



MedStar Family Choice

Guidelines for the Diagnosis and Management of Asthma in Children and Adolescents Clinical Practice Guideline MedStar Health

“These guidelines are provided to assist physicians and other clinicians in making decisions regarding the care of their patients. They are not a substitute for individual judgment brought to each clinical situation by the patient’s primary care provider in collaboration with the patient. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but should be used with the clear understanding that continued research may result in new knowledge and recommendations.”

MedStar Health, MedStar Prompt Care, and MedStar Family Choice accept and endorse the following clinical guidelines:

National Heart, Lung, and Blood Institute Expert Panel on Asthma, 2020 Focused Updates to the Asthma Management Guidelines: A Report from the National Asthma Education and Prevention Program Coordinating Committee Expert Panel Working Group

<https://www.nhlbi.nih.gov/health-topics/all-publications-and-resources/clinician-guide-2020-focused-updates-asthma-management-guidelines>

Focused summary:

<https://www.nhlbi.nih.gov/health-topics/asthma-management-guidelines-2020-updates>

National Heart, Lung, and Blood Institute Expert Panel on Asthma, Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma – Full Report, 2007

<http://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines>

Global Initiative for Asthma: GINA 2023

https://ginasthma.org/wp-content/uploads/2023/07/GINA-2023-Full-report-23_07_06-WMS.pdf

The following overview and diagrams are intended to help clinicians integrate the guidelines into clinical care, and are meant to assist, and not replace, clinical judgment or decision-making for individual patient management, with input from individuals with asthma about their preferences.

<p><u>Initial Approval Date and Reviews:</u> Effective 1997, 7/15 (by Adult Committee), 08/15 (by Pediatric Committee), 7/17- Decision to Separate Adult and Pediatric Guideline, 8/17, 8/19, 6/21</p>	<p><u>Most Recent Revision and Approval Date:</u> 6/23</p>	<p><u>Next Scheduled Review</u> <u>Date:</u> 6/25 Condition: Asthma</p>
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Key components of asthma management:

(*See charts below by age group)

1. Appropriate Asthma Classification *
2. Assess Asthma Control *
3. Treatment*: Goal to reduce impairment and risk (*Key changes in 2020 updates NHLBI*)
 - ***Using inhaled corticosteroids when needed for recurrent wheezing or persistent asthma.***
 - ***Using long-acting antimuscarinic agents (LAMAs) with inhaled corticosteroids for long-term asthma management.***
 - Children 0–4 y/o with recurrent wheezing triggered by respiratory tract infections and no wheezing between infections, recommend starting a short course of daily ICS at the onset of a respiratory tract infection with as-needed SABA for quick-relief therapy compared to as-needed SABA for quick-relief therapy only.
 - Ages >4 y/o with mild to moderate persistent asthma who are likely to be adherent to daily ICS treatment, recommends against a short-term increase in the ICS dose for increased symptoms.
 - > 4 y/o older with moderate to severe persistent asthma, recommends ICS-formoterol in a single inhaler used as both daily controller and reliever therapy.
4. Environmental control: for individuals with asthma who are exposed to an allergen within the home and who have allergy symptoms or a positive test result suggesting that they have an allergy to certain indoor substances (e.g., dust mites or cat dander), the use a multicomponent intervention to try to control the indoor allergen in question. Consider referral for Immunotherapy
5. Educate appropriately including proper use of medication and spacers and asthma action plan.
6. Follow up closely
7. Referral to a specialist as indicated
 - a. Life-threatening asthma exacerbation
 - b. Exacerbation requiring hospitalization.
 - c. Step 3 care or higher or Step 2 for children 0–4 years of age
 - d. >2 oral corticosteroids in 1 year
 - e. Unresponsive to therapy: not meeting therapeutic goals after 3–6 months of treatment
 - f. Other conditions complicate asthma or its diagnosis: sinusitis, nasal polyps, aspergillosis, severe rhinitis, VCD, GERD
 - g. Considering immunotherapy
 - h. Confirmation of unclear diagnosis: fractional exhaled nitric oxide (FeNO) tests

