travelers who frequently use inhaled bronchodilators before travel or participate in intensive trekking during travel are at increased risk to develop asthma attacks. Therapy should be intensified to achieve better disease control; intensive trekking should be discouraged.

**Reviewer’s Comments.** What really impressed me is that these travelers took vacations for a “median duration of 13 weeks.” Who’s at home doing all the work while these guys are trekking for months at a time? It would appear that the combination of poorly controlled asthma (ie, frequent bronchodilator use) combined with the heavy exertion during treks was a nasty combination for inducing attacks of asthma. It would also seem that in anticipation of travel involving heavy exertion such as high altitude treks, asthma control really needs to be tightened up or these patients might be (and you knew this was coming) “too loose to trek.”

**THE IMPACT OF FOLLOW-UP PHYSICIAN VISITS ON EMERGENCY READMISSIONS FOR PATIENTS WITH ASTHMA AND CHRONIC OBSTRUCTIVE PULMONARY DISEASE: A POPULATION-BASED STUDY**

**Sin DD, Bell NR, Svenson LW, Man SF. Am J Med. 2002;112:120–125**

**Purpose of the Study.** The purpose of this study was to examine the relation between follow-up office visits after emergency discharge and the risk of emergency readmissions in patients with asthma or chronic obstructive pulmonary disease (COPD).

**Study Population and Methods.** We used population-based data to identify all patients in Alberta, Canada, who had at least 1 emergency visit for asthma or COPD between April 1, 1996, and March 31, 1997 (N = 25 256). A Cox proportional hazards model was used to estimate the adjusted relative risk (RR) of a repeat visit to an emergency department (ED) within 90 days of an initial emergency visit in patients who did or did not have an office follow-up within the first 30 days.

**Results.** There were 7829 patients (31%) who had an office visit during the 30 days after their initial emergency encounter. Follow-up visits were associated with a significant reduction in the 90-day risk of an emergency readmission (RR: 0.79; 95% confidence interval [CI]: 0.73–0.86). Sensitivity analyses showed that a follow-up visit was inversely associated with a repeat emergency visit after adjusting for age, sex, area of residence, and income.

**Conclusions.** Although these data should be interpreted with caution because of missing information on factors such as quality of care, they suggest that follow-up office visits are effective in reducing early relapses in patients who have been recently treated in EDs for asthma or COPD.

**Reviewer’s Comments.** These results come as no surprise to those of us in office practices. I try to have telephone contact within 24 hours and an office visit within 72 hours for asthmatics treated in an ED for an attack of asthma. Unfortunately, in this country too many patients don’t have an office to follow-up with (which is why they used the ED in the first place).

**A PROSPECTIVE MULTICENTER STUDY OF FACTORS ASSOCIATED WITH HOSPITAL ADMISSION AMONG ADULTS WITH ACUTE ASTHMA**


**Purpose of the Study.** The authors sought to determine patient characteristics associated with hospital admission after emergency treatment for asthma, and whether disposition guidelines are followed.

**Study Population and Methods.** The authors performed a prospective multicenter cohort study involving 64 emergency departments in the United States and Canada. Consecutive adult patients with asthma exacerbations were interviewed, and their charts were reviewed using standardized protocols. Telephone follow-up at 2 weeks determined relapse.

**Results.** Of 1805 patients, 363 (20%; 95% confidence interval [CI]: 18%–22%) were hospitalized. Among patients with severe exacerbations (final peak flow <50% of predicted), 122 (49%; 95% CI: 43%–55%) were hospitalized. Admission was associated with final peak flow, female sex, non-white race, severity of chronic illness, and severity of exacerbation. Admission predictors were similar regardless of hospital funding, region, or size. Among patients with mild or moderate exacerbations of asthma (peak flow ≥50% predicted), the likelihood of admission was associated significantly with the number of predefined risk factors for death from asthma. Of patients who were discharged from the emergency department, 62 (5%; 95% CI: 4%–6%) relapsed within 72 hours. Relapse was not associated with final peak flow (P = .39).

**Conclusions.** Associations between patient characteristics and disposition were similar across sites. Despite guidelines to the contrary, half of patients with final peak flow <50% were discharged. After emergency department treatment and discharge, short-term relapse was uncommon among patients with asthma, suggesting that strict peak flow cutoffs may be unnecessary if risk factors in patients with mild or moderate exacerbations are considered.

**Reviewer’s Comments.** Results of this and other similar studies suggest that rational criteria for hospital admission can be established for patients with attacks of asthma. It’s good to see that emergency departments have developed admission criteria that extend beyond just peak flow measurements.

**EPIDEMIOLOGY**

**CHILDHOOD VACCINATIONS AND RISK OF ASTHMA**


**Purpose of the Study.** A few previous studies have suggested that childhood vaccines may increase the risk of asthma, especially whole cell pertussis vaccine. The aim of this study was to evaluate the suggested association between childhood vaccination and risk of asthma.

**Study Population.** A cohort of 167 240 children enrolled in 4 large health maintenance organizations in the western United States was followed from birth until at least 18 months to a maximum of 6 years.
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Allen Adinoff

Pediatrics 2003;112;478

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