ABSTRACT

Asthma is the most common chronic respiratory condition of childhood worldwide, with around 14% of children and young people affected. Despite the high prevalence, paediatric asthma outcomes are inadequate, and there are several avoidable deaths each year. Characteristic asthma features include wheeze, shortness of breath and cough, which are typically triggered by a number of possible stimuli. There are several diagnostic challenges, and as a result, both overdiagnosis and under-diagnosis of paediatric asthma remain problematic. Effective asthma management involves a holistic approach addressing both pharmacological and non-pharmacological management, as well as education and self-management aspects. Working in partnership with children and families is key in promoting good outcomes. Education on how to take treatment effectively, trigger avoidance, modifiable risk factors and actions to take during acute attacks via personalised asthma action plans is essential. This review aimed to provide an overview of good clinical practice in the diagnosis and management of paediatric asthma. We discuss the current diagnostic challenges and predictors of life-threatening attacks. Additionally, we outline the similarities and differences in global paediatric asthma guidelines and highlight potential future developments in care. It is hoped that this review will be useful for healthcare providers working in a range of child health settings.

INTRODUCTION

Asthma is a chronic respiratory disease characterised by episodes of wheeze, cough, and shortness of breath. Around 14% of children worldwide have a diagnosis of asthma, making it the most common chronic respiratory disease of childhood.

Poor asthma control is associated with a number of negative effects on children and families. For example, they are more likely to be absent from school, have additional educational needs and have lower educational attainment. Caregivers also experience missed work days and financial challenges as a result. Some children will experience severe symptoms and life-threatening attacks.

Taking the UK as an example, paediatric asthma outcomes are poor overall with considerable associated morbidity and high rates of emergency hospital admissions, and most pertinently, there are several preventable deaths each year. Alarmingly, the National Review of Asthma Deaths (NRAD) found that in almost all paediatric cases, there were a number of significant avoidable contributing factors and that these deaths may have been preventable.

There are several factors that make the diagnosis and management of asthma in children challenging. The aim of this review was to explore these issues and highlight good clinical practice in the diagnosis and management of paediatric asthma.

Key messages

- Paediatric asthma outcomes are poor and many deaths are preventable.
- Diagnosing asthma in childhood can be challenging, and the diagnosis should be reviewed during follow-up to ensure it is correct.
- Asthma attacks should be viewed as never events. Postattack reviews are essential to optimise maintenance therapy and prevent future attacks.
- Education is key to improving asthma outcomes.
- Personalised asthma action plans are essential, and a significant number of children with asthma do not have one.

PRESENTATION OF ASTHMA

Children with asthma typically present with a symptom triad of wheeze, shortness of breath and cough. However, ‘asthma’ is an umbrella term used to describe this collection of symptoms and, when present, should prompt practitioners to ask, ‘What type of asthma is this?’ There are a number of asthma subtypes that present and respond to treatment differently. Identification of the features of asthma and modifiable or treatable traits should only be the start of the diagnostic journey.

Asthma symptoms are normally intermittent in nature and may not be present at the time of clinical review, making the diagnosis challenging in some cases. Additionally, disease phenotypes are not fixed and may evolve over time, necessitating ongoing review of symptoms and treatment.
Wheeze is a key feature of asthma and, if not present, a diagnosis of asthma in a child is unlikely. Wheeze is an expiratory high-pitched whistle that occurs as a result of inflammation and narrowing of the small airways. Parental understanding of wheeze varies, and clarifying what is meant when it is reported is key in making an accurate diagnosis.

The prevalence of ‘preschool wheeze’ is an additional challenge when diagnosing asthma in young children. In the first few years of life, many children will experience wheeze, but not all will go on to develop true asthma. The diagnosis of asthma should therefore be reviewed routinely to identify true asthma and alter treatment where necessary. Favourable response to an appropriate trial of asthma treatment is an important confirmatory piece of diagnostic evidence.

Clinical examination may be normal in children and adolescents with asthma if they present during asymptomatic periods. During acute attacks, use of accessory muscles of respiration and widespread wheeze may be present. Chest hyperinflation may be identified in acute and chronic disease settings.

**Asthma triggers**

Asthma attacks commonly occur following exposure to one or several triggers. Viral respiratory infections remain the leading cause, but there are a number of other known triggers (box 1), including aeroallergens, secondhand smoke exposure, or changes in ambient air temperature or humidity. Identification and documentation of specific asthma triggers should be part of routine care. Education on trigger recognition and avoidance is essential.

