



Difficult-to-manage asthma Desktop Helper no2

Case study 1: Alice

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GSK provided an unrestricted educational grant to support the development of this case study but did not contribute to its content

Desktop-helper No. 2 on difficult-to-manage asthma

- **A practical guide to improve difficult-to-manage asthma in primary care**
- How to identify a person with difficult-to-manage asthma?
 - Ensure that the diagnosis is correct
 - Find and manage comorbidities
- What should you check when conducting a structured review?



A practical guide to improve difficult-to-manage asthma in primary care

Difficult-to-manage asthma occurs either when the person or their clinician finds control and treatment challenging, despite the (apparently) best possible treatment. This leads to the person facing difficulties dealing with some of the following:

- Daytime asthma symptoms, more than twice/week
- Any night awakening due to asthma-related symptoms
- More than two exacerbations per year requiring rescue systemic corticosteroids¹
- Frequent use of SABA (≥3 canisters per year or ≥3 times per week)
- Poor control despite prescription of high-dose ICS often in combination with LABA/LAMA or use of OCS²
- Frequent primary care out-of-hours contacts (one or more per month)

ICS inhaled corticosteroid, SABA short-acting beta-agonist, LABA long-acting beta-agonist, LAMA long-acting muscarinic antagonist, OCS oral corticosteroid

ASTHMA: A PROBLEM THAT CAN BE MANAGED

Studies estimate that in primary care about one out of every six people living with asthma have difficult-to-manage asthma, and of those, between a quarter and a half will have severe asthma.^{2,3} Having difficult-to-manage asthma puts people of higher risk of exacerbations and even death, which are preventable with effective management. Similarly, they are at greater risk of steroid-related adverse effects (if treated with high-dose ICS or avoidable courses of OCS or low-dose OCS over a period of time), and their morbidity and health costs are disproportionately higher. People with well-controlled asthma have a better quality of life, reduced symptoms and exacerbations, reduced hospital visits and admissions and lower risk of premature death.^{4,5} But most importantly, difficult-to-manage asthma can be managed using a structured approach.⁶ People with asthma and clinicians should collaborate to improve asthma control, especially those with difficult-to-manage asthma, supporting the individual to take an active role in setting goals and targets, self-monitoring, and adopting a healthier lifestyle. This guide provides practical support to primary care and other community healthcare professionals to improve the care of people with difficult-to-manage asthma and to avoid unnecessary referrals of patients who could be better managed in primary care.

HOW TO IDENTIFY A PERSON WITH DIFFICULT-TO-MANAGE ASTHMA?

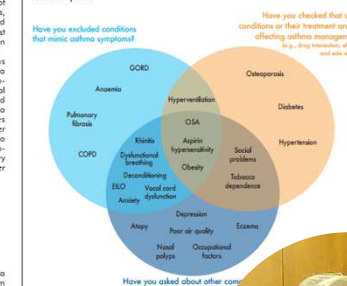
Ensure that the diagnosis is correct
Over one-third of people living with asthma have an incorrect diagnosis.^{6,13} Confirm that the person really has asthma before stepping up treatment as a surprising number of people diagnosed and treated for asthma (from 12 to 30%)¹⁴ either do not

have the disease or have it in association with other conditions causing persistent symptoms (see below).^{15,16} Potential confounding factors for the diagnosis of asthma or its severity are dysfunctional breathing, anxiety, exercise-induced laryngeal obstruction (EILO), vocal cord dysfunction (VCD), obesity and low level of fitness (deconditioning) (Figure 1). All of which may also co-exist with asthma. Diagnosis can be achieved by reviewing clinical history; the diagnostic probability is significantly increased using a lung function

More information on diagnosis

- DH 15 - The 'saw puzzle' approach to building a diagnostic picture of asthma in primary care over time
- DH 14 - Quick guide to spirometry
- Spirometry Simplified (pdf)

Figure 1 - Potential confounding factors for the diagnosis of asthma or its severity: reflection points



This Desktop Helper can be accessed at

<https://www.ipcrg.org/dth2>

Case study 1

Alice attends a scheduled appointment with her mother who is worried that her asthma is not well since, the last two months, she has had some days with wheezing and breathlessness during the night and while playing basketball. She has been well for a long time, but recently started feeling these symptoms again.

