SYMPOSIUM 3

CHILDHOOD ASTHMA

S3.1

ASTHMA: OLD DISEASE; NEW CPG

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This is the third revision of the childhood asthma guidelines. The committee had met many times reviewing the literature consisted of randomized controlled trials, systematic reviews and other international guidelines namely the Gina, BTS, Australian and Scottish guidelines.

Asthma is a chronic inflammatory disease requiring long term treatment. The key treatment remained treating the underlying inflammation with inhaled corticosteroid, combination therapy with long acting Beta2 agonists or anti leukotrienes depending on the level of severity. Many studies showed that long term inhaled steroids did not alter the long term outcome of the disease.

Despite the widely availability of asthma therapy, there is still significant morbidity such as hospital admission, emergency visits to hospitals and loss of school days based on the AIRIAP data and our own National Health Morbidity Survey III conducted in 2006. These surveys showed that the prescription of preventer medications remained low.

Diagnosing asthma in the pre-school remains baffling particularly with the new classifications of recurrent wheeze. The Asthma Predictive Index was added in this guideline to assist practitioners in diagnosing and managing which group of wheezes were asthmatics.

As wheezing is a common presentation in children with respiratory airway obstruction, many other diseases such as tracheomalacia, bronchiolitis obliterans may be treated as asthma. Differential diagnosis of asthma were discussed in this guideline particularly the common conditions.

A comprehensive treatment plan for asthma includes asthma education, avoidance of trigger factors and strategies to optimize pharmacotherapy was discussed in this current guidelines. The management plan should be individualized because each patient has different trigger factors, asthma phenotypes and different responses to the medications.

Although pharmacologic treatments focused on host factors, interventions directed at environmental factors and preventions were critical for optimal management of allergic disease. These included breast feeding, food and medication allergy and other environmental allergens including smoking and obesity.

Special categories of asthma such as intermittent severe asthma, difficult asthma brittle asthma and exercise-induced asthma were briefly discussed.

This guideline is useful for all medical practitioners who manage children with asthma. It is hope that this guideline will be translated into clinical practice by all with the aims of improving and optimizing care, reducing morbidity and mortality among asthmatic children in Malaysia.