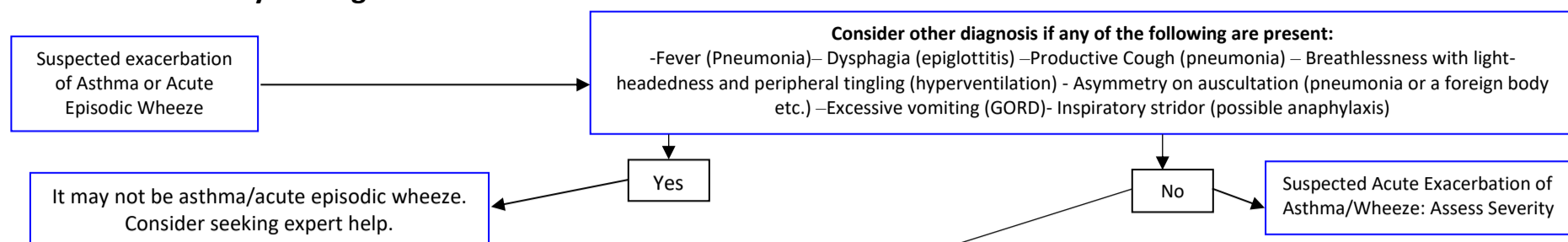


Clinical Assessment Tool for the Child with Acute Exacerbation of Asthma/ Acute Episodic Wheeze Age > 2 years - Management within a Community Setting



	Green- Mild/Moderate	Amber- Severe	Red- Life Threatening
Behaviour	Normal	Anxious/Agitated	Exhaustion/Confusion
Talking	In sentences	Not able to complete a sentence in one breath Too breathless to talk or feed	Not able to talk/ Not responding
Respiratory	Rate: <40 breaths/min (2-5 years) <30breaths/min (5-12 years) <25 breaths/min (>12 years)	Rate: >40 breaths/min (2-5 years) >30 breaths/min (>5 years) >25 breaths/min (>12 years) Use of accessory muscles	Poor respiratory effort Silent chest Cyanosis
Heart Rate	<140bpm (2-5 years) <125bpm (>5 years) <110bpm (>12 years)	>140bpm (2-5 years) >125 bpm (> 5 years) Consider influence of fever &/or salbutamol	Extreme tachycardia/bradycardia Or Arrhythmias
SaO2	≥ 92% in air	<92% in air	< 92 in air plus any of the above symptoms
PEFR	> 50% predicted (Ref to tablet 3)	33-50% of predicted (Ref to table 3)	< 33% predicted (Ref in table 3)

