
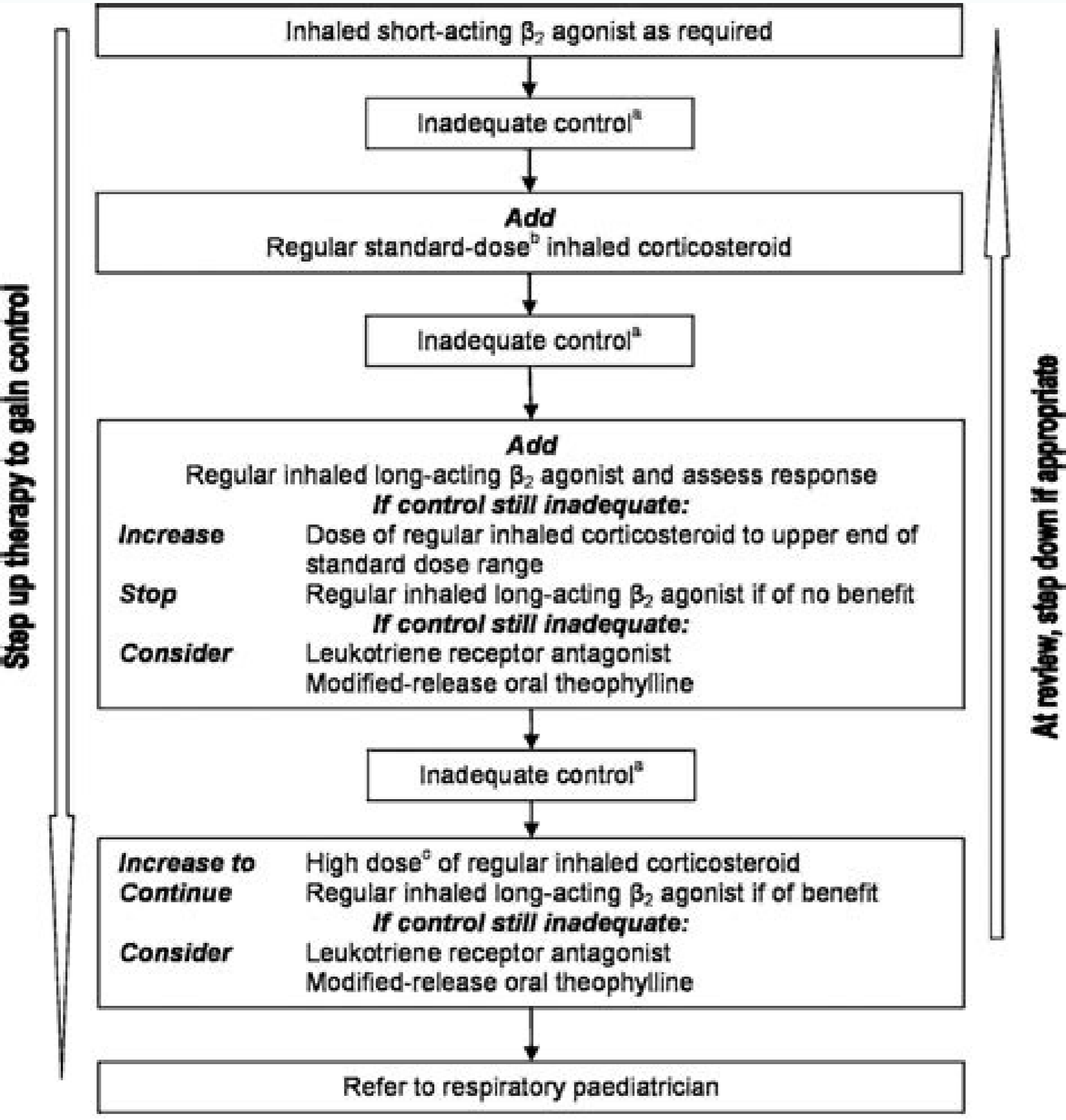
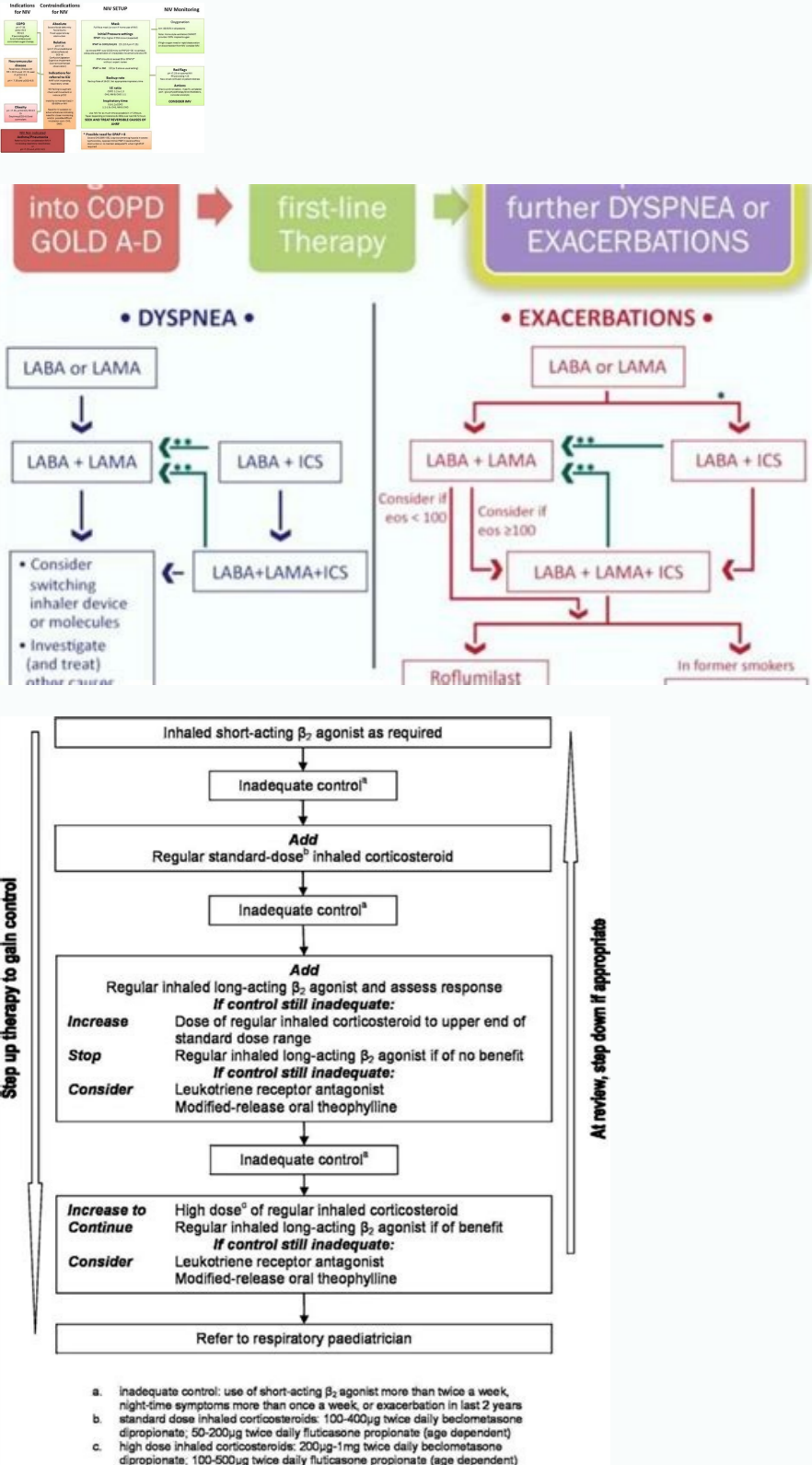
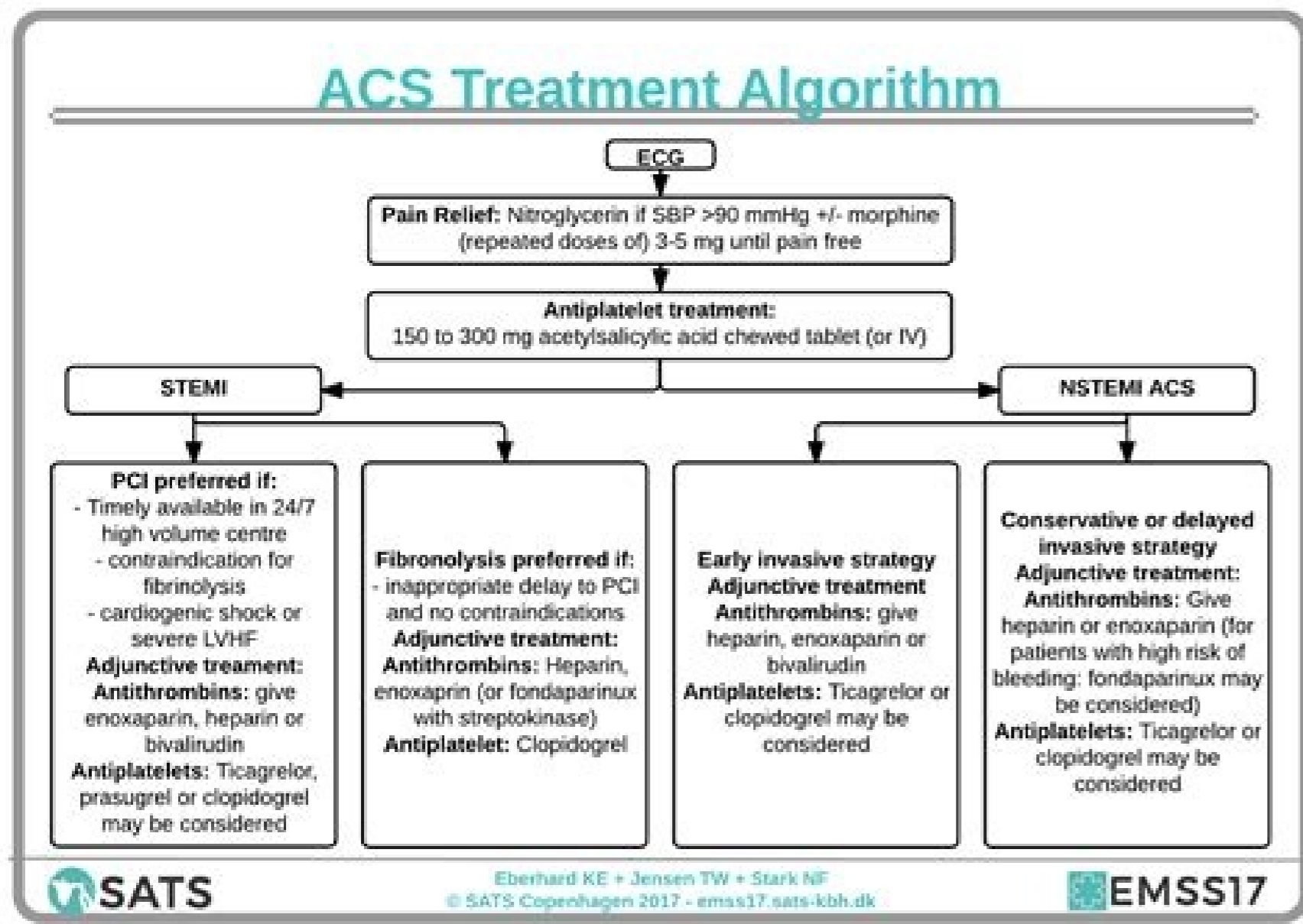


British thoracic society acute asthma guidelines

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Next



- a. Inadequate control: use of short-acting β_2 agonist more than twice a week, night-time symptoms more than once a week, or exacerbation in last 2 years
- b. standard dose inhaled corticosteroids: 100-400µg twice daily beclometasone dipropionate; 50-200µg twice daily fluticasone propionate (age dependent)
- c. high dose inhaled corticosteroids: 200µg-1mg twice daily beclometasone dipropionate; 100-500µg twice daily fluticasone propionate (age dependent)

Produced jointly by the signal and the British of the Toricica Society (BTS) since 2003, the guide covers the diagnosis and management of asthma in adults and children and sections of the guide are updated well. Refer and target users, the 2019 update includes a complete review of the section on monitoring asthma, including new information on predicting a future risk of asthma attacks, and updates to the sections on pharmacological asthma management, self-service management admitted, non-pharmacological asthma management, and management of acute asthma in adults and children. This guide will be of interest to health professionals involved in the care of people with asthma, including general doctors, consultants and specialists in respiratory medicine, nurses, pharmacists and other health professionals with an interest in respiratory care. The guide will also be of interest to people with asthma, their parents and caregivers; those who interact with people with asthma outside the NHS, such as teachers; voluntary organizations with interest in asthma; and those who plan to deliver services at the NHS in England, Wales, Northern Ireland and Scotland. This asthma guide is expected to continue to serve as a basis for the management of high quality acute and chronic asthma and a stimulus for research in management areas for which there is little evidence. How this guide developed This guide developed using a standard methodology based on a systematic review of the evidence. More details can be found in the 50 sign: a manual of the developer of guidelines (Edition 2011). Staying up to date with this guide was issued in 2019. The review history, and any update of the guide in the intermediate period, will be noted in the review report. \hat{a}^c News ≤ 3 years future Nice, BTS and SIGN are pleased to report further progress towards the production of coming guide for diagnosis, monitoring and handling of chronic asthma. The guide has been commissioned to the National Orientation Center. Read more ... Signature 158, July 2019 ISBN 978 1 909 103 70 2 Recent update: July 2021 Original Published: September 2004 Updated by: Jennifer E. Ferguson, D.O. Division of allergy and immunology, South