FOREWORD
When the Spanish Society of Clinical Immunology and Paediatric Allergy and the Spanish Society of Paediatric Pneumology agreed to organise a joint meeting in May 2004, they set up a commission to draw up a document that would review the basic features of children’s asthma treatment and would unify criteria that had been apparently diverse up to then.

The first meeting of this Commission was held in June 2003 and laid down the guiding principles for this document. Special attention would be paid to those periods of life in which asthma is more complicated for both diagnosis and treatment. The prediction of the asthma phenotype, as a variable to be borne in mind in certain therapy decisions, was included for the first time in a guide of this kind.

The document was not conceived as an exhaustive guide. Consequently, such basic questions as education and self-care were not dealt with because there is general consensus on them.

The most important aspect of the document is the bringing together of two hitherto disparate visions of children’s asthma. Both societies assume full responsibility for the document, in which every sentence has been checked carefully. The basic aim is to offer clear, uniform criteria for asthma treatment in Paediatrics.

Both societies hope that this is not the end of our joint work, but that it will continue on a regular basis with other initiatives, including the updating of this document in the future.

INTRODUCTION
Epidemiology
The epidemiology of asthma in Spain is well-known in children over 6, but no studies on younger children exist. Unlike the Anglo-Saxon countries, asthma prevalence in Spain is relatively low: about 9% of 13-14 year olds report symptoms during the preceding twelve months, and 10% of parents of 6-7 year-old children report that their children suffered wheezing in the same period. This prevalence was the same in older children in 2002 as in 1994, whereas it increased markedly in 6-7 year olds (from 7% to 10%). Grave wheezing is much less common in both age groups (around 2%). This also increased in the 6-7 year-old group, whereas it remained steady among 13-14 year olds. At these ages there appears to be greater prevalence and gravity of asthma in the coastal areas than on the central plain.1

Definition
For the purpose of this document, which refers to children, with particular emphasis on the first years of life, and as the physiopathology of asthma is largely unknown, the consensus paediatric definition4,5 is the best one to use: “Recurrent wheezing and/or persistent coughing in a situation in which asthma is likely and other less frequent illnesses have been ruled out”. From the age of 3, asthma becomes steadily more definitive; and from the age of 6-7, the stricter physiopathological definitions of general consensus criteria can be used (GINA6, NHLBI7, GEMA8, etc.).

ASTHMA PHENOTYPES
Although the physiopathology of asthma is little understood, there are various clinical phenotypes of it that have been characterised in various cohorts in several countries9-18 and can be consulted in a number of publications. Though cautiously, we think that these phenotypes can be applied to Spain. This document aims to establish the best line of treatment for each pheno-
type, based on the scientific evidence available. Therefore, accurate definitions of these phenotypes are fundamental:

**Transient asthma**
1. This starts before 3 and tends to disappear between the ages of 6 and 8. It accounts for between 40% and 50% of all cases of asthma.
2. It is not atopic: total IgE normal and/or negative skin tests and/or Phadiatop, along with absence of stigmata – atopic dermatitis (eczema), for example – and family background of allergy.
3. Lung function reduced from birth, but normal by 11 years old.

**Early-onset persistent asthma**
1. This starts before 3 and lasts beyond the age of 6-8. It accounts for 28% to 30% of all asthma cases.
2. Normal lung function at 12 months and reduced at 6 years.

Two sub-phenotypes of this can be distinguished:

- **Atopic**
  1. Total IgE high and/or skin tests positive, generally with stigmata and family background of allergy.
  2. Positive bronchial hyper-responsiveness.
  3. Usually still persists at the age of 13.
  4. The first crisis usually appears after 12 months.
  5. Predominantly in boys.

- **Not atopic**
  1. Total IgE normal and skin tests negative, without stigmata or family background of allergy.
  2. Increase in bronchial hyper-responsiveness, which diminishes over the years.
  3. Usually disappears at the age of 13.
  4. The first crisis is usually before 12 months and related to Bronchiolitis due to respiratory syncytial virus.
  5. Affects both sexes equally.