**Risk factors for asthma**

There are a number of risk factors that should be explored in the history of children who present with features of asthma. In symptomatic children, a personal or family history of atopic features, including asthma, eczema or rhinitis, supports a diagnosis of asthma. Some additional risk factors are outlined in box 2. Education on modifiable risk factors, for example, exposure to secondhand smoke or air pollution and obesity, should be delivered routinely during consultations and asthma reviews. A range of social determinants that are linked to poverty impact on outcomes and the health of children with asthma.

**Paediatric asthma phenotypes**

Asthma is a heterogeneous disease in which there are several phenotypes and underlying endotypes. Phenotypes are subtypes of asthma that share clinical characteristics such as symptom triggers, atopic features, disease severity and response to treatment. Endotypes are subtypes of asthma that are characterised by similar underlying biological mechanisms.

Key endotypes include ‘type 2-high’ and ‘type 2-low’ asthma. Identifying asthma phenotypes and endotypes can facilitate targeted treatment based on the pathophysiology occurring in a specific individual. For example, allergic or eosinophilic asthma that frequently starts in childhood is type 2-high and is characterised by eosinophilic airway inflammation, raised IgE and fractional exhaled nitric oxide (FeNO) levels. Typically, type 2-high asthma responds well to inhaled corticosteroid (ICS) treatment. A number of biologic agents can be used in the management of asthma, under specialist supervision, and their use varies on asthma endotypes (table 8).

**Differential diagnoses and diagnostic uncertainty**

Misdiagnosis of asthma remains a major problem with rates of both underdiagnosis and overdiagnosis being high. Overdiagnosis is problematic as it exposes children to unnecessary side effects of medications and runs the risk of trivialising asthma.

There are several conditions that may be associated with chronic cough, wheeze and/or shortness of breath in children and therefore present similarly to asthma (table 1). Due to the difficulties with diagnosis, especially in young children where objective testing is not possible, the diagnosis of asthma should be reviewed at each clinical presentation and interaction.
Diagnosing asthma in children

There is no single ‘gold-standard’ test that can be used to accurately diagnose asthma. In practice, a diagnosis should be made based on characteristic symptom patterns, evidence of variability in airflow limitation in the presence of airway inflammation, likelihood of alternative diagnoses and response to treatment. Getting the diagnosis correct is key for optimal management of paediatric asthma.

Lung function tests can be used to aid the diagnosis of asthma in children over the age of 5 years. Peak expiratory flow (PEF) and spirometry are commonly used to assess airflow obstruction and reversibility. PEF can be used to detect diurnal variation, which is a typical feature of asthma. The Global Initiative for Asthma (GINA) specifically recommends the use of either PEF or spirometry in the diagnosis of asthma in children over 5 years. Once a child is old enough to reliably perform lung function testing, it is recommended that this be undertaken if the diagnosis of asthma has not been previously confirmed. In children under 5, lung function testing is rarely practical outside a research setting. This makes diagnosis in this age group additionally challenging. Guidelines vary between countries and regions with regard to diagnostic criteria. An overview of the similarities and differences between these guidelines is displayed in table 2. Lung function testing is frequently used to monitor progress of children with asthma as part of their care. Objective testing should be repeated if there is poor response to treatment or diagnostic uncertainty.

FeNO is used to detect and quantify eosinophilic airway inflammation with levels elevated in those with eosinophilic asthma. Once staff are trained, and provided equipment is available, FeNO is a practically useful test that is quick to perform in school-aged children. The exact positioning of FeNO testing varies between guidelines worldwide (table 2). FeNO monitoring may also be useful in titrating dosage of ICS in those with an established diagnosis of asthma.

Allergy testing (skin prick testing or measurement of specific IgE levels) is not routinely carried out in the diagnostic process; however, it is recommended in a number of clinical guidelines and may identify individual triggers.

There are several aspects that make paediatric asthma diagnosis challenging. Most diagnoses are made in primary care where there is often limited access to objective testing at present. Despite guideline recommendations, objective testing is frequently only available in secondary or tertiary care settings where equipment and trained staff are available. The COVID-19 pandemic has served to exacerbate these issues and increase backlogs. Various solutions have been proposed, including community diagnostic hubs. In some healthcare systems, the cost of undertaking objective testing is a cause of health inequalities.

Additionally, the symptom onset for most cases of paediatric asthma occurs before the age of 3 years when lung function testing cannot be used to aid diagnosis. In this age group, response to an asthma treatment trial is useful to aid diagnostic decision making and is recommended in a number of national guidelines.

