

Evidence Table 1. Assessment and Monitoring: Predictors of Exacerbation

Abbreviations used in table:

| | | | |
|------------------------|---|--------------|--|
| AAI | acute asthma index | IDR | incidence density ratio |
| AQLQ | Asthma-Related Quality of Life Questionnaire | LA | long acting |
| AR | allergic rhinitis | OCS | oral corticosteroid |
| AHR | airway hyperresponsiveness | OR | odds ratio |
| BTS | British Thoracic Society | NAG | National Asthma Guidelines |
| CAS | Clinical Asthma Score | PEF | peak expiratory flow |
| CI | confidence interval | PASS | Asthma Severity Score |
| COPD | chronic obstructive pulmonary disease | PEFR | PEF rate |
| ED | emergency department | PL | placebo |
| FEV₁ | forced expiratory volume in 1 sec | ROC | receiver operating characteristics |
| FVC | forced vital capacity | RR | relative risk |
| IBA | inhaled beta-agonist | SA | short acting |
| ICS | inhaled corticosteroid | TRUST | The Regular Use of Salbutamol Trial |
| ICU | intensive care unit | | |

Evidence Table 1. Assessment and Monitoring: Predictors of Exacerbation

| Citation (Sponsor) | Study Design | Study Population | | |
|---|--|---|--|--|
| | | Study N (Number Evaluable) | Population Characteristics | Asthma Severity at Baseline (if reported) |
| <p>Connolly et al. The Darlington and Northallerton Prospective Asthma Study: best function predicts mortality during the first 10 years. <i>Respir Med</i> 1998;92(11):1274–1280. (National Asthma Campaign, United Kingdom; Breathe North, GlaxoWellcome)</p> | <p>Prospective 10-year followup study (hospital and private clinics)</p> | <p>628</p> | <p>Age >18 yr, mean = 51.7 yr</p> <p>Gender 49.4% male, 50.6% female</p> <p>Smoking 15.6% current smokers, 38.2% exsmokers, 46.2% nonsmokers</p> | <p>Persons with asthma referred to secondary care</p> <p>Mean duration = 19.5 yr</p> <p>FEV₁ mean = 2.07 L</p> <p>PEF ≥15% reversibility to ≥200 L/min</p> <p>PEF mean = 318 L/min</p> <p>Median best function approximately 80% predicted for vital capacity and peak flow</p> <p>Treatment: 22.8% on bronchodilators alone, 7.7% on cromoglycate, 48.8% on ICS, and 20.5% on oral corticosteroids (OCS)</p> |
| <p>Lieu et al. Computer-based models to identify high-risk children with asthma. <i>Am J Respir Crit Care Med</i> 1998;157(4 Pt 1): 1173–1180. (Kaiser Permanente Innovation Program)</p> | <p>Retrospective cohort design (computerized database from a regional health maintenance organization)</p> | <p>16,520 (14,963 person-years of followup)</p> | <p>Age 0–14 yr, median 7 yr</p> <p>Gender 61% male, 39% female</p> <p>88% with outpatient copayment \$0–5; 81% with medication copayment \$0–5</p> | <p>All with asthma-related health services utilization</p> <p>3% had been hospitalized and 10% had ED visits in 12 months before start of followup period</p> <p>22% had ≥3 prescriptions filled for beta-agonists, 20% received cromolyn, 9% received ICS, and 26% received OCS</p> |
| <p>Rodrigo & Rodrigo. Early prediction of poor response in acute asthma patients in the emergency department. <i>Chest</i> 1998;114(4): 1016–1021.</p> | <p>Prospective predictive study plus validation sample (tertiary care hospital)</p> | <p>145 + validation sample of 77</p> | <p>(original sample)</p> <p>Age ≥18 yr, mean = 33.7 yr</p> <p>Gender 33.7% male, 66.3% female</p> <p>Ethnicity Not reported</p> | <p>(original sample)</p> <p>Severely asthmatic</p> <p>FEV₁ mean = 0.73 L</p> <p>FEV₁ % pred. mean = 23.6</p> <p>PEF mean 128.2 L/min</p> <p>PEF % pred. mean = 27.7</p> <p>Heart rate, mean 105.4 beats/min</p> <p>Respiratory rate, mean = 21.4 breaths/min</p> <p>Duration of attack, mean = 24.3 h</p> |

| Citation (Sponsor) | Study Design | Study Population | | |
|---|---|----------------------------|---|--|
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| Adams et al. Factors associated with hospital admissions and repeat emergency department visits for adults with asthma. Thorax 2000;55(7):566–573. (University of Adelaide, The Queen Elizabeth Hospital Research Foundation) | Longitudinal observational design | 293 (212) | <p>Age 41% 15–34 yr, 14% 35–44 yr, 15% 45–54 yr, 17% 55–64 yr, 13% 65 yr or older; mean age = 42 yr</p> <p>Gender 33% male, 67% female</p> <p>Education 46% ≤10 yr, 26% >10 yr, 28% some postschool</p> <p>Smoking 18% current smokers</p> | <p>42% moderate, 58% severe (NAEPP criteria)</p> <p>FEV₁ % pred. 30% <60%, 40% 60%–80%, 30% ≥80%</p> <p>ICS use, 80%; regular OCS use, 40%; long-acting beta-agonist use, 18%; other asthma medications, 44%</p> <p>Written asthma action plan, 55% yes</p> |
| Black et al. Sensitivity to fungal allergens is a risk factor for life-threatening asthma. Allergy 2000;55(5):501–504. | Retrospective case control | 137 | <p>Age 18–50 yr, mean = 34.7 yr</p> <p>Gender 31.4% male, 68.6% female</p> | <p>Community group: Never admitted to hospital because of asthma and never required nebulized bronchodilators</p> <p>Hospital group: admitted with acute exacerbation or treated with nebulized bronchodilators</p> <p>Intensive care: admitted to ICU with acute, severe attack of asthma</p> |
| Hoskins et al. Risk factors and costs associated with an asthma attack. Thorax 2000;55(1):19–24. (AstraZeneca Pharmaceutical) | Retrospective cohort design (393 practices in the United Kingdom) | 12,203 | <p>Age 5% <5 yr, 28% 5–15 yr, 35% 16–44 yr, 28% 45–74 yr, 4% ≥75 yr</p> <p>Gender 50% male, 50% female</p> | <p>74% on step 2 or above of the British Thoracic Society (BTS) asthma guidelines</p> <p>22% had at least 1 asthma attack during the year of data collection</p> <p>16% had poor compliance with medication</p> <p>9% had poor inhaler technique</p> |
| Cowie et al. Predicting emergency department utilization in adults with asthma; a cohort study. Journal of Asthma 2001;38(2):179–184. (Alberta, Canada, Lung Association) | Prospective cohort study | 378 (378) | <p>Age 16–85 yr, mean = 40 yr</p> <p>Gender 38% male, 62% female</p> <p>Smoking 11% current smokers 22% smoker in household</p> <p>Animals 48% animal in home</p> | <p>Duration of asthma, range 1–69 yr, mean = 16 yr</p> <p>FEV₁ % pred., mean = 79%</p> <p>beta-agonist use, 79%; mean = 4.8 doses/day</p> <p>Waking at night with asthma, 38%</p> |

