

SUMMARY

Family physicians were asked about their recent experience with caring for dying patients at home and for their evaluation of a recently established Palliative Care Home Support Team. Ninety-four percent of the respondents had cared for at least one dying patient at home during the previous 2 years. About two thirds felt comfortable, competent, confident, supported, and in control. One quarter felt personally drained by the experience, but almost as many found it personally renewing. Of those who had referred patients to the team, two thirds gave the team high ratings for being supportive, helpful, quick to respond, and effective in communication.

RÉSUMÉ

Une enquête auprès des médecins de famille visait à connaître leur expérience récente au niveau des soins dispensés à domicile aux patients en phase terminale et leur évaluation de la nouvelle équipe de soins palliatifs offrant des services à domicile. Parmi les répondants, 94% avaient prodigué des soins à au moins un patient en phase terminale au cours des deux années précédentes. Les deux tiers se sont dits à l'aise, compétents, confiants, en contrôle et satisfaits du support requis. Le quart se sont sentis "vidés" personnellement par cette expérience mais à peu près le même nombre ont senti un renouveau personnel. Parmi ceux qui avaient référé des patients à l'équipe, les deux tiers ont accordé à l'équipe une cote élevée pour son soutien, son aide, sa rapidité de réponse et son efficacité de communication.

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Home care of dying patients

Family physicians' experience with a palliative care support team

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IN THE EARLY DECADES OF THIS century, most people died at home, cared for by their families and attended by their family physicians.

Since the 1950s, however, home death after chronic or progressive illness has become much less common, even though patients are at home for much of their terminal illness.^{1,2}

During the next few decades, the increasing prevalence of cancer and other chronic disease and the reduced number of acute care hospital beds are likely to increase the number of home deaths. Even when patients die in hospital, their length of stay is likely to be reduced, so that a longer portion of the terminal illness will be spent at home.

Because many people express a wish to die at home, this trend might be welcomed by the public. However, certain conditions must be met if home care is to become a satisfactory alternative to hospital care. Among these are suitable accommoda-

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tion, family support, help in the home, and nursing and medical services capable of providing both day-to-day care and a rapid response to emergencies.³

Since the beginning of the palliative care movement, two models of home support for dying patients have developed. One of these is a multidisciplinary team providing all the professional support needed by the patient and family. The other is a consulting team acting as advisers and supports for the patient's regular caregivers, the home care nurses and attending physician.

In 1988, Parkwood Hospital in London, Ont, established a team based on the second model. Subsequently, a grant was received from the Ontario Ministry of Health to evaluate the team, and as part of this evaluation a survey of London family physicians was carried out to ascertain the doctors' experience with caring for dying patients at home, their feelings about the experience, and their assessment of the team's services. In this paper we describe the results of the survey, which was carried out after the team had been in operation for 20 months.

Care of the dying in London, Ont

London has approximately 200 family physicians for a population of 300 000 (245 family physicians if the immediate surrounding area is included). Family physicians are the main source of primary

Table 1. Physicians' feelings about caring for their dying patients at home

NEGATIVE FEELINGS	1 TO 3 (%)*	4 TO 6 (%)*	7 TO 9 (%)*	POSITIVE FEELINGS	NO. ANSWERING THE ITEM
Incompetent	2.8	19.3	77.9	Competent	181
Not confident	10.6	26.8	62.6	Confident	179
Isolated	11.7	30.7	57.5	Supported	179
Uncomfortable	12.2	24.3	63.5	Comfortable	181
Out of control	8.2	28.0	63.7	In control	182
Anxious	13.1	37.2	49.7	Not anxious	183
Sad	16.8	54.7	28.5	Happy	179
Overwhelmed	10.0	30.0	60.0	Not overwhelmed	180
Personally drained	26.3	50.8	22.9	Personally renewed	179

*Percentage of response in each third of a nine-point scale.

medical care. The city has a medical school, three acute care teaching hospitals, and two chronic care hospitals. The London Regional Cancer Centre provides specialized cancer care for the Southwest Ontario region.

At the time of the survey, London had a 14-bed palliative care unit at Parkwood (one of the chronic care hospitals) and a 4-bed unit at St Joseph's Health Centre. The three acute care hospitals had established consulting palliative care teams for inpatient services. In addition, the London Regional Cancer Centre had a home support team for patients under the care of the institution.