MANAGEMENT OF ASTHMA IN CHILDREN

The management of asthma is multifactorial, and to optimise disease control, a number of pharmacological, non-pharmacological and self-management aspects need to be considered.

Pharmacological management

The pharmacological management of asthma involves two key components: maintenance and reliever therapies. Maintenance therapies are the mainstay of asthma management, and the treatment aim is that no reliever therapies are required. Use of reliever therapy suggests asthma control is poor.

An overview of maintenance and reliever therapies is outlined in tables 3 and 4, respectively. A stepwise approach to asthma management is encouraged, and pharmacological management varies on age, symptom control and the national guideline used. An overview of
Table 2  Summary of paediatric asthma national guidelines: focusing on diagnosis

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Year</th>
<th>Diagnostic criteria</th>
<th>Recommended objective testing</th>
<th>When to refer to a specialist</th>
<th>When to consider alternative diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>NICE Guidelines (UK)</td>
<td>2017</td>
<td>Under 5 years: findings in clinical history and examination that are suggestive of asthma or either spirometry demonstrating obstructive airflow and bronchodilator reversibility or a FeNO level of 35 ppb or more.</td>
<td>Over 5 years: Spirometry and bronchodilator reversibility or FeNO first line. Additional tests, PEF, bronchial challenge test with histamine or methacholine.</td>
<td>Children who are not responding to treatment and/or cannot complete objective testing. If there is obstructive spirometry but negative bronchodilator reversibility and negative FeNO.</td>
<td>When children have symptoms of asthma but normal objective testing results.</td>
</tr>
<tr>
<td>Global Initiative for Asthma (global)</td>
<td>2021</td>
<td>6 years and over: findings in clinical history that are suggestive of asthma plus evidence of variability in expiratory airflow limitation with either spirometry and bronchodilator reversibility, repeated PEF measurements, positive exercise challenge or positive bronchial challenge.</td>
<td>6 years and over: either spirometry, PEF, exercise challenge or bronchial challenge to detect variability in lung function.</td>
<td>Diagnostic uncertainty, previous life-threatening attack, no/poor response to asthma treatment.</td>
<td>Atypical asthma features, atypical clinical examination findings, for example, cardiac murmurs.</td>
</tr>
<tr>
<td>Canadian Thoracic Society (Canada)</td>
<td>2021</td>
<td>Aged 1–5 years: more than one presentation of asthma-like symptoms plus a response to asthma treatment trial or Over 6 years: findings in clinical history that are suggestive of asthma plus spirometry showing obstructive expiration and demonstration of reversibility of airflow limitation of at least 12%.</td>
<td>Over 6 years: spirometry and bronchodilator reversibility (first line) additional tests that may be useful: peak flow variability, bronchial challenge and exercise challenge.</td>
<td>Diagnostic uncertainty, severe asthma, previous life-threatening attack, need for allergy testing, any hospitalisation as a result of asthma.</td>
<td>Atypical asthma features, no response to treatment trials. Results of objective testing do not suggest asthma.</td>
</tr>
<tr>
<td>National Asthma Council Australia (Australia)</td>
<td>2021</td>
<td>Aged 1–5 years: findings in clinical history and examination that are suggestive of asthma plus a response to treatment trial with SABA and/or ICS or 6 years and over: findings in clinical history and examination that are suggestive of asthma plus spirometry demonstrating of reversibility of airflow limitation of at least 12%.</td>
<td>Aged 1–5 years: none or 6 years and over: spirometry first line Bronchial challenge test and exercise testing to be considered if spirometry results do not show a reversibility of airflow limitation of at least 12%.</td>
<td>When child has characteristic asthma symptoms and diagnosis is not clear from objective testing results.</td>
<td>Atypical asthma features.</td>
</tr>
<tr>
<td>ARF NZ (New Zealand)</td>
<td>2020</td>
<td>Aged 1–11: findings in clinical history that are suggestive of asthma plus a response to asthma treatment trial.</td>
<td>Aged 5–11 years: Spirometry should be considered if asthma symptoms are atypical or in those with typical asthma symptoms that do not respond to a treatment trial.</td>
<td>When there is no response to asthma treatment trials and/or there is diagnostic uncertainty.</td>
<td>Atypical asthma features.</td>
</tr>
</tbody>
</table>

Continued
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management approach in a number of national guidelines is summarised in table 5.