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| | | Study N (Number Evaluable) | Population Characteristics | Asthma Severity at Baseline (if reported) |
| Eisner et al. Beta agonists, inhaled steroids, and the risk of intensive care unit admission for asthma. <i>Eur Respir J</i> 2001;17(2): 233–240. (National Research Service Award and NHLBI, NIH) | Retrospective cohort design (Northern California Kaiser Permanente) | 2,344 | Age >18 yr, mean = 55.5 yr Gender 31% male, 69% female Ethnicity 67% White | All hospitalized for asthma |
| Eisner et al. Risk factors for hospitalization among adults with asthma: the influence of sociodemographic factors and asthma severity. <i>Respir Res</i> 2001;2(1): 53–60. (NHLBI; National Institute for Occupational Safety and Health, Centers for Disease Control; and National Research Service Award) | Prospective longitudinal cohort study (allergy and pulmonary physician practices in Northern California) | 242 | Age 18–50 yr, mean = 40.5 yr Gender 27% male, 73% female Ethnicity 71% White, 29% non-White Smoking 7% current smokers, 36% exsmokers, 57% nonsmokers | 48% childhood onset 82% atopic history 25% hospitalization during 12 months prior to baseline or 18 months prior to 18-month followup interview SF-36 Physical component score, mean = 43.1; Mental component score mean = 44.3 |
| Ford et al. Patterns and predictors of asthma-related emergency department use in Harlem. <i>Chest</i> 2001;120(4): 1129–1135. (NHLBI, NIH) | Cross-sectional survey (Harlem Hospital Center) | 375 | Age Mean = 40 yr Gender 36% male, 64% female Ethnicity 93% Black or African American Smoking 46% current smokers, 15% exsmokers, 39% never smoked Education 59% ≥12 yr | Visited the emergency department (ED) for asthma 28% with comorbid bronchitis |

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|---|--|-------------------------------------|---|---|
| | | Study N (Number Evaluable) | Population Characteristics | Asthma Severity at Baseline (if reported) |
| Fuhlbrigge et al. FEV ₁ is associated with risk of asthma attacks in a pediatric population. J Allergy Clin Immunol 2001;107(1):61–67. (AstraZeneca Pharmaceutical and NHLBI, NIH) | Retrospective cohort design (6 U.S. cities) | 3,542 children; 31,075 observations | Age Mean = 13.0 yr (observations) Gender 51% male, 49% female (observations) Ethnicity 90.4% White (observations) | FEV ₁ % pred (observations): 0.3% ≤60% 5.5% >60%–80% 50.9% >80%–100% 43.3% >100% |
| Keogh et al. Predictors of hospitalization in children with acute asthma. J Pediatr 2001;139(2): 273–277. | Prospective cohort study (tertiary care university hospital) | 278 (172) | Age ≥1 yr, mean = 4.9 yr Gender 66% male, 34% female Ethnicity Not reported | Diagnosis of asthma or bronchodilator use or first-time wheezing if >24 months of age 10% previous ICU admission 7.3% ≥3 admissions in year SaO ₂ mean = 94.1% Clinical Asthma Score (CAS) median 6/9 |
| Leuppi et al. Predictive markers of asthma exacerbation during stepwise dose reduction of inhaled corticosteroids. Am J Respir Crit Care Med 2001;163(2):406–412. (National Health and Medical Research Council, the Australian ARDS Association, and Rhone-Poulenc Rorer, Australia) | Prospective design | 50 | Age 18–69 yr, mean = 43.7 yr Gender 48% male, 52% female Smoking 28% exsmokers | 8% severe, 22% moderate, 70% mild Duration of asthma 2.5–60 yr, mean = 24.2 yr Mean duration of ICS use = 6.2 yr ICS drug: 31% fluticasone, 51% budesonide, 18% beclomethasone Mean ICS dose = 1,344 mcg beclomethasone equivalent 30% had airway hyperresponsiveness (AHR) to histamine, 48% to mannitol, and 26% to both in run-in period. |
| Lovis et al. Elevation of creatine kinase in acute severe asthma is not of cardiac origin. Intensive Care Med 2001;27(3): 528–533. | Prospective design | 15 | Age 17–61 yr, mean = 36 yr Gender 60% male, 40% female Smoking 27% smokers | Acute severe bronchial asthma Admitted to ICU 53% had grade III asthma and 47% had grade IV FVC mean = 91% FEV ₁ % pred, mean = 77% |

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|--|---|---|---|---|
| | | Study N (Number Evaluable) | Population Characteristics | Asthma Severity at Baseline (if reported) |
| <p>Crystal-Peters et al. Treating allergic rhinitis in patients with comorbid asthma: the risk of asthma-related hospitalizations and emergency department visits. <i>J Allergy Clin Immunol</i> 2002;109(1): 57–62. (Integrated Therapeutics Groups, Inc., subsidiary of Schering Plough)</p> | <p>Retrospective cohort analysis using 1994–95 MarketScan claims data</p> | <p>4,944</p> | <p>Age 12–60 yr; 22.1% ages 12–20, 8.4% ages 21–30, 19.4% ages 31–40, 50.1% ages 41–60 Gender 36.1% male, 63.9% female</p> | <p>Diagnosed with both asthma and allergic rhinitis (AR) In prior year: ICS use, 46.6%; oral steroid use, 34.4%; theophylline use, 22.7% In prior year, 3.8% had asthma ED visit and 1.25% were hospitalized for asthma</p> |
| <p>Diette et al. Asthma in older patients: factors associated with hospitalization. <i>Arch Intern Med</i> 2002;162(10):1123–1132. (Managed Health Care Association, Washington, DC)</p> | <p>Prospective cohort design (15 managed care organizations)</p> | <p>6,590 at baseline; 4,870 at 1 year</p> | <p>Age 27% 18–34 yr, 65% 35–64 yr, 8% 65 yr or older Gender 48% male, 52% female Ethnicity 82% White, 11% Black, 7% other Smoking 45% ever smoked</p> | <p>46% sinusitis; 26% chronic bronchitis; 5% emphysema; 79% allergy or hay fever</p> |
| <p>Golan et al. Asthma in adventure travelers: a prospective study evaluating the occurrence and risk factors for acute exacerbations. <i>Arch Intern Med</i> 2002;162(21): 2421–2426.</p> | <p>Prospective study of travelers</p> | <p>203</p> | <p>Age ≥18 yr, mean = 23.9 yr Gender 50% male, 50% female Ethnicity Not reported Smoking 32% current smokers</p> | <p>76% seasonal asthma 59% diagnosed before 10 years of age 83% used bronchodilators during previous year 9% had ED visits for asthma during previous year</p> |