Parkwood home support team

The Parkwood Palliative Care Home Support Team (PCHST) consisted of two experienced palliative care nurses, each working half time, backed up by a family physician and a social worker (both with extensive experience in palliative care). The role of the team is to support family physicians and home care nurses in caring for patients dying at home. Most referrals come from family physicians, and in all cases the family physician's approval of the referral is required.

Within 3 days of referral, a detailed nursing assessment is done in the home and a report, with recommendations, is made to the family physician, to the referring physician (if different), and, if the patient is receiving home care under the Middlesex-London

Home Care Program, to the case manager and home care nurse. Follow-up arrangements are made in accordance with the wishes of the patient, family, and caregivers. If a medical consultation has been requested, the patient is also visited at home by the team physician. A nurse and physician are on call at all times, and patients are told that they may call the team if their home care nurse or family doctor is unavailable. New assessments and all active cases are reviewed at weekly team meetings. The team receives an average of four new referrals weekly.

METHOD

In 1989, the Centre for Studies in Family Medicine received a grant to evaluate the PCHST. At the beginning of the trial, a survey of all family physicians in London was done to ascertain their attitudes to, and experience with, home care of dying patients. Doctors were also asked to evaluate the services of the team. A questionnaire was sent to all family physicians in London and the immediate surrounding area served by the PCHST. As well as being asked about their recent experience in caring for dying patients at home, they were asked to rate, on a nine-point scale, their feelings about caring for dying patients and their experience with the PCHST. Finally, they were invited to respond to five open-ended questions.

Table 2. Physicians' evaluation of the Palliative Care Home Support Team

NEGATIVE EXPERIENCES	1 TO 3 (%)*	4 TO 6 (%)*	7 TO 9 (%)*	POSITIVE EXPERIENCES	NO. ANSWERING THE ITEM
Too slow in responding to call	4.8	10.3	84.9	Quick to respond	127
Unhelpful response	4.7	12.5	82.8	Helpful response	128
Telephone communication ineffective	12.8	12.0	75.2	Telephone communication effective	125
Written communication ineffective	12.4	26.8	60.8	Written communication effective	97
Nurses were threatening	2.5	5.8	91.7	Nurses were not threatening	120
I learned nothing from the team	4.1	38.2	57.7	I learned a lot from the team	123
Negative experience	8.9	24.2	66.9	Positive experience	124

*Percentage of response in each third of a nine-point scale.

RESULTS

One hundred eighty-nine of the 245 mailed questionnaires were received, a response rate of 77% after two follow-up mailings. Seventy-four percent of respondents were male, compared with 64% of nonrespondents. More respondents than nonrespondents had practised for less than 3 years (13% versus 7%), and fewer had practised more than 10 years (59% versus 65%). Subsequent analyses were based on the 189 respondents.

Responses to multiple choice questions

Sixty-five percent of respondents (123 physicians) believed that it was better to care for dying patients at home than in hospital, but considered either setting appropriate, depending on the needs and wishes of the patient and family.

Nearly all respondents (94.2%) had cared for terminally ill patients during the previous 2 years. One hundred sixty of the 189 (84.7%) had cared for at least one patient at home and 35% had cared for more than two during the previous 2 years.

The physicians' ratings of their feelings about caring for dying patients at home are shown in Table 1. None of the respondents answered all the questions. About two thirds felt comfortable, competent, confident, supported, and in control. About a quarter of

physicians (26.3%) felt personally drained by the experience, but almost as many (22.9%) found it personally renewing. There were no differences in the responses of male and female physicians. Physicians with more than 4 years' experience in practice rated their confidence more highly ($\chi^2 = 13.5$, $df = 6$, $P = .04$) and those with 7 to 10 years' experience reported themselves less overwhelmed than those with either less or more experience ($\chi^2 = 12.1$, $df = 6$, $P = .06$).

Nearly all of the family physicians (93.7%) had heard of the PCHST and 82% had wanted to use it. Of these, most (94%) had been able to do so. Those who were unable to use the service cited family refusal or confusion about the service provided as reasons. In one case, however, delayed response was cited as the reason.

