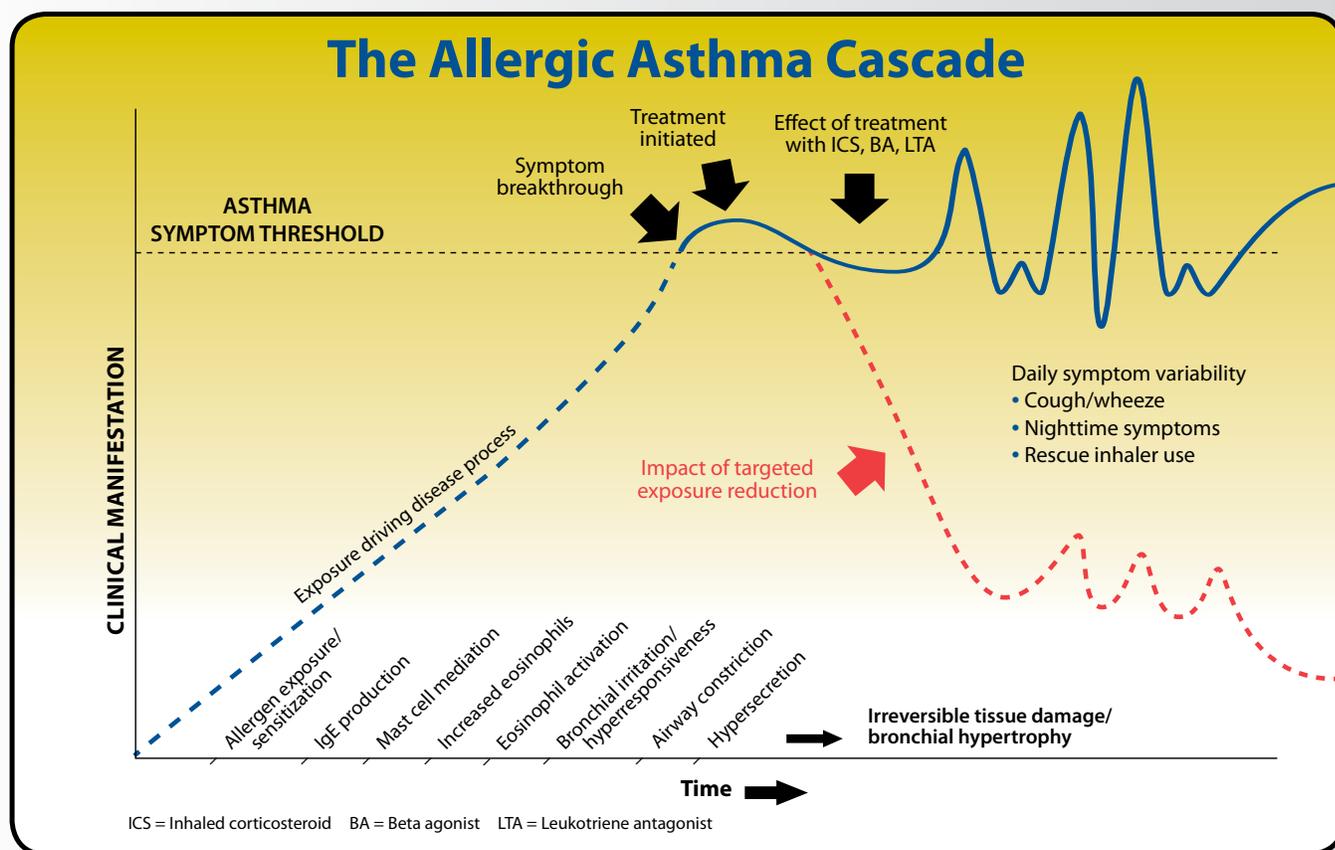




# Asthma

The presence of allergy drives the underlying disease process<sup>1-3</sup>

60% of adult asthmatics and up to 90% of asthmatic children have allergic triggers<sup>4-6</sup>



- Current medications do not change the natural course of disease progression<sup>7,8</sup>
- Reduce allergen exposure and preserve lung integrity<sup>1,9,10</sup>