- What factors are hindering the control and treatment of this patient?
- Is this a case of difficult-to-manage asthma?



Learning objectives

At the end of this case study exercise, the HCP should be able to:

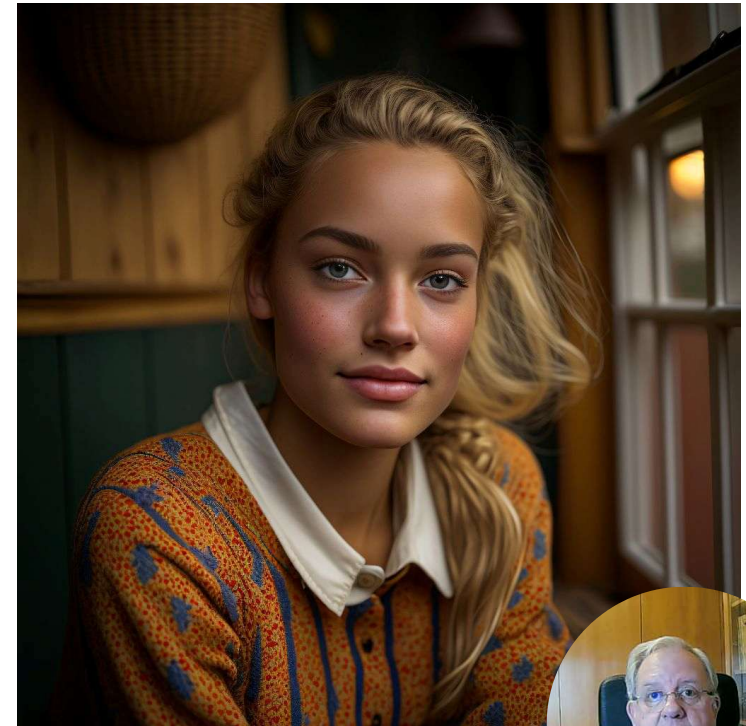
- List and recognise some challenges in the management of asthma.
- Analyse and evaluate the impact of the patient's clinical history and consider the patient's own beliefs and preconceptions in asthma management.
- Plan and execute periodical reviews of patient with symptoms of wheezing and breathlessness, promote medication adherence and support self-management.



Consultation 1

The patient: Alice

- 14-year-old from a family of four: father (40), mother (38) and a brother (11).
- Her father works in an insurance company and her mother is a shop manager.
- The family is fairly health conscious in what regards diet and exercise.
- Nobody smokes at home. Most of Alice's friends are also non-smokers.
- Alice plays basketball at school and in the local team; she trains three times a week and occasionally has games during weekends.



Desktop-helper No. 2 on difficult-to-manage asthma

• What should you check when conducting a structured review?

1. Control of asthma
2. Tobacco dependence
3. Patient education and self-monitoring
4. Aggravating factors and triggers
5. Pharmacotherapy
6. Adherence and inhaler technique
7. Obesity
8. Psychological support
9. Referral for specialist assessment



A practical guide to improve difficult-to-manage asthma in primary care

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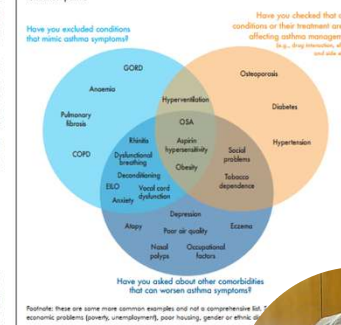
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More information on diagnosis

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Figure 1 - Potential confounding factors for the diagnosis of asthma or its severity: reflection points



Consultation 1

Medical history

- She was diagnosed with asthma by her GP when she was 8 years old because she had frequent episodes of wheezing, breathlessness and occasional coughing when she had colds or in spring.
- Alice reports allergies to house dust mites and grass pollen.
- Two years ago, she had blood and skin prick tests which confirmed sensitisation. She also had lung function tests, which confirmed asthma.
- Since her asthma was diagnosed and treatment started, Alice has been quite well, with a few rare episodes related to viral infections. She has never been admitted to hospital, apart from a couple of times in her childhood when she went to A&E twice.



