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## SIGN 141 • British guideline on the management of asthma

*A national clinical guideline*

October 2014

## KEY TO EVIDENCE STATEMENTS AND GRADES OF RECOMMENDATIONS

### LEVELS OF EVIDENCE

1 <sup>++</sup>	High quality meta-analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias
1 <sup>+</sup>	Well conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias
1 <sup>-</sup>	Meta-analyses, systematic reviews, or RCTs with a high risk of bias
2 <sup>++</sup>	High quality systematic reviews of case control or cohort studies High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal
2 <sup>+</sup>	Well conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal
2 <sup>-</sup>	Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal
3	Non-analytic studies, eg case reports, case series
4	Expert opinion

### GRADES OF RECOMMENDATION

*Note: The grade of recommendation relates to the strength of the evidence on which the recommendation is based. It does not reflect the clinical importance of the recommendation.*

<b>A</b>	At least one meta-analysis, systematic review, or RCT rated as 1 <sup>++</sup> , and directly applicable to the target population; <i>or</i> A body of evidence consisting principally of studies rated as 1 <sup>+</sup> , directly applicable to the target population, and demonstrating overall consistency of results
<b>B</b>	A body of evidence including studies rated as 2 <sup>++</sup> , directly applicable to the target population, and demonstrating overall consistency of results; <i>or</i> Extrapolated evidence from studies rated as 1 <sup>++</sup> or 1 <sup>+</sup>
<b>C</b>	A body of evidence including studies rated as 2 <sup>+</sup> , directly applicable to the target population and demonstrating overall consistency of results; <i>or</i> Extrapolated evidence from studies rated as 2 <sup>++</sup>
<b>D</b>	Evidence level 3 or 4; <i>or</i> Extrapolated evidence from studies rated as 2 <sup>+</sup>

### GOOD PRACTICE POINTS

- ✓ Recommended best practice based on the clinical experience of the guideline development group



NHS Evidence has accredited the process used by **Scottish Intercollegiate Guidelines Network** to produce guidelines. Accreditation is applicable to guidance produced using the processes described in SIGN 50: a guideline developer's handbook, 2008 edition ([www.sign.ac.uk/guidelines/fulltext/50/index.html](http://www.sign.ac.uk/guidelines/fulltext/50/index.html)). More information on accreditation can be viewed at [www.evidence.nhs.uk](http://www.evidence.nhs.uk)

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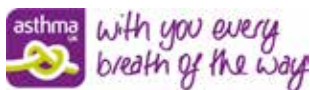
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British Thoracic Society  
Scottish Intercollegiate Guidelines Network

# British guideline on the management of asthma

A national clinical guideline



Revised 2014

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SIGN and the BTS consent to the photocopying of this guideline for the purpose of implementation in the NHS in England, Wales, Northern Ireland and Scotland.

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# 1 Introduction

## 1.1 THE NEED FOR A GUIDELINE

Asthma is a common condition which produces a significant workload for general practice, hospital outpatient clinics and inpatient admissions. It is clear that much of this morbidity relates to poor management particularly the under use of preventative medicine.

In 1999 the British Thoracic Society (BTS) and the Scottish Intercollegiate Guidelines Network (SIGN) agreed to jointly produce a comprehensive new asthma guideline, both having previously published guidance on asthma. The original BTS guideline dated back to 1990 and the SIGN guidelines to 1996. Both organisations recognised the need to develop the new guideline using explicitly evidence based methodology. The joint process was further strengthened by collaboration with Asthma UK, the Royal College of Physicians of London, the Royal College of Paediatrics and Child Health, the General Practice Airways Group (now Primary Care Respiratory Society UK), and the British Association of Accident and Emergency Medicine (now the College of Emergency Medicine). The outcome of these efforts was the British Guideline on the Management of Asthma published in 2003.<sup>1</sup>

The 2003 guideline was developed using SIGN methodology.<sup>2</sup> Electronic literature searches extended to 1995, although some sections required searches back as far as 1966. The pharmacological management section utilised the North of England Asthma guideline to address some of the key questions on adult management.<sup>3</sup> The North of England guideline literature search covered a period from 1984 to 1997, and SIGN augmented this with a search from 1997 onwards.

### 1.1.1 UPDATING THE EVIDENCE

Between 2004 and 2012 sections within the guideline were updated annually and made available on both the BTS ([www.brit-thoracic.org.uk](http://www.brit-thoracic.org.uk)) and SIGN ([www.sign.ac.uk](http://www.sign.ac.uk)) websites. Subsequently, updating moved to a biennial basis, beginning with the 2014 update.

A summary of the search histories for each section is given in Annex 1. It is hoped that this asthma guideline continues to serve as a basis for high quality management of both acute and chronic asthma and a stimulus for research into areas of management for which there is little evidence.

## 1.2 REMIT OF THE GUIDELINE

### 1.2.1 OVERALL OBJECTIVES

This guideline provides recommendations based on current evidence for best practice in the management of asthma. It makes recommendations on management of adults, including pregnant women, adolescents, and children with asthma. In sections 6 and 7 on pharmacological management and inhaler devices respectively, each recommendation has been graded and the supporting evidence assessed for adults and adolescents over 12 years old, children 5–12 years, and children under 5 years. In section 10 recommendations are made on managing asthma in adolescents (10–19 years of age as defined by the World Health Organisation (WHO)).<sup>4</sup>

The guideline considers asthma management in all patients with a diagnosis of asthma irrespective of age or gender (although there is less available evidence for people at either age extreme). The guideline does not cover patients whose primary diagnosis is not asthma, for example those with chronic obstructive pulmonary disease or cystic fibrosis, but patients with these conditions can also have asthma. Under these circumstances many of the principles set out in this guideline will apply to the management of their asthma symptoms.

The key questions on which the guideline is based can be found on the SIGN website, [www.sign.ac.uk](http://www.sign.ac.uk), as part of the supporting material for this guideline.

### 1.2.2 TARGET USERS OF THE GUIDELINE

This guideline will be of interest to healthcare professionals involved in the care of people with asthma. The target users are, however, much broader than this, and include people with asthma, their parents/carers and those who interact with people with asthma outside of the NHS, such as teachers. It will also be of interest to those planning the delivery of services in the NHS in England, Wales, Northern Ireland and Scotland.

### 1.2.3 SUMMARY OF UPDATES TO THE GUIDELINE, BY SECTION

2	Key recommendations	2014
3	Diagnosis and monitoring	2008, 2011
4	Supported self management	2004, 2008, 2014
5	Non-pharmacological management	2008, 2014
6	Pharmacological management	2004, 2005, 2006, 2008, 2009, 2011, 2014
7	Inhaler devices	2005, 2014
8	Management of acute asthma	2004, 2009, 2014
9	Difficult asthma	2008, 2014
10	Asthma in adolescents	2011
11	Asthma in pregnancy	2005, 2008, 2009, 2014
12	Occupational asthma	2005, 2008, 2014
13	Organisation and delivery of care, and audit	2008, 2014

In 2004 the sections on pharmacological management, acute asthma and patient self management and compliance were revised. In 2005 sections on pharmacological management, inhaler devices, outcomes and audit and asthma in pregnancy were updated, and occupational asthma was rewritten with help from the British Occupational Health Research Foundation.

In 2006 the pharmacological management section was again updated. While the web-based alterations appeared successful, it was felt an appropriate time to consider producing a new paper-based version in which to consolidate the various yearly updates. In addition, since 2006, the guideline has had input from colleagues from Australia and New Zealand.



The 2008 guideline considered literature published up to March 2007. It contained a completely rewritten section on diagnosis for both adults and children; a section on special situations which included occupational asthma, asthma in pregnancy and the new topic of difficult asthma; updated sections on pharmacological and non-pharmacological management; and amalgamated sections on patient education and compliance, and on organisation of care and audit.

The 2009 revisions included updates to pharmacological management, the management of acute asthma and asthma in pregnancy. Update searches were conducted on inhaler devices but there was insufficient new evidence to change the existing recommendations. The annexes were also amended to reflect current evidence.

The 2011 revisions included updates to monitoring asthma and pharmacological management, and a new section on asthma in adolescents.

In 2014 the approach to updating the guideline changed and revisions were made to sub-sections throughout the guideline based on new evidence relating to specific key questions. In addition, major revisions were made to the section on non-pharmacological management, and the organisation and delivery of care and supported self management sections were revised. The structure of the guideline also changed, with a new section highlighting key recommendations for implementation from across the guideline (see *section 2*); the original section 7 on special situations split into four separate sections covering difficult asthma, asthma in adolescents, asthma in pregnancy and occupational asthma; and the revised section 4 on supported self management moved to the beginning of the guideline.

Also new for 2014 is the replacement of the term 'asthma exacerbation' with the new term 'asthma attack'. The guideline development group believes that is more understandable and gives clearer indication of the need for action.

### 1.3 STATEMENT OF INTENT

This guideline is not intended to be construed or to serve as a standard of care. Standards of care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns of care evolve. Adherence to guideline recommendations will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgement must be made by the appropriate healthcare professional(s) responsible for clinical decisions regarding a particular clinical procedure or treatment plan. This judgement should only be arrived at following discussion of the options with the patient, covering the diagnostic and treatment choices available. It is advised, however, that significant departures from the national guideline or any local guidelines derived from it should be fully documented in the patient's case notes at the time the relevant decision is taken.

### 1.3.1 PATIENT VERSION

Patient versions of this guideline are available from the SIGN website, [www.sign.ac.uk](http://www.sign.ac.uk)

### 1.3.2 PRESCRIBING OF LICENSED MEDICINES OUTWITH THEIR MARKETING AUTHORISATION

Recommendations within this guideline are based on the best clinical evidence. Some recommendations may be for medicines prescribed outwith the marketing authorisation (MA) also known as product licence. This is known as 'off label' use.

Medicines may be prescribed off label in the following circumstances:

- for an indication not specified within the marketing authorisation
- for administration via a different route
- for administration of a different dose
- for a different patient population.

An unlicensed medicine is a medicine which does not have MA for medicinal use in humans.

Generally the off label use of medicines becomes necessary if the clinical need cannot be met by licensed medicines within the marketing authorisation. Such use should be supported by appropriate evidence and experience.<sup>5</sup>

"Prescribing medicines outside the conditions of their marketing authorisation alters (and probably increases) the prescribers' professional responsibility and potential liability."<sup>5</sup>

The General Medical Council (GMC) recommends that when prescribing a medicine 'off label', doctors should:

- be satisfied that such use would better serve the patient's needs than an authorised alternative (if one exists).
- be satisfied that there is sufficient evidence/experience of using the medicines to show its safety and efficacy, seeking the necessary information from appropriate sources.
- record in the patient's clinical notes the medicine prescribed and, when not following common practice, the reasons for the choice.
- take responsibility for prescribing the medicine and for overseeing the patient's care, including monitoring the effects of the medicine.

Non-medical prescribers should ensure that they are familiar with the legislative framework and their own professional prescribing standards.

Prior to any prescribing, the licensing status of a medication should be checked in the summary of product characteristics (SPC) (electronic Medicines Compendium (eMC)).

The prescriber must be competent, operate within the professional code of ethics of their statutory bodies and the prescribing practices of their employers.<sup>6</sup>

### 1.3.3 ADDITIONAL ADVICE ON THE USE OF NEW AND EXISTING MEDICINES AND TREATMENTS

The National Institute for Health and Care Excellence (NICE) develops multiple (MTA) and single (STA) technology appraisals that make recommendations on the use of new and existing medicines and treatments within the NHS in England and Wales. Healthcare Improvement Scotland processes MTAs for NHSScotland.

STAs are not applicable to NHSScotland. The Scottish Medicines Consortium (SMC) provides advice to NHS Boards and their Area Drug and Therapeutics Committees about the status of all newly licensed medicines and any major new indications for established products.

Practitioners should be aware of this additional advice on medicines and treatments recommended in this guideline and that recommendations made by these organisations and restrictions on their use may differ between England and Wales and Scotland.

## 2 Key recommendations

The following recommendations were highlighted by the guideline development group as the key clinical recommendations that should be prioritised for implementation. The grade of recommendation relates to the strength of the supporting evidence on which the recommendation is based. It does not reflect the clinical importance of the recommendation.

In 2013, the National Institute for Health and Clinical Excellence published a quality standard for asthma comprising 11 quality statements.<sup>7</sup> The quality statements draw on existing guidance including the SIGN/BTS British guideline on the management of asthma. Quality standards describe high priority areas for quality improvement with each quality standard consisting of a prioritised set of specific, concise and measurable statements. The quality statements are shown below under the key recommendations from the guideline that most closely relate to them.

### 2.1 DIAGNOSIS AND MONITORING

#### 2.1.1 DIAGNOSIS

**B** Focus the initial assessment in children suspected of having asthma on:

- presence of key features in the history and examination
- careful consideration of alternative diagnoses.

✓ In children, record the basis on which a diagnosis of asthma is suspected.

✓ In adults, initial diagnosis should be based on a careful assessment of symptoms and a measure of airflow obstruction.

**D** Spirometry is the preferred initial test to assess the presence and severity of airflow obstruction in adults.

#### 2.1.2 MONITORING ADULTS IN PRIMARY CARE

✓ In adults, the following factors should be monitored and recorded in primary care:

- symptomatic asthma control
- lung function, assessed by spirometry or by PEF
- asthma attacks, oral corticosteroid use and time off work or school since last assessment
- inhaler technique
- adherence
- bronchodilator reliance
- possession of and use of a self management plan/personal action plan.

NICE quality statement 1: People with newly diagnosed asthma are diagnosed in accordance with BTS/SIGN guidance.

NICE quality statement 6: People with asthma who present with respiratory symptoms receive an assessment of their asthma control.

## 2.2 SUPPORTED SELF MANAGEMENT

**A** All people with asthma (and/or their parents or carers) should be offered self-management education which should include a written personalised asthma action plan and be supported by regular professional review.

**A** Prior to discharge, inpatients should receive written personalised asthma action plans, given by healthcare professionals with expertise in providing asthma education.

**A** Adherence to long-term asthma treatment should be routinely and regularly addressed by all healthcare professionals within the context of a comprehensive programme of accessible proactive asthma care.

NICE quality statement 3: People with asthma receive a written personalised action plan.

NICE quality statement 5: People with asthma receive a structured review at least annually.

NICE quality statement 9: People admitted to hospital with an acute exacerbation of asthma have a structured review by a member of a specialist respiratory team before discharge.

## 2.3 NON-PHARMACOLOGICAL MANAGEMENT

**B** Parents with asthma should be advised about the danger to themselves and to their children with asthma, of smoking, and be offered appropriate support to stop smoking.

**C** Weight loss in overweight patients has many health benefits, and should be supported in people with asthma; if successful, it may lead to improvements in asthma symptoms.

**A** Breathing exercise programmes (including physiotherapist-taught methods) can be offered to people with asthma as an adjuvant to pharmacological treatment to improve quality of life and reduce symptoms.

## 2.4 PHARMACOLOGICAL MANAGEMENT

✓ Before initiating a new drug therapy practitioners should check adherence with existing therapies, inhaler technique and eliminate trigger factors.

A	A	A	Inhaled corticosteroids are the recommended preventer drug for adults and children for achieving overall treatment goals.
A	B		The first choice as add-on therapy to inhaled corticosteroids in adults and children (5–12 years) is an inhaled long-acting $\beta_2$ agonist, which should be considered before going above a dose of 400 micrograms BDP or equivalent per day and certainly before going above 800 micrograms BDP.
		B	The first choice as add-on therapy to inhaled corticosteroids in children under five years old is a leukotriene receptor antagonist.
D	D		If asthma control remains suboptimal after the addition of an inhaled long acting $\beta_2$ agonist then the dose of inhaled corticosteroids should be increased to 800 micrograms/day in adults or 400 micrograms/day in children (5–12 years), if not already on these doses.

## 2.5 INHALER DEVICES

B ✓ ✓ Prescribe inhalers only after patients have received training in the use of the device and have demonstrated satisfactory technique.

✓ In children, pMDI and spacer are the preferred method of delivery of  $\beta_2$  agonists or inhaled corticosteroids. A face mask is required until the child can breathe reproducibly using the spacer mouthpiece. Where this is ineffective a nebuliser may be required.

NICE quality statement 4: People with asthma are given specific training and assessment in inhaler technique before starting any new inhaler treatment.

## 2.6 ACUTE ASTHMA

### 2.6.1 ADULTS

D Refer to hospital any patients with features of acute severe or life-threatening asthma.

C Give supplementary oxygen to all hypoxaemic patients with acute severe asthma to maintain an SpO<sub>2</sub> level of 94–98%. Lack of pulse oximetry should not prevent the use of oxygen.

A Use high-dose inhaled  $\beta_2$  agonists as first line agents in patients with acute asthma and administer as early as possible. Reserve intravenous  $\beta_2$  agonists for those patients in whom inhaled therapy cannot be used reliably.

A Give steroids in adequate doses in all cases of acute asthma attack.

## 2.6.2 CHILDREN AGED 2 YEARS AND OVER

✓ Children with life-threatening asthma or  $\text{SpO}_2 < 94\%$  should receive high flow oxygen via a tight fitting face mask or nasal cannula at sufficient flow rates to achieve normal saturations of 94–98%.

**A** Inhaled  $\beta_2$  agonists are the first line treatment for acute asthma.

**A** Give oral steroids early in the treatment of acute asthma attacks.

## 2.6.3 CHILDREN AGED LESS THAN 2 YEARS

**B** In infants, consider steroid tablets early in the management of severe asthma attacks in the hospital setting.

## 2.6.4 ALL PATIENTS

✓ It is essential that the patient's primary care practice is informed within 24 hours of discharge from the emergency department or hospital following an asthma attack. Ideally this communication should be directly with a named individual responsible for asthma care within the practice, by means of fax or email.

NICE quality statement 7: People with asthma who present with an exacerbation of their symptoms receive an objective measurement of severity at the time of presentation.

NICE quality statement 8: People aged 5 years or older presenting to a healthcare professional with a severe or life-threatening acute exacerbation of asthma receive oral or intravenous steroids within one hour of presentation.

NICE quality statement 10: People who received treatment in hospital or through out-of-hours services for an acute exacerbation of asthma are followed up by their own GP practice within two working days of treatment.

## 2.7 DIFFICULT ASTHMA

**D** Patients with difficult asthma should be systematically evaluated, including:

- confirmation of the diagnosis of asthma, and
- identification of the mechanism of persisting symptoms and assessment of adherence to therapy.

NICE quality statement 11: People with difficult asthma are offered an assessment by a multidisciplinary difficult asthma service.

## 2.8 ASTHMA IN PREGNANCY

**B** Women should be advised of the importance of maintaining good control of their asthma during pregnancy to avoid problems for both mother and baby.

**B** Counsel women with asthma regarding the importance and safety of continuing their asthma medications during pregnancy to ensure good asthma control.

## 2.9 OCCUPATIONAL ASTHMA

**B** In patients with adult onset, or reappearance of childhood asthma, healthcare professionals should consider that there may be an occupational cause.

✓ Adults with airflow obstruction should be asked:

- Are you better on days away from work?
- Are you better on holiday?

Those with positive answers should be investigated for occupational asthma.

NICE quality statement 2: Adults with new onset asthma are assessed for occupational causes.



## 3 Diagnosis and monitoring

The diagnosis of asthma is a clinical one; there is no standardised definition of the type, severity or frequency of symptoms, nor of the findings on investigation. The absence of a gold standard definition means that it is not possible to make clear evidence based recommendations on how to make a diagnosis of asthma.

Central to all definitions is the presence of symptoms (more than one of wheeze, breathlessness, chest tightness, cough) and of variable airflow obstruction. More recent descriptions of asthma in children and in adults have included airway hyper-responsiveness and airway inflammation as components of the disease. How these features relate to each other, how they are best measured and how they contribute to the clinical manifestations of asthma, remains unclear.

Although there are many shared features in the diagnosis of asthma in children and in adults there are also important differences. The differential diagnosis, the natural history of wheezing illnesses, the ability to perform certain investigations and their diagnostic value, are all influenced by age.

### 3.1 DIAGNOSIS IN CHILDREN

Asthma in children causes recurrent respiratory symptoms of:

- wheezing
- cough
- difficulty breathing
- chest tightness.

Wheezing is one of a number of respiratory noises that occur in children. Parents often use wheezing as a non-specific label to describe any abnormal respiratory noise. It is important to distinguish wheezing – a continuous, high-pitched musical sound coming from the chest – from other respiratory noises, such as stridor or rattly breathing.<sup>8</sup>

There are many different causes of wheeze in childhood and different clinical patterns of wheezing can be recognised in children. In general, these patterns (phenotypes) have been assigned retrospectively. They cannot reliably be distinguished when an individual child first presents with wheezing. In an individual child the pattern of symptoms may change as they grow older.

The commonest clinical pattern, especially in pre-school children and infants, is episodes of wheezing, cough and difficulty breathing associated with viral upper respiratory infections (colds), with no persisting symptoms. Most of these children will stop having recurrent chest symptoms by school age.

A minority of those who wheeze with viral infections in early life will go on to develop wheezing with other triggers so that they develop symptoms between acute episodes (interval symptoms) similar to older children with classical atopic asthma.<sup>9-13</sup>

2<sup>++</sup>

Children who have persisting or interval symptoms are most likely to benefit from therapeutic interventions.

## 3.1.1 MAKING A DIAGNOSIS IN CHILDREN

*Initial clinical assessment*

The diagnosis of asthma in children is based on recognising a characteristic pattern of episodic respiratory symptoms and signs (see Table 1) in the absence of an alternative explanation for them (see Tables 2 and 3).

Table 1: Clinical features that increase the probability of asthma

- More than one of the following symptoms: wheeze, cough, difficulty breathing, chest tightness, particularly if these symptoms:
  - are frequent and recurrent<sup>14-17</sup>
  - are worse at night and in the early morning<sup>15, 16, 18</sup>
  - occur in response to, or are worse after, exercise or other triggers, such as exposure to pets, cold or damp air, or with emotions or laughter
  - occur apart from colds<sup>14</sup>
- Personal history of atopic disorder<sup>14, 17, 19</sup>
- Family history of atopic disorder and/or asthma<sup>14, 20</sup>
- Widespread wheeze heard on auscultation
- History of improvement in symptoms or lung function in response to adequate therapy

Table 2: Clinical features that lower the probability of asthma

- Symptoms with colds only, with no interval symptoms<sup>14</sup>
- Isolated cough in the absence of wheeze or difficulty breathing<sup>21</sup>
- History of moist cough<sup>22</sup>
- Prominent dizziness, light-headedness, peripheral tingling
- Repeatedly normal physical examination of chest when symptomatic
- Normal peak expiratory flow (PEF) or spirometry when symptomatic
- No response to a trial of asthma therapy<sup>23</sup>
- Clinical features pointing to alternative diagnosis (see Table 3)

Several factors are associated with a high (or low) risk of developing persisting wheezing or asthma through childhood.<sup>19, 24</sup> The presence of these factors increases the probability that a child with respiratory symptoms will have asthma.

These factors include:

*Age at presentation*

The natural history of wheeze is dependent on age at first presentation. In general, the earlier the onset of wheeze, the better the prognosis. Cohort studies show a break point at around two years; most children who present before this age become asymptomatic by mid-childhood.<sup>10, 12, 13, 25</sup> Co-existent atopy is a risk factor for persistence of wheeze independent of age of presentation.

2<sup>++</sup>

### Sex

Male sex is a risk factor for asthma in pre-pubertal children. Female sex is a risk factor for the persistence of asthma in the transition from childhood to adulthood.<sup>26, 27</sup> Boys with asthma are more likely to grow out of their asthma during adolescence than girls.<sup>14, 25, 26, 28-41</sup>

### Severity and frequency of previous wheezing episodes

Frequent or severe episodes of wheezing in childhood are associated with recurrent wheeze that persists into adolescence.<sup>9, 12, 17, 20, 25, 30, 42, 43</sup> 2++

### Co-existence of atopic disease

A history of other atopic conditions such as eczema and rhinitis increases the probability of asthma. Positive tests for atopy in a wheezing child also increase the likelihood of asthma. A raised specific immunoglobulin E (IgE) to wheat, egg white, or inhalant allergens such as house dust mite and cat dander, predicts later childhood asthma.<sup>44, 45</sup> 2++

Other markers of allergic disease at presentation, such as positive skin prick tests and a raised blood eosinophil count, are related to the severity of current asthma and persistence through childhood.

### Family history of atopy

A family history of atopy is the most clearly defined risk factor for atopy and asthma in children. The strongest association is with maternal atopy, which is an important risk factor for the childhood onset of asthma and for recurrent wheezing that persists throughout childhood.<sup>10, 38, 41, 46, 47</sup> 2++

### Abnormal lung function

Persistent reductions in baseline airway function and increased airway responsiveness during childhood are associated with having asthma in adult life.<sup>27</sup> 3

Case detection studies have used symptom questionnaires to screen for asthma in school-aged children. A small number of questions about current symptoms, their relation to exercise and their occurrence at night, has been sufficient to detect asthma relatively efficiently.<sup>15, 16, 18, 48</sup> The addition of spirometry<sup>15, 48</sup> or bronchial hyper-responsiveness testing<sup>49</sup> to these questionnaires adds little to making a diagnosis of asthma in children. 2+

## B

### Focus the initial assessment in children suspected of having asthma on:

- presence of key features in the history and examination
- careful consideration of alternative diagnoses.



In children, record the basis on which a diagnosis of asthma is suspected

Table 3: Clinical clues to alternative diagnoses in wheezy children (features not commonly found in children with asthma)

Perinatal and family history	Possible diagnosis
Symptoms present from birth or perinatal lung problem	Cystic fibrosis; chronic lung disease of prematurity; ciliary dyskinesia; developmental lung anomaly
Family history of unusual chest disease	Cystic fibrosis; neuromuscular disorder
Severe upper respiratory tract disease	Defect of host defence; ciliary dyskinesia
Symptoms and signs	
Persistent moist cough <sup>22</sup>	Cystic fibrosis; bronchiectasis; protracted bacterial bronchitis; recurrent aspiration; host defence disorder; ciliary dyskinesia
Excessive vomiting	Gastro-oesophageal reflux ( $\pm$ aspiration)
Dysphagia	Swallowing problems ( $\pm$ aspiration)
Breathlessness with light headedness and peripheral tingling	Hyperventilation/panic attacks
Inspiratory stridor	Tracheal or laryngeal disorder
Abnormal voice or cry	Laryngeal problem
Focal signs in chest	Developmental anomaly; post-infective syndrome; bronchiectasis; tuberculosis
Finger clubbing	Cystic fibrosis; bronchiectasis
Failure to thrive	Cystic fibrosis; host defence disorder; gastro-oesophageal reflux
Investigations	
Focal or persistent radiological changes	Developmental lung anomaly; cystic fibrosis; post-infective disorder; recurrent aspiration; inhaled foreign body; bronchiectasis; tuberculosis

### 3.1.2 ASSESSING THE PROBABILITY OF A DIAGNOSIS OF ASTHMA

Based on the initial clinical assessment it should be possible to determine the probability of a diagnosis of asthma.

With a thorough history and examination, an individual child can usually be classed into one of three groups (*see Figure 1*):

- high probability – diagnosis of asthma likely
- low probability – diagnosis other than asthma likely
- intermediate probability – diagnosis uncertain.

### 3.1.3 HIGH PROBABILITY OF ASTHMA

In children with a high probability of asthma based on the initial assessment, move straight to a diagnostic trial of treatment. The initial choice of treatment will be based on an assessment of the degree of asthma severity (*see section 6*).

The clinical response to treatment should be reassessed within 2–3 months. In this group, reserve more detailed investigations for those whose response to treatment is poor or those with severe disease.<sup>23</sup>



In children with a high probability of asthma:

- start a trial of treatment
- review and assess the response
- reserve further testing for those with a poor response.

### 3.1.4 LOW PROBABILITY OF ASTHMA

Where symptoms, signs or initial investigations suggest that a diagnosis of asthma is unlikely (*see Table 2*), or they point to an alternative diagnosis (*see Table 3*), consider further investigations. This may require referral for specialist assessment (*see Table 4*).

Reconsider a diagnosis of asthma in those who do not respond to specific treatments.



In children with a low probability of asthma, consider more detailed investigation and specialist referral.

### 3.1.5 INTERMEDIATE PROBABILITY OF ASTHMA

In some children, and particularly those below the age of four to five, there is insufficient evidence at the first consultation to make a firm diagnosis of asthma, but no features to suggest an alternative diagnosis. There are several possible approaches to reaching a diagnosis in this group. Which approach is taken will be influenced by the frequency and severity of the symptoms. These approaches include:

*Watchful waiting with review*

In children with mild, intermittent wheeze and other respiratory symptoms which occur only with viral upper respiratory infections (colds), it is often reasonable to give no specific treatment and to plan a review of the child after an interval agreed with the parents/carers.

*Trial of treatment with review*

The choice of treatment (for example, inhaled bronchodilators or corticosteroids) depends on the severity and frequency of symptoms. Although a trial of therapy with inhaled or oral corticosteroids is widely used to help make a diagnosis of asthma, there is little objective evidence to support this approach in children with recurrent wheeze.

It can be difficult to assess the response to treatment, as an improvement in symptoms or lung function may be due to spontaneous remission. If it is unclear whether a child has improved, careful observation during a trial of withdrawing the treatment may clarify whether a response to asthma therapy has occurred.

*Spirometry and reversibility testing*

In children, as in adults, tests of airflow obstruction, airway responsiveness and airway inflammation may provide support for a diagnosis of asthma.<sup>16,48</sup> However, normal results on testing, especially if performed when the child is asymptomatic, do not exclude a diagnosis of asthma.<sup>50</sup> Abnormal results may be seen in children with other respiratory diseases. Measuring lung function in young children is difficult and requires techniques which are not widely available.

2+

Above five years of age, conventional lung function testing is possible in most children in most settings. This includes measures of airway obstruction (spirometry and peak flow), reversibility with bronchodilators, and airway hyper-responsiveness.

The relationship between asthma symptoms and lung function tests including bronchodilator reversibility is complex. Asthma severity classified by symptoms and use of medicines correlates poorly with single measurements of forced expiratory volume in one second (FEV<sub>1</sub>) and other spirometric indices: FEV<sub>1</sub> is often normal in children with persistent asthma.<sup>50,51</sup> Serial measures of peak flow variability and FEV<sub>1</sub> show poor concordance with disease activity and do not reliably rule the diagnosis of asthma in or out.<sup>51</sup> Measures of gas trapping (residual volume and the ratio of residual volume to total lung capacity, RV/TLC) may be superior to measurements of expiratory flow at detecting airways obstruction especially in asymptomatic children.<sup>50,52</sup>

2+

A significant increase in FEV<sub>1</sub> (>12% from baseline)<sup>53</sup> or PEF after bronchodilator indicates reversible airflow obstruction and supports the diagnosis of asthma. It is also predictive of a good response to inhaled corticosteroids (ICS).<sup>54</sup> However, an absent response to bronchodilators does not exclude asthma.<sup>55</sup>

2+  
3

Between two and five years of age, many children can perform several newer lung function tests that do not rely on their cooperation or the ability to perform a forced expiratory manoeuvre. In general, these tests have not been evaluated as diagnostic tests for asthma. There is often substantial overlap between the values in children with and without asthma.<sup>56</sup> Of the tests available, specific airways resistance (sRaw), impulse oscillometry (IOS), and measurements of residual volume (RV) appear the most promising.<sup>57</sup> While some of these tests have been useful in research, their role in clinical practice is uncertain.<sup>52, 57, 58</sup> Most have only been used in specialist centres and are not widely available elsewhere. It is often not practical to measure variable airway obstruction in children below the age of five.

2+

### 3.1.6 CHILDREN WITH AN INTERMEDIATE PROBABILITY OF ASTHMA AND EVIDENCE OF AIRWAY OBSTRUCTION

Asthma is the by far the commonest cause of airways obstruction on spirometry in children. Obstruction due to other disorders, or due to multiple causes, is much less common in children than in adults. Spirometry and other lung function tests, including tests of PEF variability,<sup>51</sup> lung volumes and airway responsiveness,<sup>49</sup> are poor at discriminating between children with asthma and those with obstruction due to other conditions.

- ✓ In children with an intermediate probability of asthma who can perform spirometry and have evidence of airways obstruction, assess the change in FEV<sub>1</sub> or PEF in response to an inhaled bronchodilator (reversibility) and/or the response to a trial of treatment for a specified period:
  - if there is significant reversibility, or if a treatment trial is beneficial, a diagnosis of asthma is probable. Continue to treat as asthma, but aim to find the minimum effective dose of therapy. At a later point, consider a trial of reduction or withdrawal of treatment.
  - if there is no significant reversibility, and a treatment trial is not beneficial, consider tests for alternative conditions (*see Table 3*).

### 3.1.7 CHILDREN WITH AN INTERMEDIATE PROBABILITY OF ASTHMA WITHOUT EVIDENCE OF AIRWAY OBSTRUCTION

In this group, further investigations, including assessment of atopic status and bronchodilator responsiveness and if possible tests of airway responsiveness, should be considered (*see section 3.2.1*). This is particularly so if there has been a poor response to a trial of treatment or if symptoms are severe. In these circumstances, referral for specialist assessment is indicated.

- C In children with an intermediate probability of asthma who can perform spirometry and have no evidence of airways obstruction:
  - consider testing for atopic status, bronchodilator reversibility and, if possible, bronchial hyper-responsiveness using methacholine, exercise or mannitol.
  - consider specialist referral.

### 3.1.8 CHILDREN WITH AN INTERMEDIATE PROBABILITY OF ASTHMA WHO CANNOT PERFORM SPIROMETRY

Most children under five years and some older children cannot perform spirometry. In these children, offer a trial of treatment for a specific period. If there is clear evidence of clinical improvement, the treatment should be continued and they should be regarded as having asthma (it may be appropriate to consider a trial of withdrawal of treatment at a later stage). If the treatment trial is not beneficial, then consider tests for alternative conditions and referral for specialist assessment.

- ✓ In children with an intermediate probability of asthma who cannot perform spirometry, offer a trial of treatment for a specified period:
  - if treatment is beneficial, treat as asthma and arrange a review
  - if treatment is not beneficial, stop asthma treatment and consider tests for alternative conditions and specialist referral.

## 3.2 OTHER INVESTIGATIONS

### 3.2.1 TESTS OF AIRWAY HYPER-RESPONSIVENESS

The role of tests of airway responsiveness (airway hyper-reactivity) in the diagnosis of childhood asthma is unclear.<sup>49,59</sup> For example, a methacholine challenge test has a much lower sensitivity than symptoms in diagnosing asthma in children and only marginally increases the diagnostic accuracy after the symptom history is taken into account.<sup>49</sup> However, a negative methacholine test in children, which has a high negative predictive value, makes a diagnosis of asthma improbable.<sup>59</sup> Similarly, a negative response to an exercise challenge test is helpful in excluding asthma in children with exercise related breathlessness.<sup>60</sup>

3

### 3.2.2 TESTS OF EOSINOPHILIC AIRWAY INFLAMMATION

Eosinophilic inflammation in children can be assessed non-invasively using induced sputum differential eosinophil count or exhaled nitric oxide concentrations ( $FE_{NO}$ ).

Sputum induction is feasible in school-aged children.<sup>61,62</sup> Higher sputum eosinophil counts are associated with more marked airways obstruction and reversibility, greater asthma severity and atopy.<sup>63</sup> In children with newly diagnosed mild asthma, sputum eosinophilia is present and declines with ICS treatment.<sup>62</sup> Sputum induction is possible in approximately 75% of children tested, but it is technically demanding and time consuming and at present remains a research tool.

2<sup>++</sup>

It is feasible to measure  $FE_{NO}$  in unsedated children from the age of 3–4 years.<sup>64</sup> A raised  $FE_{NO}$  is neither a sensitive nor a specific marker of asthma with overlap with children who do not have asthma.<sup>65</sup>  $FE_{NO}$  is closely linked with atopic status, age and height.<sup>66,67</sup> In some studies,  $FE_{NO}$  correlated better with atopic dermatitis and allergic rhinitis than with asthma. It is not closely linked with underlying lung function. Measuring  $FE_{NO}$  could not differentiate between groups once atopy was taken into account.<sup>68</sup> Home measurements of  $FE_{NO}$  have a highly variable relationship with other measures of disease activity and vary widely from day to day.<sup>69</sup>

2<sup>+</sup>

At present, there is insufficient evidence to support a role for markers of eosinophilic inflammation in the diagnosis of asthma in children. They may have a role in assessing severity of disease or response to treatment.



### 3.2.3 TESTS OF ATOPY

Positive skin tests,<sup>70</sup> blood eosinophilia  $\geq 4\%$ ,<sup>14</sup> or a raised specific IgE to cat, dog or mite,<sup>71, 72</sup> increase the probability of asthma in a child with wheeze, particularly in children over five years of age.<sup>70</sup> It is important to recognise that non-atopic wheezing is as frequent as atopic wheezing in school-aged children.<sup>73</sup>

2++

### 3.2.4 CHEST X-RAY

A study in primary care in children age 0–6 years concluded that a chest X-ray (CXR), in the absence of a clinical indication, need not be part of the initial diagnostic work up.<sup>74</sup>



Reserve chest X-rays for children with severe disease or clinical clues suggesting other conditions.

## 3.3 SUMMARY

### Focus the initial assessment of children suspected of having asthma on:

- the presence of key features in the history and clinical examination
- careful consideration of alternative diagnoses.

### Record the basis on which the diagnosis of asthma is suspected.

Using a structured questionnaire may produce a more standardised approach to the recording of presenting clinical features and the basis for a diagnosis of asthma.

#### 1. In children with a high probability of asthma:

- move straight to a trial of treatment
- reserve further testing for those with a poor response.

#### 2. In children with a low probability of asthma:

- consider more detailed investigation and specialist referral.

#### 3. In children with an intermediate probability of asthma who can perform spirometry and have evidence of airways obstruction, offer a reversibility test and/or a trial of treatment for a specified period:

- if there is reversibility, or if treatment is beneficial, treat as asthma
- if there is insignificant reversibility, and/or treatment trial is not beneficial, consider tests for alternative conditions.

#### 4. In children with an intermediate probability of asthma who can perform spirometry, and have no evidence of airways obstruction, consider testing for atopic status, bronchodilator reversibility and, if possible, bronchial hyper-responsiveness using methacholine or exercise.

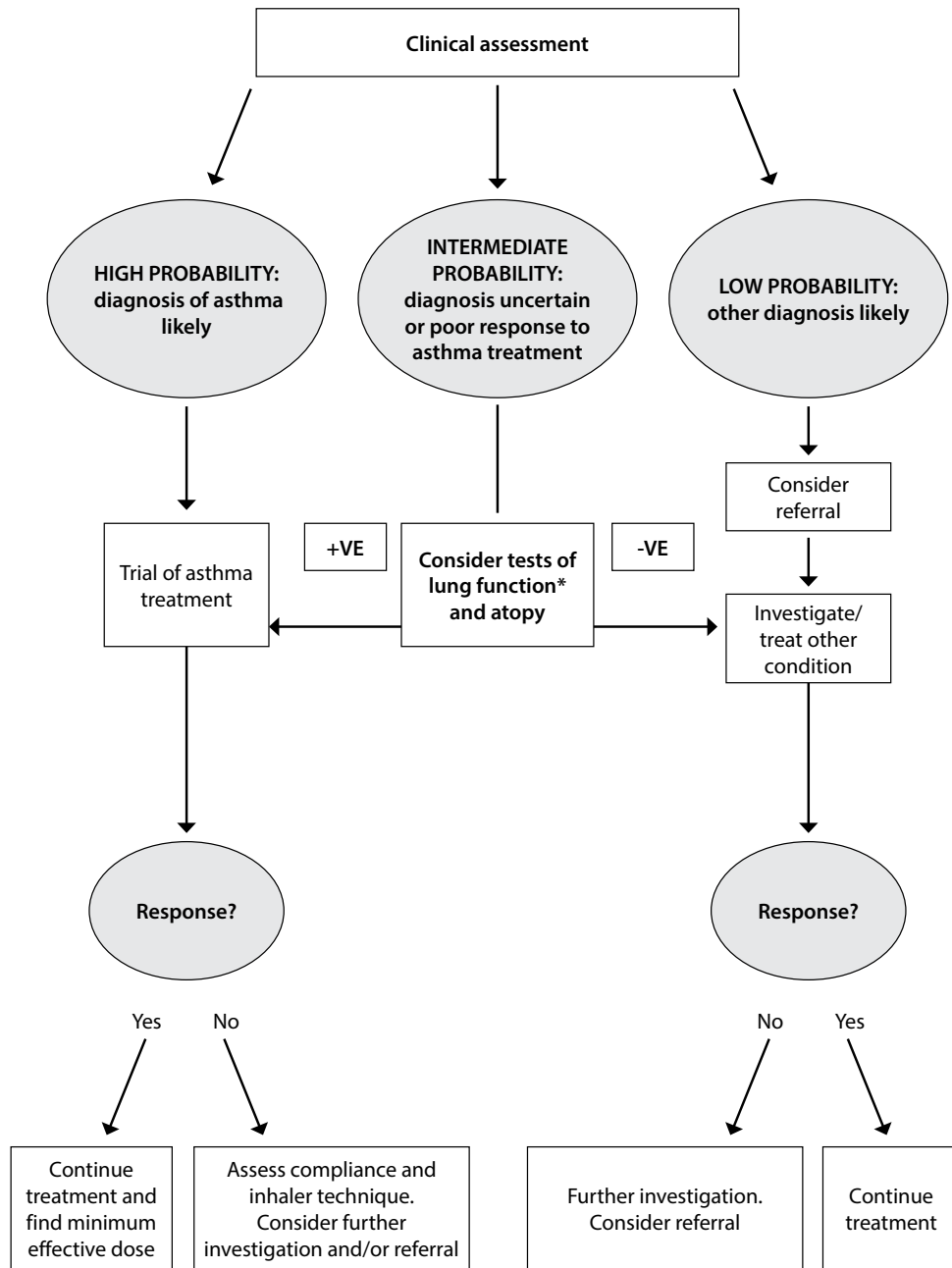
#### 5. In children with an intermediate probability of asthma, who cannot perform spirometry, offer a trial of treatment for a specified period:

- if treatment is beneficial, treat as asthma
- if treatment is not beneficial, stop asthma treatment, and consider tests for alternative conditions and specialist referral.

*Table 4: Indications for specialist referral in children*

- Diagnosis unclear or in doubt
- Symptoms present from birth or perinatal lung problem
- Excessive vomiting or possetting
- Severe upper respiratory tract infection
- Persistent wet or productive cough
- Family history of unusual chest disease
- Failure to thrive
- Nasal polyps
- Unexpected clinical findings eg focal signs, abnormal voice or cry, dysphagia, inspiratory stridor
- Failure to respond to conventional treatment (particularly inhaled corticosteroids above 400 micrograms per day or frequent use of steroid tablets)
- Parental anxiety or need for reassurance

Figure 1: Presentation with suspected asthma in children



\* Lung function tests include spirometry before and after bronchodilator (test of airway reversibility) and possible exercise or methacholine challenge (tests of airway responsiveness). Most children over the age of 5 years can perform lung function tests.

### 3.4 DIAGNOSIS IN ADULTS

The diagnosis of asthma is based on the recognition of a characteristic pattern of symptoms and signs and the absence of an alternative explanation for them (*see Table 5*). The key is to take a careful clinical history. In many cases this will allow a reasonably certain diagnosis of asthma, or an alternative diagnosis, to be made. If asthma does appear likely, the history should also explore possible causes, particularly occupational.

In view of the potential requirement for treatment over many years, it is important even in relatively clear cut cases, to try to obtain objective support for the diagnosis. Whether or not this should happen before starting treatment depends on the certainty of the initial diagnosis and the severity of presenting symptoms. Repeated assessment and measurement may be necessary before confirmatory evidence is acquired.

Confirmation hinges on demonstration of airflow obstruction varying over short periods of time. Spirometry, which is now becoming more widely available, is preferable to measurement of peak expiratory flow because it allows clearer identification of airflow obstruction, and the results are less dependent on effort. It should be the preferred test where available (although some training is required to obtain reliable recordings and to interpret the results). Of note, a normal spirogram (or PEF) obtained when the patient is not symptomatic does not exclude the diagnosis of asthma.

Results from spirometry are also useful where the initial history and examination leave genuine uncertainty about the diagnosis. In such cases, the differential diagnosis and approach to investigation is different in patients with and without airflow obstruction (*see Figure 2 and Table 6*). In patients with a normal or near-normal spirogram when symptomatic, potential differential diagnoses are mainly non-pulmonary;<sup>75,76</sup> these conditions do not respond to ICS and bronchodilators. In contrast, in patients with an obstructive spirogram the question is less whether they will need inhaled treatment but rather exactly what form and how intensive this should be.

Other tests of airflow obstruction, airway responsiveness and airway inflammation can also provide support for the diagnosis of asthma, but to what extent the results of the tests alter the probability of a diagnosis of asthma has not been clearly established, nor is it clear when these tests are best performed.

For adults of working age with airflow obstruction, occupational asthma should be considered and suitable screening questions asked (*see section 12.3*).

Table 5: Clinical features in adults that influence the probability that episodic respiratory symptoms are due to asthma

Features that increase the probability of asthma
<ul style="list-style-type: none"> <li>• More than one of the following symptoms: wheeze, breathlessness, chest tightness and cough, particularly if:               <ul style="list-style-type: none"> <li>- symptoms are worse at night and in the early morning</li> <li>- symptoms are present in response to exercise, allergen exposure and cold air</li> <li>- symptoms are present after taking aspirin or beta blockers</li> </ul> </li> <li>• History of atopic disorder</li> <li>• Family history of asthma and/or atopic disorder</li> <li>• Widespread wheeze heard on auscultation of the chest</li> <li>• Otherwise unexplained low FEV<sub>1</sub> or PEF (historical or serial readings)</li> <li>• Otherwise unexplained peripheral blood eosinophilia</li> </ul>
Features that lower the probability of asthma
<ul style="list-style-type: none"> <li>• Prominent dizziness, light-headedness, peripheral tingling</li> <li>• Chronic productive cough in the absence of wheeze or breathlessness</li> <li>• Repeatedly normal physical examination of chest when symptomatic</li> <li>• Voice disturbance</li> <li>• Symptoms with colds only</li> <li>• Significant smoking history (ie &gt; 20 pack-years)</li> <li>• Cardiac disease</li> <li>• Normal PEF or spirometry when symptomatic*</li> </ul> <p><i>* A normal spirogram/spirometry when not symptomatic does not exclude the diagnosis of asthma. Repeated measurements of lung function are often more informative than a single assessment.</i></p>

✓ In adults, initial diagnosis should be based on a careful assessment of symptoms and a measure of airflow obstruction.

✓ In patients with a high probability of asthma move straight to a trial of treatment. Reserve further testing for those whose response to a trial of treatment is poor.

✓ In patients with a low probability of asthma, whose symptoms are thought to be due to an alternative diagnosis, investigate and manage accordingly. Reconsider the diagnosis of asthma in those who do not respond.

✓ In patients with an intermediate probability of asthma, the preferred approach is to carry out further investigations, including an explicit trial of treatments for a specified period, before confirming a diagnosis and establishing maintenance treatment.

**D** Spirometry is the preferred initial test to assess the presence and severity of airflow obstruction in adults.

### 3.4.1 FURTHER INVESTIGATION OF PATIENTS WITH AN INTERMEDIATE PROBABILITY OF ASTHMA

#### *Patients with airways obstruction*

Tests of peak expiratory flow variability, lung volumes, gas transfer, airway hyper-responsiveness and airway inflammation are of limited value in discriminating patients with established airflow obstruction due to asthma from those whose airflow obstruction is due to other conditions.<sup>77-80</sup> Patients may have more than one cause of airflow obstruction, which complicates the interpretation of any test. In particular, asthma and chronic obstructive pulmonary disease (COPD) commonly co-exist.

- ✓ Offer patients with airways obstruction and intermediate probability of asthma a reversibility test and/or a trial of treatment for a specified period:
  - if there is significant reversibility, or if a treatment trial is clearly beneficial treat as asthma\*
  - if there is insignificant reversibility and a treatment trial is not beneficial, consider tests for alternative conditions.\*

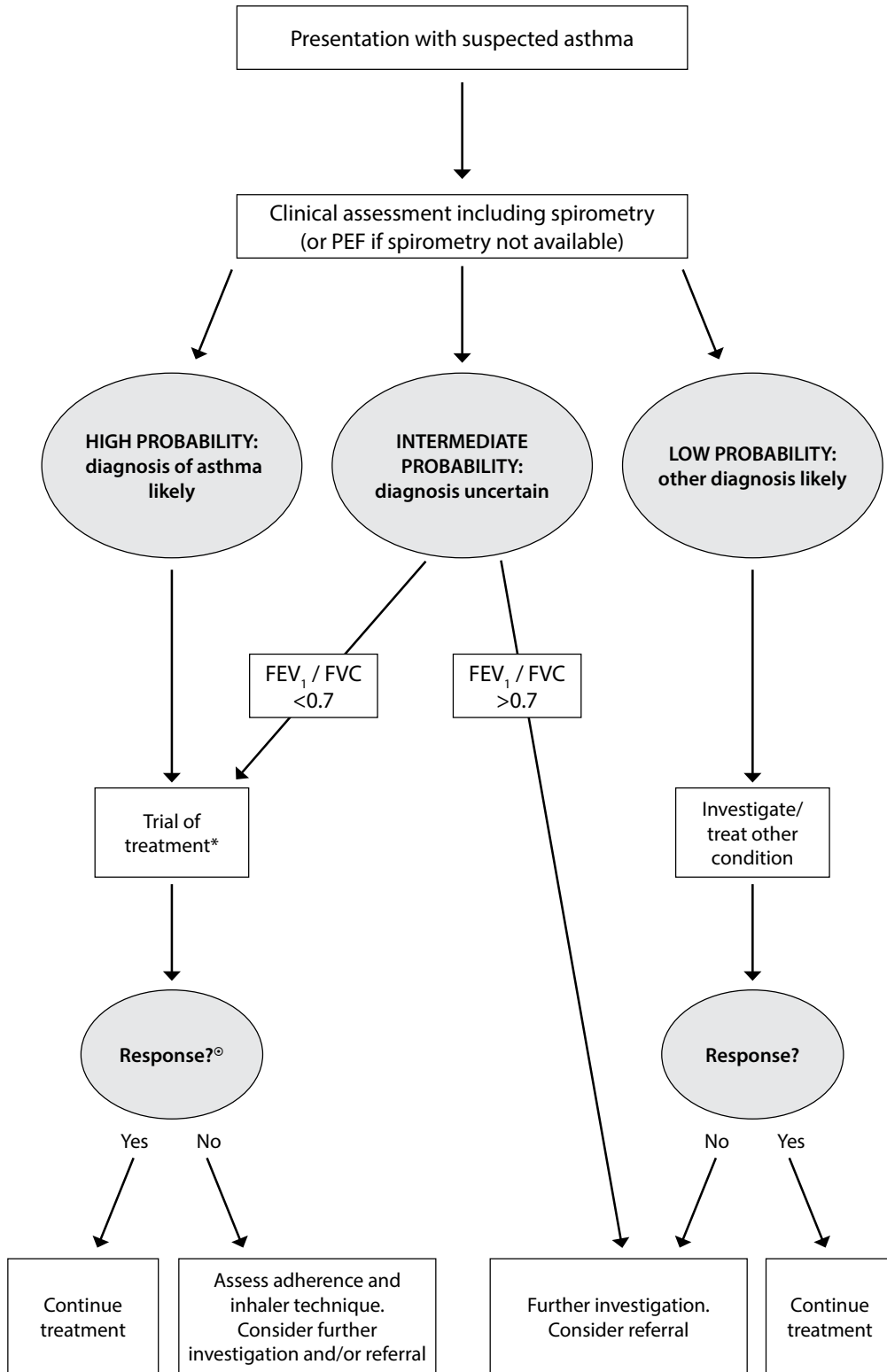
#### *Patients without airways obstruction*

In patients with a normal or near-normal spirogram it is more useful to look for evidence of airway hyperresponsiveness and/or airway inflammation.<sup>75, 81-83</sup> These tests are sensitive so normal results provide the strongest evidence against a diagnosis of asthma.

- ✓ In patients without evidence of airways obstruction and with an intermediate probability of asthma, arrange further investigations\* before commencing treatment.

\* see section 3.5 for more detailed information on further tests

Figure 2: Presentation with suspected asthma in adults



\* see section 3.5.1

® see Table 6

Table 6: Differential diagnosis of asthma in adults, according to the presence or absence of airflow obstruction ( $FEV_1/FVC < 0.7$ )

Without airflow obstruction
<ul style="list-style-type: none"> <li>• Chronic cough syndromes</li> <li>• Hyperventilation syndrome</li> <li>• Vocal cord dysfunction</li> <li>• Rhinitis</li> <li>• Gastro-oesophageal reflux</li> <li>• Cardiac failure</li> <li>• Pulmonary fibrosis</li> </ul>
With airflow obstruction
<ul style="list-style-type: none"> <li>• COPD</li> <li>• Bronchiectasis*</li> <li>• Inhaled foreign body*</li> <li>• Obliterative bronchiolitis</li> <li>• Large airway stenosis</li> <li>• Lung cancer*</li> <li>• Sarcoidosis*</li> </ul> <p>* may also be associated with non-obstructive spirometry</p>

- ✓ Consider performing chest X-ray in any patient presenting atypically or with additional symptoms or signs. Additional investigations such as full lung function tests, blood eosinophil count, serum IgE and allergen skin prick tests may be of value in selected patients.

The criteria for referral are:

- diagnosis unclear
- unexpected clinical findings (ie crackles, clubbing, cyanosis, cardiac disease)
- unexplained restrictive spirometry
- suspected occupational asthma
- persistent non-variable breathlessness
- monophonic wheeze or stridor
- prominent systemic features (myalgia, fever, weight loss)
- chronic sputum production
- CXR shadowing
- marked blood eosinophilia ( $>1 \times 10^9/l$ )
- poor response to asthma treatment
- severe asthma attack.



### 3.5 FURTHER INVESTIGATIONS THAT MAY BE USEFUL IN PATIENTS WITH AN INTERMEDIATE PROBABILITY OF ASTHMA

Three studies have looked at tests to discriminate patients with asthma from those with conditions that are commonly confused with asthma.<sup>75,81,83</sup> These studies provide a basis for evaluating the diagnostic value of different tests. Table 7 summarises the sensitivity and specificity of different findings on investigation. As not all studies included patients with untreated asthma, these values may underestimate the value of the investigations in clinical practice, where many patients will be investigated before treatment is started. The diagnostic value of testing may also be greater when more than one test is done or if there are previous lung function results available in the patient's notes. The choice of test will depend on a number of factors including severity of symptoms and local availability of tests.

An alternative and promising approach to the classification of airways disease is to use tests which best identify patients who are going to respond to corticosteroid therapy.<sup>82,84</sup> A raised sputum eosinophil count and an increased FE<sub>NO</sub> are more closely related to corticosteroid response than other tests in a variety of clinical settings.<sup>82,85-87</sup> There is also evidence that markers of eosinophilic airway inflammation are of value in monitoring the response to corticosteroid treatment.<sup>88-90</sup> More experience with these techniques and more information on the long term response to corticosteroid in patients who do not have a raised sputum eosinophil count or FE<sub>NO</sub> is needed before this approach can be recommended.

Table 7: Estimates of sensitivity and specificity of test results in adults with suspected asthma and normal or near-normal spirometric values<sup>75,81,83</sup>

Test	Normal range	Validity	
		sensitivity	specificity
Methacholine PC <sub>20</sub>	>8 mg/ml	High	Medium
Indirect challenges*	varies	Medium****	High
FE <sub>NO</sub>	<25 ppb	High****	Medium
Sputum eosinophil count	<2%	High****	Medium
PEF A%H	<8** <20%***	Low	Medium

PC<sub>20</sub> = the provocative concentration of methacholine required to cause a 20% fall in FEV<sub>1</sub>.  
FE<sub>NO</sub> = exhaled nitric oxide concentration. PEF A%H = peak expiratory flow amplitude per cent highest. ppb = parts per billion.

\*ie exercise challenge, inhaled mannitol, \*\*with twice daily readings, \*\*\*with four or more readings, \*\*\*\* in untreated patients

### 3.5.1 TREATMENT TRIALS AND REVERSIBILITY TESTING

Treatment trials with bronchodilators or ICS in patients with diagnostic uncertainty should use one or more objective methods of assessment. Using spirometric values or PEF as the prime outcome of interest is of limited value in patients with normal or near-normal pre-treatment lung function since there is little room for measurable improvement. One study has shown that the sensitivity of a positive response to ICS, defined as a >15% improvement in PEF, is 24%.<sup>83</sup>

2+

A variety of tools to assess asthma control are available to assess the response to a trial of treatment (*see Table 8*).

Using FEV<sub>1</sub> or PEF as the primary method to assess reversibility or the response to treatment trials may be more helpful in patients with established airflow obstruction.

In adults, most clinicians would try a 6–8 week treatment trial of 200 micrograms of inhaled beclomethasone (or equivalent) twice daily. In patients with significant airflow obstruction there may be a degree of ICS resistance<sup>91</sup> and a treatment trial with oral prednisolone 30 mg daily for two weeks is preferred.

2+

A >400 ml improvement in FEV<sub>1</sub> to either  $\beta_2$  agonists or corticosteroid treatment trials strongly suggests underlying asthma. Smaller improvements in FEV<sub>1</sub> are less discriminatory<sup>75</sup> and a decision on continuation of treatment should be based on objective assessment of symptoms using validated tools (*see Table 8*). Trials of treatment withdrawal may be helpful where there is doubt.

2+

C

#### Assess FEV<sub>1</sub> (or PEF) and/or symptoms:

- **before and after 400 micrograms inhaled salbutamol in patients with diagnostic uncertainty and airflow obstruction present at the time of assessment**
- **in other patients, or if there is an incomplete response to inhaled salbutamol, after either inhaled corticosteroids (200 micrograms twice daily beclomethasone equivalent for 6–8 weeks) or oral prednisolone (30 mg once daily for 14 days).**

### 3.5.2 PEAK EXPIRATORY FLOW MONITORING

PEF should be recorded as the best of three forced expiratory blows from total lung capacity with a maximum pause of two seconds before blowing.<sup>92</sup> The patient can be standing or sitting. Further blows should be done if the largest two PEF are not within 40 l/min.<sup>92</sup>

PEF is best used to provide an estimate of variability of airflow from multiple measurements made over at least two weeks. Increased variability may be evident from twice daily readings. More frequent readings will result in a better estimate<sup>93</sup> but the improved precision is likely to be achieved at the expense of reduced patient compliance.<sup>94</sup>

PEF variability is best calculated as the difference between the highest and lowest PEF expressed as a percentage of either the mean or highest PEF.<sup>95–97</sup>

The upper limit of the normal range for the A%H is around 20% using four or more PEF readings per day<sup>95, 97, 98</sup> but may be lower using twice daily readings.<sup>99</sup> Epidemiological studies have shown sensitivities of between 19% and 33% for identifying physician-diagnosed asthma.<sup>96, 100</sup>

PEF variability can be increased in patients with conditions commonly confused with asthma<sup>75, 77</sup> so the specificity of abnormal PEF variability is likely to be less in clinical practice than it is in population studies.

PEF records from frequent readings taken at work and away from work are useful when considering a diagnosis of occupational asthma (*see section 12.3.1*). A computer generated analysis of occupational records which provides an index of the work effect is available.<sup>101</sup>

✓ Peak flow records should be interpreted with caution and with regard to the clinical context. They are more useful in the monitoring of patients with established asthma than in making the initial diagnosis.

### 3.5.3 ASSESSMENT OF AIRWAY RESPONSIVENESS

Tests of airway responsiveness have been useful in research but are not yet widely available in everyday clinical practice. The most widely used method of measuring airway responsiveness relies on measuring response in terms of change in FEV<sub>1</sub> a set time after inhalation of increasing concentrations of histamine or methacholine. The agent can be delivered by breath-activated dosimeter, via a nebuliser using tidal breathing, or via a hand held atomiser.<sup>102</sup> The response is usually quantified as the concentration (or dose) required to cause a 20% fall in FEV<sub>1</sub> (PC<sub>20</sub> or PD<sub>20</sub>) calculated by linear interpolation of the log concentration or dose response curve.

Community studies in adults have consistently shown that airway responsiveness has a unimodal distribution with between 90% and 95% of the normal population having a histamine or methacholine PC<sub>20</sub> of >8 mg/ml (equivalent to a PD<sub>20</sub> of >4 micromoles).<sup>96, 103, 104</sup> This value has a sensitivity of between 60–100% in detecting physician-diagnosed asthma.<sup>96, 100, 103, 104</sup>

In patients with normal or near-normal spirometric values, assessment of airway responsiveness is significantly better than other tests in discriminating patients with asthma from patients with conditions commonly confused with asthma (*see Table 6*).<sup>75, 81</sup> In contrast, tests of airway responsiveness are of little value in patients with established airflow obstruction as the specificity is low.<sup>77, 80</sup>

Other potentially helpful constrictor challenges include indirect challenges such as inhaled mannitol and exercise.<sup>105</sup> A positive response to these indirect stimuli, such as a >15% fall in FEV<sub>1</sub>, is a specific indicator of asthma but the tests are less sensitive than tests using methacholine and histamine, particularly in patients tested while on treatment.<sup>105, 106</sup>

### 3.5.4 TESTS OF EOSINOPHILIC AIRWAY INFLAMMATION

Eosinophilic airway inflammation can be assessed non-invasively using the induced sputum differential eosinophil count or FE<sub>NO</sub><sup>107, 108</sup>. A raised sputum eosinophil count (>2%) or FE<sub>NO</sub> (>25 ppb at 50 ml/sec) is seen in 70–80% of patients with untreated asthma.<sup>78, 107</sup> Neither finding is specific to asthma: 30–40% of patients with chronic cough<sup>86, 109, 110</sup> and a similar proportion of patients with COPD<sup>85</sup> have abnormal results.

There is growing evidence that measures of eosinophilic airway inflammation are more closely linked to a positive response to corticosteroids than other measures even in patients with diagnoses other than asthma.<sup>85, 87, 109</sup>

Experience with induced sputum and FE<sub>NO</sub> is limited to a few centres and more research needs to be done before any recommendations can be made.

**C** In patients in whom there is diagnostic uncertainty and no evidence of airflow obstruction on initial assessment, test airway responsiveness wherever possible.

## 3.6 MONITORING ASTHMA

### 3.6.1 MONITORING ASTHMA IN CHILDREN

#### *Biomarkers*

Studies in children have shown that routine serial measurements of peak expiratory flow,<sup>111-113</sup> airway hyper-responsiveness<sup>114</sup> or FE<sub>NO</sub><sup>115-118</sup> do not provide additional benefit when added to a symptom-based management strategy as normal lung function does not always indicate well controlled asthma. One clinical trial, however, reported that a 90-day average seasonal 5% reduction in peak flow was associated with a 22% increase in risk of asthma attack (p=0.01).<sup>119</sup> In a further study of children with asthma who were not taking ICS, compared with children with an FEV<sub>1</sub> ≥100%, children with FEV<sub>1</sub> 80% to 99%, 60% to 79%, and <60% were 1.3, 1.8, and 4.8, respectively, more likely to have a serious asthma attack in the following four months.<sup>120</sup>

A small prospective observational study in 40 children suggested that serial measurements of FE<sub>NO</sub> and/or sputum eosinophilia may guide step down of ICS.<sup>121</sup> Another small study of 40 children showed that a rising FE<sub>NO</sub> predicted relapse after cessation of ICS.<sup>117</sup> The number of children involved in these step-down and cessation studies is small and the results should be interpreted with some caution until replicated in larger datasets.

A better understanding of the natural variability of biomarkers independent of asthma is required and studies are needed to establish whether subgroups of patients can be identified in which biomarker guided management is effective. Table 8 summarises the methodology, measurement characteristics and interpretation of some of the validated tools used to assess symptoms and other aspects of asthma.

#### *Clinical issues*

When assessing asthma control a general question, such as “how is your asthma today?”, is likely to yield a non-specific answer; “I am ok”. Using closed questions, such as “do you use your blue inhaler every day?”, is likely to yield more useful information. As in any chronic disease of childhood, it is good practice to monitor growth at least annually in children diagnosed with asthma.

- ✓ When assessing asthma control use closed questions.
- ✓ Growth (height and weight centile) should be monitored at least annually in children with asthma.
- ✓ Healthcare professionals should be aware that the best predictor of future asthma attacks is current control.

### 3.6.2 MONITORING ASTHMA IN ADULTS

In the majority of patients with asthma symptom-based monitoring is adequate. Patients achieving control of symptoms with treatment have a low risk of asthma attacks.<sup>122</sup> Patients with poor lung function and with a history of asthma attacks in the previous year may be at greater risk of future asthma attacks for a given level of symptoms.

- ✓ Closer monitoring of individuals with poor lung function and with a history of asthma attacks in the previous year should be considered.

A management strategy that controls eosinophilic airway inflammation<sup>88-90</sup> or airway hyper-responsiveness<sup>123</sup> can result in better control of asthma attacks than one which controls immediate clinical manifestations; the benefits of inflammation guided management are greater in patients with severe asthma, when asthma attacks can occur frequently and unpredictably. More research is needed to assess the relative roles of the different measures and to address the feasibility and cost of incorporating them into monitoring protocols before they can be recommended more widely.

Table 8 summarises the methodology, measurement characteristics and interpretation of some of the validated tools used to assess symptoms and other aspects of asthma. Some measures provide information about future risk and potential corticosteroid responsiveness, such as sputum eosinophil count, airway responsiveness and FE<sub>N<sub>O</sub></sub>, rather than immediate clinical control. Risk reduction, for example minimising future adverse outcomes such as asthma attacks, is an important goal of asthma management. Some patients have an accelerated decline in lung function in terms of FEV<sub>1</sub>; risk factors and treatment strategies for these patients are poorly defined. Further research in this area is an important priority.

- ✓ When assessing asthma control in adults use specific questions, such as “how many days a week do you use your blue inhaler?”.

### 3.6.3 MONITORING CHILDREN IN PRIMARY CARE

Asthma is best monitored in primary care by routine clinical review on at least an annual basis (*see section 13.3*).

- ✓ The factors that should be monitored and recorded include:
  - symptom score, eg Children’s Asthma Control Test, Asthma Control Questionnaire
  - asthma attacks, oral corticosteroid use and time off school/nursery due to asthma since last assessment
  - inhaler technique (*see section 7*)
  - adherence (*see section 4.4*), which can be assessed by reviewing prescription refill frequency
  - possession of and use of a self management plan/written personalised asthma action plan (*see section 4.3.2*)
  - exposure to tobacco smoke
  - growth (height and weight centile).

### 3.6.4 MONITORING ADULTS IN PRIMARY CARE

Asthma is best monitored in primary care by routine clinical review on at least an annual basis (*see section 13.3*). The factors that should be monitored and recorded include: symptomatic asthma control; lung function; asthma attacks, oral corticosteroid use and time off work or school since last assessment; inhaler technique (*see section 7*); adherence (*see section 4.4*); bronchodilator reliance; and possession of and use of a self-management plan/written personalised asthma action plan (*see section 4.3.2*).

Symptomatic asthma control is best assessed using directive questions such as the Royal College of Physicians' (RCP) '3 questions',<sup>124</sup> or the Asthma Control Questionnaire or Asthma Control Test (*see Table 8*), since broad non-specific questions may underestimate symptoms. Reduced lung function compared to previously recorded values may indicate current bronchoconstriction or a long term decline in lung function and should prompt detailed assessment. Patients with irreversible airflow obstruction may have an increased risk of asthma attacks. Adherence to treatment and bronchodilator reliance can both be assessed by reviewing prescription refill frequency.

- ✓ In adults the following factors should be monitored and recorded in primary care:
  - symptomatic asthma control
  - lung function assessed by spirometry or by PEF
  - asthma attacks, oral corticosteroid use and time off work or school since last assessment
  - inhaler technique
  - adherence
  - bronchodilator reliance
  - possession of and use of a self management plan/personal action plan.