**Late-onset asthma**
1. Starts between 3 and 6 years old. It accounts for 20%-30% of all cases of asthma.
2. Normal lung function at 6 years of age, which deteriorates subsequently.
3. Often atopic history in mother, Rhinitis in early years and positive cutaneous tests by the age of 6.
4. Mainly in boys.
5. It is atopic persistent asthma, but with a late onset.

**Prediction of asthma phenotype**
For practical reasons, it is important to try and establish the phenotype of a particular child in his/her first crises. A child with early wheezing and a major or two minor risk factors from the lists below will be highly likely to suffer persistent atopic asthma. However, it must not be forgotten that these criteria provide low sensitivity (59.3%, i.e. they include a lot of false negatives), but quite high specificity (82.1%, i.e. they exclude almost all the false positives).

**Major risk factors**
1. A parent with medical diagnosis of asthma.

**Minor risk factors**
1. Medical diagnosis of Rhinitis.
2. Wheezing unrelated to colds.
3. Eosinophilia ≥ 4%.

The development of specific IgE antibodies to egg during the first year of life is a predictive indicator of risk of atopic illness. It is the main and earliest serological marker of subsequent sensitisation to inhaled allergens and the development of respiratory allergic pathology. In addition, when allergy to egg is linked to atopic dermatitis, there is 80% probability of respiratory allergic pathology presenting at 4 years of age.

**DIAGNOSIS OF ASTHMA IN CHILDREN**

**Clinical assessment**
The taking of the clinical history must aim to clarify the most important asthma-related points, especially those relating to the differential diagnosis. The symptoms, signs and characteristics of crises must be recorded; the inter-crisis periods have to be assessed; and any precipitating and aggravating factors need to be identified (see the diagnosis algorithm in figure 1).

**Function assessment**
The examination of respiratory function serves to confirm the diagnosis of asthma, measure the seriousness of the illness, control its evolution and clarify the response to treatment. In collaborative children, Forced Spirometry can be used, as its simplicity and cost make it the main test for measuring bronchial obstruction. Other tests can be used for non-collaborative children, such as body plethysmography, impulse oscillometry, resistance after occlusion or thorax-abdomen compression.

The reversibility of this bronchial obstruction and/or the degree of hyper-responsiveness of the bronchi need to be studied. For this, bronchodilator tests and tests of non-specific bronchial hyper-responsiveness (metacholine, exercise etc.), are used.
**Bronchodilator test**

This consists of a basal forced spirometry, repeated 15 minutes after administering a β₂-adrenergic agonist inhaled for a short time (400 µg salbutamol = 4 pulses, or equivalent of terbutalin). This should be a normal examination in every child with suspected asthma, including when the FEV₁ is normal. The use of portable machines to measure peak expiratory flow (PEF) for functional diagnosis of asthma is not recommended.

There are various methods or indexes to express bronchodilatory response and the most common of them is the percentage change from the initial value in FEV₁, i.e.: Δ% = [(FEV₁ post – FEV₁ pre)/FEV₁ pre] × 100. Increase in FEV₁ of 12% over the base figure or 9% over the theoretical figure* (Proof C) is considered positive. Normal lung function with negative bronchodilatory test does not rule out a diagnosis of asthma.

**Bronchial Hyper-responsiveness**

Bronchial provocation tests demonstrate the presence or absence of non-specific and/or specific (due to allergens) bronchial hyper-responsiveness. Normally, these are not needed for the diagnosis and monitoring of asthmatic children, but may be very useful for a differential diagnosis.

**Allergologiological assessment**

The aim of this evaluation is to determine whether there is/are a relevant allergen or allergens involved in the pathology of the child with asthma. Then, proper measures of prevention can be adopted.

The fundamental techniques in this evaluation are the cutaneous tests: the prick (simple, rapid and safe) or intradermoreaction test. However, on occasions, we may find false positives or negatives, and the cutaneous test has to be complemented by other diagnostic tests such as the determination of antigen-specific IgE in serum (RAST or CAP system). On occasions, the specific bronchial provocation test may be necessary, to detect the trigger allergen involved.

