



ASTHMA GUIDELINE ADAPTATION



Evidence-Based Clinical Practice Guideline

Bronchial Asthma Prevention and Management

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**NGCEBM
Guideline
Development
Program**



NATIONAL AND GULF CENTRE FOR EVIDENCE BASED MEDICINE:
A COLLABORATING CENTRE OF THE JOANNA BRIGGS INSTITUTE

Evidence Based Clinical Practice Guideline

The National and Gulf Centre for Evidence Based Medicine Clinical Practice Guideline Program.

The NGCEBM encourages the development and use of evidence based clinical practice guidelines and provides resources and assistance to guideline developers in the Kingdom of Saudi Arabia and the Gulf Countries in the development and dissemination of Clinical Practice Guidelines (CPGs). CPGs that inform health professionals about clinical practice and specifically what constitutes best practice in health care. The NGCEBM publishes CPGs submitted by any guideline developers in the region that are derived from reviews of health care research and that follow the principles laid out in the Centre's publication "Draft Guidance for Clinical Practice Guideline Development, Adaptation and Endorsement."

Aims and scope of Clinical Practice Guidelines

CPG development involves rigorous, standardised methods to ensure that all information provided to health professionals is of the highest standard and constitutes best practice. The conduct of an evidence review and development of the guideline are two parts of a staged process. All aspects of the conduct of the evidence review and the development of the accompanying *guideline* are documented so that these methods may be scrutinised.

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Disclaimer

"The procedures described in Guidelines must only be used by people who have appropriate expertise in the field to which the procedure relates. The applicability of any information must be established before relying on it. While care has been taken to ensure that this guideline summarizes available research and expert consensus, any loss, damage, cost, expense or liability suffered or incurred as a result of reliance on these procedures (whether arising in contract, negligence or otherwise) is, to the extent permitted by law, excluded".

Publisher

National and Gulf Centre for Evidence Based
Medicine
© National and Gulf Centre for Evidence Based
Medicine
<DATE>
ISSN <> (Online)

INTRODUCTION

Asthma is a serious public health problem throughout the world, affecting people of all ages. When uncontrolled, asthma can place severe limits on daily life, and is sometimes fatal. Bronchial asthma is the one of the most common disease in the kingdom of Saudi Arabia. It is associated with an increase in morbidity and mortality. It's urged the international and local medical organizations to exert and unify effort to control, contain and manage this disease with most up-to-date scientific methods.

SCOPE

Disease / condition

Asthma

Guideline Category

Counseling

Diagnosis

Evaluation

Management

Prevention

Treatment

Clinical Specialty

Allergy and Immunology

Emergency Medicine

Family Practice

Internal Medicine

Nursing

Pulmonary Medicine

Intended user

Emergency medicine

Health educator

Nurses

Pharmacist

Respiratory therapist

Physician (PHC, Internist)

Guideline objective

- To present information about asthma management in as comprehensive manner as possible.
- To present a comprehensive plan to manage asthma with goal of reducing chronic disability and premature deaths.
- To develop a network of individuals, organizations, and public health officials to disseminate information about the care of the patient with asthma.

Target population

Patients of all ages with Bronchial asthma.

Intervention and practice considered

Diagnosis:

1. Clinical diagnosis:
 - Consideration of signs and symptoms.
 - Measurements of lung function via spirometry or peak expiratory flow.
 - Consideration of challenges diagnosing asthma in children 5 years and younger and in the elderly, and occupational asthma.
2. Consideration of severity.
3. Classification of asthma based on level of control (clinical control, frequency of symptoms, limitations, need for reliever treatment)

Management, Prevention and treatment:

1. Development of patient-doctor relationship.
 - Patient education, including self- monitoring.
 - Personal asthma treatment action plan.
2. Identification and reduction of risk factors, including exacerbation triggers.

3. Assessment, treatment and monitoring of asthma.
 - Assessment of control based on daytime and nocturnal symptoms, activity limitation, need for reliever/rescue treatment, lung function, and exacerbation.
 - Assessment of patient adherence to treatment.
 - Treatment to achieve control. Use of stepped system that includes as needed reliever medication alone and reliever plus one or more controllers.
 - Treatment to maintain control stepping down /stepping up in asthma control.
4. Management of asthma exacerbations
 - Assessment of severity.
 - Management in community settings(bronchodilator, glucocorticoids)
 - Management in acute care setting (assessment, treatment with oxygen, rapid acting inhaled beta2 agonist, epinephrine, and additional bronchodilators).
5. Consideration of special circumstances, including pregnancy; surgery; rhinitis, sinusitis, and nasal polyps; respiratory infection; gastro esophageal reflux; aspirin-induced asthma; and anaphylaxis.

Major outcome considered

- Asthma symptoms, including nocturnal.
- Exacerbation of symptoms.
- Limitation of daily activities, including physical exercise.
- Requirement for rescue medications.
- Lung function peak expiratory flow or fraction of expired volume in one second.
- Emergency department visits.
- Morbidity, including quality of life, due to exacerbation and chronic symptoms.
- Mortality.
- Socioeconomic burden.

METHODOLOGY

THIS GUIDELINE IS ADAPTATION OF GLOBAL INITIATIVE FOR ASTHMA (GINA) REPORT (2006).

We review four Bronchial Asthma Guideline:

- 1- British Guideline on the management of Asthma. July 2007.
- 2- National Heart, Lung and Blood institute. Expert Panel Report 3: Guideline for diagnosis and management of asthma.2007.
- 3- Global Initiative for Asthma. 2006.
- 4- Kaiser Permanente Care Management Institute. Adult asthma clinical practice guidelines. Oakland (CA): Kaiser Permanente Care Management Institute; 2007.

After complete the AGREE form we accept three Guideline (1st three from above) and reject one guideline (last one from the above). The recommendation matrix help us in review the all recommendation between the all three guideline, we come with high recommendation from GINA.

METHODS USED BY GINA GUIDELINE TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases.

DESCRIPTION OF GINA GUIDLEINE METHODS USED TO COLLECT/SELECT THE EVIDENCE

The process producing 2007 update included a Pub Med search using search fields established by the Committee: 1) asthma, All Fields, All ages, only items with abstracts, Clinical Trial, Human, sorted by Authors; and 2) asthma AND systematic, all fields, ALL ages, only items with abstracts, Human, sorted by author. In addition, publications in peer review journals not captured by Pub Med could be submitted to individual members of the Committee providing an abstract and the full paper were submitted in (or translated into) English. Between July 1, 2006 and June 30, 2007, 406 articles met the search criteria; 5 additional publications were brought to the attention of the committee. Of the 205 reviewed, 40 papers were identified to have an impact on the Global Initiative for Asthma (GINA) Report that was posted on the website (www.ginasthma.org) in December 2006 either by: 1) confirming, that is, adding or replacing an existing reference, or 2) modifying, that is, changing the text or introducing a concept requiring a new recommendation to the report.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee).
Weighting According to a Rating Scheme (Scheme Given).

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Description of Levels of Evidence

A. Randomized controlled trials (RCTs). Rich body of data.

Definition: Evidence is from endpoints of well-designed RCTs that provide a consistent pattern of findings in the population for which the recommendation is made. Category A requires substantial numbers of studies involving substantial numbers of participants.

B. Randomized controlled trials. Limited body of data.

Definition: Evidence is from endpoints of intervention studies that include only a limited number of patients, post hoc or subgroup analysis of RCTs, or metaanalysis of RCTs. In general, Category B pertains when few randomized trials exist, they are small in size, they were undertaken in a population that differs from the target population of the recommendation, or the results are somewhat inconsistent.

C. Nonrandomized trials. Observational studies.

Definition: Evidence is from outcomes of uncontrolled or nonrandomized trials or from observational studies.

D. Panel consensus judgment.

Definition: This category is used only in cases where the provision of some guidance was deemed valuable but the clinical literature addressing the subject was deemed insufficient to justify placement in one of the other categories. The Panel Consensus is based on clinical experience or knowledge that does not meet the above-listed criteria.

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

All members of the Committee received a summary of citations and all abstracts.

Each abstract was assigned to two Committee members, and an opportunity to provide an opinion on any single abstract was offered to all members. Members evaluated the abstract or, up to her/his judgment, the full publication, by answering specific written questions from a short questionnaire, indicating whether the scientific data presented affected recommendations in the Global Initiative for Asthma (GINA) Report. If so, the member was asked to specifically identify modifications that should be made. The entire GINA Science Committee met on a regular basis to discuss each individual publication that was judged by at least one member to have an impact on asthma management and prevention recommendations, and to reach a consensus on the changes in the Report.