Florida University Morsani College of Medicine James A. Haley Veterans' Hospital Tampa, FL 33 612 Email: jfergese@health.usf.edu Richard F. Lockey, M.D. Distinguished University Professor of Health Professor of Medicine, Pediatrics and Health Public Director, Division of Allergy and Immunology Joy McCann Culverhouse Cat, Allergy and Immunology Southern University of the Florida Morsani School of Medicine James A. Haley Veterans' Hospital Email: RLOCK @ Health.USF.USF. Original Authors: Michael A. Kaliner, MD Faaai Médico Director, Institute for Asthma and Allergy Chevy Chase and Wheaton, Maryland Medical Professor, Medicine School of George Washington University, DC Richard F. Lockey, MD Professor of Medicine, Pediatrics and Health Public Director of the Division of Allergy and Immunology Joy McCann Culverhouse President of Allergy and Immunology of South Florida College of Medicine and the Hospital of Veterans James A. Haley Tampa, FL Summary Asthma affects about 300 Millions of people around the world and more than 400,000 annual deaths [1,2]. Approximately 12 million people in the United States each year experience an acute exacerbation of their asthma. Acute asthma should be differentiated from asthma, acute asthma, patients will exhibit a growing difficulty for breathing, chest oppression, cough and / or wheezing. In contrast, asthma malcon It is typically presented with a diurnal variability in the air flow and is a characteristic that is generally not observed during an exacerbation [3]. Several clinical signs and symptoms can help medical The severity of acute asthma. For for The audible freedom is usually a sign of moderate asthma, while no sign of severe air flow obstruction can be recognized. The main risk factors for almost fatal and fatal asthma should be recognized, and its presence causes the early recognition and the treatment of an exence asthma exacerbation. History should include a review of comorbidities; adherence and adequate use of medicines, especially adequate techniques in the use of measured dose inhalers; Previous episodes of almost fatal asthma; \hat{A} \hat{e} and if the patient has experienced multiple visits to the emergency room or hospitalizations, particularly those that require income to an intensive care unit, which involve respiratory failure, intubation and mechanical ventilation [3,10]. It is important to ensure that the patient understands that asthma is mainly a chronic disease and requires the avoidance of the allergens, the prevention of infections, adhesion with routine vaccines, the management of common conditions and adherence to regulations of treatment An individual management plan should include how to recognize an imminent exacerbation and provide an increase in incremental therapy to be implemented according to the degree of severity and when seeking medical attention. In addition, social factors