Asthma remains the most common chronic disease in childhood.  
• At least half of children with asthma begin having symptoms before 2 years of age.  
• Identifying children with poor lung function and repeated asthma flares can lead to improved symptom control and improved quality of life.  
• Unnecessary hospitalizations and emergency department visits can be avoided with aggressive education and management.  

• Instruction regarding proper use of bronchodilator delivery systems including multidose inhaler with spacer or nebulizer (of little value without using a mask or mouth piece) should be provided both verbally and in writing.  
• Use of an asthma action plan using sixth-grade language and reviewing the family’s understanding of the steps in asthma management is shown to improve outcomes. Families should understand the difference between rescue bronchodilators and daily controller medications.  
• The Childhood Asthma Control Test* (ACT) is a simple questionnaire and reliable way to identify children with poorly controlled asthma. The test is available online: http://www.asthma.com/resources/childhood-asthma-control-test.html  
  – Children who score less than 19 on the ACT should be considered poorly controlled.  
  – Strong consideration should be given to starting these children on a trial of therapy with low-dose inhaled steroids (such as fluticasone 44 mcg, 2 puffs twice daily, or beclomethasone dipropionate hfa 40 mcg, 2 puffs twice a day, preferred by some insurers) for 3–6 months if they have not been treated previously, or doubling the dose for children already receiving inhaled steroids.  
  – Linear growth should be carefully measured before and during steroid use.  
  – Before increasing or changing controller therapy, the family should be asked about their understanding of and adherence to the regimen. Open-ended questions such as, “How many times a week do you think you forget to give his Flovent?” are helpful in allowing families to divulge the situation at home.  

*The Childhood Asthma Control Test was developed by GSK.

Many families are reassured by a specialist evaluation in the following situations:  
• When a child’s asthma does not improve with treatment  
• When there is a concern that the child has a wheezing or pulmonary disorder other than asthma  
• When another condition(s) complicates asthma or its diagnosis  
• When a child has required more than 2 bursts of oral corticosteroids in 1 year or has an exacerbation requiring hospitalization  
• When a child or caregiver needs additional education on the diagnosis of asthma and/or the treatment plan  
• When there are psychosocial, financial or family problems that interfere with the child’s asthma action plan. In this case, consider referral to a mental health therapist and/or a social worker.

(continued)
Sample asthma action plan:


**Information regarding MDI and nebulizer use in children**

Patient education sheets for MDI with spacer use:

Patient information regarding use of a nebulizer:


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