Consultation 1

Medical history

- Her parents are well. No other members of the household have asthma or allergies.
- Her father's sister and one of her maternal cousins have asthma, and her father's father has allergic rhinitis.
- The family lives in a modern house and have no pets at home.
- Her only regular medication is her asthma medication, ICS twice daily, and she has been advised to take two puffs of SABA before exercise.
- She doesn't take any medication for her occasional nose symptoms, which seldom bother her if she avoids dusty rooms. In spring she sometimes needs an oral antihistamine for a few days.



Consultation 1

Current presentation

You know Alice and her family for a long time, as they have been attending your practice over time. Alice had an appointment with you for an asthma review approximately a year ago and with the practice nurse 6 months ago.

1. Control of asthma

Alice reports a good control. Nevertheless, her answers in the [Asthma Control Test \(ACT\)](#) resulted in a score of 19, corresponding to poorly controlled asthma.

2. Tobacco

She is a non-smoker, her closest friends don't smoke, though, sometimes, she meets friends who do.

3. Patient education and self-monitoring

The nurse checked her inhaler technique prior to the appointment. Alice is able to use her inhaler correctly. She has been taking extra SABA (salbutamol) when she experiences symptoms, approximately once a week or, occasionally, before doing sports.



Asthma Control Test

Ages 12+

1	In the <u>past 4 weeks</u> , how much of your time did your asthma keep you from getting as much done at work, school, or at home?	All of the time	Most of the time	Some of the time	A little of the time	None of the time	score
		1	2	3	4	5	<input type="text"/>
2	During the <u>past 4 weeks</u> , how often have you had shortness of breath?	More than once per day	Once per day	3-6 times per week	Once or twice per week	Not at all	score
		1	2	3	4	5	<input type="text"/>
3	During the <u>past 4 weeks</u> , how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?	4 or more times per day	1 or 2 times per day	2 or 3 times per week	Once per week or less	Not at all	score
		1	2	3	4	5	<input type="text"/>
4	During the <u>past 4 weeks</u> , how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?	3 or more times per day	1 or 2 times per day	2 or 3 times per week	Once a week or less	Not at all	score
		1	2	3	4	5	<input type="text"/>
5	How would you rate your asthma control during the <u>past 4 weeks</u> ?	Not controlled at all	Poorly controlled	Somewhat controlled	Well controlled	Completely controlled	score
		1	2	3	4	5	<input type="text"/>

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total
19

<https://www.asthmacontroltest.com/en-gb/welcome/>



Consultation 1

Current presentation, continued

4. **Aggravating factors and triggers**

Alice notices a worsening of symptoms (running nose and slight wheeze) whenever she's exposed to dust while visiting some friends who have old sofas or books at home. In spring, when people are mowing lawns near her home, she also feels worse. She has a history of allergy to house dust mites and grass pollen.

5. **Pharmacotherapy**

Alice has been prescribed inhaled budesonide 200 mcg (DPI), twice a day; inhaled salbutamol as needed, via pMDI.

6. **Adherence and inhaler technique**

Alice reports she doesn't always use her ICS as recommended. She rarely uses it twice a day and often forgets or decides not to use it if she doesn't have any symptoms. When she has wheezing or feels breathless, she uses her SABA rescue inhaler. Though she has been advised to take two puffs of SABA before exercise, she seldom does, because she feels her heartbeat increasing. She's able to use her inhaler correctly.



Consultation 1

Current presentation, continued

7. Obesity

Normal range of BMI.

8. Psychological support

Alice is worried as her physical performance is not the same and this is interfering with her playing basketball. This could be the main drive for change, as she is very keen on being part of the team.

9. Exploring Alice's health beliefs & preconceptions

She is not happy to have to use an inhaler every day. Some of her colleagues who have asthma tell her that inhalers can be harmful. She has been looking at some sites and she also read that regular treatment is important. She doesn't know what to believe. She is also concerned that it can impact on her performance in basketball.

