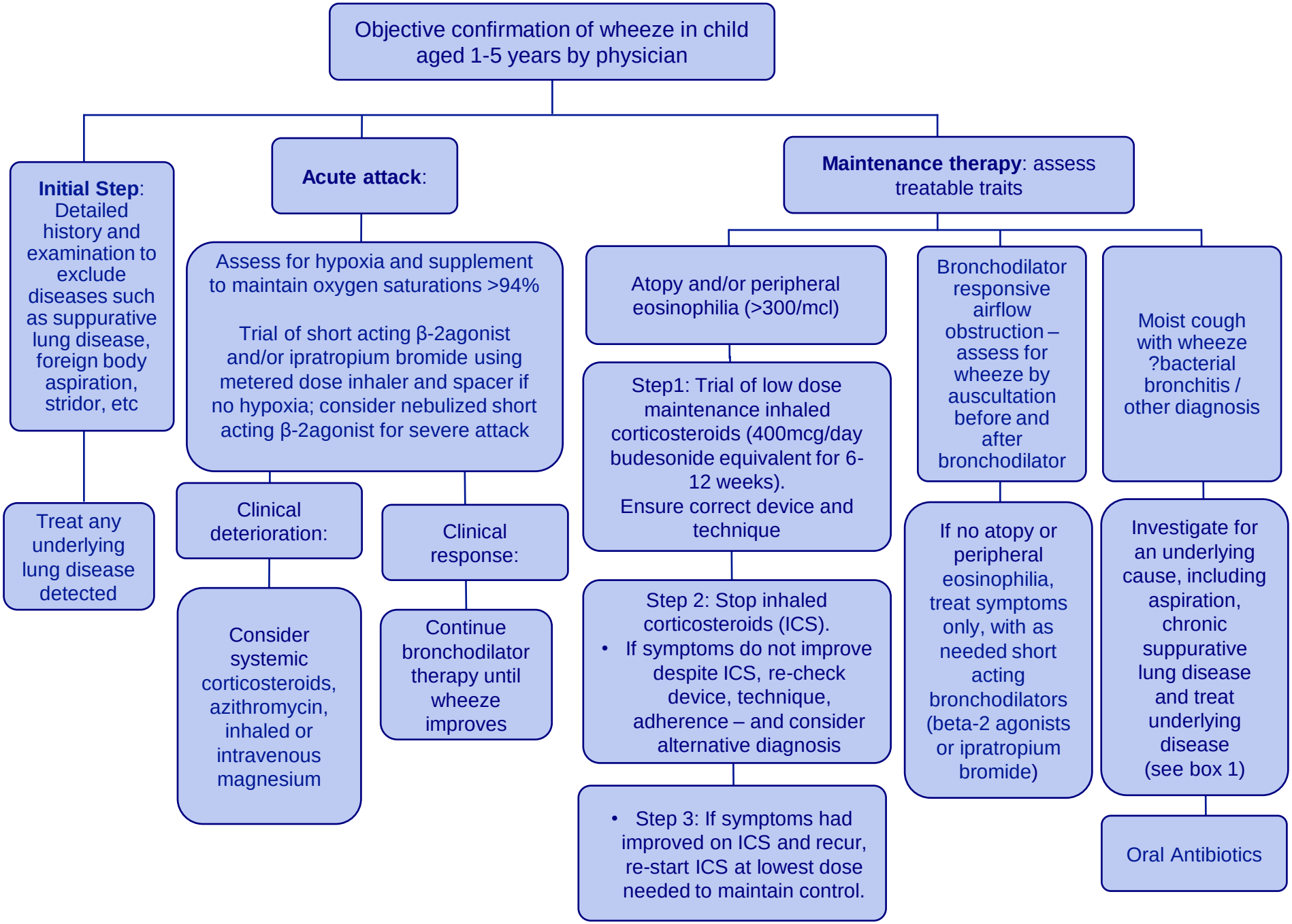
Objective confirmation of wheeze in child aged 1-5 years by physician
Initial Step: Detailed history and examination to exclude diseases such as suppurative lung disease, foreign body aspiration, stridor, etc
Treat any underlying lung disease detected
Acute attack:
Assess for hypoxia and supplement to maintain oxygen saturations >94%
Trial of short acting β-2agonist and/or ipratropium bromide using metered dose inhaler and spacer if no hypoxia; consider nebulized short acting β-2agonist for severe attack
Clinical deterioration:
Consider systemic corticosteroids, azithromycin, inhaled or intravenous magnesium
Clinical response:
Continue bronchodilator therapy until wheeze improves
Maintenance therapy: assess treatable traits
Atopy and/or peripheral eosinophilia (>300/mcl)
Step1: Trial of low dose maintenance inhaled corticosteroids (400mcg/day budesonide equivalent for 6-12 weeks).
Ensure correct device and technique
Step 2: Stop inhaled corticosteroids (ICS).
• If symptoms do not improve despite ICS, re-check device, technique, adherence – and consider alternative diagnosis
• Step 3: If symptoms had improved on ICS and recur, re-start ICS at lowest dose needed to maintain control.
Bronchodilator responsive airflow obstruction – assess for wheeze by auscultation before and after bronchodilator
If no atopy or peripheral eosinophilia, treat symptoms only, with as needed short acting bronchodilators (beta-2 agonists or ipratropium bromide)
Moist cough with wheeze ?bacterial bronchitis / other diagnosis
Investigate for an underlying cause, including aspiration, chronic suppurative lung disease and treat underlying disease (see box 1)
Oral Antibiotics