The positive result of cutaneous tests or the determination of specific IgE only indicates allergic sensitisation.

**TREATMENT OF ACUTE EPISODES IN PEDIATRICS**

**General considerations**

1. Therapeutic management of acute asthma crises will depend on their gravity.

2. As there are few protocols on the acute episode in the nursing child, use of medication is based on clinical experience and extrapolation from data obtained from older children.

3. It is recommended that Health Centres have a Pulseoxymeter available to improve evaluation of asthma crises.

4. On treating an acute episode, the following must be borne in mind:

   a) The evolution time of the acute period.

   b) The medication administered previously.

   c) The maintenance treatment that the patient may be receiving.

   d) The existence of associated illnesses.

5. Mild and moderate crises can be treated in Primary Care.

6. The child must be referred to Hospital Emergencies when there is:

   a) A grave crisis.

   b) Suspected complications.

   c) A history of high-risk crises.

   d) Impossibility of proper follow-up.


7. Drug dosage and administration times have to be modified in relation to the gravity of the crisis and the response to treatment.

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*Proof C*
Busquets Monge RM, et al. Consensus on asthma treatment in Paediatrics

Ann Pediatr (Barc) 2006;64(4):365-78

Assessment of gravity

Table 1 establishes a system for evaluating the seriousness of the acute asthma episode, modified from the GINA guidelines4.5.

TABLE 1. Seriousness of the acute episode of asthma

<table>
<thead>
<tr>
<th>Mild</th>
<th>Moderate</th>
<th>Grave</th>
<th>Severe respiratory failure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dyspnea</td>
<td>Walking</td>
<td>On talking</td>
<td>As not</td>
</tr>
<tr>
<td>Can lie down</td>
<td>In feeding, the cries more soft and brief, difficulty in feeding</td>
<td>Breast-feeding child stops eating</td>
<td></td>
</tr>
<tr>
<td>Talk</td>
<td>Long sentences</td>
<td>Short sentences</td>
<td>Words</td>
</tr>
<tr>
<td>Awareness</td>
<td>Possible agitation</td>
<td>Agitation</td>
<td>Confusion</td>
</tr>
<tr>
<td>Respiratory frequencies in awake children</td>
<td>Increased</td>
<td>Increased</td>
<td>Much increased</td>
</tr>
<tr>
<td>&lt; 2 months</td>
<td>&lt; 60/min</td>
<td>&lt; 50/min</td>
<td></td>
</tr>
<tr>
<td>2-12 months</td>
<td>&lt; 40/min</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-5 years</td>
<td>&lt; 30/min</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-6 years</td>
<td>&lt; 30/min</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accessory muscles and suprasternal retractions</td>
<td>Not usually</td>
<td>Usually</td>
<td>Usually</td>
</tr>
<tr>
<td>Wheezing</td>
<td>Marked, at the end of expiration</td>
<td>Marked</td>
<td>Generally audible</td>
</tr>
<tr>
<td>Pulse beats/min</td>
<td>Normal</td>
<td>Increased</td>
<td>Much increased</td>
</tr>
<tr>
<td>Normal pulse rates in children</td>
<td>Breast-feeding</td>
<td>Pre-school</td>
<td>School-children</td>
</tr>
<tr>
<td>&lt; 2 months</td>
<td>&lt; 160/min</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2-12 months</td>
<td>&lt; 120/min</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-5 years</td>
<td>&lt; 110/min</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PFR (Peak Expiratory Flow) > 80% | 60-80% | < 60% |

Patient (% of best | Environment air (%) | Environment air % |
| > 65 mmHg | < 65 mmHg |
| > 65 mmHg | < 65 mmHg |

*Presence of several parameters, though not necessarily all, indicates the general classification of exacerbation.

Medication

Short-term β2 adrenergic agonists: These are the first line of treatment. Their benefits in treating crises have been sufficiently contrasted24-33 (Proof B). Inhalation is the pathway of choice, as it gives greater effectiveness with fewer side-effects.

