

EL PASO HEALTH

General Principles for the Diagnosis and Management of Asthma

The following guideline recommends general principles and key clinical activities for the diagnosis and management of asthma

Eligible Population	Key Components	Recommendations
<p>Children and adults with the following:</p> <ul style="list-style-type: none"> * Wheezing * History of cough (worse particularly at night), recurrent wheeze, recurrent difficulty in breathing, recurrent chest tightness * Symptoms occur or worsen in the presence of exercise, viral infection, inhalant allergens, irritants, changes in weather, strong emotional expression (laughing or crying hard), stress, menstrual cycles * Symptoms occur or worsen at night, awakening the patient 	Diagnosis and management goals	<ul style="list-style-type: none"> * Detailed medical history and physical exam to determine that symptoms of recurrent episodes of airflow obstruction are present * Use of spirometry (FEV₁, FEV₆, FVC, FEV₁/FVC) in all patients ≥ 5 years of age to determine that airway obstruction is at least partially reversible * Consider alternative causes of airway obstruction <p>Goals of therapy are to achieve control by:</p> <ul style="list-style-type: none"> *reducing impairment: chronic symptoms, need for rescue therapy and maintain near-normal lung function and activity level * Reducing risk: exacerbations, need for emergency care or hospitalization, loss of lung function or reduced lung growth in children, or adverse effects of therapy
	Assessment and monitoring	<ul style="list-style-type: none"> *Assess asthma severity to initiate therapy using severity classification chart for impairment and risk. *Assess asthma control to monitor and adjust therapy. (Use asthma control chart, for impairment and risk. Step up if necessary; step down if possible). *Obtain spirometry (FEV₁, FEV₆, FVC, FEV₁/FVC) to confirm control, and at least every 1-2 years, more frequently for not well-controlled asthma. *Schedule follow-up care: within 1 week, or sooner, if acute exacerbation; at 2- to 6-week intervals while gaining control; monitor control at 1- to 6-month intervals, at 3-month interval if a step-down in therapy is anticipated)
	Education	<ul style="list-style-type: none"> * Develop written action plan in partnership with patient. Update annually, more frequently if needed. * Provide self-management education. Teach and reinforce: self-monitoring to assess control and signs of worsening asthma (either symptoms or peak flow monitoring); using written asthma action plan; taking medication correctly (inhaler technique and use of devices); avoiding environmental and occupational factors that worsen asthma. * Tailor education to literacy level of patient; appreciate potential role of patient's cultural beliefs and practices in asthma mgmt.
	Control environmental factors and comorbid conditions	<ul style="list-style-type: none"> * Recommend measures to control exposure to allergens and pollutants or irritants that make asthma worse * Consider allergen immunotherapy for patients with persistent asthma and when there is a clear evidence of a relationship between symptoms and exposure to an allergen to which the patient is sensitive. * Treat comorbid conditions (e.g., allergic bronchopulmonary aspergillosis, gastroesophageal reflux, obesity, obstructive sleep apnea, rhinitis and sinusitis, chronic stress or depression. *Inactivated influenza vaccine for all patients over 6 months of age unless contraindicated. Intranasal influenza vaccine not for use in persons with asthma.
	Medications	<ul style="list-style-type: none"> *initial treatment should be based on the severity of asthma, both impairment and risk. * Inhaled corticosteroids (ICS) are the most effective long-term control therapy. Optimize use before advancing to other therapies. * Re-evaluate in 2-6 weeks for control. Modify treatment based on level of control. * Consider step down if well-controlled for 3 months. <p>Warning for use of Long-acting beta-agonists (LABA). See Black Box Warning:</p> <ul style="list-style-type: none"> *Do not use LABA as monotherapy. Use only with an asthma controller such as inhaled corticosteroids. *Use for the shortest duration possible * Only use if not controlled on medium-dose ICS. <p>Pediatric and adolescent patients who require the addition of a LABA to an inhaled corticosteroid should use a combination product containing both.</p>
Referral	<p>Refer to an asthma specialist for consultation or comanagement if there are difficulties achieving or maintaining control; immunotherapy or omalizumab is considered; additional testing is indicated; or if the patient required 2 bursts of oral corticosteroids in the past year or a hospitalization.</p>	

This guideline is based on the 2007 National Asthma Education and Prevention Program Expert Panel Report 3, Guidelines for the Diagnosis and Management of Asthma. National Heart, Lung and Blood Institute (www.nhlbi.nih.gov)
 Rev: 07/15/2015