GINA guidelines recommend dual ICS and short-acting beta-2 agonist (SABA) therapy to children over the age of 5. SABA monotherapy was previously the main management starting point; however, compared with combined treatment, SABA monotherapy has been shown to be associated with asthma mortality. SABA monotherapy is now only recommended by GINA for use in children aged 5 or less. As seen in table 5, GINA recommends symptom-driven ICS use, compared with daily ICS use, as initial therapy in children over 6 years of age. In the past, SABA monotherapy was used as initial therapy in children aged 5 or less. However, recent studies have shown that combined ICS and SABA therapy is more effective in managing asthma in children under 5 years old.

Table 2 Continued

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Year</th>
<th>Diagnostic criteria</th>
<th>Recommended objective testing</th>
<th>When to refer to a specialist</th>
<th>When to consider alternative diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irish College of GPs (Ireland) 20</td>
<td>2020</td>
<td>Under 6 years: findings in clinical history that are suggestive of asthma</td>
<td>Under 6 years: treatment trial</td>
<td>Parental concern or request, failure to respond to treatment trial, failure to thrive, diagnostic uncertainty</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Over 6 years: findings in clinical history that are suggestive of asthma plus evidence of obstructive airflow limitation and reversibility with bronchodilators</td>
<td>Over 6 years: PEF or spirometry.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Japanese Society of Allergology (Japan) 2020</td>
<td>2020</td>
<td>All ages: findings in clinical history that are suggestive of asthma plus a response to asthma treatment trial</td>
<td>Lung function testing (non-specified), skin prick testing, bronchodilator reversibility testing, bronchial challenge</td>
<td>Poor response to multiple-agent therapy or multiple courses of oral steroids</td>
<td>Atypical asthma features, no response to treatment trial or atypical results on objective testing</td>
</tr>
<tr>
<td>International Consensus on Pediatric Asthma (global) 2015</td>
<td>2015</td>
<td>Under 5 years: findings in clinical history that are suggestive of asthma</td>
<td>Over 5 years: spirometry first line PEF is useful for aiding, FeNO and skin prick testing for detecting allergic asthma can be useful.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Over 5 years: findings in clinical history that are suggestive of asthma plus spirometry with bronchodilator reversibility demonstration of reversibility of airflow limitation of at least 12%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GEMA (Spain) 2009 24</td>
<td>2009</td>
<td>Under 6 years: findings in clinical history that are suggestive of asthma</td>
<td>6 years and over: spirometry with combined bronchodilator reversibility. FeNO and allergy testing may be useful if diagnosis is unclear.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Over 6 years: findings in clinical history that are suggestive of asthma plus spirometry with bronchodilator reversibility demonstration of reversibility of airflow limitation of at least 12%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ministry of Health (Singapore) 2008</td>
<td>2008</td>
<td>All ages: findings in clinical history and examination that are suggestive of asthma</td>
<td>No objective testing normally required for diagnosis. PEF at every consultation and spirometry at least annually in children over 6 years to assess asthma severity. Tests that may be considered: CXR to exclude foreign bodies and chronic LRTIs, skin prick testing to detect atopy and exercise testing to assess exercise induced asthma</td>
<td>High-risk patients with poor control, young age and poor response to treatment trial, when requiring high doses of steroids to control symptoms</td>
<td>–</td>
</tr>
</tbody>
</table>

Resources, in terms of equipment and appropriately trained staff to perform testing in children, are substantial limitations in primary care at present. Ideally PEF, spirometry and FeNO could be performed in primary care. With the addition of skin prick testing and blood work in secondary care and bronchial challenge and exercise testing reserved for tertiary care. CXR, chest X-ray; FeNO, fractional exhaled nitric oxide; ICS, inhaled corticosteroid; LRTI, lower respiratory tract infection; NICE, National Institute for Health and Care Excellence; PEF, peak expiratory flow; ppb, parts per billion; SABA, short-acting beta agonist.
In comparison to daily ICS use, symptom-driven use has demonstrated a similar exacerbation risk and reduces the risk of ICS adverse effects.\textsuperscript{34} Single maintenance and reliever therapy (SMART) inhalers are combined inhalers offering both maintenance and reliever therapy in those with asthma. These inhalers contain a number of maintenance and reliever therapies in different combinations. The use of these inhalers has been shown to reduce the risk of asthma attacks and emergency department (ED) admissions.\textsuperscript{35} There is limited evidence in the effectiveness of SMART inhalers in children, but children over 12 years may be prescribed a SMART inhaler, which acts as both a maintenance and reliever therapy, if symptoms are not well controlled.\textsuperscript{37}

