Pathway diagrams – Annex F

Fig 1 Asthma: The patient journey Asthma is diagnosed

Making the diagnosis of asthma Confirming the diagnosis may depend on history, response to treatment, measurement of airflow limitation before

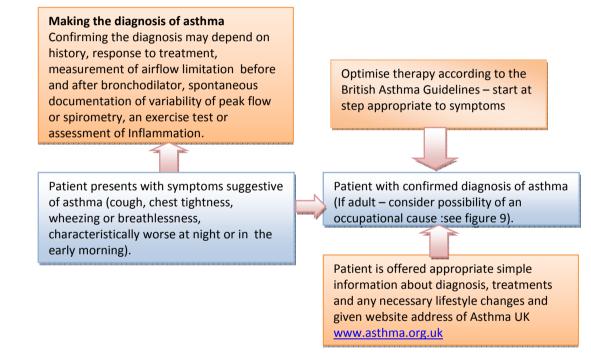
and after bronchodilator, spontaneous documentation of variability of peak flow or spirometry, an exercise test or assessment of inflammation.

Patient presents with symptoms suggestive of asthma (cough, chest tightness, wheezing or breathlessness, characteristically worse at night or in the early morning)

Diagnosis may be made by Doctor or Nurse, sometimes with assistance of Clinical Scientists

Primary or Secondary Care or Community Diagnostic Assessment Unit

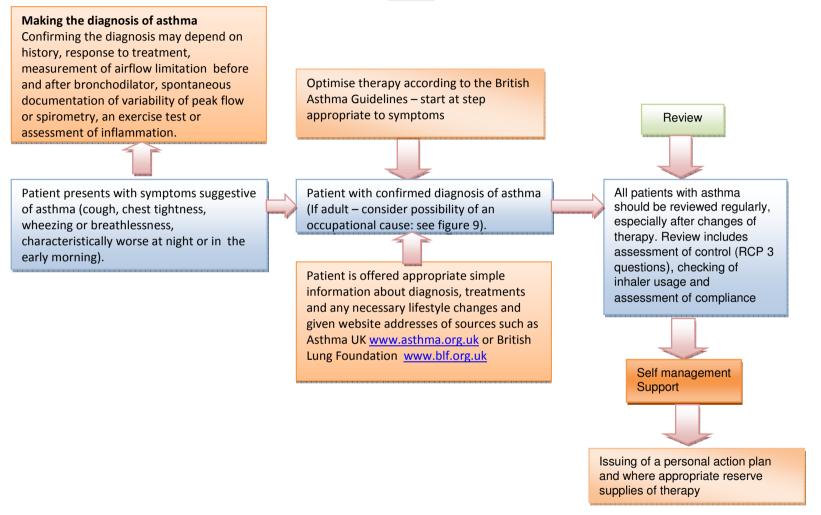
Asthma: The patient journey Fig 2 Treatment is recommended



Initial therapy would usually be instituted by the Health Care Practitioner making the diagnosis, with full consideration of the patients wishes, concerns and expectations.