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|---|---|----------------------------|--|---|
| | | Study N (Number Evaluable) | Population Characteristics | Asthma Severity at Baseline (if reported) |
| Goldman et al. Within- and between-day variability of respiratory impedance, using impulse oscillometry in adolescent asthmatics. <i>Pediatr Pulmonol</i> 2002;34(4):312–319. (NIH/NCRR/RCMI Clinical Research Infrastructure and Clinical Center of Research Excellence) | Clinical trial; testing of single group on 3 consecutive days | 24 | Age 10–17 yr, mean = 12.7 yr Gender 50% male, 50% female | Varied from mild intermittent to severe persistent Stable drug regimen and well-controlled at time of testing FEV ₁ 1.3–5.4 L, mean = 2.89 L FEV ₁ % pred 49–106, = mean 88.3 FVC 1.9–6.9 L, mean = 3.45 L FEV ₁ /FVC 55%–95%, mean = 83.1% |
| Hartert et al. Risk factors for recurrent asthma: hospital visits and death among a population of indigent older adults with asthma. <i>Ann Allergy Asthma Immunol</i> 2002;89(5):467–473. (American Federation of Aging Research, Foundation for Fellows in Asthma Research, American Lung Association, Agency for Healthcare Research and Quality, and Geriatric Research Education and Clinical Center Department of Veterans Affairs) | Retrospective cohort analysis | 510 | Age 51% ages 65–74, 36% ages 75–84, 13% age ≥85 Gender 21% male, 79% female Ethnicity 73% White, 20% Black, 7% other/unknown Smoking 17% current smoker, 60% noncurrent smoker, 24% unknown Comorbidities 56% chronic heart disease, 10% depression, 14% diabetes, 9% cancer, 50% hypertension | All required hospital care for asthma. 19% intermittent, 67% moderate-to-severe persistent, 14% near-fatal asthma None required asthma hospital visits during previous year. 62% with definite and 38% with probable asthma 53% of those with confirmed asthma also had recorded diagnosis of chronic obstructive pulmonary disease (COPD). |
| Kelly et al. Patients with a longer duration of symptoms of acute asthma are more likely to require admission to hospital. <i>Emerg Med (Fremantle)</i> 2002;14(2):142–145. [Asthma Snapshot 2000 group] | Prospective observational design (20 EDs throughout Australia) | 381 (348) | Age 1–60 yr Gender Not reported | Moderate or severe (NAG) |

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|---|--|----------------------------|--|--|
| | | Study N (Number Evaluable) | Population Characteristics | Asthma Severity at Baseline (if reported) |
| <p>Weber et al. A prospective multicenter study of factors associated with hospital admission among adults with acute asthma. <i>Am J Med</i> 2002;113(5):371–378. (MARC supported by National Institutes of Health, GlaxoWellcome Inc., and Monaghan Medical Corp, Syracuse, NY)</p> | <p>Secondary data analysis from 4 prospective cohort studies (64 EDs in 21 U.S. States and 4 Canadian provinces)</p> | <p>1,805</p> | <p>Age ≥18 yr, mean = 35 yr</p> <p>Gender 35% male, 65% female</p> <p>Ethnicity 7.6% White, 62.5% Black, 26.9% Hispanic, 3.0% other</p> <p>Smoking 35% current smokers</p> | <p>Acute asthma</p> <p>61% ever hospitalized for asthma</p> <p>29% admitted for asthma in past year</p> <p>Systemic corticosteroids during past 4 weeks: 85% not on oral steroids, 6% on chronic steroids, 6% on short-course oral steroids</p> <p>Inhaled beta-agonists during past 4 weeks: 86%</p> <p>ICS during past 4 weeks: 44%</p> <p>Use of home nebulizer during past 4 week:, 29%</p> <p>Other asthma medications during past 4 weeks: 37%</p> |
| <p>Wilson et al. A prospective evaluation of the 1-hour decision point for admission versus discharge in acute asthma. <i>J Intensive Care Med</i> 2003;18(5):275–285. (Program for Healthcare Innovation, U. of Massachusetts Medical Center)</p> | <p>Prospective preintervention and postintervention comparison</p> | <p>50</p> | <p>Age 6–48 yr, mean = 24 yr</p> <p>Gender 38% male, 62% female</p> <p>Smoking 32% current smokers</p> | <p>Acute asthma</p> <p>Mean duration of asthma = 12 yr</p> <p>Regular outpatient monitoring of PEFr by 40%</p> <p>4% with prior history of intubation for acute asthma</p> |

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|---|---|-----------------------------------|--|--|
| | | Study N (Number Evaluable) | Population Characteristics | Asthma Severity at Baseline (if reported) |
| <p>Belessis et al. Risk factors for an intensive care unit admission in children with asthma. <i>Pediatr Pulmonol</i> 2004;37(3):201–209.</p> <p>(Sydney, Australia, Children’s Hospital Foundation Fellowship)</p> | Case-control design | 141 (141) | <p>Age Mean = 5.3 yr; 62% 1–4 yr, 24% 5–9 yr, 14% 10–15 yr</p> <p>Gender 80% male, 20% female</p> <p>Ethnicity 74% White 26% other</p> <p>Other 47% with bronchiolitis 12% born prematurely 55% breast-fed 6 months 19% mother smoked during pregnancy; 22% mother smoked after pregnancy 86% first-degree relatives with asthma, eczema, or hay fever</p> | <p>Oxygen saturation on presentation, mean = 92; 38% were $\leq 91\%$</p> <p>Median time from onset of asthma to receiving bronchodilator, 2 hours</p> <p>Median time from onset to visiting doctor, 10 hours</p> <p>Median time from onset to receiving oral steroid, 12 hours</p> |
| <p>Gorelick et al. Difficulty in obtaining peak expiratory flow measurements in children with acute asthma. <i>Pediatr Emerg Care</i> 2004;20(1):22–26.</p> <p>(Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services)</p> | Observational, prospective cohort study (2 EDs) | 1,221 ED1, n=852 ED2, n=369 | <p>Age 1–18 yr, mean = 7.0 (ED1) and 5.9 (ED2)</p> <p>Gender 61% male, 39% female</p> <p>Ethnicity (ED1) 7.8% White, 89.9% African American, 0.8% Hispanic, 1.5% other (ED2) 23.3% White, 15.7% African American, 60.2% Hispanic, 0.8% other</p> | <p>(ED1) 66.5% mild intermittent, 17.5% mild persistent, 9.1% moderate persistent, 3.9% severe persistent</p> <p>(ED2) 49% mild intermittent, 26% mild persistent, 21% moderate persistent, 4% severe persistent</p> <p>Use of bronchodilators: 17% regular use and 83% use as needed</p> |

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|--|---|--|--|---|
| | | Study N (Number Evaluable) | Population Characteristics | Asthma Severity at Baseline (if reported) |
| Kelly et al. Is severity assessment after one hour of treatment better for predicting the need for admission in acute asthma? <i>Respir Med</i> 2004;98(8):777–781. (Commonwealth Department of Health and Aged Care, Australia) | Prospective, observational study (36 EDs in Australia) | 720 | Age 1–55 yr, 62% under 16 yr Gender 56% male, 44% female Ethnicity Not reported | Acute asthma 60% mild, 36% moderate, 4% severe (NAG classification) |
| Tierney et al. Assessing symptoms and peak expiratory flow rate as predictors of asthma exacerbations. <i>J Gen Intern Med</i> 2004;19(3):237–242. (Agency for Healthcare Research and Quality) | Analysis of data gathered as part of a randomized controlled trial of a pharmaceutical care intervention (36 commercial drug stores randomly assigned) | 660 | Age >17 yr, mean = 45 yr Gender 18% male, 82% female Ethnicity 81% White, 17% Black, 2% other | Had prescription filled for a breathing medication in previous 3 months 3% had asthma-related ED or hospitalization in month prior to enrollment PEFR mean = 351 L/min % pred. PEFR 71 Overall mean Asthma Quality of Life Questionnaire mean item score = 4.4 out of 7.0 |
| Yurk et al. Predicting patient-reported asthma outcomes for adults in managed care. <i>Am J Manag Care</i> 2004;10(5):321–328. (Managed Health Care Association Outcomes Management System Asthma Project) | Prospective cohort design (16 managed care organizations in the United States) | 4,888 (10,539 in original study; study sample of 4,888 completed both baseline and 1-year questionnaires) | Age >17 yr, mean = 45 yr Gender 31% male, 69% female Ethnicity 83% White, 13% Black, 4% other Smoking 46% current or former smokers | Moderate-to-severe asthma 39% had hospitalization or ED visit in previous 2 years |
| Dennis et al. Increase in daytime symptoms is a sensitive and specific criterion for predicting corticosteroid-treated exacerbations in a clinical asthma trial. <i>Clin Exp Allergy</i> 2005;35(3):308–312. | Secondary data analysis of diary card observations from a randomized controlled trial | 983 patients and more than 200,000 days of diary card observations | Age Not reported Gender Not reported | Mild-to-moderate asthma |