and psychiatric disorders should be treated properly because each can affect access to care, adherence and access to care. Drive to other common conditions [3,23]. This article is a shruch review of the literature available on the diagnosis and the management of acute asthma. Keywords: flash of asthma; Acute asthma; Asthma attack; Wheezing; Acute asthma diagnosis; Acute Amazing Abbreviations EPR-3 Abbreviations - Report of the Panel of Experts 3 EPR-4 "The Report of the Expert Panel 4 FENO: \hat{A} Nitric Xido Exhaled Fractional OCS - Oral Corticosteria ICS \hat{e} " inhalo corticosteroids GERD - gastroesophageal reflux disease OSA - obstructive COPD SYSTEM APNEA - chronic obstructive pulmonary disease PEF - MDI respiratory low peak Flow - measured doseSaba \hat{a} \hat{e} "Beta Action Agonist cut AE \times Adverse events SCS- Sistic corticosteroids CVF- forced vital capacity Introduction Asthma's exacerbations can be avoided with adequate and regular treatment and patient education. To regret it, the Asthma affects about 300 million people around the world and more than 400,000 annual deaths [1, 2]. Only in the United States, approximately 12 million people experience an acute exacerbation of their asthma [3,4]. The Global Health Organization has reported 180,000 deaths due to acute exacerbations of asthma in 2013 [5,6]. Admás, the financial impact of acute asthma exacerbations in patients and society is significant, with an estimated total expenditure At \$ 56 billion in the year in the United States [7,8]. This manuscript deals with acute asthma, its diagnosis, prognostics and treatment. Several symptoms and clinical signs can help the medical to determine the severity of acute asthma (Figure 1) [3]. To prevent severe asthma exacerbations, the objectives for the doctor who handles patients with asthma include: 1. Recognition of patients at higher risk of suffering almost fatal or deadly asthma. 2. Education of the patient to recognize the deterioration of his illness. 3. Provision of an individual action plan so that the patient

handle the exacerbation and know when seeking professional help. This is often associated with better health outcomes and a reduction of hospitalizations [5,9]. 4. Management of comorbidities, for example, rhinitis, sinusitis, obesity, gastroesophageal reflux disease (GERD), obstructive sleep apnea (AOS), Chronic obstructive pulmonary disease (COPD), Dysfunction of the Vocal M tor (VCD) and atopic dermatitis [8-12]. Physical examination The clinical estimates of gravity based on an interview and a physical examination can lead to an inaccurate estimate of the severity of the disease; audible wheezing are usually a sign mild asthma, while no wheezing can be a sign of severe obstruction of airflow. symptoms ofAsthma includes chest tightness, cough (with or without a spike), feeling of air hunger, inability to lay, insomnia and