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Age 0-4 years old

Classification

Components of Severity		Classification of Asthma Severity (0–4 years of age)			
		Intermittent	Persistent		
			Mild	Moderate	Severe
Impairment	Symptoms	≤2 days/week	>2 days/week but not daily	Daily	Throughout the day
	Nighttime awakenings	0	1–2x/month	3–4x/month	>1x/week
	Short-acting beta ₂ -agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week but not daily	Daily	Several times per day
	Interference with normal activity	None	Minor limitation	Some limitation	Extremely limited
Risk	Exacerbations requiring oral systemic corticosteroids	0–1/year	≥2 exacerbations in 6 months requiring oral systemic corticosteroids, or ≥4 wheezing episodes/1 year lasting >1 day AND risk factors for persistent asthma ← Consider severity and interval since last exacerbation. Frequency and severity may fluctuate over time. → Exacerbations of any severity may occur in patients in any severity category.		
Recommended Step for Initiating Therapy (See figure 4–1a for treatment steps.)		Step 1	Step 2	Step 3 and consider short course of oral systemic corticosteroids	
		In 2–6 weeks, depending on severity, evaluate level of asthma control that is achieved. If no clear benefit is observed in 4–6 weeks, consider adjusting therapy or alternative diagnoses.			

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Control

Components of Control		Classification of Asthma Control (0–4 years of age)		
		Well Controlled	Not Well Controlled	Very Poorly Controlled
Impairment	Symptoms	≤2 days/week	>2 days/week	Throughout the day
	Nighttime awakenings	≤1x/month	>1x/month	>1x/week
	Interference with normal activity	None	Some limitation	Extremely limited
	Short-acting beta ₂ -agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week	Several times per day
Risk	Exacerbations requiring oral systemic corticosteroids	0–1/year	2–3/year	>3/year
	Treatment-related adverse effects	Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.		
Recommended Action for Treatment (See figure 4–1a for treatment steps.)		<ul style="list-style-type: none"> • Maintain current treatment. • Regular followup every 1–6 months. • Consider step down if well controlled for at least 3 months. 	<ul style="list-style-type: none"> • Step up (1 step) and • Reevaluate in 2–6 weeks. • If no clear benefit in 4–6 weeks, consider alternative diagnoses or adjusting therapy. • For side effects, consider alternative treatment options. 	<ul style="list-style-type: none"> • Consider short course of oral systemic corticosteroids, • Step up (1–2 steps), and • Reevaluate in 2 weeks. • If no clear benefit in 4–6 weeks, consider alternative diagnoses or adjusting therapy. • For side effects, consider alternative treatment options.

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Treatment

AGES 0-4 YEARS: STEPWISE APPROACH FOR MANAGEMENT OF ASTHMA

	Intermittent Asthma	Management of Persistent Asthma in Individuals Ages 0-4 Years				
Treatment	STEP 1	STEP 2	STEP 3	STEP 4	STEP 5	STEP 6
Preferred	PRN SABA and At the start of RTI: Add short course daily ICS [▲]	Daily low-dose ICS and PRN SABA	Daily medium-dose ICS and PRN SABA	Daily medium-dose ICS-LABA and PRN SABA	Daily high-dose ICS-LABA and PRN SABA	Daily high-dose ICS-LABA + oral systemic corticosteroid and PRN SABA
Alternative		Daily montelukast* or Cromolyn,* and PRN SABA		Daily medium-dose ICS + montelukast* and PRN SABA	Daily high-dose ICS + montelukast* and PRN SABA	Daily high-dose ICS + montelukast*+ oral systemic corticosteroid and PRN SABA
			For children age 4 years only, see Step 3 and Step 4 on Management of Persistent Asthma in Individuals Ages 5-11 Years diagram.			

Assess Control

- First check adherence, inhaler technique, environmental factors,[▲] and comorbid conditions.
 - **Step up** if needed; reassess in 4-6 weeks
 - **Step down** if possible (if asthma is well controlled for at least 3 consecutive months)
- Consult with asthma specialist if Step 3 or higher is required. Consider consultation at Step 2.
- Control assessment is a key element of asthma care. This involves both impairment and risk. Use of objective measures, self-reported control, and health care utilization are complementary and should be employed on an ongoing basis, depending on the individual's clinical situation.

Abbreviations: ICS, inhaled corticosteroid; LABA, long-acting beta₂-agonist; SABA, inhaled short-acting beta₂-agonist; RTI, respiratory tract infection; PRN, as needed

[▲] Updated based on the 2020 guidelines.

