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ALLERGIC CRITERIA LEADING TO BRONCHIAL ASTHMA IN CHILDREN

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Relevance

Asthma is the the most common chronic respiratory condition of childhood worldwide, with around 14% of children and young people affected. Despite the high prevalence, paediatric asthma outcomes are inadequate, and there are several avoidable deaths each year. Characteristic asthma features include wheeze, shortness of breath and cough, which are typically triggered by a number of possible stimuli. There are several diagnostic challenges, and as a result, both overdiagnosis and underdiagnosis of paediatric asthma remain problematic.

Effective asthma management involves a holistic approach addressing both pharmacological and non-pharmacological management, as well as education and self-management aspects.

Purpose of the study: Study of allergic criteria leading to bronchial asthma in children.

Materials and methods

There is no single ‘gold-standard’ test that can be used to accurately diagnose asthma. In practice, a diagnosis should be made based on characteristic symptom patterns, evidence of variability in airflow limitation in the presence of airway inflammation, likelihood of alternative diagnoses and response to treatment. Getting the diagnosis correct is key for optimal management of paediatric asthma.

Lung function tests can be used to aid the diagnosis of asthma in children over the age of 5 years. Peak expiratory flow (PEF) and spirometry are commonly used to assess airflow obstruction and reversibility. PEF can be used to detect diurnal variation, which is a typical feature of asthma. The Global Initiative for Asthma (GINA) specifically recommends the use of either PEF or spirometry in the diagnosis of asthma in children over 5 years.Once a child is old enough to reliably perform lung function testing, it is recommended that this be undertaken if the

diagnosis of asthma has not been previously confirmed. In children under 5, lung function testing is rarely practical outside a research setting. Allergy testing (skin prick testing or measurement of specific IgE levels) is not routinely carried out in the diagnostic process; however, it is recommended in a number of clinical guidelines and may identify individual triggers.

Research results:

Lung function tests can be used to aid the diagnosis of asthma in children over the age of 5 years.

Wheeze is a key feature of asthma and, if not present, a diagnosis of asthma in a child is unlikely. Wheeze is an expiratory high-pitched whistle that occurs as a result of inflammation and narrowing of the small airways. Parental understanding of wheeze varies, and clarifying what is meant when it is reported is key in making an accurate diagnosis.

The prevalence of 'preschool wheeze' is an additional challenge when diagnosing asthma in young children. In the first few years of life, many children will experience wheeze, but not all will go on to develop true asthma. The diagnosis of asthma should therefore be reviewed routinely to identify true asthma and alter treatment where necessary. Favourable response to an appropriate trial of asthma treatment is an important confirmatory piece of diagnostic evidence.

Conclusions

Paediatric asthma outcomes are currently poor and many deaths are preventable. The aim should be to avoid asthma attacks occurring with appropriate maintenance therapy, and they should be viewed as never events. In order to improve outcomes, accurate diagnosis and management are essential. Good asthma care extends beyond providing medication and should include education, as well as supported self-management advice. The use of PAAPs remains limited and a significant number of young people with asthma do not have one. Postattack asthma reviews are a key opportunity to review maintenance medication and current symptom control.

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