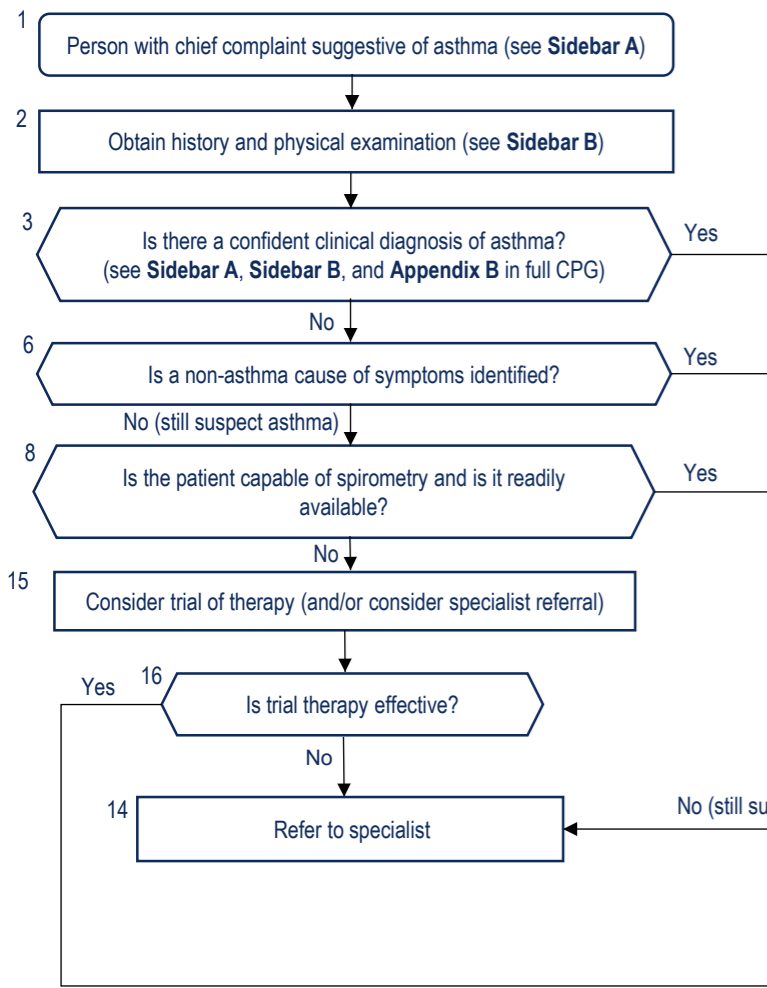
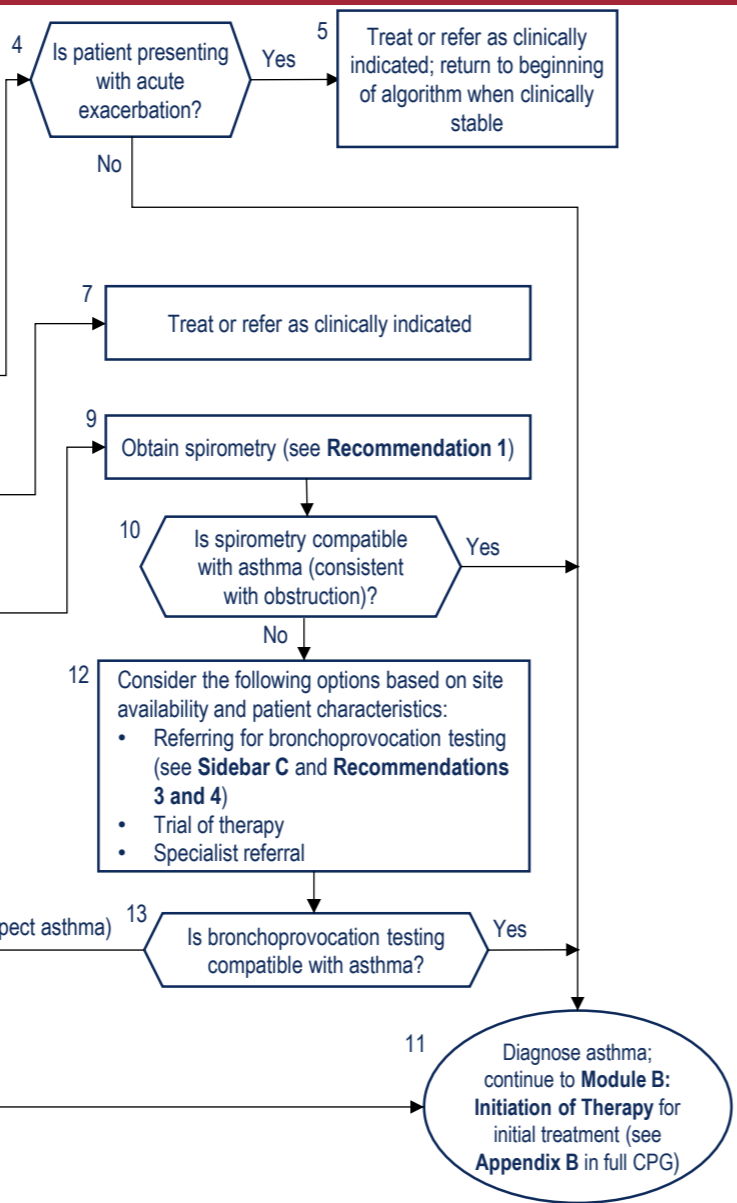


