"ON MY MIND"…

Reactions to and expansion of the comments by Dr. Cloutier on Pediatric Asthma

By George A. Sprecace, M.D., J.D.

- **About Pediatricians in general: despite being overworked and professionally overtaxed, they refer to Specialists too infrequently.**
- **An evaluation of a new child patient with bronchial asthma requires at least 45-60 minutes. Central to that evaluation is a full evaluation of the allergic status of that child. For allergies are the central issues in the large majority of childhood asthmatics.**
- **The term "allergic" was used once, in passing, by Dr. Cloutier.**
- **It is vital, as soon as possible, to determine whether the particular asthmatic has a noisy chest and a noisy approach to complaining about his or her asthma - or a silent chest and a silent approach to the problem. The latter is much the more dangerous, for patient and for physician.**
- **Environmental control, of smoking, of pets, of household conditions, etc. must be effective – and must be demanded by the physician. Indoor pets should be discouraged – and pets must *never* be allowed in the sleeping quarters.**
- **Compliance – after discussion – is key to success and to avoidance of disasters.**
- **With rare exception, bronchial asthma should never be a cause of death.**
- **The asthmatic should be seen and monitored regularly: at least quarterly and often weekly until control and compliance are achieved.**
- **Superimposed URI should be addressed promptly with an established protocol and with easy availability of the health professional for further instructions.**
- **From a very early age, the child is a good source of information and cooperation…if engaged directly. The parent should not be the only contact here.**
- **The physician dealing with asthmatics should arrange for 24 hour availability by himself or by a trained professional. The ER is generally a poor source of treatment for asthmatics.**
- **The approach to exacerbations of asthma often involves too high a dose of oral steroids and too long a duration. Lower and shorter works.**
- **The threshold for adding an antibiotic for an exacerbation is and should be lower than for the general population.**
- **Long-acting beta agonists should not be used over a 24 hour period, only over a 12 hour period, if at all. The development of tolerance is a real risk, impacting the utility of a rescue inhaler when the condition becomes urgent. Likewise, the use of rescue inhalers should be carefully monitored for overuse.**

- **An allergy evaluation, of which a careful history is followed by appropriate testing, should be considered for every child asthmatic. In most children with positive findings, allergy immunotherapy is an effective and proven treatment – and is the only form of therapy that can effect desensitization, and even "cure".**
- **Pre- and post-bronchodilator spirometry is a useful guide to the adequacy of control of the asthmatic condition, both clinically and physiologically. Occult bronchospasm, despite apparently adequate treatment and clinical course, equals inflammation which leads to more frequent attacks and to remodeling of the airways.**
- **"Level of Evidence", as in "evidence – based medical care" is categorized as in classes A, B, C, and D. Clinical experience is generally characterized as in Class D. Ridiculous, and harmful to proper medical care.**

Dr. Cloutier is correct in saying that the treatment of bronchial asthma is not rocket science. However, it does require attention to detail, comprehensive treatment, patient and family cooperation, close follow-up, and physician control of the situation. The alternative is a prescription for disaster, for all concerned.

GS - September 5, 2013