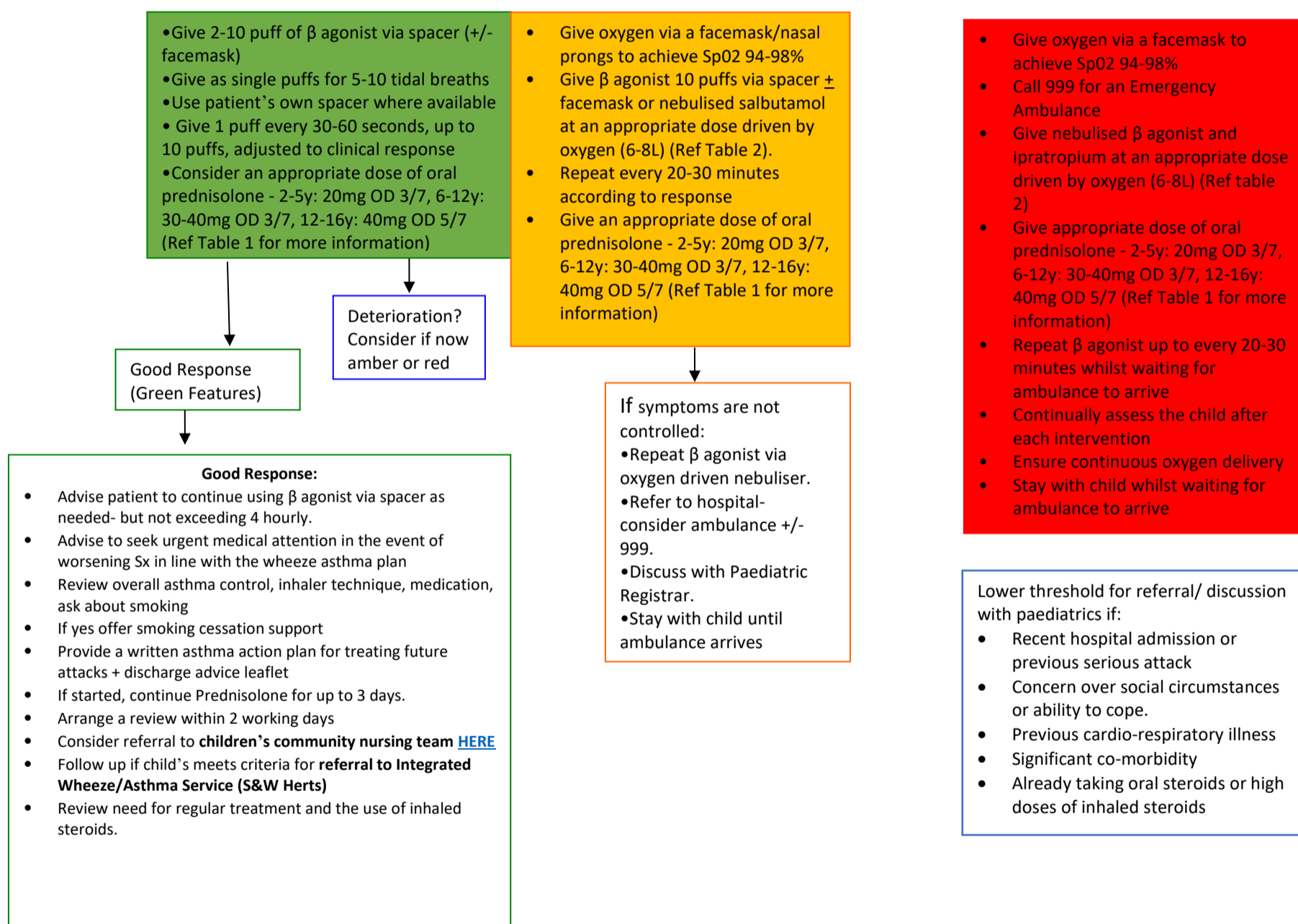


Table 1: Prednisolone Guidelines

There is limited evidence for the use of oral steroids in pre-school children (<5 yrs.) with episodic wheeze and there are potential side effects. * * Consider oral steroids in this group, if:

- Significant atopic history e.g., eczema requiring treatment with topical steroids; history of anaphylaxis.
- OR • History of multi-trigger wheeze or history of interval symptoms in preceding 2-4 weeks; OR
- History of HDU/ITU admission or current life-threatening exacerbation

- Give Prednisolone by mouth:
2-5y: 20mg Prednisolone OD for 3/7
6-12y: 30-40mg Prednisolone OD for 3/7
12-16y: 40mg Prednisolone OD for 5/7

- For children on maintenance steroid give 2mg/kg to max 60mg. Start early in attack: within 1 hour if possible.
- Length of course should be tailored to number of days necessary to bring about recovery.
- Tapering is unnecessary unless the course exceeds 14 days, or if recent multiple courses of prednisolone
- Repeat the dose in children who vomit.

Table 2: Guideline for nebuliser

- Significantly low sats despite inhaler and spacer use
- Oxygen Saturations persistently below 96%
- Requiring oxygen
- Unable to use volumetric/spacer device
- Severe respiratory distress.

Age (years)	2-5	5-12	>12
Salbutamol	2.5mg	5mg	5mg
Ipratropium	250micrograms (mcg)		500 mcg

Table 3: Episodic Wheeze vs Multiple Trigger Wheeze

- 1/3 of children have an episode of wheezing in the first 3 years of life, usually triggered by a viral infection. Only 20% of these children will go on to have asthma. The classification and treatment of wheeze in the preschool age group continues to be debated.
- They should not routinely be labelled as having asthma as the pathophysiology of a Viral induced wheeze is different from that of asthma.
- Caveat: early onset asthma may be indistinguishable from Viral Induced Wheeze at first presentation.

- It is important to consider the temporal pattern of wheezing:
- **Episodic (viral) wheeze:** child only wheezes with viral URTIs and is symptom free in between episodes.
- **Multiple-trigger wheeze:** child wheezes with URTIs but also with other triggers such as exercise, smoke, and allergen exposure.

Table 4: Guidelines for Peak Flow

Height (m)	Height (ft)	Predicted EU PEF(L/min)	Height (m)	Height (ft)	Predicted EU PEF(L/min)
0.85	2'9"	87	1.30	4'3"	212
0.90	2'11"	95	1.35	4'5"	233
0.95	3'1"	104	1.40	4'7"	254
1.00	3'3"	115	1.45	4'9"	276
1.05	3'5"	127	1.50	4'11"	299
1.10	3'7"	141	1.55	5'1"	323
1.15	3'9"	157	1.60	5'3"	346
1.20	3'11"	174	1.65	5'5"	370
1.25	4'1"	192	1.70	5'7"	393