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|---|---|---|---|---|
| | | Study N (Number Evaluable) | Population Characteristics | Asthma Severity at Baseline (if reported) |
| <p>Frey et al. Risk of severe asthma episodes predicted from fluctuation analysis of airway function. <i>Nature</i> 2005;438(7068):667–670. (Swiss National Science Foundation and U.S. National Science Foundation)</p> | <p>Secondary time series analysis of peak expiratory flow data from a randomized, placebo-controlled, double-blind, crossover study</p> | <p>165 (80)</p> | <p>Age 19–64 yr, mean = 42.4 yr Other Nonsmokers</p> | <p>Persistent asthma</p> |
| <p>Sturdy et al. Deaths certified as asthma and use of medical services: a national case-control study. <i>Thorax</i> 2005; 60(11):909–915. (National Research and Development Asthma Management Programme, United Kingdom; National Asthma Campaign, United Kingdom, through grant from GlaxoSmithKline)</p> | <p>Case-control design</p> | <p>1064 (1,064)</p> | <p>Age Median 53 yr Gender 38% male, 62% female Other 24% family history of asthma, 58% history of smoking, 44% major nonrespiratory illness</p> | <p>Cases identified as asthma deaths; controls had primary hospital discharge diagnosis of asthma</p> |
| <p>Boychuk et al. Correlation of initial emergency department pulse oximetry values in asthma severity classes (steps) with the risk of hospitalization. <i>Am J Emerg Med</i> 2006;24(1):48–52. (The Robert Wood Johnson Foundation)</p> | <p>Multicenter prospective cohort study (6 emergency care centers, including tertiary care medical center, 2 general community hospitals, urgent care center, rural general hospital, rural clinic)</p> | <p>706 encounters in Phase I; 513 encounters in Phase 2; total of 1,008 unique patients</p> | <p>By encounters Age 54% 1–3 yr, 37% 4–11 yr, 9% 12–17 yr; mean = 4.3 yr Gender 62% male, 38% female</p> | <p>(By encounters) Diagnosed with wheezing or bronchospasm Severity classification: 45% mild intermittent (step 1), 14% mild persistent (step 2), 18% moderate persistent (step 3), 23% severe-persistent (step 4) Disposition: 85% discharged home, 15% hospitalized In previous 4 months: 0.84 ED visits, 1.66 office visits In previous 12 months: 1.74 ED visits, 3.75 office visits Medication use before ED encounter: 64% beta agent, 11% as-needed controller medication, 13% daily controller medication</p> |

| Citation/Sponsor | Study Characteristics | | Findings | | |
|---|--|---|---------------------------------------|---|-------|
| | Purpose/Objective | Other | Admission/Emergency Department Visits | Exacerbation/Mortality | Other |
| <p>Connolly et al. The Darlington and Northallerton Prospective Asthma Study: best function predicts mortality during the first 10 years. <i>Respir Med</i> 1998;92(11): 1274–1280.</p> <p>(National Asthma Campaign, United Kingdom; Breathe North, GlaxoWellcome)</p> | <p>To follow mortality, change in best function, and treatment necessary to maintain optimal control, in the light of the socio-demographic variables and pulmonary function</p> | <p>Study began in 1983 with review and new entry at 5-year intervals.</p> | | <p>Standardized Mortality Ratio 1.47 (95% CI 1.20 to 1.71). Observed proportion of respiratory deaths was 56% (expected 10%).</p> <p>Adjusting for age and gender, OR for dying was 1.51 (95% CI 1.33–1.72) for each 10% deficit in FVC. There was no difference between smokers and nonsmokers.</p> <p>Those in worst quartile of FVC were 5.5 times more likely to die than those in the best quartile, but pattern varied with age.</p> <p>Adjusting for age and gender, first quartile FVC OR=1.80, second quartile OR 1.98, fourth quartile OR 1.18.</p> <p>Best FVC was a strong predictor of mortality in subjects <65 yr at entry.</p> | |

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|--|--|---|--|------------------------|---|
| | Purpose/Objective | Other | Admission/Emergency Department Visits | Exacerbation/Mortality | Other |
| <p>Lieu et al. Computer-based models to identify high-risk children with asthma. Am J Respir Crit Care Med 1998;157(4 Pt 1):1173–1180.</p> <p>(Kaiser Permanente Innovation Program)</p> | <p>(1) To develop and validate prediction models that use computerized data to identify children at high risk for asthma-related hospitalization or ED visits and (2) to evaluate the projected cost-effectiveness of a hypothetical asthma-management program with these models</p> | <p>Used split-sample validation with receiver operating characteristics (ROC) curves to validate the proportional hazards models.</p> | <p>Age (RR=0.90), having a personal physician listed (RR=0.64), number of prior hospitalizations (RR=1.74), number of prior ED visits (RR=1.50), number of different physicians prescribing asthma medications (RR=1.19), obtaining oral steroids (RR=1.88), and obtaining ≥ 3 units of beta-agonists (RR=1.53) were predictive of subsequent hospitalization. Classification tree identified hospitalization during prior 6 months and obtaining >6 units of beta-agonists (sensitivity of model = $32\pm 8\%$; specificity $94\pm 0.5\%$).</p> <p>Number of ED visits (RR=2.14), number of different physicians prescribing asthma medications (RR=1.31), ≥ 3 units of beta-agonists (RR=1.46), receiving oral steroids (RR=1.28), number of cromolyn units (RR=0.86), outpatient visit copayment (RR=0.96), and medication copayment (RR=1.01) were associated with subsequent ED visits. Classification tree identified ED visit during prior 6 months and ≥ 3 physicians prescribing asthma medications during prior 6 months as predictive of subsequent ED visits (sensitivity $48\pm 5\%$, specificity $82\pm 0.9\%$).</p> | | <p>In 1995, the average cost of a hospital day was approximately \$1,200; the average cost of an ED visit was \$230. Using the most inclusive prediction criteria to select hypothetical patients for intervention, 3 hospital days and 27 ED visits could be prevented at a net cost to the health plan of \$46,000 and net cost to society of \$21,000.</p> |