There are a number of biologic agents (table 6) that may be used in the management of paediatric asthma. These are endotype-specific, targeted therapies that should be used only under the supervision of specialists. Their availability and cost vary between countries and different healthcare systems. Detailed appraisal of the evidence base for their use is provided in the individual management guidelines and has been recently reviewed.\textsuperscript{17}

### Non-pharmacological management

Non-pharmacological aspects of asthma management include providing education on modifiable risk factors and comorbidities to caregivers and conducting annual asthma reviews to assess control and future risk. Education is key to improving caregiver and child understanding of asthma and its management. Clear information regarding modifiable risk factors, such as smoke exposure, domestic pollutants and obesity, should be given. Short-term educational interventions aimed to improve self-management have been shown to increase age. In comparison to daily ICS use, symptom-driven use has demonstrated a similar exacerbation risk and reduces the risk of ICS adverse effects.\textsuperscript{34}

### Table 3 Maintenance therapies

<table>
<thead>
<tr>
<th>Maintenance therapies</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICS</td>
<td>Currently used as a first-line maintenance agent in a number of national guidelines; when using ICS, the lowest possible dose to effectively control symptoms should be used to prevent possible adverse effects of growth reduction and risk of adrenal suppression.</td>
</tr>
<tr>
<td>LABA</td>
<td>Used as an add-on therapy when dual ICS and SABA therapy is ineffective. In comparison to SABA, bronchodiolation duration is prolonged to 12 hours.</td>
</tr>
<tr>
<td>Leukotriene receptor antagonists (eg, montelukast)</td>
<td>Used as an add-on therapy in those who have poor symptom control despite ICS and LABA treatments. There have been a number of concerns raised regarding possible adverse reactions to montelukast. These include neuropsychiatric features ranging from poor sleep to suicidal ideation.</td>
</tr>
<tr>
<td>Long-acting muscarinic antagonists (eg, tiotropium)</td>
<td>Used as an add-on therapy in those who have poor symptoms control despite ICS and LABA therapies</td>
</tr>
<tr>
<td>Oral theophylline</td>
<td>Used as an add-on therapy, usually in those with uncontrolled symptoms despite several maintenance and reliever therapies. Monitoring of plasma level required on initiation of treatment and dose changes</td>
</tr>
<tr>
<td>Biologics</td>
<td>Use as an add-on therapy, under specialist care, in those who have poorly controlled symptoms despite being on several maintenance and reliever therapies. A number of biologic agents are available (table 6). Various individual biologics have been shown to reduce attacks, improve lung function and reduce oral corticosteroid use.\textsuperscript{18}</td>
</tr>
</tbody>
</table>

ICS, inhaled corticosteroid; LABA, long-acting beta-2 agonists; SABA, short-acting beta-2 agonist.

### Table 4 Reliever therapies

<table>
<thead>
<tr>
<th>Reliever therapies</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>SABAs</td>
<td>Currently used as a first-line reliever agent in a number of national guidelines; effects of bronchodilation last for up to 4 hours. SABAs work by rapidly relaxing the smooth muscle of small airways, providing quick relief from asthma symptoms. Should be delivered via an age-appropriate spacer device or only if requiring supplemental oxygen via a nebuliser; older children may be able to use a handheld device without a spacer if trained and deemed competent in using it effectively.</td>
</tr>
<tr>
<td>Oral corticosteroids</td>
<td>Used as a short-term therapy during asthma attacks to reduce airway inflammation and ease symptoms; repeated short-term courses of oral steroids suggest poor chronic symptom control and should trigger a review of maintenance therapy.</td>
</tr>
</tbody>
</table>