Disagreements were decided by vote.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

In January 2005, the Global Initiative for Asthma (GINA) Science Committee initiated its work on this new report. During a two-day meeting, the Committee established that the main theme of the new report should be the control of asthma. A table of contents was developed, themes for each chapter identified, and writing teams formed. The Committee met in May and September 2005 to evaluate progress and to reach consensus on messages to be provided in each chapter. Throughout its work, the Committee made a commitment to develop a document that would reach a global audience, be based on the most current scientific literature, and be as concise as possible, while at the same time recognizing that one of the values of the GINA Report has been to provide background information about asthma management and the scientific information on which management recommendations are based.

In January 2006, the Committee met again for a two-day session during which another in-depth evaluation of each chapter was conducted. At this meeting, members reviewed the literature that appeared in 2005—using the same criteria developed for the update process. The list of 285 publications from 2005 that were considered is posted on the GINA website. At the January meeting, it was clear that work remaining would permit the report to be finished during the summer of 2006 and, accordingly, the Committee requested that as publications appeared throughout early 2006, they be reviewed carefully for their impact on the recommendations. At the Committee's next meeting in May, 2006 publications meeting the search criteria were considered and incorporated into the current drafts of the chapters, where appropriate. A final meeting of the Committee was held in September 2006, at which publications that appear from July 1, 2006 through June 30, 2007 were considered for their impact on the document.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

Cost is recognized as an important barrier to the delivery of optimal evidence based health care in almost every country, although its impact on patients' access to treatments varies widely both between and within countries. At the country or local level, health authorities make resource availability and allocation decisions affecting populations of asthma patients by considering the balance and tradeoffs between costs and clinical outcomes (benefits and harms), often in relation to competing public health and medical needs. Treatment costs must also be explicitly considered at each consultation between health care provider and patient to assure that cost does not present a barrier to achieving asthma control.

Thus, those involved in the adaptation and implementation of asthma guidelines require an understanding of the cost and cost effectiveness of various management recommendations in asthma care. To this end, a short discussion of cost-effectiveness evaluation for asthma care, including utilization and cost of health care resources and determining the economic value of interventions in asthma, can be found in the original guideline document.

METHOD OF GUIDELINE VALIDATION

External Peer Review

Internal Peer Review

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Evidence grades (A-D) are defined and provided at the end of the "Major Recommendations" field.

Summary of Recommendations in the 2007 Update

See "Methodology and Summary of New Recommendations Global Strategy for Asthma Management and Prevention: 2007 Update" in the original guideline document for a list of changes in the 2007 update. The summary is reported in three segments: A) Modifications in the text; B) References that provided confirmation or an update of previous recommendations; and C) Changes to the text for clarification or to correct errors.

Diagnosis and Classification

Key Points

- A clinical diagnosis of asthma is often prompted by symptoms such as episodic breathlessness, wheezing, cough, and chest tightness.
- Measurements of lung function (spirometry or peak expiratory flow) provide an assessment of the severity of airflow limitation, its reversibility, and its variability, and provide confirmation of the diagnosis of asthma.
- Measurements of allergic status can help to identify risk factors that cause asthma symptoms in individual patients.
- Extra measures may be required to diagnose asthma in children 5 years and younger and in the elderly, and occupational asthma.
- For patients with symptoms consistent with asthma, but normal lung function, measurement of airway responsiveness may help establish the diagnosis.
- Asthma has been classified by severity in previous reports (see Figure 2-4 in the original guideline document & Appendix). However, asthma severity may change over time, and depends not only on the severity of the underlying disease but also its responsiveness to treatment.
- To aid in clinical management, a classification of asthma by level of control is recommended (see Figure 2-5 in the original guideline document & Appendix).
- Clinical control of asthma is defined as:
 - No (twice or less/week) daytime symptoms
 - No limitations of daily activities, including exercise
 - No nocturnal symptoms or awakening because of asthma

- No (twice or less/week) need for reliever treatment
- Normal or near-normal lung function
- No exacerbations

Refer to the original guideline document for more details about the diagnosis and classification of asthma.

Asthma Treatments

Key Points

- Medications to treat asthma can be classified as controllers or relievers. Controllers are medications taken daily on a long-term basis to keep asthma under clinical control chiefly through their anti-inflammatory effects. Relievers are medications used on an as-needed basis that act quickly to reverse bronchoconstriction and relieve its symptoms.
- Asthma treatment can be administered in different ways—inhaled, orally, or by injection. The major advantage of inhaled therapy is that drugs are delivered directly into the airways, producing higher local concentrations with significantly less risk of systemic side effects.
- Inhaled glucocorticosteroids are the most effective controller medications currently available.
- Rapid-acting inhaled beta2-agonists are the medications of choice for relief of bronchoconstriction and for the pretreatment of exercise-induced bronchoconstriction, in both adults and children of all ages.
- Increased use, especially daily use, of reliever medication is a warning of deterioration of asthma control and indicates the need to reassess treatment.

Refer to the original guideline document for more information about specific controller and reliever medications.

Asthma Management and Prevention

Introduction

Asthma has a significant impact on individuals, their families, and society. Although there is no cure for asthma, appropriate management that includes a partnership between the physician and the patient/family most often results in the achievement of control. The goals for successful management of asthma are to:

- Achieve and maintain control of symptoms
- Maintain normal activity levels, including exercise
- Maintain pulmonary function as close to normal as possible
- Prevent asthma exacerbations
- Avoid adverse effects from asthma medications
- Prevent asthma mortality

These goals for therapy reflect an understanding of asthma as a chronic inflammatory disorder of the airways characterized by recurrent episodes of wheezing, breathlessness, chest tightness, and coughing. Clinical studies have shown that asthma can be effectively controlled by intervening to suppress and reverse the inflammation as well as treating the bronchoconstriction and related symptoms. Furthermore, early intervention to stop exposure to the risk factors that sensitized the airway may help improve the control of asthma and reduce medication needs. Experience in

occupational asthma indicates that long-standing exposure to sensitizing agents may lead to irreversible airflow limitation. The management of asthma can be approached in different ways, depending on the availability of the various forms of asthma treatment and taking into account cultural preferences and differing health care systems. The recommendations in this section reflect the current scientific understanding of asthma. They are based as far as possible on controlled clinical studies, and the text references many of these studies. For those aspects of the clinical management of asthma that have not been the subject of specific clinical studies, recommendations are based on literature review, clinical experience, and expert opinion of project members.

The recommendations for asthma management are laid out in five interrelated components of therapy:

1. Develop Patient/Doctor Partnership
2. Identify and Reduce Exposure to Risk Factors
3. Assess, Treat, and Monitor Asthma
4. Manage Asthma Exacerbations
5. Special Considerations

Component 1: Develop Patient/Doctor Relationship

Key Points

- The effective management of asthma requires the development of a partnership between the person with asthma and his or her health care professional(s) (and parents/caregivers, in the case of children with asthma).
- The aim of this partnership is guided self-management—that is, to give people with asthma the ability to control their own condition with guidance from health care professionals.
- The partnership is formed and strengthened as patients and their health care professionals discuss and agree on the goals of treatment, develop a personalized, written self-management plan including self-monitoring, and periodically review the patient's treatment and level of asthma control.
- Education should be an integral part of all interactions between health care professionals and patients, and is relevant to asthma patients of all ages.
- Personal asthma action plans help individuals with asthma make changes to their treatment in response to changes in their level of asthma control, as indicated by symptoms and/or peak expiratory flow, in accordance with written predetermined guidelines.

Essential Features of the Doctor-Patient Partnership to Achieve Guided Self-Management in Asthma

- Education
- Joint setting of goals
- Self-monitoring. The person with asthma is taught to combine assessment of asthma control with educated interpretation of key symptoms
- Regular review of asthma control, treatment, and skills by a health care professional
- Written action plan. The person with asthma is taught which medications to use regularly and which to use as needed, and how to adjust treatment in response to worsening asthma control
- Self-monitoring is integrated with written guidelines for both the long-term treatment of asthma and the treatment of asthma exacerbations.

Asthma Education

Education should be an integral part of all interactions between health care professionals and patients, and is relevant to asthma patients of all ages. Although the focus of education for small children will be on the parents and caregivers, children as young as 3 years of age can be taught simple asthma management skills. Adolescents may have some unique difficulties regarding adherence that may be helped through peer support group education in addition to education provided by the health care professional. The Table below outlines the key features and components of an asthma education program. The information and skills training required by each person may vary, and their ability or willingness to take responsibility similarly differs. Thus all individuals require certain core information and skills, but most education must be personalized and given to the person in a number of steps. Social and psychological support may also be required to maintain positive behavioral change.

Education and the Patient/Doctor Partnership

Goal: To provide the person with asthma, their family, and other caregivers with suitable information and training so that they can keep well and adjust treatment according to a medication plan developed with the health care professional.