* Cromolyn and montelukast were not considered for this update and/or have limited availability for use in the United States. The FDA issued a Boxed Warning for montelukast in March 2020.

[†]The full-length report, *2020 Focused Updates to the Asthma Management Guidelines: A Report from the National Asthma Education and Prevention Program Coordinating Committee Expert Panel Working Group*, can be accessed at nhlbi.nih.gov/asthmaguidelines.

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NOTES FOR INDIVIDUALS AGES 0-4 YEARS DIAGRAM

Quick-relief medications	<ul style="list-style-type: none"> Use SABA as needed for symptoms. The intensity of treatment depends on severity of symptoms: up to 3 treatments at 20-minute intervals as needed. Caution: Increasing use of SABA or use >2 days a week for symptom relief (not prevention of EIB) generally indicates inadequate control and may require a step up in treatment. Consider short course of oral systemic corticosteroid if exacerbation is severe or individual has history of previous severe exacerbations.
Each step: Assess environmental factors, provide patient education, and manage comorbidities▲	<ul style="list-style-type: none"> In individuals with sensitization (or symptoms) related to exposure to pests†; conditionally recommend integrated pest management as a single or multicomponent allergen-specific mitigation intervention.▲ In individuals with sensitization (or symptoms) related to exposure to identified indoor allergens, conditionally recommend a multi-component allergen-specific mitigation strategy.▲ In individuals with sensitization (or symptoms) related to exposure to dust mites, conditionally recommend impermeable pillow/mattress covers only as part of a multicomponent allergen-specific mitigation intervention, but not as a single component intervention.▲
Notes	<ul style="list-style-type: none"> If clear benefit is not observed within 4-6 weeks and the medication technique and adherence are satisfactory, the clinician should consider adjusting therapy or alternative diagnoses.
Abbreviations	<p>EIB, exercise-induced bronchoconstriction; SABA, inhaled short-acting beta₂-agonist.</p> <p>▲Updated based on the 2020 guidelines.</p> <p>† Refers to mice and cockroaches, which were specifically examined in the Agency for Healthcare Research and Quality systematic review.</p>

WHAT'S NEW (AGES 0-4 YEARS)

- Step 1:** In children ages 0-4 years with recurrent wheezing, a short (7-10 day) course of daily ICS with as-needed SABA for quick-relief therapy is recommended starting at the onset of a respiratory tract infection.
 - ✓ Recurrent wheezing is defined as at least three episodes of wheezing triggered by apparent infection in their lifetime, or two episodes in the past year, and no symptoms between infections.
 - ✓ One regimen, used in two reviewed studies, is budesonide inhalation suspension, 1 mg twice daily for 7 days at the first sign of respiratory tract infection-associated symptoms.
 - ✓ The main benefit during respiratory tract infections is a reduction in exacerbations requiring systemic corticosteroids.
 - ✓ Caregivers can initiate intermittent ICS treatment at home without a visit to a health care provider when they have clear instructions.
 - ✓ This treatment could affect growth. Carefully monitor growth in children who use this treatment.
- Steps 3 and 4:** For children age 4 years only with persistent asthma, see Steps 3 and 4 on Management of Persistent Asthma in Individuals Ages 5-11 Years.
- Each step:**
 - ✓ Consider the severity of an individual's asthma, the small potential benefit, and the extent of previous symptoms and exacerbations when recommending allergen mitigation interventions.

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Ages 5-11 years old

Classification

Components of Severity		Classification of Asthma Severity (5–11 years of age)			
		Intermittent	Persistent		
			Mild	Moderate	Severe
Impairment	Symptoms	≤2 days/week	>2 days/week but not daily	Daily	Throughout the day
	Nighttime awakenings	≤2x/month	3–4x/month	>1x/week but not nightly	Often 7x/week
	Short-acting beta ₂ -agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week but not daily	Daily	Several times per day
	Interference with normal activity	None	Minor limitation	Some limitation	Extremely limited
	Lung function	<ul style="list-style-type: none"> • Normal FEV₁ between exacerbations • FEV₁ >80% predicted • FEV₁/FVC >85% 	<ul style="list-style-type: none"> • FEV₁ = >80% predicted • FEV₁/FVC >80% 	<ul style="list-style-type: none"> • FEV₁ = 60–80% predicted • FEV₁/FVC = 75–80% 	<ul style="list-style-type: none"> • FEV₁ <60% predicted • FEV₁/FVC <75%
Risk	Exacerbations requiring oral systemic corticosteroids	0–1/year (see note)	≥2/year (see note)	<p>← Consider severity and interval since last exacerbation. →</p> <p>← Frequency and severity may fluctuate over time for patients in any severity category. →</p> <p>Relative annual risk of exacerbations may be related to FEV₁.</p>	
Recommended Step for Initiating Therapy (See figure 4–1b for treatment steps.)		Step 1	Step 2	Step 3, medium-dose ICS option	Step 3, medium-dose ICS option, or step 4 and consider short course of oral systemic corticosteroids
In 2–6 weeks, evaluate level of asthma control that is achieved, and adjust therapy accordingly.					