SABA, short-acting beta-2 agonist.
<table>
<thead>
<tr>
<th>Guideline</th>
<th>Year</th>
<th>First-line management</th>
<th>Add-on therapies*</th>
<th>Treatment withdrawal</th>
</tr>
</thead>
<tbody>
<tr>
<td>GINA (global)²⁰</td>
<td>2021</td>
<td>5 years and under: SABA monotherapy 6–11 years: combined low-dose ICS+SABA (as needed) Adolescents: combined low-dose ICS+SABA</td>
<td>5 years and under: second line: low-dose ICS, third line: medium-dose ICS or low-dose ICS and LABA or medium-dose ICS or daily SMART combined ICS/LABA; refer for expert advice Aged 6–11 years: second line: low-dose ICS; third line: low-dose ICS and LABA or medium-dose ICS or LTRA; fourth line: refer for phenotype assessment Adolescents: second line: low-dose ICS; third line: medium-dose ICS; fourth line: medium-dose/high-dose ICS±LAMA; refer for phenotype assessment</td>
<td>Stepping down treatment should be considered when both asthma symptoms and lung function have been stable for a period of 3 months or more.</td>
</tr>
<tr>
<td>Canadian Thoracic Society (Canada)³²</td>
<td>2021</td>
<td>Aged 1–5 years: SABA monotherapy Aged 6–11: SABA monotherapy Age 12+: SABA monotherapy</td>
<td>Aged 1–5 years: second line: ICS and LTRA, third line: high-dose ICS and LTRA, fourth line: referral for specialist management Aged 6–11: second line: ICS and LTRA; third line: high-dose ICS and LTRA; fourth line: high-dose ICS, LTRA and LABA; fifth line: high-dose ICS, LTRA, LABA and oral steroids Age 12+: second line: ICS and LTRA; third line: ICS, LTRA and LABA; fourth line: medium-dose ICS, LTRA, LABA and tiotropium</td>
<td>After asthma has been well controlled for a period of 3–6 months</td>
</tr>
<tr>
<td>National Asthma Council Australia³⁰</td>
<td>2021</td>
<td>Age 1–5 years: SABA monotherapy Aged six and over: SABA monotherapy</td>
<td>Age 1–5 years: second line: low-dose ICS or LTRA; third line: low-dose ICS and LTRA; fourth line: referral for specialist management Aged 6 and over: second line: low-dose ICS or LTRA; third line: low-dose ICS and LTRA or high-dose ICS or ICS/LABA combination; fourth line: referral for specialist management</td>
<td>Step-down of treatment should be considered when symptoms have been well controlled for a period of at least 6 months.</td>
</tr>
<tr>
<td>Asthma and Respiratory Foundation NZ (New Zealand)³¹</td>
<td>2020</td>
<td>Aged 1–4 years: SABA and low-dose ICS Aged 5–11 years: SABA monotherapy</td>
<td>Aged 1–4 years: referral for specialist management Aged 5–11 years: second line: SABA and low-dose ICS; third line: LABA and low-dose ICS; fourth line: LABA, high dose ICS, LTRA and referral for specialist management</td>
<td>If the child has been stable for 3 months or more on treatment, step-down with an incremental approach.</td>
</tr>
<tr>
<td>Irish College of General Practitioners (Ireland)³⁰</td>
<td>2020</td>
<td>Aged 6–11: ICS and SABA (ICS only to be taken when SABA is used as a reliever) Adolescents: ICS and SABA (ICS only to be taken when SABA is used as a reliever)</td>
<td>Aged 6–11: second line: low-dose ICS or LTRA (if ICS is not appropriate); third line: low-dose ICS and LABA or high dose ICS; fourth line: medium-dose ICS, LABA and referral to paediatrics for management advice; fifth line: refer to paediatrics for phenotype assessment Adolescents: second line: low-dose ICS; third line: low-dose ICS and LABA; fourth line: medium-dose ICS and LABA or low dose ICS, LABA and LAMA; fifth line: refer to paediatrics for phenotype assessment</td>
<td>–</td>
</tr>
<tr>
<td>The Japanese Society of Allergology (Japan)³⁷</td>
<td>2020</td>
<td>Aged 1–5 years: SABA monotherapy Aged 6–15 years: SABA monotherapy</td>
<td>Age 1–5 years: second line: low-dose ICS or LTRA or disodium cromoglycate, third line: medium-dose ICS, fourth line: high dose ICS and LTRA Age 6–15 years: second line: low-dose ICS or LTRA, third line: medium-dose ICS or combined low-dose ICS/LABA; fourth line: high-dose ICS or combined medium dose ICS/LABA</td>
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Continued
All young people with asthma should have asthma reviews at least annually. These reviews should focus on current symptom control and management, previous attacks, triggers, modifiable risk factors and personal asthma action plans (PAAPs). Asthma reviews are opportunities to assess child and caregiver understanding of asthma and provide education, if necessary. Annual asthma reviews are also opportunities to assess inhaler technique (including spacer use) and provide education on this if necessary. Poor inhaler technique is common in young people with asthma and associated with poor disease control.

Taking time to understand the perceptions of young people and their caregivers in relation to their asthma diagnosis and management is important, and exploring such perceptions may enhance engagement during consultations, subsequently improving outcomes for young people.

