Asthma Action Plans: New literature regarding what to do in the ‘yellow zone’

Asthma action plans (AAPs) are the cornerstone of guided self-management. Coupled with appropriate medical therapy, the evidence for their efficacy has been highlighted in several systematic reviews (1, 2). The Canadian Thoracic Society (CTS) 2012 Asthma Guideline Update (3) reviewed the evidence for escalating therapy in the ‘yellow-zone’ of an AAP, based upon the maintenance (‘green zone’) therapy. In doing so, 15 formal evidence-based recommendations were made regarding intermittent inhaled corticosteroids (ICS), escalating ICS, starting or escalating a fixed-dose ICS/long-acting beta-agonist (LABA) combination controller while using a fast-acting beta-agonist as a reliever, and the use of systemic steroids. One of the most important recommendations, based on level 2B evidence, was not to routinely double the dose of ICS in children and adults already on maintenance ICS monotherapy (3). Another recommendation, based on level 2C evidence, was to suggest trialing quadrupling or quintupling the ICS maintenance dose for 7 to 14 days – but only in a subset of individuals (adults 16 years of age and over who have had a severe exacerbation in the previous year) (3). Many gaps in evidence regarding what to do in the yellow zone were identified. Two recent articles were published in the prestigious New England Journal of Medicine which attempt to address two of these gaps, and investigate:

i) whether quadrupling the ICS dose in individuals with asthma who are 16 years of age and over reduces the use of oral corticosteroids or unscheduled health care visits (4), and

ii) the efficacy and safety of quintupling the ICS dose in children 5-11 years old with mild to moderate persistent asthma (5).
The study by McKeever et al. (4) was a randomized, unblinded, pragmatic multicentre trial of adolescents and adults with a clinical diagnosis of asthma, who were receiving an ICS +/- add-on therapy, and who had at least one exacerbation treated with systemic steroids in the previous year. Subjects were randomized to one of 2 symptom and peak expiratory flow (PEF)-guided 4-zone self-management plans, which were identical apart from the yellow zone instructions. In step 2 of the AAP (yellow zone), instructions for the intervention group were to increase use of the reliever medication and to quadruple the ICS dose in the intervention group, while the control group’s instructions were to increase use of the reliever medication and to continue the normal dose of ICS. The primary outcome measure was time to first severe exacerbation, defined as treatment with systemic steroid or an unscheduled health care visit. The subjects were enrolled primarily from primary care settings (81%), were mostly female (68%), on low-dose ICS (78%), plus add-on therapy with a LABA (70%). The time to first exacerbation was significantly decreased in the quadrupling group (Adjusted HR: 0.81 [0.71-0.92]; p=0.002). Overall, the proportion experiencing a severe exacerbation in the following year was 45% in the quadrupling group compared with 52% in the non-quadrupling group. Side effects (predominantly oral candidiasis and dysphonia) were more common in the quadrupling group. The authors report the number needed to treat to prevent 1 serious asthma exacerbation was 15.

This study had a number of strengths, including the size and representativeness of the participants, and generalizability of the findings, including to all ICSs with or without add-on LABA therapy and regardless of smoking status. However, lack of blinding was a major limitation. Participants’ and/or their physicians’ awareness of their treatment arm may have biased the primary outcomes of decision to seek urgent care or prescribe systemic steroids. The magnitude of benefit, while statistically significant, was less than anticipated (19% versus 30%), and was associated with more side effects in the upper airway.

In the same issue, the study by Jackson et al. (5) tackled a similar question but in children, 5-11 years old using a randomized, double-blind, parallel group design. All participants were prescribed low-dose fluticasone (44 mcg 2 puffs twice daily) as maintenance (‘green zone’) therapy and were provided a separate (blinded) yellow-zone inhaler to use, which was either the same low-dose fluticasone as used in the green zone, or high-dose fluticasone (220 mcg 2 puffs bid), for 7 days. Adherence was determined in a run-in period, and there were clear criteria for yellow-zone episodes based on reliever use and nighttime awakenings. The primary outcome was the rate of severe exacerbations treated with systemic steroids. The participants were on average 8 years of age, predominantly male (64%), white race (55%), with documented atopy to at least one aeroallegen (77%). The results were negative. There were no statistically significant differences in the rate of severe exacerbations between groups or any of the secondary outcomes, which included time to first exacerbation, rate of emergency or urgent care visits, symptom scores, or reliever use. The total glucocorticoid dose was 16% higher in the quintupling group, and their growth rate was adversely affected, particularly in children under 8 years of age (by 0.12 cm/year per yellow-zone episode; p=0.02).

