinic antagonist), dual therapy with LABA/LAMA and dual therapy ICS/LABA. Primary outcome was annual rate of exacerbations in each group. Triple therapy was shown to be superior to LABA/LAMA or LABA/ICS in reducing moderate to severe exacerbations. What was not brought out at the conference but was shown in the editorial for this paper was that many patients enrolled were already on triple therapy and initially there was a spike in exacerbations in the LABA/LAMA group which may have been the result of removing the ICS initially. This makes results more challenging to interpret. My feeling is the current GOLD (Global initiative on Obstructive Lung Disease) guideline algorithm for treatment is our best bet currently, reserving triple therapy for those with the most symptoms and frequent exacerbations.

Another interesting study was also presented looking at ICS in COPD this time in the context of increasing the dose at the onset of upper respiratory tract infection (URTI). The PREVENT study[7] compared maintenance ICS/LABA plus an intensified dose (i.e. double dose) at the onset of URTI for 10 days with ICS/LABA maintenance and a placebo increase at onset of URTI for 10 day. This was a smaller study that showed some promising results. Primary outcome was exacerbation rate in each group. Intensifying the dose did not decrease the incidence of exacerbations but it did show a reduction in the severity of an exacerbation. This shows promise in reducing hospital admissions and courses of oral steroids. A smaller subset of patients who had higher eosinophil levels faired even better.

This conference has given respiratory health professionals much to reflect on. When and if these studies change our current guidelines remains to be decided, however being aware of emerging evidence alerts health professionals to possible changes to practice in the future.

1 O'Byrne P et al. *N Engl J Med 2018*; 378: 1865-76

2 Global initiative for Asthma 2017

3 Reddel HK et al. *BMJ Open 2017*;7

4 Partridge MR et al. *BMC pulm med 2006*; 6:13

5 Reddel HK et al. *Lancet 2017*; 389;157-166

6 Lipson DA et al. *N Engl J Med 2018*; 378:1671-1680

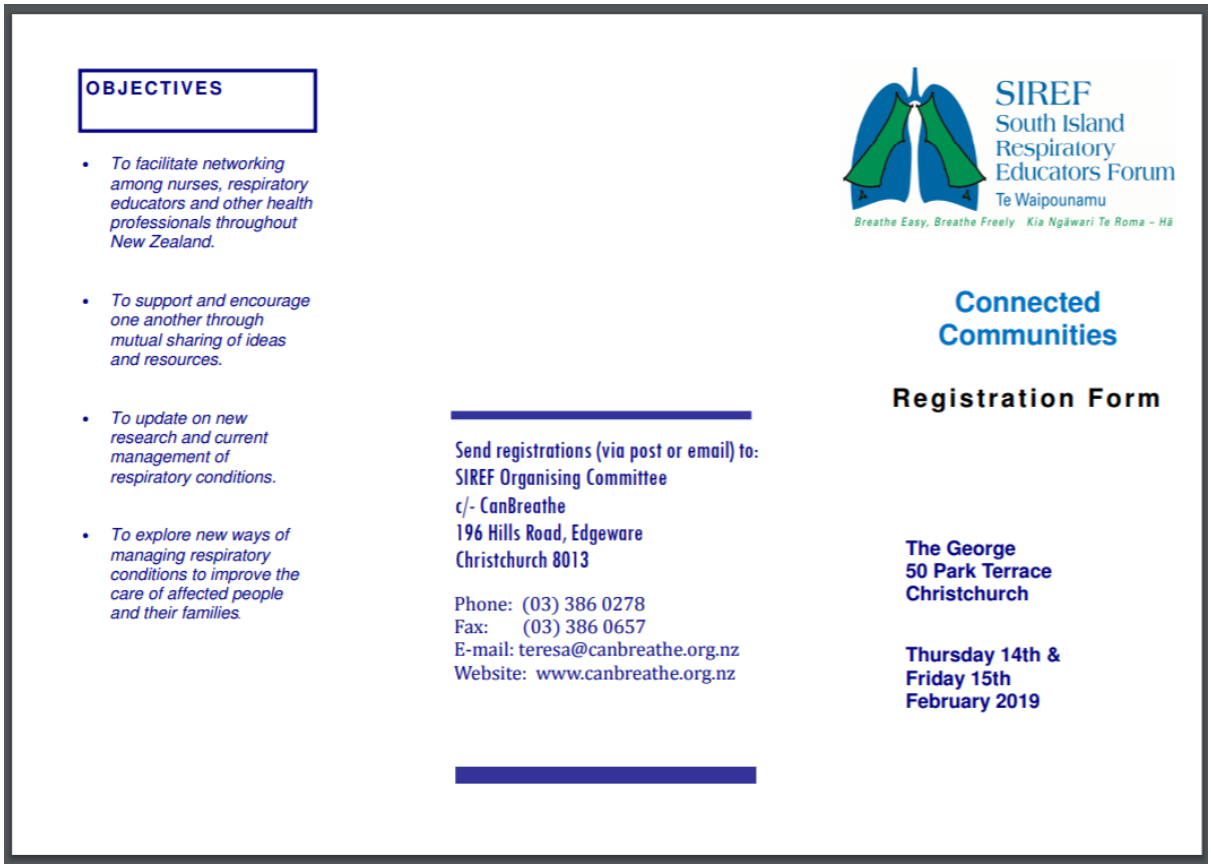
7 Stolz D et al. *Am J Respir Crit Care Med 2018*; 197(9):1136-1146