Table 8: Summary of tools that can be used to assess asthma

Measurement	Methodology	Measurement characteristics	Comments
Spirometry <sup>125, 126</sup>	<p>Widely available.</p> <p>Enables clear demonstration of airflow obstruction.</p> <p>FEV<sub>1</sub> largely independent of effort and highly repeatable.</p> <p>Less applicable in acute severe asthma. Only assesses one aspect of the disease state.</p> <p>Can be achieved in children as young as five years.</p>	<p>Normal ranges widely available and robust.</p> <p>In the short term (20 minutes) 95% range for repeat measures of FEV<sub>1</sub> &lt;160 ml; FVC &lt;330 ml, independent of baseline value.</p>	<p>Good for short and longer term reversibility testing in adults with pre-existing airflow obstruction.</p> <p>&gt;400 ml increase in FEV<sub>1</sub> post-bronchodilator highly suggestive of asthma in adults.</p> <p>Values usually within normal range in adults and children with asthma.</p>
Peak expiratory flow (PEF) <sup>92, 95, 96, 111-113, 127</sup>	<p>Widely available and simple.</p> <p>Applicable in a wide variety of circumstances including acute severe asthma.</p> <p>PEF variability can be determined from home readings in most patients.</p> <p>PEF effort dependent and not as repeatable as FEV<sub>1</sub></p>	<p>Normal ranges of PEF are wide, and currently available normative tables are outdated and do not encompass ethnic diversity.</p> <p>Change in PEF more meaningful than absolute value.</p> <p>&gt;60 l/min increase in PEF suggested as best criteria for defining reversibility.</p> <p>Normal range of PEF variability defined as amplitude % highest varies between &lt;8% or &lt;20%. It is likely to depend on number of readings and degree of patient coaching.</p>	<p>Useful for short and longer term reversibility testing in adults with pre-existing airflow obstruction.</p> <p>PEF monitoring not proven to improve asthma control in addition to symptom score in adults and children. There may be some benefit in adult patients with more severe disease and in those with poor perception of bronchoconstriction.</p>

Measurement	Methodology	Measurement characteristics	Comments
Royal College of Physicians (RCP) 3 Questions <sup>124</sup>	<p>Yes/no or graded response to the following three questions:</p> <p>In the last week (or month)</p> <ol style="list-style-type: none"> <li>1. Have you had difficulty sleeping because of your asthma symptoms (including cough)?</li> <li>2. Have you had your usual asthma symptoms during the day (cough, wheeze, chest tightness or breathlessness)?</li> <li>3. Has your asthma interfered with your usual activities (eg housework, work/school etc)?</li> </ol>	No to all questions consistent with controlled asthma.	<p>Not well validated in adults. Not validated in children.</p> <p>Simplicity is attractive for use in day to day clinical practice.</p>
Asthma Control Questionnaire (ACQ) <sup>128-131</sup>	<p>Response to 7 questions, 5 relating to symptoms, 1 rescue treatment use and 1 FEV<sub>1</sub>.</p> <p>Response usually assessed over the preceding week.</p> <p>Shortened, five question symptom only questionnaire is as valid.</p>	<p>Well controlled <math>\leq 0.75</math>, inadequately controlled <math>\geq 1.5</math>. 95% range for repeat measure <math>\pm 0.36</math>.</p> <p>Minimal important difference 0.5.</p>	<p>Well validated in adults and children older than 5 years.</p> <p>A composite scoring system with a strong bias to symptoms.</p> <p>Could be used to assess response to longer term treatment trials.</p> <p>Shortened five-point questionnaire is probably best for those with normal or near-normal FEV<sub>1</sub>.</p>



Measurement	Methodology	Measurement characteristics	Comments
Asthma Control Test (ACT) <sup>132, 133</sup>	Response to 5 questions, 3 related to symptoms, 1 medication use and 1 overall control. 5 point response score.	Reasonably well controlled 20–24; under control 25.  Within subject intraclass correlation coefficient 0.77.  95% range for repeat measure and minimally clinically important difference not defined.	Validated in adults and children aged 4 years and older (the childhood asthma control test is valid for 4–11 year olds).  Could be used to assess response to longer term treatment trials, particularly in those with normal or near normal spirometric values.  95% range for repeat measure and minimally clinically important difference need to be defined.
Mini Asthma Quality of Life Questionnaire (AQLQ) <sup>129, 134, 135</sup>	Response to 15 questions in 4 domains (symptoms, activity limitations, emotional function and environmental stimuli).  Response usually assessed over the preceding 2 weeks.  Closely related to larger 32-item asthma quality of life questionnaire.  The Paediatric Asthma Quality of Life Questionnaire (PAQLQ) has 23 questions each with seven possible responses.	95% range for repeat measure $\pm 0.36$ .  Minimal important difference 0.5.  Scores usually reported as the mean of responses across the four domains with values lying between 1 and 7; higher scores indicate better quality of life.	Well validated quality of life questionnaire.  Could be used to assess response to longer term treatment trials.  The AQLQ is validated in adults and the PAQLQ has been validated for the age range 7–17 years.

Measurement	Methodology	Measurement characteristics	Comments
Airway responsiveness <sup>123</sup>	<p>Only available in selected secondary care facilities.</p> <p>Responsive to change (particularly indirect challenges such as inhaled mannitol).</p> <p>Less of a ceiling effect than FEV<sub>1</sub> and PEF.</p> <p>Not applicable in patients with impaired lung function (ie FEV<sub>1</sub>/FVC &lt;0.7 and FEV<sub>1</sub> &lt;70% predicted).</p>	<p>Normal methacholine PC<sub>20</sub> &gt;8 mg/ml.</p> <p>95% range for repeat measure ±1.5–2 doubling doses.</p>	<p>Has not been widely used to monitor disease and assess treatment responses.</p> <p>Regular monitoring not proven to improve asthma control in children.</p>
Exhaled nitric oxide (FE <sub>NO</sub> ) <sup>82, 89, 107, 117, 121, 136, 137</sup>	<p>Increasingly available in secondary care.</p> <p>Monitors still relatively expensive although expect the technology to become cheaper and more widespread.</p> <p>Measurements can be obtained in almost all adults and most children over 5 years.</p> <p>Results are available immediately.</p> <p>Reasonably close relationship between FE<sub>NO</sub> and eosinophilic airway inflammation, which is independent of gender, age, atopy and ICS use.</p> <p>Relationship is lost in smokers.</p> <p>Not closely related to other measures of asthma morbidity.</p>	<p>Normal range &lt;25 ppb at exhaled flow of 50 ml/sec. 95% range for repeat measure 4 ppb.</p> <p>&gt;50 ppb highly predictive of eosinophilic airway inflammation and a positive response to corticosteroid therapy.</p> <p>&lt;25 ppb highly predictive of its absence of and a poor response to corticosteroids or successful step down in corticosteroid therapy.</p>	<p>Raised FE<sub>NO</sub> (&gt;50 ppb in adults and &gt;35 ppb in children) is predictive of a positive response to corticosteroids.</p> <p>The evidence that FE<sub>NO</sub> can be used to guide corticosteroid treatment is mixed.</p> <p>Protocols for diagnosis and monitoring have not been well defined and more work is needed.</p> <p>Low FE<sub>NO</sub> (&lt;25 ppb in adults; &lt;20 ppb in the under 12 year old range) may have a role in identifying patients who can step down corticosteroid treatment safely.</p>

Measurement	Methodology	Measurement characteristics	Comments
Eosinophil differential count in induced sputum <sup>87,88,138,139,121</sup>	<p>Only available in specialist centres although technology is widely available and inexpensive.</p> <p>Information available in 80–90% of patients although immediate results are not available.</p> <p>Sputum eosinophil count not closely related to other measures of asthma morbidity.</p>	Normal range <2%; 95% range for repeat measure $\pm 2$ –3 fold.	<p>Close relationship between raised sputum eosinophil count and corticosteroid responsiveness in adults.</p> <p>Use of sputum eosinophil count to guide corticosteroid therapy has been shown to reduce asthma attacks in adult patients with severe disease.</p> <p>In children, one study found benefit in using sputum eosinophils to guide reductions of ICS treatment in conjunction with FE<sub>NO</sub>.</p>

Research is needed to develop asthma attack risk stratification tables on the basis of these data. These might facilitate communication between patients and healthcare professionals resulting in better outcomes, as has been shown in coronary artery disease.

## 4 Supported self management

Self management has been defined as the tasks that individuals must undertake to live with chronic conditions including, “having the confidence to deal with medical management, role management and emotional management of their conditions.”<sup>140</sup> In the context of asthma, self management has focused on the medical aspects of living with a variable condition and emphasised the importance of recognising and acting on symptoms and signs of deterioration. Personalised asthma action plans (PAAPs), however, need to be seen in the context of the broader challenges of living with asthma.<sup>141</sup>

### 4.1 EFFECTIVENESS OF SUPPORTED SELF MANAGEMENT

There is a substantial body of evidence to show that self-management education incorporating written PAAPs improves health outcomes for people with asthma. Twenty-two systematic reviews of 261 randomised controlled trials (RCTs) encompass evidence from a broad range of demographic, clinical and healthcare contexts.<sup>142-163</sup> In addition, 35 RCTs provide further evidence about self management in pre-school children,<sup>164-172</sup> ethnic minorities,<sup>173-184</sup> and primary care-based populations.<sup>182,185-193</sup>

1+

Self-management education delivered to adults or children with asthma (and/or their parents/carers):

- reduces emergency use of healthcare resources, including emergency department (ED) visits, hospital admissions and unscheduled consultations<sup>142,144,148-151,153,163</sup>
- improves markers of asthma control, including reduced symptoms and days off work, and improves quality of life.<sup>142,144,145,151,153-155</sup>

1++

Patients with all severities of asthma were included in these systematic reviews, although some focused specifically on people who had attended EDs,<sup>163</sup> or with severe or difficult asthma.<sup>148</sup> Most self-management education was delivered in healthcare settings, but some specifically evaluated school,<sup>157</sup> home,<sup>159</sup> or community-based interventions.<sup>160</sup> Typically, education was delivered by healthcare professionals either in individual consultations or group settings, but some systematic reviews included technologically-based interventions,<sup>146,147</sup> or were part of community health interventions for deprived and/or ethnic minority groups.<sup>161,162</sup>

### 4.2 COMPONENTS OF A SELF-MANAGEMENT PROGRAMME

Successful programmes varied considerably, but core components included structured education, reinforced with written PAAPs, although the duration, intensity and format for delivery varied.

#### 4.2.1 PATIENT EDUCATION

Education is a core component of effective self-management programmes in adults.<sup>142,148,163</sup> and children.<sup>149-153</sup> There is evidence that educational interventions that were supported by a written PAAP and regular professional review were more effective than less intensive regimes.<sup>142,145,150,152,153</sup>

1++

Information technology (IT)-based education has been shown to have potential, but as yet there is no consistent evidence on which to base recommendations on format, target audiences or the context in which it should be delivered.<sup>146</sup>

#### 4.2.2 PERSONALISED ASTHMA ACTION PLANS

Written PAAPs (*see Annex 10 for an example from Asthma UK*) are crucial components of effective self-management education.<sup>27,142,144,154-156,163</sup> One systematic review identified the features of PAAPs associated with beneficial outcomes (*see Table 9*).<sup>144</sup> These include:

- specific advice about recognising loss of asthma control, assessed by symptoms or peak flows or both.<sup>27,144,145</sup> In children, symptom-based written plans are effective in reducing emergency consultations for asthma, although (in older children) peak flow-based plans may be as effective for other outcomes.<sup>154,155</sup>
- actions, summarised as two or three action points, to take if asthma deteriorates, including seeking emergency help, starting oral steroids (which may include provision of an emergency course of steroid tablets), restarting or temporarily increasing (as opposed to just doubling) ICS, as appropriate to clinical severity<sup>144</sup> (*see Table 9 for further advice*).

1++  
1+

**A** All people with asthma (and/or their parents or carers) should be offered self-management education which should include a written personalised asthma action plan and be supported by regular professional review.

**A** In adults, written personalised asthma action plans may be based on symptoms and/or peak flows: symptom-based plans are generally preferable for children.

#### 4.2.3 GOOD PRACTICE POINTS

Every asthma consultation is an opportunity to review, reinforce and extend both the patient's knowledge and skills. This is true whether the patient is seen in primary care, the ED or the outpatient clinic. It is important to recognise that education is a process and not a single event.

- ✓ • A hospital admission represents a window of opportunity to review self-management skills. No patient should leave hospital without a written personalised asthma action plan.
- An acute consultation offers the opportunity to determine what action the patient has already taken to deal with the asthma attack. Their self-management strategy may be reinforced or refined and the need for consolidation at a routine follow up considered.
- A consultation for an upper respiratory tract infection or other known trigger is an opportunity to rehearse with the patient their self management in the event of their asthma deteriorating.
- Education should include personalised discussion of issues such as trigger avoidance and achieving a smoke-free environment to support people and their families living with asthma.
- Brief simple education linked to patient goals is most likely to be acceptable to patients.

Table 9. Summary of the key components of a written personalised asthma action plan (adapted from Gibson et al)<sup>144</sup>

Component of an action plan	Result	Practical considerations
<p><i>Format of action points:</i></p> <p>Symptom vs peak flow triggered</p> <p>Standard written instructions</p> <p>Traffic light configuration</p>	<p>Similar effect</p> <p>Consistently beneficial</p> <p>Not clearly better than standard instructions</p>	<p>Asthma UK personalised asthma action plans include both symptom triggers and peak flow levels at which action should be taken.</p>
<p><i>Number of action points:</i></p> <p>2–3 action points</p> <p>4 action points</p>	<p>Consistently beneficial</p> <p>Not clearly better than 2–3 points</p>	<p>Commonly used action points have been:</p> <p>PEF &lt;80% best: increase inhaled corticosteroids</p> <p>PEF &lt;60% best: commence oral steroids and seek medical advice</p> <p>PEF &lt;40% best: seek urgent medical advice</p>
<p><i>Peak expiratory flow (PEF) levels:</i></p> <p>Based on percentage personal best PEF</p> <p>Based on percentage predicted PEF</p>	<p>Consistently beneficial</p> <p>Not consistently better than usual care</p>	<p>Personal best should be assessed once treatment has been optimised and peak flows are stable. Best peak flow should be updated every few years in adults, and, if a peak flow is being used, more frequently in growing children.</p>
<p><i>Treatment instructions:</i></p> <p>Individualised using inhaled and oral corticosteroids</p> <p>Individualised using oral corticosteroids only</p>	<p>Consistently beneficial</p> <p>Insufficient data to evaluate</p>	<p>Patients may safely hold an emergency supply of prednisolone tablets for use if their symptoms continue to deteriorate and/or if their peak flow falls to 60% of their best.</p>

Component of an action plan	Result	Practical considerations
Individualised using inhaled corticosteroids	Insufficient data to evaluate	<p>Increasing inhaled corticosteroids is ineffective if patients are already taking moderate or high doses (<math>\geq 400</math> micrograms daily) and these patients should be advised to move straight to the oral steroid step.</p> <p>Those on low doses (eg 200 micrograms) of inhaled corticosteroids may be advised to increase the dose substantially (eg to 1,200 micrograms daily) at the onset of a deterioration.<sup>194</sup></p> <p>Patients who have stopped medication should be reminded to restart their inhaled corticosteroids.</p>

### 4.3 SELF MANAGEMENT IN SPECIFIC PATIENT GROUPS

A range of different patient populations are included in the trials of self management. It cannot be assumed that a successful intervention in one setting will be feasible or appropriate in another.

#### 4.3.1 PRIMARY CARE

Studies of self-management interventions based in primary care have shown that they can:

- reduce emergency use of healthcare resources, including ED attendances, hospital admissions and unscheduled consultations<sup>182, 188</sup>
- improve markers of asthma control.<sup>182, 185, 186, 188-191, 195</sup>

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Implementation of self-management interventions is challenging. The improved asthma control demonstrated in trials of interventions delivered by members of the research team<sup>182, 188</sup> or in a centrally administered initiative<sup>190, 189</sup> are reflected in some,<sup>185, 186, 191, 195</sup> but not all,<sup>192, 193</sup> trials in which members of the practice team are trained to deliver self-management education in routine clinical care.

1+

One study showed no difference in outcomes when self-management education was delivered by lay people compared to practice asthma nurses.<sup>187</sup> Studies based in the USA suggest that in deprived and/or ethnic communities the involvement of community health workers reduces ED attendance.<sup>160</sup>

2

**A** Self-management education, supported by a written personalised asthma action plan, should be offered to all patients on general practice 'active asthma' registers.

**A** Primary care practices should ensure that they have trained professionals and an environment conducive to providing supported self management.

✓ Implementation of self-management interventions is challenging in the non-specialist environment of primary care and needs to consider not only specific training in self-management skills, but also the logistics of when and how self-management education is incorporated into routine care. Strategies that have been used in effective interventions include:

- the use of proactive triggers to ensure routine reviews
- structured protocols for asthma reviews
- support of community pharmacists
- routine mailing of educational resources
- telephone calls to provide ongoing support and advice
- IT-based education and monitoring
- involvement of community workers to support clinical teams in deprived and/or ethnic minority communities.

#### 4.3.2 SECONDARY CARE

There is good evidence that self-management education targeted at people who have a history of ED attendances<sup>163</sup> or hospital admissions<sup>183, 196</sup> can reduce subsequent use of health care resources. Self-management education delivered prior to discharge can reduce readmissions<sup>197-199</sup> and should be a core component of discharge planning (see section 8.9.5).

1<sup>++</sup>

One wide reaching review of the evidence for self management in severe or difficult asthma concluded that provision of psycho-educational interventions (especially those incorporating formal self management) may reduce hospital admissions and, in children, improve symptoms.<sup>148</sup>

1<sup>+</sup>

**A** Prior to discharge, inpatients should receive written personalised asthma action plans, given by healthcare professionals with expertise in providing asthma education.

#### 4.3.3 SCHOOLCHILDREN

School-based asthma education has been shown to:

- improve process outcomes (knowledge, self-efficacy, self-management behaviours)<sup>157</sup>
- improve markers of asthma control (number of days and nights with asthma symptoms, school absences, asthma-related quality of life).<sup>157, 158</sup>

There was considerable heterogeneity in the school-based interventions, which incorporated combinations of classroom teaching for all pupils, peer support groups, individual education sessions with school nurses, interactive computer programmes, and involvement of parents.<sup>157</sup>

1<sup>++</sup>

**A** School health services should consider providing in-school asthma self-management education programmes provided by appropriately trained personnel.



## 4.3.4 PRE-SCHOOL CHILDREN

There is a paucity of evidence about effective self-management strategies delivered to parents of pre-school children. Trials recruiting only pre-school children (5 years of age or under) showed no impact on emergency use of healthcare resources, including ED visits, hospital admissions and unscheduled consultations,<sup>166, 171</sup> and no<sup>166</sup> or limited<sup>171</sup> reduction in symptoms, despite increased ownership of PAAPs.<sup>171</sup>

1-

Other trials including pre-school children and children up to the age of eight years showed only small and often transient effects of no apparent clinical significance.<sup>164, 165, 168-170</sup>

## 4.3.5 ETHNIC MINORITY GROUPS

Interventions specifically designed for ethnic minority groups, predominantly deprived African-American, Hispanic or Puerto Rican populations from inner cities in the USA,<sup>162, 173-181</sup> can:

- reduce emergency use of healthcare resources, including ED attendances, hospital admissions and unscheduled consultations<sup>161,162,176,177,179</sup>
- improve markers of asthma control<sup>161,162,173,174,177,179</sup>
- improve process outcomes (knowledge).<sup>161,162,178,180</sup>

1++

1+

1-

2+

In two UK-based RCTs, however, interventions which provided appropriate language materials and were delivered by bilingual professionals were reported as showing no<sup>182</sup> or less benefit on healthcare outcomes in the South Asian population compared to the benefits seen in the white European population.<sup>182,183</sup>

1++

1+

There is insufficient evidence to identify all the aspects of cultural tailoring which may potentially contribute to effectiveness of self-management interventions, but addressing language barriers (for example, with appropriate language materials and bilingual support) is not sufficient to enable an intervention to deliver equivalent outcomes in an ethnic minority group compared to a white European group.<sup>182, 183</sup>

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The strategies employed in ethnic minority groups are varied and include community-based neighbourhood projects,<sup>175,179,180</sup> family-based education,<sup>176</sup> nurse-led home visits,<sup>174</sup> IT-based programmes,<sup>173,177,178</sup> and school-based educational interventions.<sup>177,181</sup>

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No one strategy stands out as being always effective, or always ineffective. Lack of engagement with programmes and high drop-out rates are major barriers to effectiveness of self-management interventions.<sup>174,175,179,180</sup> Reconfiguration of the supporting healthcare system appears to increase the impact.<sup>162</sup>

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**B**

**Culturally appropriate supported self-management education should be provided for people with asthma in ethnic minority groups. Addressing language barriers is insufficient.**

- ✓ Consideration should be given to:
  - translation of materials into community languages with ethnically appropriate pictures
  - asthma educators fluent in community languages
  - identifying culturally appropriate support agencies within the local community
  - inclusion of culturally specific beliefs and practices
  - reference to culturally appropriate role models
  - involvement of a local community health worker to support clinical teams.

#### 4.4 ADHERENCE AND CONCORDANCE

The term adherence (or compliance) embodies a traditional model of prescriptive care which refers to the objectively measured usage of prescribed medication, or frequency of monitoring. The term 'concordance' signifies a negotiated agreement between the professional and the patient. Non-concordance describes an inability of both parties to come to an understanding, not merely a failure of the patient to follow the health professional's instructions.<sup>200</sup> Sharing decision making and achieving concordance improves (though does not guarantee) adherence.<sup>201</sup>

##### 4.4.1 ADHERENCE TO MONITORING AND TREATMENT

Adherence to regular monitoring with peak flow meters, even in clinical drug trials is poor, with recorded daily use as low as 6%.<sup>202, 203</sup> The lack of evidence supporting long-term peak flow monitoring,<sup>204-207</sup> however, does not negate the use of home peak flow monitoring at critical times, for example at diagnosis and initial assessment, when assessing response to changes in treatment, as part of a PAAP during asthma attacks.<sup>207</sup> Comparison should be with the patient's best peak flow (not predicted).<sup>144</sup>

Non-adherence may be intentional and/or unintentional and may be understood as a combination of perceptual factors (for example, beliefs about illness and treatment) and practical factors (capacity, resources and opportunity).<sup>208</sup> It is thought that between a third and a half of all medicines prescribed for long-term conditions are not taken as recommended,<sup>208</sup> and poor adherence should be considered when there is a failure to control asthma symptoms.

Patient self reporting is simple, inexpensive and feasible in most clinical settings, although typically overestimates adherence to regular medication.<sup>208</sup> Being non-judgemental, and asking specific questions about use of a treatment over a short time period (for example, in the last week/month) can help elicit an accurate response.<sup>208</sup> Computer repeat-prescribing systems, widely available in general practice, provide a useful indication of adherence with prescribed asthma regimens. Electronic monitoring, whilst the most accurate method, is only practical in clinical drug trials.

- ✓ Computer repeat-prescribing systems provide a practical index of adherence and should be used in conjunction with a non-judgemental discussion about adherence.

#### 4.4.2 INTERVENTIONS TO IMPROVE MEDICATION ADHERENCE

Six systematic reviews were identified that evaluated interventions to improve adherence, one specifically in asthma,<sup>209</sup> and five including a number of long-term conditions including asthma.<sup>210-214</sup> The body of evidence represents 26 unique asthma trials.

The interventions were divided into 'informational' interventions (individual and/or group sessions with or without written/electronic materials), or 'behavioural' interventions (including dosage simplification, regular monitoring including assessment of medication use with feedback, psychological therapies) or a combination of these two approaches.

Interventions to improve adherence have modest effects on adherence and less, or sometimes no, effect on clinical outcomes.<sup>209, 210, 212, 213</sup>

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The effect is greater if interventions:

- include behavioural components<sup>212, 213</sup>
- include practical facilitators (such as simplified dosage regimes), monitoring and follow up<sup>209, 210</sup>
- are delivered and sustained as part of a comprehensive programme of accessible proactive asthma care.<sup>209</sup>

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Innovative, IT-based ways to provide this supportive care have shown some promise in other disease areas but have not been explored in the context of improving asthma adherence.<sup>214</sup>

**A Adherence to long-term asthma treatment should be routinely and regularly addressed by all healthcare professionals within the context of a comprehensive programme of accessible proactive asthma care.**

- ✓ Initiatives to promote adherence to regular treatment should consider:
- information requirements, eg individual and/or group sessions, written/electronic materials, ongoing access to information
  - practical facilitators, eg simple dosage regimes
  - behavioural support, eg regular monitoring including assessment of medication use with feedback, counselling, psychological therapies
  - context – accessible proactive asthma care, eg, Chronic Care Model
  - consultation skills required to achieve shared decision-making: adherence is more likely when the patient and the health professional agree that the action is appropriate.

#### 4.5 IMPLEMENTATION IN PRACTICE

Despite the robust evidence base for self-management education, implementation in routine practice remains poor with only a third of people with asthma having a PAAP.<sup>215, 216</sup> Implementation in routine clinical practice depends as much on the context in which it is delivered as the content of the intervention. Given the diversity of healthcare systems, generalising approaches from one context to another is problematic. Despite these limitations, however, the evidence reviewed identified consistent messages that are suitable for adoption and adaptation in different healthcare settings.

A systematic review (including 14 RCTs, 2,438 patients, 107 doctors and 43 primary care teams) investigated the promotion of PAAP ownership and usage.<sup>217</sup> In addition, 19 implementation studies from the USA,<sup>189, 192, 218-224</sup> UK,<sup>193, 225-227</sup> Scandinavia,<sup>228-230</sup> Italy,<sup>231</sup> and Brazil were identified.<sup>232, 233</sup>

#### 4.5.1 TYPES OF INTERVENTION

The interventions in the implementation studies adopted four main strategies:

- primarily professional training<sup>192, 193</sup>
- primarily organisational change<sup>225, 226, 228</sup>
- primarily patient education<sup>189, 219-222, 231</sup>
- a whole systems approach with components operating explicitly at patient, professional and organisational levels.<sup>218, 223, 224, 227, 229, 230, 232, 233</sup>

Study designs varied, with five cluster randomised trials,<sup>192, 193, 220, 221, 225</sup> a preference trial with randomised groups,<sup>189</sup> or controlled implementation.<sup>226</sup> Seven were based on longitudinal, often large, databases,<sup>218, 219, 222-224, 229, 230, 233</sup> one with a control cohort,<sup>232</sup> and two uncontrolled before-and-after<sup>227, 231</sup> or cross-sectional studies.<sup>228</sup>

#### 4.5.2 IMPLEMENTATION OF INTERVENTIONS

Complex whole systems interventions in which motivated informed patients and trained professionals operate within an organisation with a culture of supported asthma self management were associated with:

- improved knowledge<sup>224</sup> and improved action plan ownership<sup>217, 222, 227</sup>
- reduced unscheduled care,<sup>223, 224, 229, 232, 233</sup> and improved markers of control.<sup>222-224, 229, 230</sup>

Implementing single components of the whole systems approach is insufficient to bring about consistent benefits. Improving professionals' knowledge is a core component of effective self-management programmes, but on its own does not improve clinical outcomes.<sup>192, 193</sup> Organisational change to support self management improves process outcomes such as the proportion of patients with PAAPs or achieving a review,<sup>225, 226, 228</sup> but improved asthma control in only one of the studies.<sup>228</sup> Targeting the patient with educational material,<sup>222</sup> support from pharmacists,<sup>219</sup> school,<sup>220, 231</sup> or telephone calls<sup>189, 220, 221</sup> improved medication use,<sup>189, 221</sup> knowledge,<sup>220</sup> and ownership of PAAPs,<sup>219</sup> and had variable effects on clinical outcomes.

**B** Commissioners and providers of services for people with asthma should consider how they can develop an organisation which prioritises and actively supports self management. This should include strategies to proactively engage and empower patients and train and motivate professionals as well as providing an environment that promotes self management and monitors implementation.

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## 5 Non-pharmacological management

There is a common perception amongst patients and carers that there are numerous environmental, dietary and other triggers of asthma and that avoiding these triggers will improve asthma and reduce the requirement for pharmacotherapy. Failure to address a patient, parent or carer's concern about environmental triggers may compromise concordance with recommended pharmacotherapy. Evidence that non-pharmacological management is effective can be difficult to obtain and more well controlled intervention studies are required.

This section distinguishes:

1. primary prevention – interventions introduced before the onset of disease and designed to reduce its incidence.
2. secondary prevention – interventions introduced after the onset of disease to reduce its impact.

### 5.1 PRIMARY PREVENTION

The evidence for primary interventional strategies is based predominantly on observational studies, although some interventions have been tested using experimental methods. Many are multifaceted and it can be difficult to disentangle the effects of one exposure or intervention from another.

#### 5.1.1 MONO AND MULTIFACETED ALLERGEN AVOIDANCE

Early life exposure to allergens (including aeroallergens and ingested food allergens) may lead to allergic sensitisation and so potentially increase the risk of subsequent asthma, particularly in children at high-risk (that is, children with a family history of asthma or atopy, particularly a parental history). It is unclear whether the risk of developing asthma in children is reduced by interventions to reduce exposure to single allergens (monofaceted), or whether multifaceted interventions targeting the reduction of more than one type of allergen exposure simultaneously will lead to a better outcome or be more effective.

A Cochrane review of trials comparing single (six studies) or multiple (three studies) interventions with a no intervention control, reported that in children who are at risk of developing childhood asthma 'multifaceted' interventions, which involve both dietary allergen reduction and environmental change to reduce exposure to inhaled allergens, reduced the odds of a doctor diagnosing asthma later in childhood by half (>5 years of age, odds ratio (OR) 0.52, 95% confidence interval (CI) 0.32 to 0.85).<sup>234</sup> However, the effect of these multifaceted interventions on wheeze reported by parents was inconsistent and there was no beneficial effect on night-time coughing or breathlessness. These interventions can be costly, demanding and inconvenient to families, and the cost effectiveness is not established. Health professionals can discuss and support this intervention in families who are motivated to follow the demanding programme.

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In children at risk of developing asthma, there is no evidence that reducing in utero or early life exposure to single allergens (either to aeroallergens such as house dust mites or pets, or food allergens) is effective in reducing asthma and single (monofaceted) interventions were not significantly more effective than controls in the reduction of any outcomes.<sup>234</sup>

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**A** Measures to reduce in utero or early life exposure to single aeroallergens, such as house dust mites or pets, or single food allergens, are not recommended for the primary prevention of asthma.

**A** For children at risk of developing asthma, complex, multifaceted interventions targeting multiple allergens may be considered in families able to meet the costs, demands and inconvenience of such a demanding programme.

## 5.1.2 AEROALLERGEN AVOIDANCE

### *House dust mites*

Exposure to high levels of house dust mite allergen in early life is associated with an increased likelihood of sensitisation to house dust mite by three to seven years of age.<sup>235</sup> Sensitisation to house dust mite is an important risk factor for the development of asthma,<sup>236,237</sup> and a few studies have suggested that high early house dust mite exposure increases the risks of subsequent asthma.<sup>238, 239</sup> A UK study showed that low levels of house dust mite and cat allergen exposures in early life increased the risk of IgE sensitisation and asthma at five years, with some attenuation at high levels of exposure, but there were significant associations with family history and birth order.<sup>240</sup>

Outcomes from intervention studies attempting to reduce exposure to house dust mites are inconsistent. A multifaceted Canadian intervention study showed a reduced prevalence of doctor-diagnosed asthma but no impact on other allergic diseases, positive skin prick tests or bronchial hyper-responsiveness;<sup>241</sup> others have shown no effect on either allergic sensitisation or symptoms of allergic diseases.<sup>242</sup> In one UK study, early results from environmental manipulation started in early pregnancy and focused mainly on house dust mite avoidance, showed reductions in some respiratory symptoms in the first year of life.<sup>243</sup> Subsequent results showed a paradoxical effect with increased allergy but better lung function in the intervention group.<sup>244</sup>

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The considerable variation in the methodology used in these studies precludes the pooling of data or meta-analyses.

**A** Healthcare professionals should not recommend house dust mite aeroallergen avoidance for the primary prevention of asthma.

### *Pets in the home*

A large number of birth cohort studies, longitudinal cohort studies and cross-sectional studies have addressed whether exposure to pets in the home in early life increases or reduces the subsequent risk of asthma and allergy, with contradictory results. Four recent systematic reviews, synthesising evidence from overlapping data sources, have provided conflicting results. One review concluded that exposure to cats in early life has a slight preventative effect on subsequent asthma, while exposure to dogs increases risk.<sup>245</sup> Another concluded, in contrast, that perinatal dog exposure protects against asthma, with no affect from cats.<sup>246</sup> Methodological factors, however, such as avoidance behaviour in at-risk families and other potential confounders, may have affected the analyses. Two

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further reviews concluded that exposure to cats and/or dogs in early childhood did not impact on asthma or wheeze in school aged children.<sup>247, 248</sup> The most methodologically sound study pooled individual participant data from 11 European birth cohort studies and so was able to harmonise exposure, outcome and age group definitions and use individual data rather than pooled risk estimates in heterogeneous groups, to minimise potential confounding.<sup>248</sup> This review concluded that exposure to cats and/or dogs in infancy does not impact on a diagnosis of asthma or on wheezing symptoms in later life, although may influence allergic sensitisation, and that parents should not make choices on pet ownership based on the desire to prevent or reduce asthma symptoms. Several of the studies and reviews reported reduced allergic sensitisation in those with early exposure to pets, but the clinical significance of this is uncertain.

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**B Healthcare professionals should not offer advice on pet ownership as a strategy for preventing childhood asthma.**

### 5.1.3 FOOD ALLERGEN AVOIDANCE

Sensitisation to foods, particularly eggs, frequently precedes the development of aeroallergy and subsequent asthma.<sup>249</sup> Food allergen avoidance in pregnancy and postnatally has not been shown to prevent the later development of asthma.<sup>250</sup> Allergen avoidance during pregnancy may adversely affect maternal, and perhaps fetal, nutrition.<sup>251</sup> High-dose food allergen exposure during pregnancy may reduce subsequent sensitisation rates by inducing tolerance.<sup>252</sup>

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**B In the absence of any evidence of benefit and given the potential for adverse effects, maternal food allergen avoidance during pregnancy and lactation is not recommended as a strategy for preventing childhood asthma.**

### 5.1.4 BREAST FEEDING

A systematic review of observational studies on the allergy preventive effects of breast feeding indicates that it is effective for all infants irrespective of family history of allergy. The preventive effect is more pronounced in infants at high risk provided they are breastfed for at least four months.<sup>253</sup> However, not all studies have demonstrated benefit and a large birth cohort reported no protective effect against atopy and asthma.<sup>254</sup>

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Observational studies have the potential to be confounded by, for example, higher rates of breast feeding in atopic families, and taking this into account, the weight of evidence is in favour of breast feeding as a preventive strategy.

**C Breast feeding should be encouraged for its many benefits, including a potential protective effect in relation to early asthma.**

### 5.1.5 MODIFIED INFANT MILK FORMULAE

Trials of modified milk formulae have not included sufficiently long follow up to establish whether there is any impact on asthma. A Cochrane review identified inconsistencies in findings and methodological concerns amongst studies, which mean that hydrolysed formulae cannot currently be recommended as part of an asthma prevention strategy.<sup>255</sup> A review of the use of soy formulae found no significant effect on asthma or any other allergic disease.<sup>256</sup>

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In the absence of any evidence of benefit from the use of modified infant milk formulae it is not possible to recommend it as a strategy for preventing childhood asthma.

## 5.1.6 WEANING

There are conflicting data on the association between early introduction of allergenic foods into the infant diet and the subsequent development of allergy and atopic eczema. No evidence was identified in relation to asthma.<sup>257</sup> In one study late introduction of egg was associated with a non-significant increase in pre-school wheezing.<sup>258</sup>

In the absence of evidence on outcomes in relation to asthma no recommendations on modified weaning can be made.

## 5.1.7 NUTRITIONAL SUPPLEMENTATION

*Fish oils*

Fish oils have a high level of omega-3 polyunsaturated fatty acids (n-3PUFAs). Western diets have a low intake of n-3PUFAs with a corresponding increase in intake of n-6PUFAs. This change has been associated with increasing rates of allergic disease and asthma.<sup>257</sup> Two randomised controlled studies have investigated early life fish oil dietary supplementation in relation to asthma outcomes in children at high risk of atopic disease (at least one parent or sibling had atopy with or without asthma). In a study, powered only to detect differences in cord blood, maternal dietary fish oil supplementation during pregnancy was associated with reduced cytokine release from allergen stimulated cord blood mononuclear cells. However, effects on clinical outcomes at one year, in relation to atopic eczema, wheeze and cough, were marginal.<sup>259</sup> In a second study, fish oil supplementation started in early infancy with or without additional house dust mite avoidance, was associated with a significant reduction in wheeze at 18 months of age. By five years of age fish oil supplementation was not associated with effects on asthma or other atopic diseases.<sup>260</sup>

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In the absence of any evidence of benefit from the use of fish oil supplementation in pregnancy it is not possible to recommend it as a strategy for preventing childhood asthma.

*Other nutrients*

A number of observational studies have suggested an increased risk of subsequent asthma following reduced (maternal) intakes of selenium (based on umbilical cord levels),<sup>261</sup> or vitamin E based on maternal pregnancy intake.<sup>262</sup> No intervention studies in relation to selenium or vitamin E have yet been conducted and overall there is insufficient evidence to make any recommendations on maternal dietary supplementation as an asthma prevention strategy.<sup>257</sup> Observational studies suggest that intervention trials are warranted.

## 5.1.8 WEIGHT REDUCTION IN OVERWEIGHT AND OBESE PATIENTS

There is consistent evidence that being overweight or obese increases the risk of a subsequent physician diagnosis of asthma by up to 50% in children and adult of both sexes.<sup>263,264</sup> A high birth weight is also associated with a higher risk of asthma (risk ratio (RR) 1.2, 95% CI 1.1 to 1.3).<sup>263</sup> The quality of the evidence is low as confounders were not adjusted for. In addition, since obesity can have direct effects on respiratory symptoms and on lung mechanics, the mechanism of this relationship is unclear.

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**Weight reduction is recommended in obese patients to promote general health and to reduce subsequent respiratory symptoms consistent with asthma.**



### 5.1.9 MICROBIAL EXPOSURE

The 'hygiene hypothesis' suggested that early exposure to microbial products would switch off allergic responses thereby preventing allergic diseases such as asthma. The hypothesis is supported by some epidemiological studies comparing large populations who have or have not had such exposure.<sup>265, 266</sup>

The concept is sometimes described as the 'microbial exposure hypothesis'. A double blind placebo controlled trial of the probiotic lactobacillus GG given to mothers resulted in a reduced incidence of atopic eczema in their children but had no effect on IgE antibody or allergic skin test responses. The small sample size and short follow up in this study limit its interpretation.<sup>267</sup> There remains insufficient understanding of the ecology of gut flora in infancy in relation to outcomes. Bifido-bacteria may be more important than lactobacilli in reducing susceptibility to allergic disease.<sup>268</sup>

There is insufficient evidence to indicate that the use of dietary probiotics in pregnancy reduces the incidence of childhood asthma.

This is a key area for further work with longer follow up to establish outcomes in relation to asthma.

### 5.1.10 AVOIDANCE OF TOBACCO SMOKE AND OTHER AIR POLLUTANTS

No evidence has been found to support a link between exposure to environmental tobacco smoke (ETS) or other air pollutants and the induction of allergy.

There is an increased risk of infant wheezing associated with maternal smoking during pregnancy which adversely affects infant lung function.<sup>269-272</sup> Evidence suggests that early life ETS exposure is associated with later persistent asthma,<sup>273,274</sup> with a strong interaction with genetic polymorphisms which affect antioxidant activity.<sup>275</sup>

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**B** Parents and parents-to-be should be advised of the many adverse effects which smoking has on their children including increased wheezing in infancy and increased risk of persistent asthma.

The limited data on antenatal or early life exposure to other pollutants suggest similar effects to those for ETS, namely increased infant wheezing, enhanced by additional ETS exposure and antioxidant gene variations.<sup>276-278</sup> There is one small study suggesting that vitamin C supplementation will modify the combined effects of genetic polymorphisms and pollution on lung function in children with asthma.<sup>279</sup> Further research is required before recommendations for practice can be made.

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### 5.1.11 IMMUNISATION

In keeping with the microbial exposure hypothesis some studies have suggested an association between tuberculin responsiveness and subsequent reduced prevalence of allergy, implying a protective effect of Bacillus Calmette-Guérin (BCG). At present, it is not possible to determine whether poor tuberculin responsiveness represents an underlying defect which increases the risk of allergy and asthma or whether the immunisation itself has a protective effect.<sup>280</sup>

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Investigation of the effects of any other childhood immunisation suggests that at worst there is no influence on subsequent allergic disease and maybe some protective effect against the development of asthma.<sup>281</sup>

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**C All childhood immunisations should proceed normally as there is no evidence of an adverse effect on the incidence of asthma.**

## 5.2 SECONDARY NON-PHARMACOLOGICAL PREVENTION

### 5.2.1 HOUSE DUST MITE AVOIDANCE

Allergic sensitisation to house dust mite-associated aeroallergens is common in people with asthma and exposure to house dust can act as a trigger in sensitised asthmatic individuals. Physical (for example mattress covers, vacuum-cleaning, heating, ventilation, freezing, washing, air-filtration and ionisers) and chemical (acaricides) measures to reduce house dust mite (HDM) aeroallergen levels and so reduce exposure have been advocated but there has been uncertainty as to whether the currently available physical and chemical measures, alone or in conjunction, can reduce the exposure levels sufficiently to allow a clinically relevant effect to be apparent.

A Cochrane review of 55 trials including 3,121 patients assessed the evidence relating to different methods of reducing exposure to HDM including:

- chemical measures, for example acaricides, (10 trials)
- physical measures, for example mattress covers (26 trials), vacuum-cleaning, heating, ventilation, freezing, washing, air-filtration and ionisers (37 trials)
- combinations of chemical and physical measures (8 trials).<sup>282</sup>

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The review showed no evidence of a beneficial effect from any individual or combination of treatments on any outcome measure, physiological or patient reported, including peak flow in the morning, number of patients improved, asthma symptom scores or medication usage. The review concludes that further studies using similar interventions are unnecessary.

**A Physical and chemical methods of reducing house dust mite levels in the home (including acaricides, mattress covers, vacuum-cleaning, heating, ventilation, freezing, washing, air-filtration and ionisers) are ineffective and should not be recommended by healthcare professionals.**

### 5.2.2 OTHER ALLERGENS

Animal allergens, particularly from cat and dog, are potent provokers of asthma symptoms. The reported effects of removal of pets from homes are paradoxical, with either no benefit for asthma<sup>283, 284</sup> or a potential for continued high exposure to induce a degree of tolerance.<sup>285</sup> In homes where there is no cat but still detectable cat allergen, there may be a benefit from introducing additional avoidance measures such as air filters and high efficiency vacuum cleaners for cat allergic patients.<sup>286, 287</sup>

Although fungal exposure has been strongly associated with hospitalisation and increased mortality in asthma, no controlled trials have addressed the efficacy of reducing fungal exposure in relation to control of asthma. Cockroach allergy is not a common problem in the UK and studies of attempts to avoid this allergen elsewhere have produced conflicting results.<sup>288</sup>

Studies of individual aeroallergen avoidance strategies show that single interventions have limited or no benefit. A multifaceted approach is more likely to be effective if it addresses all the indoor asthma triggers. Such approaches may even be cost effective.<sup>289</sup> A strategy with a potential impact on mites, mould allergens and indoor pollutants is the use of a mechanical ventilation system to reduce humidity and increase indoor air exchange. The only trial that has assessed this in a controlled fashion failed to demonstrate any significant effects, but the numbers involved were small.<sup>290</sup> A systematic review of this topic concluded that more research is required.<sup>291</sup>

### 5.2.3 SMOKING

Direct or passive exposure to cigarette smoke adversely affects quality of life, lung function, need for rescue medications for acute episodes of asthma and long-term control with ICS.<sup>292-295</sup>

There are very few trials which have assessed smoking cessation in relation to asthma control. Two studies have demonstrated decreases in childhood asthma severity when parents were able to stop smoking.<sup>296, 297</sup> One study in adults with asthma suggested that smoking cessation improved asthma specific quality of life, symptoms and drug requirements.<sup>298</sup> Intervention to reduce smoking has had disappointing outcomes.<sup>299,300</sup> It is likely that more intensive intervention will be required to achieve meaningful outcomes.<sup>301</sup>

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Uptake of smoking in teenagers increases the risks of persisting asthma. One study showed a doubling of risk for the development of asthma over six years in 14 year old children who started to smoke (*see section 6.2.4 for the effect of smoking on treatment*).<sup>302</sup>

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**B** Parents with asthma should be advised about the danger to themselves and to their children with asthma, of smoking, and be offered appropriate support to stop smoking.

### 5.2.4 AIR POLLUTION

Challenge studies demonstrate that various pollutants can enhance the response to allergen inhalation in patients with asthma.<sup>303, 304</sup> Time-series studies suggest that air pollution may provoke acute asthma attacks or aggravate existing chronic asthma although the effects are very much less than in those with infection or allergen exposure.<sup>305, 306</sup> While it might seem likely that moving from a highly polluted environment might help, in the UK, asthma is more prevalent in 12–14 year olds in non-metropolitan rather than metropolitan areas.<sup>307</sup> Much less attention has been focused on indoor pollutants in relation to asthma and more work is required.<sup>308, 309</sup>

### 5.2.5 ELECTROLYTES

Increasing dietary sodium has been implicated in the geographical variations in asthma mortality and high sodium intake is associated with increased bronchial hyper-responsiveness.<sup>310-312</sup> A systematic review of intervention studies reducing salt intake identified only minimal effects and concluded that dietary salt reduction could not be recommended in the management of asthma.<sup>313</sup> Low magnesium intake has been associated with a higher prevalence of asthma with increasing intake resulting in reduced bronchial hyper-responsiveness and higher lung function.<sup>314</sup> Magnesium plays a beneficial role in the treatment of asthma through bronchial smooth muscle relaxation, leading to the use of intravenous or inhaled preparations of magnesium

sulphate for acute asthma attacks.<sup>315</sup> Studies of oral supplementation are limited and more trials are required.<sup>316-318</sup>

#### 5.2.6 FISH OILS/LIPIDS

In vitro studies suggest that supplementing the diet with n-3PUFAs, which are most commonly found in fish oils, might reduce the inflammation associated with asthma.<sup>319,320</sup> Results from observational studies are inconsistent and a Cochrane review of nine RCTs concluded that there was insufficient evidence to recommend fish oil supplementation for the treatment of asthma.<sup>321</sup>

#### 5.2.7 ANTIOXIDANTS

Observational studies have reported that low vitamin C, vitamin E and selenium intakes are associated with a higher prevalence of asthma.<sup>257</sup> Intervention studies suggest that neither supplementation with vitamin C, vitamin E nor selenium is associated with clinical benefits in people with asthma.<sup>322-324</sup> Observational studies in both adults and children have also consistently shown that a high intake of fresh fruit and vegetable is associated with less asthma and better pulmonary function.<sup>325-33</sup> No intervention studies evaluating the intake of fruit or vegetables and their effects on asthma have been reported.

#### 5.2.8 WEIGHT REDUCTION IN OVERWEIGHT AND OBESE PATIENTS WITH ASTHMA

The current evidence base for weight reduction interventions to improve asthma control is inadequate in quantity and quality. A Cochrane review concluded that as the benefit of weight loss as an intervention for asthma control is uncertain, "...clinicians should be prepared to help patients to make a decision that is consistent with their own values...."<sup>332</sup> The management of obesity is covered in SIGN 115.<sup>333</sup>

There was insufficient evidence on which to base a recommendation relating to bariatric surgery.

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**C** **Weight loss in overweight patients has many health benefits, and should be supported in people with asthma; if successful, it may lead to improvements in asthma symptoms.**

#### 5.2.9 PROBIOTICS

Studies have suggested that an imbalance in gut flora is associated with a higher risk of development of allergy.<sup>334</sup> Trials have investigated the use of probiotics in the treatment of established allergic disease with variable results.<sup>335, 336</sup> Only one study focused on asthma, finding a decrease in eosinophilia but no effect on clinical parameters.<sup>337</sup>

In the absence of evidence of benefit, it is not possible to recommend the use of probiotics in the management of asthma.

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#### 5.2.10 IMMUNISATIONS

A number of large studies have concluded that high vaccination coverage has no significant impact on any allergic outcome or asthma. There is a suggestion that the higher the vaccine coverage the greater the possibility that there is a degree of protection against the development of allergy in the first years of life.<sup>338-341</sup>

There is some discussion about whether BCG immunisation may confer protection against allergy and asthma. Research has focused on primary prophylaxis, although

there are some studies investigating the use of BCG, with or without allergen, as a means to switch off allergic immune responses. There are some observations suggesting that benefit might occur,<sup>342</sup> but results of trials have been disappointing.<sup>343,344</sup> This is an area that requires further investigation.

There has been concern that influenza vaccination might aggravate respiratory symptoms, although any such effect would be outweighed by the benefits of the vaccination.<sup>345</sup> Studies in children have suggested that immunisation with the vaccine does not exacerbate asthma,<sup>346</sup> but has a small beneficial effect on quality of life in children with asthma.<sup>347</sup> The immune response to the immunisation may be adversely affected by high-dose ICS therapy and this requires further investigation.<sup>348</sup> A Cochrane review of pneumococcal vaccine found very limited evidence to support its use specifically in individuals with asthma.<sup>349</sup>

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**B** Immunisations should be administered independent of any considerations related to asthma. Responses to vaccines may be attenuated by high-dose inhaled corticosteroids.

#### 5.2.11 ACUPUNCTURE

A Cochrane review of 21 trials highlighted many methodological problems with the studies reviewed. Only seven of the trials, involving 174 patients, employed randomisation to active (recognised in traditional Chinese medicine to be of benefit in asthma) or sham acupuncture points (with no recognised activity) for the treatment of persistent or chronic asthma. Blinding was a major problem in the assessment of the results and there were considerable inconsistencies in methodology. The review concluded that there was no evidence for a clinically valuable benefit for acupuncture and no significant benefits in relation to lung function.<sup>350</sup> A later systematic review and meta-analysis of 11 randomised controlled trials found no evidence of an effect in reducing asthma severity but a suggestion that where bronchoconstriction was induced to establish efficacy of acupuncture there was a beneficial effect. Concern was expressed about potential preferential publication in favour of positive outcome studies.<sup>351</sup> Two other trials of acupuncture in relation to induced asthma were also negative.<sup>352,353</sup>

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#### 5.2.12 AIR IONISERS

Ionisers have been widely promoted as being of benefit for patients with asthma. A Cochrane review of five studies using negative ion generators and one with a positive ion generator found no evidence of benefit in reducing symptoms in patients with asthma.<sup>354</sup> One study demonstrated an increase in night-time cough to a level which approached statistical significance.<sup>355</sup>

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**A** Air ionisers are not recommended for the treatment of asthma.

## 5.2.13 BREATHING EXERCISES

Behavioural programmes centred on breathing exercises and hyperventilation reduction techniques (including physiotherapist-delivered breathing programmes such as the Papworth method, and the Butekyo method) can improve asthma symptoms, quality of life and reduce bronchodilator requirement in adults with asthma, although have little effect on lung function.<sup>356</sup> These techniques involve instruction by a trained therapist in exercises to reduce respiratory rate, minute volume and to promote nasal, diaphragmatic breathing. Trials that include more than five hours of intervention appeared more likely to be effective. They can help patient's experience of their condition and quality of life although do not affect lung function or airways inflammation. They should ideally be provided as part of integrated medical care.

1++

There is currently insufficient evidence relating to other breathing exercise methods, such as yoga breathing techniques and inspiratory muscle training, on which to base a recommendation.

**A Breathing exercise programmes** (including physiotherapist-taught methods) **can be offered to people with asthma as an adjuvant to pharmacological treatment to improve quality of life and reduce symptoms.**

## 5.2.14 HERBAL AND TRADITIONAL CHINESE MEDICINE

A Cochrane review identified 17 trials, nine of which reported some improvement in lung function but it was not clear that the results would be generalisable.<sup>357</sup> A more recent double blind placebo controlled trial of a Chinese herb decoction (Ding Chuan Tang) showed improvement in airway hyper-responsiveness in children with stable asthma.<sup>358</sup> It is difficult to disentangle the effects of multiple ingredients; Ding Chuan Tang for example contains nine components. In a second study, 100 children with asthma found that a five herb mixture gave some benefits in relation to lung function and symptoms compared with placebo.<sup>359</sup>

1+

The conclusions of these trials of Chinese herbal therapy are not generalisable due to variations in the herbal mixtures and study designs. There are likely to be pharmacologically active ingredients in the mixtures and further investigations are warranted. There is a need for large appropriately powered placebo controlled studies.

## 5.2.15 HOMEOPATHY

A Cochrane review identified only three methodologically sound randomised controlled trials, two of which reported some positive effects. A criticism of the studies was that they did not employ individualised homeopathy, which is the essence of this approach to treatment.<sup>360</sup> A more recent trial of individualised homeopathy in childhood asthma, which was placebo controlled and appropriately powered, failed to show any evidence of benefit over conventional treatment in primary care.<sup>361</sup>

1++  
1+

## 5.2.16 HYPNOSIS AND RELAXATION THERAPIES

A systematic review of relaxation therapies, including hypnotherapy, identified five controlled trials, two of which showed some benefits. Overall the methodology of the studies was poor and the review concluded that there was a lack of evidence of efficacy but that muscle relaxation could conceivably benefit lung function in patients with asthma.<sup>362</sup>

1++

#### 5.2.17 MANUAL THERAPY INCLUDING MASSAGE AND SPINAL MANIPULATION

A Cochrane review identified four relevant RCTs.<sup>363</sup> The two trials of chiropractic suggest that there is no role for this modality of treatment in the management of asthma. No conclusions can be drawn on massage therapy.

#### 5.2.18 PHYSICAL EXERCISE TRAINING

A Cochrane review has shown no effect of physical training on PEF, FEV<sub>1</sub>, forced vital capacity (FVC) or ventilation at maximal exercise capacity ( $V_{E_{max}}$ ).<sup>364</sup> However, oxygen consumption, maximum heart rate, and work capacity all increased significantly. Most studies discussed the potential problems of exercise induced asthma, but none made any observations on this phenomenon. As physical training improves indices of cardiopulmonary efficiency, it should be seen as part of a general approach to improving lifestyle and rehabilitation in people with asthma, with appropriate precautions advised about exercise induced asthma (*see section 6.7.2*).

#### 5.2.19 FAMILY THERAPY

A Cochrane review identified two trials, in 55 children, showing that family therapy may be a useful adjunct to medication in children with asthma.<sup>365</sup> Small study size limits the recommendations.



In difficult childhood asthma, there may be a role for family therapy as an adjunct to pharmacotherapy.

## 6 Pharmacological management

The aim of asthma management is control of the disease. Complete control of asthma is defined as:

- no daytime symptoms
- no night-time awakening due to asthma
- no need for rescue medication
- no asthma attacks
- no limitations on activity including exercise
- normal lung function (in practical terms FEV<sub>1</sub> and/or PEF > 80% predicted or best)
- minimal side effects from medication.

✓ Lung function measurements cannot be reliably used to guide asthma management in children under five years of age.

In clinical practice patients may have different goals and may wish to balance the aims of asthma management against the potential side effects or inconvenience of taking medication necessary to achieve perfect control.

A stepwise approach aims to abolish symptoms as soon as possible and to optimise peak flow by starting treatment at the level most likely to achieve this. Patients should start treatment at the step most appropriate to the initial severity of their asthma. The aim is to achieve early control and to maintain it by stepping up treatment as necessary and stepping down treatment when control is good (see Figures 4, 5 and 6 for summaries of stepwise management in adults and children).

✓ Before initiating a new drug therapy practitioners should check adherence with existing therapies (see section 4.4), inhaler technique (see section 7) and eliminate trigger factors (see section 5).

Until May 2009 all doses of ICS in this section were referenced against beclometasone dipropionate (BDP) given via chlorofluorocarbon metered dose inhalers (CFC-MDIs). As BDP-CFC is now unavailable, the reference ICS will be the BDP hydrofluoroalkane (BDP-HFA) product, which is available at the same dosage as BDP-CFC. Note that some BDP-HFA products are more potent and all should be prescribed by brand (see Table 10). Adjustments to doses will have to be made for other inhaler devices and other corticosteroid molecules (see section 6.2).

In this and the following section, each recommendation has been graded and the supporting evidence assessed for adults and adolescents >12 years old, children 5–12 years, and children under 5 years. The evidence is less clear in children under two and the threshold for seeking an expert opinion should be lowest in these children.

1	2	3	1 Adults and adolescents aged over 12
			2 Children aged 5–12 years
			3 Children under 5 years

■ Recommendation does not apply to this age group.



## 6.1 STEP 1: MILD INTERMITTENT ASTHMA

The following medicines act as short-acting bronchodilators:

- inhaled short-acting  $\beta_2$  agonists<sup>3</sup>
- inhaled ipratropium bromide<sup>366</sup>
- $\beta_2$  agonist tablets or syrup<sup>3</sup>
- theophyllines.<sup>3</sup>

>12 years	5-12 years	<5 years
1 <sup>++</sup>	1 <sup>+</sup>	4
1 <sup>+</sup>	1 <sup>++</sup>	
1 <sup>++</sup>		

Short-acting inhaled  $\beta_2$  agonists work more quickly and/or with fewer side effects than the alternatives.<sup>3</sup>

**A B D** Prescribe an inhaled short-acting  $\beta_2$  agonist as short term reliever therapy for all patients with symptomatic asthma.

### 6.1.1 FREQUENCY OF DOSING OF INHALED SHORT-ACTING $\beta_2$ AGONISTS

Using short-acting  $\beta_2$  agonists as required is at least as good as regular (four times daily) administration.<sup>367, 368</sup>

>12 years	5-12 years	<5 years
1 <sup>++</sup>	1 <sup>++</sup>	1 <sup>++</sup>

Good asthma control is associated with little or no need for short-acting  $\beta_2$  agonist.



Anyone prescribed more than one short acting bronchodilator inhaler device a month should be identified and have their asthma assessed urgently and measures taken to improve asthma control if this is poor.

## 6.2 STEP 2: INTRODUCTION OF REGULAR PREVENTER THERAPY

For steps 2, 3, and 4, treatments have been judged on their ability to improve symptoms, improve lung function, and prevent asthma attacks, with an acceptable safety profile. Improvement of quality of life, while important, is the subject of too few studies to be used to make recommendations at present.

### 6.2.1 COMPARISON OF INHALED CORTICOSTEROIDS

Many studies comparing different ICS are of inadequate design and have been omitted from further assessment. In view of the clear differences between normal volunteers and asthma patients in the absorption of ICS, data from normal volunteers have not been taken into account. Only studies in which more than one dose of at least one of the ICS or both safety and efficacy had been studied together in the same trial were evaluated. Non-blinded studies also had to be considered because of the problems of obtaining competitors' delivery devices. A series of Cochrane reviews comparing different ICS using a different methodology have come to the same conclusion.

BDP and budesonide are approximately equivalent in clinical practice, although there may be variations with different delivery devices. There is limited evidence from two open studies of suboptimal design that budesonide via the turbohaler is more clinically effective.<sup>369</sup> However, at present a 1:1 ratio should be assumed when changing between BDP and budesonide.

Fluticasone provides equal clinical activity to BDP and budesonide at half the dosage. The evidence that it causes fewer side effects at doses with equal clinical effect is limited. Mometasone appears to provide equal clinical activity to BDP and budesonide at half the dosage.<sup>370</sup> The relative safety of mometasone is not fully established.

Table 10: Equivalent doses of inhaled corticosteroids relative to beclometasone dipropionate (BDP) and licensed age indications

Inhaled corticosteroid	BDP equivalent dose	UK licence covers		
		>12 years	5–12 years	<5 years
<b>Beclometasone dipropionate</b>				
<i>Aerosol inhaler (prescribe by brand name)</i>				
Non-proprietary	400 micrograms	See individual preparation SPC*		
Clenil modulite	400 micrograms	✓	✓	✓
Qvar	200 micrograms	✓	✗	✗
Fostair	200 micrograms	Over age 18	✗	✗
<i>Dry powder inhaler</i>				
Asmabec Clickhaler	400 micrograms	✓	Over age 6	✗
<b>Budesonide</b>				
<i>Dry powder inhaler</i>				
Easyhaler, Novolizer	400 micrograms	✓	Over age 6	✗
Turbohaler preparations	400 micrograms	See individual preparation SPC*		
<b>Ciclesonide</b>				
<i>Aerosol inhaler</i>	200 to 300 micrograms	✓	✗	✗
<b>Fluticasone propionate</b>				
<i>Aerosol inhaler</i>				
Flixotide, Flutiform and Seretide	200 micrograms	See individual preparation SPC*		
<i>Dry powder inhaler</i>				
Flixotide and Seretide	200 micrograms	See individual preparation SPC*		
<b>Fluticasone furoate</b>				
<i>Dry powder inhaler</i>				
Relvar	**	✓	✗	✗
<b>Mometasone furoate</b>				
<i>Dry powder inhaler</i>				
Twisthaler	200 micrograms	✓	✗	✗

\* SPC: summary of product characteristics

\*\* Evidence for Relvar not reviewed. See the British National Formulary (BNF) and SPC.

- Dosage equivalents are approximate and dose delivered will depend on other factors such as inhaler technique
- Adult patients requiring doses of 1,000 micrograms BDP equivalent or above should be given a steroid card.<sup>371</sup>

## 6.2.2 INHALED CORTICOSTEROIDS

Inhaled corticosteroids are the most effective preventer drug for adults and older children for achieving overall treatment goals.<sup>372-376</sup> There is an increasing body of evidence demonstrating that, at recommended doses, they are also safe and effective in children under five with asthma.<sup>377-387</sup>

>12 years	5-12 years	<5 years
1++	1++	1++

Many non-atopic children under five with recurrent episodes of viral-induced wheezing do not go on to have chronic atopic asthma. The majority do not require treatment with regular ICS (*see section 3.1*).

**A A A** Inhaled corticosteroids are the recommended preventer drug for adults and children for achieving overall treatment goals.

Inhaled corticosteroids should be considered for adults, children aged 5–12 and children under the age of five with any of the following features: using inhaled  $\beta_2$  agonists three times a week or more; symptomatic three times a week or more; or waking one night a week. In addition, ICS should be considered in adults and children aged 5–12 who have had an asthma attack requiring oral corticosteroids in the last two years.<sup>388-392</sup>

>12 years	5-12 years	<5 years
1+	1+	1+

**Inhaled corticosteroids should be considered for patients with any of the following asthma-related features:**

B	C	• asthma attack in the last two years
B	B	• using inhaled $\beta_2$ agonists three times a week or more
B	B	• symptomatic three times a week or more
B	C	✓ • waking one night a week.

*Starting dose of inhaled corticosteroids*

In mild to moderate asthma, starting at very high doses of ICS and stepping down confers no benefit.<sup>393</sup>

>12 years	5-12 years	<5 years
1+	1+	

- ✓ Start patients at a dose of inhaled corticosteroids appropriate to the severity of disease.
- ✓ In adults, a reasonable starting dose of inhaled corticosteroids will usually be 400 micrograms BDP per day and in children 200 micrograms BDP per day. In children under five years, higher doses may be required if there are problems in obtaining consistent drug delivery.
- ✓ Titrate the dose of inhaled corticosteroid to the lowest dose at which effective control of asthma is maintained.

*Frequency of dosing of inhaled corticosteroids*

Most current ICS are slightly more effective when taken twice rather than once daily, but may be used once daily in some patients with milder disease and good or complete control of their asthma.<sup>3, 373, 390, 394, 395</sup>

>12 years	5-12 years	<5 years
1+	1+	1+

There is little evidence of benefit for dosage frequency more than twice daily.<sup>373</sup>

A	A	A	<b>Give inhaled corticosteroids initially twice daily</b> (except ciclesonide which is given once daily).
A	A	A	<b>Once a day inhaled corticosteroids at the same total daily dose can be considered if good control is established.</b>

### 6.2.3 SAFETY OF INHALED CORTICOSTEROIDS

The safety of ICS is of crucial importance and a balance between benefits and risks for each individual needs to be assessed. Account should be taken of other topical steroid therapy when assessing systemic risk. It has been suggested that steroid warning cards (for example, the *High Dose Inhaled Corticosteroid Safety Card* developed by the London Respiratory Network for NHS England<sup>371</sup>) should be issued to patients on higher dose ICS, but the benefits and possible disadvantages, particularly with regard to adherence, to such a policy remain to be established.

*Adults*

There is little evidence that doses below 800 micrograms BDP per day cause any short term detrimental effects apart from the local side effects of dysphonia and oral candidiasis. However, the possibility of long term effects on bone has been raised. One systematic review reported no effect on bone density at doses up to 1,000 micrograms BDP per day.<sup>396</sup> The significance of small biochemical changes in adrenocortical function is unknown.

- ✓ Titrate the dose of inhaled corticosteroid to the lowest dose at which effective control of asthma is maintained.

*Children*

Administration of ICS at or above 400 micrograms BDP a day or equivalent may be associated with systemic side effects.<sup>397</sup> These may include growth failure and adrenal suppression. Isolated growth failure is not a reliable indicator of adrenal suppression and monitoring growth cannot be used as a screening test of adrenal function.<sup>394, 398</sup>

Clinical adrenal insufficiency has been identified in a small number of children who have become acutely unwell at the time of intercurrent illness. Most of these children had been treated with high doses of ICS. The dose or duration of ICS treatment required to place a child at risk of clinical adrenal insufficiency is unknown but is likely to occur at  $\geq 800$  micrograms BDP per day or equivalent. The low-dose adrenocorticotrophic hormone (ACTH) test is considered to provide a physiological stimulation of adrenal responsiveness but it is not known how useful such a sensitive test is at predicting clinically relevant adrenal insufficiency.<sup>63, 399</sup> In addition, it is unknown how frequently tests of adrenal function would need to be repeated if a child remained on high-dose inhaled corticosteroid. At higher doses, add-on agents, for example, long-acting  $\beta_2$  agonists, should be actively considered.

While the use of ICS may be associated with adverse effects (including the potential to reduced bone mineral density) with careful ICS dose adjustment this risk is likely to be outweighed by their ability to reduce the need for multiple bursts of oral corticosteroids.<sup>400</sup>

- ✓ Monitor growth (height and weight centile) of children with asthma on an annual basis.
- ✓ The lowest dose of inhaled corticosteroids compatible with maintaining disease control should be used.

For children treated with  $\geq 800$  micrograms BDP per day or equivalent:

- ✓ Specific written advice about steroid replacement in the event of a severe intercurrent illness or surgery should be part of the management plan.
- ✓ The child should be under the care of a specialist paediatrician for the duration of the treatment.

Adrenal insufficiency is a possibility in any child maintained on ICS presenting with shock or a decreased level of consciousness; serum biochemistry and blood glucose levels should be checked urgently. Intramuscular (IM) hydrocortisone may also be required.

#### 6.2.4 SMOKING

Current and previous smoking reduces the effect of ICS, which may be overcome with increased doses.<sup>292, 401</sup>

>12 years	5-12 years	<5 years
1+		

Patients should be advised that smoking reduces the effectiveness of therapy.

**B** Clinicians should be aware that higher doses of inhaled corticosteroids may be needed in patients who are smokers or ex-smokers

#### 6.2.5 OTHER PREVENTER THERAPIES

Inhaled corticosteroids are the first choice preventer drug. Long-acting inhaled  $\beta_2$  agonists should not be used without ICS.<sup>402</sup> Alternative, less effective preventer therapies in patients taking short-acting  $\beta_2$  agonists alone are:

- Leukotriene receptor antagonists have some beneficial clinical effect<sup>373, 403, 404</sup>
  - In children under five years who are unable to take ICS, leukotriene receptor antagonists may be used as an alternative preventer.
- Sodium cromoglicate and nedocromil sodium
  - Sodium cromoglicate is of some benefit in adults<sup>3, 405</sup> and is effective in children aged 5–12<sup>406</sup>
  - Nedocromil sodium is of benefit in adults and children  $>5$ <sup>3, 407</sup>
  - There is no clear evidence of benefit with sodium cromoglicate in children aged  $<5$ <sup>408</sup>
- Theophyllines have some beneficial effect<sup>3, 372</sup>
- Antihistamines and ketotifen are ineffective.<sup>409</sup>

>12 years	5-12 years	<5 years
1++	1++	1++
1+	1+	
1++	1+	
1++	1++	1++
1++	1++	1++

- ✓ In children under five years who are unable to take inhaled corticosteroids, leukotriene receptor antagonists are an effective first line preventer.

### 6.3 STEP 3: INITIAL ADD-ON THERAPY

A proportion of patients with asthma may not be adequately controlled at step 2. Before initiating a new drug therapy practitioners should recheck adherence (*see section 4.4*), inhaler technique and eliminate trigger factors. The duration of a trial of add-on therapy will depend on the desired outcome. For instance, preventing nocturnal awakening may require a relatively short trial of treatment (days or weeks), whereas preventing asthma attacks or decreasing steroid tablet use may require a longer trial of therapy (weeks or months). If there is no response to treatment the drug should be discontinued.

#### 6.3.1 CRITERIA FOR INTRODUCTION OF ADD-ON THERAPY

No exact dose of ICS can be deemed the correct dose at which to add another therapy. The addition of other treatment options to ICS has been investigated at doses from 200–1,000 micrograms BDP in adults and up to 400 micrograms BDP in children.<sup>410-413</sup> Many patients will benefit more from add-on therapy than from increasing ICS above doses as low as 200 micrograms BDP/day. At doses of ICS above 800 micrograms BDP/day side effects become more frequent. An absolute threshold for introduction of add-on therapy in all patients cannot be defined.

>12 years	5-12 years	<5 years
1 <sup>++</sup>	1 <sup>+</sup>	

#### 6.3.2 ADD-ON THERAPY

Options for add-on therapy are summarised in Figure 3.

In adult patients taking ICS at doses of 200–800 micrograms BDP/day and in children taking ICS at a dose of 400 micrograms/day the following interventions are of value.

- **Inhaled long-acting  $\beta_2$  agonist (LABA)** is the first choice for add-on therapy; it improves lung function and symptoms, and decreases asthma attacks.<sup>410, 414-419</sup>
- **Leukotriene receptor antagonists** may provide improvement in lung function, a decrease in asthma attacks, and an improvement in symptoms.<sup>404, 420-422</sup>
- **Theophyllines** may improve lung function and symptoms, but side effects occur more commonly.<sup>411</sup>
- **Slow-release  $\beta_2$  agonist tablets** may also improve lung function and symptoms, but side effects occur more commonly.<sup>410</sup>

>12 years	5-12 years	<5 years
1 <sup>++</sup>	1 <sup>++</sup>	
1 <sup>++</sup>	1 <sup>++</sup>	1 <sup>+</sup>
1 <sup>+</sup>	1 <sup>-</sup>	
1 <sup>++</sup>		

A	B		<p><b>The first choice as add-on therapy to inhaled corticosteroids in adults and children (5-12 years) is an inhaled long-acting <math>\beta_2</math> agonist, which should be considered before going above a dose of 400 micrograms BDP or equivalent per day and certainly before going above 800 micrograms BDP.</b></p>

		B	<p><b>The first choice as add-on therapy to inhaled corticosteroids in children under five years old is a leukotriene receptor antagonist.</b></p>
--	--	---	--

If, as occasionally happens, there is no response to inhaled long-acting  $\beta_2$  agonist, stop the LABA and increase the dose of ICS to 800 micrograms BDP/day (adults) or 400 micrograms BDP/day (children) if not already on this dose. If there is a response to LABA, but control remains suboptimal, continue with the LABA and increase the dose of ICS to 800 micrograms/day (adults) or 400 micrograms/day (children 5–12 years).<sup>423</sup>

>12 years	5-12 years	<5 years
4	4	

**D D** If asthma control remains suboptimal after the addition of an inhaled long acting  $\beta_2$  agonist then the dose of inhaled corticosteroids should be increased to 800 micrograms/day in adults or 400 micrograms/day in children (5–12 years), if not already on these doses.