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Control

Components of Control		Classification of Asthma Control (5–11 years of age)		
		Well Controlled	Not Well Controlled	Very Poorly Controlled
Impairment	Symptoms	≤2 days/week but not more than once on each day	>2 days/week or multiple times on ≤2 days/week	Throughout the day
	Nighttime awakenings	≤1x/month	≥2x/month	≥2x/week
	Interference with normal activity	None	Some limitation	Extremely limited
	Short-acting beta ₂ -agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week	Several times per day
	Lung function • FEV ₁ or peak flow • FEV ₁ /FVC	>80% predicted/ personal best >80%	60–80% predicted/ personal best 75–80%	<60% predicted/ personal best <75%
Risk	Exacerbations requiring oral systemic corticosteroids	0–1/year	≥2/year (see note)	
		Consider severity and interval since last exacerbation		
	Reduction in lung growth	Evaluation requires long-term followup.		
	Treatment-related adverse effects	Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.		
Recommended Action for Treatment (See figure 4–1b for treatment steps.)		<ul style="list-style-type: none"> Maintain current step. Regular followup every 1–6 months. Consider step down if well controlled for at least 3 months. 	<ul style="list-style-type: none"> Step up at least 1 step and Reevaluate in 2–6 weeks. For side effects: consider alternative treatment options. 	<ul style="list-style-type: none"> Consider short course of oral systemic corticosteroids, Step up 1–2 steps, and Reevaluate in 2 weeks. For side effects, consider alternative treatment options.

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Treatment

AGES 5-11 YEARS: STEPWISE APPROACH FOR MANAGEMENT OF ASTHMA

	Intermittent Asthma	Management of Persistent Asthma in Individuals Ages 5-11 Years				
Treatment	STEP 1	STEP 2	STEP 3	STEP 4	STEP 5	STEP 6
Preferred	PRN SABA	Daily low-dose ICS and PRN SABA	Daily and PRN combination low-dose ICS-formoterol [▲]	Daily and PRN combination medium-dose ICS-formoterol [▲]	Daily high-dose ICS-LABA and PRN SABA	Daily high-dose ICS-LABA + oral systemic corticosteroid and PRN SABA
Alternative		Daily LTRA,* or Cromolyn,* or Nedocromil,* or Theophylline,* and PRN SABA	Daily medium-dose ICS and PRN SABA or Daily low-dose ICS-LABA, or daily low-dose ICS + LTRA,* or daily low-dose ICS + Theophylline,* and PRN SABA	Daily medium-dose ICS-LABA and PRN SABA or Daily medium-dose ICS + LTRA* or daily medium-dose ICS + Theophylline,* and PRN SABA	Daily high-dose ICS + LTRA* or daily high-dose ICS + Theophylline,* and PRN SABA	Daily high-dose ICS + LTRA* + oral systemic corticosteroid or daily high-dose ICS + Theophylline* + oral systemic corticosteroid, and PRN SABA
		Steps 2-4: Conditionally recommend the use of subcutaneous immunotherapy as an adjunct treatment to standard pharmacotherapy in individuals ≥ 5 years of age whose asthma is controlled at the initiation, build up, and maintenance phases of immunotherapy [▲]			Consider Omalizumab** [▲]	

Assess Control

- First check adherence, inhaler technique, environmental factors,[▲] and comorbid conditions.
- **Step up** if needed; reassess in 2-6 weeks
- **Step down** if possible (if asthma is well controlled for at least 3 consecutive months)

Consult with asthma specialist if Step 4 or higher is required. Consider consultation at Step 3.

