I NTERNATIONAL
S TUDY OF
A STHMA AND
A LLERGIES IN
C HILDHOOD

Newsletter - March 1994

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The Newsletter

If you have any items for inclusion in the next newsletter, please let me have these by 4 May 1994. *IA*

SHARE WITH A COLLEAGUE !!

In the interests of conservation of both money and trees we ask that the receiver of this newsletter copies and distributes it for other colleagues at the same address.

Excerpt I from "Organisation of ISAAC Study"

Collaborating Centres

The responsibilities of the collaborating centre are to:

- complete the registration form
- liaise with the national coordinator
- carry out Phase I according to the protocol in the manual
- forward a "clean" data set to the national coordinator

..... *more to follow on page 2*

INTERNATIONAL VIDEO QUESTIONNAIRE

An international version of the video questionnaire has recently been developed for the ISAAC programme. This international version, which has video scenes of children from different ethnic groups, replaces the all-Caucasian video for use by participating centres.

Two of the sequences have been kept from the all-Caucasian version of the video (the first sequence of asthma at rest and the third sequence of waking with wheezing) to provide standardisation with those centres that are already using this video. The other sequences have been refilmed with children from Asia and the Western Pacific to enable one composite international video to be produced. The original video may continue to be used in centres who are already using it, or in centres with a majority of "European" children.

The other change in the use of the video is that there will be no written or spoken word on the videotape. Instead, the research worker who administers the video questionnaire will read out the instructions in their local language and the children will complete the questionnaire which likewise has been translated. These modifications will overcome the most difficult problem of attempting to develop the video questionnaires in every language for all ethnic groups who will be participating in this study.

The international video is available in both PAL and NTSC, and will be sent to all participating centres which register in the ISAAC programme.

Richard Beasley
Phase One Implementation Subcommittee

ISAAC MANUAL

The manual has been reprinted in Münster. It is available directly from Stephan Weiland and Ulrich Keil:

Institut für Epidemiologie und Sozialmedizin
Westfälische Wilhelms Universität
Von Esmarch Straße 56
D-48129 Münster ph: (49) 251-835 396
GERMANY fax: (49) 251-835 300

or from your Regional Coordinator

ISAAC CODING MANUAL

This is issued to collaborating centres once data collection is under way. It is available from Stephan and Ulrich in Germany.

NEWS FROM INVESTIGATORS IN COLLABORATING CENTRES

Spain

All the centers in Spain are on the move. Cartagena and Barcelona has recently finished Phase One data collection. Pamplona started in December, and Bilbao and Valladolid will do it in January. Bilbao has received a $US20,000 grant from the "Fondo de Investigación Sanitaria" (Health Research Funding Institute). Valencian Health Service will pay for the expenses generated by Phase One in Castellón. We are expecting to know about our coordinated request during the weeks coming.

- *Luis García-Marcos Alvarez (Fax: (34) 68-527 497)*
  National Coordinator for Spain

NEWS FROM INVESTIGATORS IN COLLABORATING CENTRES ctd...

Peoples Republic of China
Four centres are interested in ISAAC Phase One and are trying to obtain funding from a pharmaceutical company.

• *Chen Yu-zhi*
Beijing

Uruguay
The plan is to start ISAAC Phase One in March 1994.

• *Dolores Holgado de Cuesta*
Montevideo

Asia-Pacific
There is one confirmed centre in Singapore, and probably one each in Japan and Korea. A regional meeting is planned for April or May. • *Chris Lai, Hong Kong*
Regional Coordinator

Northern & Eastern Europe
Estonia: Phase One, both age groups started in January 1994 in Tallinn and Narva (predominantly Russian speaking)
Latvia: Phase One, both age groups planned. Latvian translation approved. Russian questionnaire from Estonia to be used.
Poland: 13-14 year age group near completion in Krakow.
Russia: 13-14 year age group completed in Moscow, 6-7 year olds planned. Russian versions used in Moscow and Estonia/Latvia compare well.
Sweden: Both age groups under way in Linköping and Uppsala.
There is the possibility of extending Phase One centres to include Albania, Bulgaria, Denmark, Finland, Georgia, Kazakstan, Norway, Romania and Tjeck Republic.

• *Bengt Björksten*
Regional Coordinator

New Zealand
We had a very useful national meeting in Auckland on 22 February 1994. Data entry is complete. The flurry of activity in organising our meeting somehow displaced the ISAAC newsletter from February to March, especially coming after January, when almost all of New Zealand is on holiday! Investigators and field workers representing the 6 centres (Auckland, Bay of Plenty, Christchurch, Hawkes Bay, Nelson and Wellington) reviewed data checking procedures. We had a first look at data analysis and considered possible papers. We were able to have a preliminary look at seasonal, regional and ethnic differences.