Key components:

- Focus on the development of the partnership
- Acceptance that this is a continuing process
- A sharing of information
- Full discussion of expectations
- Expression of fears and concerns

Provide specific information, training, and advice about:

- Diagnosis
- Difference between “relievers” and “controllers”
- potential side effects of medications
- Use of inhaler devices
- Prevention of symptoms and attacks
- Signs that suggest asthma is worsening and actions to take
- Monitoring control of asthma
- How and when to seek medical attention

The person then requires:

- A guided self-management plan
- Regular supervision, revision, reward, and reinforcement

See the original guideline document for more information about developing the patient/doctor relationship.

Component 2: Identify and Reduce Exposure to Risk Factors

Key Points

- Pharmacologic intervention to treat established asthma is highly effective in controlling symptoms and improving quality of life. However, measures to prevent the development of asthma, asthma symptoms, and asthma exacerbations by avoiding or reducing exposure to risk factors should be implemented wherever possible.
- At this time, few measures can be recommended for prevention of asthma because the development of the disease is complex and incompletely understood.
- Asthma exacerbations may be caused by a variety of risk factors, sometimes referred to as "triggers," including allergens, viral infections, pollutants, and drugs.
- Reducing a patient's exposure to some categories of risk factors improves the control of asthma and reduces medication needs.
- The early identification of occupational sensitizers and the removal of sensitized patients from any further exposure are important aspects of the management of occupational asthma.

Introduction

Although pharmacologic intervention to treat established asthma is highly effective in controlling symptoms and improving quality of life, measures to prevent the development of asthma, asthma symptoms, and asthma by avoiding or reducing exposure to risk factors should be implemented wherever possible. At this time, few measures can be recommended for prevention of asthma because the development of the disease is complex and incompletely understood. This area is a focus of intensive research, but until such measures are developed prevention efforts must primarily focus on prevention of asthma symptoms and attacks.

Asthma Prevention

Measures to prevent asthma may be aimed at the prevention of allergic sensitization (i.e., the development of atopy, likely to be most relevant prenatally and perinatally), or the prevention of asthma development in sensitized people. Other than preventing tobacco exposure both in utero and after birth, there are no proven and widely accepted interventions that can prevent the development of asthma.

See the original guideline document for a discussion of other topics related to asthma prevention.

Prevention of Asthma Symptoms and Exacerbations

Asthma exacerbations may be caused by a variety of factors, sometimes referred to as "triggers," including allergens, viral infections, pollutants, and drugs. Reducing a patient's exposure to some of these categories of risk factors (e.g., smoking cessation, reducing exposure to secondhand smoke, reducing or eliminating exposure to occupational agents known to cause symptoms, and avoiding foods/additives/drugs known to cause symptoms) improves the control of asthma and reduces medication needs. In the case of other factors (e.g., allergens, viral infections and pollutants), measures where possible should be taken to avoid these. Because many asthma patients react to multiple factors that are ubiquitous in the environment, avoiding these factors completely is usually impractical and very limiting to the patient. Thus, medications to maintain asthma control have an important role because patients are often less sensitive to these risk factors when their asthma is under good control.

See the original guideline document for a discussion of risk factors, including indoor and outdoor allergens, indoor and outdoor air pollutants, occupational exposures, food and food additives, drugs, influenza vaccination, obesity, emotional stress, and other factors that may exacerbate asthma.

Component 3: Assess, Treat, and Monitor Asthma

Key Points

- The goal of asthma treatment, to achieve and maintain clinical control, can be reached in a majority of patients with a pharmacologic intervention strategy developed in partnership between the patient/family and the doctor.
- Treatment should be adjusted in a continuous cycle driven by the patients' asthma control status. If asthma is not controlled on the current treatment regimen, treatment should be

stepped up until control is achieved. When control is maintained for at least three months, treatment can be stepped down.

- In treatment-naïve patients with persistent asthma, treatment should be started at Step 2, or, if very symptomatic (uncontrolled), at Step 3. For Steps 2 through 5, a variety of controller medications are available.
- At each treatment step, reliever medication should be provided for quick relief of symptoms as needed.
- Ongoing monitoring is essential to maintain control and to establish the lowest step and dose of treatment to minimize cost and maximize safety.

Introduction

The goal of asthma treatment, to achieve and maintain clinical control, can be reached in the majority of patients with a pharmacologic intervention strategy developed in partnership between the patient/family and the doctor. Each patient is assigned to one of five "treatment steps" depending on their current level of control and treatment is adjusted in a continuous cycle driven by changes in their asthma control status. This cycle involves:

- Assessing Asthma Control
- Treating to Achieve Control
- Monitoring to Maintain Control

In this Component, this cycle is described for long-term treatment of asthma.

Treatment for exacerbations is detailed in Component 4, below.

Assessing Asthma Control

Each patient should be assessed to establish his or her current treatment regimen, adherence to the current regimen, and level of asthma control. A simplified scheme for recognizing controlled, partly controlled, and uncontrolled asthma in a given week is provided in the Table below. This is a working scheme based on current opinion and has not been validated. Several composite control measures (e.g., Asthma Control Test, Asthma Control Questionnaire, Asthma Therapy Assessment Questionnaire, Asthma Control Scoring System) have been developed and are being validated for various applications, including use by health care providers to assess the state of control of their patients' asthma and by patients for self-assessments as part of a written personal asthma action plan. Uncontrolled asthma may progress to the point of an exacerbation, and immediate steps, described in Component 4, should be taken to regain control.

Levels of Asthma Control			
Characteristic	Controlled (All of the following)	Partly Controlled (Any measure present in any week)	Uncontrolled
Daytime symptoms	None (twice or less/week)	More than twice/week	Three or more features of partly controlled asthma present in any week
Limitations of activities	None	Any	
Nocturnal symptoms/awakening	None	Any	
Need for reliever/rescue treatment	None (twice or less/week)	More than twice/week	
Lung function (PEF or FEV1)‡	Normal	< 80% predicted or personal best (if known)	
Exacerbations	None	One or more/year*	

PEF=peak expiratory flow; FEV1 = fraction of expired volume in 1 second

* Any exacerbation should prompt review of maintenance treatment to ensure that it is adequate.

** By definition, an exacerbation in any week makes that an uncontrolled asthma week.

Lung function is not a reliable test for children 5 years and younger.

Treating to Achieve Control

The patient's current level of asthma control and current treatment determine the selection of pharmacologic treatment. For example, if asthma is not controlled on the current treatment regimen, treatment should be stepped up until control is achieved. If control has been maintained for at least three months, treatment can be stepped down with the aim of establishing the lowest step and dose of treatment that maintains control (see "Monitoring to Maintain Control," below.) If asthma is partly controlled, an increase in treatment should be considered, subject to whether more effective options are available (e.g., increased dose or an additional treatment), safety and cost of possible treatment options, and the patient's satisfaction with the level of control achieved. The scheme presented in (Figure 4.3-2 in the original guideline document & Appendix) is based upon these principles, but the range and sequence of medications used in each clinical setting will vary depending on local availability (for cost or other reasons), acceptability, and preference.

Treatment Steps for Achieving Asthma Control

Step 1: As-Needed Reliever Medication

Step 1 treatment with an as-needed reliever medication is reserved for untreated patients with occasional daytime symptoms (cough, wheeze, dyspnea occurring twice or less per week, or less frequently if nocturnal) of short duration (lasting only a few hours) comparable with controlled asthma (see Table above). Between episodes, the patient is asymptomatic with normal lung function and there is no nocturnal awakening. When symptoms are more frequent, and/or worsen periodically, patients require regular controller treatment (see Steps 2 or higher) in addition to as-needed reliever medication (**Evidence B**).

For the majority of patients in Step 1, a rapid-acting inhaled beta2-agonist is the recommended reliever treatment (**Evidence A**). An inhaled anticholinergic, short acting oral beta2-agonist, or short-acting theophylline may be considered as alternatives, although they have a slower onset of action and higher risk of side effects (**Evidence A**).

Exercise-induced bronchoconstriction. Physical activity is an important cause of asthma symptoms for most asthma patients, and for some it is the only cause. However, exercise-induced bronchoconstriction often indicates that the patient's asthma is not well controlled, and stepping up controller therapy generally results in the reduction of exercise-related symptoms. For those patients who still experience exercise-induced bronchoconstriction despite otherwise well-controlled asthma, and for those in whom exercise-induced bronchoconstriction is the only manifestation of asthma, a rapid-acting inhaled beta2-agonist (short- or long acting), taken prior to exercise or to relieve symptoms that develop after exercise, is recommended. A leukotriene modifier or cromone are alternatives (**Evidence A**). Training and sufficient warm-up also reduce the incidence and severity of exercise-induced bronchoconstriction (**Evidence B**).