✓ If control remains inadequate after stopping a LABA and increasing the dose of inhaled corticosteroid, consider sequential trials of add-on therapy, ie leukotriene receptor antagonists, theophyllines, slow-release  $\beta_2$  agonist tablets (in adults only).

Addition of short-acting anticholinergics is generally of no value.<sup>412, 424</sup> Addition of nedocromil is of marginal benefit.<sup>405, 413</sup>

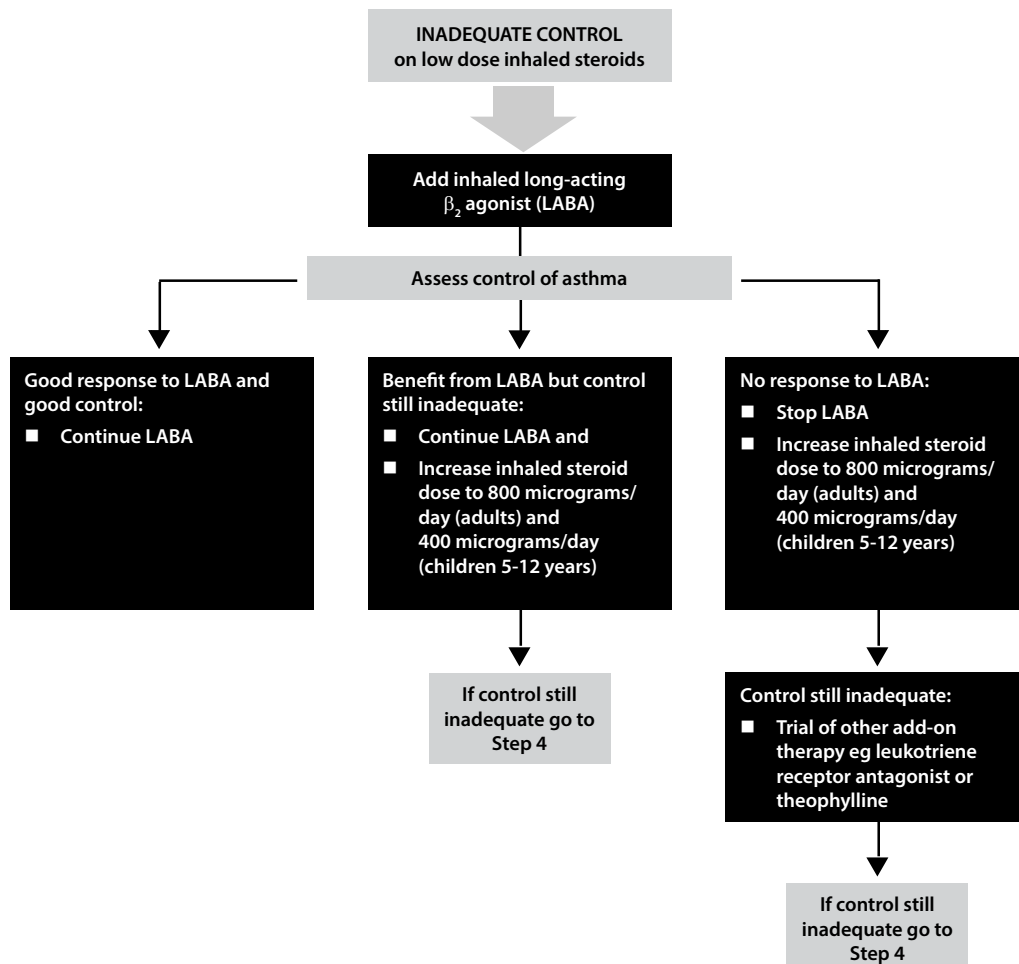
>12 years	5-12 years	<5 years
1+		

### 6.3.3 SAFETY OF LONG-ACTING $\beta_2$ AGONISTS

Following a review in 2007 of LABA in the treatment of adults, adolescents, and children with asthma, the Medicines and Healthcare products Regulatory Agency (MHRA) further reviewed the use of LABA, specifically in children younger than 12 years of age and concluded that the benefits of these medicines used in conjunction with ICS in the control of asthma symptoms outweigh any apparent risks.<sup>425</sup>

✓ Long-acting inhaled  $\beta_2$  agonists should only be started in patients who are already on inhaled corticosteroids, and the inhaled corticosteroid should be continued.

Figure 3: Summary of step 3 in adults and children >5 years: add-on therapy



6.3.4 COMBINATION INHALED CORTICOSTEROID/LONG-ACTING  $\beta_2$  AGONIST INHALERS

In efficacy studies, where there is generally good adherence, there is no difference in efficacy in giving ICS and a LABA in combination or in separate inhalers.<sup>423</sup>

>12 years	5-12 years	<5 years
1++	1++	

In clinical practice, however, it is generally considered that combination inhalers aid adherence and also have the advantage of guaranteeing that the LABA is not taken without the ICS.

- ✓ Combination inhalers are recommended to:
  - guarantee that the long-acting  $\beta_2$  agonist is not taken without inhaled corticosteroid
  - improve inhaler adherence.

In selected adult patients at step 3 who are poorly controlled or in selected adult patients at step 2 (above BDP 400 micrograms/day and poorly controlled), the use of budesonide/formoterol in a single inhaler as rescue medication instead of a short-acting  $\beta_2$  agonist, in addition to its regular use as controller therapy has been shown to be an effective treatment regime.<sup>426-430</sup> When this management option is introduced the total regular dose of daily ICS should not be decreased. The regular maintenance dose of ICS may be budesonide 200 micrograms twice daily or budesonide 400 micrograms twice daily. Patients taking rescue budesonide/formoterol once a day or more on a regular basis should have their treatment reviewed. Careful education of patients about the specific issues around this management strategy is required.

## 6.4 STEP 4: POOR CONTROL ON MODERATE DOSE OF INHALED CORTICOSTEROID + ADD-ON THERAPY: ADDITION OF FOURTH DRUG

In a small proportion of patients asthma is not adequately controlled on a combination of short-acting  $\beta_2$  agonist as required, ICS (800 micrograms BDP daily), and an additional drug, usually a LABA. There are very few clinical trials in this specific patient group to guide management. The following recommendations are largely based on extrapolation from trials of add-on therapy to ICS alone (see section 6.3.2).

D	D	<p><b>If control remains inadequate on 800 micrograms BDP daily (adults) and 400 micrograms daily (children) of an inhaled corticosteroid plus a long-acting <math>\beta_2</math> agonist, consider the following interventions:</b></p> <ul style="list-style-type: none"> <li>• increasing inhaled corticosteroids to 2,000 micrograms BDP/day (adults) or 800 micrograms BDP/day (children 5-12 years) *</li> <li>• leukotriene receptor antagonists</li> <li>• theophyllines</li> <li>• slow release <math>\beta_2</math> agonist tablets, although caution needs to be used in patients already on long-acting <math>\beta_2</math> agonists.</li> </ul>
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\* at high doses of inhaled corticosteroid via pMDI, a spacer should be used.



Long-acting muscarinic antagonists appear to be as effective as salmeterol in the short term and may be superior to doubling the dose of ICS in fixed airways obstruction. Longer term studies are required to confirm this evidence. There would also appear to be benefit in adding tiotropium to ICS and salmeterol in patients who remain symptomatic despite these medications.<sup>431, 432</sup>

There are no controlled trials indicating which of these is the best option, although the potential for side effects is greater with theophyllines and  $\beta_2$  agonist tablets.

- ✓ If a trial of an add-on treatment is ineffective, stop the drug (or in the case of increased dose of inhaled corticosteroid, reduce to the original dose).
- ✓ Before proceeding to step 5, refer patients with inadequately controlled asthma, especially children, to specialist care.
- ✓ Although there are no controlled trials, children (all ages) who are under specialist care may benefit from a trial of higher doses ICS (greater than 800 micrograms/day) before moving to step 5.

## 6.5 STEP 5: CONTINUOUS OR FREQUENT USE OF ORAL STEROIDS

The aim of treatment is to control asthma using the lowest possible doses of medication.

Some patients with very severe asthma not controlled at step 4 with high-dose ICS, and who have also been tried on or are still taking long-acting  $\beta$ -agonists, leukotriene antagonists or theophyllines, require regular long-term steroid tablets.

- ✓ For the small number of patients not controlled at step 4, use daily steroid tablets in the lowest dose providing adequate control.

### 6.5.1 PREVENTION AND TREATMENT OF STEROID TABLET-INDUCED SIDE EFFECTS

Patients on long-term steroid tablets (for example, longer than three months) or requiring frequent courses of steroid tablets (for example, three to four per year) will be at risk of systemic side effects.<sup>63</sup>

- blood pressure should be monitored
- urine or blood sugar and cholesterol should be checked: diabetes mellitus and hyperlipidaemia may occur
- bone mineral density should be monitored in adults. When a significant reduction occurs, treatment with a long-acting bisphosphonate should be offered (see British Osteoporosis Society guidelines, [www.nos.org.uk](http://www.nos.org.uk))<sup>433</sup>
- bone mineral density should be monitored in children >5 (see statement from the American Academy of Pediatrics)<sup>434</sup>
- growth (height and weight centile) should be monitored in children
- cataracts may be screened for in children through community optometric services.

### 6.5.2 STEROID FORMULATIONS

Prednisolone is the most widely used steroid for maintenance therapy in patients with chronic asthma. There is no evidence that other steroids offer an advantage.

6.5.3 FREQUENCY OF DOSING OF STEROID TABLETS

Although popular in paediatric practice, there are no studies to show whether alternate day steroids produce fewer side effects than daily steroids. No evidence was identified to guide timing of dose or dose splitting.

6.5.4 OTHER MEDICATIONS AND POTENTIAL STEROID TABLET-SPARING TREATMENTS

*Anti IgE monoclonal antibody*

Omalizumab is a humanised monoclonal antibody which binds to circulating IgE, reducing levels of free serum IgE.<sup>435, 436</sup> In adults and children over six years of age, it is licensed in the UK with the following indication: patients on high-dose ICS and long-acting  $\beta_2$  agonists who have impaired lung function, are symptomatic with frequent asthma attacks, and have allergy as an important cause of their asthma. Omalizumab is given as a subcutaneous injection every two to four weeks depending on dose. The total IgE must be <1,300 international units (IU)/ml for children over six years of age.<sup>437</sup> In adults and children >12 years, the licensed indication is a IgE up to 1,500 IU/ml but there is no published data to support its efficacy and safety above 700 IU/ml.

In a study in adults and children >12 years, there was a 19% reduction in asthma attacks requiring oral steroids which was non-significant. When corrected for imbalance in the asthma attack history at baseline, there was a 26% reduction in severe asthma attacks (0.91 on placebo v 0.68 on omalizumab over a 28 week period, p=0.042). This was associated with a significant 2.8% increase in FEV<sub>1</sub> (p=0.043), a non-significant 0.5 puffs/day decrease in  $\beta_2$  agonist use and 13% more patients having clinically meaningful improvement in health related quality of life compared with those taking placebo (60.8% v 47.8%, p=0.008). At IgE levels below 76 IU/ml the beneficial effect is reduced.<sup>438</sup>

Omalizumab as add-on therapy to ICS has been studied in children 6–12 years of age with moderate to severe asthma and has been shown to significantly reduce clinically significant asthma attacks over a period of 52 weeks. The majority of children were taking long-acting  $\beta_2$  agonists and many a leukotriene antagonist.<sup>437</sup>

Local skin reactions may occur. Anaphylaxis, presenting as bronchospasm, hypotension, syncope, urticaria, and/or angioedema of the throat or tongue has been reported to occur after administration of omalizumab. Anaphylaxis has occurred as early as the first dose, but has also occurred after one year. Due to risk of anaphylaxis, omalizumab should only be administered to patients in a healthcare setting under direct medical supervision.

>12 years	5-12 years	<5 years
1 <sup>c</sup>	1 <sup>c</sup>	1 <sup>c</sup>
	1 <sup>c</sup>	

✓ Omalizumab treatment should only be initiated in specialist centres with experience of evaluation and management of patients with severe and difficult asthma

*Other agents*

Immunosuppressants (methotrexate, ciclosporin and oral gold) decrease long term steroid tablet requirements, but all have significant side effects. There is no evidence of persisting beneficial effect after stopping them; and there is marked variability in response.<sup>439</sup>

>12 years	5-12 years	<5 years
1++	3	

- ✓ Immunosuppressants (methotrexate, ciclosporin and oral gold) may be given as a three month trial, once other drug treatments have proved unsuccessful. Their risks and benefits should be discussed with the patient and their treatment effects carefully monitored. Treatment should be in a centre with experience of using these medicines.

Colchicine and intravenous immunoglobulin have not been shown to have any beneficial effect in adults.<sup>439</sup>

>12 years	5-12 years	<5 years
1+		
4	3	3

Continuous subcutaneous terbutaline infusion has been reported to be beneficial in patients with severe asthma but efficacy and safety have not been assessed in RCTs.<sup>440-442</sup>

Anti-tumour necrosis factor alpha (anti-TNF alpha) therapy has been investigated in patients with severe asthma but these studies are too small and too short term to allow recommendation of anti-TNF alpha therapy outside the context of a controlled clinical trial.<sup>443, 444</sup>

*Patients on oral steroids not previously tried on inhaled therapy*

For patients who are on long-term steroid tablets and have not been tried on adequate doses of inhaled medication an aim is to control the asthma using the lowest possible dose of oral steroid or, if possible, to stop long-term steroid tablets completely.

Inhaled corticosteroids are the most effective drug for decreasing requirement for long-term steroid tablets.<sup>374, 375</sup>

>12 years	5-12 years	<5 years
1++	4	

There is limited evidence for the ability of long-acting  $\beta_2$  agonists, theophyllines, or leukotriene receptor antagonists to decrease requirement for steroid tablets, but they may improve symptoms and pulmonary function.<sup>445</sup>

A	D	D	<b>In adults, the recommended method of eliminating or reducing the dose of steroid tablets is inhaled corticosteroids, at doses of up to 2,000 micrograms/day, if required.</b>
D	D	D	<b>In children aged 5–12, consider very carefully before going above an inhaled corticosteroid dose of 800 micrograms/day.</b>
D	D	D	<b>There is a role for a trial of treatment with long-acting <math>\beta_2</math> agonists, leukotriene receptor antagonists, and theophyllines for about six weeks. They should be stopped if no improvement in steroid dose, symptoms or lung function is detected.</b>

6.5.5 IMMUNOTHERAPY FOR ASTHMA

Studies using both subcutaneous and sublingual allergen immunotherapy (SCIT and SLIT) have shown some benefit in reducing asthma symptoms and bronchial hyper-reactivity (BHR) in children and adults currently on a range of other preventative strategies including ICS. There are, however, few studies comparing immunotherapy with ICS or of adding immunotherapy to ICS so there is difficulty precisely defining where it should sit in step-wise asthma management.

*Subcutaneous immunotherapy*

Trials of allergen specific immunotherapy by subcutaneous injection of increasing doses of allergen extracts have consistently demonstrated beneficial effects compared with placebo in the management of allergic asthma. Allergens included house dust mite, grass pollen, tree pollen, cat and dog allergen and moulds. Cochrane reviews have concluded that immunotherapy reduces asthma symptoms, the use of asthma medications and improves bronchial hyper-reactivity. The most recent review included 42 trials with house dust mite, 27 with pollen, 10 with animal allergens, two with cladosporium mould, two with latex and six with multiple allergens.<sup>446</sup>

The effect of immunotherapy is difficult to quantify due to the use of different symptom scores and variation in the way outcomes are reported. Reductions in asthma medication use and a small symptomatic benefit have been reported but there are significant side effects including 1 in 16 patients reporting a local adverse reaction and 11% reporting a systemic adverse reaction defined as anaphylaxis, asthma, rhinitis, urticaria or a combination of these.<sup>446</sup> Immunotherapy is not licensed for the treatment of asthma; the current license is for grass pollen induced allergic rhinitis.

One study directly compared allergen immunotherapy with ICS and found that symptoms and lung function improved more rapidly in the group on ICS.<sup>447</sup>

Immunotherapy for allergic rhinitis has been shown to have a carry over effect after therapy has stopped.<sup>448</sup>

>12 years	5-12 years	<5 years
1++		
1++	1++	
2+		
3		

**B B** The use of subcutaneous immunotherapy is not recommended for the treatment of asthma in adults or children.

*Sublingual immunotherapy*

There has been increasing interest in the use of sublingual immunotherapy, which is associated with far fewer adverse reactions than subcutaneous immunotherapy. A systematic review reported that although there appeared to be some benefits in terms of asthma control, the magnitude of the effect was small and was based on mixed results for allergic symptoms overall (including asthma, rhinitis and conjunctivitis).<sup>449</sup> The review showed no significant effect on asthma symptoms or asthma medication use but did show a significant increase in side effects.

A systematic review of five earlier meta-analyses, including 43 studies, 17 of which were included in more than one meta-analysis, highlighted a number of problems relating to earlier meta-analyses, including possible misinterpretation of study findings and publication bias.<sup>450</sup>

>12 years	5-12 years	<5 years
1++	1++	
1++		

A meta-analysis of SLIT for house dust mites, reported a significant reduction in symptoms and medication required in children, although differences in reporting of symptoms scores mean it is not possible to determine the magnitude of the effect. <sup>451</sup> The analysis included only one study in adults which showed no effect on symptoms or medication use.	>12 years 1+	5-12 years 1+	<5 years
--	-----------------	------------------	----------

Sublingual immunotherapy is not licensed for use in the treatment of asthma.

<b>B</b>	<b>B</b>	<b>Sublingual immunotherapy cannot currently be recommended for the treatment of asthma in routine practice in children or adults.</b>
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### 6.5.6 BRONCHIAL THERMOPLASTY

In selected adult patients with moderate to severe asthma (aged 18–65 years), at steps 4 and 5, who have poorly controlled asthma despite maximal therapy, bronchial thermoplasty treatment has been shown to reduce the frequency of severe asthma attacks, emergency department visits and days lost from school or work in the year after treatment. <sup>452</sup> Emergency department visits, but not severe asthma attacks, are reduced in the period from first treatment to one year post-treatment. <sup>452</sup> The reduction in the frequency of asthma attacks and emergency department visits may persist for up to five years after treatment. <sup>453</sup>	>12 years 1++ 3	5-12 years	<5 years
--	-----------------------	------------	----------

Bronchial thermoplasty results in a modest improvement in asthma quality of life in the year after treatment. <sup>454</sup>	1++		
--	-----	--	--

Bronchial thermoplasty produces no consistent improvement in asthma symptoms or FEV <sub>1</sub> . <sup>452,455,456</sup> and at best a very small increase in PEF.	1++ 1+		
---	-----------	--	--

Bronchial thermoplasty results in increases in asthma-related symptoms and hospital admissions during the treatment period. <sup>454</sup> Despite this, there is no overall increase in hospital admissions with bronchial thermoplasty at one year. <sup>454</sup>	1++		
--	-----	--	--

There is some evidence for the long-term safety of the procedure from one up to five years post-treatment in relation to adverse events reporting, stable lung function and lack of increase in hospital admissions and emergency room visits. <sup>453,457</sup>	1+ 3		
---	---------	--	--

<b>A</b>	<b>Bronchial thermoplasty may be considered for the treatment of adult patients who have poorly controlled asthma despite optimal therapy.</b>
----------	--

✓	Assessment and treatment for bronchial thermoplasty should be undertaken in centres that have expertise in the assessment of difficult to control asthma and in fiberoptic bronchoscopic procedures.
---	--

✓	The balance of risks and benefits of bronchial thermoplasty treatment should be discussed with patients being considered for the procedure.
---	---

✓	Longer term follow up of treated patients is recommended.
---	---

✓	Further research is recommended into factors that identify patients who will or will not benefit from bronchial thermoplasty treatment.
---	---

Figure 4: Summary of stepwise management in adults

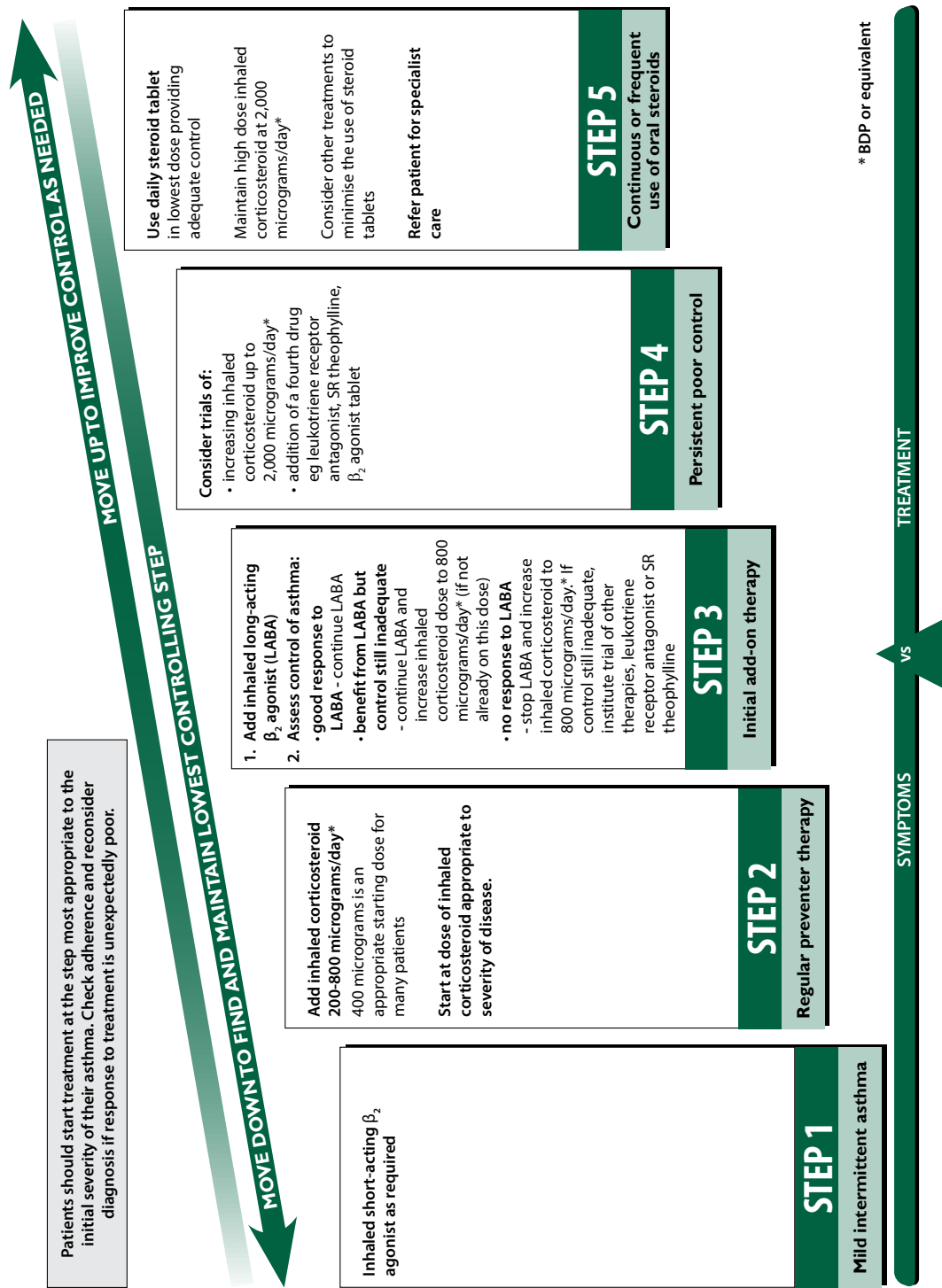


Figure 5: Summary of stepwise management in children aged 5-12 years

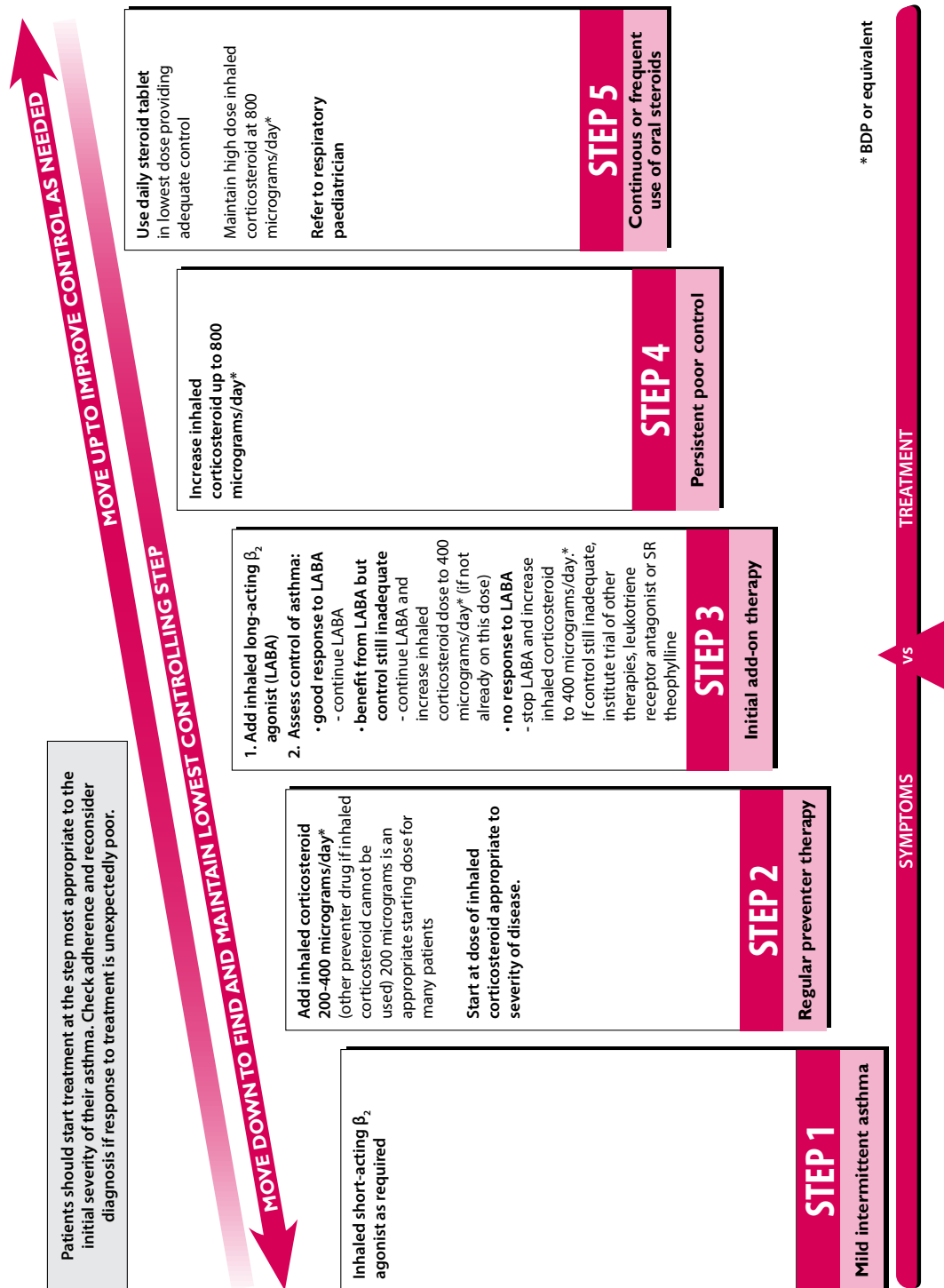
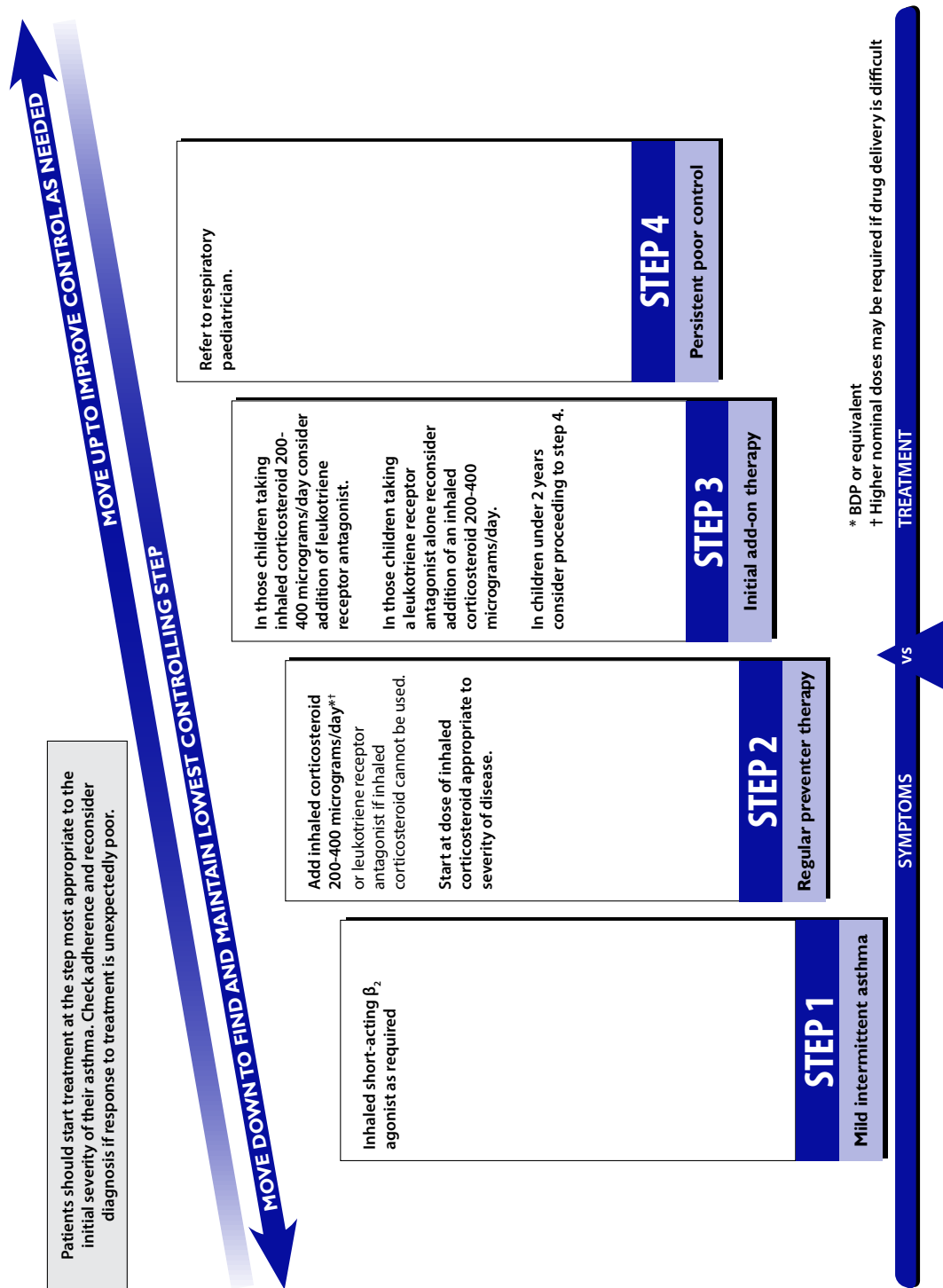


Figure 6: Summary of stepwise management in children less than 5 years





## 6.6 STEPPING DOWN

Stepping down therapy once asthma is controlled is recommended, but often not implemented leaving some patients overtreated. There are few studies that have investigated the most appropriate way to step down treatment. A study in adults on at least 900 micrograms per day of ICS has shown that for patients who are stable it is reasonable to attempt to halve the dose of ICS every three months.<sup>444</sup>

Some children with milder asthma and a clear seasonal pattern to their symptoms may have a more rapid dose reduction during their 'good' season.

✓ Regular review of patients as treatment is stepped down is important. When deciding which drug to step down first and at what rate, the severity of asthma, the side effects of the treatment, time on current dose, the beneficial effect achieved, and the patient's preference should all be taken into account.

✓ Patients should be maintained at the lowest possible dose of inhaled corticosteroid. Reduction in inhaled corticosteroid dose should be slow as patients deteriorate at different rates. Reductions should be considered every three months, decreasing the dose by approximately 25–50% each time.

## 6.7 SPECIFIC MANAGEMENT ISSUES

### 6.7.1 ASTHMA ATTACKS

Although recommended for both adults and children in previous guidelines and as part of asthma action plans, doubling the dose of ICS at the time of an exacerbation is of unproven value.<sup>458</sup> In adult patients on a low dose (200 micrograms BDP) of ICS, a fivefold increase in dose at the time of an asthma attack leads to a decrease in the severity of asthma attacks.<sup>458</sup> This study cannot be extrapolated to patients already taking higher doses of ICS and further evidence in this area is required (*see Table 9*).

A Cochrane review including five trials in 1,222 adults and 28 children (three in adults >15 years; one including adolescents >13 years; and one including children 6–14 years), showed that doubling the dose of ICS, from 1,000 to 2,000 micrograms per day, was of unproven benefit in reducing rescue oral corticosteroids.<sup>459</sup>

There is some limited evidence that leukotriene antagonists may be used intermittently in children with episodic asthma. Treatment is started at the onset of either asthma symptoms or of coryzal symptoms and continued for seven days.<sup>460</sup>

>12 years	5-12 years	<5 years
1 <sup>++</sup>		
	1 <sup>++</sup>	1 <sup>++</sup>

### 6.7.2 EXERCISE INDUCED ASTHMA

The following medicines have been shown to give protection against exercise induced asthma:

- inhaled corticosteroids<sup>374, 375, 461</sup>
- short-acting  $\beta_2$  agonists<sup>3,462</sup>
- long-acting  $\beta_2$  agonists<sup>463</sup>
- theophyllines<sup>445, 464</sup>
- leukotriene receptor antagonists<sup>465</sup>
- sodium cromoglicate or nedocromil sodium<sup>466</sup>
- $\beta_2$  agonist tablets.<sup>467</sup>

>12 years	5-12 years	<5 years
1 <sup>++</sup>	1 <sup>++</sup>	
1 <sup>++</sup>	1 <sup>++</sup>	
1 <sup>++</sup>	1 <sup>++</sup>	
1 <sup>-</sup>	2 <sup>+</sup>	
1 <sup>++</sup>	2 <sup>+</sup>	
1 <sup>++</sup>	2 <sup>+</sup>	
1 <sup>++</sup>	1 <sup>+</sup>	

The following medicines do not give protection against exercise induced asthma at normal doses:

- anticholinergics<sup>468</sup>
- ketotifen<sup>469</sup>
- antihistamine.<sup>470</sup>

Long-acting  $\beta_2$  agonists and leukotriene antagonists provide more prolonged protection than short-acting  $\beta_2$  agonists, but a degree of tolerance develops with LABA particularly with respect to duration of action. No tolerance has been demonstrated with leukotriene receptor antagonists.<sup>463, 465, 471</sup>

>12 years	5-12 years	<5 years
1+	1+	
1+	1+	
1++	1++	
1++	1++	

✓ For most patients, exercise induced asthma is an expression of poorly controlled asthma and regular treatment including inhaled corticosteroids should be reviewed.

**If exercise is a specific problem in patients taking inhaled corticosteroids who are otherwise well controlled, consider adding one of the following therapies:**

- |   |   |  |
|---|---|--|
| A | C | • leukotriene receptor antagonists         |
| A | A | • long-acting $\beta_2$ agonists           |
| C | C | • sodium cromoglicate or nedocromil sodium |
| A | A | • oral $\beta_2$ agonists                  |
| C | C | • theophyllines.                           |

Immediately prior to exercise, inhaled short-acting  $\beta_2$  agonists are the drug of choice.<sup>3, 462</sup>

A A Immediately prior to exercise, inhaled short-acting  $\beta_2$  agonists are the drug of choice.

>12 years	5-12 years	<5 years
1++	1++	

### 6.7.3 COMORBID RHINITIS

Patients with asthma often have rhinitis. The most effective therapy for rhinitis is intranasal steroids.<sup>472, 473</sup> Treatment of allergic rhinitis with intranasal steroids has not been shown, in double blind placebo-controlled trials, to improve asthma control.

>12 years	5-12 years	<5 years
1+	1+	

### 6.7.4 ALLERGIC BRONCHOPULMONARY ASPERGILLOSIS

In adult patients with allergic bronchopulmonary aspergillosis, itraconazole may decrease steroid tablet dose and improve asthma control.<sup>474, 475</sup>

>12 years	5-12 years	<5 years
1++		
2+		

C In adult patients with allergic bronchopulmonary aspergillosis, a four month trial of itraconazole should be considered.

✓ Careful monitoring for side effects, particularly hepatic, is recommended.

### 6.7.5 ASPIRIN-INTOLERANT ASTHMA

There are theoretical reasons to suggest that leukotriene receptor antagonists might be of particular value in the treatment of aspirin-intolerant asthma. However, there is little evidence to justify managing patients with aspirin-intolerant asthma in a different manner to other patients with asthma, apart from the rigorous avoidance of non-steroidal anti-inflammatory medications.<sup>476</sup>

### 6.7.6 COMORBID GASTRO-OESOPHOGEAL REFLUX

A Cochrane review of twelve double blind controlled trials found that treatment of gastro-oesophageal reflux (GORD) had no benefit on asthma symptoms or lung function when both conditions were present. Reduction in dry cough was observed although this was probably not due to improved asthma control.<sup>477, 478</sup>

A systematic review identified a single RCT which found that proton pump inhibitors (PPIs) did not improve asthma symptoms in children with GORD.<sup>479</sup>

A further systematic review, including 11 trials and 2,524 patients who had received at least four weeks of daily therapy with PPIs found a small but statistically significant improvement in morning peak expiratory flow rate (PEFR) (8.86 l/min, 95% CI 2.35 to 15.02) in study participants compared to controls, but no differences in asthma symptom score, Asthma Quality of Life Questionnaire score, evening PEF, FEV<sub>1</sub> and adverse events. The review concluded that there was insufficient evidence to support the routine use of PPIs in the treatment of asthma.<sup>480</sup>

>12 years	5-12 years	<5 years
1++		

### 6.7.7 β-BLOCKERS

β-blockers, including eye drops, are contraindicated in patients with asthma.

## 7 Inhaler devices

Although studies of inhaler devices are more suitable for an evidence-based approach than many other aspects of asthma management, a number of methodological issues complicate evidence review in this area. In young (0–5 years) children, little or no evidence is available on which to base recommendations.

### 7.1 TECHNIQUE AND TRAINING

Studies of technique and the effects of training have used arbitrary non-standardised scores making comparison difficult. Although technique will have some bearing, it does not necessarily relate to clinical effectiveness.

The proportion of patients making no mistakes with an inhaler in one well conducted study was 23–43% for pressurised metered dose inhaler (pMDI), 53–59% for dry powder inhaler (DPI) and 55–57% for pMDI + spacer. When technique was assessed as number of steps correct out of the total number of steps, pMDI + spacer was slightly better than DPI.<sup>481</sup>

Teaching technique improved the correct usage score from a mean of 60% to 79%. Figures for no mistakes after teaching were 63% for pMDI, 65% for DPI, and 75% for breath-actuated MDI (the latter figure based on one study of 2,467 patients).<sup>481</sup>

>12 years	5-12 years	<5 years
1+	1+	

**B** ✓ ✓ **Prescribe inhalers only after patients have received training in the use of the device and have demonstrated satisfactory technique.**

### 7.2 $\beta_2$ AGONIST DELIVERY

#### 7.2.1 ACUTE ASTHMA

A pMDI + spacer is at least as good as a nebuliser at treating mild and moderate asthma attacks in children and adults.<sup>482-485</sup>

>12 years	5-12 years	<5 years
1++	1++	

**A** **A** **B** **Children and adults with mild and moderate asthma attacks should be treated with a pMDI + spacer with doses titrated according to clinical response.**

There are no data on which to make recommendations in severe (life-threatening) asthma.

### 7.2.2 STABLE ASTHMA

For children aged 0–5, there is no evidence comparing nebulisers and other inhalers and the data are insufficiently extensive or robust to draw conclusions for pMDI compared to DPI.

In children aged 5–12 there is no significant difference between pMDI and DPI. In adults there is no significant difference between pMDI + spacer and DPI. The lower pulse rate with pMDI compared to Turbohaler is the only difference with regard to side effects. Patients have been shown to prefer Turbohaler to pMDI.<sup>481,486,487</sup>

>12 years	5-12 years	<5 years
1++	1++	



**In children aged 5–12, pMDI + spacer is as effective as any other hand held inhaler.**



**In adults, pMDI ± spacer is as effective as any other hand held inhaler, but patients may prefer some types of DPI.**

There are no data to make recommendations in children under five.



Choice of reliever inhaler for stable asthma should be based on patient preference and assessment of correct use. Many patients will not be prepared to carry a spacer.

### 7.3 INHALED CORTICOSTEROIDS FOR STABLE ASTHMA

No comparative data on ICS for stable asthma in children under five years were identified.

For the delivery of ICS in stable asthma in children aged 5–12 years, pMDI is as effective as Clickhaler,<sup>488,489</sup> and Pulvinal is as effective as Diskhaler.<sup>490</sup> No significant clinical difference was found between pMDI and Turbohaler at half the dose for the same drug (budesonide).<sup>481, 491</sup> This comparison cannot necessarily be made against other ICS/device combinations.

>12 years	5-12 years	<5 years
1++	1++	

In adults, there is no clinical difference in effectiveness of pMDI ± spacer compared to DPI. Breath-actuated MDI is as effective as pMDI. More recent DPIs are as effective as older DPIs.<sup>406</sup> Nebulisers have not been shown to be superior to pMDI + spacer for delivery of ICS in patients with chronic asthma. A specialised specific nebuliser may provide improved lung function and reduced rescue therapy use, but at high prescribed doses. Higher doses (>2 mg) are generally only licensed for use from a nebuliser.<sup>481, 491</sup>



**In children aged 5–12 years, pMDI + spacer is as effective as any DPI.**



**In adults, a pMDI ± spacer is as effective as any DPI.**

No recommendation can be given for nebulised therapy in children aged 5–12 years and there is no evidence relating to children aged <5 years.

## 7.4 PRESCRIBING DEVICES

There is no evidence to dictate an order in which devices should be tested for those patients who cannot use pMDI. In the absence of evidence, the most important points to consider are patient preference and local cost.

- ✓ The choice of device may be determined by the choice of drug.
  - If the patient is unable to use a device satisfactorily an alternative should be found.
  - The patient should have their ability to use the prescribed inhaler device (particularly for any change in device) assessed by a competent healthcare professional (*see section 7.1*).
  - The medication needs to be titrated against clinical response to ensure optimum efficacy.
  - Reassess inhaler technique as part of structured clinical review (*see section 13.3*).

- ✓ In children, pMDI and spacer are the preferred method of delivery of  $\beta_2$  agonists or inhaled corticosteroids. A face mask is required until the child can breathe reproducibly using the spacer mouthpiece. Where this is ineffective a nebuliser may be required.

No prospective controlled trials were found that compared using different devices for preventer and reliever treatments with using the same device for both treatments. Two cross-sectional studies found an association between increased errors in the use of inhalers when different types of inhaler were used (*see section 6.3.4*).<sup>492, 493</sup>

>12 years	5-12 years	<5 years
3		

- ✓ Prescribing mixed inhaler types may cause confusion and lead to increased errors in use. Using the same type of device to deliver preventer and reliever treatments may improve outcomes.

## 7.5 USE AND CARE OF SPACERS

- ✓
  - The spacer should be compatible with the pMDI being used.
  - The drug should be administered by repeated single actuations of the metered dose inhaler into the spacer, each followed by inhalation.
  - There should be minimal delay between pMDI actuation and inhalation.
  - Tidal breathing is as effective as single breaths.
  - Spacers should be cleaned monthly rather than weekly as per manufacturer's recommendations or performance is adversely affected. They should be washed in detergent and allowed to dry in air. The mouthpiece should be wiped clean of detergent before use
  - Drug delivery via a spacer may vary significantly due to static charge. Metal and other antistatic spacers are not affected in this way
  - Plastic spacers should be replaced at least every 12 months but some may need changing at six months.

## 8 Management of acute asthma

### 8.1 LESSONS FROM ASTHMA DEATHS AND NEAR-FATAL ASTHMA

Confidential enquires into over 200 asthma deaths in the UK conclude there are factors associated with the disease, the medical management and the patient's behaviour or psychosocial status which contribute to death. Most deaths occurred before admission to hospital.<sup>494-498</sup> The report of the UK-wide National Review of Asthma Deaths (NRAD) in 2014 reiterates many of the findings from earlier studies.<sup>499</sup>

#### 8.1.1 DISEASE FACTORS

Most patients who died of asthma had chronically severe asthma. In a minority the fatal attack occurred suddenly in a patient with mild or moderately severe background disease.<sup>494-498, 500</sup>

2++

#### 8.1.2 MEDICAL MANAGEMENT

Many of the deaths occurred in patients who had received inadequate treatment with ICS or steroid tablets and/or inadequate objective monitoring of their asthma. Follow up was inadequate in some and others should have been referred earlier for specialist advice. There was widespread underuse of written management plans. Heavy or increasing use of  $\beta_2$  agonist therapy was associated with asthma death.<sup>494-498, 501, 502</sup>

2++

Deaths continue to be reported following inappropriate prescription of  $\beta$ -blockers and non-steroidal anti-inflammatory drugs (NSAIDs); all asthma patients should be asked about past reactions to these agents (*see sections 6.7.5 and 6.7.7*).

Patients with an acute asthma attack should not be sedated unless this is to allow anaesthetic or intensive care procedures (*see section 8.3.12*).<sup>500</sup>

#### 8.1.3 ADVERSE PSYCHOSOCIAL AND BEHAVIOURAL FACTORS

Behavioural and adverse psychosocial factors were recorded in the majority of patients who died of asthma.<sup>494-498</sup> The most important of these are shown in Table 11.

Case control studies support most of these observations.<sup>503, 504</sup> Compared with control patients admitted to hospital with asthma, those who died were significantly more likely to have learning difficulties, psychosis or prescribed antipsychotic drugs, financial or employment problems, repeatedly failed to attend appointments or discharged themselves from hospital, drug or alcohol abuse, obesity or a previous near-fatal attack.

2++

Compared with control patients with asthma in the community, patients who died had more severe disease, more likelihood of a hospital admission or visit to the ED for their asthma in the previous year, more likelihood of a previous near-fatal attack, poor medical management, failure to measure pulmonary function, and non-adherence.

**B**

**Healthcare professionals must be aware that patients with severe asthma and one or more adverse psychosocial factors are at risk of death.**

Table 11: Patients at risk of developing near-fatal or fatal asthma<sup>494-498, 501, 502</sup>

<b>A combination of severe asthma recognised by one or more of:</b>
<ul style="list-style-type: none"> <li>• previous near-fatal asthma, eg previous ventilation or respiratory acidosis</li> <li>• previous admission for asthma especially if in the last year</li> <li>• requiring three or more classes of asthma medication</li> <li>• heavy use of <math>\beta_2</math> agonist</li> <li>• repeated attendances at ED for asthma care especially if in the last year</li> </ul>
<b>AND adverse behavioural or psychosocial features recognised by one or more of:</b>
<ul style="list-style-type: none"> <li>• non-adherence with treatment or monitoring</li> <li>• failure to attend appointments</li> <li>• fewer GP contacts</li> <li>• frequent home visits</li> <li>• self discharge from hospital</li> <li>• psychosis, depression, other psychiatric illness or deliberate self harm</li> <li>• current or recent major tranquilliser use</li> <li>• denial</li> <li>• alcohol or drug abuse</li> <li>• obesity</li> <li>• learning difficulties</li> <li>• employment problems</li> <li>• income problems</li> <li>• social isolation</li> <li>• childhood abuse</li> <li>• severe domestic, marital or legal stress</li> </ul>

Studies comparing near-fatal asthma with deaths from asthma have concluded that patients with near-fatal asthma have identical adverse factors to those described in Table 11, and that these contribute to the near-fatal asthma attack.<sup>505-507</sup> Compared with patients who die, those with near-fatal asthma are significantly younger, are significantly more likely to have had a previous near-fatal asthma attack, are less likely to have concurrent medical conditions, are less likely to experience delay in receiving medical care, and more likely to have ready access to acute medical care.

2+

With near-fatal asthma it is advisable to involve a close relative when discussing future management.

Patients with difficult asthma should also be identified (*see section 9.1*).



Keep patients who have had a near-fatal asthma attack under specialist supervision indefinitely.



#### 8.1.4 SEASONAL FACTORS

In the UK there is a peak of asthma deaths in young people aged up to 44 years in July and August and in December and January in older people.<sup>505, 508</sup>

2<sup>++</sup>

#### 8.1.5 PREDICTION AND PREVENTION OF A SEVERE ASTHMA ATTACK

Most attacks of asthma severe enough to require hospital admission develop relatively slowly over a period of six hours or more. In one study, over 80% developed over more than 48 hours.<sup>509-514</sup> There is therefore time for effective action to reduce the number of attacks requiring hospitalisation. There are many similarities between patients who die from asthma, patients with near-fatal asthma and control patients with asthma who are admitted to hospital.

2<sup>++</sup>

A respiratory specialist should follow up patients admitted with a severe asthma attack for at least one year after the admission.

### 8.2 ACUTE ASTHMA IN ADULTS

Annexes 2–4 contain algorithms summarising the recommended treatment for patients presenting with acute or uncontrolled asthma in primary care (*see Annex 2*), the ED (*see Annex 3*), and hospital (*see Annex 4*).

#### 8.2.1 RECOGNITION OF ACUTE ASTHMA

Definitions of increasing levels of severity of acute asthma attacks are provided in Table 12.<sup>515-520</sup> Predicted PEF values should be used only if the recent best PEF (within two years) is unknown.<sup>521</sup>

2<sup>+</sup>  
4

#### 8.2.2 SELF TREATMENT BY PATIENTS DEVELOPING ACUTE OR UNCONTROLLED ASTHMA

Patients with asthma, and all patients with severe asthma, should have an agreed written PAAP and their own peak flow meter, with regular checks of inhaler technique and adherence. They should know when and how to increase their medication and when to seek medical assistance. Written PAAPs can decrease hospitalisation for,<sup>142</sup> and deaths from asthma (*see section 4.3.2*).<sup>522</sup>

#### 8.2.3 INITIAL ASSESSMENT

All possible initial contact personnel, for example, practice receptionists, ambulance call takers, NHS 111 (England and Wales), NHS 24 (Scotland), and out-of-hours providers, should be aware that asthma patients complaining of respiratory symptoms may be at risk and should have immediate access to a doctor or trained asthma nurse. The assessments required to determine whether the patient is suffering from an acute attack of asthma, the severity of the attack and the nature of treatment required are detailed in Tables 12 and 13. It may be helpful to use a systematic recording process. Proformas have proved useful in the ED setting.<sup>523</sup>

Table 12: Levels of severity of acute asthma attacks in adults<sup>515-520</sup>

<b>Moderate asthma</b>	Increasing symptoms PEF >50–75% best or predicted No features of acute severe asthma	
<b>Acute severe asthma</b>	Any one of: - PEF 33–50% best or predicted - respiratory rate $\geq$ 25/min - heart rate $\geq$ 110/min - inability to complete sentences in one breath	
<b>Life-threatening asthma</b>	Any one of the following in a patient with severe asthma:	
	Clinical signs	Measurements
	Altered conscious level	PEF <33% best or predicted
	Exhaustion	SpO <sub>2</sub> < 92%
	Arrhythmia	PaO <sub>2</sub> < 8 kPa
	Hypotension	'normal' PaCO <sub>2</sub> (4.6–6.0 kPa)
	Cyanosis	
	Silent chest	
	Poor respiratory effort	
<b>Near-fatal asthma</b>	Raised PaCO <sub>2</sub> and/or requiring mechanical ventilation with raised inflation pressures <sup>504-507</sup>	

PaO<sub>2</sub>: partial arterial pressure of oxygen

kPa: kiloPascals

PaCO<sub>2</sub>: partial arterial pressure of carbon dioxide

#### 8.2.4 PREVENTION OF ACUTE DETERIORATION

A register of patients at risk may help primary care health professionals to identify patients who are more likely to die from their asthma. A system should be in place to ensure that these patients are contacted if they fail to attend for follow up.

#### 8.2.5 CRITERIA FOR REFERRAL

**D** Refer to hospital any patients with features of acute severe or life-threatening asthma.

Other factors, such as failure to respond to treatment, social circumstances or concomitant disease, may warrant hospital referral.

Table 13: Initial assessment of symptoms, signs and measurements

<b>Clinical features</b>	<p>Clinical features can identify some patients with severe asthma, eg severe breathlessness (including too breathless to complete sentences in one breath), tachypnoea, tachycardia, silent chest, cyanosis, accessory muscle use, altered consciousness or collapse.<sup>515-520, 524</sup></p> <p>None of these singly or together is specific. Their absence does not exclude a severe attack.</p>	2+
<b>PEF or FEV<sub>1</sub></b>	<p>Measurements of airway calibre improve recognition of the degree of severity, the appropriateness or intensity of therapy, and decisions about management in hospital or at home.<sup>525, 526</sup></p> <p>PEF or FEV<sub>1</sub> are useful and valid measures of airway calibre. PEF is more convenient in the acute situation.</p> <p>PEF expressed as a percentage of the patient's previous best value is most useful clinically. PEF as a percentage of predicted gives a rough guide in the absence of a known previous best value. Different peak flow meters give different readings. Where possible the same or similar type of peak flow meter should be used.</p>	2+
<b>Pulse oximetry</b>	<p>Measure oxygen saturation (SpO<sub>2</sub>) with a pulse oximeter to determine the adequacy of oxygen therapy and the need for arterial blood gas (ABG) measurement. The aim of oxygen therapy is to maintain SpO<sub>2</sub> 94–98%.<sup>527</sup></p>	
<b>Blood gases (ABG)</b>	<p>Patients with SpO<sub>2</sub> &lt;92% (irrespective of whether the patient is on air or oxygen) or other features of life-threatening asthma require ABG measurement.<sup>515-518, 520, 528</sup> SpO<sub>2</sub> &lt;92% is associated with a risk of hypercapnia. Hypercapnia is not detected by pulse oximetry.<sup>528</sup> In contrast, the risk of hypercapnia with SpO<sub>2</sub> &gt;92% is much less.<sup>527</sup></p>	2+ 4
<b>Chest X-ray</b>	<p>Chest X-ray is not routinely recommended in patients in the absence of:</p> <ul style="list-style-type: none"> <li>- suspected pneumomediastinum or pneumothorax</li> <li>- suspected consolidation</li> <li>- life-threatening asthma</li> <li>- failure to respond to treatment satisfactorily</li> <li>- requirement for ventilation.</li> </ul>	4
<b>Systolic paradox</b>	<p>Systolic paradox (<i>pulsus paradoxus</i>) is an inadequate indicator of the severity of an attack and should not be used.<sup>515-520, 529</sup></p>	2+

## 8.2.6 CRITERIA FOR ADMISSION

Adult patients with any feature of a life-threatening or near-fatal asthma attack or a severe asthma attack that does not resolve after initial treatment should be admitted to hospital. Admission may also be appropriate when peak flow has improved to greater than 75% best or predicted one hour after initial treatment but concerns remain about symptoms, previous history or psychosocial issues (*see sections 8.1 and 8.2*).<sup>505, 507, 515-520</sup>

2<sup>++</sup>  
2<sup>+</sup>

**B** Admit patients with any feature of a life-threatening or near-fatal asthma attack.

**B** Admit patients with any feature of a severe asthma attack persisting after initial treatment.

**C** Patients whose peak flow is greater than 75% best or predicted one hour after initial treatment may be discharged from ED unless they meet any of the following criteria, when admission may be appropriate:

- still have significant symptoms
- concerns about adherence
- living alone/socially isolated
- psychological problems
- physical disability or learning difficulties
- previous near-fatal asthma attack
- asthma attack despite adequate dose steroid tablets pre-presentation
- presentation at night
- pregnancy.

## 8.3 TREATMENT OF ACUTE ASTHMA IN ADULTS

## 8.3.1 OXYGEN

Many patients with acute severe asthma are hypoxaemic.<sup>530-533</sup> Supplementary oxygen should be given urgently to hypoxaemic patients, using a face mask, Venturi mask or nasal cannulae with flow rates adjusted as necessary to maintain SpO<sub>2</sub> of 94–98%.<sup>527</sup>

2<sup>+</sup>  
4

Emergency oxygen should be available in hospitals, ambulances and primary care.

Hypercapnia indicates the development of near-fatal asthma and the need for emergency specialist/anaesthetic intervention.

**C** Give supplementary oxygen to all hypoxaemic patients with acute severe asthma to maintain an SpO<sub>2</sub> level of 94–98%. Lack of pulse oximetry should not prevent the use of oxygen.

8.3.2  $\beta_2$  AGONIST BRONCHODILATORS

In most cases inhaled  $\beta_2$  agonists given in high doses act quickly to relieve bronchospasm with few side effects.<sup>534-536</sup> There is no evidence for any difference in efficacy between salbutamol and terbutaline. Nebulised adrenaline (epinephrine), a non-selective  $\beta_2$  agonist, does not have significant benefit over salbutamol or terbutaline.<sup>537</sup>

1++  
1+

In patients with acute asthma without life-threatening features,  $\beta_2$  agonists can be administered by repeated activations of a pMDI via an appropriate large volume spacer or by wet nebulisation driven by oxygen, if available.<sup>538</sup> Inhaled  $\beta$  agonists are as efficacious and preferable to intravenous  $\beta_2$  agonists (meta-analysis has excluded subcutaneous trials) in adult acute asthma in the majority of cases.<sup>539</sup>

1++

Metered dose inhalers with spacers can be used for patients with asthma attacks other than life threatening.<sup>538</sup>

1++

**A Use high-dose inhaled  $\beta_2$  agonists as first line agents in patients with acute asthma and administer as early as possible. Reserve intravenous  $\beta_2$  agonists for those patients in whom inhaled therapy cannot be used reliably.**

Oxygen-driven nebulisers are preferred for nebulising  $\beta_2$  agonist bronchodilators because of the risk of oxygen desaturation while using air-driven compressors.<sup>482, 515, 540</sup>

1++

A flow rate of 6 l/min is required to drive most nebulisers. Where oxygen cylinders are used, a high flow regulator must be fitted.<sup>527</sup>

4

The absence of supplemental oxygen should not prevent nebulised therapy from being administered when appropriate.<sup>541</sup>

4

**A In hospital, ambulance and primary care, nebulisers for giving nebulised  $\beta_2$  agonist bronchodilators should preferably be driven by oxygen.**

✓ In patients with acute asthma with life-threatening features the nebulised route (oxygen-driven) is recommended.

Parenteral  $\beta_2$  agonists, in addition to inhaled  $\beta_2$  agonists, may have a role in ventilated patients or those in extremis, however there is limited evidence to support this.

Most acute asthma attacks will respond adequately to bolus nebulisation of  $\beta_2$  agonists. Continuous nebulisation of  $\beta_2$  agonists with an appropriate nebuliser may be more effective than bolus nebulisation in relieving acute asthma for patients with a poor response to initial therapy.<sup>542-545</sup>

1+

**A In severe asthma that is poorly responsive to an initial bolus dose of  $\beta_2$  agonist, consider continuous nebulisation with an appropriate nebuliser.**

Repeat doses of  $\beta_2$  agonists at 15–30 minute intervals or give continuous nebulisation of salbutamol at 5–10 mg/hour (requires appropriate nebuliser) if there is an inadequate response to initial treatment. Higher bolus doses, for example 10 mg of salbutamol, are unlikely to be more effective.

## 8.3.3 STEROID THERAPY

Steroids reduce mortality, relapses, subsequent hospital admission and requirement for  $\beta_2$  agonist therapy. The earlier they are given in the acute attack the better the outcome.<sup>546, 547</sup> 1++

**A Give steroids in adequate doses in all cases of acute asthma attack.**

Steroid tablets are as effective as injected steroids, provided they can be swallowed and retained.<sup>546</sup> Prednisolone 40–50 mg daily or parenteral hydrocortisone 400 mg daily (100 mg six-hourly) are as effective as higher doses.<sup>548</sup> For convenience, steroid tablets may be given as 2 x 25 mg tablets daily rather than 8–10 x 5 mg tablets. Where necessary soluble prednisolone (sodium phosphate) 5 mg tablets are available. In cases where oral treatment may be a problem consider intramuscular methylprednisolone 160 mg as an alternative to a course of oral prednisolone.<sup>549</sup> 1++

✓ Continue prednisolone 40–50 mg daily for at least five days or until recovery.

Following recovery from the acute asthma attack steroids can be stopped abruptly. Doses do not need tapering provided the patient receives ICS (apart from patients on maintenance steroid treatment or rare instances where steroids are required for three or more weeks).<sup>550, 551</sup> 1+

It is not known if ICS provide further benefit in addition to systemic steroids. Inhaled corticosteroids should, however, be started or continued as soon as possible to start the chronic asthma management plan.<sup>552, 553</sup> 1+

## 8.3.4 IPRATROPIUM BROMIDE

Combining nebulised ipratropium bromide with a nebulised  $\beta_2$  agonist produces significantly greater bronchodilation than  $\beta_2$  agonist alone, leading to faster recovery and shorter duration of admission. Anticholinergic treatment is not necessary and may not be beneficial in milder asthma attacks or after stabilisation.<sup>554-556</sup> 1++

**B Add nebulised ipratropium bromide (0.5 mg 4–6 hourly) to  $\beta_2$  agonist treatment for patients with acute severe or life-threatening asthma or those with a poor initial response to  $\beta_2$  agonist therapy.**

## 8.3.5 MAGNESIUM SULPHATE

There is some evidence that magnesium sulphate has bronchodilator effects.<sup>557</sup> 1++

A review of 16 trials involving 838 patients showed that nebulised magnesium sulphate when used in addition to nebulised  $\beta_2$  agonist (with or without nebulised ipratropium) provided no benefit in terms of lung function or need for hospital admission.<sup>558</sup> 1++

A double-blind, placebo controlled study of 1,109 patients aged over 16 years presenting with an acute asthma attack to 34 emergency departments across the UK randomised patients to intravenous (IV) or nebulised magnesium or to placebo.<sup>559</sup> Many of these patients had PEF >50% at presentation and the study failed to show improvement in either rate of hospital admission or breathlessness as judged by visual analogue score. A single dose of IV magnesium sulphate is safe and may improve lung function and reduce intubation rates in patients with acute severe asthma.<sup>315, 560-562</sup> Intravenous magnesium sulphate may also reduce hospital admissions in adults with acute asthma who have had little or no response to standard treatment. However, the heterogeneous 1++  
1+

nature of the studies included in this review and lack of information on the severity of the asthma attack or when IV magnesium was given in relation to standard treatment limit the conclusions that can be drawn.<sup>562</sup> | 1++  
1+

The safety and efficacy of repeated IV doses have not been assessed. Repeated doses could cause hypermagnesaemia with muscle weakness and respiratory fatigue.

**A** Nebulised magnesium sulphate is not recommended for treatment in adults with acute asthma.

**B** Consider giving a single dose of IV magnesium sulphate to patients with acute severe asthma (PEF <50% best or predicted) who have not had a good initial response to inhaled bronchodilator therapy.

✓ Magnesium sulphate (1.2–2 g IV infusion over 20 minutes) should only be used following consultation with senior medical staff.

### 8.3.6 INTRAVENOUS AMINOPHYLLINE

In an acute asthma attack, IV aminophylline is not likely to result in any additional bronchodilation compared to standard care with inhaled bronchodilators and steroids. Side effects such as arrhythmias and vomiting are increased if IV aminophylline is used.<sup>563</sup> | 1++

✓ Use IV aminophylline only after consultation with senior medical staff.

Some patients with near-fatal asthma or life-threatening asthma with a poor response to initial therapy may gain additional benefit from IV aminophylline (5 mg/kg loading dose over 20 minutes unless on maintenance oral therapy, then infusion of 0.5–0.7 mg/kg/hr). Such patients are probably rare and could not be identified in a meta-analysis of trials.<sup>563</sup> If IV aminophylline is given to patients already taking oral aminophylline or theophylline, blood levels should be checked on admission. Levels should be checked daily for all patients on aminophylline infusions.

### 8.3.7 LEUKOTRIENE RECEPTOR ANTAGONISTS

Current evidence on oral leukotriene receptor antagonists does not support their use in patients with acute asthma.<sup>564</sup> Further studies are required to assess whether IV treatment is effective and safe. | 1++

### 8.3.8 ANTIBIOTICS

When an infection precipitates an asthma attack it is likely to be viral. The role of bacterial infection has been overestimated.<sup>565</sup> | 1++

**B** Routine prescription of antibiotics is not indicated for patients with acute asthma.

### 8.3.9 HELIOX

The use of heliox, (helium/oxygen mixture in a ratio of 80:20 or 70:30), either as a driving gas for nebulisers, as a breathing gas, or for artificial ventilation in adults with acute asthma is not supported on the basis of present evidence.<sup>566, 567</sup> A systematic review of ten trials, including 544 patients with acute asthma, found no improvement in pulmonary function or other outcomes in adults treated with heliox, although the possibility of benefit in patients with more severe obstruction exists.<sup>568, 569</sup> Heliox requires the use of specifically designed or modified breathing circuits and ventilators. | 1++  
1+

**B Heliox is not recommended for use in patients with acute asthma outside a clinical trial setting.**

### 8.3.10 INTRAVENOUS FLUIDS

There are no controlled trials, observational or cohort studies of differing fluid regimes in patients with acute asthma. Some patients require rehydration and correction of electrolyte imbalance. Hypokalaemia can be caused or exacerbated by  $\beta_2$  agonist and/or steroid treatment and must be corrected.

### 8.3.11 NEBULISED FUROSEMIDE

Although theoretically furosemide may produce bronchodilation, a review of three small trials failed to show any significant benefit of treatment with nebulised furosemide compared to  $\beta_2$  agonists.<sup>570</sup>

1+

### 8.3.12 REFERRAL TO INTENSIVE CARE

Indications for admission to intensive care or high-dependency units include patients requiring ventilatory support and those with acute severe or life-threatening asthma who are failing to respond to therapy, as evidenced by:

- deteriorating PEF
- persisting or worsening hypoxia
- hypercapnia
- arterial blood gas analysis showing fall in pH or rising H<sup>+</sup> concentration
- exhaustion, feeble respiration
- drowsiness, confusion, altered conscious state
- respiratory arrest.<sup>515, 516</sup>

2+

✓ In patients with acute severe or life-threatening asthma, anaesthetists and intensivists should be notified as soon as possible if there is no improvement in or deterioration of asthma.

Not all patients admitted to the intensive care unit (ICU) need ventilation, but those with worsening hypoxia or hypercapnia, drowsiness or unconsciousness and those who have had a respiratory arrest require intermittent positive pressure ventilation. Intubation in such patients is very difficult and should be performed by an anaesthetist or ICU consultant.<sup>515, 516</sup>

2+

**C All patients transferred to intensive care units should be accompanied by a doctor suitably equipped and skilled to intubate if necessary.**

### 8.3.13 NON-INVASIVE VENTILATION

Non-invasive ventilation (NIV) is well established in the management of ventilatory failure caused by extrapulmonary restrictive conditions and exacerbations of COPD. Hypercapnic respiratory failure developing during an acute asthmatic attack is an indication for urgent ICU admission. It is unlikely that NIV would replace intubation in these very unstable patients but it has been suggested that this treatment can be used safely and effectively.<sup>571</sup>

4



A Cochrane review found only one trial, with 30 patients, on NIV which showed improvement in hospitalisation rates, discharge from emergency departments and lung function. Larger RCTs are needed to determine the role of NIV in treating patients with acute asthma.<sup>572</sup>

1<sup>++</sup>

- ✓ NIV should only be considered in an ICU or equivalent clinical setting.

#### 8.4 FURTHER INVESTIGATION AND MONITORING

- ✓
  - Measure and record PEF 15–30 minutes after starting treatment, and thereafter according to the response. Measure and record PEF before and after nebulised or inhaled  $\beta_2$  agonist.
  - Record oxygen saturation by oximetry and maintain arterial SpO<sub>2</sub> at 94–98%.
  - Repeat measurements of blood gas tensions within one hour of starting treatment if:
    - the initial PaO<sub>2</sub> is <8 kPa unless SpO<sub>2</sub> is >92%; or
    - the initial PaCO<sub>2</sub> is normal or raised; or
    - the patient's condition deteriorates.
- ✓
  - Measure them again if the patient's condition has not improved by 4–6 hours.
  - Measure and record the heart rate.
  - Measure serum potassium and blood glucose concentrations.
  - Measure the serum theophylline concentration if aminophylline is continued for more than 24 hours (aim at a concentration of 10–20 mg/l or 55–110 mol/l).

#### 8.5 ASTHMA MANAGEMENT PROTOCOLS AND PROFORMAS

The use of structured proformas facilitates improvements in the process of care in emergency departments and hospital wards and improves patient outcomes. The use of this type of documentation can assist data collection aimed at determining quality of care and outcomes.<sup>523, 573, 574</sup>

2<sup>++</sup>

#### 8.6 HOSPITAL DISCHARGE AND FOLLOW UP

Annex 4 summarises management of acute severe asthma in hospital.

##### 8.6.1 TIMING OF DISCHARGE

No single physiological parameter defines absolutely the timing of discharge from an admission with acute asthma. Patients should have clinical signs compatible with home management, be on reducing amounts of  $\beta_2$  agonist (preferably no more than four hourly) and be on medical therapy they can continue safely at home.

Although diurnal variability of PEF is not always present during an asthma attack, evidence suggests that patients discharged with PEF <75% best or predicted and with diurnal variability >25% are at greater risk of early relapse and readmission.<sup>575, 576</sup>

2<sup>+</sup>

## 8.6.2 PATIENT EDUCATION

Following discharge from hospital or emergency departments, a proportion of patients re-attend with more than 15% re-attending within two weeks. Some repeat attenders need emergency care, but many delay seeking help, and are undertreated and/or undermonitored.<sup>577</sup>

2+

Prior to discharge, trained staff should give asthma education. This should include education on inhaler technique and PEF record keeping, with a written PEF and symptom-based PAAP being provided allowing the patient to adjust their therapy within recommendations. These measures have been shown to reduce morbidity after the asthma attack and reduce relapse rates.<sup>578</sup>

1++

There is some experience of a discrete population of patients who use emergency departments rather than primary care services for their asthma care.<sup>90</sup> Education has been shown to reduce subsequent hospital admission and improve scheduled appointments and self management techniques but does not improve re-attendance at emergency departments.<sup>163</sup>

1++

For the above groups there is a role for a trained asthma liaison nurse based in, or associated with, the Emergency Department.<sup>163</sup>

Patient education is covered in section 4.2.1.

