Asthma in Children Camden Pathway

This pathway has been developed from published guidance, in collaboration with the Camden CYP atopy working group, in response to the findings from the 2016 Local Care Strategy strategic review
This guidance is to assist GPs in decision making and is not intended to replace clinical judgment.

NHS Camden Clinical Commissioning Group

Management of Asthma

Making a diagnosis

No single diagnostic test so assess **probability** of asthma based on history and investigations (where available).

When determining probability consider the following:

- Presence of ≥1 variable symptom of wheeze, cough, breathlessness and chest tightness
- Can be worse at night or early morning
- Triggered or exacerbated by exercise, viral infection, emotion, laughter , cold air or allergens
- Personal or FH atopy may support diagnosis
- Peak flow monitoring and variability. Interpret with caution - **lack of variability does not exclude asthma**
- Spirometry if > 5yrs. Fev_1/FVC ratio normally >90% children. If less when symptomatic is suggestive of asthma
- Bronchodilator reversibility- in children > 5yrs – improvement FEV_1 of 12% = +ve result

Low probability

Consider other diagnosis e.g. viral wheeze
Watchful waiting

Consider alternative diagnosis if any of the following:

- Sx present from birth
- FH if unusual chest disease
- Severe upper respiratory tract disease
- Persistent moist cough
- Viral induced wheeze
- Excessive vomiting
- Paroxysmal coughing bouts leading to vomiting
- Dysphagia
- Breathlessness with light-headedness and peripheral tingling
- Inspiratory stridor
- Abnormal voice or cry
- Focal signs in chest
- Finger clubbing
- Failure to thrive

Intermediate or high probability

Age 5 years or older
- Make diagnosis of asthma and record in notes

Age under 5 years
- Make diagnosis of asthma or can consider using term Multiple Trigger Wheeze (MTW)
- If using MTW use EMIS code 17371 (no exact code for MTW) to support searches
- MTW is managed in the same way as asthma
- If using MTW as diagnosis, children will not appear in QOF register or searches
- Ensure process is in place for annual reviews
- If symptoms persist to age 5 years, it is essential to update diagnosis to asthma

All ages
- Initiate treatment as per guidelines. Note: salbutamol prn is not considered a first line treatment
- Refer all children newly diagnosed to community atopy nurse for education and initial action plan
- All children should have a spacer device and be educated in its use
- Review progress at maximum of 6 weeks and review diagnosis
- If improvement with inhaled corticosteroid, can use EMIS code 33K1 (confirmation of diagnosis for QOF)

Refer to Atopy Nurse

Eligibility Criteria

- All children with a new diagnosis of asthma
- Children needing frequent salbutamol prescriptions, more than one course of prednisolone in a year or those with frequent exacerbations whom you feel you are not able to improve
- Children with asthma where compliance or other wider parental/social factors may be impacting control

Do not refer

- Patients with acute asthma exacerbations
- Patients where there is diagnostic uncertainty

