MANAGEMENT OF ACUTE ASTHMA IN CHILDREN OVER 5 YEARS (PRIMARY CARE)

ASSESS ASTHMA SEVERITY

Clinical signs may correlate poorly with severity of attack. Some children with acute asthma may not appear distressed

ASSESS ABC

Moderate Exacerbation

- SpO2 ≥92%
- PEF ≥50% best or predicted
- No clinical features of severe asthma

Severe Exacerbation

- SpO2 < 92%
- PEF < 50% best or predicted
- Heart rate > 125/min
- Respiratory rate > 30/min
- Use of accessory neck muscles

Life Threatening Asthma

- SpO2 < 92%
- PEF < 33% best or predicted
- Silent chest
- Poor respiratory effort
- Altered consciousness
- Cyanosis

- Salbutamol 2-6 puffs via spacer
- Consider Prednisolone 30-40mg
- Reassess after 20 minutes

- Oxygen via face mask to achieve normal saturations
- Nebulised Salbutamol 5mg
- Soluble Prednisolone 30-40mg
- If poor response add Nebulised Ipratropium Bromide 250micrograms
- If poor response, repeat every 20-30 minutes until ambulance arrives

CALL 999

- Oxygen via face mask to achieve normal saturations
- Nebulised Salbutamol 5mg plus Ipratropium Bromide 250micrograms
- Soluble Prednisolone 30-40mg if able to tolerate oral medication or IV hydrocortisone 100mg
- Repeat every 20-30 mins or until ambulance arrives

RESPONSE TO TREATMENT

- Continue using salbutamol up to 4 hourly
- Continue any pre-prescribed inhaled steroids
- Monitor PEFR and seek advice if drops

ADMIT IF:

- Symptoms persist
- Symptoms worsen
- Risk factors for severe attack:
  - -Poor adherence
  - -Previous severe attack
  - -Deterioration despite oral steroids
  - -Recent hospital admission for asthma
  - -Presentation in the evening

FOLLOW UP

Review within 48 hrs of attack or within 2 days of discharge from hospital

Review:

- Symptoms
- PEFR
- Inhaler technique
- PAAP and avoidance of triggers
- Long term preventer therapy and assess need to step up treatment
- Understanding of recognition of worsening control and signpost to information sheet