## 8.6.3 FOLLOW UP

A careful history should elicit the reasons for the asthma attack and explore possible actions the patient should take to prevent future emergency presentations.

Medication should be altered depending upon the assessment and the patient provided with an asthma action plan aimed at preventing relapse, optimising treatment and preventing delay in seeking assistance in the future.

Follow up should be arranged prior to discharge with the patient's general practitioner or asthma nurse within two working days and with a hospital specialist asthma nurse or respiratory physician at about one month after admission.

In a small RCT, follow-up care by a nurse specialist was as effective and safe as that given by a respiratory doctor.<sup>579</sup>

1+

Assisting patients in making appointments while being treated for an acute asthma attack in emergency departments may improve subsequent attendance at primary care centres.<sup>580</sup>

1+



It is essential that the patient's primary care practice is informed within 24 hours of discharge from the emergency department or hospital following an asthma attack. Ideally this communication should be directly with a named individual responsible for asthma care within the practice, by means of fax or email.

## 8.7 ACUTE ASTHMA IN CHILDREN AGED 2 YEARS AND OVER

### 8.7.1 CLINICAL ASSESSMENT

Table 14 details criteria for assessment of severity of acute asthma attacks in children. Annexes 5–7 contain algorithms summarising the recommended treatments for children presenting with acute or uncontrolled asthma in primary care (*see Annex 5*), the ED (*see Annex 6*), and hospital (*see Annex 7*).

Table 14: Levels of severity of acute asthma attacks in children<sup>581</sup>

<b>Moderate asthma</b>	<p>Able to talk in sentences</p> <p>SpO<sub>2</sub> ≥92%</p> <p>PEF ≥50% best or predicted</p> <p>Heart rate ≤140/min in children aged 2–5 years ≤125/min in children &gt;5 years</p> <p>Respiratory rate ≤40/min in children aged 2–5 years ≤30/min in children &gt;5 years</p>	
<b>Acute severe asthma</b>	<p>Can't complete sentences in one breath or too breathless to talk or feed</p> <p>SpO<sub>2</sub> &lt;92%</p> <p>PEF 33–50% best or predicted</p> <p>Heart rate &gt;140/min in children aged 2–5 years &gt;125/min in children aged &gt;5 years</p> <p>Respiratory rate &gt;40/min in children aged 2–5 years &gt;30/min in children aged &gt;5 years</p>	
<b>Life-threatening asthma</b>	Any one of the following in a child with severe asthma:	
	<b>Clinical signs</b>	<b>Measurements</b>
	Silent chest	SpO <sub>2</sub> <92%
	Cyanosis	PEF <33% best or predicted
	Poor respiratory effort	
	Hypotension	
	Exhaustion	
	Confusion	

Before children can receive appropriate treatment for an acute asthma attack in any setting, it is essential to assess accurately the severity of their symptoms. The following clinical signs should be recorded:

- Pulse rate  
*(increasing tachycardia generally denotes worsening asthma; a fall in heart rate in life-threatening asthma is a pre-terminal event)*
- Respiratory rate and degree of breathlessness  
*(ie too breathless to complete sentences in one breath or to feed)*
- Use of accessory muscles of respiration  
*(best noted by palpation of neck muscles)*
- Amount of wheezing  
*(which might become biphasic or less apparent with increasing airways obstruction)*
- Degree of agitation and conscious level  
*(always give calm reassurance).*

Clinical signs correlate poorly with the severity of airways obstruction.<sup>582-585</sup> Some children with acute severe asthma do not appear distressed. | 2<sup>++</sup>

✓ Decisions about admission should be made by trained clinicians after repeated assessment of the response to bronchodilator treatment.

#### 8.7.2 PULSE OXIMETRY

Accurate measurements of oxygen saturation are essential in the assessment of all children with acute wheezing. Oxygen saturation monitors should be available for use by all health professionals assessing acute asthma in both primary and secondary care settings.

Low oxygen saturations after initial bronchodilator treatment selects a group of patients with more severe asthma.<sup>582, 585</sup> | 2<sup>++</sup>

**B** Consider intensive inpatient treatment of children with SpO<sub>2</sub> <92% in air after initial bronchodilator treatment.

#### 8.7.3 PEF

PEF measurements can be of benefit in assessing children who are familiar with the use of such devices. The best of three PEF measurements, ideally expressed as a percentage of personal best, can be useful in assessing the response to treatment.

A measurement of <50% predicted PEF or FEV<sub>1</sub> with poor improvement after initial bronchodilator treatment is predictive of a more prolonged asthma attack.

#### 8.7.4 CHEST X-RAY

Chest X-rays rarely provide additional useful information and are not routinely indicated.<sup>586, 587</sup>

✓ A chest X-ray should be performed if there is subcutaneous emphysema, persisting unilateral signs suggesting pneumothorax, lobar collapse or consolidation and/or life-threatening asthma not responding to treatment.

#### 8.7.5 BLOOD GASES

Blood gas measurements should be considered if there are life-threatening features not responding to treatment. Arteriolised ear lobe blood gases can be used to obtain an accurate measure of pH and PaCO<sub>2</sub>.<sup>527</sup> If ear lobe sampling is not practicable a finger prick sample can be an alternative. Normal or raised PaCO<sub>2</sub> levels are indicative of worsening asthma. A more easily obtained free flowing venous blood PaCO<sub>2</sub> measurement of <6 kPa (45 millimetres of mercury (mm Hg) excludes hypercapnia.<sup>527</sup> | 4

### 8.8 INITIAL TREATMENT OF ACUTE ASTHMA IN CHILDREN AGED 2 YEARS AND OVER

There is good evidence supporting recommendations for the initial treatment of children with acute asthma presenting to primary and secondary healthcare resources. There is less evidence to guide the use of second line therapies to treat the small number of severe cases poorly responsive to first line measures. Despite this, the risks of death and other adverse outcomes after admission to hospital are extremely small irrespective of the treatment options chosen.

Emergency departments attending to children with acute asthma should have a nurse trained in paediatrics available on duty at all times and staff familiar with the specific needs of children. Using a proforma can increase the accuracy of severity assessment.

The use of an assessment-driven algorithm and an integrated care pathway has been shown to reduce hospital stay without substantial increases in treatment costs.<sup>588</sup>

4

**D The use of structured care protocols detailing bronchodilator usage, clinical assessment, and specific criteria for safe discharge is recommended.**

### 8.8.1 OXYGEN

✓ Children with life-threatening asthma or  $\text{SpO}_2 < 94\%$  should receive high flow oxygen via a tight fitting face mask or nasal cannula at sufficient flow rates to achieve normal saturations of 94–98%.

### 8.8.2 INHALED SHORT-ACTING $\beta_2$ AGONISTS

Inhaled  $\beta_2$  agonists are the first line treatment for acute asthma in children aged 2 years and over.<sup>589-592</sup> Assessment of response should be based on accurately recorded clinical observations and repeat measurements of oxygenation ( $\text{SpO}_2$ ) (see Table 14). Children receiving  $\beta_2$  agonists via pMDI + spacer are less likely to have tachycardia and hypoxia than when the same drug is given via a nebuliser.<sup>482</sup>

1+

**A Inhaled  $\beta_2$  agonists are the first line treatment for acute asthma.**

✓ Discontinue long-acting  $\beta_2$  agonists when short-acting  $\beta_2$  agonists are required more often than four hourly.

**A A pMDI + spacer is the preferred option in children with mild to moderate asthma.**

Children less than three years of age are likely to require a face mask connected to the mouthpiece of a spacer for successful drug delivery. Inhalers should be actuated into the spacer in individual puffs and inhaled immediately by tidal breathing (for five breaths).

Frequent doses of  $\beta_2$  agonists are safe for the treatment of acute asthma,<sup>589-591</sup> although children with mild symptoms benefit from lower doses.<sup>592</sup>

1+

**B Individualise drug dosing according to severity and adjust according to the patient's response.**

Two to four puffs of salbutamol 100 micrograms pMDI via a spacer might be sufficient for mild asthma attacks, although up to 10 puffs might be needed for more severe attacks. Single puffs should be given one at a time and inhaled separately with five tidal breaths. Relief from symptoms should last 3–4 hours. If symptoms return within this time a further or larger dose (maximum 10 puffs) should be given and the parents/carer should seek urgent medical advice.

Children with severe or life-threatening asthma ( $\text{SpO}_2 < 92\%$ ) should receive frequent doses of nebulised bronchodilators driven by oxygen (2.5–5 mg salbutamol). If there is poor response to the initial dose of  $\beta_2$  agonists, subsequent doses should be given in combination with nebulised ipratropium bromide. Doses of nebuliser bronchodilator can be repeated every 20–30 minutes. Continuous nebulised  $\beta_2$  agonists are of no greater

benefit than the use of frequent intermittent doses in the same total hourly dosage.<sup>593,594</sup> Once improving on two to four-hourly salbutamol, patients should be switched to pMDI and spacer treatment as tolerated.

- ✓ Increase  $\beta_2$  agonist dose by giving one puff every 30–60 seconds, according to response, up to a maximum of ten puffs.
- ✓ Parents/carers of children with an acute asthma attack at home and symptoms not controlled by up to 10 puffs of salbutamol via pMDI and spacer, should seek urgent medical attention.
- ✓ If symptoms are severe additional doses of bronchodilator should be given as needed whilst awaiting medical attention.
- ✓ Paramedics attending to children with an acute asthma attack should administer nebulised salbutamol, using a nebuliser driven by oxygen if symptoms are severe, whilst transferring the child to the emergency department.
- ✓ Children with severe or life-threatening asthma should be transferred to hospital urgently.

### 8.8.3 IPRATROPIUM BROMIDE

There is good evidence for the safety and efficacy of frequent doses of ipratropium bromide (every 20–30 minutes) used in addition to  $\beta_2$  agonists for the first two hours of a severe asthma attack. Benefits are more apparent in the most severe patients.<sup>595</sup>

1+

**A** If symptoms are refractory to initial  $\beta_2$  agonist treatment, add ipratropium bromide (250 micrograms/dose mixed with the nebulised  $\beta_2$  agonist solution).

Frequent doses up to every 20–30 minutes (250 micrograms/dose mixed with 5 mg of salbutamol solution in the same nebuliser) should be used for the first few hours of admission. Salbutamol dose should be weaned to one to two-hourly thereafter according to clinical response. The ipratropium dose should be weaned to four to six-hourly or discontinued.

- ✓ Repeated doses of ipratropium bromide should be given early to treat children who are poorly responsive to  $\beta_2$  agonists.

### 8.8.4 STEROID THERAPY

#### *Steroid tablets*

The early use of steroids in emergency departments and assessment units can reduce the need for hospital admission and prevent a relapse in symptoms after initial presentation.<sup>546,547</sup> Benefits can be apparent within three to four hours. In head-to-head comparisons there is insufficient evidence to suggest that dexamethasone offers an advantage over prednisolone for the management of mild to moderate acute asthma in children. Furthermore, correctly powered studies may indicate whether a single dose of dexamethasone may offer clinical benefit over multiple doses of prednisolone.<sup>596-598</sup>

1+  
1-

**A** Give oral steroids early in the treatment of acute asthma attacks.

**B** Oral prednisolone is the steroid of choice for asthma attacks in children unless the patient is unable to tolerate the dose.

A soluble preparation dissolved in a teaspoonful of water is preferable in those unable to swallow tablets. Use a dose of 20 mg of prednisolone for children 2–5 years old and 30–40 mg for children >5 years.

Oral and intravenous steroids are of similar efficacy.<sup>548, 599, 600</sup> Intravenous hydrocortisone (4 mg/kg repeated four hourly) should be reserved for severely affected children who are unable to retain oral medication. 1+

Larger doses do not appear to offer a therapeutic advantage for the majority of children.<sup>601</sup> There is no need to taper the dose of steroid tablets at the end of treatment.<sup>550, 551</sup> 2+

- ✓ • Use a dose of 20 mg prednisolone for children aged 2–5 years and a dose of 30–40 mg for children >5 years. Those already receiving maintenance steroid tablets should receive 2 mg/kg prednisolone up to a maximum dose of 60 mg.
- Repeat the dose of prednisolone in children who vomit and consider intravenous steroids in those who are unable to retain orally ingested medication.
- Treatment for up to three days is usually sufficient, but the length of course should be tailored to the number of days necessary to bring about recovery. Tapering is unnecessary unless the course of steroids exceeds 14 days.

A large UK study of pre-school children with mild to moderate wheeze associated with viral infection showed no reduction in hospital stay (or other outcomes) following treatment with oral steroids. In the acute situation, it is often difficult to determine whether a pre-school child has asthma or episodic viral wheeze. Children with severe symptoms requiring hospital admission should still receive oral steroids. In children who present with moderate to severe wheeze without a previous diagnosis of asthma it is still advisable to give oral steroids. For children with frequent episodes of wheeze associated with viruses caution should be taken in prescribing multiple courses of oral steroids.<sup>602</sup> 1++

#### *Inhaled corticosteroids*

There is insufficient evidence to support the use of ICS as alternative or additional treatment to steroid tablets for children with acute asthma.<sup>552, 603-610</sup> 1++  
1+  
1-

**A Do not use inhaled corticosteroids in place of oral steroids to treat children with an acute asthma attack.**

Children with chronic asthma not receiving regular preventative treatment will benefit from starting ICS as part of their long-term management. There is no evidence that increasing the dose of ICS is effective in treating acute symptoms, but it is good practice for children already receiving ICS to continue with their usual maintenance doses.

- ✓ It is good practice for children already receiving inhaled corticosteroids to continue with their usual maintenance dose during an asthma attack whilst receiving additional treatment.

## 8.8.5 LEUKOTRIENE RECEPTOR ANTAGONISTS

Initiating oral montelukast in primary care settings, early after the onset of an acute asthma attack, can result in decreased asthma symptoms and the need for subsequent healthcare attendances in those with mild asthma attacks.<sup>460,611</sup> Current evidence shows no benefit for the addition of leukotriene receptor antagonists to standard asthma treatment for moderate to severe asthma attacks.<sup>564</sup>

1++  
1+

## 8.8.6 NEBULISED MAGNESIUM SULPHATE

There is no evidence to support the use of nebulised magnesium sulphate, either in place of or in conjunction with inhaled  $\beta_2$  agonists in children with mild to moderate asthma.<sup>558</sup> A sub group analysis from a large RCT suggests a possible role in children with more severe asthma attacks (oxygen saturation less than 92%) or with short duration of deterioration. Further studies are required to evaluate which clinical groups would benefit the most from this intervention.<sup>612</sup>

1++

**A** Nebulised magnesium sulphate is not recommended for children with mild to moderate asthma attacks.

**C** Consider adding 150 mg magnesium sulphate to each nebulised salbutamol and ipratropium in the first hour in children with a short duration of acute severe asthma symptoms presenting with an oxygen saturation less than 92%.

## 8.9 SECOND LINE TREATMENT OF ACUTE ASTHMA IN CHILDREN AGED 2 YEARS AND OVER

Children with continuing severe asthma despite frequent nebulised  $\beta_2$  agonists and ipratropium bromide plus oral steroids, and those with life-threatening features, need urgent review by a specialist with a view to transfer to a high dependency unit or paediatric intensive care unit (PICU) to receive second line intravenous therapies. There are three options to consider; salbutamol, aminophylline and magnesium sulphate. There is no clear evidence that one IV therapy is preferential to another. A systematic review of four paediatric trials comparing IV salbutamol with IV aminophylline demonstrated equivalence. One study found a shorter length of stay in the aminophylline group although these patients received a bolus followed by an infusion, compared to a single bolus of IV salbutamol. Both IV salbutamol and IV aminophylline can cause side effects and should be administered with appropriate monitoring. There are no head-to-head studies of magnesium sulphate and another IV therapy.<sup>613</sup>

1++

## 8.9.1 IV SALBUTAMOL

The role of intravenous  $\beta_2$  agonists in addition to nebulised treatment remains unclear.<sup>539</sup> One study has shown that an IV bolus of salbutamol given in addition to near-maximal doses of nebulised salbutamol results in clinically significant benefits for those with moderate to severe asthma.<sup>539</sup>

1+

**B** Consider early addition of a single bolus dose of intravenous salbutamol (15 micrograms/kg over 10 minutes) in a severe asthma attack where the patient has not responded to initial inhaled therapy.



A continuous intravenous infusion of salbutamol should be considered when there is uncertainty about reliable inhalation or for severe refractory asthma. This should be given in a high dependency unit with continuous electrocardiogram (ECG) monitoring and twice daily electrolyte monitoring. Doses above 1–2 micrograms/kg/min (200 micrograms/ml solution) should be given in a PICU setting (up to 5 micrograms/kg/min). Nebulised bronchodilators should be continued while the patient is receiving intravenous bronchodilators. Once the patient is improving the intravenous infusion should be reduced before reducing the frequency of nebulised bronchodilators.

- ✓ When inserting an IV cannula take a blood sample to measure serum electrolytes. Serum potassium levels are often low after multiple doses of  $\beta_2$  agonists and should be replaced.

### 8.9.2 IV AMINOPHYLLINE

There is no evidence that aminophylline is of benefit for mild to moderate asthma and side effects are common and troublesome.<sup>563, 614</sup> One well conducted study has shown evidence of benefit in children with acute severe asthma unresponsive to multiple doses of  $\beta_2$  agonists and steroids, although the loading dose used was double that currently recommended in the UK and a third of patients were withdrawn from active medication because of vomiting.<sup>615</sup>

1+  
2+

**A** Aminophylline is not recommended in children with mild to moderate acute asthma.

**B** Consider aminophylline for children with severe or life-threatening asthma unresponsive to maximal doses of bronchodilators and steroids.

A 5 mg/kg loading dose should be given over 20 minutes with ECG monitoring (omit in those receiving maintenance oral theophyllines) followed by a continuous infusion at 1 mg/kg/hour. Measure serum theophylline levels in patients already receiving oral treatment and in those receiving prolonged treatment.

### 8.9.3 IV MAGNESIUM SULPHATE

Intravenous magnesium sulphate is a safe treatment for acute asthma although its place in management is not yet established.<sup>561, 616</sup> Doses of up to 40 mg/kg/day (maximum 2 g) by slow infusion have been used. Studies of efficacy for severe childhood asthma unresponsive to more conventional therapies have been inconsistent in providing evidence of benefit.

1+

### 8.9.4 OTHER THERAPIES

There is no evidence to support the use of heliox for the treatment of acute asthma in childhood.

There is insufficient evidence to support or refute the role of antibiotics in acute asthma,<sup>406</sup> but the majority of acute asthma attacks are triggered by viral infection.

- ✓ Do not give antibiotics routinely in the management of children with acute asthma.

### 8.9.5 DISCHARGE PLANNING

Children can be discharged when stable on 3–4 hourly inhaled bronchodilators that can be continued at home.<sup>617</sup> PEF and/or FEV<sub>1</sub> should be >75% of best or predicted and SpO<sub>2</sub> >94%.

Adult studies show that optimal care comprising self monitoring, regular review and a written PAAP can improve outcomes.<sup>142</sup> Acute asthma attacks should be considered a failure of preventive therapy and thought should be given about how to help families avoid further severe episodes.

Discharge plans should address the following:

- check inhaler technique
- consider the need for preventer treatment
- provide a written PAAP for subsequent asthma attacks with clear instructions about the use of bronchodilators and the need to seek urgent medical attention in the event of worsening symptoms not controlled by up to 10 puffs of salbutamol four hourly
- arrange follow up by primary care services within 48 hours
- arrange follow up in a paediatric asthma clinic within one to two months
- arrange referral to a paediatric respiratory specialist if there have been life-threatening features.

### 8.10 ASSESSMENT OF ACUTE ASTHMA IN CHILDREN AGED LESS THAN 2 YEARS

The assessment of acute asthma in early childhood can be difficult (*see Annex 8*). Intermittent wheezing attacks are usually due to viral infection and the response to asthma medication is inconsistent. Prematurity and low birth weight are risk factors for recurrent wheezing. The differential diagnosis of symptoms includes aspiration pneumonitis, pneumonia, bronchiolitis, tracheomalacia, and complications of underlying conditions such as congenital anomalies and cystic fibrosis. These guidelines are intended for those who are thought to have asthma causing acute wheeze. They should not be used as a guide for treating acute bronchiolitis (*see SIGN 91: Bronchiolitis in children*).<sup>618</sup>

### 8.11 TREATMENT OF ACUTE ASTHMA IN CHILDREN AGED LESS THAN 2 YEARS

#### 8.11.1 $\beta_2$ AGONIST BRONCHODILATORS

A trial of bronchodilator therapy should be considered when symptoms are of concern. If inhalers have been successfully administered but there is no response, review the diagnosis and consider the use of other treatment options.

Inhaled  $\beta_2$  agonists are the initial treatment of choice for acute asthma. Close fitting face masks are essential for optimal drug delivery. The dose received is increased if the child is breathing appropriately and not taking large gasps because of distress and screaming.

There is good evidence that pMDI + spacer is as effective as, if not better than, nebulisers for treating mild to moderate asthma in children aged  $\leq 2$  years.<sup>484, 619, 620</sup>

1+

**A**

**For mild to moderate acute asthma attacks, a pMDI + spacer and mask is the optimal drug delivery device.**

Whilst  $\beta_2$  agonists offer marginal benefits to children aged less than two years old with acute wheeze, there is little evidence for an impact on the need for hospital admission or length of hospital stay.<sup>621-623</sup> 1+

Oral  $\beta_2$  agonists have not been shown to affect symptom score or length of hospital stay for acute asthma in infancy when compared to placebo.<sup>624</sup> 1+

**B Oral  $\beta_2$  agonists are not recommended for acute asthma in infants.**

### 8.11.2 STEROID THERAPY

Steroid tablets in conjunction with  $\beta_2$  agonists have been shown to reduce hospital admission rates when used in the emergency department.<sup>625</sup> Steroid tablets have also been shown to reduce the length of hospital stay.<sup>621, 624, 625</sup> 1+

A large UK study of pre-school children with mild to moderate wheeze associated with viral infection showed no reduction in hospital stay (or other outcomes) following treatment with oral steroids. In the acute situation it is often difficult to determine whether a pre-school child has asthma or episodic viral wheeze. Children with severe symptoms requiring hospital admission should still receive oral steroids. In children who present with moderate to severe wheeze without a previous diagnosis of asthma it may still be advisable to give oral steroids. For children with frequent episodes of wheeze associated with viruses caution should be taken in prescribing multiple courses of oral steroids.<sup>602</sup> 1++

**B In infants, consider steroid tablets early in the management of severe asthma attacks in the hospital setting.**

One study has shown similar benefits when comparing oral and nebulised steroids for acute asthma.<sup>621</sup>

✓ Steroid tablet therapy (10 mg of soluble prednisolone for up to three days) is the preferred steroid preparation for use in this age group.

### 8.11.3 IPRATROPIUM BROMIDE

The addition of ipratropium bromide to  $\beta_2$  agonists for acute severe asthma may lead to some improvement in clinical symptoms and reduce the need for more intensive treatment. It does not reduce the length of hospital stay either in combination with  $\beta_2$  agonists or in comparison with placebo.<sup>626</sup> 1+

**B Consider inhaled ipratropium bromide in combination with an inhaled  $\beta_2$  agonist for more severe symptoms.**

### 8.11.4 FURTHER INVESTIGATION AND MONITORING

Many children with recurrent episodes of viral-induced wheezing in infancy do not go on to have chronic atopic asthma. The majority do not require treatment with regular ICS. Parents should be advised about the relationship between cigarette smoke exposure and wheezy illnesses (*see sections 5.1.10 and 5.2.3*). Referral to suitable agencies should be offered to those who wish to give up smoking.

Parents of wheezy infants should receive appropriate discharge plans along similar lines to those given for older children (*see section 8.9.5*).

## 9 Difficult asthma

### 9.1 DEFINING AND ASSESSING DIFFICULT ASTHMA

The term difficult asthma generally refers to a clinical situation where a prior diagnosis of asthma exists, and asthma-like symptoms and asthma attacks persist, despite prescription of high-dose asthma therapy. There is no universally agreed definition of difficult asthma in children or adults, and specifically at what level of treatment prescription or asthma attack frequency, the term difficult asthma should apply. Consequently there are no precise data on the prevalence of this clinical problem. Previous consensus studies have suggested failure to achieve symptom control despite prescribed high-dose ICS as a minimum requirement, whilst more recent consensus work has stipulated a treatment level equivalent to at least step 4 (see section 6 and Figures 4, 5 and 6), before labelling as 'difficult'.<sup>627, 628</sup>

In this guideline difficult asthma is defined as persistent symptoms and/or frequent asthma attacks despite treatment at step 4 or step 5.

Observational uncontrolled studies in participants with difficult asthma, using multidisciplinary assessment models have identified high rates of alternative or coexistent diagnoses and psychological comorbidity.<sup>33, 629-631</sup> These uncontrolled studies, using systematic multidisciplinary assessment and management, have suggested improved outcomes in adults and children, but controlled clinical trials are required. Within this broadly defined group of subjects with difficult asthma, a proportion will have refractory disease, which is relatively resistant to currently available therapies. This group can only be identified after detailed evaluation, including exclusion of alternative causes of persistent symptoms, management of other comorbidities and confirmation of adherence with therapy.

**D** Patients with difficult asthma should be systematically evaluated, including:

- confirmation of the diagnosis of asthma, and
- identification of the mechanism of persisting symptoms and assessment of adherence to therapy.

**D** This assessment should be facilitated through a dedicated multidisciplinary difficult asthma service, by a team experienced in the assessment and management of difficult asthma.

### 9.2 FACTORS CONTRIBUTING TO DIFFICULT ASTHMA

#### 9.2.1 POOR ADHERENCE

Poor adherence with asthma medication is associated with poor asthma outcome in adults and children (see section 4.4). Two UK studies in adults attending specialist difficult asthma services documented high levels of poor adherence identified by low prescription filling. A study of 182 patients in the Northern Ireland Regional Difficult Asthma Service found that 63 patients (35%) filled 50% or fewer inhaled LABA/ICS prescriptions and 88% admitted poor adherence with inhaled therapy after initial denial; 23 of the 51 patients (45%) prescribed oral steroids were found to be non-adherent using serum prednisolone/cortisol testing.<sup>632</sup> In another study, 75 of 115 (65.2%) patients filled

prescriptions for <80% of ICS medication and had significantly worse lung function, higher sputum eosinophil counts and prior ventilation compared to adherent patients.<sup>633</sup> A study of 71 school-aged children with persistent symptoms, despite treatment at step 4/5 of this guideline, attending one hospital in London, found that 56 (79%) had potentially modifiable risk factors, the two most common of which were psychosocial factors (59%) and medication issues including adherence (48%). In 39 children (55%) the factors identified and the interventions recommended meant that further escalation of treatment was avoided.<sup>634</sup> In a paediatric case control series, poor adherence based on prescription records was identified in 22% of children with difficult to control asthma, although adherence was not reported in the stable controls.<sup>635</sup> In a descriptive study of 100 adult participants with a physician diagnosis of 'severe asthma', 28 patients were on >15 mg prednisolone and of these nine (32%) were found to be non-adherent with prednisolone.<sup>630</sup>

2+  
3

**C Healthcare professionals should always consider poor adherence to maintenance therapy before escalating treatment in patients with difficult asthma.**

### 9.2.2 PSYCHOSOCIAL FACTORS

Fatal and near-fatal asthma have been associated with adverse psychosocial factors (see section 8.1.3). Most observational studies<sup>33, 630, 636-639</sup> and a case control study<sup>640</sup> in patients with difficult asthma have also suggested a high level of psychological morbidity, though this observation has not been universal.<sup>641, 642</sup>

2+  
3

A meta-analysis of behavioural adjustment in children suggested increasing asthma severity, defined on the basis of treatment requirements, was associated with greater behavioural difficulties.<sup>643</sup> The core issue of cause and effect remains unclear; specifically the extent to which persistent asthma symptoms, despite aggressive treatment, results in psychological morbidity or whether pre-existing psychological morbidity makes asthma difficult to control.

2++

There is a lack of evidence that interventions specifically targeting psychological morbidity in difficult asthma are of benefit. A small proof of concept study targeting treatment of depression demonstrated a reduction in oral steroid use,<sup>644</sup> and an observational study in high-risk children with asthma suggested potential benefit from joint consultation with a child psychiatrist with an improvement in symptom scores and adherence to therapy.<sup>645</sup> However, a non-blinded randomised intervention study in adults with difficult asthma showed no benefit from a six month nurse-delivered psycho-educational programme.<sup>646</sup> A meta-analysis of psycho-educational interventions in patients with difficult asthma concluded that many of the studies were of poor quality, although there was some evidence of a positive effect from psychosocial educational interventions on hospital admissions in adults and children and on symptoms in children. There was not enough evidence to warrant significant changes in clinical practice and little information available on cost effectiveness.<sup>647</sup>

1+  
3

**C Healthcare professionals should be aware that difficult asthma is commonly associated with co-existent psychological morbidity.**

**D Assessment of co-existent psychological morbidity should be performed as part of a difficult asthma assessment. In children this may include a psychosocial assessment of the family.**

## 9.2.3 DYSFUNCTIONAL BREATHING

Observational uncontrolled studies in patients with difficult asthma have identified high rates of dysfunctional breathing as an alternative or concomitant diagnosis to asthma causing symptoms.<sup>33, 630</sup> It remains unclear what is the best mechanism of identifying and managing this problem.

3

**D** Dysfunctional breathing should be considered as part of a difficult asthma assessment.

## 9.2.4 ALLERGY

Acute asthma has been associated with IgE dependent sensitisation to indoor allergens.<sup>648</sup> In case control studies, mould sensitisation has been associated with recurrent admission to hospital and oral steroid use<sup>649, 650</sup> and with intensive care unit admissions and respiratory arrest.<sup>651, 652</sup> There is no published evidence of any intervention study in this patient group. Research in this area is required.

2++  
3

**C** In patients with difficult asthma and recurrent hospital admission, allergen testing to moulds should be performed.

## 9.2.5 MONITORING AIRWAY RESPONSE

Two randomised blinded controlled trials and one open randomised study have supported the use of titrating steroid treatment against sputum eosinophilia in adults with moderate to severe asthma, with greatest benefit seen in patients receiving higher doses of ICS therapy.<sup>88, 90, 653</sup> In the study with the largest numbers of patients receiving high dose ICS treatment, patients who were considered to be poorly adherent with treatment, or had inadequately controlled aggravating factors, such as rhinitis or gastro-oesophageal reflux were specifically excluded.<sup>88</sup> Case series have suggested that sputum induction is safe in patients with difficult to control asthma.<sup>61, 654-657</sup>

1+  
1-  
3

Controlled studies using FE<sub>NO</sub> to target treatment have not specifically targeted adults or children with difficult asthma.<sup>89, 117</sup>

1+

**B** In patients with difficult asthma, consider monitoring induced sputum eosinophil counts to guide steroid treatment.

# 10 Asthma in adolescents

## 10.1 DEFINITIONS

Adolescence is the transitional period of growth and development between puberty and adulthood, defined by the WHO as between 10 and 19 years of age.<sup>4</sup>

There is international agreement on best practice for working with adolescents with health problems outlined in consensus publications.<sup>658-660</sup> Key elements of working effectively with adolescents in the transition to adulthood include:<sup>661</sup>

- seeing them on their own, separate from their parents, for part of the consultation, and
- discussing confidentiality and its limitations.

For diagnosing and managing asthma in adolescents, the evidence base is limited. Much recent research has focused on the prevalence of asthma and ecological risk associations rather than on diagnosis and management of asthma in adolescents.

## 10.2 PREVALENCE OF ASTHMA IN ADOLESCENCE

Asthma is common in adolescence with a prevalence of wheeze in 13–14 year olds in Western Europe in the past 12 months (current wheeze) of 14.3%.<sup>662</sup> For more severe asthma (defined as  $\geq 4$  attacks of wheeze or  $\geq 1$  night per week sleep disturbance from wheeze or wheeze affecting speech in the past 12 months) the prevalence was 6.2%.

There is evidence of under-diagnosis of asthma in adolescents, with estimates of 20–30% of all asthma present in this age group being undiagnosed.<sup>662-665</sup> This has been attributed to under-reporting of symptoms. A number of risk factors have independently been associated with under-diagnosis including: female gender, smoking (both current smoking and passive exposure), low socioeconomic status, family problems, low physical activity and high body mass, and race/ethnicity.<sup>665</sup> Children with undiagnosed frequent wheezing do not receive adequate healthcare for their illness<sup>665</sup> and the health consequences of not being diagnosed with asthma are substantial.<sup>666, 667</sup>

Although feasible, there is insufficient evidence to support screening for asthma in adolescents.<sup>668, 669</sup>



Clinicians seeing adolescents with any cardiorespiratory symptoms should ask about symptoms of asthma.

## 10.3 DIAGNOSIS AND ASSESSMENT

No evidence was identified to suggest that the symptoms and signs of asthma in adolescents are different from those of other age groups.

### 10.3.1 EXERCISE-RELATED SYMPTOMS

Exercise-related wheezing and breathlessness are common asthma symptoms in adolescents. However, these symptoms are poor predictors of exercise-induced asthma. Only a minority of adolescents referred for assessment of exercise-induced respiratory symptoms show objective evidence of exercise-induced bronchospasm.<sup>670</sup> Other diagnoses producing reproducible symptoms on exercise include normal physiological exercise limitation, with and without poor physical fitness, vocal cord dysfunction, hyperventilation, habit cough, and supraventricular tachycardia.<sup>60</sup>

Most exercise-related wheezing in adolescents can be diagnosed and managed by careful clinical assessment.<sup>671</sup> The absence of other features of asthma and an absent response to pre-treatment with  $\beta_2$  agonist make exercise-induced asthma unlikely. Exercise testing with cardiac and respiratory monitoring that reproduces the symptoms may be helpful in identifying the specific cause.<sup>60</sup>

### 10.3.2 USE OF QUESTIONNAIRES

When using questionnaires, the prevalence of current symptoms is higher when the adolescent completes the questions rather than the parents, while questions about the last 12 months give similar results between the parents and the adolescent.<sup>672</sup>

In one study in adolescents, internet and written questionnaires about asthma provided equivalent results.<sup>673</sup> The ACQ and the ACT have been validated in adolescents with asthma (see Table 8).<sup>131</sup>

### 10.3.3 QUALITY OF LIFE MEASURES

Quality of life (QoL) scales (such as AQLQ12+) can be used in adolescents.<sup>674, 675</sup>

### 10.3.4 LUNG FUNCTION

In adolescents with asthma, tests of airflow obstruction and airway responsiveness may provide support for a diagnosis of asthma. However, most adolescents with asthma have normal lung function despite having symptoms.

### 10.3.5 BRONCHIAL HYPER-REACTIVITY

Although many children with asthma go into long lasting clinical remission at adolescence, BHR may persist. Whether persisting BHR reflects ongoing airway inflammation is debated.<sup>676</sup>

A negative response to an exercise test is helpful in excluding asthma in children with exercise-related breathlessness.<sup>60</sup>

## 10.4 RISK FACTORS

There is a body of evidence from cohort studies highlighting risk factors for asthma in adolescents.

### 10.4.1 ATOPY

Studies confirm that atopic dermatitis and atopic rhinitis are amongst the factors most strongly associated with asthma persisting into teenage years.<sup>677-680</sup>



#### 10.4.2 PREMATURETY AND EARLY LIFE WHEEZING

Adolescents who were very low birth weight due to prematurity (as opposed to intrauterine growth retardation) were more prone to chronic cough, wheezing and asthma and showed medium and small airway obstruction compared with matched controls.<sup>681</sup>

Frequent or severe episodes of wheezing in childhood are associated with recurrent wheeze that persists into adolescence.<sup>9, 12, 17, 20, 25, 30, 42, 43, 680</sup>

#### 10.4.3 GENDER

During adolescence there is a reversal of the gender association of asthma with the disease being more prevalent in females than males from 13–14 years onwards.<sup>682</sup> The same change is seen with asthma attacks, with risk of an asthma admission in females becoming double that observed in males from around 13–14 years.<sup>683</sup> This phenomenon has been attributed to a greater incidence of asthma among teenage girls.<sup>684</sup>

#### 10.4.4 CHLORINATED SWIMMING POOLS

Exposure to chlorinated swimming pools has been associated with an increased risk of asthma, airway inflammation and some respiratory allergies.<sup>685</sup> Such associations were not found among adolescents without atopy or in those who attended copper-silver sanitised pools.<sup>686</sup>

### 10.5 COMORBIDITIES AND MODIFIABLE BEHAVIOURS

#### 10.5.1 ANXIETY AND DEPRESSIVE DISORDERS

Asthma in adolescence is associated with an increased likelihood of major depression, panic attacks and anxiety disorder. This may reflect effects of common factors associated with anxiety and depressive disorders rather than a direct causal link with asthma.<sup>687</sup> In young people with asthma, the presence of an anxiety or depressive disorder is highly associated with increased asthma symptom burden.<sup>688</sup> Depressive symptoms were one risk factor identified in children and adolescents who died of asthma. Assessment of anxiety may help identify individuals who are at risk for poorer asthma specific quality of life.<sup>689</sup>

Clinical conditions associated with anxiety may be mistaken for, or overlap with asthma. These include dysfunctional breathing (hyperventilation syndrome and sighing dyspnoea), vocal cord dysfunction, and psychogenic cough. These conditions can present acutely and may often be frightening to the young person. This may lead to a cycle of bronchodilator overuse, which then further exacerbates the symptoms. Detailed medical assessment with careful attention to the adolescent's personal perceptions and experiences of their symptoms is required to make an accurate diagnosis.<sup>690</sup>

Brief screening questionnaires for anxiety and depression suitable for use in adolescents are available and may help identify those with significant anxiety and depression.<sup>691</sup>

#### 10.5.2 OBESITY

The evidence on whether asthma is more common in overweight and obese adolescents with asthma is conflicting.<sup>677, 692-694</sup> While weight reduction in obese adults with asthma improves lung function, symptoms, morbidity and health status, this has not yet been established in adolescents with asthma.

### 10.5.3 GASTRO-OESOPHAGEAL REFLUX AND GASTRO-OESOPHAGEAL REFLUX DISEASE

Gastro-oesophageal reflux and gastro-oesophageal disease (GORD) is common in patients with asthma, including adolescents.<sup>695</sup> A systematic review confirmed an association between GORD and asthma in children and adolescents in secondary and tertiary referral settings. The nature of the association, however, is unclear.<sup>696</sup> There is no evidence that treatment for GORD improves asthma symptoms in children and adolescents with GORD and asthma.<sup>478, 479</sup>

## 10.6 ASTHMA ATTACKS AND THE RISK OF HOSPITAL ADMISSION

Clinical characteristics and markers of severity, including frequent respiratory symptoms, airway hyper-responsiveness, atopy, and low lung function, identify those at high risk of hospitalisation for asthma, particularly with respect to multiple admissions.<sup>697</sup>

## 10.7 LONG-TERM OUTLOOK AND ENTRY INTO THE WORK PLACE

A long-term follow-up study of vocational and working careers found that adolescents and young adults (10–22 years) with relatively mild asthma had slightly more limitations in vocational and professional careers than those without asthma. They had a small increased risk of limitations in daily activity attributable to respiratory health and of absence from work. In the majority, however, the differences amounted to only a few days per year.<sup>698</sup> Young adults with asthma had a low awareness of occupations that might worsen asthma (for example, exposure to dusts, fumes, spray, exertion and temperature changes) and did not generally discuss career plans with their general practitioner. Further details about occupational asthma can be found in section 12.



Clinicians should discuss future career choices with adolescents with asthma and highlight occupations that might increase susceptibility to work related asthma symptoms.

## 10.8 NON-PHARMACOLOGICAL MANAGEMENT

### 10.8.1 TOBACCO SMOKING AND ENVIRONMENTAL EXPOSURE TO TOBACCO SMOKE

Exposure to passive smoking remains a significant health risk.

One study of asthma morbidity among urban young adolescents (mean approximately 11 years of age) found at baseline that 28% of caregivers reported exposure to environmental tobacco smoke (ETS) in the home and 19% reported exposure outside the primary household. Children who received a 20 minute educational intervention about ETS exposure and whose ETS exposure had decreased at follow up had fewer hospitalisations ( $p=0.034$ ) and emergency department visits ( $p\leq 0.001$ ) reported in the next 12 months, as well as fewer episodes of poor asthma control ( $p=0.042$ ).<sup>699</sup>

In a national survey in Denmark, 37.7% of adolescents with asthma smoked currently, 16.5% daily. Smoking was more common in girls. More of those with asthma smoked daily, smoked more cigarettes and had tried to quit smoking.<sup>700</sup>

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Among adolescents, smoking is a risk factor for asthma.<sup>678,701-703</sup> A longitudinal study of asthma and allergic disease in school children in Sweden found that both passive and active smoking were significantly related to asthma and wheeze in adolescents. Maternal ETS exposure was associated with lifetime symptoms, but daily smoking among the adolescents was more strongly related to current symptoms.<sup>704</sup>

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NICE has recommended that all smokers should be offered a brief intervention about stopping smoking. Young people aged 12–17 years who have a strong commitment to quit smoking should be offered advice on how to stop and encouraged to use local NHS smoking cessation services by providing details of when, where and how to access them.

✓ Adolescents with asthma (and their parents and carers) should be encouraged to avoid exposure to environmental tobacco smoke, and should be informed about the risks and urged not to start smoking.

✓ Adolescents with asthma should be asked if they smoke personally. If they do and wish to stop, they should be offered advice on how to stop and encouraged to use local NHS smoking cessation services.

#### 10.8.2 COMPLEMENTARY AND ALTERNATIVE MEDICINE

In a small study, 16% of Italian teenagers had used complementary and alternative medicine (CAM; homeopathy, acupuncture, herbal medicines).<sup>705</sup> In a study in the USA, 80% of urban adolescents (aged 13–18 years) with asthma reported that they had used CAM, most commonly rubs, herbal teas, prayer and massage.<sup>706</sup> While most adolescents used CAM with conventional asthma therapy, 27% reported they used it instead of prescribed therapy,<sup>706</sup> suggesting that CAM use may be a marker of non-adherence to prescribed asthma treatment.

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✓ Health care professionals should be aware that CAM use is common in adolescents and should ask about its use.

#### 10.9 PHARMACOLOGICAL MANAGEMENT

Specific evidence about the pharmacological management of adolescents with asthma is limited and is usually extrapolated from paediatric and adult studies. Recommendations for pharmacological management of asthma in children and adults can be found in section 6.

#### 10.10 INHALER DEVICES

Specific evidence about inhaler device use and choice in adolescents is limited. Inhaler devices are covered in section 7.

Two small studies comparing two different types of inhalers in adolescents found that both DPI and pMDIs plus spacer are of value in adolescent asthma.<sup>707,708</sup> There were no differences between the two inhaler devices in terms of symptoms or lung function but patients preferred the DPI.

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Although adolescents with asthma may be competent at using their inhaler devices, their actual adherence to treatment may be affected by other factors such as preference. In particular, many adolescents prescribed a pMDI with spacer do not use the spacers as they are felt to be too inconvenient.<sup>709,710</sup>

- ✓ Adolescent preference for inhaler device should be taken into consideration as a factor in improving adherence to treatment.
- ✓ As well as checking inhaler technique it is important to enquire about factors that may affect inhaler device use in real life settings, such as school.
- ✓ Consider prescribing a more portable device (as an alternative to a pMDI with spacer) for delivering bronchodilators when away from home.

## 10.11 ORGANISATION AND DELIVERY OF CARE

### 10.11.1 HEALTHCARE SETTING

Very little evidence was identified to determine the best healthcare setting to encourage attendance amongst adolescents with asthma.

A two-year follow-up study found that a multidisciplinary day programme improved asthma control in a group of adolescents with very severe asthma. This study involved a highly selected group of patients and a wide range of interventions and is not generalisable to most adolescents with asthma.<sup>629</sup>

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### 10.11.2 SCHOOLS AS A SETTING FOR HEALTHCARE DELIVERY AND ASTHMA EDUCATION

Some innovative approaches have used schools as setting for asthma education and review. One focus has been on healthcare delivery, such as school-based clinics. Evidence from a single cluster randomised, controlled trial suggests that school-based, nurse-led asthma clinics increase the uptake of asthma reviews in adolescents from 51% in practice care to 91%.<sup>711</sup> Knowledge of asthma, inhaler techniques and positive attitudes increased and a majority of the adolescents preferred the setting, but there was no improvement in clinical outcomes. This may be because the nurses were not able to change or prescribe treatment (which relied on a separate visit to a doctor).

Other approaches have used schools as a setting for asthma education including peer-led education. In a single, well-conducted RCT peer-led education in schools improved quality of life, asthma control and days off school for adolescents with asthma.<sup>712</sup> In a study in the USA, a randomised trial of a web-based tailored asthma management programme delivered using school computers found that, after 12 months, students reported fewer symptoms, school days missed, restricted-activity days, and hospitalisations for asthma than control students. The programme was inexpensive to deliver.<sup>177</sup>

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A number of countries, particularly Australia and New Zealand, have developed national programmes to ensure that schools can deliver appropriate first aid and emergency response to students with asthma as well as encouraging participation in sporting activities.<sup>713</sup>

**B** School based clinics may be considered for adolescents with asthma to improve attendance.

**B** Peer-led interventions for adolescents in the school setting should be considered.

- ✓ Integration of school based clinics with primary care services is essential.

### 10.11.3 TRANSITION TO ADULT-BASED HEALTHCARE

Transition to adult services is important for all adolescents with asthma, irrespective of the asthma severity. No studies on transition of adolescents with asthma to adult services were identified although there are many studies looking at transition of adolescents with chronic illness. Few studies compare different approaches and many recommendations come from consensus statements rather than randomised, controlled trials.<sup>658-660</sup> In the UK, information on transition is available from the Royal College of Paediatrics and Child Health and Department of Health websites.

It is important that the process of transition is coordinated and it is recommended that a healthcare professional be identified to oversee transition and either link with a counterpart in adult services or remain involved until the young person is settled within adult services.<sup>714, 715</sup>



In the initial period after transition to adult services in secondary care, adolescents are best seen by one consultant to build their confidence and encourage attendance.

### 10.11.4 PREPARATION FOR TRANSITION

Transition should be seen as a process and not just the event of transfer to adult services.<sup>714</sup> It should begin early, be planned, involve the young person, and be both age and developmentally appropriate (see Table 15).<sup>714</sup>

Table 15: Recommendations for organising transition services<sup>714</sup>

Young people should be given the opportunity to be seen without their parents/carers.
Transition services must address the needs of parents/carers whose role in their child's life is evolving at this time.
Transition services must be multidisciplinary and multi-agency. Optimal care requires a cooperative working relationship between adult and paediatric services, particularly where the young person has complex needs with multiple specialty involvement.
Coordination of transitional care is critical. There should be an identified coordinator who supports the young person until he or she is settled within the adult system.
Young people should be encouraged to take part in transition/support programmes and/or put in contact with other appropriate youth support groups.
The involvement of adult physicians prior to transfer supports attendance and adherence to treatment.
Transition services must undergo continued evaluation.

## 10.12 PATIENT EDUCATION AND SELF MANAGEMENT

### 10.12.1 EDUCATION IN SELF MANAGEMENT

Section 4 covers self management, education and the components of a self-management programme.

Effective transition care involves preparing adolescents with asthma to take independent responsibility for their own asthma management and enabling them to be able to negotiate the health system effectively (*see Table 16*). Clinicians need to educate and empower adolescents to manage as much of their asthma care as they are capable of doing while supporting parents to gradually hand over responsibility for management to their child.<sup>716</sup>

*Table 16: Specific knowledge, attitudes and skills that underpin independent self-management practices in adolescents with asthma<sup>716</sup>*

Can name and explain their condition
Can list their medications, treatments or other management practices (eg special diet)
Can explain why each medication or management practice is necessary
Can remember to take their medications most of the time
Can answer questions asked of them by doctors or health professionals
Can ask questions of their doctor or other health professional
Can arrange (and cancel) appointments
Can consult with a doctor or other health professional without a parent/carer
Remembers to order more medication before it runs out
Can have prescriptions filled at the pharmacy
Develops the desire for their healthcare to be independent of their parents/carers
Can prioritise their health over (some) other desires

For adolescents with asthma, the available evidence about self management is mainly qualitative and provides insight about the concerns adolescents have about their asthma and its management. Adolescents with asthma report embarrassment over using inhalers in front of others, sadness over not being able to take part in normal activities, frustration and anger at the way they are treated by their families (for example, being limited in what they are allowed to do, being fussed over by parents). They also report specific anxieties around fear of dying and feeling guilty over the effect their illness has on the rest of the family. They are concerned about needing to rely on someone else when they have a bad asthma attack and that teachers do not know what to do. They stress the importance of support from friends at school, especially those with asthma.<sup>717, 718</sup>

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Studies of adolescents with chronic illness (including adolescents with asthma) have highlighted factors that adolescents feel are important in delivering education about self management to them.<sup>719</sup> These included:

- education must be adapted to meet individual needs and repeated and developed as understanding and experience increases and should include emotional support for coping with feelings
- education should be delivered by educators that respect, engage, encourage and motivate the adolescents
- accompanying information, both written and oral, should be personalised rather than general and use non-medical language that adolescents can understand
- education should be delivered in an appropriate and uninterrupted setting and make appropriate use information technology.

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**D Design of individual or group education sessions delivered by healthcare professionals should address the needs of adolescents with asthma.**

#### 10.12.2 ADHERENCE

Adherence with asthma treatment, and with asthma trigger avoidance, is often poor in adolescents. The evidence for poor adherence comes mainly from questionnaire-based and qualitative studies rather than objective electronic monitoring.<sup>720</sup>

When directly asked, most adolescents admit they do not always follow their treatment plans. Reasons for not adhering include both unintentional reasons (confusion about medications and forgetfulness) and intentional reasons (inhalers being ineffective/hard to use, treatment plan too complicated, more important things to do, concern about adverse effects, denial, can't be bothered and embarrassment).<sup>710, 721</sup> Background factors, such as younger age, family size, exercise and not smoking or drinking alcohol as well as disease-related factors such as sense of normality, energy and will-power, support from the parents, physicians and nurses, and a positive attitude towards the disease and treatment were related to good reported adherence.<sup>722</sup>

Non-adherence to medication regimens in adolescents has been linked to other health risk behaviours including tobacco, alcohol and drug use and also to depression.<sup>723</sup> Not only are specific behaviours such as smoking, poor adherence to medication regimens or medical review appointments detrimental to asthma control, they also have been highlighted as potential beacons of distress in adolescents.<sup>724</sup> Clinical tools such as the HEADSS (Home, Education/Employment, Activities, Drugs, Sexuality, Suicide/depression) adolescent health screen provide practitioners with an easily usable psychosocial screen.<sup>725</sup>

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Strategies to improve adherence in adolescents emphasise the importance of focusing on the individual and their lifestyle and using individualised asthma planning and personal goal setting.<sup>726</sup> One study found that once-daily supervised asthma preventer therapy at school improved asthma control and quality of life.<sup>727</sup>

# 11 Asthma in pregnancy

## 11.1 NATURAL HISTORY AND MANAGEMENT OF STABLE ASTHMA

The majority of women with asthma have normal pregnancies and the risk of complications is small in those with well-controlled asthma. Several physiological changes occur during pregnancy that could worsen or improve asthma, but it is not clear which, if any, are important in determining the course of asthma during pregnancy. Pregnancy can affect the course of asthma and asthma and its treatment can affect pregnancy outcomes.

### 11.1.1 COURSE OF ASTHMA IN PREGNANCY

The natural history of asthma during pregnancy is extremely variable. In a prospective cohort study of 366 pregnancies in 330 women with asthma, the asthma worsened during pregnancy in 35%.<sup>728</sup> A prospective cohort study of 1,739 pregnant women showed an overall improvement in 23% and deterioration in 30.3%.<sup>729</sup> The conclusions of a meta-analysis of 14 studies is in agreement with the commonly quoted generalisation that during pregnancy about one third of asthma patients experience an improvement in their asthma, one third experience a worsening of symptoms, and one third remain the same.<sup>730</sup> There is also some evidence that the course of asthma is similar in successive pregnancies.<sup>728, 731</sup> A systematic review showed no effect of pregnancy or stage of pregnancy on FEV<sub>1</sub>.<sup>732</sup>

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Studies suggest that 11–18% of pregnant women with asthma will have at least one emergency department visit for acute asthma and of these 62% will require hospitalisation.<sup>733,734</sup> Severe asthma is more likely to worsen during pregnancy than mild asthma,<sup>728</sup> but some patients with very severe asthma may experience improvement, whilst symptoms may deteriorate in some patients with mild asthma. In a large study in the USA, the rates of asthma attack were 13%, 26% and 52% in those with mild, moderate and severe asthma respectively.<sup>729</sup> The corresponding rates of hospitalisation were 2%, 7% and 27%.

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A systematic review concluded that, if symptoms do worsen, this is most likely in the second and third trimesters, with the peak in the sixth month.<sup>731</sup> In a large cohort study, the most severe symptoms were experienced by patients between the 24<sup>th</sup> and 36<sup>th</sup> week of pregnancy. Thereafter symptoms decreased significantly in the last four weeks and 90% had no asthma symptoms during labour or delivery. Of those who did, only two patients required anything more than inhaled bronchodilators.<sup>728</sup> A further study has confirmed the observation that the last month of pregnancy is the one in which patients are least likely to have an asthma attack.<sup>735</sup>

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### 11.1.2 EFFECT OF ASTHMA IN PREGNANCY

A systematic review has shown that baseline asthma severity does determine what happens to the course of asthma in pregnancy and asthma may affect the risk of adverse outcomes.<sup>736</sup> A cohort study comparing 198 pregnant women with asthma to 198 women without asthma reported that non-atopic patients with asthma tend to have more severe asthma. Pre-eclampsia was also more common in this group. However with adequate surveillance and treatment, pregnancy and delivery complications can be avoided.<sup>737</sup>

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Uncontrolled asthma is associated with many maternal and fetal complications, including hyperemesis, hypertension, pre-eclampsia, vaginal haemorrhage, complicated labour, fetal growth restriction, pre-term birth, increased perinatal mortality, and neonatal hypoxia.<sup>729, 738-741</sup> A large Swedish population-based study using record linkage data demonstrated increased risks for pre-term birth, low birth weight, perinatal mortality and pre-eclampsia in women with asthma. The risks for pre-term delivery and low birth weight were higher in women with more severe asthma necessitating admission.<sup>742</sup>

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A large prospective cohort study comparing women with moderate and severe asthma with women without asthma found the only significant difference was an increased Caesarean section rate (OR 1.4, 95% CI, 1.1 to 1.8).<sup>729</sup> Logistic regression analysis of the severe group showed an increased risk of gestational diabetes (adjusted odds ratio (AOR) 3, 95% CI 1.2 to 7.8) and pre-term delivery <37 weeks AOR 2.2, 95% CI 1.2 to 4.2) but this could have been an effect of corticosteroids. In the Yale asthma study no effect of asthma symptoms or severity was seen on pre-term delivery but oral steroids increased the rate of pre-term delivery and reduced gestation by 2.2 weeks (AOR 1.05, 95% CI 1.01 to 1.09).<sup>743</sup> Daily asthma symptoms were associated with an increased risk of fetal growth restriction (AOR 2.25, 95% CI 1.25 to 4.06) and there was a 24% increase with each increased symptom step. This is supported by a systematic review of four studies that concluded asthma exacerbation in pregnancy increases the risk of low birth weight.<sup>744</sup> The RR was 2.54 (95% CI 1.52 to 4.25) compared to women without asthma. In a large cohort study of 2,123 women with asthma, there was an association of both mean FEV<sub>1</sub> and mean FEV<sub>1</sub> <80% predicted with gestational hypertension, pre-term delivery <37 weeks and <32 weeks, and low birth weight.<sup>745</sup>

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In contrast, if asthma is well controlled throughout pregnancy there is little or no increased risk of adverse maternal or fetal complications.<sup>728, 733</sup> Pregnancy should therefore be an indication to optimise therapy and maximise lung function in order to reduce the risk of acute asthma attacks.

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**C** Monitor pregnant women with moderate/severe asthma closely to keep their asthma well controlled.

**B** Women should be advised of the importance of maintaining good control of their asthma during pregnancy to avoid problems for both mother and baby.

✓ Advise women who smoke about the dangers for themselves and their babies and give appropriate support to stop smoking.

## 11.2 MANAGEMENT OF ACUTE ASTHMA IN PREGNANCY

The management of acute asthma in pregnancy may be affected by concerns about harmful effects of medication on the fetus. In a prospective controlled study of 51 pregnant women and 500 non-pregnant women presenting with acute asthma to an emergency department in Boston, USA, pregnant patients with asthma were less likely to receive appropriate treatment with steroids and, as a result, were more likely to experience ongoing asthma attacks at two weeks.<sup>746</sup> Available studies give little cause for concern regarding treatment side effects and the maternal and fetal risks of uncontrolled asthma are much greater than the risks from using conventional asthma medications for management of acute asthma. In the five confidential enquiries into maternal deaths in the UK (covering 1994–2008) there were 22 deaths from asthma.<sup>747-750,751</sup> The recent

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report from the Intensive Care National Audit and Research Centre on female admissions to adult critical care units in England, Wales and Northern Ireland between 2009 and 2012 found that of 1,188 currently pregnant women, 94 (8%) were admitted with acute asthma and of 5,605 postpartum women, 32 (0.6%) were admitted with acute asthma.<sup>752</sup>

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Oxygen should be delivered to maintain saturation 94–98% in order to prevent maternal and fetal hypoxia.<sup>527</sup> When interpreting arterial blood gases in pregnancy it should be remembered that the progesterone-driven increase in minute ventilation may lead to relative hypocapnia and a respiratory alkalosis, and higher PaO<sub>2</sub>,<sup>753,754</sup> but oxygen saturations are unaltered.<sup>755</sup> Acidosis is poorly tolerated by the fetus.

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Drug therapy should be given as for a non-pregnant patient with acute asthma, including nebulised  $\beta_2$  agonists and early administration of steroid tablets (*see section 8*).<sup>728, 734, 735, 738, 739</sup> In severe cases, intravenous  $\beta_2$  agonists, aminophylline, or intravenous bolus magnesium sulphate can be used as indicated.<sup>756</sup>

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Continuous fetal monitoring should be performed when asthma is uncontrolled or severe, or when fetal assessment on admission is not reassuring. Consideration should be given to early referral to critical care services as impaired ventilatory mechanics in late pregnancy can lower functional residual capacity and may result in earlier oxygen desaturation.<sup>757</sup> Pregnant women may be more difficult to intubate due to anatomical changes especially if they have pre-eclampsia.<sup>758</sup>

**C** Give drug therapy for acute asthma as for non-pregnant patients including systemic steroids and magnesium sulphate.

**D** Deliver high flow oxygen immediately to maintain saturation 94–98%.

**D** Acute severe asthma in pregnancy is an emergency and should be treated vigorously in hospital.

✓ Continuous fetal monitoring is recommended for acute severe asthma.

✓ For women with poorly controlled asthma during pregnancy there should be close liaison between the respiratory physician and obstetrician, with early referral to critical care physicians for women with acute severe asthma.

### 11.3 DRUG THERAPY IN PREGNANCY

In general, the medicines used to treat asthma are safe in pregnancy.<sup>759, 760</sup> A large UK population-based case control study found no increased risk of major congenital malformations in children of women receiving asthma treatment in the year before or during pregnancy.<sup>761</sup> The risk of harm to the fetus from severe or chronically undertreated asthma outweighs any small risk from the medications used to control asthma.

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**B** Counsel women with asthma regarding the importance and safety of continuing their asthma medications during pregnancy to ensure good asthma control.

11.3.1  $\beta_2$  AGONISTS

No significant association has been demonstrated between major congenital malformations or adverse perinatal outcome and exposure to short-acting  $\beta_2$  agonists.<sup>759-763</sup> A prospective study of 259 pregnant patients with asthma who were using bronchodilators compared with 101 pregnant patients with asthma who were not, and 295 control subjects, found no differences in perinatal mortality, congenital abnormalities, prematurity, mean birth weight, Apgar scores or labour/delivery complications.<sup>764</sup> A case control study including 2,460 infants exposed to short-acting  $\beta_2$  agonists found no increased risk of congenital malformations in exposed infants.<sup>729</sup>

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With regard to LABAs, evidence from prescription event monitoring suggests that salmeterol is safe in pregnancy and although there are some data on formoterol, numbers are small.<sup>765,766</sup> A systematic review of studies including 190 exposures to LABA demonstrated no increased risk of congenital malformations, pre-term delivery or pre-eclampsia.<sup>767</sup> A case control study including 156 infants exposed to LABA found no increased risk of major congenital malformations.<sup>761</sup> As in other settings, LABAs should be used with an ICS, ideally as a combination product.<sup>768</sup>

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Data on the use of combination products in pregnancy are limited although there are no theoretical reasons why these would be more harmful than the same agents given separately. There are some safety data for seretide (salmeterol/fluticasone propionate) but with small numbers.<sup>769</sup>

C

**Use short acting  $\beta_2$  agonists as normal during pregnancy.**

C

**Use long acting  $\beta_2$  agonists (LABA) as normal during pregnancy.**

## 11.3.2 INHALED CORTICOSTEROIDS

No significant association has been demonstrated between major congenital malformations or adverse perinatal outcome and exposure to ICS.<sup>759,761,767,770-778</sup> A meta-analysis of four studies of ICS use in pregnancy showed no increase in the rate of major malformations, pre-term delivery, low birth weight or pregnancy-induced hypertension.<sup>779</sup> The UK case control study included 1,429 infants exposed to ICSs and found no increased risk of major congenital malformations.<sup>761</sup>

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Inhaled anti-inflammatory treatment has been shown to decrease the risk of an acute attack of asthma in pregnancy and the risk of re-admission following an asthma attack.<sup>734,735</sup> A randomised placebo controlled trial of inhaled beclometasone versus oral theophylline in moderate asthma in pregnancy showed no difference in the primary outcome of one or more asthma attacks resulting in medical intervention, but inhaled beclometasone was better tolerated.<sup>729</sup>

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B

**Use inhaled corticosteroids as normal during pregnancy.**

## 11.3.3 THEOPHYLLINES

No significant association has been demonstrated between major congenital malformations or adverse perinatal outcome and exposure to methylxanthines.<sup>759, 780</sup> 2+

For women requiring theophylline to maintain asthma control, measurement of theophylline levels is recommended. Since protein binding decreases in pregnancy, resulting in increased free drug levels, a lower therapeutic range is probably appropriate.<sup>781</sup> 4

**C** Use oral and intravenous theophyllines as normal during pregnancy.

**D** Check blood levels of theophylline in pregnant women with acute severe asthma and in those critically dependent on therapeutic theophylline levels.

## 11.3.4 STEROID TABLETS

There is much published literature showing that steroid tablets are not teratogenic,<sup>738,759,782</sup> but there is a slight concern that they may be associated with oral clefts. Data from several studies have failed to demonstrate this association with first trimester exposure to steroid tablets.<sup>782,783</sup> One case control study, however, found a significant association, although this increase is not significant if only paired controls are considered.<sup>784</sup> Although one meta-analysis reported an increased risk,<sup>785</sup> a prospective study by the same group found no difference in the rate of major birth defects in prednisolone-exposed and control babies.<sup>785</sup> A more recent population-based case control study revealed a crude odds ratio of corticosteroid exposure from four weeks before through to 12 weeks after conception of 1.7 (95% CI, 1.1 to 2.6) for cleft lip.<sup>786</sup> Another case control study including 262 exposed infants found no such association, although this was not limited to first trimester exposure.<sup>761</sup> 2+  
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The association is therefore not definite and even if it is real, the benefit to the mother and the fetus of steroids for treating a life-threatening disease justify the use of steroids in pregnancy.<sup>740, 753</sup> Moreover, the various studies of steroid exposure include many patients with conditions other than asthma, and the pattern of steroid use was generally as a regular daily dose rather than as short courses, which is how asthma patients would typically receive oral steroids. 2+

Prednisolone is extensively metabolised by placental enzymes so only 10% reaches the fetus, making this the oral steroid of choice to treat maternal asthma in pregnancy. Pregnant women with acute asthma attacks are less likely to be treated with steroid tablets than non-pregnant women.<sup>746</sup> Failure to administer steroid tablets when indicated increases the risk of ongoing asthma attacks and therefore the risk to the mother and her fetus. 2+

Some studies have found an association between steroid tablet use and pregnancy-induced hypertension or pre-eclampsia, pre-term labour and fetal growth but severe asthma may be a confounding variable.<sup>737,787</sup> 2+

**C** Use steroid tablets as normal when indicated during pregnancy for severe asthma. Steroid tablets should never be withheld because of pregnancy. Women should be advised that the benefits of treatment with oral steroids outweigh the risks.

### 11.3.5 LEUKOTRIENE RECEPTOR ANTAGONISTS

Data regarding the safety of leukotriene receptor antagonists (LTRAs) in pregnancy are limited. A case control study with 96 cases exposed to LTRAs found no increased risk of major malformations between women with asthma exposed to LTRA and women with asthma taking only  $\beta$  agonists.<sup>787</sup> A systematic review found no increased risk of malformations or pre-term delivery in nine exposed women.<sup>743,767</sup> Three studies looking at infant outcomes in women exposed to LTRAs (two in women taking montelukast) showed no increased risk of congenital malformations.<sup>788-790</sup>

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**C** If leukotriene receptor antagonists are required to achieve adequate control of asthma then they should not be withheld during pregnancy.

### 11.3.6 SODIUM CROMOGLICATE AND NEDOCROMIL SODIUM

No significant association has been demonstrated between major congenital malformations or adverse perinatal outcome and exposure to sodium cromoglicate and nedocromil sodium.<sup>767,759,787</sup>

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**C** Use sodium cromoglicate and nedocromil sodium as normal during pregnancy.

### 11.3.7 IMMUNOMODULATION THERAPY

There are as yet no clinical data on the use of omalizumab for moderate-severe allergic asthma in pregnancy.

## 11.4 MANAGEMENT DURING LABOUR

Acute attacks of asthma are very rare in labour, perhaps due to endogenous steroid production. In women receiving steroid tablets there is a theoretical risk of maternal hypothalamic-pituitary-adrenal axis suppression. Women with asthma may safely use all forms of usual labour analgesia.

In some studies there is an association between asthma and an increased Caesarean section rate,<sup>737,791,792</sup> but this may be due to planned Caesarean sections or inductions of labour rather than due to any direct effect of asthma on intrapartum indications.<sup>735</sup> A large prospective cohort study comparing women with moderate and severe asthma with women without asthma found the only significant difference was an increased Caesarean section rate (OR 1.4, 95% CI 1.1 to 1.8).<sup>729</sup>

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Data suggest that the risk of postpartum asthma attacks is increased in women having Caesarean sections.<sup>791</sup> This may relate to the severity of their asthma rather than to the Caesarean section, or to factors such as postoperative pain with diaphragmatic splinting, hypoventilation and atelectasis. Prostaglandin E2 may safely be used for labour inductions.<sup>781</sup> Prostaglandin F2 $\alpha$  (carboprost/hemobate<sup>®</sup>) used to treat postpartum haemorrhage due to uterine atony may cause bronchospasm.<sup>781</sup> Although ergometrine may cause bronchospasm particularly in association with general anaesthesia,<sup>781</sup> this is not a problem encountered when syntometrine (syntocinon/ergometrine) is used for postpartum haemorrhage prophylaxis.

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Although suppression of the fetal hypothalamic-pituitary-adrenal axis is a theoretical possibility with maternal systemic steroid therapy, there is no evidence from clinical practice or the literature to support this.<sup>793</sup>

- ✓ Advise women that an acute asthma attack is rare in labour.
- ✓ Advise women to continue their usual asthma medications in labour.
- ✓ In the absence of an acute severe asthma attack, reserve Caesarean section for the usual obstetric indications.
- C** **If anaesthesia is required, regional blockade is preferable to general anaesthesia in women with asthma.**
- ✓ Women receiving steroid tablets at a dose exceeding prednisolone 7.5 mg per day for more than two weeks prior to delivery should receive parenteral hydrocortisone 100 mg 6–8 hourly during labour.
- D** **Use prostaglandin F2 $\alpha$  with extreme caution in women with asthma because of the risk of inducing bronchoconstriction.**

## 11.5 DRUG THERAPY IN BREASTFEEDING MOTHERS

The medicines used to treat asthma, including steroid tablets, have been shown in early studies to be safe to use in nursing mothers.<sup>794</sup> There is less experience with newer agents. Less than 1% of the maternal dose of theophylline is excreted into breast milk.<sup>794</sup>

Prednisolone is secreted in breast milk, but milk concentrations of prednisolone are only 5–25% of those in serum.<sup>478</sup> The proportion of an oral or intravenous dose of prednisolone recovered in breast milk is less than 0.1%.<sup>795-797</sup> For maternal doses of at least 20 mg once or twice daily the nursing infant is exposed to minimal amounts of steroid with no clinically significant risk.<sup>795, 796, 797</sup>

- C** **Encourage women with asthma to breastfeed.**
- C** **Use asthma medications as normal during lactation, in line with manufacturers' recommendations.**

## 12 Occupational asthma

### 12.1 INCIDENCE

The true frequency of occupational asthma is not known, but under reporting is likely. Published reports, which come from surveillance schemes, compensation registries or epidemiological studies, estimate that occupational asthma may account for about 9–15% of adult onset asthma.<sup>798-800</sup> It is now the commonest industrial lung disease in the developed world with over 400 reported causes.<sup>801-803</sup>

The diagnosis should be suspected in all adults with symptoms of airflow limitation, and positively searched for in those with high-risk occupations or exposures. Patients with pre-existing asthma aggravated non-specifically by dust and fumes at work (work-aggravated asthma) should be distinguished from those with pre-existing asthma who become additionally sensitised to an occupational agent.

