

Management of acute asthma in adults in hospital

Features of acute severe asthma

- Peak expiratory flow (PEF) 33–50% of best (use % predicted if recent best unknown)
- Can't complete sentences in one breath
- Respiration ≥ 25 breaths/min
- Pulse ≥ 110 beats/min

Life-threatening features

- PEF <33% of best or predicted
- SpO₂ <92%
- Silent chest, cyanosis, or poor respiratory effort
- Arrhythmia or hypotension
- Exhaustion, altered consciousness

If a patient has any life-threatening feature, measure arterial blood gases. No other investigations are needed for immediate management.

Blood gas markers of a life-threatening attack:

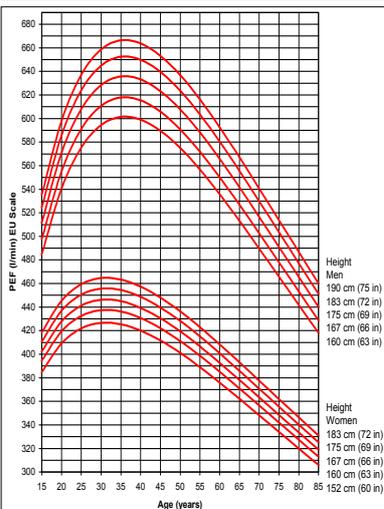
- 'Normal' (4.6–6 kPa, 35–45 mmHg) PaCO₂
- Severe hypoxia: PaO₂ <8 kPa (60 mmHg) irrespective of treatment with oxygen
- A low pH (or high H⁺)

Caution: Patients with severe or life-threatening attacks may not be distressed and may not have all these abnormalities. The presence of any should alert the doctor.

Near-fatal asthma

- Raised PaCO₂
- Requiring mechanical ventilation with raised inflation pressures

Peak Expiratory Flow Rate - Normal Values



Adapted by Clement Clarke for use with EN13826 / EU scale peak flow meters from Nunn AJ Gregg I, Br Med J 1989;298:1068-70

IMMEDIATE TREATMENT

- Oxygen to maintain SpO₂ 94–98%
- β_2 bronchodilator (salbutamol 5 mg) via an oxygen-driven nebuliser
- Ipratropium bromide 0.5 mg via an oxygen-driven nebuliser
- Prednisolone tablets 40–50 mg or IV hydrocortisone 100 mg
- No sedatives of any kind
- Chest X-ray if pneumothorax or consolidation are suspected or patient requires mechanical ventilation

IF LIFE-THREATENING FEATURES ARE PRESENT:

- Discuss with senior clinician and ICU team
- Consider IV magnesium sulphate 1.2–2 g infusion over 20 minutes (unless already given)
- Give nebulised β_2 bronchodilator more frequently eg salbutamol 5 mg up to every 15–30 minutes or 10 mg per hour via continuous nebulisation (requires special nebuliser)

SUBSEQUENT MANAGEMENT

IF PATIENT IS IMPROVING continue:

- Oxygen to maintain SpO₂ 94–98%
- Prednisolone 40–50mg daily or IV hydrocortisone 100 mg 6 hourly
- Nebulised β_2 bronchodilator with ipratropium 4–6 hourly

IF PATIENT NOT IMPROVING AFTER 15–30 MINUTES:

- Continue oxygen and steroids
- Use continuous nebulisation of salbutamol at 5–10 mg/hour if an appropriate nebuliser is available. Otherwise give nebulised salbutamol 5 mg every 15–30 minutes
- Continue ipratropium 0.5 mg 4–6 hourly until patient is improving

IF PATIENT IS STILL NOT IMPROVING:

- Discuss patient with senior clinician and ICU team
- Consider IV magnesium sulphate 1.2–2 g over 20 minutes (unless already given)
- Senior clinician may consider use of IV β_2 bronchodilator or IV aminophylline or progression to mechanical ventilation

MONITORING

- Repeat measurement of PEF 15–30 minutes after starting treatment
- Oximetry: maintain SpO₂ >94–98%
- Repeat blood gas measurements within 1 hour of starting treatment if:
 - initial PaO₂ <8 kPa (60 mmHg) unless subsequent SpO₂ >92% or
 - PaCO₂ normal or raised or
 - patient deteriorates
- Chart PEF before and after giving β_2 bronchodilator and at least 4 times daily throughout hospital stay

Transfer to ICU accompanied by a doctor prepared to intubate if:

- Deteriorating PEF, worsening or persisting hypoxia, or hypercapnia
- Exhaustion, altered consciousness
- Poor respiratory effort or respiratory arrest

DISCHARGE

When discharged from hospital, patients should have:

- Been on discharge medication for 12–24 hours and have had inhaler technique checked and recorded
- PEF >75% of best or predicted and PEF diurnal variability <25% unless discharge is agreed with respiratory physician
- Treatment with **oral steroids (prednisolone 40–50 mg until recovery - minimum 5 days) and inhaled steroids** in addition to bronchodilators
- Own PEF meter and **written asthma action plan**
- GP follow up arranged within **2 working days**
- Follow-up appointment in respiratory clinic **within 4 weeks**

Patients with severe asthma (indicated by need for admission) and adverse behavioural or psychosocial features are at risk of further severe or fatal attacks.

- Determine reason(s) for exacerbation and admission
- Send details of admission, discharge and potential best PEF to GP