This pediatric trial was well-designed, but several limitations merit comment. The number of yellow zone activations and exacerbations meeting criteria for systemic steroids were lower than anticipated, which reduced the power of the study to detect a difference between groups. As the authors point out (5), the results are only generalizable to children 5-11 years old with mild-moderate asthma who are adherent to low-dose ICS therapy.
There is limited high-quality evidence regarding what to do in the ‘yellow zone’ of an AAP. These two recent studies certainly add to the available literature. In this author’s opinion, the current CTS recommendations that cautiously suggest a trial of escalating ICS by 4-fold in adults 16 years of age and older, *but not in children*, at the onset of an acute deterioration in asthma control remain relevant. We should consider that at least part of the benefit of written AAPs within comprehensive self-management education programs may be to reinforce adherence with green zone therapy. Furthermore, apparent real-world effectiveness of ICS escalation may be influenced by non-adherence to green zone therapy, followed by adherence to yellow zone medication during exacerbations. Clearly, additional research is still greatly needed in this important area.

References

Cannabis, also known as marijuana, is derived from the Cannabis Sativa plant. It represents the most commonly used psychoactive drug in Canada. Cannabis can either be smoked (joint, blunt, spliff, or in a pipe), heated (bongs), or ingested orally (cookies, etc). The mode of administration will influence the intensity and duration of the effects of cannabis.

Despite the best efforts of government, law enforcement, and public health, marijuana prohibition has demonstrated little success in Canada. From 1985 to 2015, the prevalence of cannabis users in Canada has more than doubled (Rottmerman et al., 2018). Nearly 45% of Canadians have used cannabis at some point in their life, with 12% of individuals over the age of 15 consuming cannabis in the previous 12 months (Statistics Canada, 2017a). Of these Canadians that have used cannabis in the past 12 months, 33% of individuals have indicated that they used cannabis either daily or almost daily (Statistics Canada, 2017b). In 2018, the federal government will reverse its stance on cannabis control as it is expected to legalize, regulate, and restrict access to recreational cannabis use. While this decision to legalize recreational cannabis use could be advantageous from an economic perspective and is supported by the majority of the Canadian population (Angus Reid Institute, 2017), it could present several unexpected challenges to health practitioners and the public health sector.

The proportion of Canadian adolescents (15-19 years of age) that report using cannabis in the past 12 months is 20.6% (Statistics Canada, 2017a). Cannabis use among adolescents is related to their perceived risk; adolescents that perceive cannabis as having no risk of harm are more likely to use cannabis (Merrill 2015). Cannabis use among youth is of great concern for many health practitioners. Adolescence represents a period in which the brain has yet to reach full development. During this period, individuals may experience greater susceptibility to the effects of delta-9-tetrahydrocannabinol (THC), the primary psychoactive compound found in cannabis (Volkow et al., 2014). As cannabis use transitions from experimental, to occasional, to regular/heavy use, adolescents may find themselves at greater risk for impaired brain development, poor academic performance leading to fewer achievements, diminished cognitive functioning, discontentment with life, and increased vulnerability to psychiatric disorders (Volkow et al., 2014). Evidence has shown that the onset of cannabis use during teenage years increases the odds of developing a cannabis use disorder (Winters and Lee, 2008). As such, educating youth of the harm associated with regular/heavy cannabis use as well as restricting access of cannabis to these individuals is imperative.

While many health practitioners are knowledgeable of the effects of cannabis on mental health and cognition, less is known pertaining to the association between cannabis use and respiratory health (MacLeod et al. 2015). Evidence has shown that cannabis use is associated with an increase in coughing, wheezing/whistling in the chest, sputum production, and chronic obstructive pulmonary disease (Hancox et al., 2015; MacLeod et al. 2015). However, the association between cannabis use and risk of lung cancer is more controversial. One meta-
analysis reported a significant increase in risk of lung cancer among individuals smoking cannabis (Khalid et al., 2014), whereas a pooled analysis of 6 case-control studies found no association pertaining to the intensity or duration of cannabis use and lung cancer (Zhang et al., 2015). Although evidence suggests that cannabis use is associated with a decline in respiratory health, improvements in coughing, sputum production, and wheezing can be achieved through cessation of cannabis (Hancox et al., 2015). More research on the effects of cannabis on respiratory health would be beneficial as inhalation continues to represent the most common route of cannabis administration (Chatkin et al. 2017).