**B** In patients with adult onset, or reappearance of childhood asthma, healthcare professionals should consider that there may be an occupational cause.

### 12.2 AT-RISK POPULATIONS

Several hundred agents have been reported to cause occupational asthma and new causes are reported regularly in the medical literature.

The most frequently reported causative agents include isocyanates, flour and grain dust, colophony and fluxes, latex, animals, aldehydes and wood dust.<sup>804-812</sup>

The workers most commonly reported to occupational asthma surveillance schemes include paint sprayers, bakers and pastry makers, nurses, chemical workers, animal handlers, welders, food processing workers and timber workers.<sup>804, 805, 807, 809-815</sup>

Workers reported to be at increased risk of developing asthma include bakers, food processors, forestry workers, chemical workers, plastics and rubber workers, metal workers, welders, textile workers, electrical and electronic production workers, storage workers, farm workers, waiters, cleaners, painters, dental workers and laboratory technicians.<sup>816-819</sup>

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### 12.3 DIAGNOSIS

Occupational asthma should be considered in all workers with symptoms of airflow limitation (*see Annex 9*). The best screening question to ask is whether symptoms improve on days away from work. This is more sensitive than asking whether symptoms are worse at work, as many symptoms deteriorate in the hours after work or during sleep. Asthma symptoms reported by the use of a questionnaire to be better on days away from work have been shown to have a sensitivity of 58–100% for subsequently validated occupational asthma and specificities of between 45–100%, with wheeze and shortness of breath the most commonly reported symptoms.<sup>820</sup> There is also some evidence, that free histories taken by experts may have a higher sensitivity than patient questionnaires administered by experts, but their specificity may be lower for a diagnosis of occupational asthma.<sup>820</sup>

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One study notes a relatively low positive predictive value of work related symptoms.<sup>821</sup>

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✓ Adults with airflow obstruction should be asked:

- Are you better on days away from work?
- Are you better on holiday?

Those with positive answers should be investigated for occupational asthma.

Occupational asthma can be present when tests of lung function are normal, limiting their use as a screening tool. Asthmatic symptoms improving away from work can produce false negative diagnoses, so further validation is needed.

Serial measurement of peak respiratory flow is the most readily available initial investigation, and the sensitivity and specificity of serial peak flow measurement in the diagnosis of occupational asthma are high.<sup>822-829</sup> 3

Although skin prick tests or blood tests for specific IgE are available, there are few standardised allergens commercially available which limits their use. A positive test denotes sensitisation, which can occur with or without disease. The diagnosis of occupational asthma can usually be made without specific bronchial provocation testing, considered to be the gold standard diagnostic test. The availability of centres with expertise and facilities for specific provocation testing is very limited in the UK and the test itself is time consuming.

As a general observation, the history is more useful in excluding occupational asthma than in confirming it. A significant proportion of workers with symptoms that improve on days away from work or on holiday have been shown by objective tests not to have occupational asthma.<sup>830</sup> 3

**D** In suspected work-related asthma, the diagnosis of asthma should be confirmed using standard objective criteria.

### 12.3.1 SENSITIVITY AND SPECIFICITY OF SERIAL PEAK FLOW MEASUREMENTS

In a meta-analysis of 31 studies in which a variety of reference standards were used, the pooled sensitivity and specificity of serial PEF measurements were 75% and 79% respectively. Higher values (82% and 88%) were obtained from pooling studies where more complete series of measurements had been made, achieved by 61% of the analysed population. Visual analysis was more sensitive (78% v 71%) but less specific (69% v 91%) than computer-based methods.<sup>829</sup> 2

There are several validated methods for interpreting serial PEF records for a diagnosis of occupational asthma which differ in their minimal data requirements. The original discriminant analysis method requires:

- at least three days in each consecutive work period
- at least four evenly spaced readings per day
- at least three series of consecutive days at work with three periods away from work (usually about three weeks).<sup>831</sup>



Shorter records without the requirement for three consecutive days at work can be analysed using the area between curves score. This requires at least eight readings a day on eight work days and three rest days.<sup>832</sup> A statistical method using the addition of timepoint analysis requires the waking time to be similar on rest and work days.<sup>833</sup>

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The analysis is best done with the aid of a criterion-based expert system. Suitable record forms and support are available from [www.occupationalasthma.com](http://www.occupationalasthma.com)

**D Objective diagnosis of occupational asthma should be made using serial peak flow measurements, with at least four readings per day.**

### 12.3.2 DIAGNOSIS OF VALIDATED CASES OF OCCUPATIONAL ASTHMA USING IgE TESTING

A review by the British Occupational Health Research Foundation states that, "...the respective sensitivities and specificities of the ability of skin prick or serological tests to detect specific IgE vary between allergens and depend on the setting of positive cut-offs."<sup>820</sup> The sensitivities and specificities of serum specific IgE antibodies to low molecular weight agents depends on whether the antibodies have been properly characterised and the availability of appropriate hapten-conjugates. The presence of specific IgE confirms sensitisation but alone does not confirm the presence of occupational asthma, nor necessarily its cause."<sup>820</sup> The review concluded that skin prick testing or tests for specific IgE should be used in the investigation of occupational asthma caused by high molecular weight agents but are less sensitive for detecting specific IgE and occupational asthma caused by low molecular weight agents. In neither case are the tests specific for diagnosing asthma.<sup>820</sup>

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**D Skin prick testing or tests for specific IgE should be used in the investigation of occupational asthma caused by high molecular weight agents.**

**D Skin prick testing or tests for specific IgE should not be used in the investigation of occupational asthma caused by low molecular weight agents.**

### 12.3.3 NON-SPECIFIC REACTIVITY

Studies of non-specific reactivity are confounded by the different methods used, different cut-offs for normality and the interval between last occupational exposure and the performance of the test (an increase in time interval may allow recovery of initial hyper-reactors). A single measurement of non-specific reactivity has been shown to have only moderate specificity and sensitivity for the validation of occupational asthma and changes in non-specific reactivity at and away from work alone have only moderate sensitivity and specificity for diagnosis.<sup>820, 834</sup>

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**D A single measurement of non-specific reactivity should not be used for the validation of occupational asthma.**

### 12.3.4 SPECIFIC BRONCHIAL PROVOCATION TESTING

Specific inhalation challenges (SIC) with occupational agents should only be carried out in hospitals with expertise in using occupational agents, and should always include: a control challenge on a separate day; a gradual increase of exposure to the suspected occupational agent; close monitoring of airway calibre during the challenge and for at least six hours after the end of the exposure.<sup>835</sup>

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A positive SIC is one in which the FEV<sub>1</sub> falls by  $\geq 15\%$  from baseline; either within the first hour after exposure (an immediate reaction) or later (a late reaction) or both. Alternatively for late reactions, two measurements below the 95% CI for three days away from exposure have been validated as a positive test.<sup>836</sup> Equivocal reactions can sometimes be clarified by finding changes in non-specific bronchial responsiveness, sputum eosinophils or exhaled nitric oxide. SIC is generally a safe procedure; excessive reactions are rare with  $<3\%$  of patients needing repeated doses of a bronchodilator and steroid treatment.

The sensitivity and specificity of SIC are high but not easily quantified as the method is usually used as the reference standard for the diagnosis of occupational asthma. False negative tests also occur, and SIC testing may be of less value where complex workplace exposures cannot be replicated in the laboratory. SIC remains the gold standard for making a diagnosis of occupational asthma.

### 12.3.5 SPUTUM EOSINOPHILIA

Eosinophilic bronchial inflammation can be assessed by cell counts in fresh sputum, induced by inhaling hypertonic saline.<sup>820</sup> Studies have shown that induced sputum eosinophilia is not sufficiently sensitive or specific to help in the diagnosis of occupational asthma although it may help in the interpretation of equivocal SIC reactions.<sup>820, 834, 837</sup> In the clinical setting the absence of sputum eosinophilia does not exclude a diagnosis of occupational asthma.<sup>820</sup>

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### 12.3.6 EXHALED NITRIC OXIDE

The 2010 review by the British Occupational Health Research Foundation states that, "...the measurement of exhaled nitric oxide produced by inflammatory and epithelial cells in the respiratory tract is non-invasive and has been studied extensively in non-occupational asthma, although it has not been fully validated as an effective diagnostic test for occupational asthma".<sup>820</sup> The review concluded that the role of exhaled nitric oxide measurements in the diagnosis of occupational asthma in this setting is not established.<sup>820</sup>

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## 12.4 MANAGEMENT OF OCCUPATIONAL ASTHMA

The aim of management is to identify the cause, remove the worker from exposure, and for the worker to have worthwhile employment.

Complete avoidance of exposure may or may not improve symptoms and bronchial hyper-responsiveness. Both the duration of continued exposure following the onset of symptoms and the severity of asthma at diagnosis may be important determinants of outcome. Early diagnosis and early avoidance of further exposure, either by relocation of the worker or substitution of the hazard offer the best chance of complete recovery. Workers who remain in the same job and continue to be exposed to the same causative agent after diagnosis are unlikely to improve and symptoms may worsen. The likelihood of improvement or resolution of symptoms or of preventing deterioration is greater in workers who have no further exposure to the causative agent.<sup>824, 838-846</sup>

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Several studies have shown that the prognosis for workers with occupational asthma is worse for those who remain exposed for more than one year after symptoms develop, compared with those removed earlier.<sup>847-849</sup>

**D Relocation away from exposure should occur as soon as diagnosis is confirmed, and ideally within 12 months of the first work-related symptoms of asthma.**

There is consistent evidence from clinical and workforce case series that about one third of workers with occupational asthma are unemployed after diagnosis. It is unclear whether this risk is higher than that for other adults with asthma.<sup>850-852</sup> The risk of unemployment may fall with increasing time after diagnosis.<sup>853</sup> There is consistent evidence that loss of employment following a diagnosis of occupational asthma is associated with loss of income. Adults with occupational asthma may find employment more difficult than adults with non-occupational asthma.<sup>851,852</sup> Approximately one third of workers with occupational asthma have been shown to be unemployed up to six years after diagnosis.<sup>849-857</sup>

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## 13 Organisation and delivery of care

### 13.1 CARE PATHWAYS

Clinical care pathways are "...structured multidisciplinary care plans used by health services to detail essential steps in the care of patients with a specific clinical problem. They aim to link evidence to practice and optimise clinical outcomes whilst maximising clinical efficiency."<sup>858</sup>

There is little high quality evidence from randomised trials addressing the impact of care pathways for asthma. Pathways have usually been implemented through a training session or programme. Two interventions, one to establish pathways for the management of people with high-risk asthma in UK primary care, the other to establish pathways for children with acute and chronic asthma in New Zealand primary care, led to non-significant reductions in ED attendance and hospitalisation.<sup>859, 860</sup> Pathways for inpatient care can improve processes of care, such as prescription of oral prednisolone and use of written asthma action plans in children,<sup>861</sup> and can reduce length of stay for children,<sup>588, 862</sup> but have not improved follow up in general practice after discharge.<sup>863</sup>

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Further well conducted studies are needed to define the benefits of care pathways for asthma. These should include large suitably powered studies to clarify the impact of pathways promoting systematic management of people with high-risk asthma in UK primary care, and pathways integrating asthma care across the primary/secondary care interface.

### 13.2 EDUCATING CLINICIANS

There is strong evidence that educating clinicians can improve health outcomes for patients. Two large Cochrane systematic reviews (covering all clinical conditions, not just asthma) found that.<sup>864, 865</sup>

- educational outreach visits (for example training visits to general practices) lead to small to moderate improvements in outcomes<sup>864</sup>
- mixed interactive and didactic education is more effective than either alone.<sup>865</sup>

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Several models of clinician education specifically for asthma have been tested in randomised trials and these broadly support the conclusions of the two Cochrane reviews. The most consistently effective of these for asthma comprises educational outreach visits which deliver multifaceted training, based on theoretical models of behaviour change, including training in consultation styles and delivery of key messages. Several studies have tested the American-developed Physician Asthma Care Education (PACE) paediatric asthma programme,<sup>165, 866</sup> or adaptations of it for Australian and UK practice,<sup>193, 867</sup> and have shown reductions in ED visits,<sup>866</sup> improved symptom control,<sup>193</sup> and increased use of written asthma action plans.<sup>867</sup> The PACE intervention has not been tested for adult populations and there is little experience of its use in the UK.

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In the USA, peer education comprising intensive training of a 'practice asthma champion' who in turn trained and supported colleagues, led to fewer asthma attacks in children.<sup>868</sup> Practice asthma champions were trained in pharmacotherapy and physician behaviour change techniques, and received ongoing support for their role as a 'change agent'. They received guideline summaries, key targets for their physician colleagues and feedback

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on their colleagues' performance along with monthly support from a nurse coordinator. When this peer education programme was combined with intensively trained outreach nurses implementing patient reviews (the Planned Care Model), children experienced fewer asthma symptoms and fewer asthma attacks.

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These interventions illustrate that, to effect change, interventions need to be of sufficient intensity to engage with, and change, the way practices are organised.

Less intensive educational interventions, such as brief outreach visits comprising simple group education are less effective, showing no impact on symptoms, quality of life, or health care use.<sup>869-872</sup>

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Remote IT educational interventions, such as remote spirometry training,<sup>873</sup> may be effective but have not been widely tested.

Further large scale studies, carried out in the UK, are needed to test the impact of intensive educational interventions, such as adapted PACE and peer education programmes.

**B Training for primary care clinicians should include educational outreach visits using multifaceted programmes that include consultation training including goal setting.**

### 13.3 ASTHMA CLINICS

#### 13.3.1 STRUCTURED REVIEW

Proactive clinical review of people with asthma improves clinical outcomes. Evidence for benefit is strongest when reviews include discussion and use of a written PAAP.<sup>142</sup> Benefits include reduced school or work absence, reduced asthma attack rate, improved symptom control and reduced attendance at the emergency department.<sup>874,875</sup> Proactive structured review, as opposed to opportunistic or unscheduled review, is associated with reduced rates of asthma attack and days lost from normal activity.<sup>194,876,877</sup> It is difficult to be prescriptive about the frequency of review as need will vary with the severity of the disease. Outcome is probably similar whether a practice nurse (PN), or a general practitioner (GP) conducts the review. Clinicians trained in asthma management achieve better outcomes for their patients.<sup>876,878,879</sup>

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**A In primary care, people with asthma should be reviewed regularly by a nurse or doctor with appropriate training in asthma management. Review should incorporate a written action plan.**

✓ It is good practice to audit the percentage of patients reviewed annually. Consider focusing on particular groups such as those overusing bronchodilators, patients on higher treatment steps, those with asthma attacks or from groups with more complex needs.

#### 13.3.2 PRIMARY CARE ASTHMA CLINICS

Primary care asthma clinics can be defined as a "...pro-active system of care sited in primary care (eg GP clinic) which occupies a defined and often regular clinical session for the routine review of patients with asthma".<sup>880</sup>

Within primary care, structured reviews may be delivered as appointments in routine surgeries, or within dedicated asthma clinics.

One systematic review which included three small studies of the asthma clinic model, showed no evidence of improvement in important outcomes such as hospitalisation, ED attendances, or quality of life, although there was a reduction in night-time waking, and no evidence that clinics were cost effective.<sup>880</sup> The poor quality of the included studies led the review to conclude that there was a lack of evidence to inform the best way to organise structured asthma care in practice.

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There is, however, no evidence that these clinics do harm. Asthma reviews in primary care may best be carried out, however, during routine surgeries rather than a dedicated asthma clinic.

### 13.3.3 SPECIALIST ASTHMA CLINICS

The evidence for whether specialist asthma clinics improve outcomes for people with severe or difficult asthma was limited to one systematic review, including 17 studies, many of poor quality and underpowered.<sup>148</sup> The review focused on psycho-educational interventions mostly for adults and adolescents (16 and above) with difficult or severe asthma, so provided incomplete evidence on the ideal content of such clinics. The review found that these interventions reduced hospitalisations (but not ED attendances) in adults and children, and improved symptoms in children. The authors concluded that the strength of evidence was insufficient to change practice.

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Further trials testing the impact of clinics run by specialists in asthma care are needed.

C

**Consider including psycho-educational interventions in clinics for adults and children with difficult asthma.**

### 13.4 TELEHEALTHCARE INTERVENTIONS

Telehealthcare interventions for asthma involving a healthcare professional are wide ranging and include telephone calls, video-conferencing, the internet, mobile phone apps, text messaging, or a combination of these. A systematic review of telehealthcare interventions for patients with asthma showed no improvement in quality of life but found a significant reduction in hospital admissions over 12 months (OR 0.21, 95% CI 0.07 to 0.61) with the predominant effect on more severe asthma managed in secondary care.<sup>881</sup> Subsequent studies have shown less consistently beneficial effects, including improvements in symptom control but not healthcare use,<sup>882-886</sup> or no benefits in either outcome.<sup>887</sup>

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Overall, telehealthcare interventions that include advice from a specialist asthma nurse appear to improve outcomes. However, further studies of telehealthcare interventions are needed to disentangle the effects of the technology itself from the addition of specialist nurse advice to patients.

### 13.5 SCHOOL-BASED INTERVENTIONS

Most school-based asthma interventions focus on education delivered by adults (usually health professionals) to school children.<sup>157</sup> Other approaches include peer education, whereby students are trained and then, in turn, train their peers,<sup>712, 888</sup> web-based programmes,<sup>889</sup> or directly observed therapy (DOT) of ICS medication,<sup>727</sup> which may additionally include education of parents.<sup>890</sup> One study tested a multifaceted intervention combining education of schoolchildren with additional training of their doctor, including provision of self management plans.<sup>891</sup> Most evaluations have been based in the USA, often involving minority ethnic groups not directly applicable to the UK.

Education for children in schools generally led to improvements in symptom control and quality of life, but had no impact on healthcare use.<sup>157</sup> Peer education was effective for adolescents<sup>712</sup> but not pre-teens.<sup>888</sup> In two studies, DOT improved symptom control.<sup>727,890</sup> Of all the school-based interventions tested, Bruzzese's multifaceted programme had the most impact, improving symptoms, quality of life, emergency department use and hospitalisation.<sup>891</sup>

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**B** Consider a multifaceted approach to school-based asthma education programmes targeting children's health professionals as well as the children themselves.

### 13.6 ETHNICITY/CULTURE-BASED INTERVENTIONS

The majority of studies examining ethnicity and culture-based interventions that tailor asthma education for people from minority ethnic groups have been carried out in the USA. Further details on the aspects of tailoring can be found in section 4.3.5. A review of system level interventions concluded that the most effective at reducing further healthcare use were those targeted at people who had attended emergency care or had been hospitalised.<sup>162</sup> Interventions were usually intensive, multisession clinic-based programmes. They were nurse-led or used experts including pharmacists or allergy specialists.<sup>162</sup> These findings mirror the little work published in the UK, which showed that a primary care-based clinic was ineffective,<sup>182</sup> while a specialist nurse-led intervention targeted at those attending emergency care reduced further unscheduled care, albeit less in people from ethnic minority groups than in those from white populations.<sup>183</sup>

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Further studies examining the impact of interventions on people from minority ethnic groups in the UK are needed.

**C** Establish intensive clinic-based programmes for people from ethnic minority groups who have attended emergency care.

### 13.7 LAY-LED INTERVENTIONS

Educational interventions led by lay, rather than health professionals, have become popular in the last decade. The NHS Expert Patient Programme, a six week group education programme, is an example. Programmes are usually generic; people attending may have a range of conditions, not specifically asthma.

A systematic review including 17 randomised trials of lay-led self-management education programmes was identified.<sup>892</sup> Only two of the included trials specifically addressed people with asthma, and these found no improvements in breathlessness, health related quality of life, healthcare use, days/nights spent in hospital, and no change in disease specific knowledge. Overall, lay-led self-management interventions may lead to small, short-term improvements in participants' self efficacy, self rated health, cognitive symptom management, and frequency of aerobic exercise. There is, however, currently no evidence to suggest that these interventions alter healthcare use or are cost effective.

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**A** Lay-led self-management programmes for people with asthma are not recommended.

### 13.8 PHARMACIST-LED INTERVENTIONS

Pharmacists have opportunities to provide education for people with asthma, and furthermore, may be able to identify those with poor asthma control. The body of evidence for pharmacy-based interventions is, however, methodologically weak or of limited relevance. Two systematic reviews were assessed. One review addressed interventions in low and middle income countries, while another addressed pharmacy interventions more generally.<sup>893, 894</sup>

Interventions generally involved educating community pharmacists to, in turn, educate patients.<sup>895-897</sup> Other models or elements included follow-up reviews for newly prescribed medication,<sup>898</sup> identifying those with poor control by using questionnaires such as the Asthma Control Test,<sup>897</sup> searching prescribing databases for patients using large numbers of reliever inhalers,<sup>899</sup> and targeting reviews or referral to general practitioners.<sup>899</sup>

Overall, the most consistent improvements in outcomes were seen in inhaler technique,<sup>895-897</sup> with a few studies showing improvements in reduced dispensing of, or need for, reliever inhalers.<sup>897, 899</sup> There was no convincing evidence of reduction in healthcare use.

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Further high quality randomised trials testing pharmacist-led interventions to improve asthma outcomes are needed

**✓** Consider training pharmacists to provide education for people with asthma



## 14 Provision of information

The provision of accurate information to patients and carers is of great importance in order to achieve good adherence to treatment and improved patient outcomes. Specific recommendations and good practice points relating to provision of information by health professionals to patients and carers are found throughout this guideline. In addition, supported self-management is covered in detail in section 4, including sections on personalised asthma action plans (*see section 4.2.2 and Table 9, Annex 10*) and adherence and concordance (*see section 4.4*).

Patient versions of this guideline, in booklet form, covering the management of asthma in adults (for patients and their families and carers) and the management of asthma in children (for parents and carers) are available on the SIGN website ([www.sign.ac.uk](http://www.sign.ac.uk)) or directly from SIGN and could be a useful addition to the patient's PAAP. Health professionals are encouraged to inform patients and carers that these booklets are available. The patient versions are reviewed and updated in line with the clinical guideline. In addition to information on care and treatment, the booklets include contact details for, and brief information about, a number of organisations that provide information for patients (*see section 14.1*).

### 14.1 SOURCES OF FURTHER INFORMATION

#### 14.1.1 NATIONAL ORGANISATIONS FOR PEOPLE WHO HAVE ASTHMA

##### **Asthma UK**

Summit House, 70 Wilson Street, London, EC2A 2DB

Tel: 020 7786 4900

Asthma UK Adviceline: 0800 121 6244

[www.asthma.org.uk](http://www.asthma.org.uk)

Asthma UK is the charity dedicated to improving the health and well-being of people with who are affected by asthma. They offer a range of information on asthma including fact sheets and booklets.

##### **British Lung Foundation**

73–75 Goswell Road, London, EC1V 7ER

Tel: 020 7688 5555 • Fax: 020 7688 5556

Helpline: 08458 50 50 20

[www.lunguk.org](http://www.lunguk.org)

The British Lung Foundation aims to help people understand and live with lung disease. They run the Breathe Easy support network which offers information, support and friendship to anyone affected by lung disease.

#### 14.1.2 OTHER ORGANISATIONS

##### **Allergy UK**

Planwell House, Lefa Business Park, Edgington Way, Sidcup, Kent, DA14 5BH  
Helpline: 01322 619898 • Fax: 01322 470 330  
[www.allergyuk.org](http://www.allergyuk.org)

Allergy UK is a charity which aims to increase people's understanding and awareness of allergies, and helps people manage their allergies.

##### **ASH (Action on Smoking and Health)**

First Floor, 144–145 Shoreditch High Street, London, E1 6JE  
Tel: 020 7739 4732  
[www.ash.org.uk](http://www.ash.org.uk)

ASH is the leading voluntary organisation campaigning for effective tobacco-control legislation and providing an expert information service.

##### **NHS 111**

Freephone: 111

This is a 24-hour helpline for people in England and Wales. It is led by nurses who provide confidential healthcare advice and information 24 hours, 365 days a year.

##### **NHS 24**

Freephone: 111  
[www.nhs24.com](http://www.nhs24.com)

This is a 24-hour helpline for people in Scotland. It is led by nurses who provide confidential healthcare advice and information 24 hours, 365 days a year.

##### **Department of Work and Pensions (DWP)**

[www.dwp.gov.uk](http://www.dwp.gov.uk)

The website gives details of state benefits patients may be entitled to.

# 15 The evidence base

## 15.1 SYSTEMATIC LITERATURE REVIEW

The evidence base for this guideline was synthesised in accordance with SIGN methodology. A systematic review of the literature was carried out using an explicit search strategy devised by a SIGN Evidence and Information Scientist. Databases searched include Medline, Embase, Cinahl, PsycINFO and the Cochrane Library. Internet searches were carried out on various websites including the US National Guidelines Clearinghouse. The main searches were supplemented by material identified by individual members of the development group. Each of the selected papers was evaluated by two members of the group using standard SIGN methodological checklists before conclusions were considered as evidence.

The evidence base builds on the reviews carried out for the original (2003) version of the guideline and subsequent updates. Annex 1 provides details of the time period covered for each topic. A copy of the search narrative, including listings of strategies, is available on the SIGN website as part of the supporting material for this guideline.

## 15.2 RECOMMENDATIONS FOR RESEARCH

The guideline development group was not able to identify sufficient evidence to answer all of the key questions asked in this guideline (*see the supporting material for the guideline on the SIGN website*) The following areas for further research have been identified:

- Is there additional benefit from nebulised magnesium sulphate in children with acute severe asthma receiving maximal doses of inhaled bronchodilators and steroids?
- Head-to-head comparison of intravenous magnesium sulphate bolus with intravenous  $\beta_2$  agonist bolus and/or aminophylline. Which intravenous therapy should be used as first line treatment?

## 15.3 REVIEW AND UPDATING

This guideline was issued in 2014 and sections of the guideline will be updated on a biennial basis. Any updates to the guideline in the interim period will be noted on the SIGN website: [www.sign.ac.uk](http://www.sign.ac.uk)

## 16 Development of the guideline

### 16.1 INTRODUCTION

SIGN is a collaborative network of clinicians, other healthcare professionals and patient organisations and is part of Healthcare Improvement Scotland. SIGN guidelines are developed by multidisciplinary groups of practising clinicians using a standard methodology based on a systematic review of the evidence. Further details about SIGN and the guideline development methodology are contained in 'SIGN 50: A guideline developer's handbook', available at [www.sign.ac.uk](http://www.sign.ac.uk)

### 16.2 EXECUTIVE AND STEERING GROUPS

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Professor Mike Shields	<i>Professor of Child Health, Queen's University, Belfast</i>
Professor Mike Thomas	<i>Professor of Primary Care Research, University of Southampton and General Practitioner</i>
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### 16.3 EVIDENCE REVIEW GROUPS

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#### 16.3.2 SUPPORTED SELF MANAGEMENT

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The membership of the guideline development group was confirmed following consultation with the member organisations of SIGN. All members of the guideline development group made declarations of interest. A register of interests is available in the supporting material section for this guideline at [www.sign.ac.uk](http://www.sign.ac.uk)

Guideline development and literature review expertise, support and facilitation were provided by the SIGN Executive.

All members of the SIGN Executive make yearly declarations of interest. A register of interests is available on the contacts page of the SIGN website [www.sign.ac.uk](http://www.sign.ac.uk)

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Professor Neil Barnes	<i>Consultant Respiratory Physician, Barts and The London NHS Trust</i>
Dr Bernard Higgins	<i>Consultant Respiratory Physician, Freeman Hospital, Newcastle upon Tyne</i>
Cher Piddock	<i>Clinical Asthma Lead, Asthma UK</i>

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## 16.5 CONSULTATION AND PEER REVIEW

### 16.5.1 CONSULTATION

The most recent changes to this guideline were presented for discussion in draft form at the Winter Meeting of the British Thoracic Society in December 2013. The draft guideline was also available on the SIGN and BTS websites for a limited period at this stage to allow those unable to attend the meeting to contribute to the development of the guideline.

### 16.5.2 SPECIALIST REVIEW

This guideline was also reviewed in draft form by the following independent expert referees, who were asked to comment primarily on the comprehensiveness and accuracy of interpretation of the evidence base supporting the recommendations in the guideline. The guideline group addresses every comment made by an external reviewer, and must justify any disagreement with the reviewers' comments. All expert referees made declarations of interest and further details of these are available on request from the SIGN Executive.

SIGN and the BTS are very grateful to all of these experts for their contribution to the guideline.

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### 16.5.3 SIGN EDITORIAL GROUP

As a final quality control check, the guideline is reviewed by an editorial group comprising the relevant specialty representatives on SIGN Council to ensure that the specialist reviewers' comments have been addressed adequately and that any risk of bias in the guideline development process as a whole has been minimised. The editorial group for this guideline was as follows. All members of SIGN Council make yearly declarations of interest. A register of interests is available on the SIGN Council Membership page of the SIGN website [www.sign.ac.uk](http://www.sign.ac.uk)

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Professor John Kinsella	<i>Chair of SIGN; Co-Editor</i>
Dr Vijay Sonthalia	<i>Scottish General Practice Committee</i>

## Abbreviations

<b>A%H</b>	amplitude per cent highest
<b>ABG</b>	arterial blood gas
<b>ACQ</b>	Asthma Control Questionnaire
<b>ACT</b>	Asthma Control Test
<b>ACTH</b>	adrenocorticotrophic hormone
<b>AOR</b>	adjusted odds ratio
<b>Apgar score</b>	A number expressing the physical condition of a newborn infant (a score of ten representing the best possible condition).
<b>AQLQ</b>	Asthma Quality of Life Questionnaire
<b>BCG</b>	Bacillus Calmette-Guérin
<b>BDP</b>	beclometasone
<b>BHR</b>	bronchial hyper-reactivity
<b>BNF</b>	British National Formulary
<b>BTS</b>	British Thoracic Society
<b>CAM</b>	complementary and alternative medicine
<b>CFC</b>	chlorofluorocarbon
<b>CI</b>	confidence interval
<b>COPD</b>	chronic obstructive pulmonary disease
<b>CXR</b>	chest X-ray
<b>DOT</b>	directly observed therapy
<b>DPI</b>	dry powder inhaler
<b>ECG</b>	electrocardiogram
<b>ED</b>	emergency department
<b>eMC</b>	electronic Medicines Compendium
<b>ETS</b>	environmental tobacco smoke
<b>FE<sub>No</sub></b>	exhaled nitric oxide concentration

<b>FEV<sub>1</sub></b>	forced expiratory volume in one second
<b>FVC</b>	forced vital capacity
<b>GMC</b>	General Medical Council
<b>GORD</b>	gastro-oesophageal reflux disease
<b>GP</b>	general practitioner
<b>HEADS</b>	Home, Education/Employment, Activity, Drugs, Sexuality, Suicide/ depression
<b>HDM</b>	house dust mite
<b>HDU</b>	high dependency unit
<b>HFA</b>	hydrofluroalkane
<b>ICS</b>	inhaled corticosteroids
<b>ICU</b>	intensive care unit
<b>IgE</b>	immunoglobulin E
<b>IM</b>	intramuscular
<b>IT</b>	information technology
<b>IOS</b>	impulse oscillometry
<b>IU</b>	international unit
<b>IV</b>	intravenous
<b>kPa</b>	kiloPascal
<b>LABA</b>	long-acting $\beta_2$ agonist
<b>LTRA</b>	leukotriene receptor antagonists
<b>MA</b>	marketing authorisation
<b>MDI</b>	metered dose inhaler
<b>MHRA</b>	Medicines and Healthcare products Regulatory Agency
<b>mmHg</b>	millimetres of mercury
<b>MTA</b>	multiple technology appraisal
<b>n-3PUFAs</b>	omega-3 polyunsaturated fatty acids

<b>NICE</b>	National Institute for Health and Care Excellence
<b>NIV</b>	non-invasive ventilation
<b>NRAD</b>	National Review of Asthma Deaths
<b>NSAID</b>	non-steroidal anti-inflammatory drug
<b>OR</b>	odds ratio
<b>PACE</b>	Physician Asthma Care Education
<b>PaCO<sub>2</sub></b>	partial arterial pressure of carbon dioxide
<b>PaO<sub>2</sub></b>	partial arterial pressure of oxygen
<b>PAAPs</b>	personalised asthma action plans
<b>PAQLQ</b>	paediatric quality of life questionnaire
<b>PC<sub>20</sub></b>	the provocative concentration of bronchoconstrictor (eg methacholine) required to cause a 20% fall in FEV <sub>1</sub>
<b>PD<sub>20</sub></b>	the provocative dose of bronchoconstrictor (eg methacholine) required to cause a 20% fall in FEV <sub>1</sub>
<b>PEF</b>	peak expiratory flow
<b>PEFR</b>	peak expiratory flow rate
<b>PICU</b>	paediatric intensive care unit
<b>pMDI</b>	pressurised metered dose inhaler
<b>PN</b>	practice nurse
<b>ppb</b>	parts per billion
<b>PPI</b>	proton pump inhibitor
<b>QoL</b>	quality of life
<b>RCP</b>	Royal College of Physicians
<b>RCT</b>	randomised controlled trial
<b>RR</b>	risk ratio
<b>RV</b>	residual volume
<b>SCIT</b>	subcutaneous immunotherapy
<b>SIC</b>	specific inhalation challenge

<b>SIGN</b>	Scottish Intercollegiate Guidelines Network
<b>SLIT</b>	sublingual immunotherapy
<b>SMC</b>	Scottish Medicines Consortium
<b>SPC</b>	summary of product characteristics
<b>SpO<sub>2</sub></b>	oxygen saturation measured by a pulse oximeter
<b>sRaw</b>	specific airways resistance
<b>STA</b>	single technology appraisal
<b>TLC</b>	total lung capacity
<b>TNF</b>	tumour necrosis factor
<b>V<sub>E</sub><sub>max</sub></b>	ventilation at maximal exercise capacity
<b>WHO</b>	World Health Organisation

# Annex 1

## Summary of search histories by section

Literature searches to support the various sections of this guideline are conducted on a rolling basis. This summary indicates the currency of the searches supporting each section. Searches in all databases began with the earliest year available at that time, which varied from database to database; for example, searches in Embase extended back to 1980 and in CINAHL to 1982. Specific date coverage is provided for Medline.

The 2014 revision saw updating of multiple sections of the guideline identified as priority areas by the guideline development group. Literature search coverage for the specific topics considered in this update is described below.

Detailed search strategies are available on the SIGN website in the supplementary material section.

### **Section 3 Diagnosis and monitoring**

#### *Diagnosis in children*

The search was last updated in April 2007. Coverage in Medline extends from 2003–2006. This search supplemented the broader search on diagnosis conducted for the original 2003 diagnosis section.

#### *Diagnosis in adults; monitoring*

The search was last updated in February 2010. Coverage in Medline extends from 1966–2009.

### **Section 4 Supported self-management**

The search was last updated in August 2012. Coverage in Medline extends from 1966–2012.

Search coverage from 2003–2012 was mainly restricted to systematic reviews. The Cochrane Library, Medline, Embase and Ebsco CINAHL were searched. Additional searches for RCTs were carried out specifically for pre-school children, ethnic minority groups and primary care programmes.

### **Section 5 Non-pharmacological management**

The last literature search considering all topics in this section was updated in February 2006. Coverage in Medline extends from 1966–2005.

The 2014 revision updated the searches in the following areas:

#### *Allergen avoidance (animal, house dust mite and multimodal interventions)*

The Cochrane Library, Medline and Embase were searched from 2006 to August 2012. No study type filters were applied.

#### *Weight loss (secondary prevention)*

Medline and The Cochrane Library were searched from 2006 to August 2012, SIGN systematic review filter applied. MEDLINE, Embase, Ebsco CINAHL 2012–September 2013, SIGN RCT filter applied.

*Breathing exercises*

Medline and The Cochrane Library were searched from 2006 to August 2012. No study filters were applied.

**Section 6 Pharmacological management**

The last literature search considering all topics in this section was updated in February 2010. Coverage in Medline extends from 1966 to December 2009.

The 2014 revision updated the searches for tiotropium, allergic bronchopulmonary aspergillosis, allergen immunotherapy, paediatric rhinitis, step-up treatment and gastro-oesophageal reflux disease. The Cochrane Library, Medline and Embase were searched from 2009 to August 2012. SIGN systematic review and RCT filters were applied.

A new search was conducted for bronchial thermoplasty. The Cochrane Library, Medline and Embase were searched from database inception to August 2012. No study type filter was applied.

**Section 7 Inhaler devices**

The last literature search considering all topics in this section was updated in June 2008. Coverage in Medline extends from 1998 to January 2008.

The 2014 revision updated the search for inhaler type. The Cochrane Library, Medline and Embase were searched from 2008 to August 2012. No study type filter was applied.

**Section 8 Management of acute asthma**

The last literature search considering all topics in this section was updated in June 2008. Coverage in Medline extends from 1966–2008.

The 2014 revision updated the searches for heliox, leukotriene receptor agonists, nebulised magnesium, nebulised  $\beta_2$  agonists and paediatric steroid therapy: The Cochrane Library, Medline and Embase were searched from 2008 to August 2012. No study type filter was applied.

**Section 9 Difficult asthma**

The last literature search considering all topics in this section was updated in July 2007 and covered 1996 to June 2007.

The 2014 revision updated the searches for non-adherence. The Cochrane Library, Medline and Embase were searched from 2007 to August 2012. No study type filter was applied.

**Section 10 Asthma in adolescents**

The search was last updated in August 2012. Coverage in Medline extends from 2001–2012.

**Section 11 Asthma in pregnancy**

The last literature search considering all topics in this section was updated in June 2008. Coverage in Medline extends from 1966 to January 2008.

The 2014 revision updated the searches on steroids and leukotriene receptor agonists: The Cochrane Library, Medline, Embase and Ebsco CINAHL were searched from 2008 to August 2012.



**Section 12 Occupational asthma**

The last literature search considering all topics in this section was updated by SIGN in March 2003. In 2005, a systematic review by the British Occupational Health Research Foundation (BOHRF) was used as the basis for updating this section.

The BOHRF systematic review was updated in 2010 and contributed to the 2014 update of the guideline. SIGN update searches were conducted for occupational asthma diagnosis. The Cochrane Library, Medline and Embase were searched from 2009 to August 2012. No study type filter was applied.

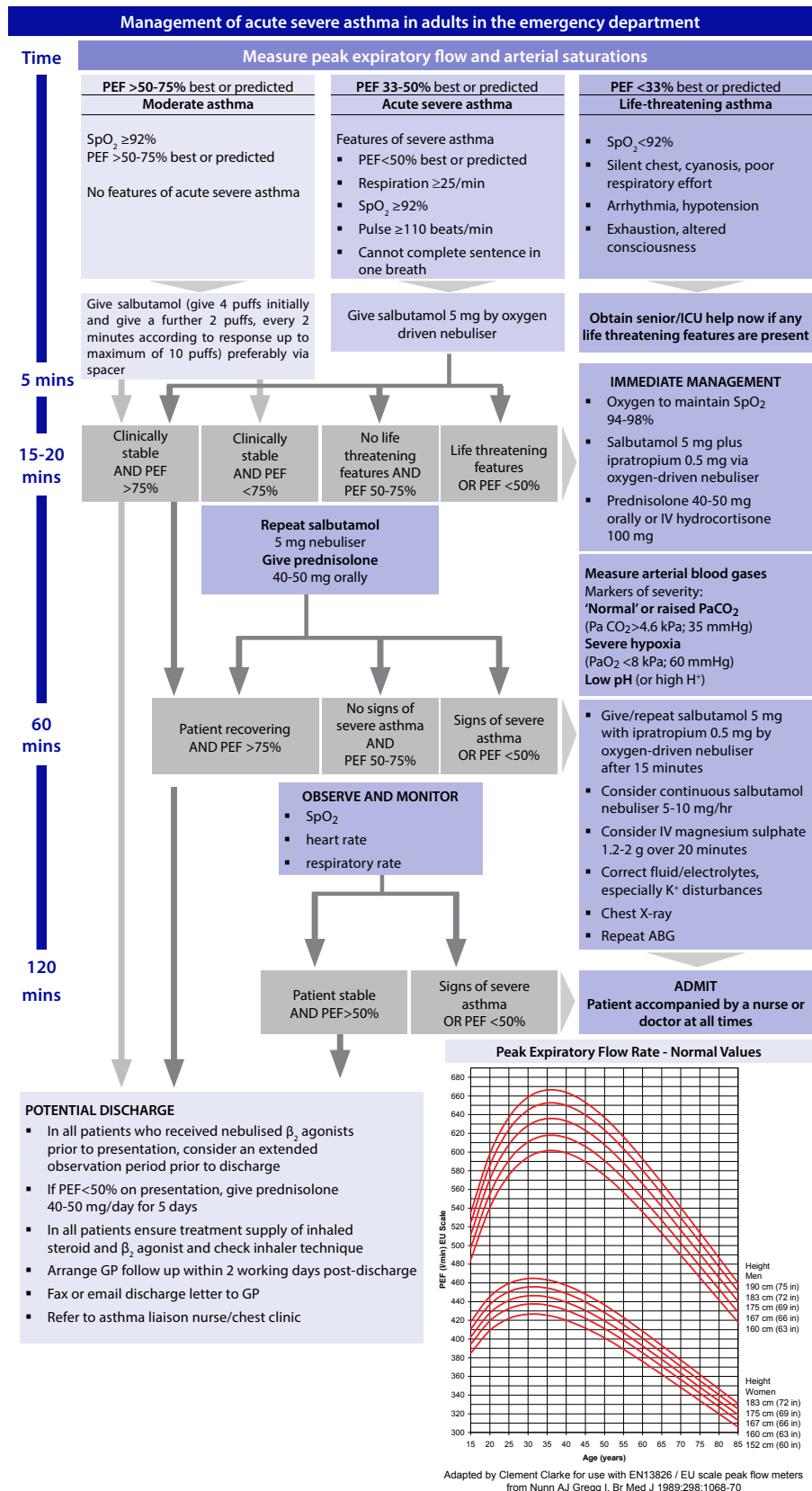
**Section 13 Organisation and delivery of care**

The search was last updated in August 2012. Coverage in Medline extends from 1966–2012. Search coverage from 2003–2012 was restricted to systematic reviews.

## Annex 2



## Annex 3



## Annex 4

Management of acute severe asthma in adults in hospital	
<p><b>Features of acute severe asthma</b></p> <ul style="list-style-type: none"> <li>Peak expiratory flow (PEF) 33-50% of best (use % predicted if recent best unknown)</li> <li>Can't complete sentences in one breath</li> <li>Respiration <math>\geq 25</math> breaths/min</li> <li>Pulse <math>\geq 110</math> beats/min</li> </ul> <p><b>Life-threatening features</b></p> <ul style="list-style-type: none"> <li>PEF &lt;33% of best or predicted</li> <li>SpO<sub>2</sub> &lt;92%</li> <li>Silent chest, cyanosis, or feeble respiratory effort</li> <li>Arrhythmia or hypotension</li> <li>Exhaustion, altered consciousness</li> </ul> <p><b>If a patient has any life-threatening feature, measure arterial blood gases. No other investigations are needed for immediate management.</b></p> <p><b>Blood gas markers of a life-threatening attack:</b></p> <ul style="list-style-type: none"> <li>'Normal' (4.6-6 kPa, 35-45 mmHg) PaCO<sub>2</sub></li> <li>Severe hypoxia: PaO<sub>2</sub> &lt;8 kPa (60mmHg) irrespective of treatment with oxygen</li> <li>A low pH (or high H<sup>+</sup>)</li> </ul> <p><b>Caution: Patients with severe or life-threatening attacks may not be distressed and may not have all these abnormalities. The presence of any should alert the doctor.</b></p> <p><b>Near fatal asthma</b></p> <ul style="list-style-type: none"> <li>Raised PaCO<sub>2</sub></li> <li>Requiring mechanical ventilation with raised inflation pressures</li> </ul> <p><b>Peak Expiratory Flow Rate - Normal Values</b></p> <p>Adapted by Clement Clarke for use with EN13826 / EU scale peak flow meters from Nunn AJ Gregg I, Br Med J 1989;298:1068-70</p>	<p><b>IMMEDIATE TREATMENT</b></p> <ul style="list-style-type: none"> <li>Oxygen to maintain SpO<sub>2</sub> 94-98%</li> <li>Salbutamol 5 mg or terbutaline 10 mg via an oxygen-driven nebuliser</li> <li>Ipratropium bromide 0.5 mg via an oxygen-driven nebuliser</li> <li>Prednisolone tablets 40-50 mg or IV hydrocortisone 100 mg</li> <li>No sedatives of any kind</li> <li>Chest X-ray if pneumothorax or consolidation are suspected or patient requires mechanical ventilation</li> </ul> <p><b>IF LIFE-THREATENING FEATURES ARE PRESENT:</b></p> <ul style="list-style-type: none"> <li>Discuss with senior clinician and ICU team</li> <li>Consider IV magnesium sulphate 1.2-2 g infusion over 20 minutes (unless already given)</li> <li>Give nebulised <math>\beta_2</math> agonist more frequently eg salbutamol 5 mg up to every 15-30 minutes or 10 mg per hour via continuous nebulisation (requires special nebuliser)</li> </ul> <p><b>SUBSEQUENT MANAGEMENT</b></p> <p><b>IF PATIENT IS IMPROVING continue:</b></p> <ul style="list-style-type: none"> <li>Oxygen to maintain SpO<sub>2</sub> 94-98%</li> <li>Prednisolone 40-50mg daily or IV hydrocortisone 100 mg 6 hourly</li> <li>Nebulised <math>\beta_2</math> agonist and ipratropium 4-6 hourly</li> </ul> <p><b>IF PATIENT NOT IMPROVING AFTER 15-30 MINUTES:</b></p> <ul style="list-style-type: none"> <li>Continue oxygen and steroids</li> <li>Use continuous nebulisation of salbutamol at 5-10 mg/hour if an appropriate nebuliser is available. Otherwise give nebulised salbutamol 5 mg every 15-30 minutes</li> <li>Continue ipratropium 0.5 mg 4-6 hourly until patient is improving</li> </ul> <p><b>IF PATIENT IS STILL NOT IMPROVING:</b></p> <ul style="list-style-type: none"> <li>Discuss patient with senior clinician and ICU team</li> <li>Consider IV magnesium sulphate 1.2-2 g over 20 minutes (unless already given)</li> <li>Senior clinician may consider use of IV <math>\beta_2</math> agonist or IV aminophylline or progression to mechanical ventilation</li> </ul> <p><b>MONITORING</b></p> <ul style="list-style-type: none"> <li>Repeat measurement of PEF 15-30 minutes after starting treatment</li> <li>Oximetry: maintain SpO<sub>2</sub> &gt;94-98%</li> <li>Repeat blood gas measurements within 1 hour of starting treatment if: <ul style="list-style-type: none"> <li>initial PaO<sub>2</sub> &lt;8 kPa (60 mmHg) unless subsequent SpO<sub>2</sub> &gt;92%</li> <li>PaCO<sub>2</sub> normal or raised</li> <li>patient deteriorates</li> </ul> </li> <li>Chart PEF before and after giving <math>\beta_2</math> agonists and at least 4 times daily throughout hospital stay</li> </ul> <p><b>Transfer to ICU accompanied by a doctor prepared to intubate if:</b></p> <ul style="list-style-type: none"> <li>Deteriorating PEF, worsening or persisting hypoxia, or hypercapnia</li> <li>Exhaustion, altered consciousness</li> <li>Poor respiratory effort or respiratory arrest</li> </ul> <p><b>DISCHARGE</b></p> <p><b>When discharged from hospital, patients should have:</b></p> <ul style="list-style-type: none"> <li>Been on discharge medication for 12-24 hours and have had inhaler technique checked and recorded</li> <li>PEF &gt;75% of best or predicted and PEF diurnal variability &lt;25% unless discharge is agreed with respiratory physician</li> <li>Treatment with oral and inhaled steroids in addition to bronchodilators</li> <li>Own PEF meter and written asthma action plan</li> <li>GP follow up arranged within 2 working days</li> <li>Follow-up appointment in respiratory clinic within 4 weeks</li> </ul> <p><b>Patients with severe asthma (indicated by need for admission) and adverse behavioural or psychosocial features are at risk of further severe or fatal attacks.</b></p> <ul style="list-style-type: none"> <li>Determine reason(s) for exacerbation and admission</li> <li>Send details of admission, discharge and potential best PEF to GP</li> </ul>

## Annex 5

Management of acute asthma in children in general practice			
Age 2-5 years			
ASSESS ASTHMA SEVERITY			
<b>Moderate asthma</b> <ul style="list-style-type: none"> <li>■ SpO<sub>2</sub> ≥92%</li> <li>■ Able to talk</li> <li>■ Heart rate ≤140/min</li> <li>■ Respiratory rate ≤40/min</li> </ul>	<b>Severe asthma</b> <ul style="list-style-type: none"> <li>■ SpO<sub>2</sub> &lt;92%</li> <li>■ Too breathless to talk</li> <li>■ Heart rate &gt;140/min</li> <li>■ Respiratory rate &gt;40/min</li> <li>■ Use of accessory neck muscles</li> </ul>	<b>Life-threatening asthma</b> <ul style="list-style-type: none"> <li>■ SpO<sub>2</sub> &lt;92% plus any of:               <ul style="list-style-type: none"> <li>■ Silent chest</li> <li>■ Poor respiratory effort</li> <li>■ Agitation</li> <li>■ Altered consciousness</li> <li>■ Cyanosis</li> </ul> </li> </ul>	
<ul style="list-style-type: none"> <li>■ β<sub>2</sub> agonist 2-10 puffs via spacer and facemask (given one puff at a time inhaled separately using tidal breathing)</li> <li>■ Give one puff of β<sub>2</sub> agonist every 30-60 seconds up to 10 puffs according to response</li> <li>■ Consider soluble prednisolone 20 mg</li> </ul>	<ul style="list-style-type: none"> <li>■ Oxygen via face mask</li> <li>■ 10 puffs of β<sub>2</sub> agonist or nebulised salbutamol 2.5 mg</li> <li>■ Soluble prednisolone 20 mg</li> </ul>	<ul style="list-style-type: none"> <li>■ Oxygen via face mask</li> <li>■ Nebulise every 20 minutes with:               <ul style="list-style-type: none"> <li>- salbutamol 2.5 mg</li> <li>+ ipratropium 0.25 mg</li> </ul> </li> <li>■ Soluble prednisolone 20 mg or</li> <li>■ IV hydrocortisone 50 mg</li> </ul>	<b>Assess response to treatment 15 mins after β<sub>2</sub> agonist</b>
<b>IF POOR RESPONSE ARRANGE ADMISSION</b>	<b>IF POOR RESPONSE REPEAT β<sub>2</sub> AGONIST AND ARRANGE ADMISSION</b>	<b>REPEAT β<sub>2</sub> AGONIST VIA OXYGEN-DRIVEN NEBULISER WHILEST ARRANGING IMMEDIATE HOSPITAL ADMISSION</b>	
<b>GOOD RESPONSE</b> <ul style="list-style-type: none"> <li>■ Continue β<sub>2</sub> agonist via spacer or nebuliser, as needed but not exceeding 4 hourly</li> <li>■ If symptoms are not controlled repeat β<sub>2</sub> agonist and refer to hospital</li> <li>■ Continue prednisolone for up to 3 days</li> <li>■ Arrange follow-up clinic visit</li> </ul>	<b>POOR RESPONSE</b> <ul style="list-style-type: none"> <li>■ Stay with patient until ambulance arrives</li> <li>■ Send written assessment and referral details</li> <li>■ Repeat β<sub>2</sub> agonist via oxygen-driven nebuliser in ambulance</li> </ul>		
<b>LOWER THRESHOLD FOR ADMISSION IF:</b> <ul style="list-style-type: none"> <li>■ Attack in late afternoon or at night</li> <li>■ Recent hospital admission or previous severe attack</li> <li>■ Concern over social circumstances or ability to cope at home</li> </ul>			<b>NB:</b> If a patient has signs and symptoms across categories, always treat according to their most severe features
Age >5 years			
ASSESS ASTHMA SEVERITY			
<b>Moderate asthma</b> <ul style="list-style-type: none"> <li>■ SpO<sub>2</sub> ≥92%</li> <li>■ PEF ≥50% best or predicted</li> <li>■ Able to talk</li> <li>■ Heart rate ≤125/min</li> <li>■ Respiratory rate ≤30/min</li> </ul>	<b>Severe asthma</b> <ul style="list-style-type: none"> <li>■ SpO<sub>2</sub> &lt;92%</li> <li>■ PEF 33-50% best or predicted</li> <li>■ Too breathless to talk</li> <li>■ Heart rate &gt;125/min</li> <li>■ Respiratory rate &gt;30/min</li> <li>■ Use of accessory neck muscles</li> </ul>	<b>Life-threatening asthma</b> <ul style="list-style-type: none"> <li>■ SpO<sub>2</sub> &lt;92% plus any of:               <ul style="list-style-type: none"> <li>■ PEF &lt;33% best or predicted</li> <li>■ Silent chest</li> <li>■ Poor respiratory effort</li> <li>■ Agitation</li> <li>■ Altered consciousness</li> <li>■ Cyanosis</li> </ul> </li> </ul>	
<ul style="list-style-type: none"> <li>■ β<sub>2</sub> agonist 2-10 puffs via spacer and mouthpiece (given one puff at a time inhaled separately using tidal breathing)</li> <li>■ Give one puff of β<sub>2</sub> agonist every 30-60 seconds up to 10 puffs according to response.</li> <li>■ Consider soluble prednisolone 30-40 mg</li> </ul>	<ul style="list-style-type: none"> <li>■ Oxygen via face mask</li> <li>■ 10 puffs of β<sub>2</sub> agonist or nebulised salbutamol 5 mg</li> <li>■ Soluble prednisolone 30-40 mg</li> </ul>	<ul style="list-style-type: none"> <li>■ Oxygen via face mask</li> <li>■ Nebulise every 20 minutes with:               <ul style="list-style-type: none"> <li>- salbutamol 5 mg</li> <li>+ ipratropium 0.25 mg</li> </ul> </li> <li>■ Soluble prednisolone 30-40 mg or</li> <li>■ IV hydrocortisone 100 mg</li> </ul>	<b>Assess response to treatment 15 mins after β<sub>2</sub> agonist</b>
<b>IF POOR RESPONSE ARRANGE ADMISSION</b>	<b>IF POOR RESPONSE REPEAT β<sub>2</sub> AGONIST AND ARRANGE ADMISSION</b>	<b>REPEAT β<sub>2</sub> AGONIST VIA OXYGEN-DRIVEN NEBULISER WHILEST ARRANGING IMMEDIATE HOSPITAL ADMISSION</b>	
<b>GOOD RESPONSE</b> <ul style="list-style-type: none"> <li>■ Continue β<sub>2</sub> agonist via spacer or nebuliser, as needed but not exceeding 4 hourly</li> <li>■ If symptoms are not controlled repeat β<sub>2</sub> agonist and refer to hospital</li> <li>■ Continue prednisolone for up to 3 days</li> <li>■ Arrange follow-up clinic visit</li> </ul>	<b>POOR RESPONSE</b> <ul style="list-style-type: none"> <li>■ Stay with patient until ambulance arrives</li> <li>■ Send written assessment and referral details</li> <li>■ Repeat β<sub>2</sub> agonist via oxygen-driven nebuliser in ambulance</li> </ul>		
<b>LOWER THRESHOLD FOR ADMISSION IF:</b> <ul style="list-style-type: none"> <li>■ Attack in late afternoon or at night</li> <li>■ Recent hospital admission or previous severe attack</li> <li>■ Concern over social circumstances or ability to cope at home</li> </ul>			<b>NB:</b> If a patient has signs and symptoms across categories, always treat according to their most severe features

# Annex 6

**Management of acute asthma in children in emergency department**

**Age 2-5 years**

**ASSESS ASTHMA SEVERITY**

<p><b>Moderate asthma</b></p> <ul style="list-style-type: none"> <li>▪ SpO<sub>2</sub> ≥92%</li> <li>▪ No clinical features of severe asthma</li> </ul> <p><b>NB: If a patient has signs and symptoms across categories, always treat according to their most severe features</b></p>	<p><b>Severe asthma</b></p> <ul style="list-style-type: none"> <li>▪ SpO<sub>2</sub> &lt;92%</li> <li>▪ Too breathless to talk or eat</li> <li>▪ Heart rate &gt;140/min</li> <li>▪ Respiratory rate &gt;40/min</li> <li>▪ Use of accessory neck muscles</li> </ul>	<p><b>Life-threatening asthma</b></p> <p>SpO<sub>2</sub> &lt;92% plus any of:</p> <ul style="list-style-type: none"> <li>▪ Silent chest</li> <li>▪ Poor respiratory effort</li> <li>▪ Agitation</li> <li>▪ Altered consciousness</li> <li>▪ Cyanosis</li> </ul>
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Oxygen via face mask/nasal prongs to achieve SpO<sub>2</sub> 94-98%

<ul style="list-style-type: none"> <li>▪ β<sub>2</sub> agonist 2-10 puffs via spacer ± facemask (given one puff at a time inhaled separately using tidal breathing)</li> <li>▪ Give one puff of β<sub>2</sub> agonist every 30-60 seconds up to 10 puffs according to response</li> <li>▪ Consider soluble oral prednisolone 20 mg</li> </ul> <p style="text-align: center;"><b>Reassess within 1 hour</b></p>	<ul style="list-style-type: none"> <li>▪ β<sub>2</sub> agonist 10 puffs via spacer ± facemask or nebulised salbutamol 2.5 mg</li> <li>▪ Soluble prednisolone 20 mg or IV hydrocortisone 4 mg/kg</li> <li>▪ <b>If poor response</b> add 0.25 mg nebulised ipratropium bromide</li> <li>▪ Repeat β<sub>2</sub> agonist and ipratropium up to every 20 minutes for 2 hours according to response</li> </ul>	<ul style="list-style-type: none"> <li>▪ Nebulised β<sub>2</sub> agonist: salbutamol 2.5 mg plus ipratropium bromide 0.25 mg nebulised</li> <li>▪ Oral prednisolone 20 mg or IV Hydrocortisone 4 mg/kg if vomiting</li> </ul> <p style="text-align: center;"><b>Discuss with senior clinician, PICU team or paediatrician</b></p> <ul style="list-style-type: none"> <li>▪ Repeat bronchodilators every 20-30 minutes</li> </ul>
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**Age >5 years**

**ASSESS ASTHMA SEVERITY**

<p><b>Moderate asthma</b></p> <ul style="list-style-type: none"> <li>▪ SpO<sub>2</sub> ≥92%</li> <li>▪ PEF ≥50% best or predicted</li> <li>▪ No clinical features of severe asthma</li> </ul> <p><b>NB: If a patient has signs and symptoms across categories, always treat according to their most severe features</b></p>	<p><b>Severe asthma</b></p> <ul style="list-style-type: none"> <li>▪ SpO<sub>2</sub> &lt;92%</li> <li>▪ PEF 33-50% best or predicted</li> <li>▪ Heart rate &gt;125/min</li> <li>▪ Respiratory rate &gt;30/min</li> <li>▪ Use of accessory neck muscles</li> </ul>	<p><b>Life-threatening asthma</b></p> <p>SpO<sub>2</sub> &lt;92% plus any of:</p> <ul style="list-style-type: none"> <li>▪ PEF &lt;33% best or predicted</li> <li>▪ Silent chest</li> <li>▪ Poor respiratory effort</li> <li>▪ Altered consciousness</li> <li>▪ Cyanosis</li> </ul>
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Oxygen via face mask/nasal prongs to achieve SpO<sub>2</sub> 94-98%

<ul style="list-style-type: none"> <li>▪ β<sub>2</sub> agonist 2-10 puffs via spacer and mouthpiece (given one puff at a time inhaled separately using tidal breathing)</li> <li>▪ Give one puff of β<sub>2</sub> agonist every 30-60 seconds up to 10 puffs according to response</li> <li>▪ Oral prednisolone 30-40 mg</li> </ul> <p style="text-align: center;"><b>Reassess within 1 hour</b></p>	<ul style="list-style-type: none"> <li>▪ β<sub>2</sub> agonist 10 puffs via spacer or nebulised salbutamol 5 mg or IV hydrocortisone 4 mg/kg if vomiting</li> <li>▪ <b>If poor response</b> add 0.25 mg nebulised ipratropium bromide</li> <li>▪ Repeat β<sub>2</sub> agonist and ipratropium up to every 20 minutes for 2 hours according to response</li> </ul>	<ul style="list-style-type: none"> <li>▪ Nebulised β<sub>2</sub> agonist: salbutamol 5 mg plus ipratropium bromide 0.25 mg nebulised</li> <li>▪ Oral prednisolone 30-40 mg or IV Hydrocortisone 4 mg/kg if vomiting</li> </ul> <p style="text-align: center;"><b>Discuss with senior clinician, PICU team or paediatrician</b></p> <ul style="list-style-type: none"> <li>▪ Repeat bronchodilators every 20-30 minutes</li> </ul>
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**DISCHARGE PLAN**

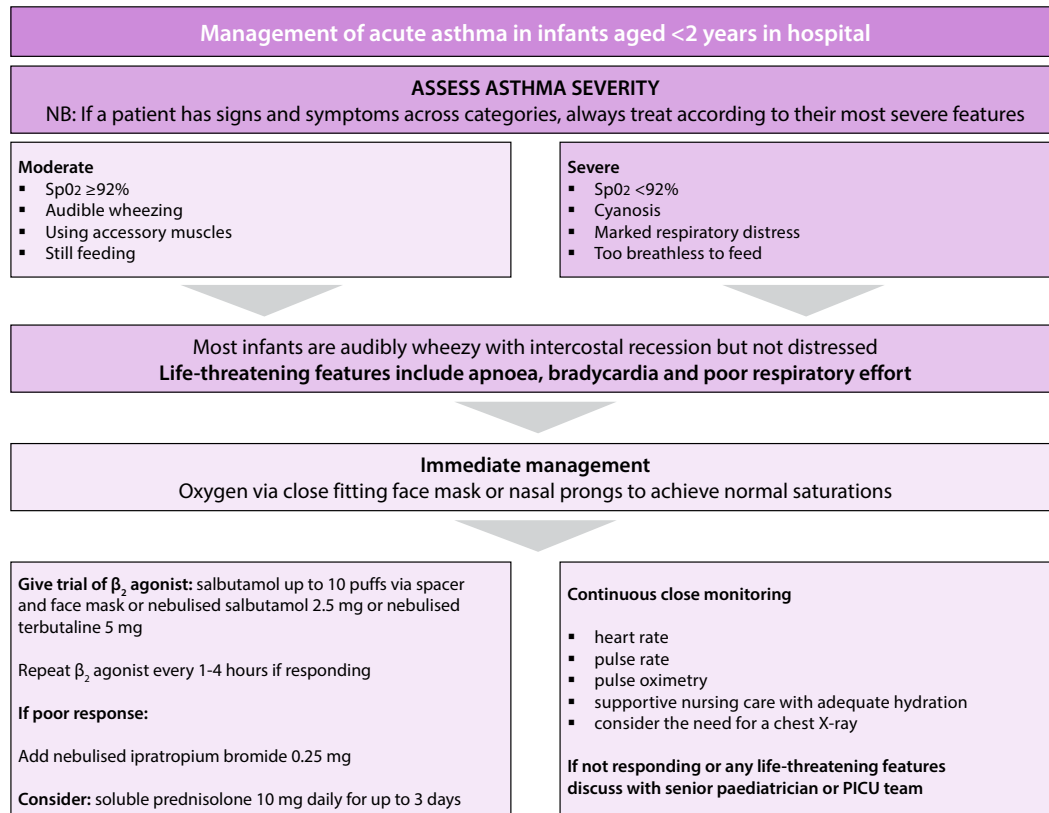
- Continue β<sub>2</sub> agonist 4 hourly as necessary
- Consider prednisolone 30-40 mg daily for up to 3 days
- Advise to contact GP if not controlled on above treatment
- Provide a written asthma action plan
- Review regular treatment
- Check inhaler technique
- Arrange GP follow up

## Annex 7

## Management of acute asthma in children in hospital

Age < 5 years		Age > 5 years			
ASSESS ASTHMA SEVERITY					
<p><b>Moderate asthma</b></p> <ul style="list-style-type: none"> <li>SpO<sub>2</sub> ≥92%</li> <li>No clinical features of severe asthma</li> </ul> <p><b>NB: If a patient has signs and symptoms across categories, always treat according to their most severe features</b></p>	<p><b>Severe asthma</b></p> <ul style="list-style-type: none"> <li>SpO<sub>2</sub> &lt;92%</li> <li>Too breathless to talk or eat</li> <li>Heart rate &gt; 140/min</li> <li>Respiratory rate &gt;40/min</li> <li>Use of accessory neck muscles</li> </ul>	<p><b>Life-threatening asthma</b></p> <p>SpO<sub>2</sub> &lt;92% plus any of:</p> <ul style="list-style-type: none"> <li>Silent chest</li> <li>Poor respiratory effort</li> <li>Agitation</li> <li>Altered consciousness</li> <li>Cyanosis</li> </ul>	<p><b>Moderate asthma</b></p> <ul style="list-style-type: none"> <li>SpO<sub>2</sub> ≥92%</li> <li>PEF &gt; 50% best or predicted</li> <li>No clinical features of severe asthma</li> </ul> <p><b>NB: If a patient has signs and symptoms across categories, always treat according to their most severe features</b></p>	<p><b>Severe asthma</b></p> <ul style="list-style-type: none"> <li>SpO<sub>2</sub> &lt;92%</li> <li>PEF 33-50% best or predicted</li> <li>Heart rate &gt; 125/min</li> <li>Respiratory rate &gt;30/min</li> <li>Use of accessory neck muscles</li> </ul>	<p><b>Life-threatening asthma</b></p> <p>SpO<sub>2</sub> &lt;92% plus any of:</p> <ul style="list-style-type: none"> <li>PEF &lt; 33% best or predicted</li> <li>Silent chest</li> <li>Poor respiratory effort</li> <li>Altered consciousness</li> <li>Cyanosis</li> </ul>
<p>Oxygen via face mask/nasal prongs to achieve SpO<sub>2</sub> 94-98%</p>		<p>Oxygen via face mask/nasal prongs to achieve SpO<sub>2</sub> 94-98%</p>			
<ul style="list-style-type: none"> <li>β<sub>2</sub> agonist 2-10 puffs via spacer ± facemask (given one puff at a time inhaled separately using tidal breathing)</li> <li>Give one puff of β<sub>2</sub> agonist every 30-60 seconds up to 10 puffs according to response</li> <li>Consider soluble oral prednisolone 20 mg</li> </ul> <p><b>Reassess within 1 hour</b></p>	<ul style="list-style-type: none"> <li>β<sub>2</sub> agonist 10 puffs via spacer ± facemask or nebulised salbutamol 2.5 mg</li> <li>Soluble prednisolone 20 mg or IV hydrocortisone 4 mg/kg</li> <li>Repeat β<sub>2</sub> agonist up to every 20-30 minutes according to response</li> <li><b>If poor response</b> add 0.25 mg nebulised ipratropium bromide</li> </ul>	<ul style="list-style-type: none"> <li>Nebulised β<sub>2</sub> agonist: salbutamol 2.5 mg plus ipratropium bromide 0.25 mg nebulised</li> <li>Oral prednisolone 20mg or IV hydrocortisone 4mg/kg if vomiting</li> <li>Consider adding 150 mg Mgso<sub>4</sub> to each β<sub>2</sub> agonist/ ipratropium nebuliser in first hour</li> </ul> <p><b>Discuss with senior clinician, PICU team or paediatrician</b></p> <ul style="list-style-type: none"> <li>Repeat bronchodilators every 20-30 minutes</li> </ul>	<ul style="list-style-type: none"> <li>β<sub>2</sub> agonist 2-10 puffs via spacer and mouthpiece (given one puff at a time inhaled separately using tidal breathing)</li> <li>Give one puff of β<sub>2</sub> agonist every 30-60 seconds up to 10 puffs according to response</li> <li>Oral prednisolone 30-40 mg</li> </ul> <p><b>Reassess within 1 hour</b></p>	<ul style="list-style-type: none"> <li>β<sub>2</sub> agonist 10 puffs via spacer or nebulised salbutamol 5 mg</li> <li>Oral prednisolone 30-40 mg or IV hydrocortisone 4 mg/kg if vomiting</li> <li><b>If poor response</b> nebulised ipratropium bromide 0.25 mg</li> <li>Repeat β<sub>2</sub> agonist and ipratropium up to every 20-30 minutes according to response</li> </ul>	<ul style="list-style-type: none"> <li>Nebulised β<sub>2</sub> agonist: salbutamol 5 mg plus ipratropium bromide 0.25 mg nebulised</li> <li>Oral prednisolone 30-40 mg or IV hydrocortisone 4mg/kg if vomiting</li> <li>Consider adding 150 mg Mgso<sub>4</sub> to each β<sub>2</sub> agonist/ ipratropium nebuliser in first hour</li> </ul> <p><b>Discuss with senior clinician, PICU team or paediatrician</b></p> <ul style="list-style-type: none"> <li>Repeat bronchodilators every 20-30 minutes</li> </ul>
<p>Record respiratory rate, heart rate and oxygen saturation every 1-4 hours</p>		<p>Record respiratory rate, heart rate, oxygen saturation and PEF/FEV every 1-4 hours</p>			
<p><b>ASSESS RESPONSE TO TREATMENT</b></p>		<p><b>ASSESS RESPONSE TO TREATMENT</b></p>			
<p><b>RESPONDING</b></p> <ul style="list-style-type: none"> <li>Continue bronchodilators 1-4 hours as necessary</li> <li>Discharge when stable on 4-hourly treatment</li> <li>Continue oral prednisolone for up to 3 days</li> </ul> <p><b>At discharge</b></p> <ul style="list-style-type: none"> <li>Ensure stable on 4-hourly inhaled treatment</li> <li>Review the need for regular treatment and the use of inhaled steroids</li> <li>Review inhaler technique</li> <li>Provide a written asthma action plan for treating future attacks</li> <li>Arrange follow up according to local policy</li> </ul>	<p><b>NOT RESPONDING</b></p> <ul style="list-style-type: none"> <li>Arrange HDU/PICU transfer</li> <li>Consider: <ul style="list-style-type: none"> <li>Chest X-ray and blood gases</li> <li>IV salbutamol 1.5 micrograms/kg bolus over 10 minutes followed by continuous infusion 1-5 micrograms/kg/min (dilute to 200 micrograms/ml)</li> <li>Bolus IV infusion of magnesium sulphate 40 mg/kg (max 2 g) over 20 minutes</li> <li>IV aminophylline 5 mg/kg loading dose over 20 minutes (omit in those receiving oral theophyllines) followed by continuous infusion 1 mg/kg/hour</li> </ul> </li> </ul>	<p><b>RESPONDING</b></p> <ul style="list-style-type: none"> <li>Continue bronchodilators 1-4 hours as necessary</li> <li>Discharge when stable on 4-hourly treatment</li> <li>Continue oral prednisolone 30-40 mg for up to 3 days</li> </ul> <p><b>At discharge</b></p> <ul style="list-style-type: none"> <li>Ensure stable on 4-hourly inhaled treatment</li> <li>Review the need for regular treatment and the use of inhaled steroids</li> <li>Review inhaler technique</li> <li>Provide a written asthma action plan for treating future attacks</li> <li>Arrange follow up according to local policy</li> </ul>	<p><b>NOT RESPONDING</b></p> <ul style="list-style-type: none"> <li>Continue 20-30 minute nebulisers and arrange HDU/PICU transfer</li> <li>Consider: Chest X-ray and blood gases</li> <li>Consider risks and benefits of</li> <li>Bolus IV salbutamol 1.5 micrograms/kg if not already given</li> <li>Continuous IV salbutamol infusion 1-5 micrograms/kg/min (200 micrograms/ml solution)</li> <li>Bolus IV infusion of magnesium sulphate 40 mg/kg (max 2g) over 20 minutes</li> <li>IV aminophylline 5 mg/kg loading dose over 20 minutes (omit in those receiving oral theophyllines) followed by continuous infusion 1mg/kg/hour</li> </ul>		

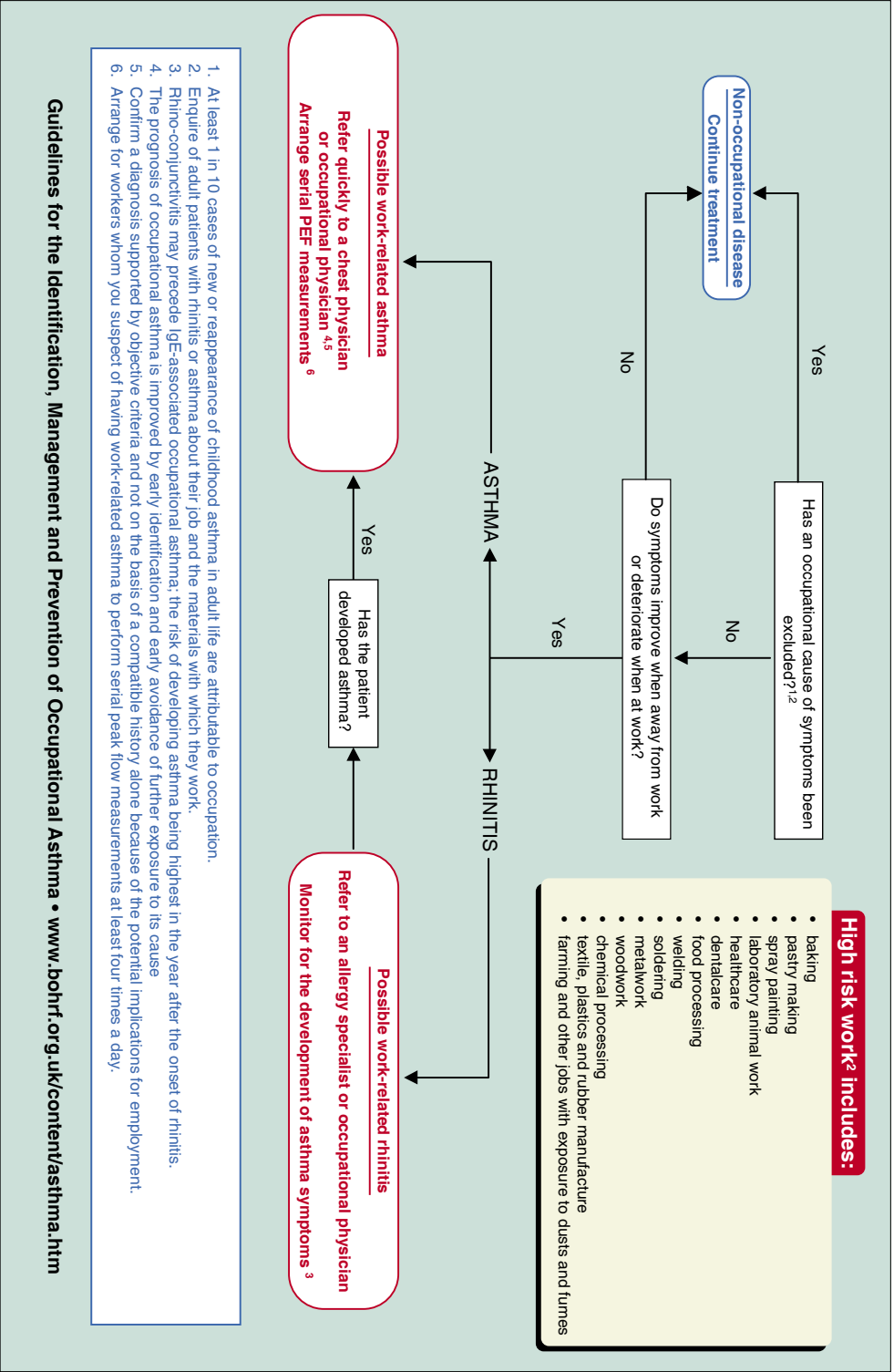
## Annex 8





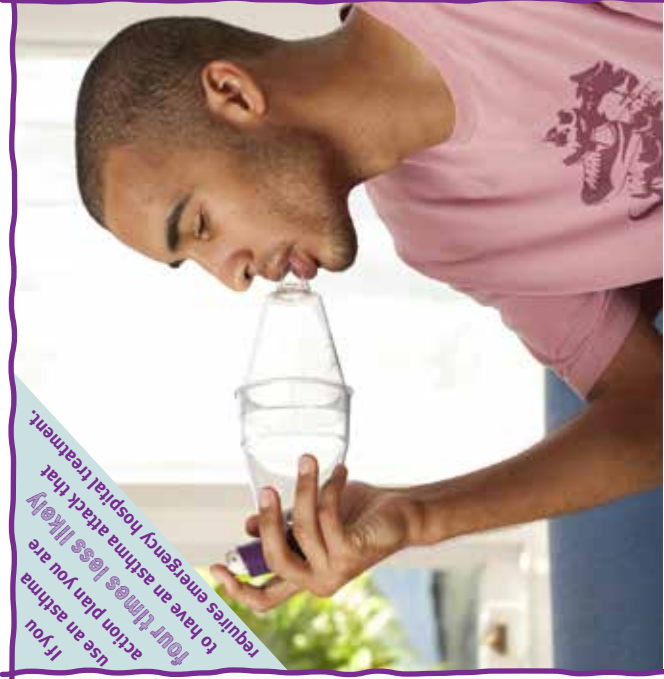
# Annex 9

## WORK-RELATED ASTHMA AND RHINITIS: CASE FINDING AND MANAGEMENT IN PRIMARY CARE



# Annex 10

## your asthma action plan




*If you have an asthma action plan you are four times less likely to have an asthma attack that requires emergency hospital treatment.*


Name

Date

Complete this with your  
asthma nurse or GP.