The Primary Care Management of Asthma

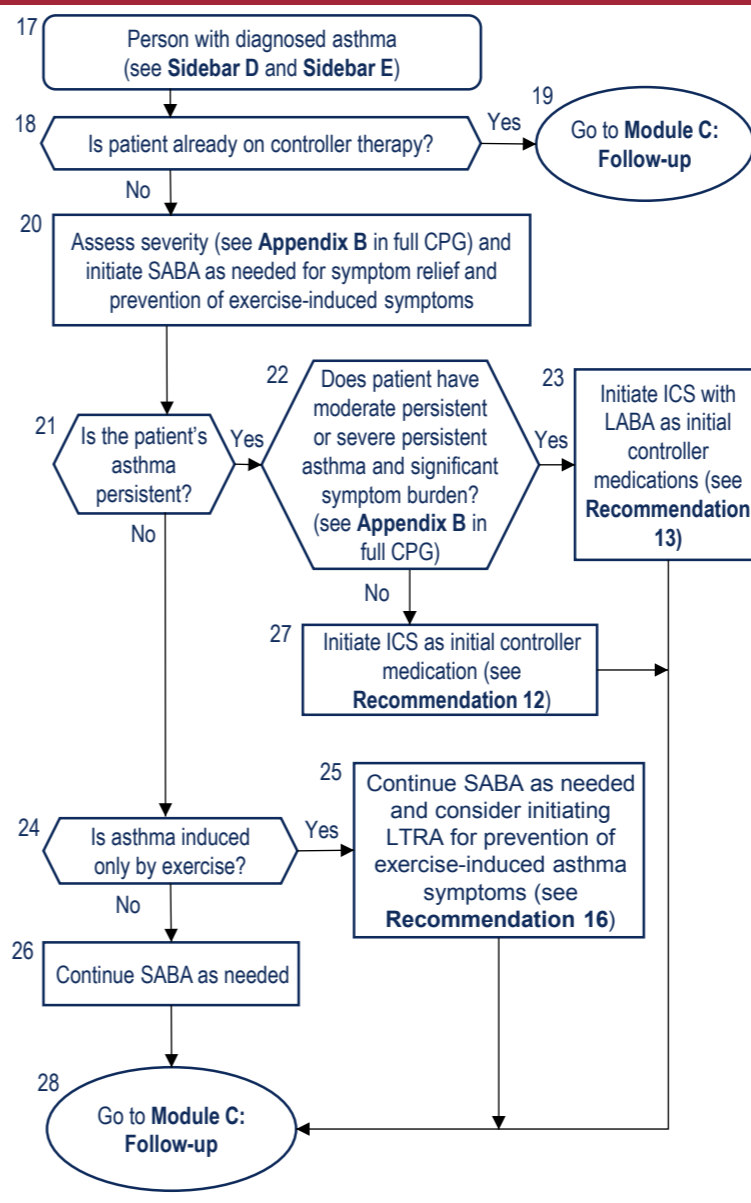
MODULE A: Assessment and Diagnosis of Asthma



