Many deaths from asthma are preventable. Delay can be fatal. Factors leading to poor outcome include:

- Clinical staff failing to assess severity by objective measurement
- Patients or relatives failing to appreciate severity
- Under use of corticosteroids

Regard each emergency asthma consultation as for acute severe asthma until shown otherwise.

### Factors leading to poor outcome include:
- Clinical staff failing to assess severity by objective measurement
- Patients or relatives failing to appreciate severity
- Under use of corticosteroids

### Initial Assessment

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<tr>
<th>Moderate asthma</th>
<th>Acute severe asthma</th>
<th>Life-threatening asthma</th>
</tr>
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<tbody>
<tr>
<td>PEF &gt;50–75% best or predicted</td>
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### Further Assessment

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### Management

- **Treat at home or in surgery and ASSESS RESPONSE TO TREATMENT**
  - Oxygen to maintain SpO₂ 94–98% if available
  - β₂ bronchodilator
    - via nebuliser (preferably oxygen-driven), salbutamol 5 mg
    - or if nebuliser not available, via spacer
  - Prednisolone 40–50 mg or IV hydrocortisone 100 mg
  - If no response in acute severe asthma: ADMIT

- **Admit to hospital if any:**
  - Life-threatening features
  - Features of acute severe asthma present after initial treatment
  - Previous near-fatal asthma

### Treat at Home or in Surgery

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### Follow up after treatment or discharge from hospital:

- Continue prednisolone until recovery (minimum 5 days)
- GP review within 2 working days
- Monitor symptoms and PEF
- Check inhaler technique
- Written asthma action plan
- Modify treatment according to guidelines for chronic persistent asthma
- Address potentially preventable contributors to admission

**[A] β₂ bronchodilator via spacer given one puff at a time, inhaled separately using tidal breathing; according to response, give another puff every 60 seconds up to a maximum of 10 puffs**