The pressurised inhaler system with spacer chamber is as effective, if not more so, than nebulisers in the Emergency Department and is the treatment of choice for mild or moderate episodes of asthma31,34,35 (Proof B).

Ipratropium Bromide: Some studies thought this useful, when linked to short-acting β2 agonists in moderate or grave crises36-38, although evidence on its use in nursing infants is limited and contradictory39-41. The nebulised dose is 250 μg/4-6 hours in children under 30 kg and 500 μg/4-6 hours in those over 30 kg. It should not replace β2 adrenergic agonists.

Glucocorticoids: They have shown their use when used early42,43 (Proof B) and the oral, rather than parenteral, is the pathway of choice44,45. There is not sufficient evidence to justify use of inhaled corticoids in acute crises46-48 (Proof B). Recommended dose is 1-2 mg/kg/day of Prednisone (maximum 60 mg) or equivalent. When the doctor decides to withdraw medication before the tenth day, there is no need for steady reduction of the dose.
Antibiotics: Since most of these episodes are due to viral infections, administration of antibiotics must be exceptional.

**Treatment in Primary Care**

The algorithm of the treatment of the acute episode of asthma in Primary Care is shown in figure 2.

**Treatment in Casualty**

Figure 3 indicates the algorithm of treatment of acute episodes of asthma in Hospital Casualty.

**Maintenance Treatment in Paediatrics**

Maintenance treatment has three sections:
TABLE 2. Objectives of asthma treatment in infancy (GINA)*

- Make chronic symptoms minimal or non-existent
- Prevent exacerbations
- Maintain lung function as close as possible to normal levels
- Maintain normal levels of activity, including exercise
- Avoid the adverse side-effects of anti-asthma medication
- Anticipate evolution towards irreversible restriction of air flow
- Prevent asthma mortality

TABLE 3. Anti-asthma medication in Pediatrics

<table>
<thead>
<tr>
<th>Bronchodilators</th>
<th>Anti-inflammatories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-acting β₂ agonists: Salbutamol</td>
<td>Inhaled Corticoids</td>
</tr>
<tr>
<td>Terbutaline</td>
<td>Budesonide</td>
</tr>
<tr>
<td>Long-acting β₂ agonists: Formoterol</td>
<td>Fluticasone</td>
</tr>
<tr>
<td>Salmeterol</td>
<td>Prednisolone</td>
</tr>
<tr>
<td>Cholinergic drugs: Ipratropium Bromide</td>
<td>Anticholinergics</td>
</tr>
<tr>
<td>Long-acting β₂ agonists: Salmeterol</td>
<td>Leukotrienes</td>
</tr>
<tr>
<td>Ipratropium Bromide</td>
<td>Montelukast</td>
</tr>
<tr>
<td>Ipratropium Bromide</td>
<td>Cromones</td>
</tr>
<tr>
<td>Ipratropium Bromide</td>
<td>Desloratadine</td>
</tr>
<tr>
<td>Long-acting β₂ agonists: Salmeterol</td>
<td>Nedocromil Sodium</td>
</tr>
</tbody>
</table>

TABLE 4. Equipotent doses of inhaled corticoids (µg/day)* (Proof D)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Low doses</th>
<th>Medium doses</th>
<th>High doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budesonide</td>
<td>≤ 200</td>
<td>200-400</td>
<td>&gt; 400</td>
</tr>
<tr>
<td>Fluticasone</td>
<td>≤ 500</td>
<td>500-250</td>
<td>&gt; 250</td>
</tr>
</tbody>
</table>

In children weighing less than 15 kg

1. Education of patients and families, along with control of the environment.
3. Immunotherapy.

This document does not pretend to be exhaustive. Therefore, for general themes of avoiding triggers, education or the pharmacology of asthma medication, short guides are recommended, such as the protocols promoted by the Spanish Paediatrics Society (AEP)53,54, or longer guides such as the SEICAP Asthmatic Child-care Guide55. Asthma in Pediatrics56, The Spanish Guidelines for Managing Asthma (GEMA)57 or the “Global Strategy for Asthma Management and Prevention” of the Global Initiative for Asthma (GINA)58.