10. Referral for specialist assessment

Not at this point.



Consultation 1

Clinical examination/investigations

Findings:

- Heart and lung sounds are normal. Pulse rate 80.
- Latest spirometry results were normal (*two years ago*).
- Her peak flow was 330 L/min.
 - 165 cm: exp 445, (74%) / patient's best, 450, (73%)

Question:

How would you evaluate these findings?



Consultation 1

Clinical examination/investigations

Conclusion:

Chest exam was unremarkable.

Her peak flow was 73% of her best.

Adherence seems to be a point for discussion

Question:

What should be the next management steps?



Consultation 1

Management

Next steps:

- **Adherence:**

- We asked her opinion about the use of inhalers. How comfortable does she feel with the one she has? Are there any unpleasant side effects? Are there any other issues with the inhaler?
- We explained her “many people forget doses, that’s quite normal” but perhaps she would do better if she’d use reminders (e.g., phone alarm) to help her remembering to take it, as she is having symptoms and not feeling so well as she would like to.

- **Possible treatment change:**

- We explained it is possible to use a controller and a reliever in the same inhaler device, that helps because when she takes a puff to relieve her symptoms, she is also using a medicine that treats her asthma. Alice prefers to try again with the same treatment but making an effort to remember the doses.
- *We agreed to have a new appointment to review the situation in four weeks’ time.*



Consultation 2, four weeks later

Summary of clinical history, physical examination and investigations

Alice informs she has been using a phone alarm and has been able to remember to take her inhaler regularly. She has been feeling better. She had a slight wheeze less than once a week and used her reliever inhaler and felt better.

She feels she needs to have the blue inhaler, but she doesn't like the effect on her heartbeat while she is doing sports.

She also confirms it is a bit confusing to use two different types of inhalers (DPI for control and pMDI for symptom relief)

Findings:

- ACT score: 22 (well-controlled asthma)
- Her peak flow reading at the practice was 370 L/min (82 %).
- Playing basketball has no impact.

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Consultation 2, four weeks later

Patient information / clinical examination/ investigations

The findings lead to:

[_____]

Question:

What is your conclusion so far?



Consultation 2, four weeks later

Diagnosis

You conclude that Alice's symptoms were mostly due to **irregular adherence to medication**.

*Occasional second-hand **exposure to cigarette smoke** doesn't seem to be a problem. Most of Alice's friends are practicing sports and don't smoke.*

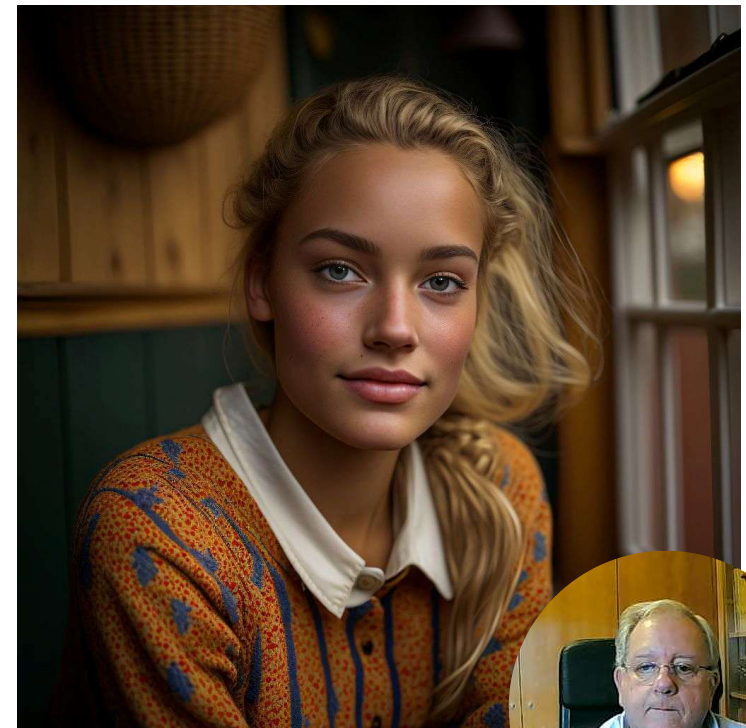
*Alice is still insecure about **using medication before exercise**. She doesn't like the secondary effect of the SABA.*

*Using **two different types of inhalers** is confusing.*

*An **ICS/ formoterol inhaler** could be considered - **MART**. Though the secondary effect might be similar, she could do it a couple of hours before starting her basketball training.*

Question:

What are your next management steps?