Step 2: Reliever Medication Plus a Single Controller

Treatment Steps 2 through 5, combine an as-needed reliever treatment with regular controller treatment. At Step 2, a slow-dose inhaled glucocorticosteroid is recommended as the initial controller treatment for asthma patients of all ages (**Evidence A**). Equivalent doses of inhaled glucocorticosteroids, some of which may be given as a single daily dose, are provided in Figure 3-1 in the original guideline document for adults and in Figure 3-4 in the original guideline document& Appendix for children 5 years and younger)

Alternative controller medications include leukotriene modifiers (**Evidence A**), appropriate particularly for patients who are unable or unwilling to use inhaled glucocorticosteroids, or who experience intolerable side effects such as persistent hoarseness from inhaled glucocorticosteroid treatment and those with concomitant allergic rhinitis (**Evidence C**).

Other options are available but not recommended for routine use as initial or first line controllers in Step 2. Sustained-release theophylline has only weak anti-inflammatory and controller efficacy (**Evidence B**) and is commonly associated with side effects that range from trivial to

intolerable. Cromones (nedocromil sodium and sodium cromoglycate) have comparatively low efficacy, though a favorable safety profile (**Evidence A**).

Step 3: Reliever Medication Plus One or Two Controllers

At Step 3, the recommended option for adolescents and adults is to combine a low-dose of inhaled glucocorticosteroid with an inhaled long-acting beta2-agonist, either in a combination inhaler device or as separate components (**Evidence A**). Because of the additive effect of this combination, the low-dose of glucocorticosteroid is usually sufficient, and need only be increased if control is not achieved within 3 or 4 months with this regimen (**Evidence A**). The long acting beta2-agonist formoterol, which has a rapid onset of action whether given alone or in combination inhaler with budesonide, has been shown to be as effective as short-acting beta2-agonist in acute asthma exacerbation. However its use as monotherapy as a reliever medication is strongly discouraged since it must always be used in association with an inhaled glucocorticosteroid.

If a combination inhaler containing formoterol and budesonide is selected, it may be used for both rescue and maintenance. This approach has been shown to result in reductions in exacerbations and improvements in asthma control in adults and adolescents at relatively low doses of treatment (**Evidence A**). Whether this approach can be employed with other combinations of controller and reliever requires further study.

Another option for both adults and children, but the one recommended for children, is to increase to a medium-dose of inhaled glucocorticosteroids (**Evidence A**). For patients of all ages on medium- or high-dose of inhaled glucocorticosteroid delivered by a pressurized metered-dose inhaler (MDI), use of a spacer device is recommended to improve delivery to the airways, reduce oropharyngeal side effects, and reduce systemic absorption (**Evidence A**).

Another option at Step 3 is to combine a low-dose inhaled glucocorticosteroid with leukotriene modifiers (**Evidence A**). Alternatively, the use of sustained-release theophylline given at low-dose may be considered (**Evidence B**). These options have not been fully studied in children 5 years and younger.

Step 4: Reliever Medication Plus Two or More Controllers

The selection of treatment at Step 4 depends on prior selections at Steps 2 and 3. However, the order in which additional medications should be added is based, as far as possible, upon evidence of their relative efficacy in clinical trials. Where possible, patients who are not controlled on Step 3 treatments should be referred to a health professional with expertise in the management of asthma for investigation of alternative diagnoses and/or causes of difficult-to-treat asthma.

The preferred treatment at Step 4 is to combine a medium- or high-dose of inhaled glucocorticosteroid with a long-acting inhaled beta2-agonist. However, in most patients, the increase from a medium- to a high-dose of inhaled glucocorticosteroid provides relatively little additional benefit (**Evidence A**), and the high-dose is recommended only on a trial basis for 3 to 6 months when control cannot be achieved with medium-dose inhaled glucocorticosteroid

combined with a long-acting beta2-agonist and/or a third controller (e.g., leukotriene modifiers or sustained-release theophylline) (**Evidence B**). Prolonged use of high-dose inhaled glucocorticosteroids is also associated with increased potential for adverse effects. At medium- and high-doses, twice-daily dosing is necessary for most but not all inhaled glucocorticosteroids (**Evidence A**). With budesonide, efficacy may be improved with more frequent dosing (four times daily) (**Evidence B**). (Refer to Figure 3-1 in the original guideline document for adults and Figure 3-4 in the original guideline document for children 5 years and younger for recommendations on dosing and frequency for different inhaled glucocorticosteroids & Appendix)

Leukotriene modifiers as add-on treatment to medium-to high-dose inhaled glucocorticosteroids have been shown to provide benefit (**Evidence A**), but usually less than that achieved with the addition of a long-acting beta2-agonist (**Evidence A**). The addition of a low-dose of sustained-release theophylline to medium- or high-dose inhaled glucocorticosteroid and long-acting beta2-agonist may also provide benefit (**Evidence B**).

Step 5: Reliever Medication Plus Additional Controller Options

Addition of oral glucocorticosteroids to other controller medications may be effective (**Evidence D**) but is associated with severe side effects (**Evidence A**) and should only be considered if the patient's asthma remains severely uncontrolled on Step 4 medications with daily limitation of activities and frequent exacerbations. Patients should be counseled about potential side effects and all other alternative treatments must be considered.

Addition of anti-immunoglobulin E (anti-IgE) treatment to other controller medications has been shown to improve control of allergic asthma when control has not been achieved on combinations of other controllers including high-doses of inhaled or oral glucocorticosteroids (**Evidence A**).

Monitoring to Maintain Control

When asthma control has been achieved, ongoing monitoring is essential to maintain control and to establish the lowest step and dose of treatment necessary, which minimizes the cost and maximizes the safety of treatment. On the other hand, asthma is a variable disease, and treatment has to be adjusted periodically in response to loss of control as indicated by worsening symptoms or the development of an exacerbation.

Asthma control should be monitored by the health care professional and preferably also by the patient at regular intervals, using either a simplified scheme as presented in the Levels of Asthma Control table, above, or a validated composite measure of control. The frequency of health care visits and assessments depends upon the patient's initial clinical severity, and the patient's training and confidence in playing a role in the ongoing control of his or her asthma. Typically, patients are seen one to three months after the initial visit, and every three months thereafter. After an exacerbation, follow-up should be offered within two weeks to one month (**Evidence D**).

Duration and Adjustments to Treatment

In all patients the minimum controlling dose of treatment must be sought through a process of regular follow-up and staged dose reductions.

At other times treatment may need to be increased either in response to loss of control or threat of loss of control (return of symptoms) or an acute exacerbation, which is defined as a more acute and severe loss of control that requires urgent treatment. An approach to exacerbations is provided in Component 4 below.

Stepping Down Treatment When Asthma Is Controlled

There is little experimental data on the optimal timing, sequence, and magnitude of treatment reductions in asthma, and the approach will differ from patient to patient depending on the combination of medications and the doses that were needed to achieve control. These changes should ideally be made by agreement between patient and health care professional, with full discussion of potential consequences including reappearance of symptoms and increased risk of exacerbations.

Although further research on stepping down asthma treatment is needed, some recommendations can be made based on the current evidence:

- When inhaled glucocorticosteroids alone in medium-to-high-doses are being used; a 50% reduction in dose should be attempted at 3 month intervals (**Evidence B**).
- Where control is achieved at a low-dose of inhaled glucocorticosteroids alone, in most patients' treatment may be switched to once-daily dosing (**Evidence A**).
- When asthma is controlled with a combination of inhaled glucocorticosteroid and long-acting beta2-agonist, the preferred approach is to begin by reducing the dose of inhaled glucocorticosteroid by approximately 50% while continuing the long-acting beta2-agonist (**Evidence B**). If control is maintained, further reductions in the glucocorticosteroid should be attempted until a low-dose is reached, when the long-acting beta2-agonist may be stopped (**Evidence D**). An alternative is to switch the combination treatment to once-daily dosing. A second alternative is to discontinue the long-acting beta2-agonist at an earlier stage and substitute the combination treatment with inhaled glucocorticosteroid monotherapy at the same dose contained in the combination inhaler. However, for some patients these alternative approaches lead to loss of asthma control (**Evidence B**).
- When asthma is controlled with inhaled glucocorticosteroids in combination with controllers other than long-acting beta2-agonists, the dose of inhaled glucocorticosteroid should be reduced by 50% until a low-dose of inhaled glucocorticosteroid is reached, then the combination treatment stopped as described above (**Evidence D**).
- Controller treatment may be stopped if the patient's asthma remains controlled on the lowest dose of controller and no recurrence of symptoms occurs for one year (**Evidence D**).