Drug treatment

This section is divided into two, depending on the age of the child to be treated: children under 3 years old and children over 3. Most guides focus on adults, with a section devoted to children. None of them specifies a treatment for nursing infants in line with the asthma phenotype classification.

Classifying a child’s asthma has the sole purpose of helping decide the treatment to choose at first. Subsequently, it will have to be the disease’s clinical evolution and the achievement of control objectives that dictate modifications in treatment.

Regardless of the classification of the seriousness or clinical situation of asthma, the final objective is to control it properly (table 2).

Anti-asthma drugs divide into two basic groups: bronchodilators (usually used to alleviate symptoms) and anti-inflammatory agents (to control the disease) (table 3).

The essential asthma-control drugs are inhaled corticoids. The equipotent doses of these drugs are shown in table 4.

The addition of prolonged-action β₂ agonists to inhaled corticoids enables lower doses of the latter to be used. These combined therapies have been extensively tested in adults and in school-age children58,59.

Infused medication must be administered by means of the systems most suited to the age of the patient (see section on inhalation systems).

Children under 3

<table>
<thead>
<tr>
<th>General considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Many nursing infants with wheezing during the first months of life will cease to have symptoms (transient wheezing), regardless of the maintenance treatment employed58.</td>
</tr>
<tr>
<td>2. Most of these episodes are side-effects of viral infections54.</td>
</tr>
<tr>
<td>3. The underlying inflammation in these cases is probably different from that in the atopic asthma of schoolchildren or adolescents50.</td>
</tr>
<tr>
<td>4. As there are few studies on which to base with any certainty treatment criteria for this age-group, physicians will often have to start a treatment and then vary or interrupt it if it is not effective55,57.</td>
</tr>
<tr>
<td>5. Therefore, the recommendations that can be made are largely empirical and in line with the following precepts:</td>
</tr>
<tr>
<td>a) The nursing child possesses functioning β₂ receptors56,58.</td>
</tr>
<tr>
<td>b) Both systemic and topical anti-inflammatory drugs have the same anti-inflammatory properties at all ages.</td>
</tr>
<tr>
<td>c) Side-effects of anti-asthma drugs in nursing children coincide with those that occur at later ages.</td>
</tr>
<tr>
<td>6. It must be borne in mind that in nursing children a differential diagnosis with other illnesses is needed, such as...</td>
</tr>
</tbody>
</table>
as gastro-oesophageal reflux, cystic fibrosis, broncho-pulmonary malformations, immunodeficiency, etc.

**Medication**

Inhaled Glucocorticoids: In this age group, children with a clinical diagnosis of asthma and risk factors of developing persistent asthma may respond adequately to this treatment\(^{18-19}\) (Proof B). However, for nursing children with post-Bronchiolitis wheezing, or wheezing episodes related solely with viral infections, inhaled corticoids are of dubious benefit\(^{20,21}\) (Proof B).

Antagonists of Leukotriene receptors: Only two studies on these children at this age exist. In one of them, treated children had few repeat episodes in the month after the episode of Bronchiolitis\(^{22}\); in the other, the drugs reduced bronchial inflammation in atopic children\(^{23}\). Therefore, there is not at present a sufficiently sound basis for their use.

Long-term \(\beta_2\) adrenergic agonists: In this age group, these are not currently recommended in a routine way. Association of long-term \(\beta_2\) adrenergic agonists and inhaled Glucocorticoids: There has only been one study (without a control group) of these drugs in children of this age-group\(^{24}\). Although its results were positive, more studies on the synergic effect of glucocorticoids and long-term \(\beta_2\) adrenergic agonists on children under 3 are needed before these two drugs together can be recommended.

Other anti-asthma drugs such as Chromones or Theophylline have proved their use in nursing children\(^{25,26}\).

**Classification**

Table 5 indicates the system for classifying asthma in children of this age group.

**Treatment**

Table 6 shows the maintenance treatment for children under 3.