Consultation 2, two weeks later

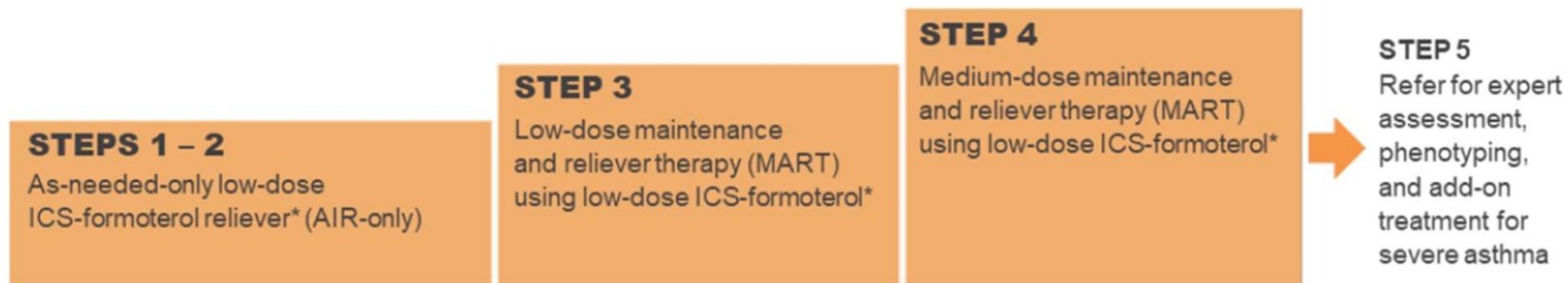
Management

Next steps:

- You initiate a conversation about Alice's fears and concerns regarding medication. You offer advice and recommend some websites for further information.
- Together with Alice, you decide to switch to an ICS /formoterol inhaler (*budesonide 160 mcg / formoterol 4,5 mcg*) DPI on a [MART regimen](#).
- You suggest she tries using the inhaler before exercise and see if it really makes a difference.
- You suggest the use of an App to record symptoms overtime.
- You tell Alice to come back for a review after 3-4 months.



GINA 2024 – Simplifying Track 1



In Track 1, ‘Steps 1–2’ treatment with as-needed-only low-dose combination ICS-formoterol is recommended for:

- 1. Step-down treatment for patients whose asthma is well controlled**
 - Step-down treatment for patients whose asthma is well controlled on low-dose maintenance and reliever therapy with ICS-formoterol or
 - on regular low-dose ICS with as-needed SABA
- 2. Initial asthma treatment for patients previously using SABA alone** (or with newly diagnosed asthma), with normal or mildly reduced lung function.

Some clinical factors, outlined below, may prompt consideration of starting treatment instead at Step 3, with low-dose ICS-formoterol maintenance and reliever therapy.

1. p 80 GINA Global Strategy for Asthma Management and Prevention www.ginaasthma.org (accessed May 7th 2024)
https://ginasthma.org/wp-content/uploads/2024/05/GINA-2024-Strategy-Report-24_05_22_WMS.pdf



Consultation 3, three months later

Clinical examination/investigations

A new review, keeping in mind the previous steps:

Conduct a structured review focusing on these elements

1. **Control of asthma**
2. Tobacco exposure
3. **Patient education and self-monitoring**
4. **Aggravating factors and triggers**
5. Pharmacotherapy
6. **Adherence and inhaler technique.**
7. Obesity
8. Psychological support
9. Referral for specialist assessment



Consultation 3, three months later

Patient information / clinical examination/ investigations

- Alice informs she has been using her inhaler regularly. She has been feeling much better.
- She had a little wheezing and cough once when she had a small viral infection. She increased the number of puffs (ICS/formoterol) and felt better.
- She thinks the MART regimen is easy and fits well in her daily schedule.
- The App was useful to help her understanding the relationship between adherence and symptoms.
- The websites helped her understanding her asthma better.
- ACT score: 25. Peak flow: 400 L/min (89%).