Stepping Up Treatment In Response To Loss Of Control

Treatment has to be adjusted periodically in response to worsening control, which may be recognized by the minor recurrence or worsening of symptoms. Treatment options are as follows:

- Rapid-onset, short-acting or long-acting beta2-agonist bronchodilators. Repeated dosing with bronchodilators in this class provides temporary relief until the cause of the worsening symptoms passes. The need for repeated doses over more than one or two days signals the need for review and possible increase of controller therapy.
- Inhaled glucocorticosteroids. Temporarily doubling the dose of inhaled glucocorticosteroids has not been demonstrated to be effective, and is no longer recommended (**Evidence A**). A four-fold or greater increase has been demonstrated to be equivalent to a short course of oral glucocorticosteroids in adult patients with an acute deterioration (**Evidence A**). The higher dose should be maintained for seven to fourteen days but more research is needed in both adults and children to standardize the approach.
- Combination of inhaled glucocorticosteroids and rapid and long-acting beta2-agonist bronchodilator (e.g., formoterol) for combined relief and control. The use of the combination of a rapid and long-acting beta2-agonist and an inhaled glucocorticosteroid in a single inhaler both as a controller and reliever is effective in maintaining a high level of asthma control and reduces exacerbations requiring systemic glucocorticosteroids and hospitalization (**Evidence A**). The benefit in preventing exacerbations appears to be the consequence of early intervention at a very early stage of a threatened exacerbation since studies involving doubling or quadrupling doses of combination treatment once deterioration is established (for 2 or more days) show some benefit but results are inconsistent. Because there are no studies using this approach with other combinations of controller and relievers, other than budesonide/formoterol, the alternative approaches described in this section should be used for patients on other controller therapies. Combination therapy with budesonide and formoterol used both as maintenance and rescue has been shown to reduce asthma exacerbations in children ages 4 years and older with moderate to severe asthma.
- The usual treatment for an acute exacerbation is a high-dose of beta2-agonist and a burst of systemic glucocorticosteroids administered orally or intravenously. Refer to Component 4 below for more information.

Following treatment for an exacerbation of asthma, maintenance treatment can generally be resumed at previous levels unless the exacerbation was associated with a gradual loss of control suggesting chronic under treatment. In this case, provided inhaler technique has been checked, a step-wise increase in treatment (either in dose or number of controllers) is indicated.

Difficult-to-Treat Asthma

Although the majority of asthma patients can obtain the targeted level of control, some patients will not do so even with the best therapy. Patients who do not reach an acceptable level of control at Step 4 (reliever medication plus two or more controllers) can be considered to have difficult-to-treat asthma. These patients may have an element of poor glucocorticosteroid

responsiveness, and require higher doses of inhaled glucocorticosteroids than are routinely used in patients whose asthma is easy to control. However, there is currently no evidence to support continuing these high doses of inhaled glucocorticosteroids beyond 6 months in the hope of achieving better control. Instead, dose optimization should be pursued by stepping down to a dose that maintains the maximal level of control achieved on the higher dose.

Because very few patients are completely resistant to glucocorticosteroids, these medications remain a mainstay of therapy for difficult-to-treat asthma, while additional diagnostic and generalized therapeutic options can and should also be considered:

- Confirm the diagnosis of asthma. In particular, the presence of chronic obstructive pulmonary disease (COPD) must be excluded. Vocal cord dysfunction must be considered.
- Investigate and confirm compliance with treatment. Incorrect or inadequate use of medications remains the most common reason for failure to achieve control.
- Consider smoking, current or past, and encourage complete cessation. A history of past tobacco smoking is associated with a reduced likelihood of complete asthma control, and this is only partly attributable to the presence of fixed airflow obstruction. In addition, current smoking reduces the effectiveness of inhaled and oral glucocorticosteroids. Counseling and smoking cessation programs should be offered to all asthma patients who smoke.
- Investigate the presence of comorbidities that may aggravate asthma. Chronic sinusitis, gastroesophageal reflux, and obesity/obstructive sleep apnea have been reported in higher percentages in patients with difficult-to-treat asthma. Psychological and psychiatric disorders should also be considered. If found, these comorbidities should be addressed and treated as appropriate, although the ability to improve asthma control by doing so remains unconfirmed.

When these reasons for lack of treatment response have been considered and addressed, a compromise level of control may need to be accepted and discussed with the patient to avoid futile over-treatment (with its attendant cost and potential for adverse effects). The objective is then to minimize exacerbations and need for emergency medical interventions while achieving as high a level of clinical control with as little disruption of activities and as few daily symptoms as possible. For these difficult-to-treat patients, frequent use of rescue medication is accepted, as is a degree of chronic lung function impairment.

Although lower levels of control are generally associated with an increased risk of exacerbations, not all patients with chronically impaired lung function, reduced activity levels, and daily symptoms have frequent exacerbations. In such patients, the lowest level of treatment that retains the benefits achieved at the higher doses of treatment should be employed. Reductions should be made cautiously and slowly at intervals not more frequent than 3 to 6 months, as carryover of the effects of the higher dose may last for several months and make it difficult to assess the impact of the dose reduction (**Evidence D**). Referral to a physician with an interest in and/or special focus on asthma may be helpful and patients may benefit from phenotyping into categories such as allergic, aspirin-sensitive, and/or eosinophilic asthma. Patients categorized as allergic might benefit from anti-IgE therapy, and leukotriene modifiers can be helpful for patients determined to be aspirin sensitive (who are often eosinophilic as well).

Component 4: Manage Asthma Exacerbations

Key Points

- Exacerbations of asthma (asthma attacks or acute asthma) are episodes of progressive increase in shortness of breath, cough, wheezing, or chest tightness, or some combination of these symptoms.
- Exacerbations are characterized by decreases in expiratory airflow that can be quantified and monitored by measurement of lung function (peak expiratory flow rate [PEF] or forced expiratory volume in one second [FEV1]).
- The primary therapies for exacerbations include the repetitive administration of rapid-acting inhaled bronchodilators, the early introduction of systemic glucocorticosteroids, and oxygen supplementation.
- The aims of treatment are to relieve airflow obstruction and hypoxemia as quickly as possible, and to plan the prevention of future relapses.
- Severe exacerbations are potentially life threatening, and their treatment requires close supervision. Most patients with severe asthma exacerbations should be treated in an acute care facility. Patients at high risk of asthma related death also require closer attention.
- Milder exacerbations, defined by a reduction in peak flow of less than 20%, nocturnal awakening, and increased use of short acting beta2-agonists can usually be treated in a community setting.

Introduction

Exacerbations of asthma (asthma attacks or acute asthma) are episodes of progressive increase in shortness of breath, cough, wheezing, or chest tightness, or some combination of these symptoms. Respiratory distress is common. Exacerbations are characterized by decreases in expiratory airflow that can be quantified by measurement of lung function (PEF or FEV1). These measurements are more reliable indicators of the severity of airflow limitation than is the degree of symptoms. The degree of symptoms may, however, be a more sensitive measure of the onset of an exacerbation because the increase in symptoms usually precedes the deterioration in peak flow rate. Still, minorities of patients perceive symptoms poorly, and may have a significant decline in lung function without a significant change in symptoms. This situation especially affects patients with a history of near-fatal asthma and also appears to be more likely in males. A clinically useful tool to assess the likelihood of asthma-related hospitalizations or emergency visits in adults with severe or difficult to treat asthma as been described elsewhere.

Strategies for treating exacerbations, though generalizable, are best adapted and implemented at a local level. Severe exacerbations are potentially life threatening, and their treatment requires close supervision. Patients with severe exacerbations should be encouraged to see their physician promptly or, depending on the organization of local health services, to proceed to the nearest clinic or hospital that provides emergency access for patients with acute asthma. Close objective monitoring (PEF) of the response to therapy is essential.

The primary therapies for exacerbations include—in the order in which they are introduced, depending on severity—repetitive administration of rapid-acting inhaled bronchodilators, early introduction of systemic glucocorticosteroids, and oxygen supplementation. The aims of treatment are to relieve airflow obstruction and hypoxemia as quickly as possible, and to plan the prevention of future relapses.

Patients at high risk of asthma-related death require closer attention and should be encouraged to seek urgent care early in the course of their exacerbations.

These patients include those:

- With a history of near-fatal asthma requiring intubation and mechanical ventilation
- Who have had a hospitalization or emergency care visit for asthma in the past year
- Who are currently using or have recently stopped using oral glucocorticosteroids
- Who are not currently using inhaled glucocorticosteroids
- Who are over dependent on rapid-acting inhaled beta2-agonists, especially those who use more than one canister of salbutamol (or equivalent) monthly
- With a history of psychiatric disease or psychosocial problems, including the use of sedatives
- With a history of noncompliance with an asthma medication plan

Response to treatment may take time and patients should be closely monitored using clinical as well as objective measurements. The increased treatment should continue until measurements of lung function (PEF or FEV1) return to their previous best (ideally) or plateau, at which time a decision to admit or discharge can be made based upon these values. Patients who can be safely discharged will have responded within the first two hours, at which time decisions regarding patient disposition can be made.

Assessment of Severity

The severity of the exacerbation (see Figure 4.4-1 in the original guideline document & Appendix) determines the treatment administered. Indices of severity, particularly PEF (in patients older than 5 years), pulse rate, respiratory rate, and pulse oximetry, should be monitored during treatment.