**Children over 3**

**General considerations**

1. Up to the age of 6, children belonging to the transient asthma group and children with early-onset persistent asthma overlap. Other children will begin to suffer asthma for the first time, making up the persistent late-onset group\(^{27}\).

2. The role of atopy from this age has to be clarified by means of a proper allergological assessment, since it is the main risk factor for persistent asthma\(^{28}\).

3. From six years of age, as there are probably few children affected by transient wheezing, most children who suffer persistent wheezing are going to have early-onset or late-onset asthma\(^{28,29,30}\).

**Medication**

Inhaled Glucocorticoids: their efficacy at these ages has been well contrasted\(^{31-39}\) (Proof A).

Long-term \(\beta_2\) adrenergic agonists: In this age group, various clinical trials with both Salmeterol and Formoterol exist. These found good results, with side-effects that coincide with those of short-acting agonists\(^{40-42}\) (Proof A).

Antagonists of leukotriene receptors: There are sufficient data on their effectiveness at these ages, although their anti-inflammatory capacity is less than that of inhaled corticoids. The dimensions of their effect on corticoid consumption are still to be determined\(^{43-45}\) (Proof A).

Chromones: A systematic review of 24 clinical trials concludes that, in long-term treatment, the effect of Sodium Chromoglycate is no greater than that of placebo. Thus, it is of doubtful utility\(^{46}\) (Proof A).

---

**Table 5. Classification of asthma in children**

<table>
<thead>
<tr>
<th>Type of asthma</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occasional and episodic</td>
<td>Episodes of few hours or days of duration &lt; once every 10-12 weeks</td>
</tr>
<tr>
<td>Frequent and episodic</td>
<td>Episodes ≥ once every 5-6 weeks (maximum 6-8 crises/year)</td>
</tr>
<tr>
<td>Persistent moderate</td>
<td>Episodes ≥ once every 4-5 weeks</td>
</tr>
<tr>
<td>Persistent grave</td>
<td>Frequent episodes</td>
</tr>
</tbody>
</table>

**Table 6. Maintenance treatment for children under 3**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inhaled Glucocorticoids</td>
<td>Once every 1-2 weeks</td>
</tr>
<tr>
<td>Antagonists of Leukotriene receptors</td>
<td>Once every 1-2 weeks</td>
</tr>
<tr>
<td>(\beta_2) adrenergic agonists</td>
<td>Once every 1-2 weeks</td>
</tr>
</tbody>
</table>

---

\(^{18,19}\) to classify children under 3, lung function does not have to be assessed. In nursing children, inter-crisis periods will be assessed by means of their repercussion on normal daily activity (crying, laughter, play and feeding).
TABLE 6. Asthma maintenance treatment in children under 3

<table>
<thead>
<tr>
<th>Basic control of the disease</th>
<th>Symptom relief</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occasional and episodic</td>
<td>Not needed</td>
</tr>
<tr>
<td>Frequent and episodic</td>
<td></td>
</tr>
<tr>
<td>Without risk factors</td>
<td>Normally not needed</td>
</tr>
<tr>
<td>With risk factors</td>
<td>Low dose IGC</td>
</tr>
<tr>
<td>Persistent moderate</td>
<td>Medium dose IGC</td>
</tr>
<tr>
<td>(Before taking this step, the diagnosis and proper administration of treatment need to be re-checked)</td>
<td>(Assume response at 3 months. Withdraw if there is no response and there are no risk factors)</td>
</tr>
<tr>
<td>Persistent grave</td>
<td>High dose IGC</td>
</tr>
<tr>
<td></td>
<td>If the control is not adequate, consider one or several of:</td>
</tr>
<tr>
<td></td>
<td>– Add AA-β₂-AL</td>
</tr>
<tr>
<td></td>
<td>– Add ALTR</td>
</tr>
<tr>
<td></td>
<td>– Add oral GC</td>
</tr>
</tbody>
</table>


Association of long-term β₂ adrenergic agonists and inhaled Glucocorticoids: There are studies on the role of long-term β₂ adrenergic agonists in controlling asthma in combined therapy with inhaled Glucocorticoids in this age-group³³,³⁴,³⁵ (Proof A). The administration of this combination in the same device could be more effective than when administered separately³⁶.

