Management

Pharmacological (Baseline Maintenance Therapy):

Based on the CTS 2012 Asthma Management continuum, to determine medication needed to achieve control (baseline maintenance therapy)

Adjust therapy to achieve and maintain control and prevent future risk:

1. All should be on a reliever on demand: SABA***
2. Still Uncontrolled (refer to "Review Control" table): Add regular controller therapy (ICBs are the first-line therapy for all ages)
3. Still Uncontrolled: Consider starting regular controller therapy if: baseline medication is ICS: add prednisone 1mg/kg x 3-5 days
4. Still Uncontrolled: Consider starting regular controller therapy if: baseline medication is ICS/LABA (BUD/FORM): 1st choice: Trail 4-6 puffs inICS (dosing should not exceed manufacturer’s recommended maximum daily doses) for 7-14 days. 2nd choice: Add prednisone 30-50mg for at least 5 days
5. Still Uncontrolled: Refer to specialist, consider adding prednisone

Pharmacological (Asthma Exacerbation):

CTS 2012 recommended controller step-up therapy when patient has acute loss of control on their baseline maintenance therapy (yellow zone of ASTHMA ACTION PLAN)

Children (≤4 yrs and 6-11yrs): increase low dose ICS to medium dose ICS Adults and children ≥ 12yrs: add LABA if ICS (ideally in the same inhaler device)

If the patient has no baseline medication maintenance: consider starting regular controller therapy if: baseline medication is ICS: add prednisone 1mg/kg x 3-5 days

If the patient has no baseline medication maintenance: consider starting regular controller therapy if: baseline medication is ICS/LABA (BUD/FORM): 1st choice: 1 to max 4 puffs BID for 7-14 days (Max 8 puffs/day). 2nd choice: Add prednisone 30-50mg for at least 5 days

If baseline maintenance is LABA (IPP/BALM or MONOFORM): 1st choice: Trail 4-6 fid in ICS for 7-14 days. 2nd choice: Add prednisone 30-50mg for at least 5 days

Note: Post-exacerbation, diligent follow-up should be done to consider stepping down add-on therapy

Non-Pharmacological (Education):

- Refer to Certified Asthma/Respiratory Educator, if available
- Discuss asthma pathophysiology, triggers, comorbidities, inhaler technique, reliever vs. controller, medication safety and side effects, adherence, asthma control
- Smoking cessation counselling when appropriate
- Create and review written ASTHMA ACTION PLAN (instruction for when there is loss of control) Note: If, after reviewing control, it is determined that the patient is not controlled on their baseline maintenance therapy, they are in the yellow zone and the CTS 2012 recommended controller step-up therapy should be started
- Prevention of exacerbations: environmental control (i.e., work, home and school environment), tobacco smoke exposure, environmental triggers, irritant triggers, vaccination (influenza), Immunotherapy

Review Control

(Reassess at each visit)


Control indicates all of the following criteria are met

Daytime symptoms (dyspnea, cough, wheeze, chest tightness) ≤ 4 days/week

Night time symptoms: ≤ 1/night

Physical activity: normal

Diurnal variability in PEF ≤ 10-15% over a 2 week period (morning and night)

Asthma exacerbations within the last 12 months ≤ 2, RIS infrequent

No absence from school/work due to asthma

Consider as an additional measure of asthma control in individuals ≥ 18 years with moderate to severe asthma who are assessed in specialized centres.

Follow-Up

- Regularly reassess control, inhaler technique, adherence, triggers, comorbidities, spirometry or PEF****
- Review medication regime and consider modifying maintenance therapy (consider stepping down add-on therapy or decrease ICS dose if asthma is well-controlled between visits)
- Review/Revise written ASTHMA ACTION PLAN

Consider Referral to a Specialist:

- Not certain of diagnosis
- Sputum eosinophil monitoring
- Difficulty in determining baseline medication regimen
- Severe asthma requiring alternate therapy
- Recent ER/hospital admission or recurring exacerbations