Control assessment is a key element of asthma care. This involves both impairment and risk. Use of objective measures, self-reported control, and health care utilization are complementary and should be employed on an ongoing basis, depending on the individual's clinical situation.

Abbreviations: ICS, inhaled corticosteroid; LABA, long-acting beta₂-agonist; LTRA, leukotriene receptor antagonist; SABA, inhaled short-acting beta₂-agonist

[▲] Updated based on the 2020 guidelines.

* Cromolyn, Nedocromil, LTRAs including montelukast, and Theophylline were not considered in this update and/or have limited availability for use in the United States, and/or have an increased risk of adverse consequences and need for monitoring that make their use less desirable. The FDA issued a Boxed Warning for montelukast in March 2020.

** Omalizumab is the only asthma biologic currently FDA-approved for this age range.

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NOTES FOR INDIVIDUALS AGES 5-11 YEARS DIAGRAM

Quick-relief medications	<ul style="list-style-type: none"> Use SABA as needed for symptoms. The intensity of treatment depends on severity of symptoms: up to 3 treatments at 20-minute intervals as needed. In Steps 3 and 4, the preferred option includes the use of ICS-formoterol 1 to 2 puffs as needed up to a maximum total daily maintenance and rescue dose of 8 puffs (36 mcg).[▲] Caution: Increasing use of SABA or use >2 days a week for symptom relief (not prevention of EIB) generally indicates inadequate control and may require a step up in treatment.
Each step: Assess environmental factors, provide patient education, and manage comorbidities [▲]	<ul style="list-style-type: none"> In individuals with sensitization (or symptoms) related to exposure to pests: conditionally recommend integrated pest management as a single or multicomponent allergen-specific mitigation intervention.[▲] In individuals with sensitization (or symptoms) related to exposure to identified indoor allergens, conditionally recommend a multi-component allergen-specific mitigation strategy.[▲] In individuals with sensitization (or symptoms) related to exposure to dust mites, conditionally recommend impermeable pillow/mattress covers only as part of a multicomponent allergen-specific mitigation intervention, but not as a single component intervention.[▲]
Notes	<ul style="list-style-type: none"> The terms ICS-LABA and ICS-formoterol indicate combination therapy with both an ICS and a LABA, usually and preferably in a single inhaler. Where formoterol is specified in the steps, it is because the evidence is based on studies specific to formoterol. In individuals ages 5-11 years with persistent allergic asthma in which there is uncertainty in choosing, monitoring, or adjusting anti-inflammatory therapies based on history, clinical findings, and spirometry, FeNO measurement is conditionally recommended as part of an ongoing asthma monitoring and management strategy that includes frequent assessment.
Abbreviations	<p>EIB (exercise-induced bronchoconstriction); FeNO (fractional exhaled nitric oxide); ICS (inhaled corticosteroid); LABA (long-acting beta₂-agonist); SABA (inhaled short-acting beta₂-agonist).</p> <p>[▲]Updated based on the 2020 guidelines.</p> <p>‡ Refers to mice and cockroaches, which were specifically examined in the Agency for Healthcare Research and Quality systematic review.</p>

WHAT'S NEW (AGES 5-11 YEARS)

- For individuals with mild to moderate persistent asthma who are taking daily ICS treatment (likely adherent with prescribed daily ICS) as a controller, increasing the regular daily ICS dose for short periods is not recommended when symptoms increase or peak flow decreases.
- Steps 2-4:** Subcutaneous immunotherapy (SCIT) is recommended as an adjunct treatment for individuals who have demonstrated allergic sensitization and evidence of worsening asthma symptoms after exposure to the relevant antigen or antigens.
 - Do not initiate, increase, or administer maintenance SCIT doses while individuals have asthma symptoms.
 - Do not administer SCIT in individuals with severe asthma.
- Steps 3 and 4:** For individuals with moderate to severe persistent asthma already taking low- or medium-dose ICS, the preferred treatment is a single inhaler with ICS-formoterol (referred to as single maintenance and reliever therapy, or "SMART") used both daily and as needed.
 - Individuals with a severe exacerbation in the prior year are particularly good candidates for SMART to reduce exacerbations.
 - Do not use ICS-formoterol as reliever therapy in individuals taking ICS-salmeterol as maintenance therapy.
 - Individuals whose asthma is uncontrolled on maintenance ICS-LABA with SABA as quick-relief therapy should receive the preferred SMART if possible before moving to a higher step of therapy.
 - In children ages 4-11 years, there may be a lower risk of growth suppression among those taking SMART versus daily higher-dose ICS treatment.
- Steps 5 and 6:** Consider Omalizumab, the only FDA-approved asthma biologic for this age group.
- Each step:**
 - Consider the severity of an individual's asthma, the small potential benefit, and the extent of previous symptoms and exacerbations when recommending allergen mitigation interventions.