Specific Immunotherapy (if the indications specified in the section devoted to it are complied with) can help control the disease.

Classification
Asthma in children over 3 is classified in the same way as for children under 3, as shown in table 5.

TABLE 7. Maintenance treatment of children over 3

<table>
<thead>
<tr>
<th>Basic control of the disease</th>
<th>Drug treatment</th>
<th>Allergic symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occasional and episodic</td>
<td>IGC, low dose</td>
<td>AAβ₂-AC on demand</td>
</tr>
<tr>
<td>Frequent and episodic</td>
<td>IGC medium doses + AAβ₂-AL</td>
<td>AAβ₂-AC on demand</td>
</tr>
<tr>
<td>Persistent moderate</td>
<td>IGC, medium doses + ALTR</td>
<td>AAβ₂-AC on demand</td>
</tr>
<tr>
<td>Persistent grave</td>
<td>IGC high dose + AAβ₂-AL</td>
<td>AAβ₂-AC on demand</td>
</tr>
</tbody>
</table>

If there is no proper control, consider one or several of:
– Increase IGC doses
– Add AAβ₂-AL
– Add oral GC


Specific Immunotherapy
A recent meta-analysis made its beneficial effects clear, in terms of reduction of symptoms, of recovery and maintenance medication, and of bronchial hyper-responsiveness, whether specific or non-specific, but only when biologically standardised extracts were used³⁶-³⁸ (Proof A).

Specific immunotherapy is indicated when the following criteria are met³⁹ (Proof D):

Table 7 shows the maintenance treatment of children over 3.
1. Frequent or persistent moderate episodic asthma, mediated by IgE, when there is sensitisation to a single allergen, a predominant allergen or a group of allergens with crossed reactivity.

2. When the symptoms are not properly controlled by means of avoidance of the allergen and the drug treatment.

3. When the patient has both nasal and lung symptoms.

4. When the patient (or his/her parents or legal guardians) do not want a long-term drug treatment.

5. When the drug treatment causes adverse side-effects.

Specific immunotherapy is contraindicated

1. In children with grave immunopathies or chronic liver disease.

2. In psychological and social situations that do not permit proper monitoring.

3. As starter therapy in pregnant adolescents, although the corresponding maintenance doses can be administered to girls who begin their treatment before the pregnancy.

4. The use of immunotherapy is not limited by age, if the previous indication criteria are met (Proof D).

5. Although there are no objective data, the minimum length of treatment should be three years and the maximum five (Proof D).

6. Subcutaneous immunotherapy can be replaced by sublingual immunotherapy (Proof C). The latter does not have the systemic adverse side-effects that on very rare occasions subcutaneous immunotherapy has had.

In both subcutaneous and sublingual immunotherapy, only biologically standardised allergen extracts can be used (Proof B).

Subcutaneous immunotherapy must be administered by trained staff. The patient will remain under observation for 30 minutes after the injection.

**SYSTEMS OF INHALATION**

**General considerations**

1. The amount of a drug that is administered to a child with asthma depends on the kind of medication, the system of inhalation, the characteristics of the patient and the interaction between these factors.

2. Of the several pathways for drug administration, inhalation is the pathway of choice (although not all anti-asthma drugs are available in this form, such as the leukotrienes and methyl-cholanthines).

3. Prescribing any system of inhalation must occur only after the child and his/her parents have been trained in its use and have demonstrated satisfactory technique (Proof B).

4. Re-evaluation of the technique must be a part of the clinical monitoring sessions.

5. In children from 0 to 5, there is little or no evidence on which to base the recommendations indicated.

6. In general, and a priori, age is what will orient us towards using one kind of system or another, and the line of division lies between the ages of 4 and 6 (Table 8).

**Pressurised inhalers**

Common problems with the administration technique mean that over 50% of the children who receive treatment with a direct-application (without chamber) pressurised inhaler benefit much less than when they use other systems. Therefore, pressurised inhalers directly applied to the mouth must NOT be used in infancy; they must always be used with spacers.