severe fatigue. Signs of severe asthma include the use of muscles breathing accessories, chest hyperinflation, tachypnea, tachycardia, , diaphoresis, obtaining apprenticeship, wheezing, inability to complete prayers and difficulty sleeping. A disturbed mental state, with or without cyanosis, is an ominous sign and immediate emergency care and hospitalization. A detailed examination should include the examination to detect signs and symptoms of pneumonia, pneumomediastine or pneumomediastine, the latter being investigated by palpation of subcutaneous crepitations, particularly in the supraclavicular areas of the chest wall. Special attention should be paid to the blood pressure, pulse and respiratory rate of the patient. Tachycardia and tachypnea may be suggestive of moderate to severe exacerbation, while bradycardia may indicate imminent respiratory arrest. Pulsus Paradoxus is often present and can be correlated with the severity of the exacerbation (Figure 1) [3,10,15].   Diagnosis differential of acute asthma The differential diagnosis of acute asthma includes COPD, VCD, bronchitis, bronchiectasia, epiglottitis, foreign body . Tracheal obstruction completely or intrahoric, cardiogenic pulmonary edema, non-cardiogenic pulmonary edema, pneumonia, pulmonary embolism, chemical pneumonitis and hyperventilation syndrome [10]. Acute asthma risk factors can identify risk factors for asthma exacerbations from clinical history. The patient's interview should include questions about recent events, including [3,15]: upper or lower respiratory tract infections, cessation or reduction of concomitant medication, for example, non-selective blockers, such as allergenor predictors of fatal contaminant exposure or Near Asthma Fatal The main risk factors for near-fatal and fatal asthma are recognized, and their presence Early recognition and treatment of an exacerbation of essential asthma. The history should include a review of previous episodes of near-fatal asthma and whether the patient has experienced multiple visits to the emergency room or hospitalizations, particularly those requiring admission to an intensive care unit, involving respiratory failure, intubation, and mechanical ventilation. A history of allergic asthma and other known or suspected allergic symptoms should be obtained. For example, Nelson et al. Identified a trigger for severe asthma is allergy to alternating mold and several species of dust mites [16]. Subjects with sensitization of alternates are 5 times more likely to exhibit increased wheezing, respiratory tract responsiveness and use of bronchodilator [7]. Adherence should be reviewed with medical treatments; Poor adherence to prescribed therapies is a major risk factor. Inadequate therapy may include overuse of   2 agonists, concomitant use of    blockers, and failure to prescribe or use inhaled corticosteroids (ICS) as primary therapy. Recent