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Ages 12+ years old

Classification

Components of Severity		Classification of Asthma Severity ≥12 years of age			
		Intermittent	Persistent		
			Mild	Moderate	Severe
Impairment Normal FEV ₁ /FVC: 8–19 yr 85% 20–39 yr 80% 40–59 yr 75% 60–80 yr 70%	Symptoms	≤2 days/week	>2 days/week but not daily	Daily	Throughout the day
	Nighttime awakenings	≤2x/month	3–4x/month	>1x/week but not nightly	Often 7x/week
	Short-acting beta ₂ -agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week but not daily, and not more than 1x on any day	Daily	Several times per day
	Interference with normal activity	None	Minor limitation	Some limitation	Extremely limited
	Lung function	<ul style="list-style-type: none"> • Normal FEV₁ between exacerbations • FEV₁ >80% predicted • FEV₁/FVC normal 	<ul style="list-style-type: none"> • FEV₁ >80% predicted • FEV₁/FVC normal 	<ul style="list-style-type: none"> • FEV₁ >60% but <80% predicted • FEV₁/FVC reduced 5% 	<ul style="list-style-type: none"> • FEV₁ <60% predicted • FEV₁/FVC reduced >5%
Risk	Exacerbations requiring oral systemic corticosteroids	0–1/year (see note)	≥2/year (see note) →		
		← Consider severity and interval since last exacerbation. → Frequency and severity may fluctuate over time for patients in any severity category. Relative annual risk of exacerbations may be related to FEV ₁ .			
Recommended Step for Initiating Treatment		Step 1	Step 2	Step 3	Step 4 or 5
(See figure 4–5 for treatment steps.)		and consider short course of oral systemic corticosteroids In 2–6 weeks, evaluate level of asthma control that is achieved and adjust therapy accordingly.			

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Control

Components of Control		Classification of Asthma Control (Youths ≥12 years of age and adults)		
		Well-Controlled	Not Well-Controlled	Very Poorly Controlled
Impairment	Symptoms	≤2 days/week	>2 days/week	Throughout the day
	Nighttime awakening	≤2x/month	1–3x/week	≥4x/week
	Interference with normal activity	None	Some limitation	Extremely limited
	Short-acting beta ₂ -agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week	Several times per day
	FEV ₁ or peak flow	>80% predicted/ personal best	60–80% predicted/ personal best	<60% predicted/ personal best
	Validated Questionnaires			
	ATAQ ACQ ACT	0 ≤0.75* ≥20	1–2 ≥1.5 16–19	3–4 N/A ≤15
Risk	Exacerbations	0–1/year	≥2/year (see note)	
		Consider severity and interval since last exacerbation		
	Progressive loss of lung function	Evaluation requires long-term followup care		
	Treatment-related adverse effects	Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.		

