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Uncovering Hidden Symptoms of Uncontrolled Type 2 Asthma

Dr. May:
This is *Clinician's Roundtable* on ReachMD, and I'm Dr. Alexandria May. Joining me to share communication strategies that can help us identify potential unreported symptoms of uncontrolled type 2 asthma is Dr. Njira Lugogo. She's a Professor of Internal Medicine and the Asthma Program Director in the Division of Pulmonary and Critical Care Medicine at the University of Michigan Health. Dr. Lugogo, welcome to the program.

Dr. Lugogo:
Thank you so much for having me. I'm excited to be here.

Dr. May:
So to start us off, Dr. Lugogo, where do you see the biggest gaps between what patients are reporting and what is happening physiologically?

Dr. Lugogo:
You know what's really interesting is that asthma is perhaps one of the only inflammatory diseases where we overemphasize symptoms and underemphasize inflammation. And so we have a condition that's driven by airway inflammation, which causes bronchoconstriction, mucus hypersecretion, and airway narrowing, which may or may not translate to significant symptoms.

Symptoms are complicated. They could be pulmonary. They could be extrapulmonary. Symptoms are also in the eye of the beholder. So there are some poor perceivers who never complain but have quite low lung function and a lot of ongoing inflammation, and there are people who complain quite frequently and get overtreated with oral corticosteroids despite having pretty normal lung function and not very high inflammatory markers.

And so I think we need to stop chasing symptoms. We do need to pay attention to them, but we need some objective measures, and we need to educate our patients on the importance of reporting what's happening so that we know it's happening, and it gives us an opportunity for further evaluation. But we really shouldn't be completely and solely focused on symptoms.

Dr. May:
And when you see these patients in clinical practice, what are some of the most common ways they may unintentionally mask poor asthma control?

Dr. Lugogo:
Well, honestly, they have very low expectations. So they're like, “Oh, I just don't ever go outside from May to August. During the day, I go outside for five minutes at 10:00 PM,” or something like that that would be completely unacceptable to us, right? Or “I just don't walk up the hill. I take multiple elevators. I have a workaround. I have figured out how to accommodate my life to the symptoms,” versus trying to deal with the symptoms so you can live unencumbered by asthma.

Dr. May:
Now, given those challenges, let's focus on some solutions. When starting a conversation with a patient, what types of questions have you found most effective in getting them to open up?

Dr. Lugogo:
So the first thing I always do with my patients, especially the new ones, is educate them on asthma. What is asthma? Talk about inflammation, the immune response, and the bronchoconstrictive symptoms. And then I tie that into, “What does this mean for your

quality of life? Are you getting steroids? Are you having exacerbations? What are the consequences of these steroids and exacerbations?" So I'm level setting what the expectations should be.

And then I'm telling them, "Okay, let me tell you what I think the goal of asthma treatment is, which is no exacerbations." Because most people think, "Oh, two ER visits in a year is not too bad. I used to have seven." Or "My whole family goes to the ER once a year. It's not a big deal." So level set that we don't expect you to have acute healthcare resource utilization. We don't want you to get steroids, which can be toxic. We want your lung function to be normal. So measure it and educate them on whether it's normal or not. If it's not, we are aiming for normal lung function. And also, we want you to live unencumbered by asthma.

And then I pause and say, "So tell me how you're doing." And so the patient now has a true north. "This is where we should be. This is where I currently am. Wow, I'm way off the true north. I'm actually having so many problems I didn't perceive were even problems." And then you really start getting that conversation going.

And you know why it's really critical? Because adherence to asthma therapies is not that great. And I think it's because buy-in is not that great. So if you don't understand you have an inflammatory disease that requires ICS, you're overusing your short-acting beta-agonist because it makes you feel better in the moment. So a lot of this is quite critical in just getting on the same page with our patients and getting the expectations set so we are both aiming for the same target because I think there's often discordance between my goals and the patient's goals, and we have to reconcile that in the clinic.

Dr. May:
That's a great point. And where do patient-generated data like symptom journals or digital trackers fit into that? Can you tell us how they affect your ability to assess control between visits?

Dr. Lugogo:
I'll start with the symptom questionnaire. We use them routinely at every visit, and I feel like because you're repeating the same questions in the same way over and over again, you can catch trends. Maybe the person always has persistent exercise symptoms, but the other symptoms are getting better. Or they're overusing their SABA even though their lung function is rather normal, and they shouldn't be.