Over the last several decades, through legislation and policies, substantial progress has been made in tobacco control thereby leading to a declining trend in the prevalence of smokers. However, when recreational cannabis becomes legalized, there is growing concern that the public may become re-introduced to tobacco smoking as it could potentially become socially acceptable once again (Schwartz, 2017). Approximately 7 to 9% of cannabis users report current tobacco use (Hublet et al. 2015). Non-tobacco users could be introduced to tobacco through social networks of cannabis smokers in addition to experimenting with tobacco through mixing cannabis and tobacco. The potential for an increase in tobacco use, as a whole, also poses additional risk of harm for others through increased second-hand exposure to cannabis and tobacco (Schwartz, 2017). Furthermore, would legalization of cannabis present an opportunity for the tobacco industry to increase their profitability by manufacturing, distributing, and marketing cannabis products (Barry et al., 2014)? This is a question that needs to be addressed as it may have a substantial impact on future tobacco and cannabis control policies (Barry et al., 2014).

With legalization of recreational cannabis approaching, health practitioners need to consider how this change in policy will impact adolescents, the health of cannabis users, and established tobacco control policies. Undoubtedly, education will be essential in the prevention of not only cannabis use, but tobacco use as well. However, education is only one aspect of what is necessary to keep any harm associated with cannabis use at a minimal level. The Centre for Addiction and Mental Health makes the following recommendations for the legalization of cannabis: 1) requiring cannabis users to be a minimum age, 2) publicly controlled entities would manage the sale of cannabis, 3) marketing, advertising, and promotion of cannabis should include plain packaging which incorporates information on THC and cannabidiol content as well as any potential risks associated with using such products, 4) restrict/limit higher-potency formulations of cannabis, 5) pricing would need to deter individuals from using higher-harm cannabis products while simultaneously reducing their desire to acquire cannabis from illegal distributors. In addition, a proportion of any revenue collected from the legalization of cannabis should be allocated towards education, prevention, and treatment strategies, and 6) develop legislation to educate, prevent, and enforce driving while under the influence of cannabis (Crepault, 2017). By incorporating educational, preventive, treatment, research, and monitoring approaches, we can reduce any harm that is associated with the legalization of cannabis.

References:


The Global Initiative for Chronic Obstructive Lung Disease (GOLD) describes COPD as a common, preventable and treatable disease that is characterized by persistent airflow limitation that is usually progressive and associated with an enhanced chronic inflammatory response in the airways and the lung to noxious particles or gases. Exacerbations and co-morbidities continue to contribute to the overall severity in individual patients. COPD is the only chronic disease where mortality and morbidity continue to rise; and acute exacerbations of COPD are a leading cause of emergency department visits and hospitalizations in Canada. In a recent report from the Canadian Institute for Health Information (CIHI), 18% of COPD patients were readmitted once within the year and 14% twice within the year. In 2012/2013 within LHIN 4, the number of readmissions for COPD within 30 days of discharge was 19.3%.

- In the HNHB LHIN, 1 in 10 people over the age of 35 has COPD.
- In the HNHB LHIN, 1 in 5 people with COPD are readmitted to hospital for COPD within 30 days of discharge, and 1 in 3 are readmitted within 90 days.
- Difficulty breathing due to COPD is a leading cause of emergency department visits and hospitalizations in the HNHB LHIN and Canada.

The high rate of prevalence and readmission rates needed to be addressed with a focus on community resources and management for those living with COPD. In keeping with the Canadian Thoracic Society (CTS) recommendations to provide pulmonary rehabilitation, the LHIN recognized the need to provide community-based pulmonary rehabilitation, and hence, the Caring for My COPD program was created.

The Caring for my COPD program is based out of four Community Health Centres (CHCs) across the LHIN. The program was initiated at North Hamilton CHC in February 2014 with three additional sites – Grand River CHC (Brantford), Welland Centre de Santé Communautaire and Niagara Falls CHC having programs initiated by June 2014. An evaluation of the program was conducted at all sites with the results awaiting publication.