Grant Application Form NZNO Respiratory College

Reproduced from the NZNO College of Respiratory Nurses web page is the following application form when applying for a scholarship grant. See also the Terms and Conditions for Education Grant Applications. We encourage members to engage with this process.

Surname
First Name
Organisation
Position/role
Postal Address
Email Address
Work Phone
Home Phone/Mobile No.
NZNO No.
Number of years you have been a member of the respiratory college/section:
EDUCATION/CONFERENCE DETAILS
Name Conference/Course/Education Opportunity
Date
Location
Paper Presentation Yes/No
Presentation Title:
COST DETAILS
Amount (Max $250.00)
Registration/Course Fees
Accommodation
Travel
Other (please specify)
TOTAL COSTS
Briefly outline what you hope to learn/achieve from your participation/attendance:
Have you received an education grant from Respiratory College in the past two years? Yes/No
☐ I have read and accepted the terms and conditions for education grand applications
Signed

South Island Respiratory Educators Forum 2019 (SIREF) Registrations Now Open



OBJECTIVES

- *To facilitate networking among nurses, respiratory educators and other health professionals throughout New Zealand.*
- *To support and encourage one another through mutual sharing of ideas and resources.*
- *To update on new research and current management of respiratory conditions.*
- *To explore new ways of managing respiratory conditions to improve the care of affected people and their families.*

