Paediatric Asthma Webinar 3: 15th March 2024
Hot Topics in Paediatric Asthma

Questions and Answers

Question	Answer
Do you think FENO or spirometry is likely to be performed more routinely in primary care in future?	Yes. There are ongoing discussions currently on how to make lung function testing more accessible in primary care
How useful would you find a full blood count in CYP under 16 and would you use a full blood count in a child aged 4 or 5? Would it be useful to what the eosinophils are doing?	Not routinely done in children eosinophilia as you don't always see a raised eosinophil in children. You would go more by clinical diagnosis and giving a trial of inhaled corticosteroid Eosonphils/IGE are neither specific nor sensitive and more so the younger the child. This is not something that any of the guidelines advocate in early diagnosis. (20:00)
If not getting full control with ICS and night time symptoms also would you add in montelukast first or change to the combination inhaler first then consider montelukast?	Yes BTS would support LTRA Montelukast to add in if low dose ICS not fully easing symptoms. Often if exercise is a trigger changing to a combined inhaler (ICS +LABA) is helpful. Montelukast does not work for everyone but is helpful in some people. Always review when you give a trial of montelukast and stop if there is no difference. Also remember to warn people about possible side effects such as poor sleep, hyperactivity and neuropsychiatric effects (rare) when starting montelukast
If you make a diagnosis of asthma for a 5 year old child of asthma, where does it fit in when you say children grow out of asthma? How do you know if they have grown out of it if you have given a diagnosis of asthma at 5 and long term inhalers?	Would depend on clinical progress because even the ones who have asthma some children grow out of it. It would depend very much on their progress and what triggers the symptoms, if there are multiple triggers there not just infection then it would be reasonable to suggest asthma diagnosis. When you do your annual review for CYP with asthma you shouldn't be afraid to step up and step down and if you do step down to no treatment then you should remove the diagnosis of asthma or move to a past diagnosis. Important to diagnose but that annual reviews should monitor this.
How long would you give before you remove a diagnosis?	12 months is an appropriate period of time and depending on what the triggers are most

	children will have cold weather and viruses as a trigger and some will have hayfever so as long as they would have had a period of time where they are exposed to all of their triggers and they haven't had any exacerbations and similarly if you step them off ICS entirely and leave them with salbutamol but they pick up more salbutamol then that should trigger a review and a discussion about whether they need to go back on ICS.
Would you ever use FENO to review treatment in children?	All the evidence suggest clinical review is as good/better than FeNo for ongoing treatment decisions once a diagnosis has been made. There is a trial ongoing currently led by Steven Turner (author of the article in session 1) to look at how spirometry and FeNO can guide treatment.
Following on from the Montelukast question, in terms of nightmares in children would it be appropriate to advise using it in the morning or would this not make a difference/be appropriate?	Tertiary services occasionally do that but it is advised to add a LABA in preference if there are unwanted side effects. The science is really good with Montelukast it actually doesn't make that much difference in the majority of the children
Would you make the diagnosis inactive? Because if not you'd have to mark in error I think with Systemone?	I personally suggest stating inactive (ie resolved) rather than error but I am not familiar with Systemone
Will slides be shared?	Yes
If a CYP only has symptoms when exercising but is totally fine at other times what's the best thing to do? PRN ICS/LABA.	Lots of discussion in paediatric asthma world about this, the GINA guideline is the way of the future and it is safer to prescribe a combined ICS and LABA where the child cant take Symbicort as a turbohaler. Most 6-8 year olds are not able to the chances of them using 2 separate inhalers is less, if you do just prescribe a SABA in this case you need to have a relatively lower threshold for prescribing an ICS and look at frequency of SABA usage. Care is required and note that some children (especially adolescents) are not good at reporting symptoms or try to put up with symptoms so you need to be sure whether they need a SABA more frequently than they are actually reporting. Sometimes it is only when they try an ICS that they realise how much better they feel and how much easier exercise becomes for them.