| Citation/Sponsor | Study Characteristics | | Findings | | |
|--|--|--|--|------------------------|---|
| | Purpose/Objective | Other | Admission/Emergency Department Visits | Exacerbation/Mortality | Other |
| Rodrigo & Rodrigo. Early prediction of poor response in acute asthma patients in the emergency department. Chest 1998;114(4): 1016–1021. | <p>To develop an acute asthma index (AAI) for early differentiation between patients with poor and good therapeutic response in the ED setting</p> <p>Poor response defined as FEV₁ ≤45% of predicted after 3 hours of treatment.</p> <p>Items on AAI: PEF at 30 minutes (0 if ≥50, 1 if 40–49, 2 if <40) and change in PEF from baseline at 30 minutes (0 if ≥90, 1 if 60–89, 2 if <60).</p> | <p>After initial assessment, patients were treated with salbutamol, 4 puffs at 10-minute intervals for 3 hours. Then, all with poor response received 500 mg IV hydrocortisone. Each received O₂ through nasal prongs at a rate of 4 L/min.</p> | <p>Thirteen (26.5%) with a score of 4 were admitted vs. 6.2% with a score of <4 (p=.012).</p> | | <p>A score of 4 on the AAI has sensitivity 0.79, specificity 0.96, area under the ROC curve 0.87, positive predictive value 0.94, negative predictive value 0.86, OR 99.6 (95% CI 25.1–541.0). In the validation sample, sensitivity was 0.80, specificity 0.88, positive predictive value 0.85, negative predictive value 0.84, and area under ROC curve 0.89.</p> <p>Of the original sample, 64.8% had a score of <4 and 35.2% had a score of 4.</p> |

| Citation/Sponsor | Study Characteristics | | Findings | | |
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| | Purpose/Objective | Other | Admission/Emergency Department Visits | Exacerbation/Mortality | Other |
| <p>Adams et al. Factors associated with hospital admissions and repeat emergency department visits for adults with asthma. <i>Thorax</i> 2000;55(7): 566–573.</p> <p>(University of Adelaide, The Queen Elizabeth Hospital Research Foundation)</p> | <p>To investigate what factors measured at baseline were associated with future hospital admissions and ED visits for asthma over a 12-month period</p> | | <p>39% admitted to hospital; 58% had ED visits.</p> <p>Adjusting for age, gender, education, income, and employment, OR (95% CI) for admission over next 12 months were moderate severity, OR=0.6 (0.2–0.9); no admission in past 12 months, OR=0.1 (0.01–0.2); no written asthma action plan, OR=4.0 (1.5–10.7); less use of avoidance coping, OR=0.4 (0.3–0.7); lower preference for autonomy in management decisions, OR=1.4 (0.96–2.0).</p> <p>Adjusted OR (95% CI) for repeated ED visits were admission in past year, OR=2.9 (1.8–4.8); moderate severity, OR=0.3 (0.1–0.8); regular use of OCS, OR=10.0 (3.1–32.4); no written asthma action plan, OR=2.2 (1.1–5.6); and less dislike of asthma medication, OR=0.7 (0.5–0.9).</p> | | |
| <p>Black et al. Sensitivity to fungal allergens is a risk factor for life-threatening asthma. <i>Allergy</i> 2000;55(5): 501–504.</p> | <p>To study the relationship between skin tests for fungal spores and admission to an intensive care unit (ICU) for asthma</p> | <p>Community sample (n=50) from disease registers of 4 general practitioners</p> <p>Hospital sample (n=50) and ICU sample (n=37) from 1 hospital</p> | | | <p>54% of ICU subjects vs. 30% of community and hospital groups were skin-test-positive for 1 or more of the fungal allergens (p=0.005).</p> <p>59.5% of ICU patients were skin-test-positive for grass mix vs. 76% in hospital and 72% in community group (p>0.05).</p> <p>51.4% of ICU patients responded to cat dander vs. 58% of community and 62% of hospital subjects (p>0.05).</p> <p>No difference in mean wheal diameter for any of the allergens.</p> |

| Citation/Sponsor | Study Characteristics | | Findings | | |
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| | Purpose/Objective | Other | Admission/Emergency Department Visits | Exacerbation/Mortality | Other |
| Hoskins et al. Risk factors and costs associated with an asthma attack. Thorax 2000;55(1):19–24. (AstraZeneca Pharmaceutical) | To identify the health service utilization patterns of a representative sample of U.K. patients with asthma observed over a 12-month period | | | <p>For those patients who were younger than 5 years of age and those 75 years of age and older, there were no factors associated with incidence of attack, but group sizes were small. For other age groups, there was a strong association between attack incidence and each of BTS treatment steps and nighttime symptoms.</p> <p>Significant risk factors were exercise-induced symptoms in the 5–15 age group and poor inhaler technique for those 16–44 years old.</p> <p>22% of patients in the attack group accounted for about 50% of total resource use costs. Average total costs per patient were 3.5 times higher (95% CI 3.2–3.87) in the attack group than in the nonattack group.</p> | |
| Cowie et al. Predicting emergency department utilization in adults with asthma: a cohort study. J Asthma 2001; 38(2)179–184. (Alberta, Canada, Lung Association) | To determine whether any initial characteristics might predict subsequent visits for treatment of asthma in an ED | Consecutive sample of individual attending an asthma clinic and education program. Cohorts were formed on the basis of emergency treatment in following 1 year (19.3% yes, 80.7% no). | <p>Factors associated with ED treatment were previous ED visits (OR=2.6, 95% CI 1.61–4.07), previous hospital admission for asthma (OR=2.4, 95% CI 1.61–3.58), initial lifestyle restriction index >3 out of 10 (OR=3.5, 95% CI 1.86–6.59), waking at night (OR=2.0, 95% CI 1.31–3.19), and using ≥1 dose beta₂-agonist per day (OR=2.2, 95% CI 1.11–4.43).</p> <p>In multivariate logistic regression, lifestyle restriction score of ≥4 (p=0.0001) and previous admission to hospital for asthma (p=0.001) were significant factors.</p> | | |

| Citation/Sponsor | Study Characteristics | | Findings | | |
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| | Purpose/Objective | Other | Admission/Emergency Department Visits | Exacerbation/Mortality | Other |
| <p>Eisner et al. Beta agonists, inhaled steroids, and the risk of intensive care unit admission for asthma. Eur Respir J 2001;17(2): 233–240.</p> <p>(National Research Service Award and NHLBI, NIH)</p> | <p>To examine the impact of ICS and inhaled beta-agonist (IBA) on the risk of ICU admission, a surrogate for life-threatening asthma exacerbation</p> | <p>Examined medications dispensed during the 3 months prior to index hospitalization.</p> | <p>12.2% (11.8–14.6%) were admitted to the ICU.</p> <p>(OR adjusted for systemic corticosteroid use, other asthma medications, and demographic characteristics) Compared to no IBA dispensing, high-level (≥ 4 units) IBA therapy was associated with increased risk of ICU admission, OR=1.4 (95% CI 1.0–2.0). Both medium- (2–3 units) and high-level IBA were associated with risk of intubation, OR=1.6 (95% CI 1.0–2.7) and 1.9 (95% CI 1.2–3.1), respectively.</p> <p>Compared to no ICS dispensing, high-level ICS dispensing (≥ 4 units) was associated with a decreased risk of ICU admission, OR=0.7 (95% CI 0.4–0.96).</p> <p>Among ICS nonusers, high-level IBA use increased risk of ICU admission, OR=1.6 (95% CI 1.02–2.4). No association between IBA use and ICU admission among ICS users.</p> | | |