Using the principles of chronic disease management, the program offers a bundle of services that includes individual case management and a strong focus on self-management skills. Exercise and education are core components of the 10 week program.

Caring for My COPD offers services tailored to each person’s unique and specific needs. The 10 week program begins with a comprehensive intake visit with the Certified Respiratory Educator (CRE) that includes spirometry, 6 minute walk test, overview of medical history, review of medications, teach back on use and role of inhalers, smoking cessation if relevant, baseline questionnaires (e.g., MRC, CAT, DASS), introduction or review of action plans, and identification of any limitations or barriers that may affect participation in the program. The program is delivered by a multi-disciplinary team that includes: Registered Kinesiologist, Physiotherapist, Occupation Therapist, Social Worker, and Dietician and in some sites, access to a Psychologist. The goal of the program is to improve quality of life and reduce hospital
admissions and ER visits. By partnering with participants to meet their educational, self-management and exercise needs, we work towards attaining these goals. Participants attend weekly education sessions and supervised exercise twice a week. Family members and/or support people are welcome to attend the education sessions. Topics covered include, but are not limited to: anatomy, medications, action plans, exercise, nutrition, managing breathlessness, anxiety, coping strategies, and energy conservation.

Following successful completion of the Caring for My COPD program, graduates are invited to continue to attend maintenance exercise classes and other programs. With the assistance of the health care teams, graduates have established peer-led social support groups that meet at the centers.

For example, North Hamilton CHC graduates have the opportunity to participate in the Take a Breath (TAB) singers group that perform across the city at special events. Take a look! https://www.youtube.com/watch?v=Rwvuc27VmUg

Who is eligible to attend the Caring for My COPD program?
Those who have:
- a confirmed diagnosis of COPD with a FEV1/FVC ratio of < 0.70
- modifiable COPD
- medical stability to participate in exercise
- the willingness to participate and the ability to travel to attend the program

Who is not eligible to attend?
Those who:
- reside in long-term care facilities
- are not medically stable
- have unconfirmed COPD

Referral sources
- Hospitals
- Primary Care, Respirology, Cardiology, other specialists
- Respiratory Rehabilitation centers
- Hospital Discharge/Outreach Programs
- Self-referrals – most responsible physician will be contacted for the referral

References
3. Canadian Institute of Health Information. Health Indicators 2008. Ottawa
The Role of Radon in the Geographies of Lung Cancer and COPD Mortality

Radon is a colourless, odourless heavy gas that permeates into basement floors and wall joints accumulating first in the lowest rooms of a building. Radon poisoning is the second leading cause of fatal lung cancer, second only to smoking and leads to an estimated 3200 deaths per year (Health Canada 2012). Radon can also be linked to increased mortality in chronic obstructive pulmonary disease (COPD) (Turner et al. 2012). Despite these risks, many of us are unaware of the danger to radon exposure in our homes. Radon gas is emitted from naturally occurring uranium in the rocks, soil and water beneath our homes and other built structures. While most rocks, soil and water contain some uranium, levels can vary significantly depending on the geological characteristics of the area. Exposure to radon is primarily a problem indoors—the difference in air pressure inside relative to the outdoors draws the radon gas in and the enclosed space of a basement keeping it trapped there. As we spend most of our time indoors, this environment represents a significant source of daily radon exposure among Canadians.

Current recommendations from Health Canada indicate that safe concentrations of radon in living areas of our homes should remain below 200 Bq/m³ (becquerels per cubic meter). While studies have shown that most Canadian homes do not likely exceed this 200 level, other homes in some areas (depending on underlying geologic characteristics, age of buildings, construction styles/quality and other factors), can far exceed these levels. Values as high as 5600 Bq/m³ have been found in an Ontario home based on a recent survey by Health Canada (Health Canada 2012).

Estimating radon exposures:
With the recognition of the health risks associated with radon exposure, there is growing international interest in assessing exposures. The best way to do this is to test our homes. Long term (> 3 months) testing using an “alpha track” (industry standard) is the recommended instrument for radon measurement. This device is about half the size of a hockey puck but much lighter. The “alpha track” is placed in the lowest room of your house where you spend at least 4 hours each day. The Lung Association of Ontario currently sells radon testing kits here: www.lungontario.ca/radon. In most countries, including Canada, only a small fraction of homes have been tested due to the high costs associated with doing this on a wide scale. As a result, residential radon data is sparse. To address this problem, researchers have developed methods to estimate exposures of populations by modelling. One example being used is the random sampling of residential radon to characterize the larger population’s
exposure. However, many of these models aggregate their residential radon values on administrative and health boundaries (unrelated to the source of radon - which is geological).