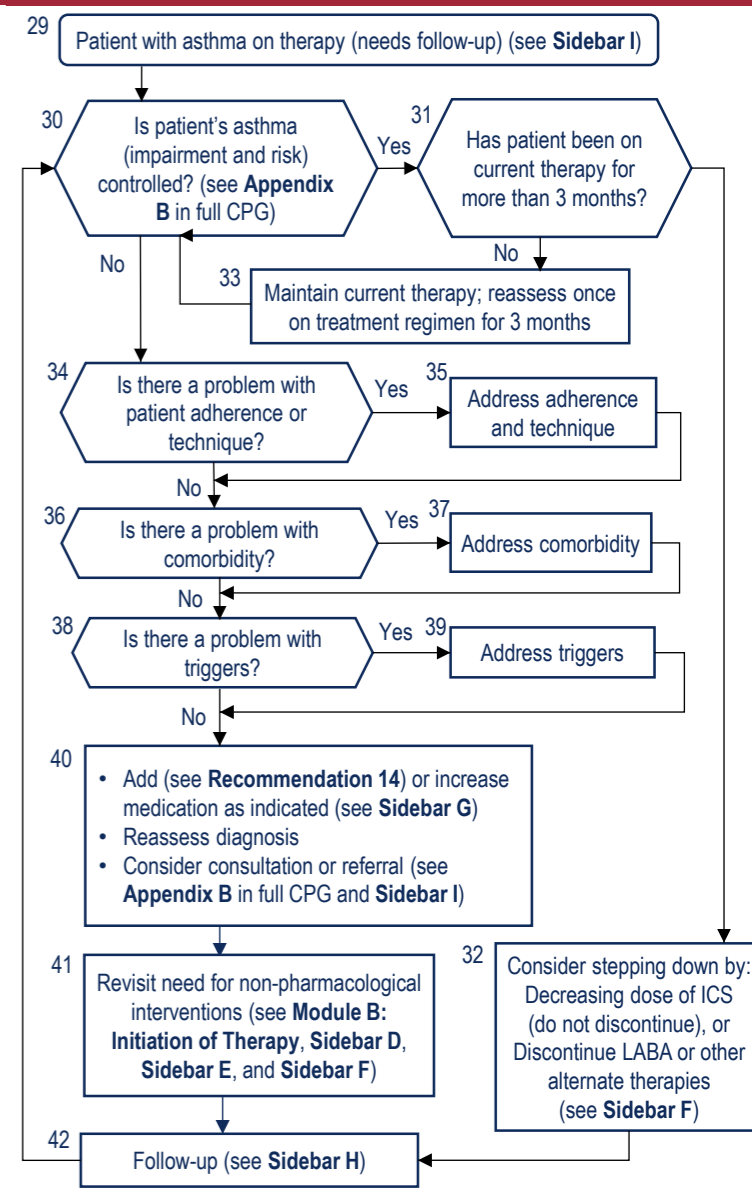
MODULE A: Assessment and Diagnosis of Asthma



MODULE B: Initiation of Therapy



MODULE C: Follow-up



**Sidebar A. Asthma Symptoms**

- **Adult:** More than 6 weeks of symptoms or recurrent episodes of cough, wheeze, shortness of breath
- **Child:** Cough or wheeze for more than 2 weeks or recurrent episodes of wheeze/significant cough

**Sidebar B. Assessment**

- Symptoms (**Sidebar A**)
- Pattern (exercise, nocturnal symptoms)
- Precipitating triggers
- Aggravating factors/risk factors (see **Recommendations 6 and 7**)
  - Adults and children: Overweight/obesity, atopy, secondhand smoke exposure in children, history of lower respiratory infection
  - Adults: Depression, current smokers, OIF/OEF combat deployment
- Comorbidities
- Response to treatment
- If not previously done, consider X-ray if other diagnoses are being considered.