removal of oral corticosteroids (OCS) suggests that the patient has an increased risk of a severe exacerbation. The lack of a written asthma action plan is another risk factor. Limited patient access to appropriate medical care and lack of education on appropriate management strategies are additional risk factors. Socioeconomic factors associated with severe asthma exacerbations include non-adherent teens or elderly asthmatic astotics living in inner city settings. Certain ethnic groups within a population may have a higher incidence of severe asthma, such as Americans of African or Spanish heritage. Comorbidities, such as the chronic lungs, the and cardiovascular diseases are other risk factors [15,17]. Physiological and laboratory parameters The serial measurements of the pulmonary function facilitate the quantification of the severity of the airflow obstruction and the response to therapy. A peak expiratory flow (PEF) (PEF) Provides a simple, quick and cost-effective assessment of the severity of airflow obstruction. Patients can be provided with an economical PEF meter and taught to take measurements at home to check for deterioration of their asthma. An individual management plan will be based on the best personal value of PEF. Default PEF values can be set at which the patient is alerted to the degree of severity of the symptoms and can institute appropriate therapy and/or consult their physician (Figure 2). In non-acute settings, evaluation of PEF and spirometry before and after administration of a bronchodilator may indicate the likely degree of improvement in lung function that can be achieved with appropriate therapy. PEF values of 50-79% of predicted or personal values indicate the need for immediate treatment with an inhaled short-acting beta agonist (SABA). Values below 50% of the best indicate the need for immediate medical attention. Values below 35% of the best personal indicators indicate a possible serious life-threatening event. This treatment should be administered with a SABA via a nebuliser or metered-dose inhaler (MDI). The dose of Saba, the response and the additional administration are shown in Figure 2. [3, 17-20]. The forced expiratory volume in one second (FEV1) is measured by spirometry to evaluate the volume of air exhaled during one second and is the most sensitive test for airflow obstruction. FEV1 is less variable than PEF and is independent of exertion once a moderate patient has exerted exertion. Reversibility after Broncodilator should be evaluated and an increase in FEV1> 12% and> 200 ml is the diagnostic of asthma [3]. The fractional exhaled nitric oxide (FENO) test is a measure of eosinophilic inflammation of the lower airway that is evaluated using a Exhaled on a device. The expert panel 4 (EPR-4) does not recommend the use of pheno only to evaluate the control of asthma or the severity of an acute exacerbation of