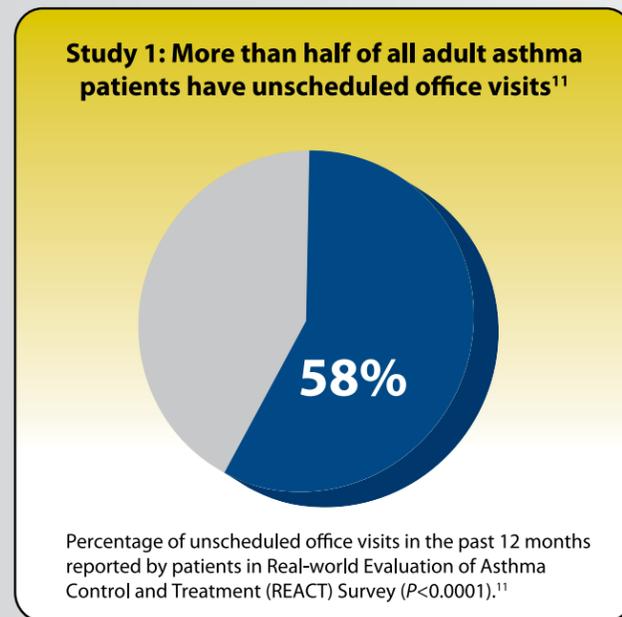
*“For successful long-term management of asthma, it is essential to identify and reduce exposures to relevant allergens....”<sup>1</sup>*

# Asthma

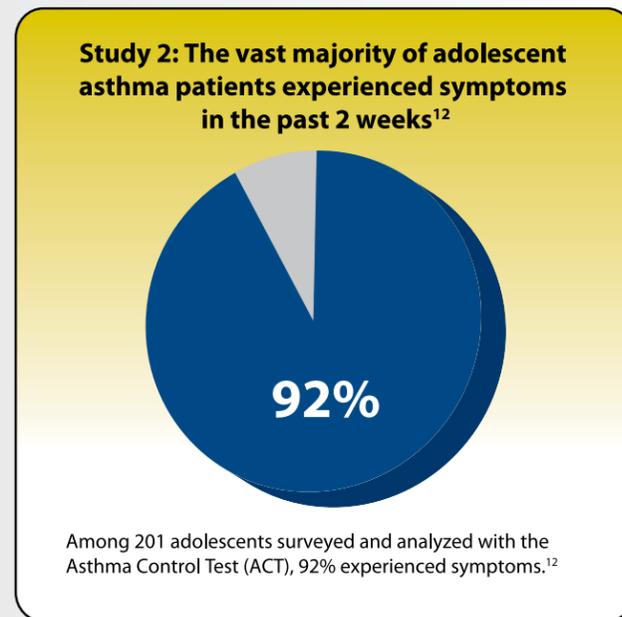
A complex progressive disease—treating symptoms is not enough!

## Medications are necessary but not always sufficient to prevent asthma symptoms<sup>1,7,8,11,12</sup>

- Despite treatment in accordance with established guidelines, a majority of asthma patients experience recurrent, persistent symptoms<sup>11</sup>



- Even among patients with controlled asthma, 43% had unscheduled office visits<sup>11</sup>
- The majority of patients visited their primary care provider 2 or more times in the past year for their asthma; some patients visited 7 or more times<sup>11</sup>



- 63% of patients reported they did not *feel* they had asthma symptoms<sup>12</sup>
- ACT analysis revealed that 92% of these same patients *had* experienced symptoms within the past 2 weeks<sup>12</sup>

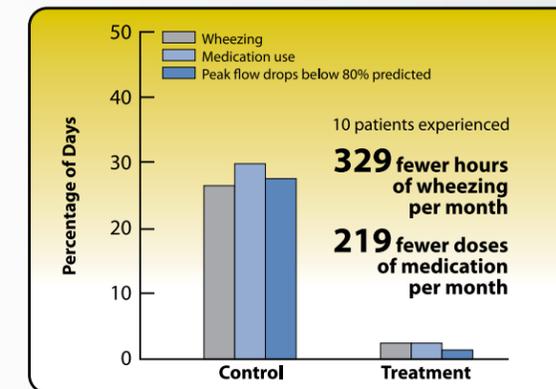
## NIH mandates that you assess for allergy in asthmatic patients<sup>1</sup>

- Allergen exposure **must be considered** for the treatment of asthma
- It is **essential to identify** and reduce exposure to relevant allergens
- Allergy testing is the **only** reliable way to determine sensitivity to perennial allergens

