key points

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The UK has one of the highest prevalence rates for asthma in the world with around 1 in 12 (4.3 million) adults affected. Depending on the exact definition used the vast majority of asthma is considered to be mild to moderate (i.e. symptoms and exacerbation frequency controlled without the need for high-dose asthma therapy) and managed predominantly in primary care.

The UK-based National Review of Asthma Deaths found that most patients who died were actually considered to have mild to moderate asthma, with 57% of fatal cases not under specialist care at the time of death. In cases of fatal asthma there was widespread underuse of inhaled corticosteroids (ICS) — 80% of patients did not receive monthly treatment — and an overreliance on short-acting beta-agonists (SABA).

The joint BTS/SIGN guideline no longer considers SABA inhalers an appropriate monotherapy apart from in those few individuals with very occasional short-lived wheeze. Asthma is an inflammatory airways disease and should always be treated with a steroid-containing inhaler. All other treatments including SABA should be considered additional to ICS.

Guidelines diverge on the recommended initial add-on therapy to regular low-dose ICS; BTS/SIGN suggests adding in a long-acting beta-agonist (LABA) in the form of a combination inhaler, which may help to avoid non adherence with steroids and is modestly superior in reducing oral corticosteroid-treated exacerbations when compared with the NICE recommendation of an oral leukotriene receptor antagonist. Both guidelines draw attention to the need to check inhaler technique and reinforce good concordance with treatment.

According to the BTS/SIGN guideline individuals with well controlled asthma: should not have bothersome symptoms in the day or night; should require little or no reliever medication; should not suffer exacerbations; and have preserved lung function. Education on self-management, in primary care, can be effective in improving asthma control and prevent unplanned use of healthcare services particularly when supported by a written personalised asthma action plan. As well as understanding what they should be taking for their asthma and when, patients must also be shown how to use their treatments and their inhaler technique reassessed at every contact with a healthcare professional. Reducing exposure to house dust mite, has not been shown to be an effective method of improving asthma control. Significant weight loss in obese asthma patients may be beneficial. Smoking is associated with poorer control and higher use of ICS.

Referral to secondary care should take place when there is diagnostic uncertainty or atypical features, the possibility of hypersensitivity to inhaled material or concerns over treatment or exacerbations. Patients who have suffered even a single life-threatening asthma attack should be under specialist supervision.