Management—Community Settings

Most patients with severe asthma exacerbations should be treated in an acute care facility (such as a hospital emergency department) where monitoring, including objective measurement of airflow obstruction, oxygen saturation, and cardiac function, is possible. Milder exacerbations, defined by a reduction in peak flow of less than 20%, nocturnal awakening, and increased use of short acting beta2-agonists can usually be treated in a community setting. If the patient responds to the increase in inhaled bronchodilator treatment after the first few doses, referral to an acute care facility is not required, but further management under the direction of a primary care physician may include the use of systemic glucocorticosteroids. Patient education and review of maintenance therapy should also be undertaken.

Treatment

Bronchodilators

For mild to moderate exacerbations, repeated administration of rapid-acting inhaled beta2-agonists (2 to 4 puffs every 20 minutes for the first hour) is usually the best and most cost-effective method of achieving rapid reversal of airflow limitation. After the first hour, the dose of beta2-agonist required will depend on the severity of the exacerbation. Mild exacerbations respond to 2 to 4 puffs every 3 to 4 hours; moderate exacerbations will require 6 to 10 puffs every 1 or 2 hours. Treatment should also be titrated depending upon the individual patient's response, and if there is a lack of response or other concern about how the patient is responding, the patient should be referred to an acute care facility.

Many patients will be able to monitor their PEF after the initiation of increased bronchodilator therapy. Bronchodilator therapy delivered via an MDI, ideally with a spacer, produces at least an equivalent improvement in lung function as the same dose delivered via nebulizer. At the clinic level, this route of delivery is the most cost effective, provided patients are able to use an MDI. No additional medication is necessary if the rapid-acting inhaled beta2-agonist produces a complete response (PEF returns to greater than 80% of predicted or personal best) and the response lasts for 3 to 4 hours.

Glucocorticosteroids

Oral glucocorticosteroids (0.5 to 1 mg of prednisolone/kg or equivalent during a 24-hour period) should be used to treat exacerbations, especially if they develop after instituting the other short-term treatment options recommended for loss of control (see "Stepping up treatment in response to loss of control" in Component 3 above and in the original guideline document). If patients fail to respond to bronchodilator therapy, as indicated by persistent airflow obstruction, prompt transfer to an acute care setting is recommended, especially if they are in a high risk group.

Management—Acute Care Settings

Severe exacerbations of asthma are life-threatening medical emergencies, treatment of which is often most safely undertaken in an emergency department.

The algorithm in Figure 4.4-2 in the original guideline document illustrates the approach to a acute care-based management of exacerbations & Appendix)

Assessment

A brief history and physical examination pertinent to the exacerbation should be conducted concurrently with the prompt initiation of therapy. The history should include severity and duration of symptoms, including exercise limitation and sleep disturbance; all current medications, including dose (and device) prescribed, dose usually taken, dose taken in response to the deterioration, and the patient's response (or lack thereof) to this therapy; time of onset and cause of the present exacerbation; and risk factors for asthma-related death.

The physical examination should assess exacerbation severity by evaluating the patient's ability to complete a sentence, pulse rate, respiratory rate, use of accessory muscles, and other signs detailed in Figure 4.4-2 in the original guideline document & Appendix). Any complicating factors should be identified (e.g., pneumonia, atelectasis, pneumothorax, or pneumomediastinum).

Functional assessments such as PEF or FEV1 and arterial oxygen saturation measurements are strongly recommended as physical examination alone may not fully indicate the severity of the exacerbation, particularly the degree of hypoxemia. Without unduly delaying treatment, a baseline PEF or FEV1 measurement should be made before treatment is initiated. Subsequent measurements should be made at intervals until a clear response to treatment has occurred.

Oxygen saturation should be closely monitored, preferably by pulse oximetry. This is especially useful in children because objective measurements of lung function may be difficult. Oxygen saturation in children should normally be greater than 95%, and oxygen saturation less than 92% is a good predictor of the need for hospitalization (**Evidence C**).

In adults a chest x-ray is not routinely required, but should be carried out if a complicating cardiopulmonary process is suspected, in patients requiring hospitalization, and in those not responding to treatment where a pneumothorax may be difficult to diagnose clinically. Similarly, in children routine chest x-rays are not recommended unless there are physical signs suggestive of parenchymal disease.

Although arterial blood gas measurements are not routinely required, they should be completed in patients with a PEF of 30 to 50% predicted, those who do not respond to initial treatment, or when there is concern regarding deterioration. The patient should continue on supplemental oxygen while the measurement is made. A partial pressure of oxygen in arterial blood (PaO₂) <60 mm Hg (8 kPa) and a normal or increased partial pressure of carbon dioxide in the arterial blood (PaCO₂) (especially >45 mm Hg, 6 kPa) indicates the presence of respiratory failure.

Treatment

The following treatments are usually administered concurrently to achieve the most rapid resolution of the exacerbation:

Oxygen

To achieve arterial oxygen saturation of >90% (>95% in children), oxygen should be administered by nasal cannulae, by mask, or rarely by head box in some infants. PaCO₂ may worsen in some patients on 100 percent oxygen, especially those with more severe airflow obstruction. Oxygen therapy should be titrated against pulse oximetry to maintain satisfactory oxygen saturation.

Rapid-Acting Inhaled beta2-Agonists

Rapid-acting inhaled beta2-agonists should be administered at regular intervals (**Evidence A**). Although most rapid-acting beta2-agonists have a short duration of effect, the long-acting bronchodilator formoterol, which has both a rapid onset of action and a long duration of effect, has been shown to be equally effective without increasing side effects, though it is considerably more expensive. The importance of this feature of formoterol is that it provides support and reassurance regarding the use of a combination of formoterol and budesonide early in asthma exacerbations.

A reasonable approach to inhaled therapy in exacerbations would be the initial use of continuous therapy, followed by intermittent on-demand therapy for hospitalized patients. There is no evidence to support the routine use of intravenous beta2-agonists in patients with severe asthma exacerbations.

Epinephrine

A subcutaneous or intramuscular injection of epinephrine (adrenaline) may be indicated for acute treatment of anaphylaxis and angioedema, but is not routinely indicated during asthma exacerbations.

Additional Bronchodilators

See the original guideline document for a discussion of the use of ipratropium bromide, theophylline, systemic and inhaled glucocorticosteroids, magnesium, helium oxygen therapy, leukotriene modifiers, and sedatives.

Criteria for Discharge from the Emergency Department vs. Hospitalization

Patients with a pre-treatment FEV1 or PEF <25% predicted or personal best, or those with a post-treatment FEV1 or PEF <40% predicted or personal best, usually require hospitalization. Patients with post-treatment lung function of 40 to 60% predicted may be discharged, provided that adequate follow-up is available in the community and compliance is assured. Patients with post-treatment lung function >60% predicted can be discharged.

Management of acute asthma in the intensive care unit is beyond the scope of this document and readers are referred to recent comprehensive reviews.

For patients discharged from the emergency department:

- At a minimum, a 7-day course of oral glucocorticosteroids for adults and a shorter course (3 to 5 days) for children should be prescribed, along with continuation of bronchodilator therapy.
- The bronchodilator can be used on an as-needed basis, based on both symptomatic and objective improvement, until the patient returns to his or her preexacerbation use of

rapid-acting inhaled beta2-agonists. Ipratropium bromide is unlikely to provide additional benefit beyond the acute phase and may be quickly discontinued.

- Patients should initiate or continue inhaled glucocorticosteroids.
- The patient's inhaler technique and use of peak flow meter to monitor therapy at home should be reviewed. Patients discharged from the emergency department with a peak flow meter and action plan have a better response than patients discharged without these resources.
- The factors that precipitated the exacerbation should be identified and strategies for their future avoidance implemented.
- The patient's response to the exacerbation should be evaluated. The action plan should be reviewed and written guidance provided.
- Use of controller therapy during the exacerbation should be reviewed: whether this therapy was increased promptly, by how much, and, if appropriate, why oral glucocorticosteroids were not added. Consider providing a short course of oral glucocorticosteroids to be on hand for subsequent exacerbations.
- The patient or family should be instructed to contact the primary health care professional or asthma specialist within 24 hours of discharge. A follow-up appointment with the patient's usual primary care professional or asthma specialist should be made within a few days of discharge to assure that treatment is continued until baseline control parameters, including personal best lung function, are reached. Prospective data indicate that patients discharged from the emergency department for follow-up with specialist care do better than patients returned to routine care.

An exacerbation severe enough to require hospitalization may reflect a failure of the patient's self-management plan. Hospitalized patients may be particularly receptive to information and advice about their illness. Health care providers should take the opportunity to review patient understanding of the causes of asthma exacerbations, avoidance of factors that may cause exacerbations (including, where relevant smoking cessation), the purposes and correct uses of treatment, and the actions to be taken to respond to worsening symptoms or peak flow values (**Evidence A**).

