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City and Hackney Asthma Urgent Care Pathway

Initial Assessment

<table>
<tr><td>Moderate acute asthma</td><td colspan="2">• Increasing symptoms
• PEF >50–75% best or predicted
• No features of acute severe asthma.</td></tr>
<tr><td>Acute severe asthma</td><td colspan="2">Any one of:
• PEF 33–50% best or predicted
• respiratory rate ≥25/min
• heart rate ≥110/min
• inability to complete sentences in one breath.</td></tr>
<tr><td rowspan="3">Life-threatening asthma</td><td colspan="2">SpO_2 <92% plus any one of the following in a patient with severe asthma:</td></tr>
<tr><td>Clinical signs</td><td>Measurements</td></tr>
<tr><td>• Altered conscious level
• Exhaustion
• Arrhythmia
• Hypotension
• Cyanosis
• Silent chest
• Poor respiratory effort</td><td>• PEF <30% best or predicted
• PaO_2 <8 kPa
• 'normal' $PaCO_2$ (4.6–6.0 kPa)</td></tr>
<tr><td>Near-fatal asthma</td><td colspan="2">Raised $PaCO_2$ and/or requiring mechanical ventilation with raised inflation pressures</td></tr>
</table>

Authors: Dr Hayley Sherratt (GP Clinical lead Urgent and Unplanned care), Laura Graham (Cardiorespiratory Consultant Physiotherapist ACERS, Dr Claire Charley (A&E Consultant Clinical lead), September 2025, review date September 2028

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Moderate Asthma

If on MART therapy, increase maintenance dose as per asthma action plan, if no improvement in 24hrs, consider prednisolone 40mg for 5 days and **refer to ACERS**

If on fixed dose ICS, prescribe prednisolone 40mg for 5 days and **refer to ACERS**

Management on ACERS virtual ward is not appropriate if:

- Pregnant
- social isolation
- previous near fatal attack
- on prednisolone prior to attack
- nighttime presentation

In these circumstances consider A&E

Note: Chest X-ray is **not** routinely recommended in patients in primary care in the absence of:

- suspected consolidation
- failure to respond to treatment satisfactorily

Acute Severe Asthma/life threatening or near fatal

Call 999

Start immediate treatment:

- 40-50mg prednisolone STAT
- **Bronchodilators***

β2 Agonist Bronchodilators:

- Use high-dose inhaled β2 agonists as first-Line agents in patients with acute asthma and administer as early as possible.
- In patients with acute asthma with life-threatening features the nebulised route (oxygen-driven) is recommended.
- In patients with severe asthma that is poorly responsive to an initial bolus dose of β2 agonist, consider continuous nebulisation with appropriate nebulisers.

Ipratropium Bromide:

- Add nebulised ipratropium bromide (0.5 mg 4–6 hourly) to β2 agonist treatment for patients with acute severe or life threatening asthma or those with a poor initial response to β2 agonist therapy

Follow up:

- It is essential that the patients GP is informed within 24 hours of discharge
- Anyone leaving the hospital with an acute asthma attack, should have their inhaler technique checked and a personalised asthma action plan NEL-Primary-and-Secondary-Care-Adult-Asthma-guidelines-v3.0.pdf
- ACERS will also follow up anyone admitted to the Homerton, in the hospital and on discharge within 24-48 hours, dependent on risk.
- Keep patients who have had a near-fatal asthma attacks under specialist supervision. A respiratory specialist should follow up patients admitted with a severe asthma attack for at least one year after the admission.

Guidance based on Overview | Asthma pathway (BTS, NICE, SIGN) | Guidance | NICE

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