BTS 5-12 years old

**Step 1**
Mild intermittent asthma

**Step 2**
Initial add-on therapy

**Step 3**
Persistent poor control

**Step 4**
Continuous or frequent use of oral steroids

**Step 5**
Use daily steroid tablet in lowest dose providing adequate control
- Maintain high dose inhaled steroid at 800 mcg/day*
- Refer to respiratory paediatrician

Patients should start treatment at the step most appropriate to the initial severity of their asthma. Check concordance and reconsider diagnosis if response to treatment is unexpectedly poor.

**Summary of stepwise management in children aged 5-12 years**

- **Inhale short-acting β₂ agonist as required**
  - **Add inhaled steroid 200-400 mcg/day** (other preventer drug if inhaled steroid cannot be used; 200 mcg is an appropriate starting dose for many patients)
  - Start at dose of inhaled steroid appropriate to severity of disease.

- **1. Add inhaled long-acting β₂ agonist (LABA)**
- **2. Assess control of asthma**
  - **good response to LABA**
    - continue LABA
  - **benefit from LABA but control still inadequate**
    - continue LABA and increase inhaled steroid dose to 400 mcg/day* (if not already on this dose)
  - **no response to LABA**
    - stop LABA and increase inhaled steroid to 400 mcg/day.* If control still inadequate, institute trial of other therapies, leukotriene receptor antagonist or SR theophylline

- **Increase inhaled steroid up to 800 mcg/day**

- **Move up to improve control as needed**
- **Move down to find and maintain lowest controlling step**

* BDP or equivalent
BTS <5 years old

**Summary of stepwise management in children less than 5 years**

**Step 1**
- Mild intermittent asthma
- Inhaled short-acting β₂ agonist as required

**Step 2**
- Initial add-on therapy
- Add inhaled steroid 200-400 mcg/day**
  or leukotriene receptor antagonist if inhaled steroid cannot be used.
  Start at dose of inhaled steroid appropriate to severity of disease.

**Step 3**
- Persistent poor control
- In those children taking inhaled steroids 200-400 mcg/day consider addition of leukotriene receptor antagonist.
  In those children taking a leukotriene receptor antagonist alone reconsider addition of an inhaled steroid 200-400 mcg/day.
  In children under 2 years consider proceeding to step 4.

**Step 4**
- Refer to respiratory paediatrician.

* **BDP or equivalent**
† Higher nominal doses may be required if drug delivery is difficult
Which Inhaler & What Strength?

**Bronchodilator**
- Salbutamol 100mcg
- Salbutamol 200mcg
- Bricanyl 500mcg

**Inhaled corticosteroid (ICS)**
- Beclometasone 50mcg
- Beclometasone 100mcg
- Fluticasone 50, 125 & 250mcg
- Fluticasone 50, 100 & 500mcg
- Pulmicort 100, 200 & 400mcg

**ICS/LABA**
- Seretide 50, 125 & 250 Plus 25mcg Salmeterol
- Seretide 100, 250 & 500 Plus 50mcg Salmeterol
- Symbicort 100/6, 200/6 & 400/12mcg
- Symbicort 100/6, 200/6 & 400/12mcg
- Formoterol 6 & 12mcg

**Meter Dose inhaler**
- Always with Spacer

**Accuhaler**

**Turbohaler**

Nb: Fluticasone is twice the potency of beclamethasone.

Image courtesy of UCH