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Treatment

AGES 12+ YEARS: STEPWISE APPROACH FOR MANAGEMENT OF ASTHMA

	Intermittent Asthma	Management of Persistent Asthma in Individuals Ages 12+ Years				
Treatment	STEP 1	STEP 2	STEP 3	STEP 4	STEP 5	STEP 6 [■]
Preferred	PRN SABA	Daily low-dose ICS and PRN SABA or PRN concomitant ICS and SABA [▲]	Daily and PRN combination low-dose ICS-formoterol [▲]	Daily and PRN combination medium-dose ICS-formoterol [▲]	Daily medium-high dose ICS-LABA + LAMA and PRN SABA [▲]	Daily high-dose ICS-LABA + oral systemic corticosteroids + PRN SABA
Alternative		Daily LTRA* and PRN SABA or Cromolyn,* or Nedocromil,* or Zileuton,* or Theophylline,* and PRN SABA	Daily medium-dose ICS and PRN SABA or Daily low-dose ICS-LABA, or daily low-dose ICS + LAMA, [▲] or daily low-dose ICS + LTRA,* and PRN SABA or Daily low-dose ICS + Theophylline* or Zileuton,* and PRN SABA	Daily medium-dose ICS-LABA or daily medium-dose ICS + LAMA, and PRN SABA [▲] or Daily medium-dose ICS + LTRA,* or daily medium-dose ICS + Theophylline,* or daily medium-dose ICS + Zileuton,* and PRN SABA	Daily medium-high dose ICS-LABA or daily high-dose ICS + LTRA,* and PRN SABA	
		Steps 2-4: Conditionally recommend the use of subcutaneous immunotherapy as an adjunct treatment to standard pharmacotherapy in individuals ≥ 5 years of age whose asthma is controlled at the initiation, build up, and maintenance phases of immunotherapy [▲]			Consider adding Asthma Biologics (e.g., anti-IgE, anti-IL5, anti-IL5R, anti-IL4/IL13)**	

Assess Control

- First check adherence, inhaler technique, environmental factors,[▲] and comorbid conditions.
- **Step up** if needed; reassess in 2-6 weeks
- **Step down** if possible (if asthma is well controlled for at least 3 consecutive months)

Consult with asthma specialist if Step 4 or higher is required. Consider consultation at Step 3.

Control assessment is a key element of asthma care. This involves both impairment and risk. Use of objective measures, self-reported control, and health care utilization are complementary and should be employed on an ongoing basis, depending on the individual's clinical situation.

Abbreviations: ICS, inhaled corticosteroid; LABA, long-acting beta₂-agonist; LAMA, long-acting muscarinic antagonist; LTRA, leukotriene receptor antagonist; SABA, inhaled short-acting beta₂-agonist

[▲] Updated based on the 2020 guidelines.

• Cromolyn, Nedocromil, LTRAs including Zileuton and montelukast, and Theophylline were not considered for this update, and/or have limited availability for use in the United States, and/or have an increased risk of adverse consequences and need for monitoring that make their use less desirable. The FDA issued a Boxed Warning for montelukast in March 2020.

** The AHRQ systematic reviews that informed this report did not include studies that examined the role of asthma biologics (e.g. anti-IgE, anti-IL5, anti-IL5R, anti-IL4/IL13). Thus, this report does not contain specific recommendations for the use of biologics in asthma in Steps 5 and 6.

■ Data on the use of LAMA therapy in individuals with severe persistent asthma (Step 6) were not included in the AHRQ systematic review and thus no recommendation is made.

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<u>Initial Approval Date and Reviews:</u>	<u>Most Recent Revision and Approval Date:</u>	<u>Next Scheduled Review Date:</u>
Effective 1997, 7/15 (by Adult Committee), 08/15 (by Pediatric Committee), 7/17- Decision to Separate Adult and Pediatric Guideline, 8/17, 8/19, 6/21	6/23	6/25
		Condition: Asthma