**Spacer chambers**

The use of a spacer chamber with a pressurised inhaler solves the problem of coordination, reduces oropharyngeal impact and improves the distribution and amount of medication that reaches the bronchial tree (Proof A). Its use with inhaled corticoids reduces the systemic bioavailability of these and the risk of systemic effects (Proof B).

Up to 4 years of age small-volume chambers are recommended: these are the ones with a face mask attached. As nasal respiration in these cases greatly reduces lung

<table>
<thead>
<tr>
<th>Choice</th>
<th>Alternative</th>
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<tbody>
<tr>
<td>&lt;4 years</td>
<td>Pressurised inhaler with chamber and face mask</td>
</tr>
<tr>
<td>4-6 years</td>
<td>Pressurised inhaler with spacer chamber with mouthpiece</td>
</tr>
<tr>
<td>≥6 years</td>
<td>Dry-powder inhaler</td>
</tr>
</tbody>
</table>

*In children between 5 and 12, there is no significant difference in terms of effectiveness between the pressurised inhaler with chamber and the dry-powder inhalers (Proof A).*
Busquets Monge RM, et al. Consensus on asthma treatment in Paediatrics

pneumologist): the child that make referral advisable.

30 L/min is sufficient. These devices are recommended with pressurised inhalers, but the results are similar when the latter is used with a spacer chamber.

Dry-powder inhalers

Dry-powder inhalers do not contain propellants and the doses are homogeneous, the inhalation technique is easier than with the pressurised inhaler and they are small and manageable, which makes it easy for the child to carry with him/her. Lung deposit is higher than that with pressurised inhalers, but the results are similar when the latter is used with a spacer chamber.

The amount of drug lodged in the oropharynx is higher than with pressurised inhalers with inhalation chamber, but lower than with pressurised inhalers without a chamber.17,18. The risk of side-effects increases with oropharyngeal deposit. The most common inhalers used are those with a multi-dose system (Accuhaler and Turbuhaler). With both systems an inspiratory flow of 30 L/min is sufficient. These devices are recommended from 5-6 years up.

Nebulisers

At present, the use of nebulisers at home in maintenance treatment is restricted to special cases.19,20. The oxygen-driven ‘jet’ kinds of nebuliser are used by the Emergency Services.

RELATIONSHIP BETWEEN PRIMARY AND SPECIALIST CARE

1. Care of asthmatic children must be coordinated between Specialist and Primary Care.
2. Each health area will need to make this coordination concrete, depending on the resources it has.
3. The organisation of plans to care for asthmatic children must include both Primary and Specialist Care.
4. The main principles of this coordination are as follows:
   a) Specialist care will be greater, depending on whether the asthma is more serious or vice versa.
   b) The Primary Care paediatrician will refer the child to the Allergy or Pneumology Unit when:
      – An allergological appraisal, which he/she will report to the Primary Care paediatrician.
      – Will make a function/allergological appraisal, which he/she will report to the Primary Care paediatrician.
      – Will recommend treatment guidelines that the PC paediatrician will try to follow, whilst not losing sight of the aim of controlling the disease.

5. Forced spirometry with the bronchodilation test may be a useful technique in Primary Care Paediatrics both for diagnosis and for monitoring the asthmatic child.
6. The Phadiatop and/or the prick test could be useful in allergy screening in Primary Care.
7. However, to perform forced spirometry and the prick test, particular equipment and proper training (acquired in Paediatric Pneumology or Allergology Units) are needed.

Levels of proof used in this document

<table>
<thead>
<tr>
<th>Level</th>
<th>Sources of proof</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Randomised trials, with abundance of data in large and representative groups with an exemplary method</td>
</tr>
<tr>
<td>B</td>
<td>Randomised trials, but with amount of data limited</td>
</tr>
<tr>
<td>C</td>
<td>Non-randomised trials, observational studies</td>
</tr>
<tr>
<td>D</td>
<td>Consensus among experts</td>
</tr>
</tbody>
</table>

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