Summary of stepwise management in children less than 5 years

Patients should start treatment at the step most appropriate to the initial severity of their asthma. Check concordance and reconsider diagnosis if response to treatment is unexpectedly poor.

Step 1
Inhaled short-acting B-agonist as required

Step 2
Add inhaled steroid 200-400 mcg/day
or leukotriene receptor antagonist if inhaled steroid cannot be used.
Start at dose of inhaled steroid appropriate to severity of disease.

Step 3
In those children taking inhaled steroids 200-400mcg/day
consider addition of leukotriene receptor antagonist.

In those children taking a leukotriene receptor antagonist alone
reconsider addition of an inhaled steroid 200-400 mcg/day.

In children under 2 years consider proceeding to step 4.

Step 4
Refer to respiratory paediatrician.

Summary of stepwise management in children aged 5-12 years

Step 1 [Mild intermittent asthma]
Inhaled short-acting B-agonist as required

Step 2 [Regular preventer therapy]
Add inhaled steroid 200-400mcg/day*
(other preventer drug if inhaled steroid cannot be used)
200 mcg is an appropriate starting dose for many patients

Start at dose of inhaled steroid appropriate to severity of disease.

Step 2
Regular preventer therapy

Step 3 [Initial add-on therapy]
1. Add inhaled long-acting B-agonist (LABA)
2. Assess control of asthma:
- good response to LABA → continue LABA
- benefit from LABA but control still inadequate
→ continue LABA and increase inhaled steroid dose to 400 mcg/day*
(if not already on this dose)
- no response to LABA → stop LABA and increase inhaled steroid to 400 mcg/ day.*
If control still inadequate, institute trial of other therapies, leukotriene receptor antagonist or SR theophylline

Step 4 [Persistent poor control]
Increase inhaled steroid up to 800 mcg/day*

Step 5 [Continuous or frequent use of oral steroids]
Use daily steroid tablet in lowest dose providing adequate control
Maintain high dose inhaled steroid at 800 mcg/day*
Refer to respiratory Paediatrician

Summary of stepwise management in adults

Step 1
Inhaled short-acting B-agonist as required

Step 2
Add inhaled steroid 200-800mcg/day*
400 mcg is an appropriate starting dose for many patients
Start at dose of inhaled steroid appropriate to severity of disease.

Step 3
1. Add inhaled long-acting B- agonist (LABA)
2. Assess control of asthma:
- good response to LABA → continue LABA
- benefit from LABA but control still inadequate
→ continue LABA and increase inhaled steroid dose to 800 mcg/day*
(if not already on this dose)
- no response to LABA → stop LABA and increase inhaled steroid to 800mcg/ day.*
If control still inadequate, institute trial of other therapies, leukotriene receptor antagonist or SR theophylline

Step 4
Consider trials of:
- increasing inhaled steroid up to 2000 mcg/day*
- addition of a fourth drug e.g. leukotriene receptor antagonist, SR theophylline, B- agonist tablet

Step 5
Use daily steroid tablet in lowest dose providing adequate control
Maintain high dose inhaled steroid at 2000 mcg/day*
Consider other treatments to minimise the use of steroid tablets
Refer patient for specialist care