*with you every  
breath of the way*

 If you have any concerns about managing your asthma, you can call an asthma nurse specialist on Asthma UK's Helpline 0800 121 62 44


Contact number for GP/specialist asthma nurse:

Asthma UK has a range of resources to help with your asthma and a team of specialist asthma nurses if you need further advice.

 Asthma UK Helpline 0800 121 62 44  [info@asthma.org.uk](mailto:info@asthma.org.uk)  Or visit our website [www.asthma.org.uk](http://www.asthma.org.uk)



*with you every  
breath of the way*



Health & care information you can trust  
The Asthma Foundation of the United Kingdom

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## Annex 10 contd.



**This is what I need to do to stay on top of my asthma:**

**My personal best peak flow is:**

**My preventer inhaler**  
(insert name/colour)

**I need to take my preventer inhaler every day even when I feel well.**

I take  puff(s) in the morning and  puff(s) at night.

**My reliever inhaler**  
(insert name/colour)

**I take my reliever inhaler only if I need to.**

I take  puff(s) of my reliever inhaler if any of these things happen:

- I'm wheezing
- My chest feels tight
- I'm finding it hard to breathe
- I'm coughing

**Other medicines I take for my asthma every day:**

If I haven't had any symptoms or needed my reliever inhaler for at least 12 weeks, talk to my GP or asthma nurse about reviewing my medicines.



**People with allergies need to be extra careful as attacks can be more severe.**



**My asthma is getting worse if I notice any of these:**

- My symptoms are coming back (wheeze, tightness in my chest, feeling breathless, cough)
- I am waking up at night
- My symptoms are interfering with my usual day-to-day activities (eg at work, exercise)
- I am using my reliever inhaler  times a week or more
- My peak flow drops to below

**This is what I can do straight away to get on top of my asthma:**

**1** If I haven't been using my preventer inhaler, start using it regularly again or:

Increase my preventer inhaler dose to  until my symptoms have gone and my peak flow is back to normal.

Take my reliever inhaler as needed (up to  puffs every four hours).

If I don't improve within 48 hours make an urgent appointment to see my GP or asthma nurse.

**2** If I have been given prednisolone tablets (steroid tablets) to keep at home:

Take  mg of prednisolone tablets (which is  x 5mg) immediately and again every morning for  days or until I am fully better.

Call my GP today and let them know I have started taking steroids and make an appointment to be seen within 24 hours.



**I am having an asthma attack if any of these happen:**

- My reliever inhaler is not helping or I need it more than every  hours
- I find it difficult to walk or talk
- I find it difficult to breathe
- I'm wheezing a lot or I have a very tight chest or I'm coughing a lot
- My peak flow is below

**THIS IS AN EMERGENCY TAKE ACTION NOW**

**1** Take two puffs of my reliever inhaler (one puff at a time)

**2** Sit up and try to take slow, steady breaths

**3** If I don't start to feel better, take two puffs of my reliever inhaler (one puff at a time) every two minutes. I can take up to ten puffs

**4** If I don't feel better I should call 999 straight away. If an ambulance doesn't arrive within ten minutes, and I'm still not feeling better, then I should repeat Step 3

**5** Even if I feel better after this I should see my GP or asthma nurse for advice the same day

**6** If I have rescue prednisolone tablets, take 40mg (8 x 5mg) altogether

Please note this asthma attack information is not designed for people who use the Symbicort SMART regime OR Fostair MART regime. If you use Symbicort SMART or Fostair MART please speak to your GP or asthma nurse about this.

## References

- British Thoracic Society, Scottish Intercollegiate Guidelines Network. British guideline on the management of asthma. *Thorax* 2003;58 Suppl 1:i1-94.
- Scottish Intercollegiate Guidelines Network (SIGN). SIGN 50: A guideline developers' handbook. Edinburgh: SIGN; 2008. (SIGN publication no. 50). [cited 1st Jul 2014]. Available from url: <http://www.sign.ac.uk/guidelines/fulltext/50/index.html>
- Table 16: nedocromil and sodium cromoglycate studies not included in the nedocromil meta-analysis. In: The primary care management of asthma in adults. North of England Evidence Based Guideline Development Project. Newcastle: University of Newcastle upon Tyne, Centre for Health Services Research; 1999. p.46-7.
- World Health Organisation. Health topics: adolescent health. [cited 1 Jul 2014]. Available from url: [http://www.who.int/topics/adolescent\\_health/en](http://www.who.int/topics/adolescent_health/en)
- Guidance on prescribing. In: The British National Formulary No. 66. London: British Medical Association and Royal Pharmaceutical Society of Great Britain; 2013.
- Medicines and Healthcare products Regulatory Agency. Off-label use or unlicensed medicines: prescribers' responsibilities. *Drug Safety Update* 2009;2(9):6-7.
- National Institute for Health and Care Excellence (NICE). Quality standard for asthma. NICE; 2013. (Quality standard 25). [cited 1 Jul 2014]. Available from url: <http://www.nice.org.uk/guidance/QS25/chapter/introduction-and-overview>
- Cane RS, Ranganathan SC, McKenzie SA. What do parents of wheezy children understand by "wheeze"? *Arch Dis Child* 2000;82(4):327-32.
- Dodge R, Martinez FD, Cline MG, Lebowitz MD, Burrows B. Early childhood respiratory symptoms and the subsequent diagnosis of asthma. *J Allergy Clin Immunol* 1996;98(1):48-54.
- Martinez FD, Wright AL, Taussig LM, Holberg CJ, Halonen M, Morgan WJ. Asthma and wheezing in the first six years of life. The Group Health Medical Associates. *N Engl J Med* 1995;332(3):133-8.
- Park ES, Golding J, Carswell F, Stewart-Brown S. Preschool wheezing and prognosis at 10. *Arch Dis Child* 1986;61(7):642-6.
- Sporik R, Holgate ST, Cogswell JJ. Natural history of asthma in childhood - a birth cohort study. *Arch Dis Child* 1991;66(9):1050-3.
- Strachan DP, Butland BK, Anderson HR. Incidence and prognosis of asthma and wheezing illness from early childhood to age 33 in a national British cohort. *BMJ* 1996;312(7040):1195-9.
- Castro-Rodriguez JA, Holberg CJ, Wright AL, Martinez FD. A clinical index to define risk of asthma in young children with recurrent wheezing. *Am J Respir Crit Care Med* 2000;162(4 Pt 1):1403-6.
- Galant SP, Crawford LJ, Morpew T, Jones CA, Bassin S. Predictive value of a cross-cultural asthma case-detection tool in an elementary school population. *Pediatrics* 2004;114(3):e307-16.
- Gerald LB, Grad R, Turner-Henson A, Hains C, Tang S, Feinstein R, et al. Validation of a multistage asthma case-detection procedure for elementary school children. *Pediatrics*. 2004;114(4):e459-68.
- Ly NP, Gold DR, Weiss ST, Celedon JC. Recurrent wheeze in early childhood and asthma among children at risk for atopy. *Pediatrics* 2006;117(6):e1132-8.
- Jones CA, Morpew T, Clement LT, Kimia T, Dyer M, Li M, et al. A school-based case identification process for identifying inner city children with asthma: the Breathmobile program. *Chest* 2004;125(3):924-34.
- Kurukulaaratchy RJ, Matthews S, Holgate ST, Arshad SH. Predicting persistent disease among children who wheeze during early life. *Eur Respir J* 2003;22(5):767-71.
- Schonberger H, van Schayck O, Muris J, Bor H, van den Hoogen H, Knottnerus A, et al. Towards improving the accuracy of diagnosing asthma in early childhood. *Eur J Gen Pract*. 2004;10(4):138-45.
- Marchant JM, Masters IB, Taylor SM, Cox NC, Seymour GJ, Chang AB. Evaluation and outcome of young children with chronic cough. *Chest* 2006;129(5):1132-41.
- Marchant JM, Masters IB, Taylor SM, Chang AB. Utility of signs and symptoms of chronic cough in predicting specific cause in children. *Thorax*. 2006;61(8):694-8.
- Saglani S, Nicholson AG, Scallan M, Balfour-Lynn I, Rosenthal M, Payne DN, et al. Investigation of young children with severe recurrent wheeze: any clinical benefit? *Eur Respir J* 2006;27(1):29-35.
- Kurukulaaratchy RJ, Matthews S, Arshad SH. Relationship between childhood atopy and wheeze: what mediates wheezing in atopic phenotypes? *Ann Allergy Asthma Immunol* 2006;97(1):84-91.
- Jenkins MA, Hopper JL, Bowes G, Carlin JB, Flander LB, Giles GG. Factors in childhood as predictors of asthma in adult life. *BMJ* 1994;309(6947):90-3.
- Aberg N, Engstrom I. Natural history of allergic diseases in children. *Acta Paediatr Scand* 1990;79(2):206-11.
- Toelle BG, Xuan W, Peat JK, Marks GB. Childhood factors that predict asthma in young adulthood. *Eur Respir J* 2004;23(1):66-70.

28. Anderson HR, Pottier AC, Strachan DP. Asthma from birth to age 23: incidence and relation to prior and concurrent atopic disease. *Thorax* 1992;47(7):537-42.
29. Barbee RA, Murphy S. The natural history of asthma. *J Allergy Clin Immunol* 1998;102(4 Pt 2):S65-72.
30. Blair H. Natural history of childhood asthma. 20-year follow-up. *Arch Dis Child* 1977;52(8):613-9.
31. Johnstone DE. A study of the natural history of bronchial asthma in children. *Am J Dis Child* 1968;115(2):213-6.
32. Laor A, Cohen L, Danon YL. Effects of time, sex, ethnic origin, and area of residence on prevalence of asthma in Israeli adolescents. *BMJ* 1993;307(6908):841-4.
33. Heaney LG, Conway E, Kelly C, Johnston BT, English C, Stevenson M, et al. Predictors of therapy resistant asthma: outcome of a systematic evaluation protocol. *Thorax* 2003;58(7):561-6.
34. Luyt DK, Burton PR, Simpson H. Epidemiological study of wheeze, doctor diagnosed asthma, and cough in preschool children in Leicestershire. *BMJ* 1993;306(6889):1386-90.
35. Martin AJ, McLennan LA, Landau LI, Phelan PD. The natural history of childhood asthma to adult life. *Br Med J* 1980;280(6229):1397-400.
36. Robertson CF, Heycock E, Bishop J, Nolan T, Olinsky A, Phelan PD. Prevalence of asthma in Melbourne schoolchildren: changes over 26 years. *BMJ* 1991;302(6785):1116-8.
37. Roorda RJ. Prognostic factors for the outcome of childhood asthma in adolescence. *Thorax* 1996;51(Suppl 1):S7-12.
38. Sears MR, Holdaway MD, Flannery EM, Herbison GP, Silva PA. Parental and neonatal risk factors for atopy, airway hyper-responsiveness, and asthma. *Arch Dis Child* 1996;75(5):392-8.
39. Sherman CB, Tosteson TD, Tager IB, Speizer FE, Weiss ST. Early childhood predictors of asthma. *Am J Epidemiol* 1990;132(1):83-95.
40. Sigurs N, Bjarnason R, Sigurbergsson F, Kjellman B, Bjorksten B. Asthma and immunoglobulin E antibodies after respiratory syncytial virus bronchiolitis: a prospective cohort study with matched controls. *Pediatrics* 1995;95(4):500-5.
41. Tariq SM, Matthews SM, Hakim EA, Stevens M, Arshad SH, Hide DW. The prevalence of and risk factors for atopy in early childhood: a whole population birth cohort study. *J Allergy Clin Immunol* 1998;101(5):587-93.
42. Clough JB, Keeping KA, Edwards LC, Freeman WM, Warner JA, Warner JO. Can we predict which wheezy infants will continue to wheeze? *Am J Respir Crit Care Med* 1999;160(5 Pt 1):1473-80.
43. Reijonen TM, Kotaniemi-Syrjanen A, Korhonen K, Korppi M. Predictors of asthma three years after hospital admission for wheezing in infancy. *Pediatrics* 2000;106(6):1406-12.
44. Kotaniemi-Syrjanen A, Reijonen TM, Romppanen J, Korhonen K, Savolainen K, Korppi M. Allergen-specific immunoglobulin E antibodies in wheezing infants: the risk for asthma in later childhood. *Pediatrics* 2003;111(3):e255-61.
45. Sears MR, Herbison GP, Holdaway MD, Hewitt CJ, Flannery EM, Silva PA. The relative risks of sensitivity to grass pollen, house dust mite and cat dander in the development of childhood asthma. *Clin Exp Allergy* 1989;19(4):419-24.
46. Rona RJ, Duran-Tauleria E, Chinn S. Family size, atopic disorders in parents, asthma in children, and ethnicity. *J Allergy Clin Immunol* 1997;99(4):454-60.
47. Rusconi F, Galassi C, Corbo GM, Forastiere F, Biggeri A, Ciccone G, et al. Risk factors for early, persistent, and late-onset wheezing in young children. SIDRIA Collaborative Group. *Am J Respir Crit Care Med* 1999;160(5 Pt 1):1617-22.
48. Yu IT, Wong TW, Li W. Using child reported respiratory symptoms to diagnose asthma in the community. *Arch Dis Child* 2004;89(6):544-8.
49. Remes ST, Pekkanen J, Remes K, Salonen RO, Korppi M. In search of childhood asthma: questionnaire, tests of bronchial hyperresponsiveness, and clinical evaluation. *Thorax* 2002;57(2):120-6.
50. Bacharier LB, Strunk RC, Mauger D, White D, Lemanske RF Jr, Sorkness CA. Classifying asthma severity in children: Mismatch between symptoms, medication use, and lung function. *Am J Respir Crit Care Med* 2004;170(4):426-32.
51. Brouwer AFJ, Roorda RJ, Brand PLP. Home spirometry and asthma severity in children. *Eur Respir J* 2006;28(6):1131-7.
52. Verini M, Peroni DG, Rossi N, Nicodemo A, De Stradis R, Spagnolo C, et al. Functional assessment of allergic asthmatic children while asymptomatic. *Allergy Asthma Proc* 2006;27(4):359-64.
53. Pellegrino R, Viegi G, Brusasco V, Crapo RO, Burgos F, Casaburi R, et al. Interpretative strategies for lung function tests. *Eur Respir J* 2005;26(5):948-68.
54. Tantisira KG, Fuhlbrigge AL, Tonascia J, Van Natta M, Zeiger RS, Strunk RC, et al. Bronchodilation and bronchoconstriction: predictors of future lung function in childhood asthma. *J Allergy Clin Immunol* 2006;117(6):1264-71.
55. Dundas I, Chan EY, Bridge PD, McKenzie SA. Diagnostic accuracy of bronchodilator responsiveness in wheezy children. *Thorax* 2005;60(1):13-6.

56. Arets HG, Brackel HJ, van der Ent CK. Applicability of interrupter resistance measurements using the MicroRint in daily practice. *Respir Med* 2003;97(4):366-74.
57. Olaguibel JM, Alvarez-Puebla MJ, Anda M, Gomez B, Garcia BE, Tabar AI, et al. Comparative analysis of the bronchodilator response measured by impulse oscillometry (IOS), spirometry and body plethysmography in asthmatic children. *J Investig Allergol Clin Immunol* 2005;15(2):102-6.
58. Marotta A, Klinnert MD, Price MR, Larsen GL, Liu AH. Impulse oscillometry provides an effective measure of lung dysfunction in 4-year-old children at risk for persistent asthma. *J Allergy Clin Immunol* 2003;112(2):317-22.
59. Joseph-Bowen J, de Klerk NH, Firth MJ, Kendall GE, Holt PG, Sly PD. Lung function, bronchial responsiveness, and asthma in a community cohort of 6-year-old children. *Am J Respir Crit Care Med* 2004;169(7):850-4.
60. Abu-Hasan M, Tannous B, Weinberger M. Exercise-induced dyspnea in children and adolescents: if not asthma then what? *Ann Allergy Asthma Immunol* 2005;94(3):366-71.
61. Lex C, Payne DN, Zacharasiewicz A, Li AM, Wilson NM, Hansel TT, et al. Sputum induction in children with difficult asthma: safety, feasibility, and inflammatory cell pattern. *Pediatr Pulmonol* 2005;39(4):318-24.
62. Ryttila P, Pelkonen AS, Metso T, Nikander K, Haahtela T, Turpeinen M. Induced sputum in children with newly diagnosed mild asthma: The effect of 6 months of treatment with budesonide or disodium cromoglycate. *Allergy* 2004;59(8):839-44.
63. Covar RA, Spahn JD, Martin RJ, Silkoff PE, Sundstrom DA, Murphy J, et al. Safety and application of induced sputum analysis in childhood asthma. *J Allergy Clin Immunol* 2004;114(3):575-82.
64. Malmberg LP, Turpeinen H, Ryttila P, Sarna S, Haahtela T. Determinants of increased exhaled nitric oxide in patients with suspected asthma. *Allergy* 2005;60(4):464-8.
65. Brussee JE, Smit HA, Kerkhof M, Koopman LP, Wijga AH, Postma DS, et al. Exhaled nitric oxide in 4-year-old children: relationship with asthma and atopy. *Eur Respir J* 2005;25(3):455-61.
66. Barreto M, Villa MP, Monti F, Bohmerova Z, Martella S, Montesano M, et al. Additive effect of eosinophilia and atopy on exhaled nitric oxide levels in children with or without a history of respiratory symptoms. *Pediatr Allergy Immunol* 2005;16(1):52-8.
67. Malmberg LP, Petays T, Haahtela T, Laatikainen T, Jousilahti P, Vartiainen E, et al. Exhaled nitric oxide in healthy nonatopic school-age children: Determinants and height-adjusted reference values. *Pediatr Pulmonol* 2006;41(7):635-42.
68. Prasad A, Langford B, Stradling JR, Ho LP. Exhaled nitric oxide as a screening tool for asthma in school children. *Respir Med* 2006;100(1):167-73.
69. Pijnenburg MW, Floor SE, Hop WC, De Jongste JC. Daily ambulatory exhaled nitric oxide measurements in asthma. *Pediatr Allergy Immunol* 2006;17(3):189-93.
70. Chan EY, Dundas I, Bridge PD, Healy MJ, McKenzie SA. Skin-prick testing as a diagnostic aid for childhood asthma. *Pediatr Pulmonol* 2005;39(6):558-62.
71. Eysink PE, ter Riet G, Aalberse RC, van Aalderen WM, Roos CM, van der Zee JS, et al. Accuracy of specific IgE in the prediction of asthma: development of a scoring formula for general practice. *Br J Gen Pract* 2005;55(511):125-31.
72. Simpson A, Soderstrom L, Ahlstedt S, Murray CS, Woodcock A, Custovic A. IgE antibody quantification and the probability of wheeze in preschool children. *J Allergy Clin Immunol* 2005;116(4):744-9.
73. Kurukulaaratchy RJ, Fenn M, Matthews S, Arshad SH. Characterisation of atopic and non-atopic wheeze in 10 year old children. *Thorax* 2004;59(7):563-8.
74. Hederos CA, Janson S, Andersson H, Hedlin G. Chest X-ray investigation in newly discovered asthma. *Pediatr Allergy Immunol* 2004;15(2):163-5.
75. Hunter CJ, Brightling CE, Woltmann G, Wardlaw AJ, Pavord ID. A comparison of the validity of different diagnostic tests in adults with asthma. *Chest* 2002;121(4):1051-7.
76. Joyce DP, Chapman KR, Kesten S. Prior diagnosis and treatment of patients with normal results of methacholine challenge and unexplained respiratory symptoms. *Chest* 1996;109(3):697-701.
77. Brand PL, Postma DS, Kerstjens HA, Koeter GH. Relationship of airway hyperresponsiveness to respiratory symptoms and diurnal peak flow variation in patients with obstructive lung disease. The Dutch CNSLD Study Group. *Am Rev Respir Dis* 1991;143(5 Pt 1):916-21.
78. Gibson PG, Fujimura M, Niimi A. Eosinophilic bronchitis: clinical manifestations and implications for treatment. *Thorax* 2002;57(2):178-82.
79. James AL, Finucane KE, Ryan G, Musk AW. Bronchial responsiveness, lung mechanics, gas transfer, and corticosteroid response in patients with chronic airflow obstruction. *Thorax* 1988;43(11):916-22.
80. Ramsdale EH, Morris MM, Roberts RS, Hargreave FE. Bronchial responsiveness to methacholine in chronic bronchitis: relationship to airflow obstruction and cold air responsiveness. *Thorax* 1984;39(12):912-8.

81. Goldstein MF, Veza BA, Dunskey EH, Dvorin DJ, Belecanech GA, Haralabatos IC. Comparisons of peak diurnal expiratory flow variation, postbronchodilator FEV(1) responses, and methacholine inhalation challenges in the evaluation of suspected asthma. *Chest* 2001;119(4):1001-10.
82. Smith AD, Cowan JO, Brassett KP, Filsell S, McLachlan C, Monti-Sheehan G, et al. Exhaled nitric oxide: a predictor of steroid response. *Am J Respir Crit Care Med* 2005;172(4):453-9.
83. Smith AD, Cowan JO, Filsell S, McLachlan C, Monti-Sheehan G, Jackson P, et al. Diagnosing asthma: comparisons between exhaled nitric oxide measurements and conventional tests. *Am J Respir Crit Care Med* 2004;169(4):473-8. (34 ref).
84. Taylor DR, Pijnenburg MW, Smith AD, De Jongste JC. Exhaled nitric oxide measurements: clinical application and interpretation. *Thorax* 2006;61(9):817-27.
85. Brightling CE, Monteiro W, Ward R, Parker D, Morgan MD, Wardlaw AJ, et al. Sputum eosinophilia and short-term response to prednisolone in chronic obstructive pulmonary disease: a randomised controlled trial. *Lancet* 2000;356(9240):1480-5.
86. Chatkin JM, Ansarin K, Silkoff PE, McClean P, Gutierrez C, Zamel N, et al. Exhaled nitric oxide as a noninvasive assessment of chronic cough. *Am J Respir Crit Care Med* 1999;159(6):1810-3.
87. Pavord ID, Brightling CE, Woltmann G, Wardlaw AJ. Non-eosinophilic corticosteroid unresponsive asthma. *Lancet* 1999;353(9171):2213-4.
88. Green RH, Brightling CE, McKenna S, Hargadon B, Parker D, Bradding P, et al. Asthma exacerbations and sputum eosinophil counts: a randomised controlled trial. *Lancet* 2002;360(9347):1715-21.
89. Smith AD, Cowan JO, Brassett KP, Herbison GP, Taylor DR. Use of exhaled nitric oxide measurements to guide treatment in chronic asthma. *N Engl J Med* 2005;352(21):2163-73.
90. Jayaram L, Pizzichini MM, Cook RJ, Boulet LP, Lemiere C, Pizzichini E, et al. Determining asthma treatment by monitoring sputum cell counts: Effect on exacerbations. *Eur Respir J* 2006;27(3):483-94.
91. Berry M, Hargadon B, Morgan A, Shelley M, Richter J, Shaw D, et al. Alveolar nitric oxide in adults with asthma: evidence of distal lung inflammation in refractory asthma. *Eur Respir J* 2005;25(6):986-91.
92. Quanjer PH, Lebowitz MD, Gregg I, Miller MR, Pedersen OF. Peak expiratory flow: conclusion and recommendations of a working party of the European Respiratory Society. *Eur Respir J Suppl* 1997;24:25-85.
93. D'Alonzo GE, Steinijans VW, Keller A. Measurements of morning and evening airflow grossly underestimate the circadian variability of FEV1 and peak expiratory flow rate in asthma. *Am J Respir Crit Care Med* 1995;152(3):1097-9.
94. Chowienzyk PJ, Parkin DH, Lawson CP, Cochrane GM. Do asthmatic patients correctly record home spirometry measurements? *BMJ* 1994;309(6969):1618.
95. Higgins BG, Britton JR, Chinn S, Jones TD, Jenkinson D, Burney PG, et al. The distribution of peak flow variability in a population sample. *Am Rev Respir Dis* 1989;140(5):1368-72.
96. Higgins BG, Britton JR, Chinn S, Cooper S, Burney PG, Tattersfield AE. Comparison of bronchial reactivity and peak expiratory flow variability measurements for epidemiologic studies. *Am Rev Respir Dis* 1992;145(3):588-93.
97. Quackenboss JJ, Lebowitz MD, Krzyzanowski M. The normal range of diurnal changes in peak expiratory flow rates. Relationship to symptoms and respiratory disease. *Am Rev Respir Dis* 1991;143(2):323-30.
98. Lebowitz MD, Krzyzanowski M, Quackenboss JJ, O'Rourke MK. Diurnal variation of PEF and its use in epidemiological studies. *Eur Respir J Suppl* 1997(24):49s-56s.
99. Boezen HM, Schouten JP, Postma DS, Rijcken B. Distribution of peak expiratory flow variability by age, gender and smoking habits in a random population sample aged 20-70 yrs. *Eur Respir J* 1994;7(10):1814-20.
100. Siersted HC, Hansen HS, Hansen NC, Hyldebrandt N, Mostgaard G, Oxhøj H. Evaluation of peak expiratory flow variability in an adolescent population sample. The Odense Schoolchild Study. *Am J Respir Crit Care Med* 1994;149(3 Pt 1):598-603.
101. Gannon PF, Newton DT, Belcher J, Pantin CF, Burge PS. Development of OASYS-2: a system for the analysis of serial measurement of peak expiratory flow in workers with suspected occupational asthma. *Thorax* 1996;51(5):484-9.
102. Crapo RO, Casaburi R, Coates AL, Enright PL, Hankinson JL, Irvin CG, et al. Guidelines for methacholine and exercise challenge testing-1999. This official statement of the American Thoracic Society was adopted by the ATS Board of Directors, July 1999. *Am J Respir Crit Care Med* 2000;161(1):309-29.
103. Cockcroft DW, Killian DN, Mellon JJ, Hargreave FE. Bronchial reactivity to inhaled histamine: a method and clinical survey. *Clin Allergy* 1977;7(3):235-43.
104. Cockcroft DW, Murdock KY, Berscheid BA, Gore BP. Sensitivity and specificity of histamine PC20 determination in a random selection of young college students. *J Allergy Clin Immunol* 1992;89(1 Pt 1):23-30.
105. Joos GF, O'Connor B, Anderson SD, Chung F, Cockcroft DW, Dahlen B, et al. Indirect airway challenges. *Eur Respir J* 2003;21(6):1050-68.
106. Anderton RC, Cuff MT, Frith PA, Cockcroft DW, Morse JL, Jones NL, et al. Bronchial responsiveness to inhaled histamine and exercise. *J Allergy Clin Immunol* 1979;63(5):315-20.

107. American Thoracic Society, European Respiratory Society. ATS/ERS recommendations for standardized procedures for the online and offline measurement of exhaled lower respiratory nitric oxide and nasal nitric oxide, 2005. *Am J Respir Crit Care Med* 2005;171(8):912-30.
108. Pavord ID, Pizzichini MM, Pizzichini E, Hargreave FE. The use of induced sputum to investigate airway inflammation. *Thorax* 1997;52(6):498-501.
109. Brightling CE, Pavord ID. Eosinophilic bronchitis: an important cause of prolonged cough. *Ann Med* 2000;32(7):446-51.
110. Carney IK, Gibson PG, Murree-Allen K, Saltos N, Olson LG, Hensley MJ. A systematic evaluation of mechanisms in chronic cough. *Am J Respir Crit Care Med* 1997;156(1):211-6.
111. Wensley D, Silverman M. Peak flow monitoring for guided self-management in childhood asthma: a randomized controlled trial. *Am J Respir Crit Care Med* 2004;170(6):606-12.
112. Burkhart PV, Rayens MK, Revelette WR, Ohlmann A. Improved health outcomes with peak flow monitoring for children with asthma. *J Asthma* 2007;44(2):137-42.
113. McCoy K, Shade DM, Irvin CG, Mastrorarde JG, Hanania NA, Castro M, et al. Predicting episodes of poor asthma control in treated patients with asthma. *J Allergy Clin Immunol* 2006;118(6):1226-33.
114. Nuijsink M, Hop WC, Sterk PJ, Duiverman EJ, de Jongste JC. Long-term asthma treatment guided by airway hyperresponsiveness in children: a randomised controlled trial. *Eur Respir J* 2007;30(3):457-66.
115. de Jongste JC, Carraro S, Hop WC, CHARISM Study Group, Baraldi E. Daily telemonitoring of exhaled nitric oxide and symptoms in the treatment of childhood asthma. *Am J Resp Crit Care Med* 2009;179(2):93-7.
116. Fritsch M, Uxa S, Horak F Jr, Putschoegl B, Dehlink E, Szepfalusi Z, et al. Exhaled nitric oxide in the management of childhood asthma: a prospective 6-months study. *Pediatr Pulmonol* 2006;41(9):855-62.
117. Pijnenburg MW, Hofhuis W, Hop WC, De Jongste JC. Exhaled nitric oxide predicts asthma relapse in children with clinical asthma remission. *Thorax* 2005;60(3):215-8.
118. Szeffler SJ, Mitchell H, Sorkness CA, Gergen PJ, O'Connor GT, Morgan WJ, et al. Management of asthma based on exhaled nitric oxide in addition to guideline-based treatment for inner-city adolescents and young adults: a randomised controlled trial. *Lancet* 2008;372(9643):1065-72.
119. Covar RA, Szeffler SJ, Zeiger RS, Sorkness CA, Moss M, Mauger DT, et al. Factors associated with asthma exacerbations during a long-term clinical trial of controller medications in children. *J Allergy Clin Immunol* 2008;122(4):741-7.
120. Fuhlbrigge AL, Weiss ST, Kuntz KM, Paltiel AD, CAMP Research Group. Forced expiratory volume in 1 second percentage improves the classification of severity among children with asthma. *Pediatrics*. 2006;118(2):e347-55.
121. Zacharasiewicz A, Wilson N, Lex C, Erin EM, Li AM, Hansel T, et al. Clinical use of noninvasive measurements of airway inflammation in steroid reduction in children. *Am J Respir Crit Care Med* 2005;171(10):1077-82.
122. Bateman ED, Boushey HA, Bousquet J, Busse WW, Clark TJ, Pauwels RA, et al. Can guideline-defined asthma control be achieved? The Gaining Optimal Asthma Control study. *Am J Respir Crit Care Med* 2004;170(8):836-44.
123. Sont JK, Willems LN, Bel EH, van Krieken JH, Vandenbroucke JP, Sterk PJ. Clinical control and histopathologic outcome of asthma when using airway hyperresponsiveness as an additional guide to long-term treatment. The AMPUL Study Group. *Am J Respir Crit Care Med* 1999;159(4 Pt 1):1043-51.
124. Pearson MG, Bucknall CE, editors. *Measuring clinical outcome in asthma : a patient-focused approach*. London: Royal College of Physicians of London; 1999.
125. Miller MR, Hankinson J, Brusasco V, Burgos F, Casaburi R, Coates A, et al. Standardisation of spirometry. *Eur Respir J* 2005;26(2):319-38.
126. Tweeddale PM, Alexander F, McHardy GJ. Short term variability in FEV1 and bronchodilator responsiveness in patients with obstructive ventilatory defects. *Thorax* 1987;42(7):487-90.
127. Dekker FW, Schrier AC, Sterk PJ, Dijkman JH. Validity of peak expiratory flow measurement in assessing reversibility of airflow obstruction. *Thorax* 1992;47(3):162-6.
128. Juniper EF, Bousquet J, Abetz L, Bateman ED, GOAL Committee. Identifying 'well-controlled' and 'not well-controlled' asthma using the Asthma Control Questionnaire. *Respir Med* 2006;100(4):616-21.
129. Juniper EF, O'Byrne PM, Guyatt GH, Ferrie PJ, King DR. Development and validation of a questionnaire to measure asthma control. *Eur Respir J* 1999;14(4):902-7.
130. Juniper EF, Svensson K, Mork AC, Ståhl E. Measurement properties and interpretation of three shortened versions of the asthma control questionnaire. *Respir Med* 2005;99(5):553-8.
131. Juniper EF, Gruffydd-Jones K, Ward S, Svensson K. Asthma Control Questionnaire in children: validation, measurement properties, interpretation. *Eur Respir J* 2010;36(6):1410-6.
132. Nathan RA, Sorkness CA, Kosinski M, Schatz M, Li JT, Marcus P, et al. Development of the asthma control test: a survey for assessing asthma control. *J Allergy Clin Immunol* 2004;113(1):59-65.



133. Schatz M, Sorkness CA, Li JT, Marcus P, Murray JJ, Nathan RA, et al. Asthma Control Test: reliability, validity, and responsiveness in patients not previously followed by asthma specialists. *J Allergy Clin Immunol* 2006;117(3):549-56.
134. Juniper EF, Guyatt GH, Ferrie PJ, Griffith LE. Measuring quality of life in asthma. *Am Rev Respir Dis* 1993;147(4):832-8.
135. Bacharier LB, Guilbert TW, Zeiger RS, Strunk RC, Morgan WJ, Lemanske RF Jr, et al. Patient characteristics associated with improved outcomes with use of an inhaled corticosteroid in preschool children at risk for asthma. *J Allergy Clin Immunol* 2009;123(5):1077-82.
136. Kharitonov SA, Gonio F, Kelly C, Meah S, Barnes PJ. Reproducibility of exhaled nitric oxide measurements in healthy and asthmatic adults and children. *Eur Respir J* 2003;21(3):433-8.
137. Berry MA, Shaw DE, Green RH, Brightling CE, Wardlaw AJ, Pavord ID. The use of exhaled nitric oxide concentration to identify eosinophilic airway inflammation: an observational study in adults with asthma. *Clin Exp Allergy* 2005;35(9):1175-9.
138. Belda J, Leigh R, Parameswaran K, O'Byrne PM, Sears MR, Hargreave FE. Induced sputum cell counts in healthy adults. *Am J Respir Crit Care Med* 2000;161(2 Pt 1):475-8.
139. Djukanovic R, Sterk PJ, Fahy JV, Hargreave FE. Standardised methodology of sputum induction and processing. *Eur Respir J Suppl* 2002;37:1s-2s.
140. Institute of Medicine of the National Academies. The 1st Annual Crossing the Quality Chasm Summit: a focus on communities. Washington D.C.:The National Academic Press; 2004.
141. Ring N, Jepson R, Hoskins G, Wilson C, Pinnock H, Sheikh A, et al. Understanding what helps or hinders asthma action plan use: a systematic review and synthesis of the qualitative literature. *Patient Educ Couns* 2011;85(2):e131-43.
142. Gibson PG, Powell H, Coughlan J, Wilson AJ, Abramson M, Haywood P, et al. Self-management education and regular practitioner review for adults with asthma. *Cochrane Database of Systematic Reviews* 2003, Issue 1.
143. Lefevre F, Piper M, Weiss K, Mark D, Clark N, Aronson N. Do written action plans improve patient outcomes in asthma? An evidence-based analysis. *J Fam Pract* 2002;51(10):842-48.
144. Gibson PG, Powell H. Written action plans for asthma: an evidence-based review of the key components. *Thorax* 2004;59(2):94-9.
145. Powell H, Gibson PG. Options for self-management education for adults with asthma. *Cochrane Database of Systematic Reviews* 2003, Issue 1.
146. Bussey-Smith KL, Rossen RD. A systematic review of randomized control trials evaluating the effectiveness of interactive computerized asthma patient education programs. *Ann Allergy Asthma Immunol* 2007;98(6):507-16.
147. de Jongh T, Gurol-Urganci I, Vodopivec-Jamsek V, Car J, Atun R. Mobile phone messaging for facilitating self-management of long-term illnesses. *Cochrane Database of Systematic Reviews* 2012, Issue 12.
148. Smith JR, Mugford M, Holland R, Noble MJ, Harrison BD. Psycho-educational interventions for adults with severe or difficult asthma: a systematic review. *J Asthma* 2007;44(3):219-41.
149. Boyd M, Lasserson TJ, McKean MC, Gibson PG, Ducharme FM, Haby M. Interventions for educating children who are at risk of asthma-related emergency department attendance. *Cochrane Database of Systematic Reviews* 2009, Issue 2.
150. Coffman JM, Cabana MD, Halpin HA, Yelin EH. Effects of asthma education on children's use of acute care services: a meta-analysis. *Pediatrics* 2008;121(3):575-86.
151. Wolf FM, Guevara JP, Grum CM, Clark NM, Cates CJ. Educational interventions for asthma in children. *Cochrane Database of Systematic Reviews* Issue 1.
152. Clarke SA, Calam R. The effectiveness of psychosocial interventions designed to improve health-related quality of life (HRQOL) amongst asthmatic children and their families: a systematic review. *Qual Life Res* 2012;21(5):747-64.
153. Bravata DM, Gienger AL, Holty JE, Sundaram V, Khazeni N, Wise PH, et al. Quality improvement strategies for children with asthma: a systematic review. *Arch Pediatr Adolesc Med* 2009;163(6):572-81.
154. Bhogal S, Zemek R, Ducharme FM. Written action plans for asthma in children. *Cochrane Database of Systematic Reviews* 2006, Issue 3.
155. Zemek RL, Bhogal SK, Ducharme FM. Systematic review of randomized controlled trials examining written action plans in children: what is the plan? *Arch Pediatr Adolesc Med* 2008;162(2):157-63.
156. Kessler KR. Relationship between the use of asthma action plans and asthma exacerbations in children with asthma: a systematic review. *J Asthma Allergy Educ* 2011;2(1):11-21.
157. Coffman JM, Cabana MD, Yelin EH. Do school-based asthma education programs improve self-management and health outcomes? *Pediatrics* 2009;124(2):729-42.
158. Ahmad E, Grimes DE. The effects of self-management education for school-age children on asthma morbidity: a systematic review. *J Sch Nurs* 2011;27(4):282-92.

159. Welsh EJ, Hasan M, Li L. Home-based educational interventions for children with asthma. *Cochrane Database of Systematic Reviews* 2011, Issue 10.
160. Viswanathan M, Kraschnewski J, Nishikawa B, Morgan LC, Thieda P, Honeycutt A, et al. Outcomes of community health worker interventions. *Evid Rep Technol Assess (Full Rep)* 2009;181:1-144.
161. Bailey EJ, Cates CJ, Kruske SG, Morris PS, Brown N, Chang AB. Culture-specific programs for children and adults from minority groups who have asthma. *Cochrane Database of Systematic Reviews* 2009, Issue 2.
162. Press VG, Pappalardo AA, Conwell WD, Pincavage AT, Prochaska MH, Arora VM. Interventions to improve outcomes for minority adults with asthma: a systematic review. *J Gen Intern Med* 2012;27(8):1001-15.
163. Tapp S, Lasserson T, Rowe B. Education interventions for adults who attend the emergency room for acute asthma. *Cochrane Database of Systematic Reviews* 2010, Issue 10.
164. Wilson SR, Latini D, Starr NJ, Fish L, Loes LM, Page A, et al. Education of parents of infants and very young children with asthma: a developmental evaluation of the Wee Wheezers program. *J Asthma* 1996;33(4):239-54.
165. Clark NM, Gong M, Schork MA, Evans D, Roloff D, Hurwitz M, et al. Impact of education for physicians on patient outcomes. *Pediatrics* 1998;101(5):831-6.
166. Stevens CA, Wesseldine LJ, Couriel JM, Dyer AJ, Osman LM, Silverman M. Parental education and guided self-management of asthma and wheezing in the pre-school child: a randomised controlled trial. *Thorax* 2002;57(1):39-44.
167. Butz AM, Malveaux FJ, Eggleston PA, Thompson L, K H, Rand CS. A review of community-based asthma interventions for inner-city children. *Pediatr Asthma Allergy Immunol* 1994;8(3):149-56.
168. Eakin MN, Rand CS, Bilderback A, Bollinger ME, Butz A, Kandasamy V, et al. Asthma in Head Start children: effects of the Breathmobile program and family communication on asthma outcomes. *J Allergy Clin Immunol* 2012;129(3):664-70.
169. Hederos CA, Janson S, Hedlin G. Group discussions with parents have long-term positive effects on the management of asthma with good cost-benefit. *Acta Paediatr* 2005;94(5):602-8.
170. Hederos CA, Janson S, Hedlin G. Six-year follow-up of an intervention to improve the management of preschool children with asthma. *Acta Paediatr* 2009;98(12):1939-44.
171. Szczepanski R, Jaeschke R, Spindler T, Ihorst G, Forster J, Group AS. Preschoolers' and parents' asthma education trial (P2AET)—a randomized controlled study. *Eur J Pediatr* 2010;169(9):1051-60.
172. Warschburger P, von Schwerin A-D, Buchholz HT, Petermann F. An educational program for parents of asthmatic preschool children: short- and medium-term effects. *Patient Educ Couns* 2003;51(1):83-91.
173. Bartholomew LK, Gold RS, Parcel GS, Czyzewski DI, Sockrider MM, Fernandez M, et al. Watch, Discover, Think, and Act: evaluation of computer-assisted instruction to improve asthma self-management in inner-city children. *Patient Educ Couns* 2000;39(2-3):269-80.
174. Brown JV, Bakeman R, Celano MP, Demi AS, Kobrynski L, Wilson SR. Home-based asthma education of young low-income children and their families. *J Pediatr Psychol* 2002;27(8):677-88.
175. Fisher EB, Strunk RC, Sussman LK, Sykes RK, Walker MS. Community organization to reduce the need for acute care for asthma among African American children in low-income neighborhoods: the Neighborhood Asthma Coalition. *Pediatrics* 2004;114(1):116-23.
176. La Roche MJ, Koinis-Mitchell D, Gualdron L. A culturally competent asthma management intervention: a randomized controlled pilot study. *Ann Allergy Asthma Immunol* 2006;96(1):80-5.
177. Joseph CL, Peterson E, Havstad S, Johnson CC, Hoerauf S, Stringer S, et al. A web-based, tailored asthma management program for urban African-American high school students. *Am J Respir Crit Care Med* 2007;175(9):888-95.
178. Mosnaim GS, Cohen MS, Rhoads CH, Rittner SS, Powell LH. Use of MP3 players to increase asthma knowledge in inner-city African-American adolescents. *Int J Behav Med* 2008;15(4):341-6.
179. Flores G, Bridon C, Torres S, Perez R, Walter T, Brotanek J, et al. Improving asthma outcomes in minority children: a randomized, controlled trial of parent mentors. *Pediatrics* 2009;124(6):1522-32.
180. Martin MA, Catrambone CD, Kee RA, Evans AT, Sharp LK, Lyttle C, et al. Improving asthma self-efficacy: Developing and testing a pilot community-based asthma intervention for African American adults. *J Allergy Clin Immunol* 2009;123(1):153-9.e3.
181. Velsor-Friedrich B, Militello LK, Richards MH, Harrison PR, Gross IM, Romero E, et al. Effects of coping-skills training in low-income urban African-American adolescents with asthma. *J Asthma* 2012;49(4):372-9.
182. Moudgil H, Marshall T, Honeybourne D. Asthma education and quality of life in the community: a randomised controlled study to evaluate the impact on white European and Indian subcontinent ethnic groups from socioeconomically deprived areas in Birmingham, UK. *Thorax* 2000;55(3):177-83.
183. Griffiths C, Foster G, Barnes N, Eldridge S, Tate H, Begum S, et al. Specialist nurse intervention to reduce unscheduled asthma care in a deprived multiethnic area: the east London randomised controlled trial for high risk asthma (ELECTRA). *BMJ* 2004;328(7432):144.

184. Poureslami I, Nimmon L, Doyle-Waters M, Rootman I, Schulzer M, Kuramoto L, et al. Effectiveness of educational interventions on asthma self-management in Punjabi and Chinese asthma patients: a randomized controlled trial. *J Asthma* 2012;49(5):542-51.
185. Barbanel D, Eldridge S, Griffiths C. Can a self-management programme delivered by a community pharmacist improve asthma control? A randomised trial. *Thorax* 2003;58(10):851-4.
186. Nokela M, Arnlinde MH, Ehlers P-O, Krakau I, Forslund L, Jonsson EW. The influence of structured information and monitoring on the outcome of asthma treatment in primary care: a cluster randomized study. *Respiration* 2010;79(5):388-94.
187. Partridge MR, Caress AL, Brown C, Hennings J, Luker K, Woodcock A, et al. Can lay people deliver asthma self-management education as effectively as primary care based practice nurses? *Thorax* 2008;63(9):778-83.
188. Guendelman S, Meade K, Benson M, Chen YQ, Samuels S. Improving asthma outcomes and self-management behaviors of inner-city children: a randomized trial of the Health Buddy interactive device and an asthma diary. *Arch Pediatr Adolesc Med* 2002;156(2):114-20.
189. Delaronde S, Peruccio DL, Bauer BJ. Improving asthma treatment in a managed care population. *Am J Manag Care*. 2005;11(6):361-8.
190. Feifer RA, Verbrugge RR, Khalid M, Levin R, O'Keefe GB, Aubert RE. Improvements in asthma pharmacotherapy and self-management: An example of a population-based disease management program. *Dis Manag Health Outcomes* 2004;12(2):93-102.
191. Glasgow NJ, Ponsonby AL, Yates R, Beilby J, Dugdale P. Proactive asthma care in childhood: general practice based randomised controlled trial. *BMJ* 2003;327(7416):659.
192. Homer CJ, Forbes P, Horvitz L, Peterson LE, Wypij D, Heinrich P. Impact of a quality improvement program on care and outcomes for children with asthma. *Arch Pediatr Adolesc Med* 2005;159(5):464-9.
193. Cleland JA, Hall S, Price D, Lee AJ. An exploratory, pragmatic, cluster randomised trial of practice nurse training in the use of asthma action plans. *Prim Care Respir J* 2007;16(5):311-8.
194. Heard AR, Richards IJ, Alpers JH, Pilotto LS, Smith BJ, Black JA. Randomised controlled trial of general practice based asthma clinics. *Med J Aust* 1999;171(2):68-71.
195. Thoonen BP, Schermer TR, Van Den Boom G, Molema J, Folgering H, Akkermans RP, et al. Self-management of asthma in general practice, asthma control and quality of life: a randomised controlled trial. *Thorax* 2003;58(1):30-6.
196. Osman LM, Abdalla MI, Beattie JA, Ross SJ, Russell IT, Friend JA, et al. Reducing hospital admission through computer supported education for asthma patients. *BMJ* 1994;308(6928):568-71.
197. Osman LM, Calder C, Godden DJ, Friend JA, McKenzie L, Legge JS, et al. A randomised trial of self-management planning for adult patients admitted to hospital with acute asthma. *Thorax*. 2002;57(10):869-74.
198. Yoon R, McKenzie DK, Bauman A, Miles DA. Controlled trial evaluation of an asthma education programme for adults. *Thorax* 1993;48(11):1110-6.
199. Madge P, McColl J, Paton J. Impact of a nurse-led home management training programme in children admitted to hospital with acute asthma: a randomised controlled study. *Thorax* 1997;52(3):223-8.
200. Royal Pharmaceutical Society of Great Britain. From compliance to concordance: achieving shared goals in medicine taking. London: Royal Pharmaceutical Society of Great Britain; 1997.
201. Wilson SR, Strub P, Buist AS, Knowles SB, Lavori PW, Lapidus J, et al. Shared treatment decision making improves adherence and outcomes in poorly controlled asthma. *Am J Respir Crit Care Med* 2010;181(6):566-77.
202. Garrett J, Fenwick JM, Taylor G, Mitchell E, Rea H. Peak expiratory flow meters (PEFMs)--who uses them and how and does education affect the pattern of utilisation? *Aust N Z J Med* 1994;24(5):521-9.
203. Redline S, Wright EC, Kattan M, Kerckmar C, Weiss K. Short-term compliance with peak flow monitoring: results from a study of inner city children with asthma. *Pediatr Pulmonol* 1996;21(4):203-10.
204. Effectiveness of routine self monitoring of peak flow in patients with asthma. Grampian Asthma Study of Integrated Care (GRASSIC). *BMJ* 1994;308(6928):564-7.
205. Burkhart PV, Dunbar-Jacob JM, Fireman P, Rohay J. Children's adherence to recommended asthma self-management. *Pediatr Nurs*. 2002;28(4):409-14.
206. Kamps AW, Roorda RJ, Brand PL. Peak flow diaries in childhood asthma are unreliable. *Thorax* 2001;56(3):180-2.
207. Yoos HL, Kitzman H, McMullen A, Henderson C, Sidora K. Symptom monitoring in childhood asthma: a randomized clinical trial comparing peak expiratory flow rate with symptom monitoring. *Ann Allergy Asthma Immunol* 2002;88(3):283-91.
208. National Collaborating Centre for Primary Care. Clinical Guidelines and Evidence Review for Medicines Adherence: involving patients in decisions about prescribed medicines and supporting adherence. London: NICE; 2009. (NICE guideline GC76). [cited 10 Jul 2014]. Available from url: <http://www.nice.org.uk/Guidance/CG76>

209. Moullec G, Gour-Provencal G, Bacon SL, Campbell TS, Lavoie KL. Efficacy of interventions to improve adherence to inhaled corticosteroids in adult asthmatics: Impact of using components of the chronic care model. *Respir Med* 2012;106(9):1211-25.
210. Haynes RB, Ackloo E, Sahota N, McDonald HP, Yao X. Interventions for enhancing medication adherence. *Cochrane Database of Systematic Reviews* 2008, Issue 2.
211. Knight KM, McGowan L, Dickens C, Bundy C. A systematic review of motivational interviewing in physical health care settings. *Br J Health Psychol* 2006;11(Pt 2):319-32.
212. Kripalani S, Yao X, Haynes RB. Interventions to enhance medication adherence in chronic medical conditions: a systematic review. *Arch Intern Med* 2007;167(6):540-50.
213. Kahana S, Drotar D, Frazier T. Meta-analysis of psychological interventions to promote adherence to treatment in pediatric chronic health conditions. *J Pediatr Psychol* 2008;33(6):590-611.
214. Oake N, Jennings A, Van Walraven C, Forster AJ. Interactive voice response systems for improving delivery of ambulatory care. *Am J Manag Care* 2009;15(6):383-91.
215. Wiener-Ogilvie S, Pinnock H, Huby G, Sheikh A, Partridge MR, Gillies J. Do practices comply with key recommendations of the British Asthma Guideline? If not, why not? *Prim Care Respir J* 2007;16(6):369-77.
216. Asthma UK. Compare your care. [cited 10 Jul 2014]. Available from url: <http://www.asthma.org.uk/compareyourcare>
217. Ring N, Malcolm C, Wyke S, Macgillivray S, Dixon D, Hoskins G, et al. Promoting the use of Personal Asthma Action Plans: a systematic review. *Prim Care Respir J* 2007;16(5):271-83.
218. Bunik M, Federico MJ, Beaty B, Rannie M, Olin JT, Kempe A. Quality improvement for asthma care within a hospital-based teaching clinic. *Acad Pediatr* 2011;11(1):58-65.
219. Bunting BA, Cranor CW. The Asheville Project: long-term clinical, humanistic, and economic outcomes of a community-based medication therapy management program for asthma. *J Am Pharm Assoc* (2003) 2006;46(2):133-47.
220. Gerald LB, Redden D, Wittich AR, Hains C, Turner-Henson A, Hemstreet MP, et al. Outcomes for a comprehensive school-based asthma management program. *J Sch Health* 2006;76(6):291-6.
221. Vollmer WM, Kirshner M, Peters D, Drane A, Stibolt T, Hickey T, et al. Use and impact of an automated telephone outreach system for asthma in a managed care setting. *Am J Manag Care* 2006;12(12):725-33.
222. Forshee JD, Whalen EB, Hackel R, Butt LT, Smeltzer PA, Martin J, et al. The effectiveness of one-on-one nurse education on the outcomes of high-risk adult and pediatric patients with asthma. *Manag Care Interface* 1998;11(12):82-92.
223. Findley SE, Thomas G, Madera-Reese R, McLeod N, Kintala S, Andres Martinez R, et al. A community-based strategy for improving asthma management and outcomes for preschoolers. *J Urban Health* 2011;88 Suppl 1:85-99.
224. Polivka BJ, Chaudry RV, Crawford J, Bouton P, Sweet L. Impact of an urban healthy homes intervention. *J Environ Health* 2011;73(9):16-20.
225. Kemple T, Rogers C. A mailed personalised self-management plan improves attendance and increases patients' understanding of asthma. *Prim Care Respir J* 2003;12(4):110-4.
226. Pinnock H, Adlem L, Gaskin S, Harris J, Snellgrove C, Sheikh A. Accessibility, clinical effectiveness, and practice costs of providing a telephone option for routine asthma reviews: phase IV controlled implementation study. *Br J Gen Pract* 2007;57(542):714-22.
227. Swanson V, Wright S, Power KG, Duncan B, Morgan J, Turner E, et al. The impact of a structured programme of asthma care in general practice. *Int J Clin Pract* 2000;54(9):573-80.
228. Lindberg M, Ahlner J, Ekstrom T, Jonsson D, Moller M. Asthma nurse practice improves outcomes and reduces costs in primary health care. *Scand J Caring Sci* 2002;16(1):73-8.
229. Haahtela T, Tuomisto LE, Pietinalho A, Klaukka T, Erhola M, Kaila M, et al. A 10 year asthma programme in Finland: major change for the better. *Thorax* 2006;61(8):663-70.
230. Kauppi P, Linna M, Martikainen J, Makela MJ, Haahtela T. Follow-up of the Finnish Asthma Programme 2000-2010: reduction of hospital burden needs risk group rethinking. *Thorax* 2013;68(3):292-3.
231. Chini L, Iannini R, Chianca M, Corrente S, Graziani S, La Rocca M, et al. Happy air®, a successful school-based asthma educational and interventional program for primary school children. *J Asthma* 2011;48(4):419-26.
232. Andrade WC, Camargos P, Lasmar L, Bousquet J. A pediatric asthma management program in a low-income setting resulting in reduced use of health service for acute asthma. *Allergy* 2010;65(11):1472-7.
233. Souza-Machado C, Souza-Machado A, Franco R, Ponte EV, Barreto ML, Rodrigues LC, et al. Rapid reduction in hospitalisations after an intervention to manage severe asthma. *Eur Respir J* 2010;35(3):515-21.
234. Maas T, Dompeling E, Muris J, Wesseling G, Knottnerus J, van Schayck OC. Prevention of asthma in genetically susceptible children: a multifaceted intervention trial focussed on feasibility in general practice. *Pediatr Allergy Immunol* 2011;22(8):794-802.

235. Wahn U, Lau S, Bergmann R, Kulig M, Forster J, Bergmann K, et al. Indoor allergen exposure is a risk factor for sensitization during the first three years of life. *J Allergy Clin Immunol* 1997;99(6 Pt 1):763-9.
236. Corver K, Kerkhof M, Brussee JE, Brunekreef B, van Strien RT, Vos AP, et al. House dust mite allergen reduction and allergy at 4 yr: follow up of the PIAMA-study. *Pediatr Allergy Immunol* 2006;17(5):329-36.
237. Lau S, Illi S, Sommerfeld C, Niggemann B, Bergmann R, von Mutius E, et al. Early exposure to house-dust mite and cat allergens and development of childhood asthma: a cohort study. Multicentre Allergy Study Group. *Lancet* 2000;356(9239):1392-7.
238. Arshad SH, Bateman B, Matthews SM. Primary prevention of asthma and atopy during childhood by allergen avoidance in infancy: a randomised controlled study. *Thorax* 2003;58(6):489-93.
239. Sporik R, Holgate ST, Platts-Mills TA, Cogswell JJ. Exposure to house-dust mite allergen (Der p I) and the development of asthma in childhood. A prospective study. *N Engl J Med* 1990;323(8):502-7.
240. Cullinan P, MacNeill SJ, Harris JM, Moffat S, White C, Mills P, et al. Early allergen exposure, skin prick responses, and atopic wheeze at age 5 in English children: a cohort study. *Thorax* 2004;59(10):855-61.
241. Chan-Yeung M, Ferguson A, Watson W, Dimich-Ward H, Rousseau R, Lilley M, et al. The Canadian Childhood Asthma Primary Prevention Study: outcomes at 7 years of age. *J Allergy Clin Immunol* 2005;116(1):49-55.
242. Horak F Jr, Matthews S, Ithorst G, Arshad SH, Frischer T, Kuehr J, et al. Effect of mite-impermeable mattress encasings and an educational package on the development of allergies in a multinational randomized, controlled birth-cohort study -- 24 months results of the Study of Prevention of Allergy in Children in Europe. *Clin Exp Allergy* 2004;34(8):1220-5.
243. Custovic A, Simpson BM, Simpson A, Kissen P, Woodcock A. Effect of environmental manipulation in pregnancy and early life on respiratory symptoms and atopy during the first year of life: a randomised trial. *Lancet* 2001;358(9277):188-93.
244. Woodcock A, Lowe LA, Murray CS, Simpson BM, Pipis SD, Kissen P, et al. Early life environmental control: effect on symptoms, sensitization, and lung function at age 3 years. *Am J Respir Crit Care Med* 2004;170(4):433-9.
245. Takkouche B, Gonzalez-Barcala FJ, Etminan M, Fitzgerald M. Exposure to furry pets and the risk of asthma and allergic rhinitis: a meta-analysis. *Allergy* 2008;63(7):857-64.
246. Lodge CJ, Allen KJ, Lowe AJ, Hill DJ, Hosking CS, Abramson MJ, et al. Perinatal cat and dog exposure and the risk of asthma and allergy in the urban environment: a systematic review of longitudinal studies. *Clin Dev Immunol* 2012;2012:176484.
247. Chen C, Tischer C, Schnappinger M, Heinrich J. The role of cats and dogs in asthma and allergy--a systematic review. *Int J Hyg Environ Health* 2010;213(1):1-31.
248. Lødrup Carlsen KC, Roll S, Carlsen K, Mowinckel P, Wijga A, Brunekreef B, et al. Does pet ownership in infancy lead to asthma or allergy at school age? Pooled analysis of individual participant data from 11 European birth cohorts. *PLoS ONE* 2012;7(8):e43214.
249. Muraro A, Dreborg S, Halken S, Høst A, Niggemann B, Aalberse R, et al. Dietary prevention of allergic diseases in infants and small children. Part I: immunologic background and criteria for hypoallergenicity. *Pediatr Allergy Immunol* 2004;15(2):103-11.
250. Muraro A, Dreborg S, Halken S, Høst A, Niggemann B, Aalberse R, et al. Dietary prevention of allergic diseases in infants and small children. Part III: Critical review of published peer-reviewed observational and interventional studies and final recommendations. *Pediatr Allergy Immunol* 2004;15(4):291-307.
251. Kramer MS, Kakuma R. Maternal dietary antigen avoidance during pregnancy or lactation, or both, for preventing or treating atopic disease in the child. *Cochrane Database of Systematic Reviews* 2006, Issue 3.
252. Vance GH, Grimshaw KE, Briggs R, Lewis SA, Mullee MA, Thornton CA, et al. Serum ovalbumin-specific immunoglobulin G responses during pregnancy reflect maternal intake of dietary egg and relate to the development of allergy in early infancy. *Clin Exp Allergy* 2004;34(12):1855-61.
253. van Odijk J, Kull I, Borres MP, Brandtzaeg P, Edberg U, Hanson LA, et al. Breast feeding and allergic disease: a multi-disciplinary review of the literature (1996-2001) on the mode of early feeding in infancy and its impact on later atopic manifestations. *Allergy* 2003;58(9):833-43.
254. Sears MR, Greene JM, Willan AR, Taylor DR, Flannery EM, Cowan JO, et al. Long-term relation between breastfeeding and development of atopy and asthma in children and young adults: a longitudinal study. *Lancet* 2002;360(9337):901-7.
255. Osborn DA, Sinn J. Formulas containing hydrolysed protein for prevention of allergy and food intolerance in infants. *Cochrane Database of Systematic Reviews* 2006, Issue 4.
256. Osborn DA, Sinn J. Soy formula for prevention of allergy and food intolerance in infants. *Cochrane Database of Systematic Reviews* 2006, Issue 4.
257. Tricon S, Willers S, Smit HA, Burney PG, Devereux G, Frew AJ, et al. Nutrition and allergic disease. *Clin Exp Allergy Rev* 2006;6(5):117-88.
258. Zutavern A, von Mutius E, Harris J, Mills P, Moffatt S, White C, et al. The introduction of solids in relation to asthma and eczema. *Arch Dis Child* 2004;89(4):303-8.