Referral to an asthma specialist should be considered for hospitalized patients. Following discharge from continuous supervision, the patient should be reviewed by the family health care professional or asthma specialist regularly over the subsequent weeks until personal best lung function is reached. Use of incentives improves primary care follow up but has shown no effect on long term outcomes .Patients who come to the emergency department with an acute exacerbation should be especially targeted for an asthma education program, if one is available.

Component 5: Special Considerations

Special considerations are required in managing asthma in relation to pregnancy; surgery; rhinitis, sinusitis, and nasal polyps; occupational asthma; respiratory infections; gastroesophageal reflux; aspirin-induced asthma; and anaphylaxis.

See the original guideline document for a discussion of these special considerations.

Definitions:

Description of Levels of Evidence

A. Randomized controlled trials (RCTs). Rich body of data.

Definition: Evidence is from endpoints of well-designed RCTs that provide a consistent pattern of findings in the population for which the recommendation is made. Category A requires substantial numbers of studies involving substantial numbers of participants.

B. Randomized controlled trials. Limited body of data.

Definition: Evidence is from endpoints of intervention studies that include only a limited number of patients, post hoc or subgroup analysis of RCTs, or metaanalysis of RCTs. In general, Category B pertains when few randomized trials exist, they are small in size, they were undertaken in a population that differs from the target population of the recommendation, or the results are somewhat inconsistent.

C. Nonrandomized trials. Observational studies.

Definition: Evidence is from outcomes of uncontrolled or nonrandomized trials or from observational studies.

D. Panel consensus judgment.

Definition: This category is used only in cases where the provision of some guidance was deemed valuable but the clinical literature addressing the subject was deemed insufficient to justify placement in one of the other categories. The Panel Consensus is based on clinical experience or knowledge that does not meet the above-listed criteria.

CLINICAL ALGORITHM(S)

Algorithms are provided in the original guideline document for: (see Appendix)

- Management Approach Based On Control
- Management of Asthma Exacerbations in Acute Care Setting.

EVIDENCE SUPPORTING THE RECOMMENDATION

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for select recommendations (see "Major Recommendations" field).

The recommendations on asthma management and prevention are based as far as possible on controlled clinical studies. For those aspects of the clinical management of asthma that have not been the subject of specific clinical studies, recommendations are based on literature review, clinical experience, and expert opinion of project members.

Levels of evidence are assigned to management recommendations in the Global Initiative for Asthma documents where appropriate in Chapter 4, the Five Components of Asthma Management. Evidence levels are indicated in boldface type enclosed in parentheses after the

relevant statement—e.g., (**Evidence A**). The methodological issues concerning the use of evidence from meta-analyses were carefully considered.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

There is now good evidence that the clinical manifestations of asthma— symptoms, sleep disturbances, limitations of daily activity, impairment of lung function, and use of rescue medications—can be controlled with appropriate treatment.

Although there is no cure for asthma, appropriate management that includes a partnership between the physician and the patient/family most often results in the achievement of control.

The goals for successful management of asthma are to:

- Achieve and maintain control of symptoms
- Maintain normal activity levels, including exercise
- Maintain pulmonary function as close to normal as possible
- Prevent asthma exacerbations
- Avoid adverse effects from asthma medications
- Prevent asthma mortality

POTENTIAL HARMS

See Chapter 3 "Asthma Treatments" in the original guideline document for a full discussion of asthma medications for adults and children, including their side effects.

CONTRAINDICATIONS

CONTRAINDICATIONS

Sedation is contraindicated in the treatment of an asthma exacerbation.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

A large segment of the world's population lives in areas with inadequate medical facilities and meager financial resources. The Global Initiative for Asthma Executive Committee recognizes that "fixed" international guidelines and "rigid" scientific protocols will not work in many

locations. Thus, the recommendations found in this Report must be adapted to fit local practices and the availability of health care resources.

IMPLEMENTATION OF THE GUIDELINE

The important stakeholders will be involved in the implementation. We will plan for 6 month of Implementation.

- We will start to collect the medical record number for the patient known to have Bronchial Asthma in 28 April 2008. Reviewing those files will give us a hint about current picture about diagnosis and management of Bronchial Asthma in Primary Health Care clinic.
- Patient will be informed early about the Bronchial Asthma guideline. One day patient education will be held in Primary Health Care in 2nd week of the coming 6 month.
- We will have a formal presentation with all staff working in Primary Health Care Clinic, to update them with the Bronchial Asthma Guideline. (During May 2008) in all PHC Centers.
- We will call for discussion and case presentation in the departmental Continues Professional Development. To keep the update and to answer the questions about the Bronchial Asthma diagnosis and treatment. (During Jun 2008).
- We will print a colored algorithm for the Bronchial Asthma management and level of Control, and will distribute it on the all PHC (3rd May 2008).
- We will call for meeting with experts (Executive Board of the Health Minister Council).
- The involvement of the pulmonologist with our lectures and activity.

Implementation tool:

- Clinical Algorithm.
- Translated to Arabic Language.
- Patient Resources.
- Pocket Guide/Reference Cards.
- Slide Presentation.

APPENDIX

Figure 2-4 Classification of Asthma Severity by Clinical Features Before Treatment
Intermittent
<p>Symptoms less than once a week</p> <p>Brief exacerbations</p> <p>Nocturnal symptoms not more than twice a month</p> <ul style="list-style-type: none"> • FEV1 or PEF \geq 80% predicted • PEF or FEV1 variability $<$ 20%
Mild Persistent
<p>Symptoms more than once a week but less than once a day</p> <p>Exacerbations may affect activity and sleep</p> <p>Nocturnal symptoms more than twice a month</p> <ul style="list-style-type: none"> • FEV1 or PEF \geq 80% predicted • PEF or FEV1 variability $<$ 20 – 30%
Moderate Persistent
<p>Symptoms daily</p> <p>Exacerbations may affect activity and sleep</p> <p>Nocturnal symptoms more than once a week</p> <p>Daily use of inhaled short-acting β_2-agonist</p> <ul style="list-style-type: none"> • FEV1 or PEF 60-80% predicted • PEF or FEV1 variability $>$ 30%
Severe Persistent
<p>Symptoms daily</p> <p>Frequent exacerbations</p> <p>Frequent nocturnal asthma symptoms</p> <p>Limitation of physical activities</p> <ul style="list-style-type: none"> • FEV1 or PEF \leq 60% predicted • PEF or FEV1 variability $>$ 30%

Figure 3-1. Estimated Equipotent Daily Doses of Inhaled Glucocorticosteroids for Adult

Drug	Low Daily Dose (ug)	Medium Daily Dose (ug)	High Daily Dose (ug)‡
Beclomethasone dipropionate	200 - 500	>500 - 1000	>1000 - 2000
Budesonide*	200 - 400	>400 - 800	>800 - 1600
Ciclesonide*	80 - 160	>160 - 320	>320 - 1280
Flunisolide	500 - 1000	>1000 - 2000	>2000
Fluticasone	100 - 250	>250 - 500	>500 - 1000
Mometasone furoate*	200 - 400	>400 - 800	>800 - 1200
Triamcinolone acetonide	400 - 1000	>1000 - 2000	>2000

† Comparisons based upon efficacy data.

‡ Patients considered for high daily doses except for short periods should be referred to a specialist for assessment to consider alternative combinations of controllers. Maximum recommended doses are arbitrary but with prolonged use are associated with increased risk of systemic side effects.

* Approved for once-daily dosing in mild patients.

Notes

- The most important determinant of appropriate dosing is the clinician’s judgment of the patient’s response to therapy. The clinician must monitor the patient’s response in terms of clinical control and adjust the dose accordingly. Once control of asthma is achieved, the dose of medication should be carefully titrated to the **minimum** dose required to maintain control, thus reducing the potential for adverse effects.
- Designation of low, medium, and high doses is provided from manufacturers’ Recommendations where possible. Clear demonstration of dose response relationships is seldom provided or available. The principle is therefore to establish the minimum effective controlling dose in each patient, as higher doses may not be more effective and are likely to be associated with greater potential for adverse effects.
- As CFC preparations are taken from the market, medication inserts for HFA preparations should be carefully reviewed by the clinician for the correct equivalent dosage.

"In this section recommendations for doses of inhaled glucocorticosteroids are given as "/day budesonide Or equivalent," because a majority of the clinical literature on these medications uses this standard.

Figure 3-4. Estimated Equipotent Daily Doses of Inhaled Glucocorticosteroids for Children

Drug	Low Daily Dose (ug)	Medium Daily Dose (ug)	High Daily Dose (ug)‡
Beclomethasone dipropionate	100 - 200	>200 - 400	>400
Budesonide*	100 - 200	>200 - 400	>400
Ciclesonide*	80 - 160	>160 - 320	>320
Flunisolide	500 - 750	>750 - 1250	>1250
Fluticasone	100 - 200	>200 - 500	>500
Mometasone furoate*	100 - 200	>200 - 400	>400
Triamcinolone acetonide	400 - 800	>800 - 1200	>1200

† Comparisons based upon efficacy data.

