

- Before moving up:**
- Check adherence
 - Assess inhaler technique
 - Eliminate trigger factors if possible
 - Reconsider diagnosis if response to treatment is unexpectedly poor
 - Review every 6-8 weeks, either face to face or telephone

Key:

Eco-friendly: 

Dry Powders

Easyhaler: 

Turbohaler: 

Nexthaler: 

Relvar ellipta: 

Aerosols

MDI (+spacer): 

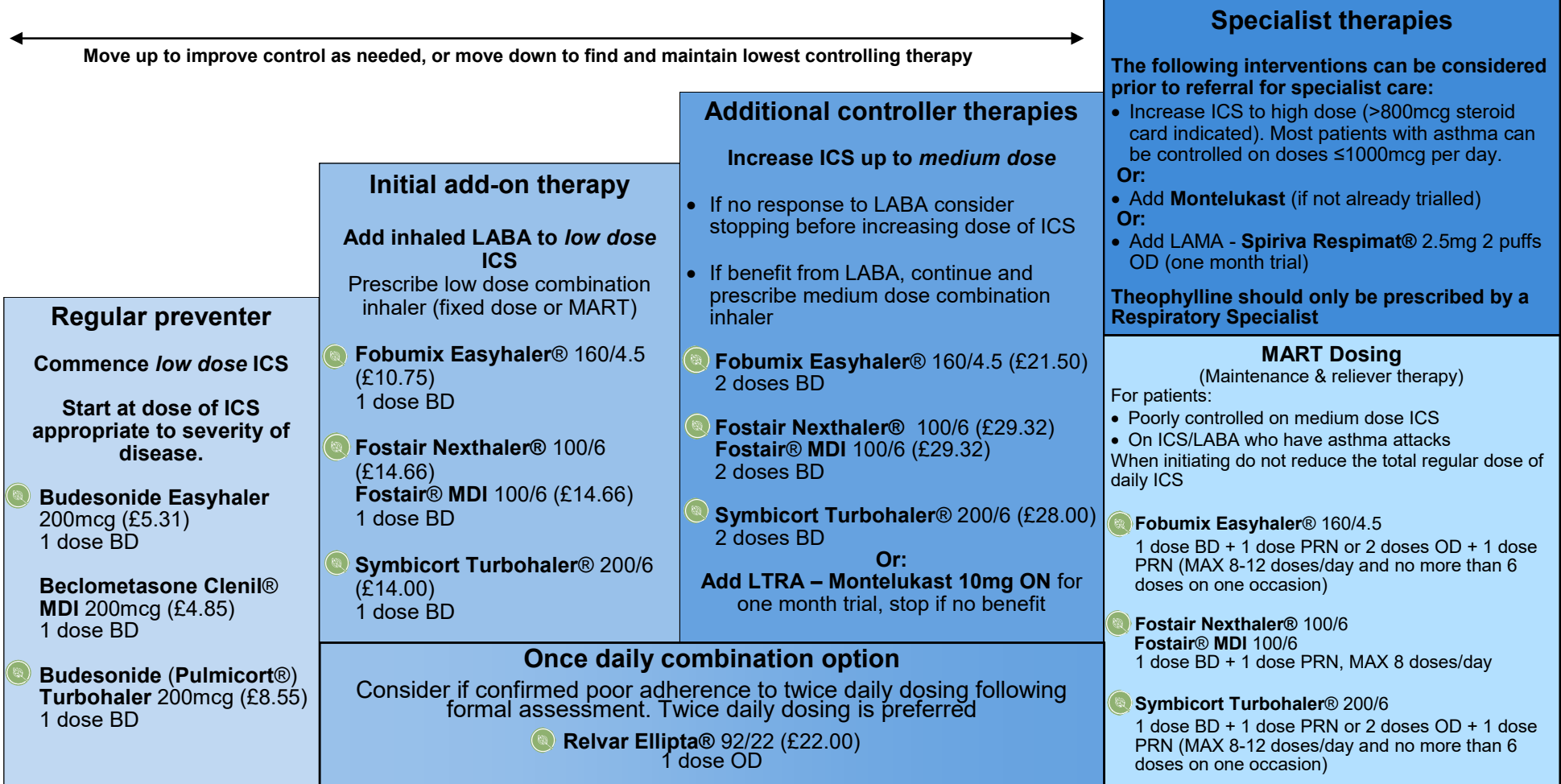
SMI Respimat: 

- Moving down**
- If patient stable consider reducing dose of ICS by 25-50% every three months
 - Review every 6-8 weeks