Self-management
Self-management aspects of paediatric asthma management include asthma education and PAAPs. PAAPs are written documents that are given to young people and/or caregivers that advise them on day-to-day asthma management and what to do in the event of an attack. Action plans should be created with patient/caregiver input, shared with relevant individuals (eg, school teachers) and should be reviewed and updated regularly. PAAPs have been shown to reduce ED attendance and missed school days and to increase caregiver confidence when managing attacks. The 2018 Annual Asthma Survey found that over 50% of children with asthma in the UK had no PAAP, and around 20% of caregivers did not seek medical advice during acute asthma attacks, highlighting large gaps in education.

Diet and exercise are additional important self-management aspects within paediatric asthma care. A number of short-term exercise interventions have demonstrated improvements in lung function and symptom control. Healthy eating interventions can help reduce body mass index and improve the quality of life of both young people and their caregivers.

Withdrawing management/stepping down
Asthma control should be reviewed at every medical contact. When asthma symptoms are well controlled on medication adherence, improve symptom control and reduce mortality.

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**Withdrawing management/stepping down**
Asthma control should be reviewed at every medical contact. When asthma symptoms are well controlled on
### Table 6  Biologic agents used in the management of asthma

<table>
<thead>
<tr>
<th>Biologic</th>
<th>Route and frequency</th>
<th>Mechanism of action</th>
<th>Effect on asthma symptoms*</th>
<th>Effect on attacks and mortality*</th>
<th>Safety concerns/common adverse reactions*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Omalizumab</td>
<td>Subcutaneous injection every 4 weeks</td>
<td>IgG1k antibody that binds to the Fc portion of IgE, resulting in the inability of IgE to bind to the IgE receptor on mast cells. This reduces the concentration of free circulating IgE and consequently mast cell degranulation.</td>
<td>Improved asthma symptoms</td>
<td>Reduced asthma attacks</td>
<td>Mild injection site reactions, headache, fever, abdominal pain, gastroenteritis and nasopharyngitis</td>
</tr>
<tr>
<td>Dupilumab</td>
<td>Subcutaneous injection every 2 weeks</td>
<td>Binds to alpha component of IL-4 receptor blocking IL-4 and IL-13 stimulation of B-cells</td>
<td>Improved asthma symptoms and quality of life</td>
<td>Reduced asthma attacks</td>
<td>Mild injection site reactions and eosinophilia</td>
</tr>
<tr>
<td>Mepolizumab</td>
<td>Subcutaneous injection every 4 weeks</td>
<td>Binds to IL-5 cytokines resulting in reduced peripheral eosinophilia and reduced airway inflammation</td>
<td>Improved asthma symptoms and quality of life</td>
<td>Reduced asthma attacks</td>
<td>Headache, attack of asthma symptoms and bronchitis</td>
</tr>
<tr>
<td>Reslizumab</td>
<td>Intravenous infusion every 4 weeks</td>
<td>Binds to IL-5 cytokines, resulting in reduced peripheral eosinophilia and reduced airway inflammation</td>
<td>Improved asthma symptoms and quality of life</td>
<td>Reduced asthma attacks</td>
<td>Attack of asthma symptoms, nasopharyngitis and upper respiratory tract infections</td>
</tr>
<tr>
<td>Benralizumab</td>
<td>Subcutaneous injection every 4 weeks for the first three doses and then every 8 weeks</td>
<td>Binds to alpha component of IL-5 receptor, resulting in reduced eosinophil activation from IL-5</td>
<td>Improved asthma symptoms and quality of life</td>
<td>Reduced asthma attacks</td>
<td>Headache, sinusitis, nasopharyngitis and fever</td>
</tr>
</tbody>
</table>

*Detailed appraisal of the evidence base for their use is provided in the individual management guidelines and has been recently reviewed. Interleukin.*
pharmacological therapy, stopping or stepping down medication should be considered to protect young people from unnecessary adverse effects.

The GINA 2021 guidelines advise that clinicians should consider stepping down asthma management to the lowest effective treatment regimen when good symptom control has been achieved for at least 3 months. When stepping down treatment, an individualised risk–benefit approach should be taken with focus on the child’s medical history, including frequency of oral corticosteroid use, frequency of asthma attacks, and previous intensive or high-dependency care admissions.

WHEN TO REFER TO A SPECIALIST
Most paediatric asthma cases are diagnosed in primary care without the input of general paediatricians or paediatric respiratory physicians. However, a number of children with asthma may need to be referred to specialists for diagnostic or management input. Common indications for specialist referral include no or poor response to asthma treatments, inconclusive objective testing, poor symptom control with appropriate treatment, frequent oral corticosteroid use or the occurrence of a severe asthma attack. A key element of specialist care is a multidisciplinary team consisting of a number of professionals, including specialist nurses, psychologists, physiologists and pharmacists. Healthcare professionals must consider any safeguarding implications at all paediatric asthma reviews as part of delivering holistic care. Unexplained or frequent ‘do not attend’ appointments or suspicion of poor medical management at home should be flagged and acted on locally.