In response to questions about the PCHST, more than two thirds of respondents gave the team high ratings for being supportive, helpful, quick to respond, and effective in telephone communication (Table 2). Written communication and learning from the team received a somewhat lower rating. More than half, however, believed that interaction with the team had been a learning experience. Female physicians were more likely than male physicians to rate highly their learning from the team ($\chi^2 = 5.6$, $df = 2$, $P = .06$), and to rate the team's telephone communication as effective ($\chi^2 = 6.5$, $df = 2$, $P = .04$). Physicians with 7 to 10 years in practice

were more likely to feel threatened by the team nurses ($\chi^2 = 13.6$, $df = 6$, $P = .04$).

Forty physicians had at least one negative response (a rating of 3 or less) about the team. Ten had criticisms about the written or telephone communication; four believed that the team had undermined the doctor-patient relationship and rated the experience as negative; four were critical because no bed was available when needed; and three believed there had been conflicts between the team and the cancer clinic team or home care program. Three rated the support they received as low; two rated the learning minimal, and one the response slow. In 13 others, there was a single negative response with otherwise very positive ratings.

Responses to open-ended questions

One hundred twenty-four physicians responded to the open-ended question: "Do you feel it is better to care for dying patients at home or in the hospital?" Sixty-one said that the answer depended on the available resources and on the wishes of the patient and family. Another 33 were in favour of home care if the above conditions were met. Another 21 stressed the advantages of home, but five emphasized the difficulties. Three stressed the disadvantages of the acute care hospital and one believed that hospital was more appropriate than home.

Seventy-four physicians responded to the question: "Are there other feelings you want to express about caring for dying patients at home?" Twenty-two had found the experience to be satisfying and rewarding. Seven found it to be stressful and two felt both stressed and satisfied. The following quotations exemplify these responses:

- "Very satisfying. I am grateful [for the] source of insights into my patient and into myself, which are not available in most other areas of practice."
- "These have all been rewarding experiences for me, both professionally and personally."
- "A privilege; produces a special bond with patient and family. [It is] a challenge to deal with one's own mortality."
- "... can probably be the most creative aspect of family medicine."

- "[Providing home care is] very time-consuming and emotionally draining at times, but worthwhile."
- "Demanding, consuming."

Ten physicians emphasized the stresses on patients' families. Eight commented on the heavy demands on their time. Two stressed the importance of being personally available, and two more mentioned difficulties with finding an appropriate deputy. Two were frustrated by lack of resources. The remaining 19 physicians made miscellaneous comments.

One hundred thirty-four answered the question: "What problems or barriers can arise when caring for dying patients at home?" Most of the respondents (61 people) identified the problems of families in caring for dying patients: fatigue, fear, anxiety, and disagreements and conflicts among family members. Twenty-seven mentioned their own problems in providing care: finding time for home visits, coping with the number of telephone calls, providing 24-hour care, and getting consultants to visit the home. The remaining 46 physicians made miscellaneous comments.

When invited to make additional comments on their experiences providing palliative care in the home, several of the respondents commented on the team's services. Most of these comments were very positive, but some were critical. Two aspects that drew criticism were conflict between the team and existing services, and the potential of the team for undermining the doctor-patient relationship.

DISCUSSION

Our study showed that most family physicians in and near London had recent experience in caring for dying patients at home. Moreover, most respondents felt confident and well supported in doing so. Although many of them stressed the logistic and economic difficulties in making frequent home visits, and in being available for emergencies, several believed that it was a fulfilling and rewarding experience. Most family physicians had used the PCHST. In their evaluation of the team, a large majority reported that the team was helpful and quick to respond and more than half considered their interaction with

the team a learning experience. About two thirds had found their experience with the team very positive. Between 2% and 12% of the responses were negative.

Other studies

The results of our study are very similar to those of a postal survey and personal interview study of a sample of general practitioners in Adelaide, Australia.⁴ The Community Hospice Program was rated highly. Critical comments about the home care services included a lack of feedback, delays in obtaining service (especially after hours), blurring of roles, and a tendency for patients to be taken over. The Australian doctors expressed a much greater need for continuing education in palliative care, an issue that was hardly mentioned in our study. The absence of specific questions about learning needs in our study could have been responsible for this.

In two semistructured interview studies of British general practitioners, Still and Todd^{5,6} found, as we did, that some physicians emphasized the stresses of caring for dying patients and some emphasized the rewards. The authors suggest that some of the stresses arise from conflict between the doctor's caring role and the curing role that is dominant in the acute care hospital and in medical education. Rosser and Maguire⁷ arrived at similar conclusions. While the doctors in our study might have felt this role ambiguity, it did not emerge from the responses. Either this was not an issue for the London family doctors or it could have been identified only by personal interview.