This is where geologically based predictive models can be effective. Radon potential geogenic risk maps (RPGR-maps) use the knowledge that radon is of geological origin (geogenic). It is a viable method that is being used with growing adoption internationally. Tested- RPGR maps use a sampling of radon residential values (tested radon concentrations in residents) and aggregate the data on geological boundaries.

Research at Ottawa University Department of Geography, Environment and Geomatics is currently underway to map the potential radon exposure of a high population density area (Ottawa, Ontario) using an innovative method of –tested RPGR-map. Testing the model (map) will be done using two surveys: 1) residential radon of 350 randomly selected residents in Ottawa and 2) an additional survey of a subset population- rental basement apartment radon values. This second survey will not only add valued data points for testing the Ottawa RPGR map but will also help to characterize radon hazard potential in a potentially lower socio-economic population (basement apartment dwellers).

Two observational retrospective case-control epidemiological studies will be undertaken to study health effects of radon exposure in a very large population area (all of Southern Ontario). The first study will link radon exposure and lung cancer mortality rates and the second will assess radon exposure and COPD mortality rates. A published tested-RPGR of Southern Ontario (Ford et al. 2015) will provide an ecological indicator of case and control’s radon exposure risk and will be used for both studies. The epidemiological study designs will incorporate the use of case/control pooled data from health administrative databases over twenty years of data collection. This data will be linked to radon dose (ecological radon exposure assigned using the test-RPGR-map of (Ford et al. 2015) and temporal variations.

This will be the first time in Canada that a tested-RPGR model will be used to estimate radon exposure and its relationship between exposures and lung cancer and COPD mortality. The results of this research will have implications for building codes and land-use regulations. In addition, it will be used to inform educational strategies aimed at raising awareness about radon risks and strategies to reduce exposures.

For further information on the research, please contact author Stephanie Woodend at sdoum090@uottawa.ca
For further information on radon, you can visit The Lung Association website: http://lungontario.ca/protect-your-breathing/air/radon/

References


My 50 year old patient with asthma is currently taking Symbicort 200/6 mcg 2 puffs twice/day. According to the latest evidence, what should the step-up therapy regimen be in the yellow-zone of her action plan?

An asthma action plan (AAP) is an individualized written plan produced by a health care professional for a patient with asthma, providing education and guidelines for self-management of worsening symptoms in a “traffic light” configuration. [1] A “green zone” describes adequate control and corresponding baseline medications, a “yellow zone” describes loss of control and corresponding instructions for therapeutic intensification, and a “red zone” indicates severe symptoms that should prompt immediate medical assistance. [2] The functional principle of this tool is very simple: if patients know what to do when their asthma starts to worsen, and do it quickly enough, they can avert a full-blown asthma flare, and with it, the need for urgent healthcare and systemic corticosteroids.

Throughout the 1990s, this intuitive concept was put to the test in a multitude of randomized-controlled trials (RCTs). In 2000, and again in 2003, Gibson and colleagues systematically reviewed these data and presented results in a Cochrane review of 18 RCTs, concluding that use of a written AAP in conjunction with education and regular clinical review significantly reduces hospitalizations [relative risk (RR) 0.64], emergency room visits (RR 0.82), unscheduled visits to the doctor (RR 0.68), number of days off work or school (RR 0.79), and nocturnal asthma symptoms (RR 0.67), and significantly improves quality of life (standard mean difference 0.29). [3] Furthermore, AAP use has been associated...
with a 70% reduction in mortality.[4] Accordingly, as early as 1996, Canadian asthma guidelines [5] and others across the world have recommended that each asthma patient should receive a written AAP.