PREDICTORS OF LIFE-THREATENING ATTACKS
The following features have been shown to increase the likelihood of future severe attacks, and particular attention should be given to these factors during asthma reviews:

1. **Previous attack.** The strongest risk factor for a future asthma attack is a personal history of a previous attack. One large systematic review and meta-analysis found that children with a recent history of ED attendance with an asthma attack were up to 5.8 times more likely to have another ED attendance and up to three times more likely to be admitted to the hospital with a future asthma attack.

2. **Frequent SABA use and prescription requests.** Frequent use of SABA reliever therapy suggests poor control of asthma symptoms. If asthma symptoms are well controlled, no more than two SABA inhalers should be required annually. The UK NRAD found that excess SABA prescription and use were prominent in individuals who died of asthma attacks. For those with data available, around 40% had been prescribed 12 or more SABA inhalers in the 12 months before death.

POSTATTACK REVIEW
Asthma attacks should be viewed as never events. It is essential that a postattack review is conducted to review asthma maintenance treatment, as this is likely to be suboptimal. Failure to review patients post attack, and to alter treatment where appropriate, is likely to predispose to future attacks, which could be life-threatening. Management of the current attack should be reviewed to ensure treatment is appropriate and symptoms are resolving. Some individuals may require additional courses of oral corticosteroids to settle symptoms.

Current NICE quality standards (UK) state that all individuals hospitalised with an asthma attack should receive a follow-up review in primary care within two working days of discharge, to review maintenance management and ensure resolution of symptoms. However, the 2018 National Asthma Survey completed in the UK found that 64% of respondents had no primary care follow-up post attack, and most patients were not aware that this was required.

**Salbutamol weaning**
Salbutamol weaning plans are commonly used by a number of healthcare organisations following discharge after an asthma attack. These plans direct caregivers to provide regular SABA therapy, often in a reducing regime, in the days following discharge. There have been a number of concerns raised with regard to these plans with some believing that providing regular SABA therapy may potentially mask deterioration and could delay caregivers seeking medical advice. Healthcare professionals should enquire about salbutamol weaning plans during postattack reviews and urge caregivers to seek medical advice if they have concerns or the effects of SABA are not lasting the 4 hours of duration.

FUTURE DEVELOPMENTS IN CARE
The management of paediatric asthma is changing over time with, just as two examples, developments in technology and service structure:

1. **Technology.** The growing use of technology in asthma care has huge potential to improve clinical outcomes. Smartphone applications can be used to provide medication reminders to users, and this has been shown to increase ICS adherence. Applications can also be used to provide educational content to young people and caregivers, as well as store PAAPs. ‘Smart’ inhalers, not to be confused with SMART inhalers, are devices that can provide audio reminders to users and record when they are used. One paediatric study found that the use of smart inhalers increased treatment adherence to 84%, compared with 30% in the control group.
2. Diagnostic hubs. In the UK, regional diagnostic hubs for asthma care have been recommended in NHS England’s Long Term Plan. Implementation of diagnostic hubs is hoped to result in earlier and more accurate asthma diagnoses by improving access to objective testing and specialised interpretation. Hubs are designed to improve asthma outcomes by enabling more appropriate treatment initiation and monitoring. There is currently no evidence in the literature of the clinical effects of diagnostic hubs being used in the management of paediatric asthma.

CONCLUSIONS

Paediatric asthma outcomes are currently poor and many deaths are preventable. The aim should be to avoid asthma attacks occurring with appropriate management therapy, and they should be viewed as never events. In order to improve outcomes, accurate diagnosis and management is essential. Good asthma care extends beyond providing medication and should include education, as well as supported self-management advice. The use of PAAPs remains limited and a significant number of young people with asthma do not have one. Postattack asthma reviews are a key opportunity to review maintenance medication and current symptom control.

Contributors All authors conceived the ideas for the article. JM wrote the first draft that was then commented on by JT and MB.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests MB received investigator-led research grants from Pfizer and Roche Diagnostics; speaker fees paid to Newcastle University from Novartis, Roche Diagnostics and TEVA; and travel expenses to educational meetings Boehringer Ingelheim and Vertex Pharmaceuticals.

Patient consent for publication Not applicable.

Ethics approval Not applicable.

Provenance and peer review Commissioned; externally peer reviewed.

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