Referral criteria for secondary care

Eligibility Criteria

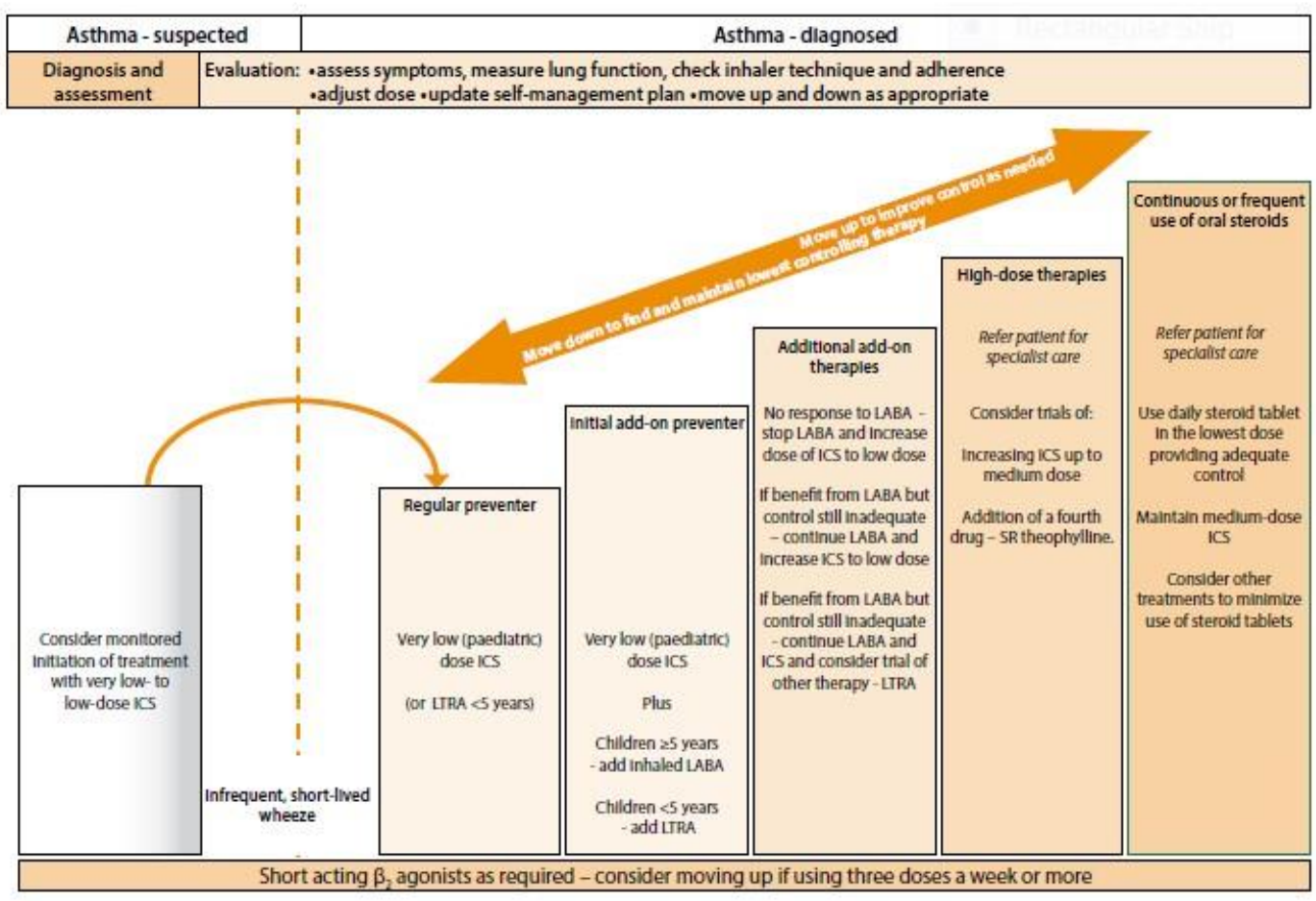
- Diagnosis unclear
- Poor response to treatment (once compliance assured)
- Severe/life threatening asthma attack
- Any patient on 'high dose therapies' (see stepped care diagram)

Monitoring

- Extended asthma review at least annually
- Consider stepping up and down treatment as per stepped care diagram
- Arrange urgent review (within 48hours) for any child with A&E attendance for asthma

Refer community nurse if:
- Frequent use of salbutamol inhalers
- >1 course oral prednisolone in a year
- More than 3 days asthma-related school absence in last 3 months
- Frequent exacerbations which you feel you are not able to improve
- Those where compliance or other wider parental/social factors may be impacting control.

- Consider referral to secondary care as per referral criteria in more severe cases



Drug treatment	Camden preferred 1st line option		Camden preferred 2nd line option	
	Inhaler and strength	Dosing	Inhaler and strength	Dosing
SABA	Salbutamol inhaler non-breath actuated MDI 100 micrograms (prescribe generically)	PRN	-	
Very low ICS dose	Clenil Modulite® MDI 100mcg or Clenil Modulite® MDI 50mcg	1 puffs BD 2 puffs BD	Pulmicort® Turbohaler 100mcg	one puff BD
Very low dose ICS +LABA	Symbicort® Turbohaler 100/6	1 puff BD	No other very low dose ICS+LABA combination inhaler licensed, however MDI and spacer are often preferable. If Symbicort® Turbohaler is not suitable, low dose ICS or low dose ICS/LABA combination can be considered following specialist advice from community atopy nurse or other specialist. ICS and LABA inhalers should not be prescribed as separate inhalers.	
Low ICS dose	Clenil Modulite® MDI 100mcg	2 puffs BD	Budesonide 100mcg (Prescribe by Brand)	2 puffs BD
Low dose ICS + LABA	Symbicort® Turbohaler 100/6 **or** Seretide® Evohaler 50/25 **or** Seretide® Accuhaler 100/50	2 puffs BD 2 puffs BD 1 puff BD		
Medium ICS dose	Clenil Modulite® MDI 200mcg (unlicensed in	2 puffs BD	Budesonide 200mcg (Prescribe by Brand)	2 puffs BD

Branded generic inhaler equivalents are available, but these are not licensed for use in children and have not been considered for use within the local health economy for paediatric patients.

References

Comments & enquiries relating to medication:
CCCG Medicines Management Team
mmt.camdenccg@nhs.net
Refer to current BNF or SPC for full medicines information

Clinical Contact for pathway queries:
Camden.pathways@nhs.net

Pathways created by the Children and Young Persons Atopy project

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