Question:

What is your conclusion so far and what will be your next steps?



Consultation 3, three months later

Management

Next steps:

- Alice seems to be well controlled and more aware of the importance of the regular use of the treatment.
- She is happy that the MART regimen gives her some flexibility and she feels more enabled to self-manage her condition.
- The mother is relieved that Alice is doing well and trusts her to take care of her own symptoms and to report if something is wrong.
- We discuss whether she would like to have a [written asthma management plan](#), but Alice prefers to use the App.
- Nevertheless, a plan is handed to the mother for safety and also as a reminder. The plan also contains clear instructions of what to do in case of asthma exacerbation.



ASTHMA ACTION PLAN

Take this ASTHMA ACTION PLAN with you when you visit your doctor

ACTION PLAN FOR	DOCTOR'S CONTACT DETAILS	EMERGENCY CONTACT DETAILS
Name _____	Name _____	Name _____
Date _____	Phone _____	Phone _____
Next asthma check-up due _____		Relationship _____

😊 WHEN WELL Asthma under control (almost no symptoms) **ALWAYS CARRY YOUR RELIEVER WITH YOU**

Peak flow* (if used) above: _____

Your preventer is: (NAME & STRENGTH) _____

Take _____ puffs/tablets _____ times every day

Use a spacer with your inhaler

Your reliever is: (NAME) _____

Take _____ puffs _____

When: You have symptoms like wheezing, coughing or shortness of breath

Use a spacer with your inhaler

OTHER INSTRUCTIONS (e.g. other medicines, trigger avoidance, what to do before exercise)

😞 WHEN NOT WELL Asthma getting worse (needing more reliever than usual, having more symptoms than usual, waking up with asthma, asthma is interfering with usual activities)

Peak flow* (if used) between _____ and _____

Keep taking preventer: (NAME & STRENGTH) _____

Take _____ puffs/tablets _____ times every day

Use a spacer with your inhaler

Your reliever is: (NAME) _____

Take _____ puffs _____

Use a spacer with your inhaler

OTHER INSTRUCTIONS (e.g. other medicines, when to stop taking extra medicine) Contact your doctor

😡 IF SYMPTOMS WORSEN Severe asthma flare-up/attack (needing reliever again within 3 hours, increasing difficulty breathing, waking often at night with asthma symptoms)

Peak flow* (if used) between _____ and _____

Keep taking preventer: (NAME & STRENGTH) _____

Take _____ puffs/tablets _____ times every day

Use a spacer with your inhaler

Your reliever is: (NAME) _____

Take _____ puffs _____

Use a spacer with your inhaler

OTHER INSTRUCTIONS (e.g. other medicines, when to stop taking extra medicine) Contact your doctor today

Prednisolone/prednisone: _____

Take _____ each morning for _____ days

😱 DANGER SIGNS Asthma emergency/severe breathing problems, symptoms get worse very quickly, reliever has little or no effect

DIAL 000 FOR AMBULANCE

Peak flow* (if used) below: _____

Call an ambulance immediately

Say that this is an asthma emergency

Keep taking reliever as often as needed

Use your adrenaline autoinjector (EpiPen or Anapen)

National Asthma Council AUSTRALIA

nationalasthma.org.au

ASTHMA ACTION PLAN

WHAT TO LOOK OUT FOR

😊 WHEN WELL

THIS MEANS:

- you have no night-time wheezing, coughing or chest tightness
- you only occasionally have wheezing, coughing or chest tightness during the day
- you need reliever medication only occasionally or before exercise
- you can do your usual activities without getting asthma symptoms

😞 WHEN NOT WELL

THIS MEANS ANY ONE OF THESE:

- you have night-time wheezing, coughing or chest tightness
- you have increasing asthma symptoms when you wake up
- you need to take your reliever more than usual
- your asthma is interfering with your usual activities

THIS IS AN ASTHMA FLARE-UP

😡 IF SYMPTOMS GET WORSE

THIS MEANS:

- you have increasing wheezing, cough, chest tightness or shortness of breath
- you are waking often at night with asthma symptoms
- you need to use your reliever again within 3 hours

THIS IS A SEVERE ASTHMA ATTACK (SEVERE FLARE-UP)

😱 DANGER SIGNS

THIS MEANS:

- your symptoms get worse very quickly
- you have severe shortness of breath, can't speak comfortably or lips look blue
- you get little or no relief from your reliever inhaler

CALL AN AMBULANCE IMMEDIATELY. DIAL 000

THIS IS AN ASTHMA EMERGENCY

DIAL 000 FOR AMBULANCE

ASTHMA MEDICINES

PREVENTERS
Your preventer medicine reduces inflammation, swelling and mucus in the airways of your lungs. Preventers need to be taken **every day**, even when you are well.
Some preventer inhalers contain 2 medicines to help control your asthma (combination inhalers).

RELIEVERS
Your reliever medicine works quickly to make breathing easier by making the airways wider.
Always carry your reliever with you - it is essential for first aid. Do not use your preventer inhaler for quick relief of asthma symptoms unless your doctor has told you to do this.

To order more Asthma Action Plans visit the National Asthma Council website.
A range of action plans are available on the website - please use the one that best suits your patient.
nationalasthma.org.au

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National Asthma Council AUSTRALIA



Consultation 3, three months later

Management

- You tell the patient to return in 6-9 months or before if she needs it.



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Summary

- Adherence is an important issue in achieving asthma control.
- Many patients forget or skip doses when they feel better.
- An open-minded non-judgmental interview using the right questions might help identifying poor adherence.
- A MART regimen can be useful to deal with symptom variation and difficulties with adherence.
- Patient enablement and the promotion of self-management is an important step to achieve asthma control and patient well-being.
- Structured care and periodical asthma reviews are important to support patients and to ensure that [Asthma Right Care](#) is provided.



What does good quality asthma care look like?

IPCRG is regularly asked by primary care clinicians to define good quality care. We take the view that primary care is person-centred, and therefore the best way to define quality is from the perspective of the person at risk of, or with the condition. From our regular conversations with expert patients and clinicians we have summarised what good quality care should look like from a patient perspective and how can clinicians provide that in 8 person-centred statements. These are divided into four areas: Diagnosis, Management, Review, When control is poor. Our vision is that clinical teams will use them to benchmark their practice and potentially identify an area for improvement. Our own programme of work is steered by these statements. We are currently defining the competencies required to deliver them and the teaching methods and tools to enable delivery.

*IPCRG tools that we already offer are listed in green italics.**

People with asthma deserve...

Diagnosis

- 1 A timely, accurate and formal/objective diagnosis of their asthma by their primary healthcare team.
The 'jigsaw puzzle' approach to building a diagnostic picture of asthma in primary care over time.

Management

- 2 To receive adequate inhaler treatment for their asthma according to the best practice recommendations for their level of disease severity. *Asthma Right Care Key Resources*
- 3 To participate in the choice of treatment for their asthma, including the decision between different options of inhaler devices eg *rightbreathe*
- 4 To have appropriate inhaler technique training and to agree an asthma action plan shared with their health care providers eg *Inhaler videos, Canadian action plan, SMART action plan*
- 5 Counselling and treatment if they are tobacco dependent, a yearly flu vaccination and COVID-19 vaccination *Desktop helper helping people quit*

Review

- 6 Follow-up appointments at acceptable intervals or after a change in management, for the management of their asthma that must include structured assessment of control eg *ACT, wellbeing & evaluation of future risk*
- 7 That their difficult-to-manage asthma is evaluated by their primary health care team following a structured approach in order to identify any solvable questions before they are referred to secondary care. *Difficult to manage asthma desktop helper (under review)*

When control is poor

- 8 To have easy and timely access/referral to a primary or secondary health care professional who is skilful in asthma management whenever their symptoms cannot be self-managed or when their asthma cannot be managed in primary care eg *referral letter*



*Interactive version available with hyperlinks. Scan the QR code.