Studies have evaluated different inhaled corticosteroid (ICS) dose intensification regimens for the “yellow zone” (acute loss of control zone) of the AAP. The evidence demonstrates that increasing the ICS dose by a factor of 4 to 5 fold for 7 to 14 days reduces the need for oral corticosteroids, whereas doubling the dose is ineffective.[6] This recommendation can be found in Canadian, United Kingdom, and International guidelines.[7] However, in this particular clinical scenario, operationalizing this recommendation is more challenging because the patient is on a single combination inhaler containing both an ICS (budesonide) and a long-acting beta agonist (LABA) (formoterol).

Recent guidelines do offer guidance for patients taking budesonide/formoterol in a regimen consisting of a maintenance dose that can be adjusted for acute loss of control (“adjustable maintenance dose - AMD”). The latest (2012) CTS Asthma Guidelines recommend increasing “to a maximum of four inhalations twice daily for 7-14 days” (with no differentiation between patients on 1 puff bid versus those on 2 puffs bid at baseline).[6] Somewhat divergently, the 2018 Global Initiative for Asthma (GINA) document recommends to “quadruple maintenance dose” across the board, but with a proviso not to exceed “maximum formoterol 72 mcg/day.”[8] Upon further review, the studies cited for these recommendations compared yellow zone dose intensification in patients on budesonide/formoterol-AMD to a higher baseline fixed dose of budesonide/formoterol. Not surprisingly, these studies showed that AMD dosing with yellow zone dose intensification is preferred to fixed dosing with no adjustment in the yellow zone. However, they did not answer the question as to which approach is best in the yellow zone.[6]

In our case, given that the patient is already on two puffs twice daily of budesonide/formoterol, the CTS recommendation to increase to 4 puffs twice daily would constitute a doubling of the ICS dose, which has been shown in previous studies to be insufficient, and which guidelines discourage. On the other hand, the GINA recommendation to quadruple is impractical, as it would result in a daily formoterol dose of 96 mcg, which is well beyond their recommended limit of 72 mcg and the Canadian regulatory daily dose limit of 48 mcg. At the same time, the patient’s baseline total daily budesonide dose is 800 mcg, whereby quadrupling would result in a total daily dose of 3200 mcg, which is also well above the Canadian regulatory daily dose limit of 2400 mcg for budesonide.

In a recent review attempting to address challenging AAP scenarios such as this one, authors reported evidence that budesonide 2400 mcg per day is non-inferior to a course of oral corticosteroids (OCS) in patients experiencing asthma exacerbations.[7] Accordingly, they suggested that adding sufficient budesonide to increase the patient’s daily dose to 2400 mcg (by adding a separate budesonide inhaler) would represent an appropriate and evidence-based asthma action plan for this patient. The easiest way to practically achieve this would be to maintain the original budesonide/formoterol and add budesonide 400 mcg 2 puffs BID. Considering the baseline daily budesonide dose of 800 mcg (in budesonide/formoterol 200/6 mcg 2 puffs BID), this addition of 1600 mcg of budesonide would attain the target total daily dose of 2400 mcg/day of budesonide.
As is evident in this example, changes to asthma medications in the yellow zone of AAPs can be achieved in various ways, including adjusting the number and/or frequency of inhalations, adding new inhalers, or temporarily changing the baseline inhaler to a new one. A set of principles for “formulating” these yellow zone prescriptions have been proposed based on best evidence with the intent to maximize patient adherence and to minimize dosing errors.[7] Clinicians should attempt to maintain the original baseline medication as part of the yellow zone whenever possible (to reinforce the message that baseline controller medications should never be stopped); use the same frequency and device type as the baseline controller medication; increase the number of inhalations of the baseline controller rather than prescribing a new inhaler (where possible); and minimize the number of inhalations required (especially avoiding prescriptions requiring more than 4 inhalations per use). The same review proposed a practical bedside chart which lists common baseline (green zone) medication regimens, and corresponding yellow zone dosing recommendations.[7] An updated version of this chart, as well as a more detailed explanatory document are available for download at http://olapep.ca/resources/

References

Upcoming Events

Health Quality Transformation – Quality Matters October 17, 2018
Metro Toronto Convention Centre

AFHTO 2018 Conference October 24 & 25, 2018
Westin Harbour Castle - Toronto

The Lung Association TB Conference – Looking Forward
November 20-21, 2018 Chelsea Hotel - Toronto

Respiratory Health Forum January 23-24, 2019
Toronto Downtown Marriott Hotel

Better Breathing Conference January 24-26, 2019
Toronto Downtown Marriott Hotel