| Citation/Sponsor | Study Characteristics | | Findings | | |
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| | Purpose/Objective | Other | Admission/Emergency Department Visits | Exacerbation/Mortality | Other |
| Eisner et al. Risk factors for hospitalization among adults with asthma: the influence of sociodemographic factors and asthma severity. <i>Respir Res</i> 2001;2(1):53–60. (NHLBI; National Institute for Occupational Safety and Health, Centers for Disease Control; and National Research Service Award) | To evaluate the effects of gender, race, income, and asthma severity on hospitalization, independent of health care access | | <p>16% had at least 1 hospitalization for asthma during the prospective 18-month followup period.</p> <p>Factors associated with hospitalization controlling for asthma severity were non-White race (OR 3.1, 95% CI 1.1–8.8), current smoking (OR 1.4, 95% CI 0.2–7.9), past smoking (OR 0.7, 95% CI 0.2–2.0), severity of asthma score (OR 3.4 per 5 points, 95% CI 1.7–6.8), recent asthma hospitalization (OR 8.3, 95% CI 2.1–33.4), and reliance on ED for urgent care (OR 3.2, 95% CI 1.0–9.8) based on multivariate analysis.</p> | | |

| Citation/Sponsor | Study Characteristics | | Findings | | |
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| | Purpose/Objective | Other | Admission/Emergency Department Visits | Exacerbation/Mortality | Other |
| Ford et al. Patterns and predictors of asthma-related emergency department use in Harlem. Chest 2001;120(4): 1129–1135. (NHLBI, NIH) | To assess criteria used to classify asthma severity and to test hypotheses that frequent ED use is associated with poor access to care, psychological risk factors, and asthma severity | | <p>In 12 months prior to interview, there were no differences between one-time and frequent ED users in age, gender, ethnicity, education, employment status, or annual household income.</p> <p>Persons with moderate or severe persistent asthma were more likely to be frequent ED users compared to those with mild asthma, OR=3.8 (95% CI 2.2–6.6).</p> <p>History of hospitalization for asthma, OR=2.5 (95% CI 1.2–5.5); ICU use, OR=10.0 (95% CI 1.3–72.7); and intubation, OR=4.4 (95% CI 1.3–14.6) were associated with frequent ED use.</p> <p>Controlling for asthma severity, having visited a doctor's office for asthma was associated with frequent ED use, OR=1.8 (95% CI 1.1–3.4).</p> | | Based on self-report, classification by the 3 NAEPP severity criteria for mild asthma converged for only 25% of the patients and classification by 2 criteria converged for 36% of patients. For moderate and severe persistent asthma, all 3 criteria converged for 38% of patients, and 2 criteria converged for 32% of patients. |

| Citation/Sponsor | Study Characteristics | | Findings | | |
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| | Purpose/Objective | Other | Admission/Emergency Department Visits | Exacerbation/Mortality | Other |
| <p>Fuhlbrigge et al. FEV₁ is associated with risk of asthma attacks in a pediatric population. J Allergy Clin Immunol 2001;107(1): 61–67. (AstraZeneca Pharmaceuticals and NHLBI, NIH)</p> | <p>To explore whether a relationship could be observed between FEV₁ and subsequent asthma attacks within a pediatric population</p> | <p>All first- and second-graders within 6 communities enrolled with other first-graders added until 1,500–2,000 children in each community. Children were followed for a maximum of 15 years. The sample in this study consisted of those observations for which a questionnaire could be paired with FEV₁ value. The questionnaire was completed by a parent/guardian for children up to grade 9 and in most cases by the child thereafter.</p> | | <p>FEV₁ % was associated with risk of asthma attack during the year after its measurement with a progressive decrease, in the proportion reporting an attack in association with increasing FEV₁ %.</p> <p>Within parental report group (children up to grade 9), 60.4% of observations with FEV₁ % <60 reported attack compared with only 25.4% of observations with FEV₁ % >80. A similar pattern found for self-report group (73.9% vs. 29.4%).</p> <p>Adjusting for age, gender, previous attack, and smoking, FEV₁ % OR=2.1 (95% CI 1.3–3.4) and OR=1.4 (95% CI 1.2–1.7) for FEV₁ % <60% and 60%–80%, respectively, compared to >80% for younger group; for older group, OR were 5.3 (95% CI 2.2–12.9) and 1.4 (95% CI 1.2–1.7), respectively.</p> | |

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| | Purpose/Objective | Other | Admission/Emergency Department Visits | Exacerbation/Mortality | Other |
| Keogh et al. Predictors of hospitalization in children with acute asthma. J Pediatr 2001; 139(2): 273-277. | To prospectively identify clinical predictors of the need for long duration of frequent bronchodilator therapy (i.e., hospitalization) in children ≥12 months of age presenting to the ED with an acute asthma exacerbation | Usual initial asthma therapy in ED is 3 doses of nebulized albuterol, 0.15 mg/kg, and ipratropium bromide, 250 mcg/dose. All also received oral prednisone, 2 mg/kg; oral dexamethasone, 0.3 mg/kg; or intravenous hydrocortisone, 5 mg/kg. | <p>Five predictors of need for long duration of therapy: previous ICU admission (OR 7.2, 95% CI 1.85-27.7), baseline SaO₂ ≤92% (OR 2.57, 95% CI 0.89-7.4), 4-hour SaO₂ ≤92% (OR 6.55, 95% CI 1.34-32.0), 4-hour CAS score ≥6/9 (OR 2.9, 95% CI 1.9-4.37), and 4-hour albuterol > every hour (OR 4.82, 95% 0.82-22.12) based on multivariate analysis.</p> <p>Presence of only 1 predictor associated with 40%-60% probability of long-term therapy and presence of ≥3 associated with ≥92% probability of long-term therapy.</p> <p>Of those with 4-hour SaO₂ ≤92%, 4-hour CAS score ≥6/9 and 4-hour albuterol > every hour, 97% required long-term therapy.</p> | | |

| Citation/Sponsor | Study Characteristics | | Findings | | |
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| | Purpose/Objective | Other | Admission/Emergency Department Visits | Exacerbation/Mortality | Other |
| <p>Leuppi et al. Predictive markers of asthma exacerbation during stepwise dose reduction of inhaled corticosteroids. <i>Am J Respir Crit Care Med</i> 2001;163(2): 406–412.</p> <p>(National Health and Medical Research Council, the Australian ARDS Association, and Rhone-Poulenc Rorer, Australia)</p> | <p>To identify predictors for failure of ICS dose reduction with loss of control</p> | <p>4-week run-in phase (baseline) and a dose-reduction phase in which current ICS dose was halved every 8 weeks until the patient suffered an asthma exacerbation or was weaned off ICS for 8 weeks. ICS treatment was stopped after a dose of 200 mcg of budesonide or beclomethasone or 125 mcg of fluticasone was achieved.</p> | | <p>78% suffered exacerbation of asthma—26% after first ICS dose reduction, 38% after second ICS reduction, 10% after third reduction, and 4% after fourth reduction.</p> | <p>Being hyperresponsive to both direct (histamine) and indirect (mannitol) challenge test at baseline was a significant predictor for failure at or before the second ICS reduction, OR=4.38 (95% CI 1.03–18.56). Age older than 40 years was borderline (p=0.059). Sputum eosinophils, eNO and PEF lowest percentage best were not significant.</p> <p>Survival analysis indicated hyperresponsiveness to mannitol was a predictor for failure of ICS reduction. Failure was not predicted by FEV₁ % predicted, PEF % predicted, or eNO.</p> |
| <p>Lovis et al. Elevation of creatine kinase in acute severe asthma is not of cardiac origin. <i>Intensive Care Med</i> 2001;27(3): 528–533.</p> | <p>To evaluate whether the cause of the increase of plasma creatine kinase and creatine kinase MB isoenzyme in acute severe bronchial asthma is of cardiac origin, and to determine the utility of troponin measurement in those patients</p> | | | | <p>Five of 15 patients had elevated plasma creatine kinase, 4 with an increase in creatine kinase MB isoenzyme fraction (mean = 22±6%). At admission to ICU, myoglobin and creatine kinase were correlated (r=0.76, p<0.001).</p> <p>No difference in clinical signs or symptoms, medical history, laboratory values or ECG in patients with or without creatine kinase elevation. Only arterial pH (7.41 vs. 7.31, p<0.001) and arterial PCO₂ (kPa) (5.29 vs. 6.41, p<0.006) differed significantly.</p> |