In a chart review of patients admitted to a Vancouver hospital for palliative care, Lubin⁸ concluded that many of the patients could have been managed at home if support from a home care team had been available.

Will enough physicians provide care at home?

The availability of physicians who will visit the home is crucial if patients are to remain at home during their terminal illness and if their wish to die at home is to be fulfilled. Little information is available about the willingness of physicians to attend dying patients at home or about their experience of doing so. An advisory group for the Metropolitan Toronto

Home Care Program,⁹ however, cited difficulty in finding family physicians willing to make home visits as one of the problems in providing palliative care in the home.

Our results are at variance with this view. There are two issues to consider here: first, to what extent is London typical; second, were physicians giving socially desirable responses? The city is certainly atypical in other respects. All of the three acute care hospitals are tertiary care teaching hospitals. Probably for this reason, the ratio of general practitioners to specialists is lower than in the rest of the country. Many of the family physicians were trained in The University of Western Ontario residency program, where all teaching practices are community based and home visits are considered integral to patient care.

Surveys of London family physicians in 1974 and 1984¹⁰ showed that 96% and 94%, respectively, did home visits. The average number of home visits for all physicians was one per working day. It is, therefore, possible that London is atypical. The responses, however, should not be taken to imply a particular level of involvement in home care of the dying. Physicians were asked for their feelings about caring for dying patients at home, not about the frequency of their visits or the intensity of their involvement. Also, there were no questions about the number of patients who actually died at home. Nevertheless, the responses to the open-ended questions did make it clear that for many physicians home care of dying patients is an important part of their practice.

As to whether or not the physicians were giving socially desirable responses indicating more involvement than was actually the case, we took steps in the design of the survey to minimize such tendencies. The mailing came from the Centre for Studies in Family Medicine rather than from the Palliative Care Unit, and the covering letter was signed by a nonphysician (M.S.) who had no affiliation with the home care services. Moreover, the responses are in accordance with the experience of members of the PCHST as to the extent of the physicians' involvement. We are, therefore, confident that the physicians' ratings do not reflect a tendency toward socially desirable responses.

Difficulties and drawbacks

Although about two thirds of respondents felt confident, supported, and in control, this should not divert our attention from the 22% who felt less than fully competent, the 37% who felt less than fully confident, the 42% who felt some isolation, and the 36% who felt less than completely comfortable and some sense of not being in control. Not surprisingly, confidence increased with greater experience. Experience with dying patients, however, comes slowly for most family physicians. An average practice of 2000 patients, for example, would have about four patients yearly with terminal cancer. As our population ages, this number will increase, and as hospital beds become fewer, more will spend their last days at home. Home care should, therefore, be an important part of the learning experience for family medicine residencies.

Working as a team member is a way of reducing feelings of professional isolation. Teamwork has been especially important in palliative care and can extend to the home in programs where a palliative care team takes over the total care of the patient. In Canada, home care programs usually involve health care professionals working in varying degrees of isolation. It is unusual, for example, for the family physician and home care nurse to meet either in the home or at team meetings. The way our health services are structured, administered, and paid for tends to reinforce this isolation. Physicians, for example, are usually paid for services to patients, not for attending team meetings or keeping in touch with nurses.

Transferring the total care of dying patients to specialized teams that do not include the attending family physician might appear to solve the problem of isolation and other negative feelings expressed by physicians. However, the disadvantages must be considered. First, it breaks the continuity of relationships between patient and nurse or physician. If these relationships have become important to the patient and family, the break may not be compensated for by any enhancement of the care. Second, the exclusion of a physician or nurse from an aspect of care eventually leads to loss of their skills and confidence. Third, such a transfer of care requires expansion of specialized palliative care services, which would not only be

expensive, but would also not be able to cover smaller communities. Finally, the transition to palliative care is not clear-cut. Some patients and families resist it because they equate palliative with terminal care. All family physicians, therefore, must expect to be involved in some way with their terminally ill patients.