Diagnosis and Assessment	Evaluation: <ul style="list-style-type: none"> • assess symptoms, measure lung function, check inhaler technique and adherence • adjust dose • update self-management plan
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Asthma-suspected: Start ICS at dose appropriate to severity of disease as per regular preventer therapy. Assess response objectively as per evaluation

Asthma - diagnosed (Brand prescribing only for all inhalers)





All prices above represent 30 days treatment

Reliever (unless using MART)

SABA PRN – consider moving up if using three doses a week or more—**red flag for poor control of asthma**

Any patient who has required more than 4 Salbutamol inhalers in 12 months should be invited for an urgent asthma review

Salamol® 100mcg 1-2 doses up to QDS PRN 200 dose inhaler £1.46 per inhaler  **Salbutamol Easyhaler** 100mcg 1-2 doses up to QDS PRN 200 dose inhaler £3.31 per inhaler  **Terbutaline** 500mcg (**Bricanyl®**) Turbohaler 1 dose up to QDS PRN 100 dose inhaler £8.30 per inhaler

Diagnosis

Features that increase probability of asthma:

- Recurrent episodes of symptoms – wheeze, breathlessness, chest tightness and cough – particularly at night or early morning
- Symptom variability and triggers including exercise, allergen exposure, cold air, aspirin, NSAIDs, or β blockers
- Absence of symptoms of alternative diagnosis .
- Recorded observation of wheeze
- Personal history of atopy
- Historical record of variable PEF or FEV₁

Remember:

- A normal spirometry (or PEF) obtained when the patient is not symptomatic does not exclude the diagnosis of asthma, consider further tests such as exhaled nitric oxide levels, bronchial provocation test, blood eosinophils, allergy testing (IgE) if diagnosis unclear
- Accurate history, include rhinitis and reflux

General management of all asthma patients

- **Review inhaler technique.** Streamline inhaler devices (prescribe all dry powder or all aerosol devices to patients)
- Asthma control test (www.asthmacontroltest.com)
- Lung function test (spirometry in preference)
- Check concordance to asthma medication
- General medication review
- Monitor use of rescue medications and offer urgent review if >4 SABAs /year
- Monitor number of unscheduled visits and steroid courses per year, arrange follow up within 48 hours post exacerbation
- Influenza vaccination
- Provide patient with a steroid alert card if on high dose inhaled steroids (>800mcg daily)
- Discuss exercise or occupational induced symptoms and management
- Offer or refer patients for smoking cessation advice and support in quit attempts
- Trigger recognition and avoidance, including occupational aeroallergens
- Written self-management/ personal asthma action plan
- Relevant patient education including weigh loss advice and support
- Agree appropriate follow up face to face or by telephone

Aims of asthma management

- No daytime symptoms
- No night time awakenings due to asthma
- No need for rescue medication
- No limitations on activity including exercise
- No exacerbations
- Normal lung function (FEV₁ and/or PEF >80% of predicted or best)
- Individualised treatment plans and goals to be negotiated and agreed with patient

Acute asthma management

Assess severity of exacerbation and refer to hospital if patient presents with one feature of acute severe or life threatening asthma	Immediate treatment	Prior to leaving surgery
Acute Severe: <ul style="list-style-type: none"> • PEF 33-50% of best or predicted • Respiratory rate \geq 25/minute, heart rate \geq 110/minute • Inability to complete sentences in one breath Life threatening: <ul style="list-style-type: none"> • SpO₂ <92% • PEF <33% of best or predicted • Silent chest, cyanosis, or poor respiratory effort • Exhaustion, altered consciousness, arrhythmia, hypotension 	<ul style="list-style-type: none"> • Salbutamol 100mcg 2-10 puffs via MDI and large volume spacer as needed • Check PEF prior and 15 minutes post bronchodilator and monitor response for at least 30 minutes • 40-50mg oral prednisolone daily for a minimum of 5 days or until recovery (not enteric coated) 	<ul style="list-style-type: none"> • Check inhaler technique/ concordance to current asthma medications • Give short-term symptom-based management plan • Arrange follow-up within 48 hours with GP/PN if good response to initial treatment • Advise patient to call for urgent medical assistance if any further deterioration in asthma

When to refer for specialist opinion

- Diagnosis unclear
- Patient requiring specialist therapies (as overleaf)
- Unexpected clinical findings (crackles, clubbing, cyanosis, cardiac disease)
- Persistent, non-variable breathlessness
- Unexplained restrictive spirometry
- Marked blood eosinophilia
- Chronic sputum production
- Monophonic or inspiratory wheeze (stridor)
- Suspected occupational asthma
- Prominent systemic features (myalgia, fever, weight loss)
- Poor response to asthma treatment (\geq 3 corticosteroid courses in 12 months)
- Severe asthma exacerbation