cise and postexercise spirometry with the addition of oxygen uptake, carbon dioxide production, continuous oximetry, and electrocardiogram monitoring during most tests. EIA was diagnosed if treadmill exercise resulted in reproduction of symptoms in association with a decrease in forced expiratory volume in 1 second of at least 15%. Endoscopy was performed if stridor and/or decreased maximal inspiratory flow were present. Criteria were established for restrictive abnormalities, physical conditioning, exercise-induced hyperventilation, and normal physiologic limitation.

RESULTS. EID was present in the subjects for an average of 30.2 months (range: <1 to 192 months) before evaluation, and in 98 patients the symptoms were attributed to asthma. Symptoms of EID were reproduced during exercise testing in 117 patients. EIA was identified as the cause of EID in only 11 of the 117. Seventy-four demonstrated only normal physiologic exercise limitation; 48 of the 74 had normal-to-high cardiovascular conditioning, and 26 had poor conditioning. Other diagnoses for reproducible EID included restrictive abnormalities in 15, vocal cord dysfunction in 13, laryngomalacia in 2, primary hyperventilation in 1, and supraventricular tachycardia in 1.

CONCLUSIONS. The diagnoses of EIA should be questioned as the etiology of EID in children and adolescents who do not have other symptoms of asthma and who do not respond to pretreatment with a β₂ agonist.

REVIEWER COMMENTS. Although asthma is the most common cause of EID, this article demonstrates the important point that not all EID is caused by asthma. Patients who experience EID but not other signs or symptoms of asthma or who do not benefit from pretreatment with an inhaled β₂ agonist clearly can benefit from a treadmill test with cardiac and respiratory physiologic monitoring. A large portion of these patients demonstrated normal physiologic limitation associated with reproduction of symptoms. Routine treatment of EID as asthma can lead to both unnecessary medication and frustration on the part of the patients and their families.

Helen Skolnick, MD
Princeton, NJ

Use of Asthma Guidelines by Primary Care Providers to Reduce Hospitalizations and Emergency Department Visits in Poor, Minority, Urban Children

PURPOSE OF THE STUDY. To determine if a standardized city-wide asthma management program delivered by pri-
Predictors of Primary Care Follow-up After a Pediatric Emergency Visit for Asthma

Harvey L. Leo

Pediatrics 2006;118;S36
DOI: 10.1542/peds.2006-0900HHH

Updated Information & Services
including high resolution figures, can be found at:
/content/118/Supplement_1/S36.2

Permissions & Licensing
Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at:
/site/misc/Permissions.xhtml

Reprints
Information about ordering reprints can be found online:
/site/misc/reprints.xhtml
Predictors of Primary Care Follow-up After a Pediatric Emergency Visit for Asthma

Harvey L. Leo

*Pediatrics* 2006;118:S36

DOI: 10.1542/peds.2006-0900HHH

The online version of this article, along with updated information and services, is located on the World Wide Web at:

/content/118/Supplement_1/S36.2