A palliative care team providing consultation and support for family physicians and home care nurses is another way of meeting the needs that have been expressed. Our survey has shown that such a team has been accepted and appreciated by nearly all physicians. A potential disadvantage of this model is that the team can become involved only to the extent desired by the referring physician and home care nurse. Team members could feel that their recommendations are not carried out, to the possible detriment of patient care. If, on the other hand, the team becomes too assertive, the family physician and home care nurse could feel undermined.

Conclusion

Whichever model is chosen, the people involved need to have a keen sense of the importance of the professional relationships among the caregivers and the pitfalls awaiting the unwary.¹¹ The initial stages of a new support team are likely to be the most difficult. As time goes on, team members and referring physicians have more opportunities to get to know each other and to develop good working relationships. The fact that the team is still, 5 years after its inception, receiving four referrals weekly suggests that it is meeting an important need.

Our study has shown that, in one Canadian city, nearly all family physicians not only care for dying patients at home, but see it as their responsibility to do so. Although most find it difficult to meet this responsibility, a substantial number find that it is a personally rewarding experience. Our study has also shown that a palliative care home support team, based on the consultative rather than the total care model, has been accepted and appreciated by physicians. Given the widespread distribution of family physicians in Canada, and their role in the health care system, this model appears to be appropriate for further development and evaluation. ■

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Rhinocort®

Turbuhaler®

Nasal Powder (budesonide) 100 µg/metered dose

THERAPEUTIC CLASSIFICATION

Glucocorticosteroid powder for the treatment of seasonal and perennial rhinitis.

ACTIONS AND CLINICAL PHARMACOLOGY

RHINOCORT TURBUHALER contains pure budesonide which is a potent non-halogenated synthetic glucocorticosteroid with strong topical and weak systemic effects. RHINOCORT TURBUHALER has a high topical anti-inflammatory potency and it is rapidly biotransformed in the liver. This favourable separation between topical anti-inflammatory activity and systemic effect is due to strong glucocorticosteroid receptor affinity and an effective first-pass metabolism with a short half-life. The minute amount absorbed in therapeutic doses has not been shown to exert any apparent clinical systemic effects. The mechanism of action of intranasally administered budesonide has not yet been completely defined.

INDICATIONS

The treatment of seasonal and perennial allergic rhinitis and vasomotor rhinitis unresponsive to conventional therapy.

CONTRAINDICATIONS

Hypersensitivity to budesonide. Active or quiescent tuberculosis. Untreated fungal, bacterial, or viral infections. Children under 6 years of age.

WARNINGS

In patients previously on prolonged periods or high doses of systemic steroids, withdrawal of steroids may cause symptoms such as tiredness, aches and pains, and depression. In severe cases, adrenal insufficiency may occur necessitating a temporary resumption of systemic steroids. Careful attention must be given to patients with asthma or other clinical conditions in whom a rapid decrease in systemic steroids may cause a severe exacerbation of their symptoms.

Use in Pregnancy: see PRECAUTIONS.

