



# Michigan Quality Improvement Consortium Guideline Management of Asthma in Youth 12 Years and Older and Adults

Key Components	Recommendation and Level of Evidence						
First, assess severity to decide initial therapy	<b>Classification of Asthma Severity</b>						
	<b>Components of Severity</b>		<i>Intermittent</i>	<i>Persistent (Mild)</i>	<i>Persistent (Moderate)</i>	<i>Persistent (Severe)</i>	
	Impairment  <i>Normal FEV<sub>1</sub>/FVC: 8-19 years/85% 20-39 years/80% 40-59 years/75% 60-80 years/70%</i>	Symptoms	≤ 2 days/week	> 2 days/week, not daily	Daily	Throughout day	
		Nighttime awakenings	≤ 2x/month	3-4x/month	> 1x/week, not nightly	Often, 7x/week	
		Short-acting beta <sub>2</sub> -agonist use for symptoms	≤ 2 days/week	> 2 days/week, not daily and not > 1/day	Daily	Several times daily	
		Interference with normal activity	None	Minor limitation	Some limitation	Extremely limited	
		Lung function: FEV <sub>1</sub> FEV <sub>1</sub> /FVC	Normal FEV <sub>1</sub> between exacerbations > 80% Normal	> 80% Normal	60%-80% Reduced 5%	< 60% Reduced > 5%	
	Risk	Exacerbations requiring oral steroids	0-1/year	≥ 2/year			
			<ul style="list-style-type: none"> <li>• Consider severity &amp; interval since last exacerbation. Frequency &amp; severity may fluctuate over time for patient of any severity class.</li> <li>• Relative annual risk of exacerbations may be related to FEV<sub>1</sub>.</li> </ul>				
	Recommended step for initiating treatment		<b>Step 1</b>	<b>Step 2</b>	<b>Step 3</b>	<b>Step 4 or 5</b>	
		Re-evaluate control in 2-6 weeks and adjust therapy accordingly.					
On follow-up, assess control and step therapy up or down	<b>Classification of Asthma Control</b>						
	<b>Components of Control</b>		<i>Well-Controlled</i>	<i>Not Well-Controlled</i>	<i>Very Poorly</i>		
	Impairment	Symptoms	≤ 2 days/week	> 2 days/week	Throughout day		
		Nighttime awakenings	≤ 2x/month	1 - 3x/week	≥ 4x/week		
		Short-acting beta <sub>2</sub> -agonist use for symptoms	≤ 2 days/week	> 2 days/week	Several times/day		
		Interference with normal activity	None	Some limitation	Extremely limited		
		FEV <sub>1</sub> or Peak Flow	> 80%	60%-80%	< 60%		
	Risk	Exacerbations requiring oral steroids	0-1x/year	≥ 2x/year			
	Treatment-related adverse effects		Intensity of medication-related side effects does not correlate to specific levels of control, but should be considered in overall assessment of risk.				
	Recommended action for treatment		<ul style="list-style-type: none"> <li>• Maintain current step</li> <li>• Regular follow-up every 1-6 months</li> <li>• Consider step down if well-controlled ≥ 3 months</li> </ul>	<ul style="list-style-type: none"> <li>• Step up 1 step</li> <li>• Re-evaluate in 2-6 weeks</li> </ul>	<ul style="list-style-type: none"> <li>• Consider oral steroids</li> <li>• Step up 1-2 steps</li> <li>• Re-evaluate in 2 weeks</li> </ul>		
• Quick relief medication for all patients: Inhaled short-acting beta <sub>2</sub> -agonist (SABA) as needed for symptoms [A]. Intensity of treatment depends on severity of symptoms; up to 3 treatments at 20-minute intervals as needed. Short course of oral corticosteroids may be needed. • Use of SABA > 2 days a week for symptom control (not prevention of exercise-induced bronchospasm) indicates inadequate control and the need to step up treatment. • Patient education and environmental control at each step. • Persistent asthma: Daily long-term control therapy [A]; consult with asthma specialist if step 4 or higher [D], or progressive decreased lung function. Consider consultation at step 3 [D].							
Step approach for asthma management (Use lowest treatment level required to maintain control.)	<b>Intermittent</b>	<b>Mild Persistent</b>		<b>Moderate Persistent</b>		<b>Severe Persistent</b>	
	<b>Step 1</b>	<b>Step 2</b>	<b>Step 3</b>	<b>Step 4</b>	<b>Step 5</b>	<b>Step 6</b>	
	Preferred Short-acting beta <sub>2</sub> -agonist as required	Preferred Low-dose inhaled corticosteroid [A]  Alternative Cromolyn Or Leukotriene receptor antagonist; or Nedocromil; or Theophylline [B]	Preferred Low-dose inhaled corticosteroid + long-acting beta <sub>2</sub> -agonist [A] or medium-dose inhaled corticosteroid [A]  Alternative Low-dose inhaled corticosteroid + either a leukotriene receptor antagonist [A], theophylline [B], or zileutin [D]	Preferred Medium-dose inhaled corticosteroid + long-acting beta <sub>2</sub> -agonist [B]  Alternative Medium-dose inhaled corticosteroid + either a leukotriene receptor antagonist, theophylline [B] or zileutin [D]	Preferred High-dose inhaled corticosteroid + long-acting beta <sub>2</sub> -agonist [B] and consider omalizumab for patients who have IgE-mediated allergies [B]	Preferred High-dose inhaled corticosteroid + long-acting beta <sub>2</sub> -agonist + oral corticosteroid [D] and consider omalizumab for patients who have IgE-mediated allergies [B]	

**Warning for use of Long-acting beta-agonists (LABA). See Black Box Warning:**

- Do not use LABA as monotherapy. Use only with an asthma controller such as inhaled corticosteroids (preferably combination product for children).
- Use for the shortest duration possible.
- Only use if not controlled on other drugs.
- Pediatric and adolescent patients who require the addition of a LABA to an inhaled corticosteroid, should use a combination product containing both.

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on the 2007 National Asthma Education and Prevention Program Expert Panel Report 3, Guidelines for the Diagnosis and Management of Asthma, National Heart, Lung and Blood Institute (www.nhlbi.nih.gov). Individual patient considerations and advances in medical science may supersede or modify these recommendations.