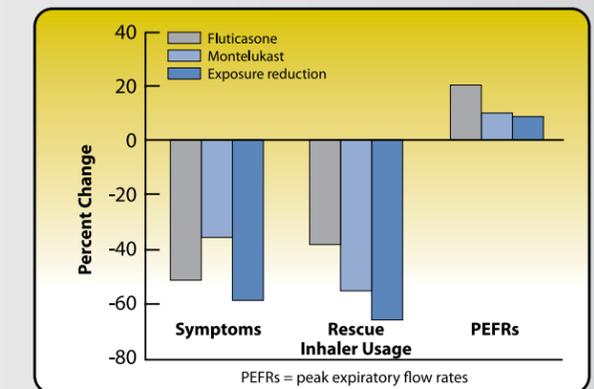
# Asthma

When you identify your patient's allergic asthma triggers, Targeted Exposure Reduction works!

## Reducing dust mite exposure reduces asthma symptoms—results of 2 studies<sup>13,14</sup>

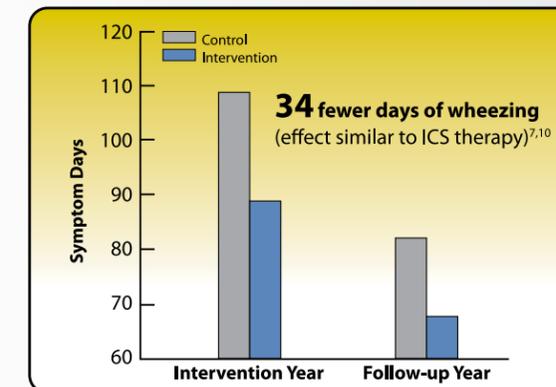


Dust mite exposure reduction dramatically reduced hours of wheezing and doses of medication.<sup>13</sup>

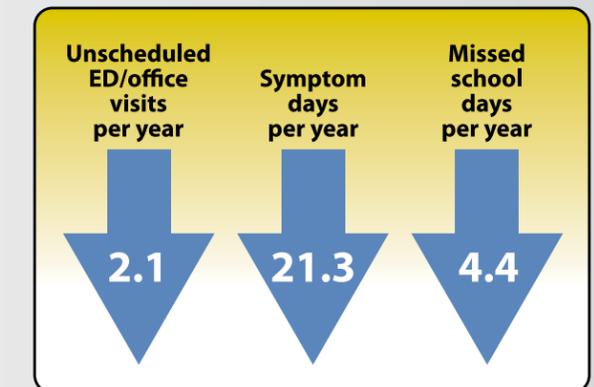


Symptom improvement was comparable to that achieved with pharmacotherapy.<sup>14</sup>

## Exposure reduction improves asthma management—results of an NEJM study<sup>10</sup>



Inner-City Asthma Study (ICAS). Controlled trial of environmental interventions (education and remediation) for exposure to allergens and environmental tobacco smoke. Symptom results per patient for intervention year and follow-up year.<sup>10</sup>



Targeted exposure reduction reduces symptoms.<sup>10</sup>

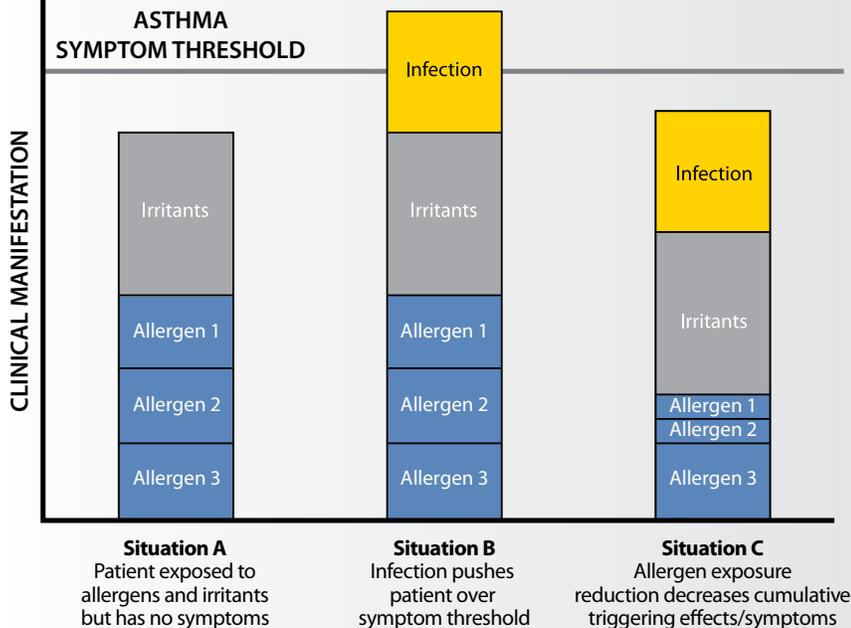
*“The first and most important step in controlling allergen-induced asthma is to advise patients to reduce exposure to relevant indoor and outdoor allergens to which the patient is sensitive....”<sup>1</sup>*