259. Dunstan JA, Mori TA, Barden A, Beilin LJ, Taylor AL, Holt PG, et al. Fish oil supplementation in pregnancy modifies neonatal allergen-specific immune responses and clinical outcomes in infants at high risk of atopy: a randomized, controlled trial. *J Allergy Clin Immunol* 2003;112(6):1178-84.
260. Miharshahi S, Peat JK, Webb K, Oddy W, Marks GB, Mellis CM, et al. Effect of omega-3 fatty acid concentrations in plasma on symptoms of asthma at 18 months of age. *Pediatr Allergy Immunol* 2004;15(6):517-22.
261. Shaheen SO, Newson RB, Henderson AJ, Emmett PM, Sherriff A, Cooke M. Umbilical cord trace elements and minerals and risk of early childhood wheezing and eczema. *Eur Respir J* 2004;24(2):292-7.
262. Devereux G, Turner SW, Craig LC, McNeill G, Martindale S, Harbour PJ, et al. Low maternal vitamin E intake during pregnancy is associated with asthma in 5-year-old children. *Am J Respir Crit Care Med* 2006;174(5):499-507.
263. Flaherman V, Rutherford GW. A meta-analysis of the effect of high weight on asthma. *Arch Dis Child* 2006;91(4):334-9.
264. Beuther DA, Sutherland ER. Overweight, obesity, and incident asthma: a meta-analysis of prospective epidemiologic studies. *Am J Respir Crit Care Med* 2007;175(7):661-6.
265. Holt PG, Sly PD, Bjorksten B. Atopic versus infectious diseases in childhood: a question of balance? *Pediatr Allergy Immunol* 1997;8(2):53-8.
266. Strachan DP. Family size, infection and atopy: the first decade of the "hygiene hypothesis". *Thorax* 2000;55(Suppl 1):S2-10.
267. Kalliomaki M, Salminen S, Arvilommi H, Kero P, Koskinen P, Isolauri E. Probiotics in primary prevention of atopic disease: a randomised placebo-controlled trial. *Lancet* 2001;357(9262):1076-9.
268. Moro G, Arslanoglu S, Stahl B, Jelinek J, Wahn U, Boehm G. A mixture of prebiotic oligosaccharides reduces the incidence of atopic dermatitis during the first six months of age. *Arch Dis Child* 2006;91(10):814-9.
269. Cook DG, Strachan DP. Health effects of passive smoking-10: Summary of effects of parental smoking on the respiratory health of children and implications for research. *Thorax* 1999;54(4):357-66.
270. Dezateau C, Stocks J, Dundas I, Fletcher ME. Impaired airway function and wheezing in infancy: the influence of maternal smoking and a genetic predisposition to asthma. *Am J Respir Crit Care Med* 1999;159(2):403-10.
271. Gilliland FD, Berhane K, McConnell R, Gauderman WJ, Vora H, Rappaport EB, et al. Maternal smoking during pregnancy, environmental tobacco smoke exposure and childhood lung function. *Thorax* 2000;55(4):271-6.
272. Lodrup Carlsen KC, Carlsen KH, Nafstad P, Bakkevig L. Perinatal risk factors for recurrent wheeze in early life. *Pediatr Allergy Immunol* 1999;10(2):89-95.
273. Arshad SH, Kurukulaaratchy RJ, Fenn M, Matthews S. Early life risk factors for current wheeze, asthma, and bronchial hyperresponsiveness at 10 years of age. *Chest* 2005;127(2):502-8.
274. Jaakkola JJ, Gissler M. Maternal smoking in pregnancy, fetal development, and childhood asthma. *Am J Public Health* 2004;94(1):136-40.
275. Kabesch M, Hoefler C, Carr D, Leupold W, Weiland SK, von Mutius E. Glutathione S transferase deficiency and passive smoking increase childhood asthma. *Thorax* 2004;59(7):569-73.
276. Belanger K, Beckett W, Triche E, Bracken MB, Holford T, Ren P, et al. Symptoms of wheeze and persistent cough in the first year of life: associations with indoor allergens, air contaminants, and maternal history of asthma. *Am J Epidemiol* 2003;158(3):195-202.
277. Lee YL, Lin YC, Lee YC, Wang JY, Hsiue TR, Guo YL. Glutathione S-transferase P1 gene polymorphism and air pollution as interactive risk factors for childhood asthma. *Clin Exp Allergy* 2004;34(11):1707-13.
278. Miller RL, Garfinkel R, Horton M, Camann D, Perera FP, Whyatt RM, et al. Polycyclic aromatic hydrocarbons, environmental tobacco smoke, and respiratory symptoms in an inner-city birth cohort. *Chest* 2004;126(4):1071-8.
279. Romieu I, Sienra-Monge JJ, Ramirez-Aguilar M, Moreno-Macias H, Reyes-Ruiz NI, Estela del Rio-Navarro B, et al. Genetic polymorphism of GSTM1 and antioxidant supplementation influence lung function in relation to ozone exposure in asthmatic children in Mexico City. *Thorax* 2004;59(1):8-10.
280. Kemp A, Bjorksten B. Immune deviation and the hygiene hypothesis: a review of the epidemiological evidence. *Pediatr Allergy Immunol* 2003;14(2):74-80.
281. Martignon G, Oryszczyn MP, Annesi-Maesano I. Does childhood immunization against infectious diseases protect from the development of atopic disease? *Pediatr Allergy Immunol* 2005;16(3):193-200.
282. Gotzsche PC, Johansen HK. House dust mite control measures for asthma. *Cochrane Database of Systematic Reviews* 2008, Issue 2.
283. Wood RA, Chapman MD, Adkinson NF Jr, Eggleston PA. The effect of cat removal on allergen content in household-dust samples. *J Allergy Clin Immunol* 1989;83(4):730-4.
284. Wood RA, Johnson EF, Van Natta ML, Chen PH, Eggleston PA. A placebo-controlled trial of a HEPA air cleaner in the treatment of cat allergy. *Am J Respir Crit Care Med* 1998;158(1):115-20.

285. Platts-Mills T, Vaughan J, Squillace S, Woodfolk J, Sporik R. Sensitisation, asthma, and a modified Th2 response in children exposed to cat allergen: a population-based cross-sectional study. *Lancet* 2001;357(9258):752-6.
286. Francis H, Fletcher G, Anthony C, Pickering C, Oldham L, Hadley E, et al. Clinical effects of air filters in homes of asthmatic adults sensitized and exposed to pet allergens. *Clin Exp Allergy* 2003;33(1):101-5.
287. Popplewell EJ, Innes VA, Lloyd-Hughes S, Jenkins EL, Khdir K, Bryant TN, et al. The effect of high-efficiency and standard vacuum-cleaners on mite, cat and dog allergen levels and clinical progress. *Pediatr Allergy Immunol* 2000;11(3):142-8.
288. Carter MC, Perzanowski MS, Raymond A, Platts-Mills TA. Home intervention in the treatment of asthma among inner-city children. *J Allergy Clin Immunol* 2001;108(5):732-7.
289. Krieger JW, Takaro TK, Song L, Weaver M. The Seattle-King County Healthy Homes Project: A randomized, controlled trial of a community health worker intervention to decrease exposure to indoor asthma triggers. *Am J Public Health*. 2005;95(4):652-9.
290. Warner JA, Frederick JM, Bryant TN, Weich C, Raw GJ, Hunter C, et al. Mechanical ventilation and high-efficiency vacuum cleaning: a combined strategy of mite and mite allergen reduction in the control of mite-sensitive asthma. *J Allergy Clin Immunol* 2000;105(1 Pt 1):75-82.
291. Singh M, Bara A, Gibson P. Humidity control for chronic asthma. *Cochrane Database of Systematic Reviews* 2002, Issue 2.
292. Chalmers GW, MacLeod KJ, Little SA, Thomson LJ, McSharry CP, Thomson NC. Influence of cigarette smoking on inhaled corticosteroid treatment in mild asthma. *Thorax*. 2002;57(3):226-30.
293. Ehrlich R, Jordaan E, Du Toit D, Potter P, Volmink J, Zwarenstein M, et al. Household smoking and bronchial hyperresponsiveness in children with asthma. *J Asthma* 2001;38(3):239-51.
294. Gallefoss F, Bakke PS. Does smoking affect the outcome of patient education and self-management in asthmatics? *Patient Educ Couns* 2003;49(1):91-7.
295. Mannino DM, Homa DM, Redd SC. Involuntary smoking and asthma severity in children: Data from the Third National Health and Nutrition Examination Survey. *Chest*. 2002;122(2):409-15.
296. Murray AB, Morrison BJ. The decrease in severity of asthma in children of parents who smoke since the parents have been exposing them to less cigarette smoke. *J Allergy Clin Immunol* 1993;91(1 Pt 1):102-10.
297. Wilson SR, Yamada EG, Sudhakar R, Roberto L, Mannino D, Mejia C, et al. A controlled trial of an environmental tobacco smoke reduction intervention in low-income children with asthma. *Chest* 2001;120(5):1709-22.
298. Tonnesen P, Pisinger C, Hvidberg S, Wennike P, Bremann L, Westin A, et al. Effects of smoking cessation and reduction in asthmatics. *Nicotine Tob Res* 2005;7(1):139-48.
299. Wakefield M, Banham D, McCaul K, Martin J, Ruffin R, Badcock N, et al. Effect of feedback regarding urinary cotinine and brief tailored advice on home smoking restrictions among low-income parents of children with asthma: a controlled trial. *Prev Med*. 2002;34(1):58-65.
300. Irvine L, Crombie IK, Clark RA, Slane PW, Feyerabend C, Goodman KE, et al. Advising parents of asthmatic children on passive smoking: randomised controlled trial. *BMJ* 1999;318(7196):1456-9.
301. Hovell MF, Meltzer SB, Wahlgren DR, Matt GE, Hofstetter CR, Jones JA, et al. Asthma management and environmental tobacco smoke exposure reduction in Latino children: a controlled trial. *Pediatrics*. 2002;110(5):946-56.
302. Rasmussen F, Siersted HC, Lambrechtsen J, Hansen HS, Hansen NC. Impact of airway lability, atopy, and tobacco smoking on the development of asthma-like symptoms in asymptomatic teenagers. *Chest* 2000;117(5):1330-5.
303. Devalia JL, Rusznak C, Herdman MJ, Trigg CJ, Tarraf H, Davies RJ. Effect of nitrogen dioxide and sulphur dioxide on airway response of mild asthmatic patients to allergen inhalation. *Lancet* 1994;344(8938):1668-71.
304. Molino NA, Wright SC, Katz I, Tarlo S, Silverman F, McClean PA, et al. Effect of low concentrations of ozone on inhaled allergen responses in asthmatic subjects. *Lancet* 1991;338(8761):199-203.
305. Department of Health, Committee on the Medical Effects of Air Pollutants. *Asthma and outdoor air pollution*. London: HMSO; 1995.
306. Lin M, Chen Y, Burnett RT, Villeneuve PJ, Krewski D. Effect of short-term exposure to gaseous pollution on asthma hospitalisation in children: a bi-directional case-crossover analysis. *J Epidemiol Community Health* 2003;57(1):50-5.
307. Kaur B, Anderson HR, Austin J, Burr M, Harkins LS, Strachan DP, et al. Prevalence of asthma symptoms, diagnosis, and treatment in 12-14 year old children across Great Britain (international study of asthma and allergies in childhood, ISAAC UK). *BMJ* 1998;316(7125):118-24.
308. Norbäck D, Björnsson E, Janson C, Widstrom J, Boman G. Asthmatic symptoms and volatile organic compounds, formaldehyde, and carbon dioxide in dwellings. *Occup Environ Med* 1995;52(6):388-95.
309. Tunnicliffe WS, Burge PS, Ayres JG. Effect of domestic concentrations of nitrogen dioxide on airway responses to inhaled allergen in asthmatic patients. *Lancet* 1994;344(8939-40):1733-6.

310. Burney P. A diet rich in sodium may potentiate asthma. Epidemiologic evidence for a new hypothesis. *Chest* 1987;91(6 Suppl):143S-8S.
311. Burney PG. The causes of asthma--does salt potentiate bronchial activity? Discussion paper. *J R Soc Med* 1987;80(6):364-7.
312. Mickleborough TD, Lindley MR, Ray S. Dietary salt, airway inflammation, and diffusion capacity in exercise-induced asthma. *Med Sci Sports Exerc* 2005;37(6):904-14.
313. Arden KD, Ram FS. Dietary salt reduction or exclusion for allergic asthma. *Cochrane Database of Systematic Reviews* 2001, Issue 4.
314. Britton J, Pavord I, Richards K, Wisniewski A, Knox A, Lewis S, et al. Dietary magnesium, lung function, wheezing, and airway hyperreactivity in a random adult population sample. *Lancet* 1994;344(8919):357-62.
315. Blitz M, Blitz S, Beasley R, Diner BM, Hughes R, Knopp JA, et al. Inhaled magnesium sulfate in the treatment of acute asthma. *Cochrane Database of Systematic Reviews* 2005, Issue 2.
316. Bede O, Suranyi A, Pinter K, Szlavik M, Gyurkovits K. Urinary magnesium excretion in asthmatic children receiving magnesium supplementation: a randomized, placebo-controlled, double-blind study. *Magn Res* 2003;16(4):262-70.
317. Fogarty A, Lewis SA, Scrivener SL, Antoniak M, Pacey S, Pringle M, et al. Oral magnesium and vitamin C supplements in asthma: a parallel group randomized placebo-controlled trial. *Clin Exp Allergy* 2003;33(10):1355-9.
318. Hill J. Magnesium and airway reactivity. *Clin Sci (Lon)* 1998;95(2):111-2.
319. Prescott SL, Calder PC. N-3 polyunsaturated fatty acids and allergic disease. *Curr Opin Clin Nutr Metab Care* 2004;7(2):123-9.
320. Stephensen CB. Fish oil and inflammatory disease: is asthma the next target for n-3 fatty acid supplements? *Nutr Rev* 2004;62(12):486-9.
321. Thien FC, De Luca S, Woods RK, Abramson MJ. Dietary marine fatty acids (fish oil) for asthma. *Cochrane Database of Systematic Reviews* 2002, Issue 3.
322. Allam MF, Lucane RA. Selenium supplementation for asthma. *Cochrane Database of Systematic Reviews* 2004, Issue 2.
323. Pearson PJ, Lewis SA, Britton J, Fogarty A. Vitamin E supplements in asthma: a parallel group randomised placebo controlled trial. *Thorax* 2004;59(8):652-6.
324. Ram FS, Rowe BH, Kaur B. Vitamin C supplementation for asthma. *Cochrane Database of Systematic Reviews* 2004, Issue 3.
325. Butland BK, Strachan DP, Anderson HR. Fresh fruit intake and asthma symptoms in young British adults: confounding or effect modification by smoking? *Eur Respir J* 1999;13(4):744-50.
326. Carey IM, Strachan DP, Cook DG. Effects of changes in fresh fruit consumption on ventilatory function in healthy British adults. *Am J Respir Crit Care Med* 1998;158(3):728-33.
327. Cook DG, Carey IM, Whincup PH, Papacosta O, Chirico S, Bruckdorfer KR, et al. Effect of fresh fruit consumption on lung function and wheeze in children. *Thorax* 1997;52(7):628-33.
328. Ellwood P, Asher MI, Bjorksten B, Burr M, Pearce N, Robertson CF. Diet and asthma, allergic rhinoconjunctivitis and atopic eczema symptom prevalence: an ecological analysis of the International Study of Asthma and Allergies in Childhood (ISAAC) data. ISAAC Phase One Study Group. *Eur Respir J* 2001;17(3):436-43.
329. Gilliland FD, Berhane KT, Li YF, Gauderman WJ, McConnell R, Peters J. Children's lung function and antioxidant vitamin, fruit, juice, and vegetable intake. *Am J Epidemiol* 2003;158(6):576-84.
330. Heinrich J, Holscher B, Bolte G, Winkler G. Allergic sensitization and diet: ecological analysis in selected European cities. *Eur Respir J* 2001;17(3):395-402.
331. Strachan DP, Cox BD, Erzincinoglu SW, Walters DE, Whiclow MJ. Ventilatory function and winter fresh fruit consumption in a random sample of British adults. *Thorax* 1991;46(9):624-9.
332. Adeniyi FB, Young T. Weight loss interventions for chronic asthma. *Cochrane Database of Systematic Reviews* 2012, Issue 7.
333. Scottish Intercollegiate Guidelines Network (SIGN). Management of Obesity. Edinburgh: SIGN; 2010. (SIGN publication no. 115). [cited 28 Jul 2014]. Available from url: <http://www.sign.ac.uk/guidelines/fulltext/115/index.html>
334. Bjorksten B, Sepp E, Julge K, Voor T, Mikelsaar M. Allergy development and the intestinal microflora during the first year of life. *J Allergy Clin Immunol* 2001;108(4):516-20.
335. Helin T, Haahtela S, Haahtela T. No effect of oral treatment with an intestinal bacterial strain, *Lactobacillus rhamnosus* (ATCC 53103), on birch-pollen allergy: a placebo-controlled double-blind study. *Allergy* 2002;57(3):243-6.
336. Isolauri E, Arvola T, Sutas Y, Moilanen E, Salminen S. Probiotics in the management of atopic eczema. *Clin Exp Allergy* 2000;30(11):1604-10.
337. Wheeler JG, Shema SJ, Bogle ML, Shirrell MA, Burks AW, Pittler A, et al. Immune and clinical impact of *Lactobacillus acidophilus* on asthma. *Ann Allergy Asthma Immunol* 1997;79(3):229-33.



338. Gruber C, Illi S, Lau S, Nickel R, Forster J, Kamin W, et al. Transient suppression of atopy in early childhood is associated with high vaccination coverage. *Pediatrics* 2003;111(3):e282-8.
339. Gruber C, Meinlschmidt G, Bergmann R, Wahn U, Stark K. Is early BCG vaccination associated with less atopic disease? An epidemiological study in German preschool children with different ethnic backgrounds. *Pediatr Allergy Immunol* 2002;13(3):177-81.
340. Henderson J, North K, Griffiths M, Harvey I, Golding J. Pertussis vaccination and wheezing illnesses in young children: prospective cohort study. The Longitudinal Study of Pregnancy and Childhood Team. *BMJ* 1999;318(7192):1173-6.
341. Nilsson L, Kjellman NI, Bjorksten B. A randomized controlled trial of the effect of pertussis vaccines on atopic disease. *Arch Pediatr Adolesc Med* 1998;152(8):734-8.
342. Choi IS, Koh YI. Therapeutic effects of BCG vaccination in adult asthmatic patients: a randomized, controlled trial. *Ann Allergy Asthma Immunol* 2002;88(6):584-91.
343. Arikian C, Bahceciler NN, Deniz G, Akdis M, Akkoc T, Akdis CA, et al. Bacillus Calmette-Guerin-induced interleukin-12 did not additionally improve clinical and immunologic parameters in asthmatic children treated with sublingual immunotherapy. *Clin Exp Allergy* 2004;34(3):398-405.
344. Tsai JJ, Peng HJ, Shen HD. Therapeutic effect of Bacillus Calmette-Guerin with allergen on human allergic asthmatic patients. *J Microbiol Immunol Infect* 2002;35(2):99-102.
345. Nicholson KG, Nguyen-Van-Tam JS, Ahmed AH, Wiselka MJ, Leese J, Ayres J, et al. Randomised placebo-controlled crossover trial on effect of inactivated influenza vaccine on pulmonary function in asthma. *Lancet* 1998;351(9099):326-31.
346. Bueving HJ, Bernsen RM, de Jongste JC, van Suijlekom-Smit LW, Rimmelzwaan GF, Osterhaus AD, et al. Influenza vaccination in children with asthma: randomized double-blind placebo-controlled trial. *Am J Respir Crit Care Med* 2004;169(4):488-93.
347. Bueving HJ, van der Wouden JC, Raat H, Bernsen RM, de Jongste JC, van Suijlekom-Smit LW, et al. Influenza vaccination in asthmatic children: Effects on quality of life and symptoms. *Eur Respir J* 2004;24(6):925-31.
348. Hanania NA, Sockrider M, Castro M, Holbrook JT, Tonascia J, Wise R, et al. Immune response to influenza vaccination in children and adults with asthma: effect of corticosteroid therapy. *J Allergy Clin Immunol* 2004;113(4):717-24.
349. Sheikh A, Alves B, Dhimi S. Pneumococcal vaccine for asthma. *Cochrane Database of Systematic Reviews* 2002, Issue 1.
350. Linde K, Jobst K, Panton J. Acupuncture for chronic asthma. *Cochrane Database of Systematic Reviews* 2000, Issue 2.
351. Martin J, Donaldson AN, Villarroel R, Parmar MK, Ernst E, Higginson IJ. Efficacy of acupuncture in asthma: systematic review and meta-analysis of published data from 11 randomised controlled trials. *Eur Respir J* 2002;20(4):846-52.
352. Gruber W, Eber E, Malle-Scheid D, Pflieger A, Weinhandl E, Dorfer L, et al. Laser acupuncture in children and adolescents with exercise induced asthma. *Thorax* 2002;57(3):222-5.
353. Malmstrom M, Ahlner J, Carlsson C, Schmekel B. No effect of chinese acupuncture on isocapnic hyperventilation with cold air in asthmatics, measured with impulse oscillometry. *Acupunct Med* 2002;20(2-3):66-73.
354. Blackhall K, Appleton S, Cates CJ. Ionisers for chronic asthma. *Cochrane Database of Systematic Reviews* 2003, Issue 3.
355. Warner JA, Marchant JL, Warner JO. A double blind trial of ionisers in children with asthma sensitive to the house dust mite. *Thorax* 1993;48(4):330-3.
356. O'Connor E, Patnode CD, Burda BU, Buckley DI, Whitlock EP. Breathing Exercises and/or Retraining Techniques in the Treatment of Asthma: Comparative Effectiveness. Rockville (MD): Agency for Healthcare Research and Quality (US); 2012. (Report number 12-EHC092-EF). [cited 10 Jul 2014]. Available from url: <http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1251>
357. Huntley A, Ernst E. Herbal medicines for asthma: a systematic review. *Thorax* 2000;55(11):925-9.
358. Chan CK, Kuo ML, Shen JJ, See LC, Chang HH, Huang JL. Ding Chuan Tang, a Chinese herb decoction, could improve airway hyper-responsiveness in stabilized asthmatic children: a randomized, double-blind clinical trial. *Pediatr Allergy Immunol* 2006;17(5):316-22.
359. Hsu CH, Lu CM, Chang TT. Efficacy and safety of modified Mai-Men-Dong-Tang for treatment of allergic asthma. *Pediatr Allergy Immunol* 2005;16(1):76-81.
360. Linde K, Jobst KA. Homeopathy for chronic asthma. *Cochrane Database of Systematic Reviews* 2000, Issue 2.
361. White A, Slade P, Hunt C, Hart A, Ernst E. Individualised homeopathy as an adjunct in the treatment of childhood asthma: a randomised placebo controlled trial. *Thorax* 2003;58(4):317-21.
362. Huntley A, White AR, Ernst E. Relaxation therapies for asthma: a systematic review. *Thorax* 2002;57(2):127-31.
363. Hondras MA, Linde K, Jones AP. Manual therapy for asthma. *Cochrane Database of Systematic Reviews* 2001, Issue 1.

364. Holloway E, Ram FS. Breathing exercises for asthma. *Cochrane Database of Systematic Reviews* 2004, Issue 1.
365. Panton J, Barley EA. Family therapy for asthma in children. *Cochrane Database of Systematic Reviews* 2000, Issue 2.
366. Scottish Intercollegiate Guidelines Network (SIGN). Pharmacological management of asthma. Evidence table 4.2: ipratropium bromide. [cited 10 Jul 2014]. Available from url: <http://www.sign.ac.uk/guidelines/published/support/guideline63/table4.2.html>
367. Dennis SM, Sharp SJ, Vickers MR, Frost CD, Crompton GK, Barnes PJ, et al. Regular inhaled salbutamol and asthma control: the TRUST randomised trial. Therapy Working Group of the National Asthma Task Force and the MRC General Practice Research Framework. *Lancet* 2000;355(9216):1675-9.
368. Walters EH, Walters J. Inhaled short acting beta2-agonist use in chronic asthma: regular versus as needed treatment. *Cochrane Database of Systematic Reviews* 2003, Issue 2.
369. Scottish Intercollegiate Guidelines Network (SIGN). Pharmacological management of asthma. Evidence table 4.25: budesonide vs beclometasone. [cited 10 Jul 2014]. Available from url: <http://www.sign.ac.uk/guidelines/published/support/guideline63/table4.25.html>
370. Scottish Intercollegiate Guidelines Network (SIGN). Pharmacological management of asthma. Evidence table 4.15: mometasone furoate dry powder inhalation. [cited 10 July 2014]. Available from url: <http://www.sign.ac.uk/guidelines/published/support/guideline63/table4.15.html>
371. London Respiratory Team. Inhaled corticosteroid safety information for adults. [cited 11 Jul 2014]. Available from url: <http://www.networks.nhs.uk/nhs-networks/london-respiratory-network/key-documents/responsible-respiratory-prescribing/LRT%20Inhaled%20steroid%20safety%20card.pdf>
372. Scottish Intercollegiate Guidelines Network (SIGN). Pharmacological management of asthma. Evidence table 4.4a: inhaled corticosteroid vs theophylline. [cited 10 July 2014]. Available from url: <http://www.sign.ac.uk/guidelines/published/support/guideline63/table4.4a.html>
373. Scottish Intercollegiate Guidelines Network (SIGN). Pharmacological management of asthma. Evidence table 4.4c: inhaled corticosteroid vs leukotriene receptor antagonists. [cited 10 Jul 2014]. Available from url: <http://www.sign.ac.uk/guidelines/published/support/guideline63/table4.4c.html>
374. Adams N, Bestall J, Jones P.W. Inhaled fluticasone propionate for chronic asthma. *Cochrane Database of Systematic Reviews* 2000, Issue 2.
375. Adams NP, Bestall JB, Malouf R, Lasserson TJ, Jones PW. Beclomethasone versus placebo for chronic asthma. *Cochrane Database of Systematic Reviews* 2005, Issue 1.
376. Calpin C, Macarthur C, Stephens D, Feldman W, Parkin PC. Effectiveness of prophylactic inhaled steroids in childhood asthma: a systemic review of the literature. *J Allergy Clin Immunol* 1997;100(4):452-7.
377. Carlsen KC, Stick S, Kamin W, Cirule I, Hughes S, Wixon C. The efficacy and safety of fluticasone propionate in very young children with persistent asthma symptoms. *Respir Med* 2005;99(11):1393-402.
378. Teper AM, Colom AJ, Kofman CD, Maffey AF, Vidaurreta SM, Bergada I. Effects of inhaled fluticasone propionate in children less than 2 years old with recurrent wheezing. *Pediatr Pulmonol* 2004;37(2):111-5.
379. Teper AM, Kofman CD, Szulman GA, Vidaurreta SM, Maffey AF. Fluticasone improves pulmonary function in children under 2 years old with risk factors for asthma. *Am J Respir Crit Care Med* 2005;171(6):587-90.
380. Bisgaard H, Allen D, Milanowski J, Kalev I, Willits L, Davies P. Twelve-month safety and efficacy of inhaled fluticasone propionate in children aged 1 to 3 years with recurrent wheezing. *Pediatrics* 2004;113(2):e87-94.
381. Busse WW, Pedersen S, Pauwels RA, Tan WC, Chen YZ, Lamm CJ, et al. The Inhaled Steroid Treatment As Regular Therapy in Early Asthma (START) study 5-year follow-up: effectiveness of early intervention with budesonide in mild persistent asthma. *J Allergy Clin Immunol* 2008;121(5):1167-74.
382. Castro-Rodriguez JA, Rodrigo GJ. Efficacy of inhaled corticosteroids in infants and preschoolers with recurrent wheezing and asthma: a systematic review with meta-analysis. *Pediatrics* 2009;123(3):e519-25.
383. Kerwin EM, Pearlman DS, de Guia T, Carlsson LG, Gillen M, Uryniak T, et al. Evaluation of efficacy and safety of budesonide delivered via two dry powder inhalers. *Curr Med Res Opin* 2008;24(5):1497-510.
384. Knuffman JE, Sorkness CA, Lemanske RF Jr, Mauger DT, Boehmer SJ, Martinez FD, et al. Phenotypic predictors of long-term response to inhaled corticosteroid and leukotriene modifier therapies in pediatric asthma. *J Allergy Clin Immunol* 2009;123(2):411-6.
385. Kooi EM, Schokker S, Marike Boezen H, de Vries TW, Vaessen-Verberne AA, van der Molen T, et al. Fluticasone or montelukast for preschool children with asthma-like symptoms: Randomized controlled trial. *Pulm Pharmacol Ther* 2008;21(5):798-804.
386. Papi A, Nicolini G, Baraldi E, Boner AL, Cutrera R, Rossi GA, et al. Regular vs prn nebulized treatment in wheeze preschool children. *Allergy* 2009;64(10):1463-71.

387. Rachelefsky G. Inhaled corticosteroids and asthma control in children: assessing impairment and risk. *Pediatrics* 2009;123(1):353-66.
388. O'Byrne PM, Barnes PJ, Rodriguez-Roisin R, Runnerstrom E, Sandstrom T, Svensson K, et al. Low dose inhaled budesonide and formoterol in mild persistent asthma: the OPTIMA randomized trial. *Am J Respir Crit Care Med* 2001;164(8 Pt 1):1392-7.
389. Pauwels RA, Pedersen S, Busse WW, Tan WC, Chen YZ, Ohlsson SV, et al. Early intervention with budesonide in mild persistent asthma: a randomised, double-blind trial. *Lancet* 2003;361(9363):1071-6.
390. Berger WE. Budesonide inhalation suspension for the treatment of asthma in infants and children. *Drugs* 2005;65(14):1973-89.
391. Sorkness CA, Lemanske RF Jr, Mauger DT, Boehmer SJ, Chinchilli VM, Martinez FD, et al. Long-term comparison of 3 controller regimens for mild-moderate persistent childhood asthma: the Pediatric Asthma Controller Trial. *J Allergy Clin Immunol* 2007;119(1):64-72.
392. Szeffler SJ, Baker JW, Uryniak T, Goldman M, Silkoff PE. Comparative study of budesonide inhalation suspension and montelukast in young children with mild persistent asthma. *J Allergy Clin Immunol* 2007;120(5):1043-50.
393. Scottish Intercollegiate Guidelines Network (SIGN). Pharmacological management of asthma. Evidence table 4.7: high dose step down. [cited Available from url: <http://www.sign.ac.uk/guidelines/published/support/guideline63/table4.7.html>]
394. Hodges IG, Netherway TA. Once-Daily Fluticasone Propionate is as Effective as Twice-Daily Treatment in Stable, Mild-to-Moderate Childhood Asthma. *Clin Drug Investig* 2005;25(1):13-22.
395. Chen YZ, Busse WW, Pedersen S, Tan W, Lamm CJ, O'Byrne PM. Early intervention of recent onset mild persistent asthma in children aged under 11 yrs: the Steroid Treatment As Regular Therapy in early asthma (START) trial. *Pediatr Allergy Immunol* 2006;17 Suppl 17:7-13.
396. Fay JK, Jones A, Ram FS. Primary care based clinics for asthma. *Cochrane Database of Systematic Reviews* 2002, Issue 1.
397. Sharek PJ, Bergman DA. The effect of inhaled steroids on the linear growth of children with asthma: a meta-analysis. *Pediatrics* 2000;106(1):E8.
398. Dunlop KA, Carson DJ, Steen HJ, McGovern V, McNaboe J, Shields MD. Monitoring growth in asthmatic children treated with high dose inhaled glucocorticoids does not predict adrenal suppression. *Arch Dis Child* 2004;89(8):713-6.
399. Bernstein DI, Allen DB. Evaluation of tests of hypothalamic-pituitary-adrenal axis function used to measure effects of inhaled corticosteroids. *Ann Allergy Asthma Immunol* 2007;98(2):118-27.
400. Kelly A, Tang R, Becker S, Stanley CA. Poor specificity of low growth hormone and cortisol levels during fasting hypoglycemia for the diagnoses of growth hormone deficiency and adrenal insufficiency. *Pediatrics* 2008;122(3):e522-8.
401. Tomlinson JE, McMahon AD, Chaudhuri R, Thompson JM, Wood SF, Thomson NC. Efficacy of low and high dose inhaled corticosteroid in smokers versus non-smokers with mild asthma. *Thorax* 2005;60(4):282-7.
402. Medicines and Healthcare products Regulatory Agency. Salmeterol (Severant) and formoterol (Oxis) in asthma management. *Current Problems in Pharmacovigilance* 2003; 29. [cited 11 Jul 2014]. Available from url: <http://www.mhra.gov.uk/Publications/Safetyguidance/CurrentProblemsinPharmacovigilance/CON007449>
403. Scottish Intercollegiate Guidelines Network (SIGN). Pharmacological management of asthma. Evidence table 4.4d: leukotriene receptor antagonists with short-acting beta-agonists. [cited 11 Jul 2014]. Available from url: <http://www.sign.ac.uk/guidelines/published/support/guideline63/table4.4d.html>
404. Ducharme FM. Inhaled glucocorticoids versus leukotriene receptor antagonists as single agent asthma treatment: systematic review of current evidence. *BMJ* 2003;326(7390):621.
405. Edwards AM, Stevens MT. The clinical efficacy of inhaled nedocromil sodium (Tilade) in the treatment of asthma. *Eur Respir J* 1993;6(1):35-41.
406. Scottish Intercollegiate Guidelines Network (SIGN). Pharmacological management of asthma. Evidence table 4.24a: Other preventor therapies - Chromones in children aged 5-12. [cited 10 Jul 2014]. Available from url: <http://www.sign.ac.uk/guidelines/published/support/guideline63/index.html>
407. Scottish Intercollegiate Guidelines Network (SIGN). Pharmacological management of asthma. Evidence table 4.4j: do chromones works as first line preventor in children >5 years? [cited 11 Jul 2014]. Available from url: <http://www.sign.ac.uk/guidelines/published/support/guideline63/table4.4j.html>
408. Scottish Intercollegiate Guidelines Network (SIGN). Pharmacological management of asthma. Evidence table 4.24b: other preventor therapies - chromones in children aged <5. [cited 10 Jul 2014]. Available from url: <http://www.sign.ac.uk/guidelines/published/support/guideline63/table4.24b.html>
409. Van Ganse E, Kaufman L, Derde MP, Yernault JC, Delaunois L, Vincken W. Effects of antihistamines in adult asthma: a meta-analysis of clinical trials. *Eur Respir J* 1997;10(10):2216-24.
410. Scottish Intercollegiate Guidelines Network (SIGN). Pharmacological management of asthma. Evidence table 4.11b: add-on drugs for inhaled steroids: long acting or oral B2 agonists. [cited 11 Jul 2014]. Available from url: <http://www.sign.ac.uk/guidelines/published/support/guideline63/table4.11b.html>

411. Scottish Intercollegiate Guidelines Network (SIGN). Pharmacological management of asthma. Evidence table 4.11d: add-on drugs for inhaled steroids: theophylline, beclometasone dipropionate, budesonide. [cited 11 Jul 2014]. Available from url: <http://www.sign.ac.uk/guidelines/published/support/guideline63/table4.11d.html>
412. Scottish Intercollegiate Guidelines Network (SIGN). Pharmacological management of asthma. Evidence table 4.11c: add-on drugs for inhaled steroids - anticholinergics. [cited 11 Jul 2014]. Available from url: <http://www.sign.ac.uk/guidelines/published/support/guideline63/table4.11c.html>
413. Scottish Intercollegiate Guidelines Network (SIGN). Pharmacological management of asthma. Evidence table 4.11a: add on drugs for inhaled steroids - chromones. [cited 11 Jul 2014]. Available from url: <http://www.sign.ac.uk/guidelines/published/support/guideline63/table4.11a.html>
414. Becker AB, Simons FE. Formoterol, a new long-acting selective beta 2-adrenergic receptor agonist: double-blind comparison with salbutamol and placebo in children with asthma. *J Allergy Clin Immunol* 1989;84(6 Pt 1):891-5.
415. Kips JC, Pauwels RA. Long-acting inhaled beta(2)-agonist therapy in asthma. *Am J Respir Crit Care Med* 2001;164(6):923-32.
416. de Blic J, Ogorodova L, Klink R, Sidorenko I, Valiulis A, Hofman J, et al. Salmeterol/fluticasone propionate vs. double dose fluticasone propionate on lung function and asthma control in children. *Pediatr Allergy Immunol* 2009;20(8):763-71.
417. Gappa M, Zachgo W, von Berg A, Kamin W, Stern-Strater C, Steinkamp G, et al. Add-on salmeterol compared to double dose fluticasone in pediatric asthma: A double-blind, randomized trial (VIAPAED). *Pediatr Pulmonol* 2009;44(11):1132-42.
418. Morice AH, Peterson S, Beckman O, Kukova Z. Efficacy and safety of a new pressurised metered-dose inhaler formulation of budesonide/formoterol in children with asthma: a superiority and therapeutic equivalence study. *Pulm Pharmacol Ther* 2008;21(1):152-9.
419. Pearlman D, Qaqudah P, Matz J, Yancey SW, Stempel DA, Ortega HG. Fluticasone propionate/salmeterol and exercise-induced asthma in children with persistent asthma. *Pediatr Pulmonol* 2009;44(5):429-35.
420. Knorr B, Franchi LM, Bisgaard H, Vermeulen JH, LeSouef P, Santanello N, et al. Montelukast, a leukotriene receptor antagonist, for the treatment of persistent asthma in children aged 2 to 5 years. *Pediatrics* 2001;108(3):E48.
421. Scottish Intercollegiate Guidelines Network (SIGN). Pharmacological management of asthma. Evidence table 4.8c: children with poor asthma control on ICS - is addition of leukotriene receptor antagonists helpful? [cited 11 Jul 2014]. Available from url: <http://www.sign.ac.uk/guidelines/published/support/guideline63/table4.8c.html>
422. Joos S, Miksch A, Szecsenyi J, Wieseler B, Groven U, Kaiser T, et al. Montelukast as add-on therapy to inhaled corticosteroids in the treatment of mild to moderate asthma: a systematic review. *Thorax* 2008;63(5):453-62.
423. Scottish Intercollegiate Guidelines Network (SIGN). Pharmacological management of asthma. Evidence table 4.22: combined therapy of inhaled steroids and long acting B2 agonists. [cited 10 Jul 2014]. Available from url: <http://www.sign.ac.uk/guidelines/published/support/guideline63/table4.22.html>
424. Westby M, Benson M, Gibson P. Anticholinergic agents for chronic asthma in adults. *Cochrane Database of Systematic Reviews* 2004, Issue 3.
425. Medicines and Healthcare products Regulatory Agency. Long-acting  $\beta$ 2-agonists: reminder for use in children and adults. *Drug Safety Update* 2010;4(2):H2.
426. Kuna P, Peters MJ, Manjra AI, Jorup C, Naya IP, Martinez-Jimenez NE, et al. Effect of budesonide/formoterol maintenance and reliever therapy on asthma exacerbations. *Int J Clin Pract* 2007;61(5):725-36.
427. O'Byrne PM, Bisgaard H, Godard PP, Pistolesi M, Palmqvist M, Zhu Y, et al. Budesonide/formoterol combination therapy as both maintenance and reliever medication in asthma. *Am J Respir Crit Care Med* 2005;171(2):129-36.
428. Rabe KF, Atienza T, Magyar P, Larsson P, Jorup C, Laloo UG. Effect of budesonide in combination with formoterol for reliever therapy in asthma exacerbations: a randomised controlled, double-blind study. *Lancet* 2006;368(9537):744-53.
429. Scicchitano R, Aalbers R, Ukena D, Manjra A, Fouquert L, Centanni S, et al. Efficacy and safety of budesonide/formoterol single inhaler therapy versus a higher dose of budesonide in moderate to severe asthma. *Curr Med Res Opin* 2004;20(9):1403-18.
430. Vogelmeier C, D'Urzo A, Pauwels R, Merino JM, Jaspal M, Boutet S, et al. Budesonide/formoterol maintenance and reliever therapy: an effective asthma treatment option? *Eur Respir J* 2005;26(5):819-28.
431. Bateman ED, Kornmann O, Schmidt P, Pivovarov A, Engel M, Fabbri LM. Tiotropium is noninferior to salmeterol in maintaining improved lung function in B16-Arg/Arg patients with asthma. *J Allergy Clin Immunol* 2011;128(2):315-22.

432. Peters SP, Kunselman SJ, Icitovic N, Moore WC, Pascual R, Ameredes BT, et al. Tiotropium bromide step-up therapy for adults with uncontrolled asthma. *N Engl J Med* 2010;363(18):1715-26.
433. National Osteoporosis Society. Guidance on the prevention and management of corticosteroid induced osteoporosis. Bath: National Osteoporosis Society; 1998.
434. Bachrach LK, Sills IN. Clinical report-bone densitometry in children and adolescents. *Pediatrics* 2011;127(1):189-94.
435. Bousquet J, Cabrera P, Berkman N, Buhl R, Holgate S, Wenzel S, et al. The effect of treatment with omalizumab, an anti-IgE antibody, on asthma exacerbations and emergency medical visits in patients with severe persistent asthma. *Allergy* 2005;60(3):302-8.
436. Holgate ST, Chuchalin AG, Hebert J, Lotvall J, Persson GB, Chung KF, et al. Efficacy and safety of a recombinant anti-immunoglobulin E antibody (omalizumab) in severe allergic asthma. *Clin Exp Allergy* 2004;34(4):632-8.
437. Lanier B, Bridges T, Kulus M, Taylor AF, Berhane I, Vidaurre CF. Omalizumab for the treatment of exacerbations in children with inadequately controlled allergic (IgE-mediated) asthma. *J Allergy Clin Immunol* 2009;124(6):1210-6.
438. Humbert M, Beasley R, Ayres J, Slavin R, Hebert J, Bousquet J, et al. Benefits of omalizumab as add-on therapy in patients with severe persistent asthma who are inadequately controlled despite best available therapy (GINA 2002 step 4 treatment): INNOVATE. *Allergy* 2005;60(3):309-16.
439. Scottish Intercollegiate Guidelines Network (SIGN). Pharmacological management of asthma. Evidence table 4.13a: immunosuppressive agents. [cited 14 Jul 2014]. Available from url: <http://www.sign.ac.uk/guidelines/published/support/guideline63/table4.13a.html>
440. O'Driscoll BR, Ruffles SP, Ayres JG, Cochrane GM. Long term treatment of severe asthma with subcutaneous terbutaline. *Br J Dis Chest* 1988;82(4):360-7.
441. Payne DN, Balfour-Lynn IM, Biggart EA, Bush A, Rosenthal M. Subcutaneous terbutaline in children with chronic severe asthma. *Pediatr Pulmonol* 2002;33(5):356-61.
442. Bremont F, Moisan V, Dutau G. Continuous subcutaneous infusion of beta 2-agonists in infantile asthma. *Pediatr Pulmonol* 1992;12(2):81-3.
443. Berry MA, Hargadon B, Shelley M, Parker D, Shaw DE, Green RH, et al. Evidence of a role of tumor necrosis factor alpha in refractory asthma. *N Engl J Med* 2006;354(7):697-708.
444. Hawkins G, McMahon AD, Twaddle S, Wood SF, Ford I, Thomson NC. Stepping down inhaled corticosteroids in asthma: randomised controlled trial. *BMJ* 2003;326(7399):1115.
445. Nassif EG, Weinberger M, Thompson R, Huntley W. The value of maintenance theophylline in steroid-dependent asthma. *N Engl J Med* 1981;304(2):71-5.
446. Abramson MJ, Puy RM, Weiner JM. Injection allergen immunotherapy for asthma. *Cochrane Database of Systematic Reviews* 2010, Issue 8.
447. Shaikh WA. Immunotherapy vs inhaled budesonide in bronchial asthma: an open, parallel, comparative trial. *Clin Exp Allergy* 1997;27(11):1279-84.
448. Durham SR, Walker SM, Varga EM, Jacobson MR, O'Brien F, Noble W, et al. Long-term clinical efficacy of grass-pollen immunotherapy. *N Engl J Med* 1999;341(7):468-75.
449. Calamita Z, Saconato H, Pela AB, Atallah AN. Efficacy of sublingual immunotherapy in asthma: systematic review of randomized-clinical trials using the Cochrane Collaboration method. *Allergy* 2006;61(10):1162-72.
450. Nieto A, Mazon A, Pamies R, Bruno L, Navarro M, Montanes A. Sublingual immunotherapy for allergic respiratory diseases: an evaluation of meta-analyses. *J Allergy Clin Immunol* 2009;124(1):157-61.e1-32.
451. Compalati E, Passalacqua G, Bonini M, Canonica GW. The efficacy of sublingual immunotherapy for house dust mites respiratory allergy: results of a GA2LEN meta-analysis. *Allergy* 2009;64(11):1570-9.
452. Castro M, Rubin AS, Laviolette M, Fiterman J, De Andrade Lima M, Shah PL, et al. Effectiveness and safety of bronchial thermoplasty in the treatment of severe asthma: a multicenter, randomized, double-blind, sham-controlled clinical trial. *Am J Respir Crit Care Med* 2010;181(2):116-24.
453. Wechsler ME, Laviolette M, Rubin AS, Fiterman J, Lapa e Silva JR, Shah PL, et al. Bronchial thermoplasty: Long-term safety and effectiveness in patients with severe persistent asthma. *J Allergy Clin Immunol* 2013;132(6):1295-302.
454. Wu Q, Xing Y, Zhou X, Wang D. Meta-analysis of the efficacy and safety of bronchial thermoplasty in patients with moderate-to-severe persistent asthma. *J Int Med Res* 2011;39(1):10-22.
455. Cox G, Thomson NC, Rubin AS, Niven RM, Corris PA, Siersted HC, et al. Asthma control during the year after bronchial thermoplasty. *N Engl J Med* 2007;356(13):1327-37.
456. Pavord ID, Cox G, Thomson NC, Rubin AS, Corris PA, Niven RM, et al. Safety and efficacy of bronchial thermoplasty in symptomatic, severe asthma. *Am J Respir Crit Care Med* 2007;176(12):1185-91.

457. Thomson NC, Rubin AS, Niven RM, Corris PA, Siersted HC, Olivenstein R, et al. Long-term (5 year) safety of bronchial thermoplasty: Asthma Intervention Research (AIR) trial. *BMC Pulm Med* 2011;11(8).
458. Scottish Intercollegiate Guidelines Network (SIGN). Pharmacological management of asthma. Evidence table 4.9: Exacerbation. [cited 14 Jul 2014]. Available from url: <http://www.sign.ac.uk/guidelines/published/support/guideline63/table4.9.html>
459. Quon BS, FitzGerald JM, Lemièrè C, Shahidi N, Ducharme FM. Increased versus stable doses of inhaled corticosteroids for exacerbations of chronic asthma in adults and children. *Cochrane Database of Systematic Reviews* 2010, Issue 12.
460. Robertson CF, Price D, Henry R, Mellis C, Glasgow N, Fitzgerald D, et al. Short course montelukast for intermittent asthma in children: A randomized controlled trial *Am J Resp Crit Care Med* 2007;175(4):323-9.
461. Henriksen JM, Agertoft L, Pedersen S. Protective effect and duration of action of inhaled formoterol and salbutamol on exercise-induced asthma in children. *J Allergy Clin Immunol* 1992;89(6):1176-82.
462. Raissy HH, Harkins M, Kelly F, Kelly HW. Pretreatment with albuterol versus montelukast for exercise-induced bronchospasm in children. *Pharmacotherapy* 2008;28(3):287-94.
463. Scottish Intercollegiate Guidelines Network (SIGN). Pharmacological management of asthma. Evidence table 4.3a: long acting B2 agonists in exercise induced asthma. [cited 14 Jul 2014]. Available from url: <http://www.sign.ac.uk/guidelines/published/support/guideline63/table4.3a.html>
464. Scottish Intercollegiate Guidelines Network (SIGN). Pharmacological management of asthma. Evidence table 4.3c: theophyllines in exercise-induced asthma. [cited 14 Jul 2014]. Available from url: <http://www.sign.ac.uk/guidelines/published/support/guideline63/table4.3c.html>
465. Scottish Intercollegiate Guidelines Network (SIGN). Pharmacological management of asthma. Evidence table 4.3d: leukotriene receptor antagonists in exercise induced asthma. [cited 14 Jul 2014]. Available from url: <http://www.sign.ac.uk/guidelines/published/support/guideline63/table4.3d.html>
466. Kelly K, Spooner CH, Rowe BH. Nedocromil sodium vs. sodium cromoglycate for preventing exercise-induced bronchoconstriction in asthmatics. *Cochrane Database of Systematic Reviews* 2000, Issue 4.
467. Scottish Intercollegiate Guidelines Network (SIGN). Pharmacological management of asthma. Evidence table 4.3g: oral B2 agonists for exercise induced asthma. [cited 14th Jul 2014]. Available from url: <http://www.sign.ac.uk/guidelines/published/support/guideline63/table4.3g.html>
468. Scottish Intercollegiate Guidelines Network (SIGN). Pharmacological management of asthma. Evidence table 4.3f: anticholinergic therapy for exercise-induced asthma. [cited 14 Jul 2014]. Available from url: <http://www.sign.ac.uk/guidelines/published/support/guideline63/table4.3f.html>
469. Scottish Intercollegiate Guidelines Network (SIGN). Pharmacological management of asthma. Evidence table 4.3b: ketotifen for exercise-induced asthma. [cited 14 Jul 2014]. Available from url: <http://www.sign.ac.uk/guidelines/published/support/guideline63/table4.3b.html>
470. Scottish Intercollegiate Guidelines Network (SIGN). Pharmacological management of asthma. Evidence table 4.3e: antihistamines for exercise-induced asthma. [cited 14 Jul 2014]. Available from url: <http://www.sign.ac.uk/guidelines/published/support/guideline63/table4.3e.html>
471. Stelmach I, Grzelewski T, Majak P, Jerzynska J, Stelmach W, Kuna P. Effect of different antiasthmatic treatments on exercise-induced bronchoconstriction in children with asthma. *J Allergy Clin Immunol* 2008;121(2):383-9.
472. Scottish Intercollegiate Guidelines Network (SIGN). Pharmacological management of asthma. Evidence table 4.10: rhinitis. [cited 14 Jul 2014]. Available from url: <http://www.sign.ac.uk/guidelines/published/support/guideline63/table4.10.html>
473. Pedroletti C, Lundahl J, Alving K, Hedlin G. Effect of nasal steroid treatment on airway inflammation determined by exhaled nitric oxide in allergic schoolchildren with perennial rhinitis and asthma. *Pediatr Allergy Immunol* 2008;19(3):219-26.
474. Scottish Intercollegiate Guidelines Network (SIGN). Pharmacological management of asthma. Evidence table 4.19: allergic bronchopulmonary aspergillosis. [cited 14 Jul 2014]. Available from url: <http://www.sign.ac.uk/guidelines/published/support/guideline63/table4.19.html>
475. Wark PA, Gibson PG, Wilson AJ. Azoles for allergic bronchopulmonary aspergillosis associated with asthma *Cochrane Database of Systematic Reviews* 2004, Issue 3.
476. Scottish Intercollegiate Guidelines Network (SIGN). Pharmacological management of asthma. Evidence table 4.21: aspirin intolerant asthma. [cited 10 Jul 2014]. Available from url: <http://www.sign.ac.uk/guidelines/published/support/guideline63/table4.21.html>
477. Coughlan JL, Gibson PG, Henry RL. Medical treatment for reflux oesophagitis does not consistently improve asthma control: a systematic review. *Thorax* 2001;56(3):198-204.
478. Gibson PG, Henry RL, Coughlan JL. Gastro-oesophageal reflux treatment for asthma in adults and children. *Cochrane Database of Systematic Reviews* 2003, Issue 2.

479. Sopo SM, Radzik D, Calvani M. Does treatment with proton pump inhibitors for gastroesophageal reflux disease (GERD) improve asthma symptoms in children with asthma and GERD? A systematic review. *J Investig Allergol Clin Immunol* 2009;19(1):1-5.
480. Chan WW, Chiou E, Obstein KL, Tignor AS, Whitlock TL. The efficacy of proton pump inhibitors for the treatment of asthma in adults: a meta-analysis. *Arch Intern Med* 2011;171(7):620-9.
481. Brocklebank D, Ram F, Wright J, Barry P, Cates C, Davies L, et al. Comparison of the effectiveness of inhaler devices in asthma and chronic obstructive airways disease: a systematic review of the literature. *Health Technol Assess* 2001;5(26):1-149.
482. Cates CJ, Rowe BH. Holding chambers versus nebulisers for beta-agonist treatment of acute asthma. *Cochrane Database of Systematic Reviews* 2000, Issue 2.
483. Leversha AM, Campanella SG, Aickin RP, Asher MI. Costs and effectiveness of spacer versus nebuliser in young children with moderate and severe acute asthma. *J Pediatr* 2000;136(4):497-502.
484. Closa RM, Ceballos JM, Gomez-Papi A, Galiana AS, Gutierrez C, Marti-Henneber C. Efficacy of bronchodilators administered by nebulizers versus spacer devices in infants with acute wheezing. *Pediatr Pulmonol* 1998;26(5):344-8.
485. Delgado A, Chou KJ, Silver EJ, Crain EF. Nebulizers vs metered-dose inhalers with spacers for bronchodilator therapy to treat wheezing in children aged 2 to 24 months in a pediatric emergency department. *Arch Pediatr Adolesc Med* 2003;157(1):76-80.
486. Ram FS, Wright J, Brocklebank D, White JE. Systematic review of clinical effectiveness of pressurised metered dose inhalers versus other hand held inhaler devices for delivering beta (2) agonists bronchodilators in asthma. *BMJ* 2001;323(7318):901-5.
487. Broeders ME, Molema J, Hop WC, Vermue NA, Folgering HT. Does the inhalation device affect the bronchodilatory dose response curve of salbutamol in asthma and chronic obstructive pulmonary disease patients? *Eur J Clin Pharmacol* 2003;59(5-6):449-55.
488. Hughes DA, Woodcock A, Walley T. Review of therapeutically equivalent alternatives to short acting beta(2) adrenoceptor agonists delivered via chlorofluorocarbon-containing inhalers. *Thorax* 1999;54(12):1087-92.
489. Farmer IS, Middle M, Savic J, Perri VL, Herdman MJ. Therapeutic equivalence of inhaled beclomethasone dipropionate with CFC and non-CFC (HFA 134a) propellants both delivered via the Easibreathe inhaler for the treatment of paediatric asthma. *Respir Med* 2000;94(1):57-63.
490. De Benedictis FM, Boner A, Cavagni G, Caffarelli C, Ferraro L, Cantini L. Treating asthma in children with beclomethasone dipropionate: Pulvinal versus Diskhaler. *J Aerosol Med* 2000;13(1):35-41.
491. Cates CJ, Adams N, Bestall J. Holding chambers versus nebulisers for inhaled steroids in chronic asthma. *Cochrane Database of Systematic Reviews* 2001, Issue 2.
492. Alotaibi S, Hassan WM, Alhashimi H. Concurrent use of metered dose inhalers without spacer and dry powder inhalers by asthmatic children adversely affect proper inhalation technique. *Internet J Pediatr Neonatol* 2011;13(1).
493. van der Palen J, Klein JJ, van Herwaarden CL, Zielhuis GA, Seydel ER. Multiple inhalers confuse asthma patients. *Eur Respir J* 1999;14(5):1034-7.
494. Accuracy of death certificates in bronchial asthma. Accuracy of certification procedures during the confidential inquiry by the British Thoracic Association. A subcommittee of the BTA Research Committee. *Thorax* 1984;39(7):505-9.
495. Bucknall CE, Slack R, Godley CC, Mackay TW, Wright SC. Scottish Confidential Inquiry into Asthma Deaths (SCIAD), 1994-6. *Thorax* 1999;54(11):978-84.
496. Burr ML, Davies BH, Hoare A, Jones A, Williamson IJ, Holgate SK, et al. A confidential inquiry into asthma deaths in Wales. *Thorax* 1999;54(11):985-9.
497. Mohan G, Harrison BD, Badminton RM, Mildenhall S, Wareham NJ. A confidential enquiry into deaths caused by asthma in an English health region: implications for general practice. *Br J Gen Pract* 1996;46(410):529-32.
498. Wareham NJ, Harrison BD, Jenkins PF, Nicholls J, Stableforth DE. A district confidential enquiry into deaths due to asthma. *Thorax* 1993;48(11):1117-20.
499. Royal College of Physicians. Why asthma still kills: the national review of asthma deaths (NRAD); confidential enquiry report 2014. London: Royal College of Physicians; 2014. [cited 15 Jul 2014]. Available from url: <http://www.rcplondon.ac.uk/sites/default/files/why-asthma-still-kills-full-report.pdf>
500. Harrison B, Slack R, Berrill WT, Burr ML, Stableforth DE, Wright SC. Results of a national confidential enquiry into asthma deaths. *Asthma J* 2000;5(4):180-6.
501. Spitzer WO, Suissa S, Ernst P, Horwitz RI, Habbick B, Cockcroft D, et al. The use of beta-agonists and the risk of death and near death from asthma. *N Engl J Med* 1992;326(8):501-6.
502. Suissa S, Blais L, Ernst P. Patterns of increasing beta-agonist use and the risk of fatal or near-fatal asthma. *Eur Respir J* 1994;7(9):1602-9.
503. Jalaludin BB, Smith MA, Chey T, Orr NJ, Smith WT, Leeder SR. Risk factors for asthma deaths: a population-based, case-control study. *Aust NZ J Public Health* 1999;23(6):595-600.
504. Rea HH, Scragg R, Jackson R, Beaglehole R, Fenwick J, Sutherland DC. A case-control study of deaths from asthma. *Thorax* 1986;41(11):833-9.

505. Campbell MJ, Cogman GR, Holgate ST, Johnston SL. Age specific trends in asthma mortality in England and Wales, 1983-95: results of an observational study. *BMJ* 1997;314(7092):1439-41.
506. Richards GN, Kolbe J, Fenwick J, Rea HH. Demographic characteristics of patients with severe life threatening asthma: comparison with asthma deaths. *Thorax* 1993;48(11):1105-9.
507. Innes NJ, Reid A, Halstead J, Watkin SW, Harrison BD. Psychosocial risk factors in near-fatal asthma and in asthma deaths. *J R Coll Physicians Lond* 1998;32(5):430-4.
508. Khot A, Evans N, Lenney W. Seasonal trends in childhood asthma in south east England. *Br Med J (Clin Res Ed)* 1983;287(6401):1257-8.
509. Barr RG, Woodruff PG, Clark S, Camargo CA Jr. Sudden-onset asthma exacerbations: clinical features, response to therapy, and 2-week follow-up. Multicenter Airway Research Collaboration (MARC) investigators. *Eur Respir J* 2000;15(2):266-73.
510. Kolbe J, Fergusson W, Garrett J. Rapid onset asthma: a severe but uncommon manifestation. *Thorax* 1998;53(4):241-7.
511. Kolbe J, Fergusson W, Vamos M, Garrett J. Case-control study of severe life threatening asthma (SLTA) in adults: demographics, health care, and management of the acute attack. *Thorax* 2000;55(12):1007-15.
512. Rodrigo GJ, Rodrigo C. Rapid-onset asthma attack: a prospective cohort study about characteristics and response to emergency department treatment. *Chest* 2000;118(6):1547-52.
513. Turner MO, Noertjojo K, Vedal S, Bai T, Crump S, Fitzgerald JM. Risk factors for near-fatal asthma. A case-control study in hospitalized patients with asthma. *Am J Respir Crit Care Med* 1998;157(6 Pt 1):1804-9.
514. Woodruff PG, Emond SD, Singh AK, Camargo CA Jr. Sudden-onset severe acute asthma: clinical features and response to therapy. *Acad Emerg Med* 1998;5(7):695-701.
515. British Thoracic Society, National Asthma Campaign, Royal College of Physicians of London in association with the General Practitioner in Asthma Group, The British Association of Accident and Emergency Medicine, The British Paediatric Respiratory Society, Royal College of Paediatrics and Child Health. The British guidelines on asthma management 1995 review and position statement. *Thorax* 1997;52(Suppl 1):S1-S21.
516. Scottish Intercollegiate Guidelines Network (SIGN). Emergency management of acute asthma. Edinburgh: SIGN; 1999. (SIGN publication no. 38).
517. International consensus report on the diagnosis and treatment of asthma. National Heart, Lung, and Blood Institute, National Institutes of Health. Bethesda, Maryland 20892. Publication no. 92-3091, March 1992. *Eur Respir J* 1992;5(5):601-41.
518. Neville E, Gribbin H, Harrison BD. Acute severe asthma. *Respir Med* 1991;85(6):463-74.
519. Brenner B, Kohn MS. The acute asthmatic patient in the ED: to admit or discharge. *Am J Emerg Med* 1998;16(1):69-75.
520. Boulet LP, Becker A, Berube D, Beveridge R, Ernst P. Canadian asthma consensus report, 1999. Canadian asthma consensus group. *CMAJ* 1999;161(11 Suppl):S1-61.
521. Nunn AJ, Gregg I. New regression equations for predicting peak expiratory flow in adults. *BMJ* 1989;298(6680):1068-70.
522. Abramson MJ, Bailey MJ, Couper FJ, Driver JS, Drummer OH, Forbes AB, et al. Are asthma medications and management related to deaths from asthma? *Am J Respir Crit Care Med* 2001;163(1):12-8.
523. Robinson SM, Harrison BD, Lambert MA. Effect of a preprinted form on the management of acute asthma in an accident and emergency department. *J Accid Emerg Med* 1996;13(2):93-7.
524. Arnold DH, Gebretsadik T, Minton PA, Higgins S, Hartert TV. Clinical measures associated with FEV1 in persons with asthma requiring hospital admission. *Am J Emerg Med* 2007;25(4):425-9.
525. Shim CS, Williams MH Jr. Evaluation of the severity of asthma: patients versus physicians. *Am J Med* 1980;68(1):11-3.
526. Emerman CL, Cydulka RK. Effect of pulmonary function testing on the management of acute asthma. *Arch Intern Med* 1995;155(20):2225-8.
527. O'Driscoll BR, Howard LS, Davison AG, British Thoracic Society. BTS guideline for emergency oxygen use in adult patients. *Thorax* 2008;63(suppl. 6):vi1-68.
528. Carruthers D, Harrison BD. Arterial blood gas analysis or oxygen saturation in the assessment of acute asthma? *Thorax* 1995;50(2):186-8.
529. Pearson MG, Spence DP, Ryland I, Harrison BD. Value of pulsus paradoxus in assessing acute severe asthma. British Thoracic Society Standards of Care Committee. *BMJ* 1993;307(6905):659.
530. McFadden ER Jr, Lyons HA. Arterial-blood gas tension in asthma. *N Engl J Med* 1968;278(19):1027-32.
531. Rebuck AS, Read J. Assessment and management of severe asthma. *Am J Med* 1971;51(6):788-98.
532. Jenkins PF, Benfield GF, Smith AP. Predicting recovery from acute severe asthma. *Thorax* 1981;36(11):835-41.



533. Molfino NA, Nannini LJ, Martelli AN, Slutsky AS. Respiratory arrest in near-fatal asthma. *N Engl J Med* 1991;324(5):285-8.
534. McFadden ER Jr. Critical appraisal of the therapy of asthma—an idea whose time has come. *Am Rev Respir Dis* 1986;133(5):723-4.
535. Rossing TH, Fanta CH, Goldstein DH, Snapper JR, McFadden ER Jr. Emergency therapy of asthma: comparison of the acute effects of parenteral and inhaled sympathomimetics and infused aminophylline. *Am Rev Respir Dis* 1980;122(3):365-71.
536. Siegel D, Sheppard D, Gelb A, Weinberg PF. Aminophylline increases the toxicity but not the efficacy of an inhaled beta-adrenergic agonist in the treatment of acute exacerbations of asthma. *Am Rev Respir Dis* 1985;132(2):283-6.
537. Rodrigo G, Nannini L. Comparison between nebulized adrenaline and beta2 agonists for the treatment of acute asthma. A meta-analysis of randomized trials. *Am J Emerg Med* 2006;24(2):217-22.
538. Cates CJ, Crilly JA, Rowe BH. Holding chambers (spacers) versus nebulisers for beta-agonist treatment of acute asthma. *Cochrane Database of Systematic Reviews* 2006, Issue 2.
539. Travers A, Jones AP, Kelly K, Barker SJ, Camargo CA, Rowe BH. Intravenous beta2-agonists for acute asthma in the emergency department. *Cochrane Database of Systematic Reviews* 2001, Issue 2.
540. Gleeson JG, Green S, Price JF. Air or oxygen as driving gas for nebulised salbutamol. *Arch Dis Child* 1988;63(8):900-4.
541. Douglas JG, Rafferty P, Fergusson RJ, Prescott RJ, Crompton GK, Grant IW. Nebulised salbutamol without oxygen in severe acute asthma: how effective and how safe? *Thorax* 1985;40(3):180-3.
542. Lin RY, Sauter D, Newman T, Sirleaf J, Walters J, Tavakol M. Continuous versus intermittent albuterol nebulization in the treatment of acute asthma. *Ann Emerg Med* 1993;22(12):1847-53.
543. Rudnitsky GS, Eberlein RS, Schoffstall JM, Mazur JE, Spivey WH. Comparison of intermittent and continuously nebulized albuterol for treatment of asthma in an urban emergency department. *Ann Emerg Med* 1993;22(12):1842-6.
544. Shrestha M, Bidadi K, Gourlay S, Hayes J. Continuous vs intermittent albuterol, at high and low doses, in the treatment of severe acute asthma in adults. *Chest* 1996;110(1):42-7.
545. Camargo CA Jr, Spooner C, Rowe BH. Continuous versus intermittent beta-agonists for acute asthma. *Cochrane Database of Systematic Reviews* 2009, Issue 4.
546. Rowe BH, Spooner C, Ducharme FM, Bretzlaff JA, Bota GW. Early emergency department treatment of acute asthma with systemic corticosteroids. *Cochrane Database of Systematic Reviews* 2001, Issue 1.
547. Rowe BH, Spooner CH, Ducharme FM, Bretzlaff JA, Bota GW. Corticosteroids for preventing relapse following acute exacerbations of asthma. *Cochrane Database of Systematic Reviews* 2001, Issue 1.
548. Manser R, Reid D, Abramson M. Corticosteroids for acute severe asthma in hospitalised patients. *Cochrane Database of Systematic Reviews* 2001, Issue 1.
549. Lahn M, Bijur P, Gallagher EJ. Randomized clinical trial of intramuscular vs oral methylprednisolone in the treatment of asthma exacerbations following discharge from an emergency department. *Chest* 2004;126(2):362-8.
550. Hatton MQ, Vathenen AS, Allen MJ, Davies S, Cooke NJ. A comparison of 'abruptly stopping' with 'tailing off' oral corticosteroids in acute asthma. *Respir Med* 1995;89(2):101-4.
551. O'Driscoll BR, Kalra S, Wilson M, Pickering CA, Carroll KB, Woodcock AA. Double-blind trial of steroid tapering in acute asthma. *Lancet* 1993;341(8841):324-7.
552. Edmonds ML, Camargo CA, Pollack CV Jr, Rowe BH. Early use of inhaled corticosteroids in the emergency department treatment of acute asthma. *Cochrane Database of Systematic Reviews* 2003, Issue 3.
553. Rodrigo GJ. Rapid effects of inhaled corticosteroids in acute asthma: an evidence-based evaluation. *Chest* 2006;130(5):1301-11.
554. Lanes SF, Garrett JE, Wentworth CE 3rd, Fitzgerald JM, Karpel JP. The effect of adding ipratropium bromide to salbutamol in the treatment of acute asthma: a pooled analysis of three trials. *Chest* 1998;114(2):365-72.
555. Rodrigo G, Rodrigo C, Burschtin O. A meta-analysis of the effects of ipratropium bromide in adults with acute asthma. *Am J Med* 1999;107(4):363-70.
556. Stoodley RG, Aaron SD, Dales RE. The role of ipratropium bromide in the emergency management of acute asthma exacerbation: a metaanalysis of randomized clinical trials. *Ann Emerg Med* 1999;34(1):8-18.
557. Mohammed S, Goodacre S. Intravenous and nebulised magnesium sulphate for acute asthma: systematic review and meta-analysis. *Emerg Med J* 2007;24(12):823-30.
558. Powell C, Dwan K, Milan SJ, Beasley R, Hughes R, Knopp-Sihota JA, et al. Inhaled magnesium sulfate in the treatment of acute asthma. *Cochrane Database of Systematic Reviews* 2012, Issue 12.

559. Goodacre S, Cohen J, Bradburn M, Gray A, Bengler J, Coats T, et al. Intravenous or nebulised magnesium sulphate versus standard therapy for severe acute asthma (3Mg trial): a double-blind, randomised controlled trial. *Lancet* 2013;1(4):293-300.
560. Blitz M, Blitz S, Hughes R, Diner B, Beasley R, Knopp J, et al. Aerosolized magnesium sulfate for acute asthma: a systematic review. *Chest* 2005;128(1):337-44.
561. Rowe BH, Bretzlaff JA, Bourdon C, Bota GW, Camargo CA Jr. Magnesium sulfate for treating exacerbations of acute asthma in the emergency department. *Cochrane Database of Systematic Reviews* 2000, Issue 2.
562. Kew KM, Kirtchuk L, Michell CI. Intravenous magnesium sulfate for treating adults with acute asthma in the emergency department. *Cochrane Database of Systematic Reviews* 2014, Issue 5.
563. Parameswaran K, Belda J, Rowe BH. Addition of intravenous aminophylline to beta2-agonists in adults with acute asthma. *Cochrane Database of Systematic Reviews* 2000, Issue 4.
564. Watts K, Chavasse RJ. Leukotriene receptor antagonists in addition to usual care for acute asthma in adults and children. *Cochrane Database of Systematic Reviews* 2012, Issue 5.
565. Graham VA, Milton AF, Knowles GK, Davies RJ. Routine antibiotics in hospital management of acute asthma. *Lancet* 1982;1(8269):418-20.
566. Kass JE, Terregino CA. The effect of heliox in acute severe asthma: a randomized controlled trial. *Chest* 1999;116(2):296-300.
567. Henderson SO, Acharya P, Kilagbhan T, Perez J, Korn CS, Chan LS. Use of heliox-driven nebulizer therapy in the treatment of acute asthma. *Ann Emerg Med* 1999;33(2):141-6.
568. Rodrigo GJ, Pollack CV, Rodrigo C, Rowe BH. Heliox for nonintubated acute asthma patients. *Cochrane Database of Systematic Reviews* 2006, Issue 4.
569. Rodrigo GJ, Rodrigo C, Pollack CV, Rowe B. Use of helium-oxygen mixtures in the treatment of acute asthma: a systematic review. *Chest* 2003;123(3):891-6.
570. Yen ZS, Chen SC. Best evidence topic report. Nebulised furosemide in acute adult asthma. *Emerg Med J* 2005;22(9):654-5.
571. Meduri GU, Cook TR, Turner RE, Cohen M, Leeper KV. Noninvasive positive pressure ventilation in status asthmaticus. *Chest* 1996;110(3):767-74.
572. Lim WJ, Mohammed Akram R, Carson KV, Mysore S, Labiszewski NA, Wedzicha JA, et al. Non-invasive positive pressure ventilation for treatment of respiratory failure due to severe acute exacerbations of asthma. *Cochrane Database of Systematic Reviews* 2012, Issue 12.
573. Lim KL, Harrison BD. A criterion based audit of inpatient asthma care. Closing the feedback loop. *J R Coll Physicians Lond* 1992;26(1):71-5.
574. Goldberg R, Chan L, Haley P, Harmata-Booth J, Bass G. Critical pathway for the emergency department management of acute asthma: effect on resource utilization. *Ann Emerg Med* 1998;31(5):562-7.
575. Udawadia ZF, Harrison BD. An attempt to determine the optimal duration of hospital stay following a severe attack of asthma. *J R Coll Physicians Lond* 1990;24(2):112-4.
576. Pearson MG, Ryland I, Harrison BD. National audit of acute severe asthma in adults admitted to hospital. Standards of Care Committee, British Thoracic Society. *Qual Health Care* 1995;4(1):24-30.
577. Emerman CL, Woodruff PG, Cydulka RK, Gibbs MA, Pollack CV Jr, Camargo CA Jr. Prospective multicenter study of relapse following treatment for acute asthma among adults presenting to the emergency department. MARC investigators. Multicenter Asthma Research Collaboration. *Chest* 1999;115(4):919-27.
578. Cowie RL, Revitt SG, Underwood MF, Field SK. The effect of a peak flow-based action plan in the prevention of exacerbations of asthma. *Chest* 1997;112(6):1534-8.
579. Nathan JA, Pearce L, Field C, Dotesio-Eyres N, Sharples LD, Cafferty F, et al. A randomized controlled trial of follow-up of patients discharged from the hospital following acute asthma: best performed by specialist nurse or doctor? *Chest* 2006;130(1):51-7.
580. Baren JM, Boudreaux ED, Brenner BE, Cydulka RK, Rowe BH, Clark S, et al. Randomized controlled trial of emergency department interventions to improve primary care follow-up for patients with acute asthma. *Chest* 2006;129(2):257-65.
581. Davies G, Paton JY, Beaton SJ, Young D, Lenney W. Children admitted with acute wheeze/asthma during November 1998-2005: a national UK audit. *Arch Dis Child* 2008 93(11):952-8.
582. Connett GJ, Lenney W. Use of pulse oximetry in the hospital management of acute asthma in childhood. *Pediatr Pulmonol* 1993;15(6):345-9.
583. Geelhoed GC, Landau LI, Le Souef PN. Evaluation of SaO<sub>2</sub> as a predictor of outcome in 280 children presenting with acute asthma. *Ann Emerg Med* 1994;23(6):1236-41.
584. Schuh S, Johnson D, Stephens D, Callahan S, Canny G. Hospitalization patterns in severe acute asthma in children. *Pediatr Pulmonol* 1997;23(3):184-92.
585. Wright RO, Santucci KA, Jay GD, Steele DW. Evaluation of pre- and posttreatment pulse oximetry in acute childhood asthma. *Acad Emerg Med* 1997;4(2):114-7.
586. Brooks LJ, Cloutier MM, Afshani E. Significance of roentgenographic abnormalities in children hospitalized for asthma. *Chest* 1982;82(3):315-8.