PRECAUTIONS

1. In transferring patients from a systemic steroid to RHINOCORT TURBUHALER, the reduction of the systemic steroid must be very gradual and carefully supervised by the physician since systemic withdrawal symptoms (e.g., joint and/or muscle pain, lassitude, depression) may occur in spite of maintenance or improvement of respiratory functions (see DOSAGE and ADMINISTRATION). 2. Patients should be informed that the full effect of RHINOCORT TURBUHALER therapy is not achieved until 2 to 3 days of treatment have been completed. Treatment of seasonal rhinitis should, if possible, start before the exposure to allergens. 3. During long-term therapy, pituitary-adrenal function, hematological status and height (in children) should be periodically assessed. 4. Treatment with RHINOCORT TURBUHALER should not be stopped abruptly but tapered off gradually. 5. Glucocorticosteroids may mask some signs of infection and new infections may appear during their use. A decreased resistance to localized infections has been observed during glucocorticosteroid therapy; this may require treatment with appropriate therapy or stopping the administration of RHINOCORT TURBUHALER. 6. Concomitant treatment may sometimes be required to counteract eye symptoms caused by allergy. 7. The long-term effects of RHINOCORT TURBUHALER are still unknown, in particular, its local effects; the possibility of atrophic rhinitis and/or pharyngeal candidiasis should be kept in mind. 8. Until greater clinical experience has been gained, the continuous, long-term treatment of children is not recommended. 9. When budesonide is administered intranasally, the following should be kept in mind: a) glucocorticosteroid effects may be enhanced in patients with hypothyroidism and in those with cirrhosis, b) in hypoprotrombinemia, salicylates should be used cautiously in conjunction with glucocorticosteroids. 10. Because of the inhibitory effect of corticosteroids on wound healing in patients who have had recent nasal surgery or trauma, a nasal corticosteroid should be used with caution until healing has occurred. 11. **Use in Pregnancy.** The safe use of RHINOCORT TURBUHALER in pregnancy has not been established. Therefore, its use during pregnancy should be avoided unless there are compelling reasons, particularly in the first trimester of pregnancy. In experimental animal studies, budesonide was found to cross the blood-placenta barrier. Like other glucocorticosteroids, budesonide is teratogenic to rodent species. High doses of budesonide administered subcutaneously produced fetal malformations, primarily skeletal defects, in rabbits, rats, and in mice. The relevance of these findings to humans has not yet been established. In the absence of further studies in humans, budesonide should be used during pregnancy only if the potential benefits clearly outweigh the risk to the fetus. Infants born of mothers who have received substantial doses of glucocorticosteroids during pregnancy should be carefully observed for hypoadrenalism. 12. **Lactation.** Glucocorticosteroids are secreted in human milk. It is not known whether budesonide would be secreted in human milk but it is suspected to be likely. The use of RHINOCORT TURBUHALER in nursing mothers requires that the possible benefits of the drug be weighed against the potential hazards to the mother or infant. 13. **Children Under 6 Years of Age.** RHINOCORT TURBUHALER is not presently recommended for children younger than 6 years of age due to limited clinical data in this age group. 14. Patients should be advised to inform subsequent physicians of the prior use of glucocorticosteroids.

steroids. 15. To ensure the proper dosage and administration of the drug, the patient should be instructed by a physician or other health professional in the use of the RHINOCORT TURBUHALER (see INFORMATION FOR THE PATIENT).

Drug Interactions

The influence of cimetidine on budesonide kinetics and dynamics after concomitant oral and intravenous administration is of minor clinical importance.

ADVERSE REACTIONS

The adverse reactions reported with RHINOCORT TURBUHALER are consistent with what one would expect when applying a topical treatment to an already inflamed membrane. All side effects are transient. The most commonly reported side effects include: nasal and throat irritation, nasal bleeding, crusting, dryness. Other adverse events reported are sneezing (at initiation of therapy), itching throat, sore throat, cough, fatigue, nausea/dizziness, and headache. When patients are transferred to RHINOCORT TURBUHALER from a systemic steroid, allergic conditions such as asthma or eczema may be unmasked. In rare cases, skin reactions (urticaria, rash, dermatitis, etc.) may occur in association with local corticosteroid therapy. Extremely rare cases of ulcerations of the mucous membranes and nasal septal perforation have been reported following the use of intranasal corticosteroids.

SYMPTOMS AND TREATMENT OF OVERDOSAGE

Like any other nasally administered corticosteroid, acute overdosing is unlikely in view of the total amount of active ingredient present. However, when used chronically in excessive doses or in conjunction with other corticosteroid formulations, systemic corticosteroid effects such as hypercorticism and adrenal suppression may appear. If such changes recur, the dosage of RHINOCORT TURBUHALER should be discontinued slowly consistent with accepted procedures for discontinuation of chronic steroid therapy (see DOSAGE and ADMINISTRATION). The restoration of the hypothalamic-pituitary-axis may be a slow process and during periods with pronounced physical stress such as severe infections, trauma, and surgical operations, a supplement with systemic steroids may be advisable.

DOSE AND ADMINISTRATION

See WARNINGS.

Careful attention must be given to patients previously treated for prolonged periods with systemic corticosteroids when transferred to RHINOCORT TURBUHALER. Initially, RHINOCORT TURBUHALER and the systemic corticosteroid must be given concomitantly, while the dose of the latter is gradually decreased. The usual rate of withdrawal of the systemic steroid is the equivalent of 2.5 mg of prednisone every four days if the patient is under close supervision. If continuous supervision is not feasible, the withdrawal of the systemic steroid should be slower, approximately 2.5 mg of prednisone (or equivalent) every ten days. If withdrawal symptoms appear, the previous dose of the systemic steroid should be resumed for a week before further decrease is attempted.

