Annex 3

Interval management of asthma in children

DIAGNOSIS

- Asthma should be suspected in any child with expiratory wheezing
- The diagnosis of asthma in children should be based on:
  - The presence of key features, and careful consideration of alternative diagnoses
  - Assessment of the response to treatment
  - Ongoing monitoring, questioning the diagnosis if management is ineffective
- The diagnosis of asthma in children <5 years old is entirely clinical and pulmonary function testing is not recommended.
- In children ≥5 years old, objective tests should be used to confirm a diagnosis of asthma before long term therapy is started
- All children with asthma should be encouraged to attend one GP for their ongoing asthma management

ASSESSMENT OF PATTERN

Infrequent Episodic	Frequent Episodic	Persistent
• Attacks ≥6 weeks apart • Attacks not usually severe • Symptoms rare between attacks • Normal examination and lung function between episodes	• Attacks <6 weeks apart • Attacks more troublesome • Increasing symptoms between attacks • Normal examination and lung function between episodes	• Attacks <6 weeks apart • Multiple ED visits or hospital admissions for acute asthma • Daytime symptoms >2 days/week • Nocturnal symptoms>1 night/week • May have abnormal lung function

NB. If a patient has signs and symptoms across categories always treat according to their most severe features

MANAGEMENT

All patients with asthma should receive an Asthma Action Plan and asthma management education

Reliever Inhaled short acting $\beta_2$agonist as required for intermittent symptoms	**Reliever** Inhaled short acting $\beta_2$agonist as required for intermittent symptoms **Preventer** Inhaled steroids	**Reliever** Inhaled short acting $\beta_2$agonist as required for intermittent symptoms **Preventer** Inhaled steroids

FURTHER CONTROLOF ASTHMA SYMPTOMS

Patients with high usage of inhaled short acting $\beta_2$agonist should have their asthma management reviewed

- Reconsider diagnosis
- Check delivery device technique
- Check compliance with management plan

Step 1. Increase steroids
Carry out trial of other treatments before increasing inhaled steroid* dose above 400mcg/day if >12 years old, or 200mcg/day if 5-12 years old

Step 2. Add long acting $\beta_2$agonists
Inhaled long acting $\beta_2$agonists are the first choice as add-on therapy to inhaled steroids

Step 3. Further increase in steroids
If asthma control remains suboptimal after the addition of an inhaled long acting $\beta_2$agonist then the dose of inhaled steroids* should be increased to 400mcg/day if >12 years old, or 200mcg/day if 5-12 years old.

Step 4. If control is still inadequate consider:

- increasing the dose of inhaled steroids* to 1000mcg/day if >12 years old, or 400mcg/day if 5-12 years old,
- or trial other add-on therapies such as theophylline.

If asthma symptoms are not well controlled review diagnosis and consider referral to paediatrician

- Prescribe inhalers only after patients have demonstrated satisfactory technique
- MDI and spacer are at least as effective as nebulisers in children from the age of 2
- Oral $\beta_2$agonists are not recommended for acute asthma

* All dosages of inhaled steroids refer to fluticasone equivalent doses.