587. Gershel JC, Goldman HS, Stein RE, Shelov SP, Ziprkowski M. The usefulness of chest radiographs in first asthma attacks. *N Engl J Med* 1983;309(6):336-9.
588. Cunningham S, Logan C, Lockerbie L, Dunn MJ, McMurray A, Prescott RJ. Effect of an integrated care pathway on acute asthma/wheeze in children attending hospital: cluster randomized trial. *J Pediatr* 2008;152(3):315-20.
589. Schuh S, Parkin P, Rajan A, Canny G, Healy R, Rieder M, et al. High-versus low-dose, frequently administered, nebulized albuterol in children with severe, acute asthma. *Pediatrics* 1989;83(4):513-8.
590. Schuh S, Reider MJ, Canny G, Pender E, Forbes T, Tan YK, et al. Nebulized albuterol in acute childhood asthma: comparison of two doses. *Pediatrics* 1990;86(4):509-13.
591. Robertson CF, Smith F, Beck R, Levison H. Response to frequent low doses of nebulized salbutamol in acute asthma. *J Pediatr* 1985;106(4):672-4.
592. Schuh S, Johnson DW, Stephens D, Callahan S, Winders P, Canny GJ. Comparison of albuterol delivered by a metered dose inhaler with spacer versus a nebulizer in children with mild acute asthma. *J Pediatr* 1999;135(1):22-7.
593. Khine H, Fuchs SM, Saville AL. Continuous vs intermittent nebulized albuterol for emergency management of asthma. *Acad Emerg Med* 1996;3(11):1019-24.
594. Papo MC, Frank J, Thompson AE. A prospective, randomized study of continuous versus intermittent nebulized albuterol for severe status asthmaticus in children. *Crit Care Med* 1993;21(10):1479-86.
595. Plotnick LH, Ducharme FM. Combined inhaled anticholinergic agents and beta-2-agonists for initial treatment of acute asthma in children. *Cochrane Database of Systematic Reviews* 2000, Issue 2.
596. Altamimi S, Robertson G, Jastaniah W, Davey A, Dehghani N, Chen R, et al. Single-dose oral dexamethasone in the emergency management of children with exacerbations of mild to moderate asthma. *Pediatr Emerg Care* 2006;22(12):786-93.
597. Gordon S, Tompkins T, Dayan PS. Randomized trial of single-dose intramuscular dexamethasone compared with prednisolone for children with acute asthma. *Pediatr Emerg Care* 2007;23(8):521-7.
598. Greenberg RA, Kerby G, Roosevelt GE. A comparison of oral dexamethasone with oral prednisone in pediatric asthma exacerbations treated in the emergency department. *Clin Pediatr* 2008;47(8):817-23.
599. Becker JM, Arora A, Scarfone RJ, Spector ND, Fontana-Penn ME, Gracely E, et al. Oral versus intravenous corticosteroids in children hospitalized with asthma. *J Allergy Clin Immunol* 1999;103(4):586-90.
600. Barnett PL, Caputo GL, Baskin M, Kuppermann N. Intravenous versus oral corticosteroids in the management of acute asthma in children. *Ann Emerg Med* 1997;29(2):212-7.
601. Langton Hower S, Hobbs J, Reid F, Lenney W. Prednisolone in acute childhood asthma: clinical responses to three dosages. *Respir Med* 1998;92(3):541-6.
602. Panickar J, Lakhampaul M, Lambert PC, Kenia P, Stephenson T, Smyth A, et al. Oral prednisolone for preschool children with acute virus-induced wheezing. *N Engl J Med* 2009;360(4):329-38.
603. Edmonds ML, Brenner BE, Camargo CA, Rowe BH. Inhaled steroids in acute asthma following emergency department discharge. *Cochrane Database of Systematic Reviews* 2000, Issue 3.
604. McKean MC, Ducharme F. Inhaled steroids for episodic viral wheeze of childhood. *Cochrane Database of Systematic Reviews* 2000, Issue 1.
605. Schuh S, Reisman J, Alshehri M, Dupuis A, Corey M, Arseneault R, et al. A comparison of inhaled fluticasone and oral prednisone for children with severe acute asthma. *N Engl J Med* 2000;343(10):689-94.
606. Ducharme FM, Lemire C, Noya FJ, Davis GM, Alos N, Leblond H, et al. Preemptive use of high-dose fluticasone for virus-induced wheezing in young children. *N Engl J Med* 2009;360(4):339-53.
607. Papi A, Nicolini G, Boner AL, Baraldi E, Cutrera R, Fabbri LM, et al. Short term efficacy of nebulized beclomethasone in mild-to-moderate wheezing episodes in pre-school children. *Ital J Pediatr* 2011;37:39.
608. Schuh S, Dick PT, Stephens D, Hartley M, Khaikin S, Rodrigues L, et al. High-dose inhaled fluticasone does not replace oral prednisolone in children with mild to moderate acute asthma. *Pediatrics* 2006;118(2):644-50.
609. Upham BD, Mollen CJ, Scarfone RJ, Seiden J, Chew A, Zorc JJ. Nebulized budesonide added to standard pediatric emergency department treatment of acute asthma: a randomized, double-blind trial. *Acad Emerg Med* 2011;18(7):665-73.
610. Volovitz B, Bilavsky E, Nussinovitch M. Effectiveness of high repeated doses of inhaled budesonide or fluticasone in controlling acute asthma exacerbations in young children. *J Asthma* 2008;45(7):561-7.
611. Harmanci K, Bakirtas A, Turktas I, Degim T. Oral montelukast treatment of preschool-aged children with acute asthma. *Ann Allergy Asthma Immunol* 2006;96(5):731-5.
612. Powell C, Kolamunnage-Dona R, Lowe J, Boland A, Petrou S, Doull I, et al. Magnesium sulphate in acute severe asthma in children (MAGNETIC): a randomised, placebo-controlled trial. *Lancet* 2013;1(4):301-8.

613. Travers AH, Jones AP, Camargo CA, Milan SJ, Rowe BH. Intravenous beta2-agonists versus intravenous aminophylline for acute asthma. *Cochrane Database of Systematic Reviews* 2012, Issue 12.
614. Goodman DC, Littenberg B, O'Connor GT, Brooks JG. Theophylline in acute childhood asthma: a meta-analysis of its efficacy. *Pediatr Pulmonol* 1996;21(4):211-8.
615. Yung M, South M. Randomised controlled trial of aminophylline for severe acute asthma. *Arch Dis Child* 1998;79(5):405-10.
616. Ciarallo L, Brousseau D, Reinert S. Higher-dose intravenous magnesium therapy for children with moderate to severe acute asthma. *Arch Pediatr Adolesc Med* 2000;154(10):979-83.
617. Stormon MO, Mellis CM, Van Asperen PP, Kilham HA. Outcome evaluation of early discharge of asthmatic children from hospital: a randomized control trial. *J Qual Clin Pract* 1999;19(3):149-54.
618. Scottish Intercollegiate Guidelines Network (SIGN). Bronchiolitis in children. Edinburgh: SIGN; 2006. (SIGN publication no. 91). [cited 01 Jul 2014]. Available from url: <http://www.sign.ac.uk/guidelines/fulltext/91/index.html>
619. Rubilar L, Castro-Rodriguez JA, Girardi G. Randomized trial of salbutamol via metered-dose inhaler with spacer versus nebulizer for acute wheezing in children less than 2 years of age. *Pediatr Pulmonol* 2000;29(4):264-9.
620. Wildhaber JH, Devadason SG, Hayden MJ, Eber E, Summers QA, LeSouef PN. Aerosol delivery to wheezy infants: a comparison between a nebulizer and two small volume spacers. *Pediatr Pulmonol* 1997;23(3):212-6.
621. Daugbjerg P, Brenoe E, Forchhammer H, Frederiksen B, Glazowski MJ, Ibsen KK, et al. A comparison between nebulized terbutaline, nebulized corticosteroid and systemic corticosteroid for acute wheezing in children up to 18 months of age. *Acta Paediatr* 1993;82(6-7):547-51.
622. Bentur L, Canny GJ, Shields MD, Kerem E, Schuh S, Reisman JJ, et al. Controlled trial of nebulized albuterol in children younger than 2 years of age with acute asthma. *Pediatrics* 1992;89(1):133-7.
623. Prah P, Petersen NT, Hornsleth A. Beta 2-agonists for the treatment of wheezy bronchitis? *Ann Allergy* 1986;57(6):439-41.
624. Fox GF, Marsh MJ, Milner AD. Treatment of recurrent acute wheezing episodes in infancy with oral salbutamol and prednisolone. *Eur J Pediatr* 1996;155(6):512-6.
625. Tal A, Levy N, Bearman JE. Methylprednisolone therapy for acute asthma in infants and toddlers: a controlled clinical trial. *Pediatrics* 1990;86(3):350-6.
626. Everard M L, Bara A, Kurian M, Elliott T M, Ducharme F. Anti-cholinergic drugs for wheeze in children under the age of two years. *Cochrane Database of Systematic Reviews* 2002, Issue 1.
627. Chung KF, Godard P, Adelroth E, Ayres J, Barnes N, Barnes P, et al. Difficult/therapy-resistant asthma: The need for an integrated approach to define clinical phenotypes, evaluate risk factors, understand pathophysiology and find novel therapies. *Eur Respir J* 1999;13(5):1198-208.
628. Prys-Picard CO, Campbell SM, Ayres JG, Miles JF, Niven RM, Consensus on Difficult Asthma Consortium UK. Defining and investigating difficult asthma: developing quality indicators. *Respir Med* 2006;100(7):1254-61.
629. Bratton DL, Price M, Gavin L, Glenn K, Brenner M, Gelfand EW, et al. Impact of a multidisciplinary day program on disease and healthcare costs in children and adolescents with severe asthma: a two-year follow-up study. *Pediatr Pulmonol* 2001;31(3):177-89.
630. Robinson DS, Campbell DA, Durham SR, Pfeffer J, Barnes PJ, Chung KF, et al. Systematic assessment of difficult-to-treat asthma. *Eur Respir J* 2003;22(3):478-83.
631. Weinstein AG, McKee L, Stapleford J, Faust D. An economic evaluation of short-term inpatient rehabilitation for children with severe asthma. *J Allergy Clin Immunol* 1996;98(2):264-73.
632. Gamble J, Stevenson M, McClean E, Heaney LG. The prevalence of nonadherence in difficult asthma. *Am J Respir Crit Care Med* 2009;180(9):817-22.
633. Murphy AC, Proeschal A, Brightling CE, Wardlaw AJ, Pavord I, Bradding P, et al. The relationship between clinical outcomes and medication adherence in difficult-to-control asthma. *Thorax* 2012;67(8):751-3.
634. Bracken M, Fleming L, Hall P, Van Stiphout N, Bossley C, Biggart E, et al. The importance of nurse-led home visits in the assessment of children with problematic asthma. *Arch Dis Child* 2009;94(10):780-4.
635. Ranganathan SC, Payne DN, Jaffe A, McKenzie SA. Difficult asthma: defining the problems. *Pediatr Pulmonol* 2001;31(2):114-20.
636. Vamos M, Kolbe J. Psychological factors in severe chronic asthma. *Aust N Z J Psychiatry* 1999;33(4):538-44.
637. Vila G, Nollet-Clemencon C, de Blic J, Mouren-Simeoni MC, Scheinmann P. Asthma severity and psychopathology in a tertiary care department for children and adolescent. *Eur Child Adolesc Psychiatry* 1998;7(3):137-44.
638. Wainwright NW, Surtees PG, Wareham NJ, Harrison BD. Psychosocial factors and incident asthma hospital admissions in the EPIC-Norfolk cohort study. *Allergy* 2007;62(5):554-60.

639. Wamboldt MZ, Weintraub P, Krafchick D, Wamboldt FS. Psychiatric family history in adolescents with severe asthma. *J Am Acad Child Adolesc Psychiatry* 1996;35(8):1042-9.
640. Miles JF, Garden GM, Tunnicliffe WS, Cayton RM, Ayres JG. Psychological morbidity and coping skills in patients with brittle and non-brittle asthma: a case-control study. *Clin Exp Allergy* 1997;27(10):1151-9.
641. ten Brinke A, Ouwerkerk ME, Bel EH, Spinhoven P. Similar psychological characteristics in mild and severe asthma. *J Psychosom Res* 2001;50(1):7-10.
642. Wamboldt MZ, Fritz G, Mansell A, McQuaid EL, Klein RB. Relationship of asthma severity and psychological problems in children. *J Amer Acad Child Adolescent Psychiatr* 1998;37(9):943-50.
643. McQuaid EL, Kopel SJ, Nassau JH. Behavioral adjustment in children with asthma: A meta-analysis. *J Dev Behav Pediatr* 2001;22(6):430-9.
644. Brown ES, Vigil L, Khan DA, Liggin JD, Carmody TJ, Rush AJ. A randomized trial of citalopram versus placebo in outpatients with asthma and major depressive disorder: a proof of concept study. *Biol Psychiatry* 2005;58(11):865-70.
645. Godding V, Kruth M, Jamart J. Joint consultation for high-risk asthmatic children and their families, with pediatrician and child psychiatrist as co-therapists: model and evaluation. *Fam Process* 1997;36(3):265-80.
646. Smith JR, Mildenhall S, Noble MJ, Shepstone L, Koutantji M, Mugford M, et al. The Coping with Asthma Study: a randomised controlled trial of a home based, nurse led psychoeducational intervention for adults at risk of adverse asthma outcomes. *Thorax* 2005;60(12):1003-11.
647. Smith JR, Mugford M, Holland R, Candy B, Noble MJ, Harrison BD, et al. A systematic review to examine the impact of psycho-educational interventions on health outcomes and costs in adults and children with difficult asthma. *Health Technol Assess* 2005;9(23):iii-iv,1-167.
648. Position statement. Environmental allergen avoidance in allergic asthma. Ad Hoc Working Group on Environmental Allergens and Asthma. *J Allergy Clin Immunol* 1999;103(2 Pt 1):203-5.
649. O'Driscoll BR, Hopkinson LC, Denning DW. Mold sensitization is common amongst patients with severe asthma requiring multiple hospital admissions. *BMC Pulmon Med* 2005;5:4.
650. Zureik M, Neukirch C, Leynaert B, Liard R, Bousquet J, Neukirch F, et al. Sensitisation to airborne moulds and severity of asthma: cross sectional study from European Community respiratory health survey. *BMJ* 2002;325(7361):411-4.
651. Black PN, Udy AA, Brodie SM. Sensitivity to fungal allergens is a risk factor for life-threatening asthma. *Allergy* 2000;55(5):501-4.
652. O'Hollaren MT, Yunginger JW, Offord KP, Somers MJ, O'Connell EJ, Ballard DJ, et al. Exposure to an aeroallergen as a possible precipitating factor in respiratory arrest in young patients with asthma. *N Engl J Med* 1991;324(6):359-63.
653. Chlumsky J, Striz I, Terl M, Vondracek J. Strategy aimed at reduction of sputum eosinophils decreases exacerbation rate in patients with asthma. *J Int Med Res* 2006;34(2):129-39.
654. Fahy JV, Boushey HA, Lazarus SC, Mauger EA, Cherniack RM, Chinchilli VM, et al. Safety and reproducibility of sputum induction in asthmatic subjects in a multicenter study. *Am J Respir Crit Care Med*. 2001;163(6):1470-5.
655. Grootendorst DC, van den Bos JW, Romeijn JJ, Veselic-Charvat M, Duiverman EJ, Vrijlandt EJ, et al. Induced sputum in adolescents with severe stable asthma. Safety and the relationship of cell counts and eosinophil cationic protein to clinical severity. *Eur Respir J* 1999;13(3):647-53.
656. Loh LC, Kanabar V, D'Amato M, Barnes NC, O'Connor BJ. Sputum induction in corticosteroid-dependant asthmatics: risks and airway cellular profile. *Asian Pac J Allergy Immunol* 2005;23(4):189-96.
657. Tarodo de la Fuente P, Romagnoli M, Carlsson L, Godard P, Bousquet J, Chanez P. Eosinophilic inflammation assessed by induced sputum in corticosteroid-dependent asthma. *Respir Med* 1999;93(3):183-9.
658. English A, Park MJ, Shafer MA, Kreipe RE, D'Angelo LJ. Health care reform and adolescents-an agenda for the lifespan: a position paper of the Society for Adolescent Medicine. *J Adolesc Health* 2009;45(3):310-5.
659. Royal Australasian College of Physicians. National standards for the care of children and adolescents. Sydney; 2008. [cited 02 Jul 2014]. Available from url: <http://www.racp.edu.au/index.cfm?objectid=393E4ADA-CDAA-D1AF-0D543B5DC13C7B46>
660. Royal College of Paediatrics and Child Health. Bridging the gaps: health care for adolescents. London: Royal College of Paediatrics and Child Health; 2003. [cited 02 Jul 2014]. Available from url: <http://www.rcpsych.ac.uk/files/pdfversion/cr114.pdf>
661. Royal Australasian College of Physicians Joint Adolescent Health Committee. Confidential Health Care for Adolescents and Young People. 2010. [cited 11th April 2011]. Available from url: <http://www.racp.edu.au/index.cfm?objectid=655B70C1-A0F2-D4A4-6DB6505DCA1AB937>
662. Lai CK, Beasley R, Crane J, Foliaki S, Shah J, Weiland S, et al. Global variation in the prevalence and severity of asthma symptoms: phase three of the International Study of Asthma and Allergies in Childhood (ISAAC). *Thorax* 2009;64(6):476-83.

663. Siersted HC, Boldsen J, Hansen HS, Mostgaard G, Hyldebrandt N. Population based study of risk factors for underdiagnosis of asthma in adolescence: Odense schoolchild study. *BMJ* 1998;316(7132):651-5.
664. Yeatts KB, Shy CM. Prevalence and consequences of asthma and wheezing in African-American and white adolescents. *J Adolesc Health* 2001;29(5):314-9.
665. Yeatts K, Davis KJ, Sotir M, Herget C, Shy C. Who gets diagnosed with asthma? Frequent wheeze among adolescents with and without a diagnosis of asthma. *Pediatrics* 2003;111(5 Pt 1):1046-54.
666. Yeatts K, Johnston Davis K, Peden D, Shy C. Health consequences associated with frequent wheezing in adolescents without asthma diagnosis. *Eur Respir J* 2003;22(5):781-6.
667. Yeatts K, Shy C, Sotir M, Music S, Herget C. Health consequences for children with undiagnosed asthma-like symptoms. *Arch Pediatr Adolesc Med* 2003;157(6):540-4.
668. Abramson JM, Wollan P, Kurland M, Yawn BP. Feasibility of school-based spirometry screening for asthma. *J Sch Health* 2003;73(4):150-3.
669. Yawn BP. Asthma screening, case identification and treatment in school-based programs. *Curr Opin Pulm Med* 2006;12(1):23-7.
670. Henriksen AH, Tveit KH, Holmen TL, Sue-Chu M, Bjermer L. A study of the association between exercise-induced wheeze and exercise versus methacholine-induced bronchoconstriction in adolescents. *Pediatr Allergy Immunol* 2002;13(3):203-8.
671. Seear M, Wensley D, West N. How accurate is the diagnosis of exercise induced asthma among Vancouver schoolchildren? *Arch Dis Child* 2005;90(9):898-902.
672. Mallo J, Castro-Rodriguez JA. Differences in prevalence of asthma, rhinitis, and eczema between parental and self-completed questionnaires in adolescents. *Pediatr Pulmonol* 2006;41(5):482-7.
673. Raat H, Mangunkusumo RT, Mohangoo AD, Juniper EF, Van Der Lei J. Internet and written respiratory questionnaires yield equivalent results for adolescents. *Pediatr Pulmonol* 2007;42(4):357-61.
674. Juniper EF, Svensson K, Mork AC, Stahl E. Modification of the asthma quality of life questionnaire (standardised) for patients 12 years and older. *Health Qual Life Outcomes* 2005;3:58.
675. Burkhardt PV, Svavarsdottir EK, Rayens MK, Oakley MG, Orlygsdottir B. Adolescents with asthma: predictors of quality of life. *J Adv Nurs* 2009;65(4):860-6.
676. Obase Y, Shimoda T, Kawano T, Saeki S, Tomari S, Izaki K, et al. Bronchial hyperresponsiveness and airway inflammation in adolescents with asymptomatic childhood asthma. *Allergy* 2003;58(3):213-20.
677. Rodriguez MA, Winkleby MA, Ahn D, Sundquist J, Kraemer HC. Identification of population subgroups of children and adolescents with high asthma prevalence: findings from the Third National Health and Nutrition Examination Survey. *Arch Pediatr Adolesc Med* 2002;156(3):269-75.
678. Duse M, Donato F, Porteri V, Piralì F, Spinoni V, Tosoni C, et al. High prevalence of atopy, but not of asthma, among children in an industrialized area in North Italy: the role of familial and environmental factors—a population-based study. *Pediatr Allergy Immunol* 2007;18(3):201-8.
679. Del-Rio-Navarro B, Berber A, Blandon-Vijil V, Ramirez-Aguilar M, Romieu I, Ramirez-Chanona N, et al. Identification of asthma risk factors in Mexico City in an International Study of Asthma and Allergy in Childhood survey. *Allergy Asthma Proc* 2006;27(4):325-33.
680. Hyvarinen MK, Kotaniemi-Syrjanen A, Reijonen TM, Korhonen K, Korppi MO. Teenage asthma after severe early childhood wheezing: an 11-year prospective follow-up. *Pediatr Pulmonol* 2005;40(4):316-23.
681. Anand D, Stevenson CJ, West CR, Pharoah PO. Lung function and respiratory health in adolescents of very low birth weight. *Arch Dis Child* 2003;88(2):135-8.
682. Fagan JK, Scheff PA, Hryhorczuk D, Ramakrishnan V, Ross M, Persky V. Prevalence of asthma and other allergic diseases in an adolescent population: association with gender and race. *Ann Allergy Asthma Immunol* 2001;86(2):177-84.
683. Debley JS, Redding GJ, Critchlow CW. Impact of adolescence and gender on asthma hospitalization: a population-based birth cohort study. *Pediatr Pulmonol* 2004;38(6):443-50.
684. Nicolai T, Pereszlenyiova-Bliznakova L, Illi S, Reinhardt D, von Mutius E. Longitudinal follow-up of the changing gender ratio in asthma from childhood to adulthood: role of delayed manifestation in girls. *Pediatr Allergy Immunol* 2003;14(4):280-3.
685. Bernard A, Nickmilder M, Voisin C. Outdoor swimming pools and the risks of asthma and allergies during adolescence. *Eur Respir J* 2008;32(4):979-88.
686. Bernard A, Carbonnelle S, de Burbure C, Michel O, Nickmilder M. Chlorinated pool attendance, atopy, and the risk of asthma during childhood. *Environ Health Perspect* 2006;114(10):1567-73.
687. Goodwin RD, Fergusson DM, Horwood LJ. Asthma and depressive and anxiety disorders among young persons in the community. *Psychol Med* 2004;34(8):1465-74.
688. Richardson LP, Lozano P, Russo J, McCauley E, Bush T, Katon W. Asthma symptom burden: relationship to asthma severity and anxiety and depression symptoms. *Pediatrics* 2006;118(3):1042-51.

689. Hommel KA, Chaney JM, Wagner JL, McLaughlin MS. Asthma-specific quality of life in older adolescents and young adults with long-standing asthma: the role of anxiety and depression. *J Clin Psychol Med Settings* 2002;9(3):185-92.
690. Powell C, Brazier A. Psychological approaches to the management of respiratory symptoms in children and adolescents. *Paediatr Respir Rev* 2004;5(3):214-24.
691. Katon W, Russo J, Richardson L, McCauley E, Lozano P. Anxiety and depression screening for youth in a primary care population. *Ambul Pediatr* 2008;8(3):182-8.
692. Brenner JS, Kelly CS, Wenger AD, Brich SM, Morrow AL. Asthma and obesity in adolescents: is there an association? *J Asthma* 2001;38(6):509-15.
693. Mai XM, Nilsson L, Axelson O, Braback L, Sandin A, Kjellman NI, et al. High body mass index, asthma and allergy in Swedish schoolchildren participating in the International Study of Asthma and Allergies in Childhood: Phase II. *Acta Paediatr* 2003;92(10):1144-8.
694. Gilliland FD, Berhane K, Islam T, McConnell R, Gauderman WJ, Gilliland SS, et al. Obesity and the risk of newly diagnosed asthma in school-age children. *Am J Epidemiol* 2003;158(5):406-15.
695. Debley JS, Carter ER, Redding GJ. Prevalence and impact of gastroesophageal reflux in adolescents with asthma: a population-based study. *Pediatr Pulmonol* 2006;41(5):475-81.
696. Thakkar K, Boatright RO, Gilger MA, El-Serag HB. Gastroesophageal reflux and asthma in children: a systematic review. *Pediatrics* 2010;125(4):e925-30.
697. Rasmussen F, Taylor DR, Flannery EM, Cowan JO, Greene JM, Herbison GP, et al. Outcome in adulthood of asymptomatic airway hyperresponsiveness in childhood: a longitudinal population study. *Pediatr Pulmonol* 2002;34(3):164-71.
698. Orbon KH, van der Gulden JW, Schermer TR, van den Nieuwenhof L, Boot CR, van den Hoogen H, et al. Vocational and working career of asthmatic adolescents is only slightly affected. *Respir Med* 2006;100(7):1163-73.
699. Gerald LB, Gerald JK, Gibson L, Patel K, Zhang S, McClure LA. Changes in environmental tobacco smoke exposure and asthma morbidity among urban school children. *Chest* 2009;135(4):911-6.
700. Precht DH, Keiding L, Madsen M. Smoking patterns among adolescents with asthma attending upper secondary schools: a community-based study. *Pediatrics*. 2003;111(5 Pt 1):e562-8.
701. Annesi-Maesano I, Oryszczyn MP, Raheison C, Kopferschmitt C, Pauli G, Taytard A, et al. Increased prevalence of asthma and allied diseases among active adolescent tobacco smokers after controlling for passive smoking exposure. A cause for concern? *Clin Exp Allergy* 2004;34(7):1017-23.
702. Genuneit J, Weinmayr G, Radon K, Dressel H, Windstetter D, Rzehak P, et al. Smoking and the incidence of asthma during adolescence: results of a large cohort study in Germany. *Thorax* 2006;61(7):572-8.
703. Larsson L. Incidence of asthma in Swedish teenagers: relation to sex and smoking habits. *Thorax* 1995;50(3):260-4.
704. Hedman L, Bjerg A, Sundberg S, Forsberg B, Ronmark E. Both environmental tobacco smoke and personal smoking is related to asthma and wheeze in teenagers. *Thorax* 2011;66(1):20-5.
705. Lombardi C, Gani F, Landi M, Boner A, Canonica GW, Passalacqua G. Clinical and therapeutic aspects of allergic asthma in adolescents. *Pediatr Allergy Immunol* 2003;14(6):453-7.
706. Reznik M, Ozuah PO, Franco K, Cohen R, Motlow F. Use of complementary therapy by adolescents with asthma. *Arch Pediatr Adolesc Med* 2002;156(10):1042-4.
707. Juntunen-Backman K, Kajosaari M, Laurikainen K, Malinen A, Kaila M, Mustala L, et al. Comparison of Easyhaler(R) metered-dose, dry powder Inhaler and a pressurised metered-dose inhaler plus spacer in the treatment of asthma in children. *Clin Drug Invest* 2002;22(12):827-35.
708. Adler LM, Anand C, Wright FG deL, Barret CF, McKeith D, Clark WI, et al. Efficacy and tolerability of beclomethasone dipropionate delivered by a novel multidose dry powder inhaler (Clickhaler®) versus a metered-dose inhaler in children with asthma. *Curr Ther Res* 2001;62(11):758-69.
709. Brennan VK, Osman LM, Graham H, Critchlow A, Everard ML. True device compliance: the need to consider both competence and contrivance. *Respir Med* 2005;99(1):97-102.
710. Edgecombe K, Latter S, Peters S, Roberts G. Health experiences of adolescents with uncontrolled severe asthma. *Arch Dis Child* 2010;95(12):985-91.
711. Salisbury C, Francis C, Rogers C, Parry K, Thomas H, Chadwick S, et al. A randomised controlled trial of clinics in secondary schools for adolescents with asthma. *Br J Gen Pract* 2002;52(485):988-96.
712. Shah S, Peat JK, Mazurski EJ, Wang H, Sindhusake D, Bruce C, et al. Effect of peer led programme for asthma education in adolescents: cluster randomised controlled trial. *BMJ* 2001;322(7286):583-5.
713. Henry RL, Lough S, Mellis C. National policy on asthma management for schools. *J Paediatr Child Health* 2006;42(9):491-5.
714. Royal College of Physicians of Edinburgh Steering Group. Think Transition: developing the essential link between paediatric and adult care. Edinburgh: Royal College of Physicians of Edinburgh; 2008. [cited 09 Jul 2014]. Available from url: <http://www.cen.scot.nhs.uk/files/16o-think-transition-edinburgh.pdf>

715. Scal P, Davern M, Ireland M, Park K. Transition to adulthood: delays and unmet needs among adolescents and young adults with asthma. *J Pediatr* 2008;152:471-5.
716. Sawyer S, Drew S, Duncan R. Adolescents with chronic disease--the double whammy. *Aust Fam Physician* 2007;36(8):622-7.
717. Cordina M, Hughes CM, McElnay JC. Health-related issues of importance to school children with asthma - a qualitative study. *J Soc Adm Pharm* 2002;19(5):162-70.
718. Cohen R, Franco K, Motlow F, Reznik M, Ozuah PO. Perceptions and attitudes of adolescents with asthma. *J Asthma* 2003;40(2):207-11.
719. Kyngas H. Patient education: perspective of adolescents with a chronic disease. *J Clin Nurs* 2003;12(5):744-51.
720. Bender BG, Rankin A, Tran ZV, Wamboldt FS. Brief-interval telephone surveys of medication adherence and asthma symptoms in the Childhood Asthma Management Program Continuation Study. *Ann Allergy Asthma Immunol* 2008;101(4):382-6.
721. Buston KM, Wood SF. Non-compliance amongst adolescents with asthma: listening to what they tell us about self-management. *Fam Pract* 2000;17(2):134-8.
722. Kyngas HA. Compliance of adolescents with asthma. *Nurs Health Sci* 1999;1(3):195-202.
723. Bender BG. Risk taking, depression, adherence, and symptom control in adolescents and young adults with asthma. *Am J Respir Crit Care Med* 2006;173(9):953-7.
724. Sawyer S, Bowes G. Caring for adolescents with asthma: do we know how to? *Med J Aust* 1996;165(9):463-4.
725. Goldenring JM, Cohen E. Getting into adolescent heads. *Contemp Pediatr* 1988;5(7):75-90.
726. Kyngas HA, Kroll T, Duffy ME. Compliance in adolescents with chronic diseases: a review. *J Adolesc Health* 2000;26(6):379-88.
727. Gerald LB, McClure LA, Mangan JM, Harrington KF, Gibson L, Erwin S, et al. Increasing adherence to inhaled steroid therapy among schoolchildren: randomized, controlled trial of school-based supervised asthma therapy. *Pediatrics* 2009;123(2):466-74.
728. Schatz M, Harden K, Forsythe A, Chilingar L, Hoffman C, Sperling W, et al. The course of asthma during pregnancy, post partum, and with successive pregnancies: a prospective analysis. *J Allergy Clin Immunol* 1988;81(3):509-17.
729. Dombrowski MP, Schatz M, Wise R, Momirova V, Landon M, Mabie W, et al. Asthma during pregnancy. *Obstet Gynecol* 2004;103(1):5-12.
730. Juniper E F, Newhouse M T. Effect of pregnancy on asthma: a systematic review and meta-analysis. In: Schatz M, Zeiger RS, Claman HN, editors. *Asthma and immunological diseases in pregnancy and early infancy*. New York: Marcel Dekker; 1998. p.401-25.
731. Gluck JC, Gluck PA. The effect of pregnancy on the course of asthma. *Immunol Allergy Clin North Am* 2006;26(1):63-80.
732. Kwon HL, Belanger K, Bracken MB. Effect of pregnancy and stage of pregnancy on asthma severity: a systematic review. *Am J Obstet Gynecol* 2004;190(5):1201-10.
733. Schatz M, Zeiger RS, Hoffman CP, Harden K, Forsythe A, Chilingar L, et al. Perinatal outcomes in the pregnancies of asthmatic women: a prospective controlled analysis. *Am J Respir Crit Care Med* 1995;151(4):1170-4.
734. Wendel PJ, Ramin SM, Barnett-Hamm C, Rowe TF, Cunningham FG. Asthma treatment in pregnancy: a randomized controlled study. *Am J Obstet Gynecol* 1996;175(1):150-4.
735. Stenius-Aarniala BS, Hedman J, Teramo KA. Acute asthma during pregnancy. *Thorax* 1996;51(4):411-4.
736. Schatz M. Interrelationships between asthma and pregnancy: a literature review. *J Allergy Clin Immunol* 1999;103(2 Pt 2):S330-6.
737. Stenius-Aarniala B, Piirila P, Teramo K. Asthma and pregnancy: a prospective study of 198 pregnancies. *Thorax* 1988;43(1):12-8.
738. Fitzsimons R, Greenberger PA, Patterson R. Outcome of pregnancy in women requiring corticosteroids for severe asthma. *J Allergy Clin Immunol* 1986;78(2):349-53.
739. Perlow JH, Montgomery D, Morgan MA, Towers CV, Porto M. Severity of asthma and perinatal outcome. *Am J Obstet Gynecol* 1992;167(4 Pt 1):963-7.
740. Schatz M, Zeiger RS, Hoffman CP. Intrauterine growth is related to gestational pulmonary function in pregnant asthmatic women. Kaiser-Permanente Asthma and Pregnancy Study Group. *Chest* 1990;98(2):389-92.
741. Demissie K, Breckenridge MB, Rhoads GG. Infant and maternal outcomes in the pregnancies of asthmatic women. *Am J Respir Crit Care Med* 1998;158(4):1091-5.
742. Kallen B, Rydhstroem H, Aberg A. Asthma during pregnancy--a population based study. *Eur J Epidemiol* 2000;16(2):167-71.
743. Bracken MB, Triche EW, Belanger K, Saftlas A, Beckett WS, Leaderer BP. Asthma symptoms, severity, and drug therapy: a prospective study of effects on 2205 pregnancies. *Obstet Gynecol* 2003;102(4):739-52.



744. Murphy VE, Clifton VL, Gibson PG. Asthma exacerbations during pregnancy: incidence and association with adverse pregnancy outcomes. *Thorax* 2006;61(2):169-76.
745. Schatz M, Dombrowski MP, Wise R, Momirova V, Landon M, Mabie W, et al. Spirometry is related to perinatal outcomes in pregnant women with asthma. *Am J Obstet Gynecol* 2006;194(1):120-6.
746. Cydulka RK, Emerman CL, Schreiber D, Molander KH, Woodruff PG, Camargo CA Jr. Acute asthma among pregnant women presenting to the emergency department. *Am J Respir Crit Care Med* 1999;160(3):887-92.
747. Department of Health. Why mothers die: report on confidential enquiries into maternal deaths in the United Kingdom 1994-1996. London: Stationery Office; 1998.
748. Lewis G, Drife J. Why mothers die, 1997-1999. The fifth report of the Confidential Enquiries into Maternal Deaths in the United Kingdom London: RCOG Press; 2001.
749. Lewis G, editor. The Confidential Enquiry into Maternal and Child Health (CEMACH). Why mothers die: the sixth report of the confidential enquiries into maternal deaths in the UK. London: RCOG Press; 2004.
750. Lewis G, editor. The Confidential Enquiry into Maternal and Child Health (CEMACH). Saving mothers' lives: reviewing maternal deaths to make motherhood safer 2003-2005. The seventh report on confidential enquiries into maternal deaths in the UK. London: CEMACH; 2007.
751. Cantwell R, Clutton-Brock T, Cooper G, Dawson A, Drife J, Garrod D, et al. Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer: 2006-2008. The Eighth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom. *BJOG* 2011;118 Suppl 1:1-203.
752. Intensive Care National Audit and Research Centre. Female admissions (aged 16-50 years) to adult, general critical care units in England, Wales and Northern Ireland reported as 'currently pregnant' or 'recently pregnant'. London: ICNARC; 2013. [cited 09 Jul 2014]. Available from url: [http://www.oaa-anaes.ac.uk/assets/\\_managed/cms/files/Obstetric%20admissions%20to%20critical%20care%202009-2012%20-%20FINAL.pdf](http://www.oaa-anaes.ac.uk/assets/_managed/cms/files/Obstetric%20admissions%20to%20critical%20care%202009-2012%20-%20FINAL.pdf)
753. Campbell LA, Klocke RA. Implications for the pregnant patient. *Am J Respir Crit Care Med* 2001;163(5):1051-4.
754. Templeton A, Kelman GR. Maternal blood-gases, (PAo<sub>2</sub>--Pao<sub>2</sub>), physiological shunt and VD/VT in normal pregnancy. *Br J Anaesth* 1976;48(10):1001-4.
755. Van Hook J, Harvey CJ, Anderson GD. Effect of pregnancy on maternal oxygen saturation values: use of reflectance pulse oximetry during pregnancy. *South Med J* 1996;89(12):1188-92.
756. Altman D, Carroli G, Duley L, Farrell B, Moodley J, Neilson J, et al. Do women with pre-eclampsia, and their babies, benefit from magnesium sulphate? The magpie trial: a randomised placebo-controlled trial. *Lancet* 2002;359(9321):1877-90.
757. Gee J, Packer B, Millen J, Robin E. Pulmonary mechanics during pregnancy. *J Clin Invest*. 1967;46(6):945-52.
758. Izci B, Riha R, Martin S, Vennelle M, Liston W, Dundas K, et al. The upper airway in pregnancy and pre-eclampsia. *Am J Respir Crit Care Med* 2003;167(2):137-40.
759. Schatz M, Zeiger RS, Harden K, Hoffman CC, Chilingar L, Petitti D. The safety of asthma and allergy medications during pregnancy. *J Allergy Clin Immunol* 1997;100(3):301-6.
760. Chambers C. Safety of asthma and allergy medications in pregnancy. *Immunol Allergy Clin North Am* 2006;26(1):13-28.
761. Tata LJ, Lewis SA, McKeever TM, Smith CJP, Doyle P, Smeeth L, et al. Effect of maternal asthma, exacerbations and asthma medication use on congenital malformations in offspring: A UK population-based study. *Thorax* 2008;63(11):981-7.
762. Rayburn WF, Atkinson BD, Gilbert K, Turnbull GL. Short-term effects of inhaled albuterol on maternal and fetal circulations. *Am J Obstet Gynecol* 1994;171(3):770-3.
763. Schatz M, Dombrowski M, Wise R, Momirova V, Landon M, Mabie W, et al. The relationship of asthma medication use to perinatal outcomes. *J Allergy Clin Immunol* 2004 113(6):1040-5.
764. Schatz M, Zeiger RS, Harden KM, Hoffman CP, Forsythe AB, Chilingar LM, et al. The safety of inhaled beta-agonist bronchodilators during pregnancy. *J Allergy Clin Immunol* 1988;82(4):686-95.
765. Mann RD, Kubota K, Pearce G, Wilton L. Salmeterol: a study by prescription-event monitoring in a UK cohort of 15,407 patients. *J Clin Epidemiol* 1996;49(2):247-50.
766. Wilton L, Shakir SA. A post-marketing surveillance study of formoterol (Foradil): its use in general practice in England. *Drug Saf* 2002;25(3):213-23.
767. Gluck JC, Gluck PA. Asthma controller therapy during pregnancy. *Am J Obstet Gynecol* 2005;192(2):369-80.
768. Nelson H, Weiss S, Bleecker E, Yancey S, Dorinsky P. The salmeterol multicenter asthma research trial (SMART Study Group): a comparison of usual pharmacotherapy for asthma or usual pharmacotherapy plus salmeterol. *Chest* 2006;129(1):15-26.
769. Perrio M, Wilton L, Shakir S. A modified prescription-event monitoring study to assess the introduction of Seretide Evohaler in England: an example of studying risk monitoring in pharmacovigilance. *Drug Saf* 2007;30(8):681-95.

770. Greenberger PA, Patterson R. Beclomethasone dipropionate for severe asthma during pregnancy. *Ann Intern Med* 1983;98(4):478-80.
771. Dombrowski M, Thom E, McNellis D. Maternal-Fetal Medicine Units (MFMU) studies of inhaled corticosteroids during pregnancy. *J Allergy Clin Immunol* 1999;103(2 Pt 2):S356-9.
772. Dombrowski MP, Brown CL, Berry SM. Preliminary experience with triamcinolone acetonide during pregnancy. *J Matern Fetal Med* 1996;5(6):310-3.
773. Kallen B, Rydhstroem H, Aberg A. Congenital malformations after the use of inhaled budesonide in early pregnancy. *Obstet Gynecol* 1999;93(3):392-5.
774. Silverman M, Sheffer A, Diaz PV, Lindmark B, Radner F, Broddene M, et al. Outcome of pregnancy in a randomized controlled study of patients with asthma exposed to budesonide. *Ann Allergy Asthma Immunol* 2005;95(6):566-70.
775. Christensson C, Thoren A, Lindberg B. Safety of inhaled budesonide: clinical manifestations of systemic corticosteroid-related adverse effects. *Drug Saf* 2008;31(11):965-88.
776. Lim A, Stewart K, Konig K, George J. Systematic review of the safety of regular preventive asthma medications during pregnancy. *Ann Pharmacother* 2011;45(7-8):931-45.
777. Breton MC, Beauchesne MF, Lemire C, Rey E, Forget A, Blais L. Risk of perinatal mortality associated with inhaled corticosteroid use for the treatment of asthma during pregnancy. *J Allergy Clin Immunol* 2010;126(4):772-7.e2.
778. Lin S, Munsie JPW, Herdt-Losavio ML, Druschel CM, Campbell K, Browne ML, et al. Maternal asthma medication use and the risk of selected birth defects. *Pediatrics* 2012;129(2):e317-24.
779. Rahimi R, Nikfar S, Abdollahi M. Meta-analysis finds use of inhaled corticosteroids during pregnancy safe: a systematic meta-analysis review. *Hum Exp Toxicol* 2006;25(8):447-52.
780. Stenius-Aarniala B, Riikonen S, Teramo K. Slow-release theophylline in pregnant asthmatics. *Chest* 1995;107(3):642-7.
781. Schatz M. Asthma during pregnancy: interrelationships and management. *Ann Allergy* 1992;68(2):123-33.
782. Czeizel AE, Rockenbauer M. Population-based case-control study of teratogenic potential of corticosteroids. *Teratology* 1997;56(5):335-40.
783. Källén B. Maternal drug use and infant cleft lip/palate with special reference to corticoids. *Cleft Palate Craniofac J* 2003;40(6):624-8.
784. Rodriguez-Pinilla E, Martinez-Frias ML. Corticosteroids during pregnancy and oral clefts: a case-control study. *Teratology* 1998;58(1):2-5.
785. Park-Wyllie L, Mazzotta P, Pastuszak A, Moretti ME, Beique L, Hunnisett L, et al. Birth defects after maternal exposure to corticosteroids: prospective cohort study and meta-analysis of epidemiological studies. *Teratology* 2000;62(6):385-92.
786. Carmichael SL, Shaw GM, Ma C, Werler MM, Rasmussen SA, Lammer EJ. Maternal corticosteroid use and orofacial clefts. *Am J Obstet Gynecol* 2007;197(6):585 e1-7.
787. Bakhireva LN, Schatz M, Chambers CD. Effect of maternal asthma and gestational asthma therapy on fetal growth. *J Asthma* 2007;44(2):71-6.
788. Bakhireva LN, Jones KL, Schatz M, Klonoff-Cohen HS, Johnson D, Slymen DJ, et al. Safety of leukotriene receptor antagonists in pregnancy. *J Allergy Clin Immunol* 2007;119(3):618-25.
789. Nelsen LM, Shields KE, Cunningham ML, Stoler JM, Bamshad MJ, Eng PM, et al. Congenital malformations among infants born to women receiving montelukast, inhaled corticosteroids, and other asthma medications. *J Allergy Clin Immunol* 2012;129(1):251-4.e1-6.
790. Sarkar M, Koren G, Kalra S, Ying A, Smorlesi C, De Santis M, et al. Montelukast use during pregnancy: a multicentre, prospective, comparative study of infant outcomes. *Eur J Clin Pharmacol* 2009;65(12):1259-64.
791. Mabie W C, Barton J R, Wasserstrum N, Sibai B M. Clinical observations on asthma in pregnancy. *J Matern Fetal Med* 1992;1(1):45-50.
792. Lao TT, Huengsborg M. Labour and delivery in mothers with asthma. *Eur J Obstet Gynecol Reprod Biol* 1990;35(2-3):183-90.
793. Arad I, Landau H. Adrenocortical reserve of neonates born of long-term, steroid-treated mothers. *Eur J Pediatr* 1984;142(4):279-80.
794. Turner ES, Greenberger PA, Patterson R. Management of the pregnant asthmatic patient. *Ann Intern Med* 1980;93(6):905-18.
795. Ost L, Wettrell G, Bjorkhem I, Rane A. Prednisolone excretion in human milk. *J Pediatr* 1985;106(6):1008-11.
796. McKenzie SA, Selley JA, Agnew JE. Secretion of prednisolone into breast milk. *Arch Dis Child* 1975;50(11):894-6.
797. Greenberger PA, Odeh YK, Frederiksen MC, Atkinson AJ Jr. Pharmacokinetics of prednisolone transfer to breast milk. *Clin Pharmacol Ther* 1993;53(3):324-8.
798. Meredith S, Nordman H. Occupational asthma: measures of frequency from four countries. *Thorax* 1996;51(4):435-40.
799. Blanc PD, Toren K. How much adult asthma can be attributed to occupational factors? *Am J Med* 1999;107(6):580-7.

800. Balmes J, Becklake M, Blanc P, Henneberger P, Kreiss K, Mapp C, et al. American Thoracic Society Statement: Occupational contribution to the burden of airway disease. *Am J Respir Crit Care Med* 2003;167(5):787-97.
801. Ross DJ. Ten years of the SWORD project. Surveillance of Work-related and Occupational Respiratory Disease. *Clin Exp Allergy* 1999;29(6):750-3.
802. Hendrick DJ, Burge PS. Asthma. In: Hendrick DJ, Beckett W, Burge PS, Chung A, editors. Occupational disorders of the lung. Recognition, management and prevention. London: WB Saunders; 2002. p.33-76.
803. Banks DE, Wang ML. Occupational asthma: "the big picture". *Occup Med* 2000;15(2):335-58.
804. Ameille J, Pauli G, Calastreng-Crinquand A, Vervloet D, Iwatsubo Y, Popin E, et al. Reported incidence of occupational asthma in France, 1996-99: the ONAP programme. *Occup Environ Med* 2003;60(2):136-41.
805. Brhel P. Occupational respiratory diseases in the Czech Republic. *Ind Health* 2003;41(2):121-3.
806. Cortona G, Pisati G, Dellabianca A, Moscato G. Respiratory occupational allergies: the experience of the Hospital Operative Unit of Occupational Medicine in Lombardy from 1990 to 1998 [Italian]. *G Ital Med Lav Ergon* 2001;23(1):64-70.
807. Gannon PF, Burge PS. The SHIELD scheme in the West Midlands Region, United Kingdom. Midlands Thoracic Society Research Group. *Br J Ind Med* 1993;50(9):791-6.
808. Hnizdo E, Esterhuizen TM, Rees D, Laloo UG. Occupational asthma as identified by the Surveillance of Work-related and Occupational Respiratory Diseases programme in South Africa. *Clin Exp Allergy* 2001;31(1):32-9.
809. McDonald JC, Keynes HL, Meredith SK. Reported incidence of occupational asthma in the United Kingdom, 1989-97. *Occup Environ Med* 2000;57(12):823-9.
810. Meyer JD, Holt DL, Cherry NM, McDonald JC. SWORD '98: surveillance of work-related and occupational respiratory disease in the UK. *Occup Med (Lond)* 1999;49(8):485-9.
811. Sallie BA, Ross DJ, Meredith SK, McDonald JC. SWORD '93. Surveillance of work-related and occupational respiratory disease in the UK. *Occup Med (Lond)* 1994;44(4):177-82.
812. Toren K, Jarvholm B, Brisman J, Hagberg S, Hermansson BA, Lillienberg L. Adult-onset asthma and occupational exposures. *Scand J Work Environ Health* 1999;25(5):430-5.
813. Meredith SK, Taylor VM, McDonald JC. Occupational respiratory disease in the United Kingdom 1989: a report to the British Thoracic Society and the Society of Occupational Medicine by the SWORD project group. *Br J Ind Med* 1991;48(5):292-8.
814. Karjalainen A, Kurppa K, Martikainen R, Karjalainen J, Klaukka T. Exploration of asthma risk by occupation-extended analysis of an incidence study of the Finnish population. *Scand J Work Environ Health* 2002;28(1):49-57.
815. Reijula K, Haahtela T, Klaukka T, Rantanen J. Incidence of occupational asthma and persistent asthma in young adults has increased in Finland. *Chest* 1996;110(1):58-61.
816. Jaakkola JJ, Piipari R, Jaakkola MS. Occupation and asthma: a population-based incident case-control study. *Am J Epidemiol* 2003;158(10):981-7.
817. Johnson AR, Dimich-Ward HD, Manfreda J, Becklake MR, Ernst P, Sears MR, et al. Occupational asthma in adults in six Canadian communities. *Am J Respir Crit Care Med* 2000;162(6):2058-62.
818. Kogevinas M, Anto JM, Soriano JB, Tobias A, Burney P. The risk of asthma attributable to occupational exposures. A population-based study in Spain. Spanish Group of the European Asthma Study. *Am J Respir Crit Care Med* 1996;154(1):137-43.
819. Kogevinas M, Anto JM, Sunyer J, Tobias A, Kromhout H, Burney P. Occupational asthma in Europe and other industrialised areas: a population-based study. European Community Respiratory Health Survey Study Group. *Lancet* 1999;353(9166):1750-4.
820. Nicholson P J, Cullinan P, Burge P S, Boyle C. Occupational asthma: Prevention, identification & management: Systematic review & recommendations. London: British Occupational Health Research Foundation; 2010. [cited 08 Jul 2014]. Available from url: <http://www.bohrf.org.uk/projects/asthma.html>
821. Chiry S, Boulet L-P, Lepage J, Forget A, Begin D, Chaboillez S, et al. Frequency of work-related respiratory symptoms in workers without asthma. *Am J Ind Med* 2009;52(6):447-54.
822. Burge PS, Pantin CF, Newton DT, Gannon PF, Bright P, Belcher J, et al. Development of an expert system for the interpretation of serial peak expiratory flow measurements in the diagnosis of occupational asthma. Midlands Thoracic Society Research Group. *Occup Environ Med* 1999;56(11):758-64.
823. Bright P, Newton DT, Gannon PF, Pantin CF, Burge PS. OASYS-3: improved analysis of serial peak expiratory flow in suspected occupational asthma. *Monaldi Arch Chest Dis* 2001;56(3):281-8.
824. Burge PS. Occupational asthma in electronics workers caused by colophony fumes: follow-up of affected workers. *Thorax* 1982;37(5):348-53.
825. Cote J, Kennedy S, Chan-Yeung M. Sensitivity and specificity of PC20 and peak expiratory flow rate in cedar asthma. *J Allergy Clin Immunol* 1990;85(3):592-8.

826. Leroyer C, Perfetti L, Trudeau C, L'Archeveque J, Chan-Yeung M, Malo JL. Comparison of serial monitoring of peak expiratory flow and FEV1 in the diagnosis of occupational asthma. *Am J Respir Crit Care Med* 1998;158(3):827-32.
827. Liss GM, Tarlo SM. Peak expiratory flow rates in possible occupational asthma. *Chest* 1991;100(1):63-9.
828. Malo JL, Cote J, Cartier A, Boulet LP, L'Archeveque J, Chan-Yeung M. How many times per day should peak expiratory flow rates be assessed when investigating occupational asthma? *Thorax* 1993;48(12):1211-7.
829. Moore VC, Jaakkola MS, Burge PS. A Systematic Review of Serial Peak Expiratory Flow Measurements in the Diagnosis of Occupational Asthma. *Ann Respir Med* 2009;1(1):31-44.
830. Malo JL, Ghezze H, L'Archeveque J, Lagier F, Perrin B, Cartier A. Is the clinical history a satisfactory means of diagnosing occupational asthma? *Am Rev Respir Dis* 1991;143(3):528-32.
831. Anees W, Gannon P F, Huggins V, Pantin C F, Burge P S. Effect of peak expiratory flow data quantity on diagnostic sensitivity and specificity in occupational asthma. *Eur Respir J* 2004;23(5):730-4.
832. Moore VC, Jaakkola MS, Burge CB, Pantin CF, Robertson AS, Vellore AD, et al. PEF analysis requiring shorter records for occupational asthma diagnosis. *Occup Med (Lond)* 2009;59(6):413-7.
833. Burge CBSG, Moore VC, Pantin CFA, Robertson AS, Burge PS. Diagnosis of occupational asthma from time point differences in serial PEF measurements. *Thorax* 2009;64(12):1032-6.
834. Malo JL, Cardinal S, Ghezze H, L'Archeveque J, Castellanos L, Maghni K. Association of bronchial reactivity to occupational agents with methacholine reactivity, sputum cells and immunoglobulin E-mediated reactivity. *Clin Exp Allergy* 2011;41(4):497-504.
835. Vandenplas O, Suojalehto H, Aasen TB, Baur X, Burge PS, de Blay F, et al. Specific inhalation challenge in the diagnosis of occupational asthma: consensus statement. *Eur Respir J* 2014;43(6):1573-87.
836. Stenton SC, Avery AJ, Walters EH, Hendrick DJ. Statistical approaches to the identification of late asthmatic reactions. *Eur Respir J* 1994;7(4):806-12.
837. Vandenplas O, D'Alpaos V, Heymans J, Jamart J, Thimpont J, Huaux F, et al. Sputum eosinophilia: an early marker of bronchial response to occupational agents. *Allergy* 2009;64(5):754-61.
838. Chan-Yeung M, Lam S, Koener S. Clinical features and natural history of occupational asthma due to western red cedar (*Thuja plicata*). *Am J Med* 1982;72(3):411-5.
839. Merget R, Schulte A, Gebler A, Breitstadt R, Kulzer R, Berndt ED, et al. Outcome of occupational asthma due to platinum salts after transferral to low-exposure areas. *Int Arch Occup Environ Health* 1999;72(1):33-9.
840. Moscato G, Dellabianca A, Perfetti L, Brame B, Galdi E, Niniano R, et al. Occupational asthma: a longitudinal study on the clinical and socioeconomic outcome after diagnosis. *Chest* 1999;115(1):249-56.
841. Pisati G, Baruffini A, Zedda S. Toluene diisocyanate induced asthma: outcome according to persistence or cessation of exposure. *Br J Ind Med* 1993;50(1):60-4.
842. Rosenberg N, Garnier R, Rousselin X, Mertz R, Gervais P. Clinical and socio-professional fate of isocyanate-induced asthma. *Clin Allergy* 1987;17(1):55-61.
843. Tarlo SM, Banks D, Liss G, Broder I. Outcome determinants for isocyanate induced occupational asthma among compensation claimants. *Occup Environ Med* 1997;54(10):756-61.
844. Valentino M, Pizzichini MA, Monaco F, Governa M. Latex-induced asthma in four healthcare workers in a regional hospital. *Occup Med (Lond)* 1994;44(3):161-4.
845. Valentino M, Rapisarda V. Course of isocyanate-induced asthma in relation to exposure cessation: longitudinal study of 50 subjects [Italian]. *G Ital Med Lav Ergon* 2002;24(1):26-31.
846. Vandenplas O, Delwiche JP, Depelchin S, Sibille Y, Vande Weyer R, Delaunois L. Latex gloves with a lower protein content reduce bronchial reactions in subjects with occupational asthma caused by latex. *Am J Respir Crit Care Med* 1995;151(3 Pt 1):887-91.
847. Chan-Yeung M, MacLean L, Paggiaro PL. Follow-up study of 232 patients with occupational asthma caused by western red cedar (*Thuja plicata*). *J Allergy Clin Immunol* 1987;79(5):792-6.
848. Malo JL, Cartier A, Ghezze H, Lafrance M, McCants M, Lehrer SB. Patterns of improvement in spirometry, bronchial hyperresponsiveness, and specific IgE antibody levels after cessation of exposure in occupational asthma caused by snow-crab processing. *Am Rev Respir Dis* 1988;138(4):807-12.
849. Gannon PF, Weir DC, Robertson AS, Burge PS. Health, employment, and financial outcomes in workers with occupational asthma. *Brit J Ind Med* 1993;50(6):491-6.
850. Axon EJ, Beach JR, Burge PS. A comparison of some of the characteristics of patients with occupational and non-occupational asthma. *Occup Med (Lond)* 1995;45(2):109-11.
851. Cannon J, Cullinan P, Newman Taylor A. Consequences of occupational asthma. *BMJ* 1995;311(7005):602-3.
852. Larbanos A, Jamart J, Delwiche JP, Vandenplas O. Socioeconomic outcome of subjects experiencing asthma symptoms at work. *Eur Respir J* 2002;19(6):1107-13.

853. Ross DJ, McDonald JC. Health and employment after a diagnosis of occupational asthma: a descriptive study. *Occup Med (Lond)* 1998;48(4):219-25.
854. Ameille J, Pairon JC, Bayeux MC, Brochard P, Choudat D, Conso F, et al. Consequences of occupational asthma on employment and financial status: a follow-up study. *Eur Respir J* 1997;10(1):55-8.
855. Marabini A, Dimich-Ward H, Kwan SY, Kennedy SM, Waxler-Morrison N, Chan-Yeung M. Clinical and socioeconomic features of subjects with red cedar asthma. A follow-up study. *Chest* 1993;104(3):821-4.
856. Vandenplas O, Jamart J, Delwiche JP, Evrard G, Larbanois A. Occupational asthma caused by natural rubber latex: outcome according to cessation or reduction of exposure. *J Allergy Clin Immunol* 2002;109(1):125-30.
857. Venables KM, Davison AG, Newman Taylor AJ. Consequences of occupational asthma. *Respir Med* 1989;83(5):437-40.
858. Rotter T, Kinsman L, James E L, Machotta A, Gothe H, Willis J, et al. Clinical pathways: effects on professional practice, patient outcomes, length of stay and hospital costs. *Cochrane Database of Systematic Reviews* 2010, Issue 3.
859. Smith JR, Noble MJ, Musgrave S, Murdoch J, Price GM, Barton GR, et al. The at-risk registers in severe asthma (ARRISA) study: A cluster-randomised controlled trial examining effectiveness and costs in primary care. *Thorax* 2012;67(12):1052-60.
860. Mitchell EA, Didsbury PB, Kruithof N, Robinson E, Milmine M, Barry M, et al. A randomized controlled trial of an asthma clinical pathway for children in general practice. *Acta Paediatr* 2005;94(2):226-33.
861. Doherty SR, Jones PD. Use of an 'evidence-based implementation' strategy to implement evidence-based care of asthma into rural district hospital emergency departments. *Rural Remote Health* 2006;6(1):529.
862. Johnson KB, Blaisdell CJ, Walker A, Eggleston P. Effectiveness of a clinical pathway for inpatient asthma management. *Pediatrics* 2000;106(5):1006-12.
863. Zorc JJ, Chew A, Allen JL, Shaw K. Beliefs and barriers to follow-up after an emergency department asthma visit: a randomized trial. *Pediatrics* 2009;124(4):1135-42.
864. O'Brien MA, Rogers S, Jamtvedt G, Oxman AD, Odgaard-Jensen J, Kristoffersen DT, et al. Educational outreach visits: effects on professional practice and health care outcomes. *Cochrane Database of Systematic Reviews* 2007, Issue 4.
865. Forsetlund L, Bjørndal A, Rashidian A, Jamtvedt G, O'Brien MA, Wolf F, et al. Continuing education meetings and workshops: effects on professional practice and health care outcomes. *Cochrane Database of Systematic Reviews* 2009, Issue 2.
866. Cabana MD, Slish KK, Evans D, Mellins RB, Brown RW, Lin X, et al. Impact of physician asthma care education on patient outcomes. *Pediatrics* 2006;117(6):2149-57.
867. Shah S, Sawyer SM, Toelle BG, Mellis CM, Peat JK, Lagleva M, et al. Improving paediatric asthma outcomes in primary health care: A randomised controlled trial. *Med J Austr* 2011;195(7):405-9.
868. Lozano P, Finkelstein JA, Carey VJ, Wagner EH, Inui TS, Fuhlbrigge AL, et al. A multisite randomized trial of the effects of physician education and organizational change in chronic-asthma care: health outcomes of the Pediatric Asthma Care Patient Outcomes Research Team II Study. *Arch Pediatr Adolesc Med* 2004;158(9):875-83.
869. Smeele IJ, Grol RP, van Schayck CP, van den Bosch WJ, van den Hoogen HJ, Muris JW. Can small group education and peer review improve care for patients with asthma/chronic obstructive pulmonary disease? *Qual Health Care* 1999;8(2):92-8.
870. Witt K, Knudsen E, Ditlevsen S, Hollnagel H. Academic detailing has no effect on prescribing of asthma medication in Danish general practice: a 3-year randomized controlled trial with 12-monthly follow-ups. *Fam Pract* 2004;21(3):248-53.
871. Liaw ST, Sulaiman ND, Barton CA, Chondros P, Harris CA, Sawyer S, et al. An interactive workshop plus locally adapted guidelines can improve general practitioners asthma management and knowledge: a cluster randomised trial in the Australian setting. *BMC Fam Pract* 2008;9:22.
872. Goeman DP, Sancu LA, Scharf SL, Bailey M, O'Hehir RE, Jenkins CR, et al. Improving general practice consultations for older people with asthma: a cluster randomised control trial. *Med J Austr* 2009;191(2):113-7.
873. Stout JW, Smith K, Zhou C, Solomon C, Dozor AJ, Garrison MM, et al. Learning from a distance: Effectiveness of online spirometry training in improving asthma care. *Acad Pediatr* 2012;12(2):88-95.
874. Charlton I, Charlton G, Broomfield J, Mullee MA. Audit of the effect of a nurse run asthma clinic on workload and patient morbidity in a general practice. *Br J Gen Pract* 1991;41(347):227-31.
875. Hoskins G, Neville RG, Smith B, Clark RA. The link between nurse training and asthma outcomes. *Br J Comm Nursing* 1999;4(5):222-8.
876. Feder G, Griffiths C, Highton C, Eldridge S, Spina M, Southgate L. Do clinical guidelines introduced with practice based education improve care of asthmatic and diabetic patients? A randomised controlled trial in general practitioners in east London. *BMJ* 1995;311(7018):1473-8.
877. Bryce FP, Neville RG, Crombie IK, Clark RA, McKenzie P. Controlled trial of an audit facilitator in diagnosis and treatment of childhood asthma in general practice. *BMJ* 1995;310(6983):838-42.

878. Dickinson J, Hutton S, Atkin A, Jones K. Reducing asthma morbidity in the community: the effect of a targeted nurse-run asthma clinic in an English general practice. *Respir Med* 1997;91(10):634-40.
879. Lindberg M, Ahlner J, Moller M, Ekstrom T. Asthma nurse practice - a resource-effective approach in asthma management. *Respir Med* 1999;93(8):584-8.
880. Baishnab E, Karner C. Primary care based clinics for asthma. *Cochrane Database of Systematic Reviews* 2012, Issue 4.
881. McLean S, Chandler D, Nurmatov U, Liu J, Pagliari C, Car J, et al. Telehealthcare for asthma. *Cochrane Database of Systematic Reviews* 2010, Issue 10.
882. Garbutt JM, Banister C, Highstein G, Sterkel R, Epstein J, Bruns J, et al. Telephone coaching for parents of children with asthma: impact and lessons learned. *Arch Pediatr Adolesc Med* 2010;164(7):625-30.
883. Gustafson D, Wise M, Bhattacharya A, Pulvermacher A, Shanovich K, Phillips B, et al. The effects of combining web-based eHealth with telephone nurse case management for pediatric asthma control: a randomized controlled trial. *J Med Internet Res* 2012;14(4):e101.
884. Joseph CLM, Ownby DR, Havstad SL, Saltzgaber J, Considine S, Johnson D, et al. Evaluation of a Web-Based Asthma Management Intervention Program for Urban Teenagers: Reaching the Hard to Reach. *J Adolesc Health* 2013;52(4):419-26.
885. van der Meer V, Bakker MJ, van den Hout WB, Rabe KF, Sterk PJ, Kievit J, et al. Internet-based self-management plus education compared with usual care in asthma: a randomized trial. *Ann Intern Med* 2009;151(2):110-20.
886. van der Meer V, van Stel HF, Bakker MJ, Roldaan AC, Assendelft WJ, Sterk PJ, et al. Weekly self-monitoring and treatment adjustment benefit patients with partly controlled and uncontrolled asthma: an analysis of the SMASHING study. *Respir Res* 2010;11:74.
887. Ryan D, Price D, Musgrave SD, Malhotra S, Lee AJ, Ayansina D, et al. Clinical and cost effectiveness of mobile phone supported self monitoring of asthma: multicentre randomised controlled trial. *BMJ* 2012;344:e1756.
888. Clark NM, Shah S, Dodge JA, Thomas LJ, Andridge RR, Little RJA. An evaluation of asthma interventions for preteen students. *J Sch Health* 2010;80(2):80-7.
889. Joseph CLM, Peterson E, Havstad S, Johnson CC, Hoerauf S, Stringer S, et al. A web-based, tailored asthma management program for urban African-American high school students. *Am J Respir Crit Care Med* 2007;175(9):888-95.
890. Halterman JS, Szilagyi PG, Fisher SG, Fagnano M, Tremblay P, Conn KM, et al. Randomized controlled trial to improve care for urban children with asthma: results of the school-based asthma therapy trial. *Arch Pediatr Adolesc Med* 2011;165(3):262-8.
891. Bruzzese JM, Sheares BJ, Vincent EJ, Du Y, Sadeghi H, Levison MJ, et al. Effects of a school-based intervention for urban adolescents with asthma: a controlled trial. *Am J Respir Crit Care Med* 2011;183(8):998-1006.
892. Foster G, Taylor SJC, Eldridge S, Ramsay J, Griffiths CJ. Self-management education programmes by lay leaders for people with chronic conditions. *Cochrane Database of Systematic Reviews* 2007, Issue
893. Pande S, Hiller JE, Nkansah N, Bero L. The effect of pharmacist-provided non-dispensing services on patient outcomes, health service utilisation and costs in low- and middle-income countries. *Cochrane Database of Systematic Reviews* 2013, Issue 2.
894. Benavides S, Rodriguez JC, Maniscalco-Feichtl M. Pharmacist involvement in improving asthma outcomes in various healthcare settings: 1997 to present. *Ann Pharmacother* 2009;43(1):85-97.
895. Basheti IA, Armour CL, Bosnic-Anticevich SZ, Reddel HK. Evaluation of a novel educational strategy, including inhaler-based reminder labels, to improve asthma inhaler technique. *Patient Educ Couns* 2008;72(1):26-33.
896. Hammerlein A, Muller U, Schulz M. Pharmacist-led intervention study to improve inhalation technique in asthma and COPD patients. *J Eval Clin Pract* 2011;17(1):61-70.
897. Mehuys E, Van Bortel L, De Bolle L, Van Tongelen I, Annemans L, Remon JP, et al. Effectiveness of pharmacist intervention for asthma control improvement. *Eur Respir J* 2008;31(4):790-9.
898. Elliott RA, Barber N, Clifford S, Horne R, Hartley E. The cost effectiveness of a telephone-based pharmacy advisory service to improve adherence to newly prescribed medicines. *Pharm World Sci* 2008;30(1):17-23.
899. Bereznicki BJ, Peterson G, Jackson S, Walters EH, George J, Stewart K, et al. Uptake and effectiveness of a community pharmacy intervention programme to improve asthma management. *J Clin Pharm Ther* 2013;38(3):212-8.

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