**Presentation:** A patient presents to the clinic with intermittent dyspnea on exertion.

**Initial Assessment:** Address severity - Daytime vs. nighttime symptoms, frequency, nocturnal awakening, use of rescue inhaler (if applicable), rule out other causes of dyspnea.

### Components of Severity

<table>
<thead>
<tr>
<th>Impairment Normal FEV₁/FVC: 8 to 19 years 85 percent</th>
<th>20 to 39 years 80 percent</th>
<th>40 to 59 years 75 percent</th>
<th>60 to 80 years 70 percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Symptoms</strong></td>
<td>≤2 days/week</td>
<td>&gt;2 days/week but not daily</td>
<td>Daily</td>
</tr>
<tr>
<td><strong>Nighttime awakenings</strong></td>
<td>≤2 2x/month</td>
<td>3 to 4x/month</td>
<td>&gt;1x/week but not nightly</td>
</tr>
<tr>
<td><strong>Short-acting beta₂-agonist use for symptom control (not prevention of EIB)</strong></td>
<td>≤2 days/week</td>
<td>&gt;2 days/week but not daily, and not more than 1x on any day</td>
<td>Daily</td>
</tr>
<tr>
<td><strong>Interference with normal activity</strong></td>
<td>None</td>
<td>Minor limitation</td>
<td>Some limitation</td>
</tr>
<tr>
<td><strong>Lung function</strong></td>
<td>• Normal FEV₁ between exacerbations • FEV₁ ≥ 80 percent predicted • FEV₁/FVC normal</td>
<td>• FEV₁ ≥80 percent predicted • FEV₁/FVC normal</td>
<td>• FEV₁ ≥60 but &lt;80 percent predicted • FEV₁/FVC reduced 5 percent</td>
</tr>
</tbody>
</table>

### Risk

**Exacerbations requiring oral systemic glucocorticoids**

- 0 to 1/year (see footnote)
- ≥2/year (see footnote)

Consider severity and interval since last exacerbation.

Frequency and severity may fluctuate over time for patients in any severity category.

Relative annual risk of exacerbations may be related to FEV₁.

### Recommended step for initiating treatment

- **Step 1**
- **Step 2**
- **Step 3**
- **Step 4 or 5**

In two to six weeks, evaluate level of asthma control that is achieved and adjust therapy accordingly.

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Assessing severity and initiating treatment for patients who are not currently taking long-term control medications. The stepwise approach is meant to assist, not replace, the clinical decision-making required to meet individual patient needs. Level of severity is determined by assessment of both impairment and risk. Assess impairment domain by patient’s caregiver’s recall of previous two to four weeks and spirometry. Assign severity to the most severe category in which any feature occurs. At present, data are inadequate to correlate frequencies of exacerbations with different levels of asthma severity. In general, more frequent and intense exacerbations (e.g., requiring urgent, unscheduled care, hospitalization, or ICU admission) indicate greater underlying disease severity. For treatment purposes, patients who had ≥2 exacerbations requiring oral systemic glucocorticoids in the past year may be considered the same as patients who have persistent asthma, even in the absence of impairment levels consistent with persistent asthma.

FEV₁: forced expiratory volume in one second; FVC: forced vital capacity; ICU: intensive care unit.


**Diagnosis:** PFTs (see FEV₁/FVC above)
The NC AHEC Program would like to acknowledge the valuable contributions of Henry Stiepel and Caleb Smith.

**References**

