

## Asthma Prescribing Guidelines: Children

### Approach to Management

1. Start treatment at the level most appropriate to initial severity.
2. Achieve early control.
3. Maintain control by:
  - increasing treatment as necessary
  - decreasing treatment when control is good.

Before initiating a new drug therapy practitioners should check adherence with existing therapies, check inhaler technique and eliminate trigger factors. The aim of asthma management is control of the disease.

The 6 Measures of Complete Asthma Control	
No	•Daytime symptoms
No	•Night-time awakening due to asthma
No	•Need for rescue medication
No	•Asthma attacks/exacerbations
No	•Limitation on activity including exercise
Normal	•Lung function (FEV <sub>1</sub> and/or PEF >80% predicted or best)
With minimal side-effects from medication	

If a patient has had treatment through A & E or through out of hours services their own GP practice should be informed within 24hrs.

Aim to contact the patient in an appropriate timeframe

Ideally within two working days of treatment.

This group of patients has a high risk of asthma harms.

Regular review of patients as treatment is decreased is important. When deciding which drug to decrease 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 on the lowest possible dose of inhaled corticosteroid. Reduction of 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.

**Management of Asthma in Children– Cost Comparator Inhaler Device Options –August 2018**

Consider initiation with a very low dose ICS or LTRA

Infrequent –short lived wheeze	Regular preventer	Initial add-on therapy	Review LABA /ICS dose and/or consider trial of additional therapies	High dose therapies	Continuous or frequent use of oral steroids
	Very Low dose (paediatric) inhaled steroid or LTRA (<5 years)	Very Low (paediatric) inhaled steroid Plus Children ≥ 5 years –add inhaled LABA (BTS SIGN 2016) or LTRA (NICE 2018) Children <5 years –add LTRA	No response to LABA stop LABA and consider increased dose of ICS to low dose ICS Children ≥ 5 years –add inhaled LABA) (NICE 2018)	<b>Refer for specialist advice</b> Consider trials of <ul style="list-style-type: none"> <li>Increasing ICS up to medium dose</li> <li>Addition of a fourth drug, SR theophylline tiotropium(licensed in children ≥ 6 years)</li> </ul>	<b>Refer for specialist advice</b> <ul style="list-style-type: none"> <li>Use daily steroid tablet in the lowest dose providing adequate control</li> </ul>
			If benefit from LABA but control still inadequate – continue LABA and increase ICS to low dose ICS Consider trial of MART regimen (NICE 2018)		<ul style="list-style-type: none"> <li>Maintain medium dose ICS</li> </ul>
			If benefit from LABA but control still inadequate – continue LABA and ICS and consider trial of other therapy e.g. LTRA,		<ul style="list-style-type: none"> <li>Consider other treatments to minimise the use of steroid tablets</li> </ul>

Short acting β2 agonist as required

Consider increasing treatment if using three doses a week or more Salbutamol Inhaler (M)-MDI (D)-DPI

Evaluation-assess symptoms, measure lung function, check inhaler technique ,adjust dose, update, self-management plan –move up and down as appropriate –move up to improve control and down to find and maintain lowest controlling therapy.



Until May 2009 all doses of inhaled corticosteroids were referenced against beclometasone dipropionate (BDP) given via CFC-MDIs. BDP-CFC is now unavailable. Doses of ICS are expressed as very low (generally paediatric dose), low (generally starting dose for adults), medium and high. Adjustments to doses will have to be made for other inhaler devices and other corticosteroid molecules.

**SMART® can be considered for patients with:**

- Inadequate asthma control and a frequent need of reliever medication
- Asthma exacerbations in the past requiring medical intervention

Patients must have received education on the use of the inhaler as maintenance and reliever therapy and clinicians must be confident patients understand how to use it appropriately. Patients should be advised to always have their inhaler available for rescue use. Patients requiring frequent use of rescue inhalations daily should be advised to return to the GP practice for reassessment. Practices should monitor the number of prescriptions requested and any dose-related adverse effects.

**Maintenance and Reliever Therapy – Adolescents 12+**

Symbicort<sup>®</sup> Turbohaler<sup>®</sup> 200/6 (D) 2 inhalations per day or twice a day and prn

Symbicort<sup>®</sup> Turbohaler<sup>®</sup> 100/6(D) 2 inhalations per day and prn

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