

Summary of Stepwise Pharmacological Management in Children Aged 5-15 Years

Step 1: Mild Intermittent Asthma

Inhaled short acting β_2 agonist as required

Step 2: Regular Preventer Therapy

Add inhaled steroid 200-400 microgram/day beclomethasone dipropionate (BDP) or budesonide (BUD), or 100-200 microgram/day fluticasone

- use the higher dose for greater severity,
(cromoglycate, nedocromil or montelukast¹ if inhaled steroid cannot be used)

Step 3: Add on Therapy

1. Add inhaled long acting β_2 agonist (LABA)²

2. Assess response to LABA:

- good response to LABA - continue LABA
some benefit from LABA in maximum dose but control still inadequate, increase inhaled steroid to 400 microgram/day BDP or BUD, **or** 200 microgram/day FP (if not already on this dose)
- no response to LABA - Stop LABA consider trial of montelukast **or** SR theophylline

Step 4: Persistent Poor Control

Increase inhaled steroid to 600-800 microgram/day BDP or BUD, or 300-400 microgram/day fluticasone³

Continue to review add on therapy

Refer to paediatrician if not improving

Step 5: Continued Poor Control

Refer to paediatrician

Maintain high dose inhaled steroid

Consider steroid tablet in lowest dose providing adequate control

1. The only NZ Registered Leukotriene Receptor Antagonist, montelukast, is not currently on the Pharmaceutical Schedule.
2. Maximum recommended dose of eformoterol is 12 microgram/bd, and salmeterol 50 microgram/bd.
3. These levels of ICS are greater than usually required to achieve optimal control, do not hesitate to seek advice from a paediatrician.

The algorithm is taken from: 'Management of Asthma in Children Aged 1-15 Years' Paediatric Society of New Zealand Available from: <http://snipurl.com/thzj>