CONCLUSIONS. Spirometry may identify presumptive refractory asthma exacerbations that, instead, are episodes of VCD.

REVIEWER COMMENTS. Several years ago we treated an 8-year-old boy who had been admitted to the hospital for status asthmaticus 4 times in 1 month but never had an oxygen requirement. A videotape of the boy when he was symptomatic (provided by the parents) showed obvious stridor, not wheezing. Similarly, in this study the cardinal observation was refractory “wheeze” without arterial desaturation. Computerized spirometry is not universally available in the ED, and in addition, not all such units have software capable of displaying the inspiratory limb of the flow-volume loop. However, in busy ED environments with large asthmatic populations, availability of this measurement should greatly aid the classification of wheezing events. Pediatricians need to be more aware that VCD may present symptoms that mimic asthma.

Value of the Bronchodilator Response in Assessing Controller Naïve Asthmatic Children

PURPOSE OF THE STUDY. To define the bronchodilator response (BDR) cutoff point that best identified asthma to determine the frequency of abnormal spirometry results across severity.

STUDY POPULATION. Children with asthma (n = 346) and 51 children without asthma, aged 4 to 17 years, who met entry criteria for spirometry were identified.

METHODS. Controller-naive children were evaluated with clinical criteria alone to establish a diagnosis of asthma and severity classification and then compared with the BDR, which was calculated as the percentage change from the initial forced expiratory volume in 1 second (FEV1). Receiver operator characteristic analysis determined the cutoff point for asthma diagnosis that gave the best combination of sensitivity and specificity.

RESULTS. The mean BDR in asthmatic subjects was 8.6% (95% confidence interval: 7.5%–9.8%), compared with 2.2% (95% confidence interval: 0.2%–4.3%) for the nonasthmatic subjects (P < .001). A BDR of ≥9% best differentiated these populations with a sensitivity rate of 42.5% and a specificity rate of 86.3%. Abnormal spirometry results, defined as a BDR of ≥9%, an FEV1 of <80% predicted, or both, ranged from 44.4% for mild-intermittent bronchial asthma to 57.0% for severe-persistent bronchial asthma.

CONCLUSIONS. Spirometric criteria that include BDR can potentially identify children who have clinically mild asthma and might benefit from controller therapy.

REVIEWER COMMENTS. What a breath of fresh air (pardon the pun). Establishing a firm diagnosis of asthma in pediatric patients can be, at times, a real challenge. Clinical history, physical examination, and a low FEV1 are all very useful in the diagnosis, but there are convincing data in children showing that an isolated, baseline FEV1 is not a good measure of the presence of asthma or its severity. The findings from this investigation demonstrate that detecting bronchodilator responsiveness (ie, 9% cutoff value for improvement in FEV1 after inhaled albuterol by metered-dose inhaler or nebulizer) can certainly aid in the diagnosis of asthma in children. A prospective assessment of this cutoff value in an unselected cohort of subjects, as well as the use of a single delivery system for the inhaled albuterol, will need to be investigated further to establish this measure as a useful diagnostic test for asthma in pediatric patients. Ultimately, use of the BDR in combination with baseline FEV1 should help clinicians detect a population of children with asthma and which children would benefit the most from therapeutic interventions such as inhaled corticosteroids.

Achieving and Maintaining Asthma Control in an Urban Pediatric Disease Management Program: The Breathmobile Program

PURPOSE OF THE STUDY. This observational study evaluated the asthma control achieved in children from a lower socioeconomic urban setting with regular participation in a disease-management guideline-based program.

STUDY POPULATION. Patients aged 3 to 18 years with asthma were a self-selected, predominately Hispanic group recruited from lower socioeconomic areas of Los Angeles, California, served by the Pediatric Asthma Disease Management Program. Enrollment was from January 1, 1998, through June 30, 2006.

METHODS. The primary measure was physician-assessed asthma control based on National Heart, Lung, and Blood Institute guidelines from parent and/or patient recall. This included symptom frequency of <2 days per week and <2 nights per month for the 4-week period.
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Pediatrics 2008;122;S209
DOI: 10.1542/peds.2008-2139HHH
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