INITIAL DOSE – Adults: Two applications into each nostril in the morning (total daily dose: 400 µg).

Children (6 Years and Older): Two applications into each nostril in the morning (total daily dose: 400 µg). **This dose should not be exceeded in children.**

MAINTENANCE DOSE – Adults and Children (6 Years and Older): Use the lowest effective dose necessary to control symptoms. **Children Under 6 Years: Not recommended for children in this age group.**

Patients should be informed that the full effect of RHINOCORT TURBUHALER therapy may not become evident until 2 to 3 days of treatment have been completed. Full therapeutic benefit requires regular usage. Explain the absence of an immediate effect to the patient in order to ensure co-operation and continuation of the treatment with a regular dosage regime. Treatment of seasonal rhinitis should, if possible, start before exposure to the allergens. Concomitant treatment may sometimes be necessary to counteract eye symptoms caused by the allergy. In continuous long-term treatment, the nasal mucosa should be inspected regularly e.g. every six months. If the nasal passages are severely blocked, the drug may fail to reach the site of action. In such cases, a course of oral steroids or decongestants may be required before initiating RHINOCORT TURBUHALER therapy. The patient may not taste or feel any medication when using RHINOCORT TURBUHALER due to the small amount of drug dispensed. Although systemic effects are negligible at recommended doses, RHINOCORT TURBUHALER treatment should not be continued beyond three weeks in the absence of significant symptomatic improvement. RHINOCORT TURBUHALER should not be used in the presence of untreated localized infections involving the nasal mucosa.

AVAILABILITY OF DOSAGE FORMS

RHINOCORT TURBUHALER is a dry powder inhaler containing 200 doses of 100 µg of micronized budesonide. Each inhalation from a TURBUHALER will provide 100 µg of budesonide active substance; no additives or carrier substances are included. The TURBUHALER cannot be refilled and should be discarded when empty.

Product monograph available upon request.

REFERENCES: 1. Clissold SP. In: *Budesonide. Clinical experience in Asthma and Rhinitis*. ADIS Press, 1988: 51-64. 2. Sykes B, et al. *EAACI* 1985; 217: 3. McArthur JG and Higgins AJ. *Allergy* 1988; 43 (suppl 7): 114. 4. Rhinocort® Turbuhaler® product monograph. 5. Penttilä M, et al. *Rhinology* 1988; 26 (suppl 1): 148. 6. Bhatia M, et al. *Cur Med Res Opin* 1991; 12: 287-95. 7. Pedersen B, et al. Powder administration of pure budesonide for the treatment of seasonal allergic rhinitis. *Allergy* 1991; 46: 582-587.

ASTRA

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References

1. Dungal H. *Terminal care in family practice* [MCISc thesis]. London, Ont: Department of Family Medicine, The University of Western Ontario, 1988.
2. McCusker J. The terminal period of cancer: definition and descriptive epidemiology. *J Chronic Dis* 1984;37:377-85.
3. Federal/Provincial/Territorial Working Group on Home Care. *Report on home care*. Ottawa: Health Services and Promotion Branch, Health and Welfare Canada, 1990.
4. Hunt RW, Radford AJ, Maddocks I, Dunsmore E, Badcock KA. The community care of terminally ill patients. *Aust Fam Physician* 1990; 19(12):1835-41.
5. Todd CJ, Still AW. Communication between general practitioners and patients dying at home. *Soc Sci Med* 1984;18(8):667-72.
6. Still AW, Todd CJ. Role ambiguity in general practice: the care of patients dying at home. *Soc Sci Med* 1986;23(5):519-25.
7. Rosser JE, Maguire P. Dilemmas in general practice: the care of the cancer patients. *Soc Sci Med* 1982;16(3):315-22.
8. Lubin S. Palliative care: could your patient have been managed at home? *J Palliat Care* 1992; 8(2):18-22.
9. Coombe ME. Planning the possibilities: community-based palliative care in metropolitan Toronto. *J Palliat Care* 1987;2(2):35-40.
10. Bass MJ, Hoddinott S. *The changing face of family practice in London, Ontario*. London, Ont: Department of Family Medicine, The University of Western Ontario, 1986.
11. McWilliam CL, Burdock J, Walmsley J. The challenging experience of palliative care support-team nursing. *Oncol Nurs Forum* 1993;20(5):779-85.