



Management of Persistent Asthma

Approved by the UM Committee: 9/27/05

Approved by the QOC:10/25/2005

The following guideline applies to patients with persistent asthma and recommends routine use of peak flow measurements, anti-inflammatory medications, a written action plan, and education to guide patients in self-management.

Eligible Population	Key Components	Recommendation and Level of Evidence	Frequency
Adults and children older than 5 years of age (1) with persistent asthma	Use of peak flow meter	• Prescribe peak flow meter [B]	At least once
	Regular use of controller medications	• Prescribe daily use of inhaled corticosteroids, *or inhaled corticosteroids with a long acting beta 2 agonist. [A] • Avoid the regular scheduled use of short-acting beta 2agonists for long term control of asthma.	Reassess at least annually
	Management of acute exacerbations	• Prescribe short-acting, inhaled beta 2agonist (4) [B] • Prescribe oral steroids for acute exacerbations that fail to respond adequately (4) [B]	During acute episode
	Medical follow-up	• Recommend and schedule if possible, follow-up outpatient visit at discharge from hospital or emergency department [D]	Visit within 7 days of discharge
	Periodic Assessment - Education, monitoring and management	• Provide written action plan for self-management • Recommend influenza immunization and ensure age appropriate immunization status (e.g., pneumococcal vaccine) • Educate patient/family regarding: - Use of peak flow meter - Use of Inhaler/Spacer - Use of medication - Recognition/treatment of symptoms and when to seek medical attention - Identification and avoidance of specific triggers - Smoking cessation/secondhand smoke avoidance [C]	Reassess at least annually

¹ For patients 5 years of age and younger, refer to the specific pediatric recommendations in the 2002 update of the National Asthma Education and Prevention Program (NAEPP) Expert Panel Report 2: Guidelines for the Diagnosis and Management of Asthma.

² Inhaled corticosteroids with beta2 agonists (preferred therapy). Alternative treatment: inhaled corticosteroids with either leukotriene modifier or theophylline.

³ Alternative therapies for mild persistent asthma include cromolyn, leukotriene modifier, nedocromil, OR sustained release theophylline to serum concentration of 5-15 mcg/mL.

⁴ Prescribe these medications for the patient to have at home to use in the event of an acute exacerbation.

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on the 2002 update of the National Asthma Education and Prevention Program (NAEPP) Expert Panel Report 2: Guidelines for the Diagnosis and Management of Asthma (www.nhlbi.nih.gov). Individual patient considerations and advances in medical science may supercede or modify these recommendations.

*2005 update: Add long acting inhaled beta 2agonist (2)(3) if persistent symptoms despite maximum inhaled steroid dose. **[A] deleted.**