Humber and North Yorkshire
Health and Care Partnership

Humber and North Yorkshire 2025 Suspected Asthma Management & Treatment Guidance in children aged 2-5 years

The enclosed suspected asthma guidelines are intended for use by clinicians working in Humber and North Yorkshire. These guidelines have been developed to inform treatment decisions for:

- Children aged 2-5 years with suspected asthma that are too young for objective diagnostic testing
- Children aged 2-5 years with uncontrolled suspected asthma symptoms, considered by their clinician to require a step up in treatment
- *These guidelines are not intended for the management of children with viral wheeze.*

Guideline Key

- ICS: inhaled corticosteroid
- SABA: short-acting beta-agonist
- LTRA: leukotriene receptor antagonist
- pMDI: pressurised Metered Dose Inhaler
- OCS: oral corticosteroid

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Wheezing in preschool aged children is common, occurring in approximately one third of all preschool children. Children with wheezing in the preschool period fall broadly into 2 categories:

1. **Viral Wheeze** – the child only wheezes episodically with upper respiratory infections and is otherwise totally symptom free. This group usually has an excellent prognosis with no increased risk of respiratory symptoms in later childhood.
2. **Multi Trigger Wheeze/Suspected Asthma** – the child wheezes with upper respiratory tract infections, but has 1 or more features suggestive of suspected asthma (see table 1)

This guidance is designed to support clinicians in the management of children with features suggestive of suspected asthma (table 1) or children under 5 experiencing severe acute episodes of difficulty breathing and wheeze.

Refer any child under 5, to secondary care, who has had 2 or more courses of oral steroids in 12 month OR hospital admission

If a child has any feature suggestive of an alternative diagnosis (see table 2) they should be referred to secondary care for specialist advice.

Treatment is guided by which category the child falls into. A child can move between the categories over time and treatments should be adjusted accordingly.

No treatment has been shown to prevent progression of preschool wheeze to school age asthma, so treatment is driven solely by current symptoms.

Table 1 – features suggestive of Suspected Asthma in preschool children
Severe acute episodes of difficulty breathing and wheeze - requiring hospital admission or needing 2+ courses of OCS *refer any child with these features to secondary care*
Interval symptoms, outside of viral infections and/or wheezing following exposure to other triggers such as exercise or allergens
Personal or family history of Atopy

Table 2 – Features suggestive of an alternative diagnosis
Failure to thrive
Unexplained clinical findings
Symptoms present from birth
Excessive vomiting or posseting
Severe upper respiratory tract infections
Persistent wet or productive cough
Family history of unusual chest disease
Nasal polyps

Child aged 2-5 years with features suggestive of suspected asthma (See table 1), treat acute episode and consider:

In children who do not tolerate inhaled medication/spacer, consider LTRA as first line trial

Consider 8–12-week trial of Paediatric low-dose ICS daily + Reliever (SABA) as needed

Soprobec 100 pMDI One puff BD **via a spacer**

Clenil® 100 pMDI One puff BD **via a spacer**

Salamol 100 (pMDI) 1-2 puffs PRN **Via a spacer**

Did Symptoms resolve during the trial of treatment?

NO
- Check inhaler technique
- Adherence
- Environmental sources (see page 2)
- Review for potential alternative diagnosis

If this doesn't explain treatment failure

***Refer the child to a specialist in asthma care:**
- - Persistent or uncontrolled symptoms despite optimised treatment
- - Frequent severe exacerbations
- - Parental concern
- - Diagnostic Uncertainty (see **table 2**

If symptoms remain uncontrolled, stop LTRA and refer to a specialist in asthma care

Montelukast 4mg OD at night
Discuss Potential side effects prior to prescribing

YES
If symptoms resolved during trial **Consider stopping** ICS+SABA treatment and **review** symptoms after a further **3 months**

If symptoms recur after review or acute episode requiring OCS and/or hospitalisation

Restart regular ICS + SABA
Begin at paediatric low dose and titrate up to paediatric *moderate dose if needed

Consider a further trial without treatment after reviewing the child within 12 months

If symptoms are uncontrolled consider adding LTRA to ICS for a trial of 8-12 weeks STOP if ineffective or Side effects Or Referral

*ICS dosages for 5-11 years , as per NICE/BTS guideline		
	Paediatric low dose	Paediatric moderate dose
Beclomethasone dipropionate	100 – 200 micrograms per day in 2 divided doses	300 – 400 micrograms per day in 2-4 divided doses

HNY Asthma Guidelines **FINAL Approved by HNY APC 04.06.25**

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Spacers

Aerochamber **plus Flow-Vu Child Small (0-18 months)**

Aerochamber **plus Flow-Vu Child Medium (1-5 years)**

Aerochamber **plus Flow-Vu Youth (5-16 years)**

Volumatic **Spacer With mask (0-5 years)**

How to use Blue (reliever) Inhaler

Is the child breathless, wheezing, coughing a lot, or working harder to breath?