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| | Purpose/Objective | Other | Admission/Emergency Department Visits | Exacerbation/Mortality | Other |
| <p>Crystal-Peters et al. Treating allergic rhinitis in patients with comorbid asthma: the risk of asthma-related hospitalizations and emergency department visits. <i>J Allergy Clin Immunol</i> 2002; 109(1):57–62.</p> <p>(Integrated Therapeutics Groups, Inc., subsidiary of Schering Plough)</p> | <p>To assess the relationship between prescription medication use for the treatment of allergic rhinitis (AR) and subsequent asthma-related ED visits and hospitalizations for patients with AR and comorbid asthma</p> | <p>Analysis variables constructed using the 1995 claims experience of patients included in the 1994 analytical sample. The study period was defined as time between January 1, 1995, and first asthma-related ED visit or hospitalization or December 31, 1995.</p> | <p>The incidence density ratio (IDR) for risk of asthma-related event for those treated with AR was 0.49 (p=0.001).</p> <p>Predictors of asthma hospitalization or ED visit were treatment for AR (IDR 0.53, p=0.0001), ≥ 7 beta-agonists (IDR 2.2, p=0.0001), ≥ 7 inhaled steroids (IRD 0.52, p=0.05), use of theophylline (IDR 1.88, p=0.0007), use of cromolyn (IDR 1.48, p=0.043), 1 ED visit (IDR 5.82, p=0.0001), ≥ 2 ED visits (IDR 7.76, p=0.0001), and ≥ 1 inpatient stay (IDR 4.14, p=0.0001) based on multivariate Poisson regression.</p> | | |
| <p>Diette et al. Asthma in older patients: factors associated with hospitalization. <i>Arch Intern Med</i> 2002;162(10): 1123–1132.</p> <p>(Managed Health Care Association, Washington, DC)</p> | <p>To determine whether quality of care was less favorable for older adults and whether patient characteristics such as symptom severity and comorbid illness explain the different age-related rates of hospitalization in patients enrolled in managed care</p> | <p>Multiple conditional imputations used for missing data</p> | <p>Older patients were more likely to be hospitalized during followup year than were younger patients (14% vs. 7%, p<0.001).</p> <p>Being female OR=1.8 (95% CI 1.3–2.4); Black OR=1.8 (95% CI 1.3–2.4) or other nonwhite OR=2.0 (95% CI 1.2–3.3); less educated, less physically healthy OR=0.99 (95% CI 0.98–0.99); and with more severe asthma symptoms OR=1.5 (95% CI 1.4–1.7) were associated with future hospitalization in multivariate analysis.</p> | | <p>Older adults had higher asthma symptom score (2.9 vs. 2.7, p<0.001) and reported more concomitant lung conditions (p<0.001).</p> <p>Older patients were less likely to report difficulty reaching a physician by telephone (p<0.001), difficulty getting an appointment (p<0.001), or getting medications (p<0.001).</p> <p>Older patients were more likely to use medications including theophylline (51% vs. 32%), inhaled ipratropium bromide (22% vs. 6%), oral beta-agonists (37% vs. 23%), and OCS (37% vs. 15%) (all p<0.001).</p> <p>Older patients were more likely to report receiving information about severe flareup (61% vs. 49%, p<0.001), use peak flow meter daily (28% vs. 12%, p<0.001), and less likely to use asthma medications for worsening of symptoms.</p> |

| Citation/Sponsor | Study Characteristics | | Findings | | |
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| | Purpose/Objective | Other | Admission/Emergency Department Visits | Exacerbation/Mortality | Other |
| Golan et al. Asthma in adventure travelers: a prospective study evaluating the occurrence and risk factors for acute exacerbations. Arch Intern Med 2002;162(21): 2421–2426. | To define the patterns of asthma during travel and to identify pretravel and intratravel risk factors for exacerbation | Subjects visited a single travel clinic in Tel Aviv, Israel, for pretravel consultation. | | | 43% had asthma attacks during travel with 5.4% reporting life-threatening attacks. Controlling for length of travel, inhaled bronchodilator use ≥ 3 times/week (RR 3.35, 95% CI 1.75–6.39) and participation in intensive physical exertion during treks (RR 2.04, 95% CI 1.04–3.98) were associated with asthma attacks during travel based on multivariate analysis. With both risk factors present, RR increased to 5.52 (95% CI 2.81–10.84). |
| Goldman et al. Within- and between-day variability of respiratory impedance, using impulse oscillometry in adolescent asthmatics. Pediatr Pulmonol 2002;34(4): 312–319. (NIH/NCRR/RCMI Clinical Research Infrastructure and Clinical Center of Research Excellence) | To assess the reproducibility of replicate spirometric indices and respiratory impedance with forced oscillation, using impulse oscillometry measures at a single sitting and serial data over 3 consecutive days, comparing inspiratory with expiratory R and X and to assess the effects of hand support of cheeks | Testing occurred on 3 consecutive days 1–3 hours after morning medications; all subjects were bronchodilated at time of testing. | | | There was no difference in spirometric data from day to day ($p > 0.05$). Significant differences from day-to-day in mean IOS R5 ($p < 0.03$), R5–R15 ($p < 0.004$), and AX ($p < 0.0001$), but not in X5. Day-to-day differences in inspiratory R5 were significant ($p < 0.002$), but those for expiratory R5 ($p > 0.07$) were not. For those with asthmatic airflow obstruction, significant difference between inspiratory and expiratory R5 (0.46 and 0.53 kPa/Lps, respectively) averaging 3 consecutive days ($p < 0.0001$). |