‡ Patients considered for high daily doses except for short periods should be referred to a specialist for assessment to consider alternative combinations of controllers. Maximum recommended doses are arbitrary but with prolonged use are associated with increased risk of systemic side effects.

* Approved for once-daily dosing in mild patients.

Notes

- The most important determinant of appropriate dosing is the clinician’s judgment of the patient’s response to therapy. The clinician must monitor the patient’s response in terms of clinical control and adjust the dose accordingly. Once control of asthma is achieved, the dose of medication should be carefully titrated to the **minimum** dose required to maintain control, thus reducing the potential for adverse effects.

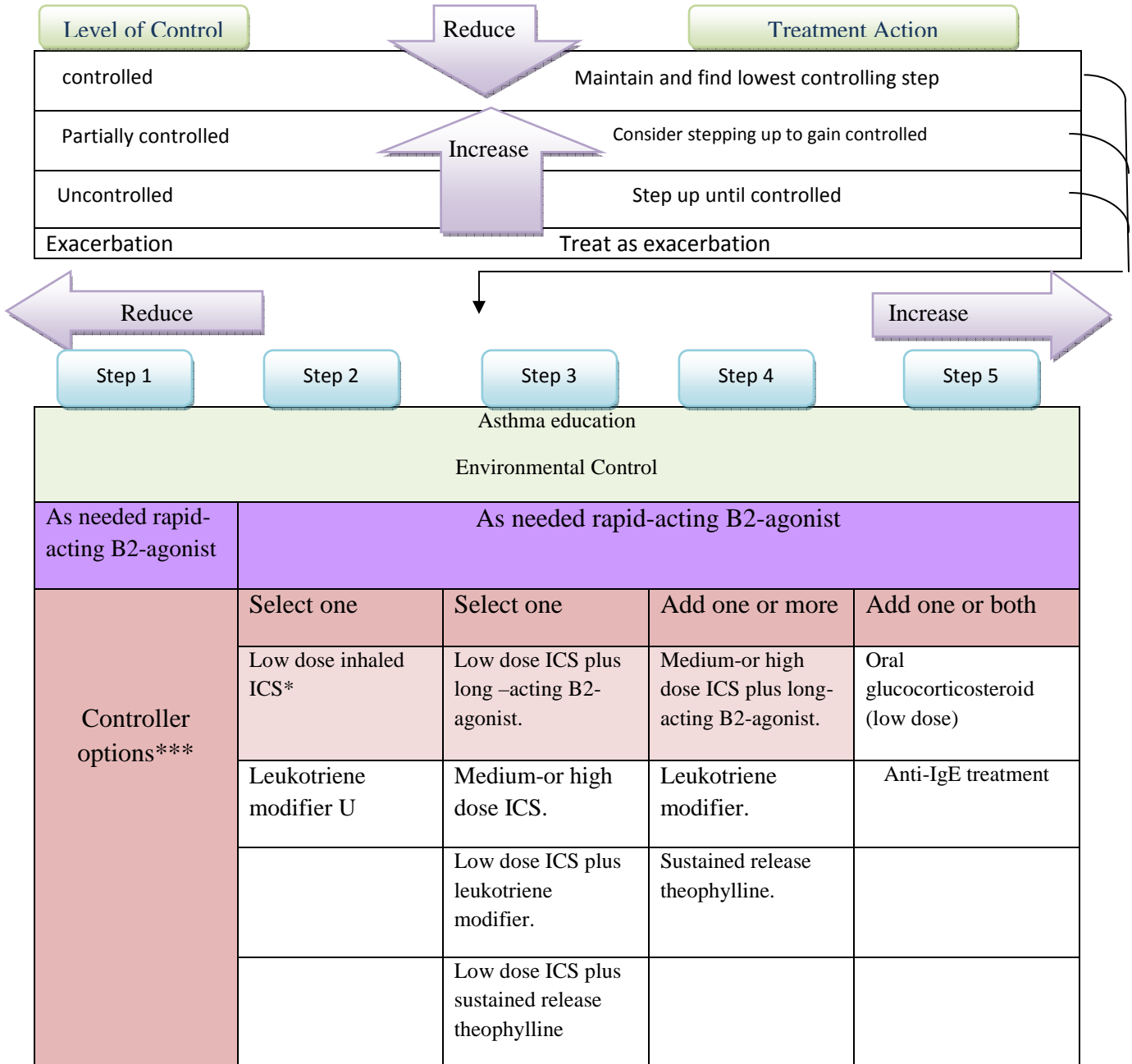
- Designation of low, medium, and high doses is provided from manufacturers’

Recommendations where possible. Clear demonstration of doseresponse relationships is seldom provided or available. The principle is therefore to establish the minimum effective controlling dose in each patient, as higher doses may not be more effective and are likely to be associated with greater potential for adverse effects.

- As CFC preparations are taken from the market, medication inserts for HFA preparations should be carefully reviewed by the clinician for the correct equivalent dosage.

Management Approach Based On Control

For children older than 5 Years, Adolescents and Adult



*ICS= inhaled glucocorticosteroids. U=Receptor antagonist or synthesis inhibitions.

*** preferred controller options are shown in shaded boxes.

Alternative reliever treatments include inhaled anticholinergics, short-acting oral B2-agonist, and short acting theophylline. Regular dosing with short and long acting B2-agonist is not advised unless accompanied by regular use of an inhaled glucocorticosteroid.

Figure 4.3-2: Management Approach Based on Control For Children 5 Years and Younger

The available literature on treatment of asthma in children 5 years and younger precludes detailed treatment recommendations. The best documented treatment to control asthma in these age groups is inhaled glucocorticosteroids and at Step 2, a low-dose inhaled glucocorticosteroid is recommended as the initial controller treatment. Equivalent doses of inhaled glucocorticosteroids, some of which may be given as a single daily dose, are provided in Chapter 3 (Asthma Medication in the original guideline document) (Figure 3-4).

Figure 4.4-1. Severity of Asthma Exacerbations*

	Mild	Moderate	Severe	Respiratory arrest imminent										
Breathless	Walking Can lie down	Talking Infant—softer shorter cry; difficulty feeding Prefers sitting	At rest Infant stops feeding Hunched forward											
Talks in	Sentences	Phrases	Words											
Alertness	May be agitated	Usually agitated	Usually agitated	Drowsy or confused										
Respiratory rate	Increased	Increased	Often > 30/min											
Normal rates of breathing in awake children: <table style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th style="text-align: center;"><i>Age</i></th> <th style="text-align: center;"><i>Normal rate</i></th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">< 2 months</td> <td style="text-align: center;">< 60/min</td> </tr> <tr> <td style="text-align: center;">2-12 months</td> <td style="text-align: center;">< 50/min</td> </tr> <tr> <td style="text-align: center;">1-5 years</td> <td style="text-align: center;">< 40/min</td> </tr> <tr> <td style="text-align: center;">6-8 years</td> <td style="text-align: center;">< 30/min</td> </tr> </tbody> </table>					<i>Age</i>	<i>Normal rate</i>	< 2 months	< 60/min	2-12 months	< 50/min	1-5 years	< 40/min	6-8 years	< 30/min
<i>Age</i>	<i>Normal rate</i>													
< 2 months	< 60/min													
2-12 months	< 50/min													
1-5 years	< 40/min													
6-8 years	< 30/min													
Accessory muscles suprasternal retractions	Usually	not Usually	Usually	Paradoxical thoracoand abdominal movement										
Wheeze	Moderate, often only end expiratory	Loud	Usually loud	Absence of wheeze										
Pulse/min.	< 100	100-120	>120	Bradycardia										
Guide to limits of normal pulse rate in children: Infants 2-12 months– Normal Rate < 160/min Preschool 1-2 years < 120/min School age 2-8 years < 110/min														
Pulsus paradoxus	Absent < 10 mm Hg	May be present 10-25 mm Hg	Often present > 25 mm Hg (adult) 20-40 mm Hg (child)	Absence suggests respiratory muscle fatigue										

PEF after initial personal best bronchodilator % predicted or % personal best	Over 80%	Approx. 60-80%	< 60% predicted or after initial personal best (< 100 L/min adults) response lasts < 2hrs	
PaO ₂ (on air) † and/or PaCO ₂ †	Normal Test not usually Necessary < 45 mm Hg	> 60 mm Hg < 45 mm Hg	< 60 mm Hg Possible cyanosis > 45 mm Hg; Possible respiratory failure (see text)	
SaO ₂ % (on air) †	> 95%	91-95%	< 90%	
	Hypercapnea (hypoventilation) develops more readily in young children than in adults and adolescents			
*Note: The presence of several parameters, but not necessarily all, indicates the general classification of the exacerbation. †Note: Kilopascals are also used internationally; conversion would be appropriate in this regard.				

Figure4, 3-2: Management of Asthma Exacerbation in Acute Care Setting.