And so doing those questionnaires really helps get people in the habit of doing them over and over again, and they tend to answer it the same way. And so you get an idea of trends. So that, I think, is really useful, and we've operationalized it so it goes to the patients automatically or the medical assistant has them fill it out when they come in. And we've used the ACT before. Currently, we're using the AIRQ because it incorporates exacerbation questions as well.

Dr. May:
For those just tuning in, this is *Clinician's Roundtable* on ReachMD. I'm Dr. Alexandria May, and I'm speaking with Dr. Njira Lugogo about how we can better identify symptoms that may signal uncontrolled type 2 asthma.

So looking beyond structured tools, Dr. Lugogo, what role does active listening play in uncovering symptoms that the patient may be hesitant to share?

Dr. Lugogo:
You have to set up a situation where people feel quite open with you. We need to know if they're actually taking those inhalers. If you ask close-ended questions like, "Oh, so you're taking your inhaler twice a day?" they'll say, "Yes, I am." But if you say, "I know it's really hard to take that inhaler regularly. How many times a day or a week do you get that inhaler in?" you might get more information back.

Dr. May:
Now, if we apply these strategies to the real world, can you walk us through a patient scenario where symptoms initially suggested controlled asthma, but deeper conversation and recognition of type 2 inflammation led to a different treatment path, such as earlier biologic use?

Dr. Lugogo:
Yes, so I'll give you an example. You have a patient come in as a new patient, and you're going through the usual questions about asthma and they're reporting, "I don't have a lot of symptoms. I'm not using my SABA. I might have had some prednisone a few times." They're not so sure how many times usually.

And then you start to really inquire about, "Are you sleeping through the night?" "Well, no, but I've been doing that for years. That's not a problem." "Well, what's waking you up?" And then it turns out they have symptoms. "Are you able to walk and exercise?" "No, I don't exercise because I have a lot of coughing and wheezing."

But in that moment, if the person has no symptoms, they are not going to report what's been happening because they're like, “I feel fine. I'm feeling good today.” They may say, “I can't breathe when I exercise, but I'm overweight. That's probably what it is. I'm out of shape, so it's not my asthma.”

And in some cases, you then measure lung function, and it's shockingly low. And you're like, “Wait, you actually have really bad airflow obstruction.” We always phenotype every patient, so we're going to look at those eosinophils. And when you look historically, you realize the person has had multiple high eosinophil counts. We get a nitric oxide on every patient. You measure that, and the patient is able to understand, “Wow, I do have airflow limitations, and I have inflammation.”

We always check to see if people are sensitized to allergens and whether they have allergen-driven asthma. And sure enough, you might actually find out that your patient has uncontrolled asthma, more exacerbations than they reported to you, low lung function, and may potentially benefit from step-up therapy. Particularly people who are adherent to their inhalers, they may just have refractory type 2 inflammation. And unfortunately, the degree to which you have type 2 inflammation is not directly correlated to symptoms. So you really have to take a more comprehensive history, measure these objective factors, and then make a decision about stepping them up.

And the beauty is we have awesome drugs that treat type 2 inflammation across the spectrum, both inhaled and biologic drugs. And so we have an opportunity to really improve a patient's life.

Dr. May:
Thank you for sharing that case with us, Dr. Lugogo. And in our final moments here, what key lessons should we take away from that patient scenario and today's discussion?

Dr. Lugogo:
I personally think that if you are to change one thing in your pulmonary practice, it would be to measure all biomarkers. You got to measure the biomarkers, including FeNO and eosinophils. You can do IgE testing, check for those historical eosinophils, and really get a good idea. In pulmonary practice, we measure a lot of lung function, so I don't need to remind people to do that. But get those measures, and understand the patient's expectations so you can incorporate those into the treatment plan. And I think if we did that, we would identify a lot of people who are being undertreated. But more importantly, there are people who are being overtreated and being harmed by getting repeated courses of oral steroids because of symptoms that frankly are not inflammatory in nature.

So it does make a big difference to have a few more objective pieces of information to add to your armamentarium when you're trying to take care of patients and not just chase symptoms either because they're not there or because they're constantly there. We need to really start thinking more objectively about contextualizing symptoms to the clinical case and the inflammatory condition of the patient.

Dr. May:
With those key takeaways in mind, I want to thank my guest, Dr. Njira Lugogo, for joining me to discuss how we can improve our communication approach to uncover hidden symptoms in uncontrolled type 2 asthma. Dr. Lugogo, it was great having you on the program.

Dr. Lugogo:
Thank you so much. I appreciate you having me.

Dr. May:
For ReachMD, I'm Dr. Alexandria May. To access this and other episodes on our series, visit *Clinician's Roundtable* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!