CLASSIFICATION OF ASTHMA SYMPTOM SEVERITY AND THERAPY

DAYTIME SYMPTOMS	NIGHTTIME SYMPTOMS	LUNG FUNCTION		LONG TERM CONTROL (see reverse side for drugs and dosages)	QUICK RELIEF	Considerations for infants and children <5 years[1,2]
Continual symptoms Limited physical activity Frequent exacerbations	Frequent	FEV_1 or PEF ≤ 60%Predicted PEF variability >30% [3]	**Severe Persistent**	**Refer to asthma specialist** Daily *high dose* inhaled steroid **AND** Long acting bronchodilator [4] +/- oral steroid **or** theophylline **AND** Consider leukotriene modifier	**Short-acting** B_2-agonist prn	Corticosteroids: Inhaled: high dose systemic steroid only *if needed*
Daily symptoms Daily use of inhaled short-acting B_2 agonist Exacerbations affect activity Exacerbations ≥ 2 times/wk, may last days	≥5 month	FEV_1 or PEF >60%-<80% Predicted PEF variability >30% [3]	**Moderate Persistent**	Daily *medium dose* inhaled steroid **AND** Consider leukotriene modifier **OR** Daily *low* *nedium dose* inhaled teroid **AND** Long acting bronchodilator [4] **AND** Consider leukotriene modifier	**Short-acting** B_2-agonist prn	Med dose ICS **OR, once controlled** Lower med dose ICS **AND** Nedocromil **OR** Lower med dose ICS **AND** Theophylline
Symptoms 3-6 times/wk Exacerbations may affect activity	3-4 times/month	FEV_1 or PEF ≥ 80% Predicted PEF variability 20 - 30% [3]	**Mild Persistent**	Daily *low dose* inhaled steroid **OR** Daily Cromolyn **or** Nedocromil **OR** Daily leukotriene modifier	**Short-acting** B_2-agonist prn	Start with Cromolyn or Nedocromil, **or** low dose inhaled corticosteriods *if needed*
Symptoms ≤ 2 times/wk Asymptomatic and normal PEF between exacerbations Exacerbations brief (hrs-days), variable intensity	≤2 times/month	FEV_1 or PEF ≥ 80% predicted PEF variability <20% [3]	**Mild Intermittent**	None	**Short-acting** B_2-agonist prn	None

Adapted from Expert Panel Report 2 *Guidelines for the Diagnosis and Management of Asthma*, National Institutes of Health, National Heart, Lung, and Blood Institute

[1] For infants and children use spacer AND MASK.
[2] Infants and young children consistently requiring symptomatic treatment more than twice a week should be given daily anti-inflammatory therapy.
[3] Assessment of diurnal variation in peak expiratory flow over 1-2 weeks is recommended when patients have asthma symptoms but normal spirometry. PEF should be measured before taking a short-acting inhaled $beta_2$ agonist in the morning and after taking one in the afternoon. A 20% difference between the morning and afternoon measurements suggests asthma.
[4] Theophylline, sustained release / Salmeterol / Albuterol, sustained release.

If a patient has seasonal asthma on a predictable basis, daily, long-term anti-inflammatory therapy (inhaled corticosteroids, cromolyn, or nedocromil) should be initiated prior to the anticipated onset of symptoms and continued through the season.

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