

## **ASTHMA PEDIATRICS CLINICAL PRACTICE GUIDELINES**

1. Classifying asthma severity in children:

**Age 0-4**

- a. Intermittent: symptoms occur less than twice a week and no nighttime awakenings
- b. Mild Persistent: symptoms occur more than twice a week and 1-2 nights/month
- c. Moderate Persistent: daily symptoms, and 3-4 nights/month
- d. Severe Persistent: symptoms throughout the day and 1 night/week

**Age 5-11**

- a. Intermittent: symptoms occur less than twice a week and less than 2 nights/month
- b. Mild Persistent: symptoms occur more than twice a week, but not daily and 3-4 nights/month
- c. Moderate Persistent: daily symptoms and symptoms occurring more than once a week, but not nightly
- d. Severe Persistent: symptoms throughout the day and 2 nights/week

2. For patients with Mild Persistent, Moderate or Severe Asthma:

- a. Patients will be prescribed inhaled steroids or an acceptable alternative medicine
- b. Patients will report peak flow meter readings to the physician
- c. Patient's personal best peak flow reading will be documented in the medical record
- d. Patient will have a documented action plan for managing Asthma if their personal best reading decreases
- e. A copy of the patient's written action plan will be maintained in the patient's medical record
- f. A copy of the patient's written action plan will be maintained at the child's school, childcare, extended care and with the athletic trainer
- g. For children age 18 and younger a treatment goal is that patients will have no less than 2 follow-up visits per year for Asthma treatment, excluding acute exacerbations

3. For all patients, a current treatment plan, including:

- a. Bronchodilator (inhaled beta-agonist) as a rescue medication
- b. Nebulizer at home for children <5 years of age as appropriate
- c. Spacer as appropriate
- d. Spirometry initially to confirm diagnosis as appropriate and then every 1-2 years as the condition warrants. Use of spirometry in all patients 5 years of age and older

4. Children should have an allergy evaluation as part of their care as appropriate

(continued)

## **ASTHMA PEDIATRICS CLINICAL PRACTICE GUIDELINES (continued)**

5. Environmental assessment, including:
  - a. Allergens (animal dander)
  - b. Irritants (primary and/or secondary smoke)
  - c. Occupational hazards
  
6. Lifestyle impact, including,
  - a. Days of work/school missed
  - b. Activity restrictions
  - c. Patient or guardian has a current medication list
  
7. Influenza vaccine having been provided to all patient 6 months of age and older

Source: NIH-*National Asthma Education and Prevention Program Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma NIH Pub No. 08-5846*