asthma. However, tests can be useful in asthma management. asthma. used in conjunction with spirometry and the patient's clinical history [21,22]. Most patients do not require laboratory tests for the diagnosis of acute asthma. If laboratory studies are obtained, they should not delay the treatment of asthma. Laboratory studies can help detect other comorbid conditions that complicate asthma treatment, such as infection, cardiovascular disease, or diabetes. Measurement of cerebral natriuretic peptides (BNP) and 2D transthoric echocardiogram in the diagnosis of congestive heart failure. For patients who take diuretics who have comorbide cardiovascular disease, serum electrolytes can be useful as frequent SABA administration can cause transient decreases in serum potassium, magnesium and phosphate. A base electrocardiogram and heart rate monitoring are appropriate in patients over 50 years of age and in those with asrbride or COPD cardiovascular disease. A complete count of blood cells (CBC) can be useful in patients with fever or purulent sputum; however, modest leucocytosis is common in asthmatics, and patients who use corticosteroids may have a corticoid-induced neutrophilic leucocytosis. Serum theophylline levels are essential for patients taking theophylline due to their narrow therapeutic window [17]. Chest X-rays are often not necessary for the diagnosis of acute asthma if the examination of the chest does not reveal abnormal findings other than expected clinical signs and symptoms associated with acute exacerbation. If a complication is suspected, such as pneumonia, pneumothorax, pneumomediastinum, congestive heart failure or atelectasis plug-in, a chest X-ray should be obtained [17]. Blood gas (BGB) analysis should be considered in patients who are seriously ill and have saturationsoxygen of 45 MMHg indicates an attack that threatens life and the need to transfer to a medical intensive care unit to continue carefully. Less than 10% of asmatic patients who present the emergency department have oxygen arterial values identified 50 mmHg and carbon oxide levels. Lactic acidosis is common in severe sharp asthma. However, elevated levels of lactic acid are also associated with high doses of inhaled treatment  2-agonist [24]. Poisonous blood gases (VBG) have been evaluated as substitutes for arterial measurements, since venous blood is easier to obtain. However, the report of the Group of Experts 3 (EPR-3) does not recommend replacing PCO2 venous (PVCO2) by the ABG. The arteriovenous correlation for PCO2 is poor, and therefore PVCO2 can not be based on an absolute representation of PACO2. However, a normal PVCO2 has a good negative predictive value for a PACO2. Therefore, it can be used as a detection test to exclude hypercapnic respiratory affliction [17,25]. Graph 1. Acute asthma severity: Clinical signs and symptoms. Originally published as Graph 5-3 in the