**Sidebar C. Considerations for Bronchoprovocation Testing**

- Bronchoprovocation should be done using methacholine challenge.
- In some situations in the DoD, patients will need to have bronchoprovocation testing
- Bronchoprovocation should not be ordered for children; refer to specialist only
- See **Recommendations 3 and 4**

**Sidebar D. Asthma Education**

Patients and caregivers should be informed of the diagnosis of asthma. Their understanding should be assessed, and they should be given the opportunity to ask questions in order to take an active role in their medical care. More robust follow-up must be provided for those with asthma in order to provide “cornerstone” treatment which may consist of the following (see **Recommendations 9 and 10**):

- Symptoms (see **Sidebar A**)
- Pattern (exercise, nocturnal symptoms)
- Precipitating triggers
- Aggravating factors/risk factors (see **Recommendations 6 & 7**)
- Nature of asthma
- Goals of treatment
- Medication use (e.g., what it does, how to use it, potential side effects)
- How to recognize loss of asthma control and what steps to take to regain control of symptoms
- When and how to seek emergency care for asthma exacerbations
- Consider a personalized written asthma action plan (see **Recommendation 8**)
- Consider a care management team approach (may consist of dietary changes, emergent responses, updated medications, monthly follow-up for those with more severe symptoms, etc.)

**Sidebar E. Care Management**

**Multidisciplinary care management:**

- Multidisciplinary care management (see **Recommendation 17**)
- CBT (see **Recommendation 19**)
- Triggers for worsening control should be identified and if possible steps taken to reduce exposure
- Comorbidities

**Lifestyle changes:**

- Smoking cessation
- Regular exercise (see **Recommendation 18**)
- Weight management
- Avoidance of triggers

**Psychosocial considerations and impact of asthma:**

- Patient ability to absorb financial burden of medication cost
- Time away from work responsibilities for follow-up (e.g., office visits, testing)

**Sidebar F. Considerations for Stepping Down Therapy**

- Do not step down in patients that cannot be closely monitored (e.g., planned travel) or at risk of severe exacerbations (e.g., pregnancy, acute illness)
- Step down (not discontinue) ICS dose
- Discontinue LABA
- In low risk patients who are still well-controlled on low-dose ICS for at least three months, consider discontinuing ICS using caution
- Refer to **Appendix F, Tables F-1 and F-2** in full CPG for discussion of specific medications

**Sidebar G. Considerations for Stepping Up Therapy**

**Preferred therapy**

- **Initial therapy:**
  - ICS (see **Recommendation 12**)
  - Combination of ICS and LABA as initial controller treatment for patients with moderate-to-severe persistent asthma and significant symptom burden (see **Recommendation 13**)
- **Step-up therapy:**
  - If on low-medium ICS mono-therapy, add LABA (see **Recommendation 14**)
  - If considering 3-drug therapy or high-dose ICS, specialty referral is recommended (see **Sidebar I**)

In the case of contraindication/intolerance to preferred treatment, refer to **Appendix F, Table F-1** in full CPG for options.

Refer to **Appendix F, Table F-2** in full CPG for relative ICS dose ranges.

**Sidebar H. Considerations for Short Follow-up**

- Recent hospitalization
- ED visit
- Step medication change
- Recent exacerbation
- Increasing use of rescue inhalers
- Inability to use inhaler correctly

**Sidebar I. Considerations for Specialty Referral**

- Desensitization
  - In selected children
  - Atopy
  - Anaphylaxis
- Patients who may benefit from biological agents
- Consider adding a third drug
- Life-threatening exacerbation/intubation
- Multiple hospitalizations

Abbreviations: CBT: cognitive behavioral therapy; CPG: clinical practice guideline; DoD: Department of Defense; ED: emergency department; ICS: inhaled corticosteroid; LABA: long-acting beta agonist; LTRA: leukotriene receptor antagonist; OIF/OEF: Operation Iraqi Freedom/Operation Enduring Freedom; SABA: short-acting beta agonist; VA: Department of Veterans Affairs

Access to the full guideline and additional resources is available at the following link: <https://www.healthquality.va.gov/guidelines/cd/asthma/index.asp>