A lot of discussion centred around identification of non-participants, especially children, who may have left school during the survey period. Simple demographic data on non-participants (age, sex) is available in all centres, and ethnic identification from school records in most centres.

Very few parents actively refused participation in the study. The largest number of non-participants were those returning blank forms, even after a third try.

It may be important to know if the questionnaire for 6-7 year olds was completed after the first issue or a subsequent issue.

For each questionnaire we have documented the date of its completion, date of receipt and whether it was a first, second or third issue. We encourage others to collect this information which may be important in interpreting the results.

• *Innes Asher*
National Coordinator

ISAAC Phase 2 AIRWAY RESPONSIVENESS (AR) MODULE

The AR satellite meeting (Auckland, December 1993) recommends that a single method using saline hyperosmolar challenge should be adopted as the core method for measuring airway responsiveness in Phase 2 of ISAAC. Sandra Anderson and Colin Robertson are writing a draft protocol based on the laboratory method developed by Sandy. This will include detailed instructions and specifications for the various equipment required.

For those wishing to undertake other methods the exercise protocol developed by Michelle Haby (Sydney) and the Yan method for field studies using De Vilbiss hand held nebulisers with histamine or methacholine were recommended.

The workshop members noted that a suitable method should fulfil the following criteria:

- easily standardised worldwide
- reproducible
- high specificity for asthma
- have a dose response relationship

After considering cold air, PEF variability, exercise and methacholine or histamine the workshop agreed unanimously that methacholine or histamine would be the agent of choice, but was impractical now on the grounds of availability, subject acceptability and approval from health authorities and ethical committees. The hyperosmolar challenge provides the only suitable alternative fulfilling the above criteria.

• *Julian Crane, AR Module Leader*
ISAAC Steering Committee

Excerpt II from "Organisation of ISAAC Study"
General Approach
The organisation of ISAAC consists of four levels:
- the Steering Committee
- National Coordinators
- Regional Coordinators
- Collaborating Centres

The general approach is that, in a particular region, a regional coordinator is appointed, who then recruits national coordinators. A regional meeting of national coordinators is held to organise the implementation of Phase I in the region. The national coordinators then complete the recruitment of collaborating centres in their own countries and a national meeting is held prior to the start of data collection. This general approach is flexible. For example, many European centres have already started data collection, or are about to start, and in some instances a national meeting has already been held.

...more to follow in next newsletter

GUIDELINES FOR THE TRANSLATION OF QUESTIONNAIRES . . . . . *Stephan Weiland*

The following steps are recommended for the translation of questionnaires:

1. The questionnaires are translated by one or more persons who are bilingual and familiar with the area in which the questionnaire will be used.

2. In order to find the most appropriate translation for tricky terms, eg 'wheezing' or 'whistling in the chest', it is proposed to:

   a) Ask local doctors about local words to describe these terms.

   b) Ask children with asthma and parents of children with asthma how they would describe the breathing during an asthma episode.

   c) Show the video and ask children with asthma and parents of children with asthma how they would describe the breathing of the children and adolescents in the video.

   d) Submit a list of possible descriptors to children with asthma and parents of children with asthma and ask them to indicate, eg using a rating system, which description(s) they favour best.

3. The most appropriate translation should be agreed upon among a group of national experts on the basis of 2a-2d. The national questionnaires should allow for differences in the wording of questions according to the local use of the language.

4. The questionnaires should be translated back into English by an independent translator. Modifications should be made if necessary.

5. The questionnaires should be tested in populations representative of the study populations. Modifications should be made if necessary.

6. Steps 2 to 5 are repeated if necessary.

Comment: The translation of questionnaires is a key issue for the validity of comparisons involving non-English speaking countries. It is recognised, however, that the steps 2c and 2d may be too costly for some countries or centres and that those countries or centres may decide to leave them out. The translated questionnaires must have the same structure and logic as the original. In addition, we draw the attention to the need that the translations must be understood by the children and parents. Thus, the translations should apply the language which is used by the children and parents themselves and experience from Germany shows that it may well differ from the terminology of medical professionals (1).

1. Weiland SK, von Mutius E, Fritzsch Ch et al: The language of pediatric asthma patients: Verbal descriptors of symptoms in Germany. Monattsschr Kinderheilkd (1993) 141:878-882.