Primary or secondary care

Asthma: The patient journey Fig 3 Review

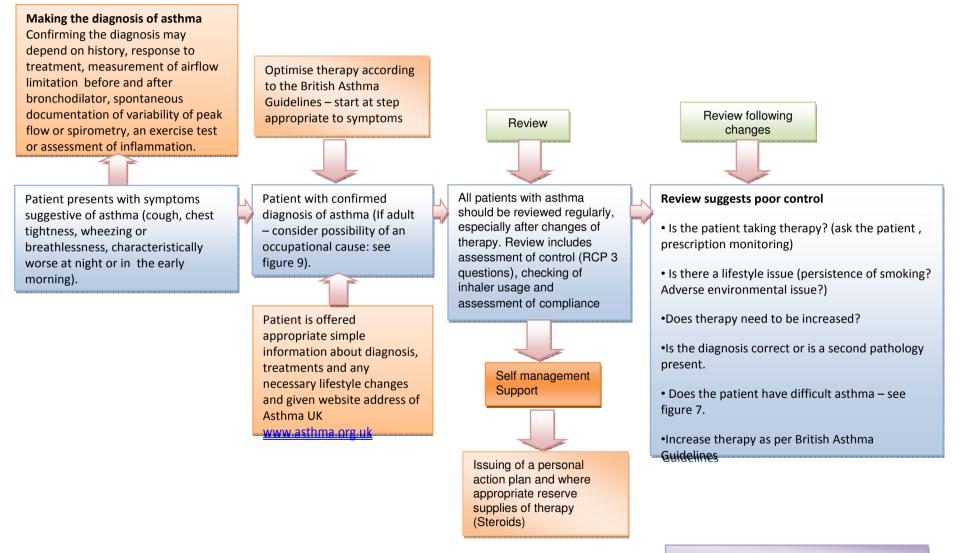


Such review maybe offered by primary care physicians, well trained nurses or lay educators or by specialists working in a hospital or an integrated care service.

Majority in Primary Care, a small number in secondary care.

School teachers, nursery assistants and other carers may need to be informed.

Asthma: The patient journey <u>Fig 4</u> Further review after treatment change



Primary care review

Specialist review may be necessary

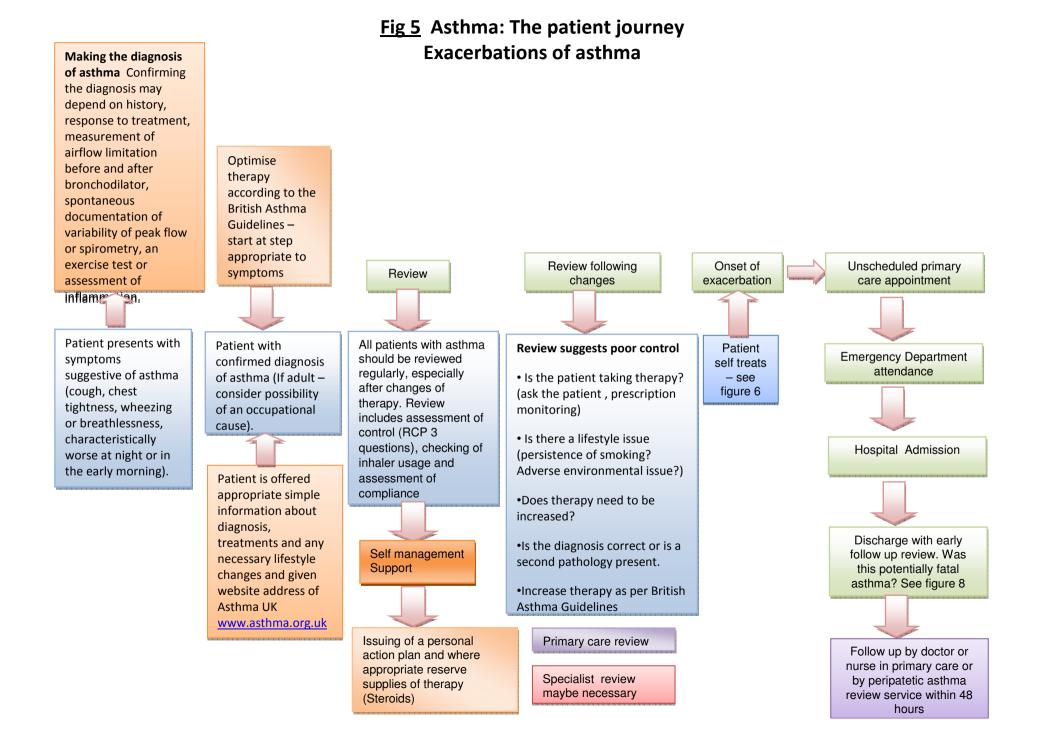


Fig 6 Asthma: The patient journey Self treatment and self management support

Patient with asthma

Aged over 5 years with asthma that is requiring step 2 or more therapies (and which is not very mild and completely controlled)

Self Management advice

 for 364 days, 23 hours and 30 minutes the patient is likely to be looking after their own condition

• They need to know usual therapy, signs that suggest worsening asthma, how to increase usual therapies, when to start reserve therapies, and when to seek urgent medical attention

Self management support involves:

• Advice being offered as per previous box.