# Is underlying allergy contributing to your patient's asthma?

## Test to know!

### The cumulative effect of asthma triggers

Allergic exposure combined with infection can dramatically increase asthma symptom severity.<sup>15</sup>



Utilize ImmunoCAP® Specific IgE blood test to implement targeted allergen exposure reduction

#### Reducing cumulative allergen load

- Reduces symptoms<sup>1,10,13,14</sup>
- Reduces need for medication<sup>1,10,13,14</sup>
- Reduces inflammation<sup>1</sup>
- Reduces asthma morbidity<sup>10,16</sup>

#### Follow-up assessments allow you to

- Assess compliance with the patient's targeted exposure reduction plan
- Evaluate effectiveness of treatment plan
- Identify any major new offending allergens

### Test to know with ImmunoCAP

- Pre-selected regional inhalant allergen profiles offered by laboratories
  - Test for key perennial and seasonal allergic asthma triggers
  - Engineered to detect >95% of patients with allergy<sup>17-20</sup>
- No need to discontinue medications during testing
- Testing is easy—requires only a single blood sample

#### References

1. NIH. *Guidelines for the Diagnosis and Management of Asthma, 2007*. NIH publication 08-4051. 2. AAAAI. *The Allergy Report: Diseases of the Atopic Diathesis*. Milwaukee, WI: AAAAI; 2000. 3. Ahlstedt S. *ACI Intl*. 1998;10:37-44. 4. Allen-Ramey F, et al. *J Am Board Fam Pract*. 2005;18(5):434-439. 5. Milgrom H. AAAAI news release. Milwaukee, WI: American Academy of Allergy, Asthma & Immunology; June 18, 2003. 6. Host A, et al. *Allergy*. 2000;55:600-608. 7. Szefer S, et al. *N Engl J Med*. 2000;343:1054-1063. 8. Guilbert TW, et al. *N Engl J Med*. 2006;354:1985-1997. 9. Piacentini GL, et al. *J Allergy Clin Immunol*. 1996;97:1079-1084. 10. Morgan WJ, et al. *N Engl J Med*. 2004;351:1068-1080. 11. Peters SP, et al. *J Allergy Clin Immunol*. 2007;119:1454-1461. 12. Britto M, et al. Adolescent medicine abstract 4300.6. Presented at: PAS & ASPR Joint Meeting, May 4, 2008; Honolulu, HI. 13. Murray AB, et al. *Pediatrics*. 1983;71:418-422. 14. Eggleston PA. *Immunol Allergy Clin N Am*. 2003;23:533-547. 15. Murray CS, et al. *Proc Am Thorac Soc*. 2004;1:99-104. 16. Krieger JW, et al. *Am J Public Health*. 2005;95:652-659. 17. Sampson HA, et al. *J Allergy Clin Immunol*. 1997;100:444-451. 18. Yunginger JW, et al. *J Allergy Clin Immunol*. 2000;105:1077-1084. 19. Poon AW, et al. *Am J Manag Care*. 1998;4:969-985. 20. Choo-Kang LR. *Chest*. 2005;128:3093-3096.

You can't know until you test!  
[www.isitalergy.com](http://www.isitalergy.com)

ImmunoCAP is a US registered trademark of Phadia AB  
 ©2009 Phadia US Inc., a subsidiary of Phadia AB

**Phadia**  
 Setting the Standard

Phadia US Inc  
 4169 Commercial Avenue  
 Portage, MI 49002  
 800.346.4364

455066.01