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Richard Parker

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Editorial Note on Pulmonary Disorders:

Richard Parker*

Department of Pharmacology research, Kesi Reddy college of pharmacy, Guntur, E-mail: Richard.Parker@gmail.com

*Corresponding author: Richard Parker, Department of Pharmacology, Kesi Reddy college of pharmacy, Guntur, E-mail: Richard.Parker@gmail.com

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Abstract

Respiratory illness is a common problem in the United States. Many times, people are genetically more likely to get respiratory conditions, but your work place or environmental exposures could also play a big role. One thing is for sure, smoking is the most common cause of respiratory disease. Chronic bronchitis is a form of COPD emphasized by a chronic cough. Usually people cough up sputum (mucus from the lungs), especially in the morning. Dr. Meyer says this happens because mucus glands in the airways increase output, and patients have to cough that extra secretion out. Since chronic bronchitis is a form of COPD, it's treated the same way. There are so many respiratory diseases but here we are discussing only top majorly effecting disorders they are Asthma, Chronic Obstructive Pulmonary Disease, Chronic Bronchitis, Emphysema, Cystic Fibrosis/Bronchiectasis, Pneumonia, Pleural Effusion.

Keywords: Pulmonary Disorders, Pneumonia, Chronic Obstructive, Emphysema.

INTRODUCTION:

Asthma is a long-term lung disease. This causes inflammation and narrowing of your airways and makes it difficult to breathe. Severe asthma can make it difficult to speak or be active. You might hear your doctor call it as chronic respiratory disease. Some people refer to asthma as "bronchial asthma". Asthma is a common chronic childhood disease. In the United States alone, asthma affects approximately 5 million children, with an estimated annual cost of over $ 4 billion, and asthma prevalence is increasing. Adoption and adherence to asthma guidelines is still far from optimal. Strategies for improving clinical outcomes depend heavily on the training of primary care physicians. In busy primary care practices, doctors lack the time to educate parents about preventive asthma management plans. It is therefore important that in addition to doctors, other medical personnel such as nurses and nurse practitioners are involved in patient / family education to improve asthma self-management. Once trained, they can help implement preventive clinical management plans, educate patients and their families, and ensure patients are receiving appropriate treatment to achieve adequate asthma control.

We have been working on this model for four years in our establishment and I can share the results and the results. The relationship between silent gastroesophageal reflux disease (GERD) and respiratory problems such as persistent wheezing in infants is not well established. In 90's we assessed the incidence of GERD in 84 otherwise healthy infants referred to the Pediatric Pulmonary Medicine Division at Kosair Children's Hospital for daily wheezing assessment, and we monitored their clinical course for 18 months. All underwent 24-hour esophageal pH studies to assess GERD. The pH probe study was performed at an average age of 8.74 ± 4.6 months. Infants with a positive GER study were treated with an H2 receptor antagonist (H2RA) and a prokinetic agent for a mean duration of 5.6 +/- 2.4 months. At first 3 weeks follow up the oesophageal pH studies, infants treated with H2RA and those who did not have GERD but continued with daily wheezing started with flunisolide nasal solution (0.025%) administered by nebulizer (125 mcg tid).

Infants in both groups were followed every 1 to 2 months for an average of 18 months and, if clinically improved, attempts to decrease their daily asthma medication were made. 64% studies of esophageal pH positive (GER-positive group), 44% had no gastrointestinal symptoms suggestive of GERD. Thirty patients had studies of normal esophageal pH (GER negative group). Thirty-five of the 54 infants (64.8%) with GERD were able to stop all daily asthma medications within 3 months of starting anti reflux therapy, while none of the infants without GERD were able to stop daily asthma medication during the follow-up period (P <0.0005). We conclude that silent GERD is common in infants who wheeze daily, and that controlling GERD improves morbidity and decreases the need for daily asthma medication.

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