•Prescription of reserve therapies

•Reinforcement of spoken advice with a written personalised asthma action plan (cognisant of the issue of health literacy)

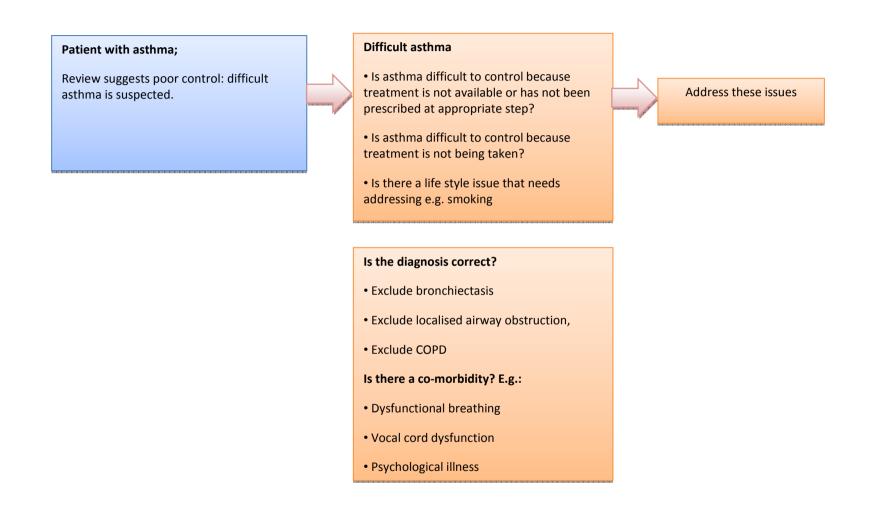
- Advice re sources of 24/7 support
- Regular review (which may be face to face or by telephone)

Support given by a knowledgeable health care provider: This may be a specialist respiratory physician, a lay educator, a primary care physician, or a nurse with a special interest and training.

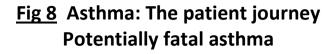
Primary or secondary care or within an integrated care service (others involved such as teachers, crèche assistants, and care home staff need to be appraised of needs.

(Others involved such as teachers, crèche assistants, and care home staff need to be appraised of needs)

Fig 7 Asthma: The patient journey Difficult asthma



Cases of difficult asthma will nearly always need specialist secondary care and may need tertiary referral to a difficult asthma centre. Such patients should be managed with a systematic proforma approach and a multidisciplinary team including specialist nurses, speech therapists, counsellors, psychologists and psychiatrists are likely to be needed.



Was this potentially fatal asthma?

Potentially fatal asthma is defined by:

- An episode of respiratory failure requiring incubation, or
- respiratory acidosis associated with an attack of asthma not requiring incubation, or
- two or more hospitalisations for asthma despite chronic use of oral steroids, or
- two episodes of pneumothorax (or pneumo-mediastinum) associated with an asthma attack.

Risk factors for potentially fatal asthma need to be addressed and these include:

- •Previous near fatal asthma (previous ventilation respiratory acidosis)
- Previous submission for asthma especially if in the last year
- requiring three or more classes or asthma medication
- heavy use of beta 2 agonist
- •repeated attendances at emergency departments for asthma care especially if in the last year
- 'brittle' asthma
- non compliance with treatment or monitoring or review
- self discharge
- psychosis, depression or other psychiatric illness
- current or recent major tranquilizer use
- denial
- alcohol or drub abuse
- obesity
- Other stresses

Cases of potentially fatal asthma should remain under life long specialist follow up.

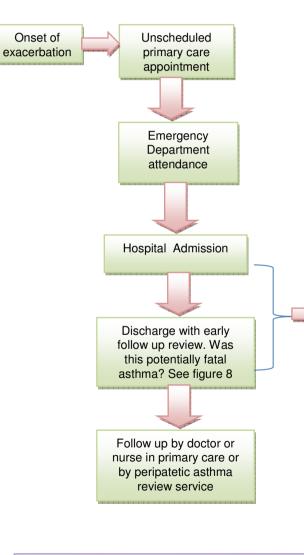


Fig 9 Asthma: The patient journey Occupational asthma

Patient with asthma;

In patients with adult onset, or reappearance of childhood asthma, clinicians should be suspicious that may be an occupational cause.

Ask the patient:

• Are your symptoms better/same/worse on days away from work?

• Are your symptoms better/same/worse on holiday?

Specialist Care, often a tertiary centre

Tertiary care: Occupational lung disease specialist