	Depends on frequency of exercising. GINA has some great information regarding frequency of symptoms guiding in which regime to go for, Symbicort AIR of MART.
Is Symbicort licenced?	Depends on age. Yes Symbicort licenced for this 6 years and above (GINA guidelines) We are waiting for the combined NICE/SIGN Guidelines in October 24
Is it ok to prescribe SABA only if exercise symptoms only? But with low threshold to start ICS	Yes with the caveat about low threshold to start an ICS. If they are using the SABA more than 3 times a week or going through more than 3 inhalers a year then they should have an ICS. It is important for children to exercise frequently but if SABA is needed for exercise induced symptoms then it is better to have a background ICS. If using SABA frequently though with exercise you would have a low threshold to start an ICS. GINA has removed SABA only from their guidelines so it will be interesting to see what the combined BTS/SIGN/NICE guidelines due in October 24 will say in terms of using a SABA only. If they are using a SABA more than 3x/week I tend to prescribe an ICS
There have been lots of queries from schools asking for SABA inhalers in schools	It is reasonable for CYP who have been recently diagnosed to be able to have inhalers located in multiple places (mums, dads, grandma's and school) However inhalers only need to be replaced when they are empty, families should be advised to keep a full one in stock and then this will be the one that is used to replace the one that has run out (in whatever location this is)
What is the implication of the government guidance for inhaler and aerochamber in school for emergencies	The difference between schools having an inhaler in emergencies (in the event that a child is having an asthma attack) and children who need salbutamol in preparation for or during exercise, they should use the one that has been prescribed for them. Prescribed inhalers that are maintained in school should be returned home with the child at the end of the summer term so that this can be used. Prescribed inhalers can then be replaced at the start of an academic year or when they have run past their expiry date or are empty..

	There are differences in primary and secondary schools where Young People in secondary schools are more independent with their medication. The emergency inhaler is for any child (with appropriate consent and processes in place) rather than for individual children, so a primary school may have 2 emergency inhalers in school for a potential population of c30 children diagnosed with asthma) for the purposes of providing medication in the event that they do not have access to their own medication for whatever reason.
Would it be preferrable to get CYP educated to be able to always have a blue inhaler with them rather than providing a school inhaler for CYP whose setting takes their inhaler from them and holds them centrally?	It would be but this depends entirely on the age of the child and their ability to take on the responsibility for their medication and self management. It might not be appropriate to trust a 5 year old to be able to manage their medication but that it might be acceptable to expect a 13 year old to self manage and therefore should have the inhaler on their person.
What is the view on proactively taking saba off repeats. Patients are still able to request as acute px but enables a closer eye on how many and ensuring they are getting the right preventor treatment	This is really good and encourages you to think about background control
Use of easyhaler, feedback from young people is negative. What is your experience of feedback from young people in secondary/tertiary care	Most patients who have it love it, they like the fact that it is hand held and can be tucked into a pocket or sock.The ones who can use the easyhaler like it. The key take away here would be about checking their technique if they are not finding it as helpful. We do always advocate though that if they have dry powder SABA that they should also have access to 1 MDI and spacer in case of severe attack, their routine treatment would be their hand held device but their treatment at home when they are unwell should be for the MDI and spacer. Young People need to be assessed for a hand held device, given a choice and prescribed the one that they prefer and are able to use.
Re SABAs should they have a mdi and spacer and then go to easyhalers?	It is usually helpful to have a SABA MDI and spacer to use for emergencies in situations where they either do not get relief from the easyhaler or cant use it because they are too out of breath
Is the referral pathway/template on Ardens? This would be helpful so it can be populated from the system.	No currently it is on HT as a downloadable resource. We will follow up this line of enquiry

Those with emis templates would not have access to Ardens templates	This will be pursued to promote consistency
What age do you think for an easyhaler should be offered to a child?	Realistically it is not as young as they say, it needs to be taken on a case by case basis, it is about assessment of their ability. Education and advice, demonstration of technique and use of at hand placebo (noting though that they would be demonstrating this in a clinical setting without an exacerbation of asthma so this would need to be carefully considered regarding sufficiency in the event of acute attack and therefore would also need access to MDI and spacer) Not all dry powders are equal, the turbohaler is difficult to use, the inspiratory flow rate with a turbohaler is significantly higher (60 litres) I personally tend to use in adolescents (around 12 years and over) if they are good with the technique
Referrals and montelukast – GPs have sent patients and queries montelukast. Traditionally this has been challenging in primary care. What is the approach that should be taken in primary care	Montelukast should be commenced in primary care, could be commenced on a therapeutic trial with adequate counselling. BTS/GINA guidelines indicate that referral to secondary care should come after step 2 and trial with montelukast is included within step 2. Therefore should be initiated in primary care before referral to secondary care. It is used very frequently in Primary care and should be supported as second line treatment. In younger children it can be used as monotherapy