Oct 2023

<https://www.ipcr.org/asthmarightcare/what-does-good-quality-asthma-care-look-like>



Desktop-helper No. 2 on difficult-to-manage asthma

- Learn more on the Desktop-helper:



DESKTOP HELPER

No. 2 April 2024

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- Daytime asthma symptoms, more than twice/week
- Any night awakening due to asthma-related symptoms
- More than two exacerbations per year requiring rescue systemic corticosteroids¹
- Frequent use of SABA (≥3 inhalers per year or ≥3 times per week)
- Poor control despite prescription of high-dose ICS often in combination with LABA/LAMA or use of OCS¹
- Frequent primary care out-of-hours contacts (one or more per month)

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ASTHMA: A PROBLEM THAT CAN BE MANAGED

Studies estimate that in primary care about one out of every six people living with asthma have difficult-to-manage asthma, and of those, between a quarter and a half will have severe asthma.^{2,3} Having difficult-to-manage asthma puts people at higher risk of exacerbations and even death, which are preventable with effective management. Similarly, they are at greater risk of steroid-related adverse effects (if treated with high-dose ICS) or avoidable courses of OCS or low-dose OCS over a period of time, and their morbidity and health costs are disproportionately higher. People with well-controlled asthma have a better quality of life, reduced symptoms and exacerbations, reduced hospital visits and admissions and lower risk of premature death.^{4,7} But most importantly, difficult-to-manage asthma can be managed using a structured approach.⁸

People with asthma and clinicians should collaborate to improve asthma control, especially those with difficult-to-manage asthma, supporting the individual to take an active role in setting goals and targets, self-monitoring, and adopting a healthier lifestyle. This guide provides practical support to primary care and other community healthcare professionals to improve the care of people with difficult-to-manage asthma and to avoid unnecessary referrals of patients who could be better managed in primary care.

HOW TO IDENTIFY A PERSON WITH DIFFICULT-TO-MANAGE ASTHMA?

Ensure that the diagnosis is correct

Over one-third of people living with asthma have an incorrect diagnosis.^{9,10} Confirm that the person really has asthma before stepping up treatment as a surprising number of people diagnosed and treated for asthma (from 12 to 50%)¹¹ either do not have the disease or have it in association with other conditions causing persistent symptoms (see below).^{15,16}

Potential confounding factors for the diagnosis of asthma or its severity are dysfunctional breathing, anxiety, exercise-induced laryngeal obstruction (EILO), vocal cord dysfunction (VCD), obesity and low level of fitness (deconditioning) (Figure 1). All of which may also co-exist with asthma. Diagnosis can be achieved by reviewing clinical history; the diagnostic probability is significantly increased using a lung function

More information on diagnosis

DH 15 - The 'jigsaw puzzle' approach to building a diagnostic picture of asthma in primary care over time

DH 14 - Quick guide to spirometry

[Spirometry Simplified \(pdf\)](#)

Figure 1 - Potential confounding factors for the diagnosis of asthma or its severity: reflection points

Have you excluded conditions that cause asthma symptoms?

- GORD
- Anemia
- Pulmonary fibrosis
- COPD
- Dysfunctional breathing
- Deconditioning
- EILO
- Anxiety
- Allergy
- Nasal polyps

Have you checked that other conditions or their treatment are not affecting asthma management? (e.g., long-term, chronic and side effect)

- Osteoporosis
- Diabetes
- Hypertension
- Social problems
- Tobacco dependence
- Depression
- Fear or quality
- Occupational factors
- Exams

Have you asked about other comorbidities that can worsen asthma symptoms?

Footnote: these are some more common examples and not a comprehensive list. Social problems include economic problems (poverty, unemployment), poor housing, gender or ethnic discrimination, low literacy, etc.

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