SIREF
South Island
Respiratory
Educators Forum
Te Waipounamu

Breathe Easy, Breathe Freely Kia Ngāwari Te Roma – Hā

Connected Communities

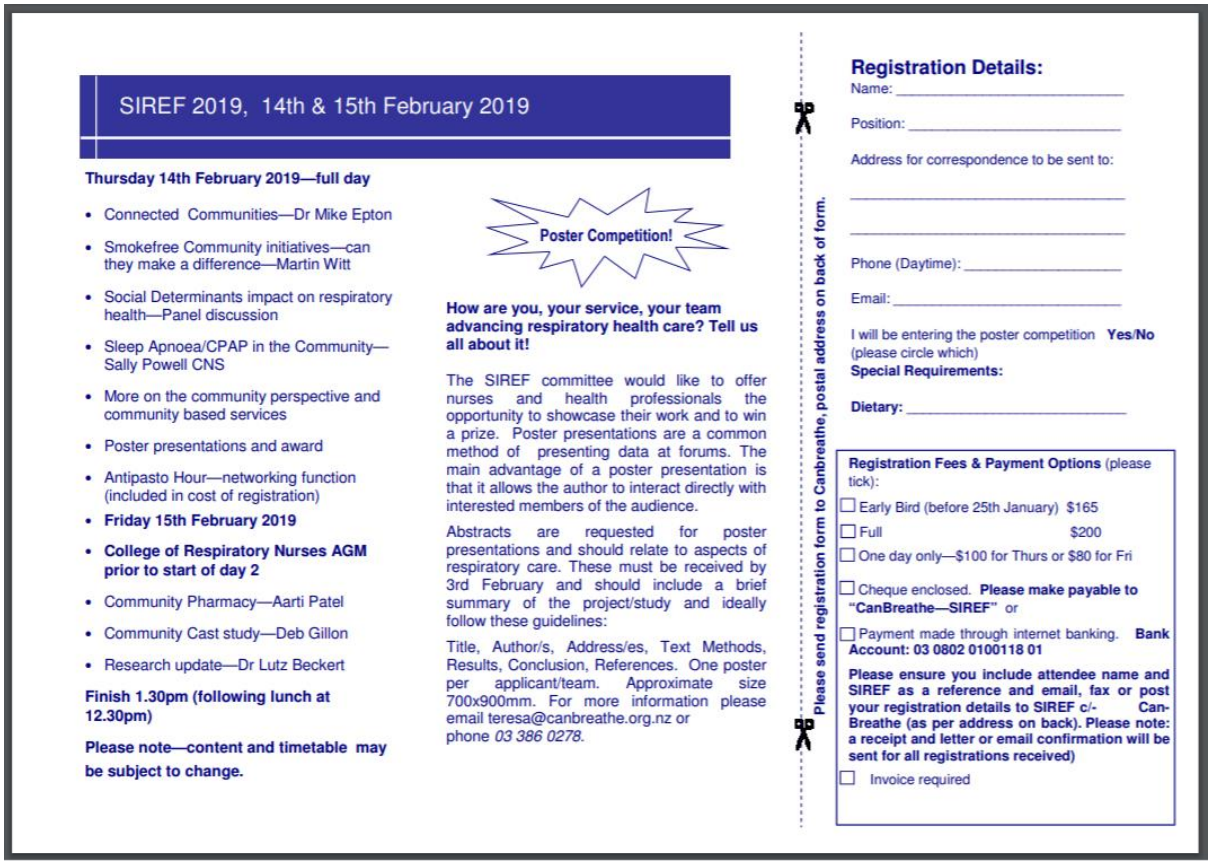
Registration Form

Send registrations (via post or email) to:
SIREF Organising Committee
c/- CanBreathe
196 Hills Road, Edgeware
Christchurch 8013

Phone: (03) 386 0278
Fax: (03) 386 0657
E-mail: teresa@canbreathe.org.nz
Website: www.canbreathe.org.nz

The George
50 Park Terrace
Christchurch

Thursday 14th &
Friday 15th
February 2019



SIREF 2019, 14th & 15th February 2019

Thursday 14th February 2019—full day

- Connected Communities—Dr Mike Epton
- Smokefree Community initiatives—can they make a difference—Martin Witt
- Social Determinants impact on respiratory health—Panel discussion
- Sleep Apnoea/CPAP in the Community—Sally Powell CNS
- More on the community perspective and community based services
- Poster presentations and award
- Antipasto Hour—networking function (included in cost of registration)
- **Friday 15th February 2019**
- **College of Respiratory Nurses AGM prior to start of day 2**
- Community Pharmacy—Aarti Patel
- Community Cast study—Deb Gillon
- Research update—Dr Lutz Beckert

Finish 1.30pm (following lunch at 12.30pm)

Please note—content and timetable may be subject to change.

Poster Competition!

How are you, your service, your team advancing respiratory health care? Tell us all about it!

The SIREF committee would like to offer nurses and health professionals the opportunity to showcase their work and to win a prize. Poster presentations are a common method of presenting data at forums. The main advantage of a poster presentation is that it allows the author to interact directly with interested members of the audience.

Abstracts are requested for poster presentations and should relate to aspects of respiratory care. These must be received by 3rd February and should include a brief summary of the project/study and ideally follow these guidelines:

Title, Author/s, Address/es, Text Methods, Results, Conclusion, References. One poster per applicant/team. Approximate size 700x900mm. For more information please email teresa@canbreathe.org.nz or phone *03 386 0278.*

Please send registration form to Canbreathe, postal address on back of form.

Registration Details:

Name: _____

Position: _____

Address for correspondence to be sent to:

_____

_____

Phone (Daytime): _____

Email: _____

I will be entering the poster competition **Yes/No** (please circle which)

Special Requirements:

Dietary: _____

Registration Fees & Payment Options (please tick):

☐ Early Bird (before 25th January) $165
☐ Full $200
☐ One day only—$100 for Thurs or $80 for Fri

☐ Cheque enclosed. **Please make payable to "CanBreathe—SIREF"** or

☐ Payment made through internet banking. **Bank Account: 03 0802 0100118 01**

Please ensure you include attendee name and SIREF as a reference and email, fax or post your registration details to SIREF c/- CanBreathe (as per address on back). Please note: a receipt and letter or email confirmation will be sent for all registrations received)

☐ Invoice required

NZNO RESPIRATORY COLLEGE COMMITTEE

Name	Committee Role	Address	Email Address
Mary Gluyas	Chairperson	Ashburton	mary.gluyas@cdhb.health.nz
Sharon Hancock	Treasurer	Palmerston North	sharon.hancock@midcentraldhb.govt.nz
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Carol George	Committee Member	Levin	Carol@hcp.co.nz
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Dawn Acker	Committee Member	Invercargill	dacker@enlivensld.nz
Annie Bradley-Ingle	PNA	Hamilton Office	annette.bradley-ingle@nzno.org.nz

Standing: Mary Cox, Marilyn Dyer, Annie Bradley-Ingle, Nicola Corna, Sharon Hancock
Sitting: Mary Gluyas (Chair), Laura Campbell (not present; Carol George and Dawn Acker)