Yes

Give Two puffs of the blue inhaler (1 at a time) via a spacer.

If this didn't relieve their symptoms after 5 -10 minutes.

Give a further Two puffs of the blue inhaler (1 at a time) via a spacer.

If this still didn't relieve their symptoms after 5 -10 minutes

Give a further Two puffs (1 at a time) via a spacer and reassess after 5-10 minutes.

They have now had Six puffs in total.

Have their symptoms resolved?

Yes → This should last at **least 4 hours, reassess regularly** for any worsening symptoms.

No → If symptoms have not resolved following or relief does not last 4 hours. The child is worsening, and immediate action is needed.

Give up to Ten puffs of the blue inhaler via a spacer, 1 puff at a time and arrange an urgent review the same day or attend the emergency department if this is not possible.

If the child is having breathing difficulties that are not resolved by Ten puffs of salbutamol call 999.

Continue to give **One** puff of their blue inhaler every 30 seconds until help arrives.

No → Child **does not** require their blue inhaler. **Reassess regularly.**

Principles of Good (suspected) Asthma Care

Check that all principles are being followed when considering stepping up asthma treatment

1. Inhaler technique should be taught and reviewed during every asthma consultation. Inhaler technique videos are available at: How to use your inhaler | Asthma UK.
2. Adherence with preventer therapy is often low and should be assessed and addressed during every consultation.
3. If prescribing a pMDI inhaler, an appropriate spacer should be prescribed and instructions about its use and maintenance provided.
4. All patients should be given a personalised asthma action plan which should be updated following any treatment change.
5. Appropriate life-style and self-management advice should be discussed during each asthma consultation (e.g. trigger avoidance, smoking cessation, physical activity, weight management etc.)
6. Review of symptoms and control should happen regularly and diagnostic testing for asthma arranged once child is old enough to perform objective testing.

Coding Tips in 2–5-year-olds

Does the child have episodic wheeze only with viral illness?

Yes → Code: VIRAL WHEEZE
CTV3 Code - **XaMe7**
Snowmed - **276191000000107**

No → Does the Child have red flags for Suspected Asthma? *See Table 1

Yes → Are you going to give a trial of treatment?

Yes → Code: SUSPECTED ASTHMA
CTV3 Code – **XalnC**
Snowmed - **394967008**

Did the trial of treatment improve their symptoms?

Yes → Code: SUSPECTED ASTHMA And review child at least annually and review diagnosis regularly

No → Consider Alternative diagnosis.

No → Consider Alternative diagnosis.

No → Consider Referral for specialist opinion if:
- Symptoms persist
- are uncontrolled
- There is diagnostic uncertainty

Pre-School Children & Air Quality

- Indoor and outdoor air pollutants can act as triggers for respiratory symptoms in children.
- During a consultation HCP's should ask about potential sources of indoor and outdoor air pollution (such as patient smoking/parental smoking, open solid fuel fires, damp and mould, proximity of homes/school to busy roads etc.) **These should be clearly documented.**
- Parental smoking and secondary exposure to tobacco smoke in children irritates the airways and make wheezing symptoms and episodes more likely.
- Cigarette smoking exposure is also linked with an increased risk of children developing asthma during their lives.
- If the child's care givers smokes or vapes, give 'Very Brief Advice' and signpost to local stop smoking services.
- Many stop smoking services use vaping as a tools to help people step down from smoking tobacco. Advise families that vaping can also act as an irritant on their child's airways, and they should avoid vaping around their child.
- If patient reports issues with damp and mould in their home, refer to HNY Air Pollution leaflet, which can be found via the Healthier together website.
- If the family need further support, regarding housing, signpost to citizens advice.
- If any concerns raised regarding outdoor air pollution, signpost patients to the Defra pollution forecast.

NHS Stop Smoking

Air Quality Leaflet

Pollution Forecast

Citizen's Advice