Report of the Group of Experts 3. Definition of abbreviations: PAO2 = Arterial pressure of oxygen; PCO2 = Partial pressure of carbon dixture; PEF = maximum expiration flow 2. Estimation of asthma exacerbations: home treatment predicted. Originally published as Graph 5-4 in the Report of the Expert Group 3. Treatment The treatment is based not only on the evaluation of the parameters of the pulmonary function but in the clinical findings and the effectiveness of the previous treatment. A seasonal exacerbation of asthma in a pollen sensitive patient is easier to treat than an exacerbation caused by a viral infection. A patient who is At short agonists  2 can be refractory to nebulized  2-agonists and will usually need an SCS. The medical knowledge of an individual patient will suggest if an SCS is required or if yes Exacerbation may be administered at high doses of BSI [17,26]. Various national and international guidelines are available for the diagnosis and management of acute asthma. In particular, the EPR-3 guidelines are referenced in this manuscript, as it focuses on a systematic review of the published scientific literature and provides the best evidence of clinical practice guidelines. Recommended treatment options for EPR-3 in order of introduction into the acute configuration are listed below and shown in Figure 3. Treatment options and their recommended doses are listed in Figure 4. "The 2020 EPR-4 provides focused updates to asthma management guidelines. However, the EPR-4 does not include new recommendations for the assessment and management of acute asthma [21]. Primary treatment options include: SABA; inhaled by MDI or by nebulizing anticholinergics; inhaled by MDI nebulizing corticosteroids or nebulizing; Parenteral oxygen, oral or inhaled, some patients may not respond to primary treatment and show signs of worsening asthma. Other treatments are sometimes used in these patients and may include: epinephrine; intramuscular (IM) or subcutaneous (SQ) magnesium sulfate; Heliox parenteral: intubation of activated albuterol nebulization and mechanical ventilation Non-invasive positive pressure ventilation Figure 3. Management of acute asthma: emergency department and hospital care. Originally published as Figure 5-6 in the Expert Panel Report 3. FEV1 = forced expiratory volume in 1 second; Ics = inhaled corticosteroids; MDI = metered-dose inhaler; PCO2 = partial pressure of carbon dioxide; PEF = maximum expiratory flow; SABA = short-acting beta2 agonist; SAO2 = Oxygen Saturation Short-acting Saturation I22-agonists EPR-3 Guidelines Recommend the use of only selective Sabas in High (I.E. Albuterol, Levalbuterol) due to the risk of cardiotoxicity, especially in elderly asbetic patients. The initial treatment should start with Albuterol, whether managed by MDI with a spacer spacer or mask (children

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