NOTES FOR INDIVIDUALS AGES 12+ YEARS DIAGRAM

Quick-relief medications	<ul style="list-style-type: none"> • Use SABA as needed for symptoms. The intensity of treatment depends on the severity of symptoms: up to 3 treatments at 20-minute intervals as needed. • In steps 3 and 4, the preferred option includes the use of ICS-formoterol 1 to 2 puffs as needed up to a maximum total daily maintenance and rescue dose of 12 puffs (54 mcg).[▲] • Caution: Increasing use of SABA or use >2 days a week for symptom relief (not prevention of EIB) generally indicates inadequate control and may require a step up in treatment.
Each step: Assess environmental factors, provide patient education, and manage comorbidities [▲]	<ul style="list-style-type: none"> • In individuals with sensitization (or symptoms) related to exposure to pests: conditionally recommend integrated pest management as a single or multicomponent allergen-specific mitigation intervention.[▲] • In individuals with sensitization (or symptoms) related to exposure to identified indoor allergens, conditionally recommend a multi-component allergen-specific mitigation strategy.[▲] • In individuals with sensitization (or symptoms) related to exposure to dust mites, conditionally recommend impermeable pillow/mattress covers only as part of a multicomponent allergen-specific mitigation intervention, but not as a single component intervention.[▲]
Notes	<ul style="list-style-type: none"> • The terms ICS-LABA and ICS-formoterol indicate combination therapy with both an ICS and a LABA, usually and preferably in a single inhaler. • Where formoterol is specified in the steps, it is because the evidence is based on studies specific to formoterol. • In individuals ages 12 years and older with persistent allergic asthma in which there is uncertainty in choosing, monitoring, or adjusting anti-inflammatory therapies based on history, clinical findings, and spirometry, FeNO measurement is conditionally recommended as part of an ongoing asthma monitoring and management strategy that includes frequent assessment. • Bronchial thermoplasty was evaluated in Step 6. The outcome was a conditional recommendation against the therapy.
Abbreviations	<p>EIB, exercise-induced bronchoconstriction; FeNO, fractional exhaled nitric oxide; ICS, inhaled corticosteroid; LABA, long-acting beta₂-agonist; SABA, inhaled short-acting beta₂-agonist.</p> <p>[▲]Updated based on the 2020 guidelines.</p> <p>‡ Refers to mice and cockroaches, which were specifically examined in the Agency for Healthcare Research and Quality systematic review.</p>

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WHAT'S NEW (AGES 12+ YEARS)

- For individuals with mild to moderate persistent asthma who are taking daily ICS treatment (likely adherent with prescribed daily ICS) as a controller, increasing the regular daily ICS dose for short periods is not recommended when symptoms increase or peak flow decreases.
- **Step 2:** For individuals with mild persistent asthma, either of the following two treatments are recommended as part of Step 2 therapy: 1) a daily low-dose ICS and as-needed SABA for quick-relief therapy, or 2) intermittent as-needed SABA and ICS used one after the other for worsening asthma.
 - ✓ One approach to intermittent therapy is two to four puffs of albuterol followed by 80–250 mcg of beclomethasone equivalent every 4 hours as needed for asthma symptoms.
 - ✓ Intermittent therapy can be initiated at home with regular provider follow-up to ensure that the intermittent regimen is still appropriate.
 - ✓ Individuals with either low or high perception of symptoms may not be good candidates for as-needed ICS therapy. Daily low-dose ICS with as-needed SABA may be preferred.
- **Steps 2–4:** Subcutaneous immunotherapy (SCIT) is recommended as an adjunct treatment for individuals who have demonstrated allergic sensitization and evidence of worsening asthma symptoms after exposure to the relevant antigen or antigens.
 - ✓ Do not initiate, increase, or administer maintenance SCIT doses while individuals have asthma symptoms.
 - ✓ Do not administer SCIT in individuals with severe asthma.
- **Steps 3 and 4:** For individuals with moderate to severe persistent asthma already taking low- or medium-dose ICS, the preferred treatment is a single inhaler with ICS-formoterol (referred to as single maintenance and reliever therapy, or “SMART”) used both daily and as needed.
 - ✓ Individuals with a severe exacerbation in the prior year are particularly good candidates for SMART to reduce exacerbations.
 - ✓ Do not use ICS-formoterol as reliever therapy in individuals taking ICS-salmeterol as maintenance therapy.
 - ✓ Individuals whose asthma is uncontrolled on maintenance ICS-LABA with SABA as quick-relief therapy should receive the preferred SMART if possible before moving to a higher step of therapy.
- **Each step:**
 - ✓ Consider the severity of an individual’s asthma, the small benefit, and the extent of previous symptoms and exacerbations when recommending allergen mitigation interventions.

Resources

National Heart, Lung, and Blood Institute Expert Panel on Asthma, 2020 Focused Updates to the Asthma Management Guidelines: A Report from the National Asthma Education and Prevention Program Coordinating Committee Expert Panel Working Group

<https://www.nhlbi.nih.gov/health-topics/all-publications-and-resources/clinician-guide-2020-focused-updates-asthma-management-guidelines>

Focused summary:

<https://www.nhlbi.nih.gov/health-topics/asthma-management-guidelines-2020-updates>

National Heart, Lung, and Blood Institute Expert Panel on Asthma, Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma – Full Report, 2007

<http://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines>

Global Initiative for Asthma: GINA 2023

https://ginasthma.org/wp-content/uploads/2023/07/GINA-2023-Full-report-23_07_06-WMS.pdf

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