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| | Purpose/Objective | Other | Admission/Emergency Department Visits | Exacerbation/Mortality | Other |
| <p>Hartert et al. Risk factors for recurrent asthma: hospital visits and death among a population of indigent older adults with asthma. <i>Ann Allergy Asthma Immunol</i> 2002; 89(5):467–473.</p> <p>(American Federation of Aging Research, Foundation for Fellows in Asthma Research, American Lung Association, Agency for Healthcare Research and Quality, and Department of Veterans Affairs)</p> | <p>To determine whether an initial hospital visit for asthma was associated with an increase in use of inhaled corticosteroids (ICS) at discharge and to identify risk factors for recurrent asthma hospital visits and death</p> | <p>Cohort assembled from persons enrolled in Tennessee Medicaid program with discharge diagnosis of asthma in 1992 and no hospitalization or ED visit for asthma in the previous year. Subjects were followed to death, recurrent hospital visit for asthma, or 1 year.</p> | <p>23% had recurrent hospital visits for asthma during followup period (32% ED and 68% hospitalization). Mean time to recurrent visit = 115 days. Risk factors were disease severity (RR for moderate-to-severe 1.92, 95% CI 1.01–3.66; RR for near-fatal 2.28, 95% CI 1.01–5.13) and ICS use at time of discharge (RR 1.69, 95% CI 1.02–2.77).</p> | <p>12% died during followup; mean time to death = 161 days. Risk factors were disease severity (RR for moderate-to-severe 2.99, 95% CI 1.07–8.32; RR for near-fatal 4.44, 95% CI 1.34–14.69), male (RR 2.03, 95% CI 1.15–3.57), and cancer (RR 2.29, 95% CI 1.08–4.85).</p> | |
| <p>Kelly et al. Patients with a longer duration of symptoms of acute asthma are more likely to require admission to hospital. <i>Emerg Med (Fremantle)</i> 2002;14(2): 142–145.</p> <p>(Asthma Snapshot 2000 group)</p> | <p>To determine whether, for patients with moderate or severe asthma presenting to EDs, there is a difference in need for hospitalization between those with duration of symptoms less than 6 hours and those with a longer duration of symptoms</p> | | <p>Patients with duration of symptoms more than 6 hours were more likely to require hospital admission or transfer (57% vs. 26%, $p < 0.0001$). Relative risk of hospital admission or transfer for patients with duration of symptoms of more than 6 hours compared with those less than 6 hours was 2.2 (95% CI 1.5–3.2).</p> | | |

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| <p>Weber et al. A prospective multicenter study of factors associated with hospital admission among adults with acute asthma. Am J Med 2002;113(5): 371–378. (MARC supported by National Institutes of Health, GlaxoWellcome Inc., and Monaghan Medical Corp, Syracuse, NY)</p> | <p>To determine which patient factors were associated with hospital admission among adults with asthma exacerbations who presented to the ED, and whether disposition followed consensus recommendations</p> | <p>Admissions included 307 admitted to inpatient units and 56 to observation units. Public hospitals accounted for 36% of the sites with the remaining private not-for-profit hospitals.</p> | <p>Overall admission rate was 20% with 49% for those with severe exacerbations, 23% for those with moderate exacerbations, and 8% for those with mild exacerbations. Female gender (OR 2.1), Black race (OR 2.0), use of home nebulizer (OR 2.7), recent chronic steroids (OR 2.2), recent short-course steroids (OR 2.5), initial respiratory rate (OR 1.3 per 5 breaths/min), initial PEF (OR 1.4 per 10% predicted increase), final PEF (OR 2.5 per 10% predicted decrease), and beta-agonist use in ED (OR 1.4) increased likelihood of admission. Area under the ROC curve was 0.91. Results were consistent among types and locations of hospitals.</p> | | <p>Among patients discharged from the ED, 5% relapsed within 72 hours. Mean PEF was 79% predicted in those who relapsed vs. 76% in those who did not relapse (p=0.39).</p> |

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| Wilson et al. A prospective evaluation of the 1-hour decision point for admission versus discharge in acute asthma. J Intensive Care Med 2003; 18(5):275–285. (Program for Healthcare Innovation, U. of Massachusetts Medical Center) | (1) To evaluate the 1-hour decision point for discharge or admission for acute asthma, (2) to compare this decision point to the admission recommendations of the Expert Panel Report–2 guidelines, and (3) to develop a model for predicting need for admission in acute asthma | Patients were randomly assigned to receive albuterol either by metered-dose inhaler or by updraft nebulizer in a double-blind, placebo-controlled manner. Treatments were repeated every 20 minutes with a minimum of 3 and a maximum of 6 treatments. | 22% were admitted to the hospital, 68% were discharged successfully to home from the ED, and 32% were discharged and relapsed. Patients successfully discharged differed only in FEV ₁ , accessory muscle use, and the ability to lie flat without dyspnea (p<0.01). Maximal accuracy of the admit versus discharge decision occurred at 1 hour of therapy based on FEV ₁ plus ability to lie flat without dyspnea (sensitivity 97.1%, specificity 62.5%). Predictive index is based on points assigned to degree of airway obstruction and ability to lie flat without dyspnea. Mean area under the curve for 1,500 bootstrap samples was 0.86 (95% CI 0.804–0.916). The model developed performed better than EPR–2 guidelines (p=0.0054). | | |

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| | Purpose/Objective | Other | Admission/Emergency Department Visits | Exacerbation/Mortality | Other |
| <p>Belessis et al. Risk factors for an intensive care unit admission in children with asthma. <i>Pediatr Pulmonol</i> 2004;37(3): 201–209. (Sydney, Australia, Children’s Hospital Foundation Fellowship)</p> | <p>To investigate risk factors for acute severe asthma needing an ICU admission</p> | <p>Cases (n=70) were admitted to the ICU with acute severe asthma; controls (n=71) were admitted to a general medical ward with an acute asthma exacerbation. Cases and controls matched on ethnicity, medical insurance status, premorbid conditions, and prevalence of asthma, eczema, or hay fever in first-degree relatives.</p> | <p>Univariate predictors of ICU admission were lower oxygen saturation on presentation (90 vs. 94, p=0.001), frequent episodic/persistent asthma (p=0.01), multiple prior hospital admissions (p=0.01), admission to the general ward in the last year (p=0.003), ≥3 ED presentations in previous year (p=0.01), longer duration of asthma (p=0.010), maternal education (p=0.004), and IgE score (p=0.05).</p> <p>In multivariate analysis, predictors of admission were IgE level (OR 1.001, 95% CI 1.000–1.002), duration of asthma (OR 1.019, 95% CI 1.003–1.036), ≥3 ED presentations in previous year (OR 4.649, 95% CI 1.671–12.931), and oxygen saturation on presentation ≤91% (OR 9.005, 95% CI 2.077–39.042).</p> | | |

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| | Purpose/Objective | Other | Admission/Emergency Department Visits | Exacerbation/Mortality | Other |
| Gorelick et al. Difficulty in obtaining peak expiratory flow measurements in children with acute asthma. <i>Pediatr Emerg Care</i> 2004;20(1): 22–26. (Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services) | To evaluate the reliability, validity, and responsiveness of a new clinical asthma score, the Pediatric Asthma Severity Score (PASS) Three item PASS: wheezing, prolonged expiration, and work of breathing Two additional items: air entry and mental status | Children were treated for acute asthma in 2 urban, academic pediatric EDs. All received inhaled albuterol in the ED with a mean of 3.3 treatments/patient; 36% received at least 1 dose of inhaled ipratropium bromide, and 78% were given systemic corticosteroids. | 32% at ED1 were admitted and 62% at ED2 were admitted. | | Interobserver reliability was good to excellent (weighted kappa 0.79, 0.81, and 0.83 for three-, four-, and five-item score). Validity: Correlation of PASS with PEF from 0.22 to 0.42 and with pulse oximetry from 0.28 to 0.47. Discrimination between patients admitted and discharged and between those requiring and not requiring admission had c-statistics >0.8. Responsiveness: Ability of change in score to categorize patients by disposition had c-statistic of 0.79 for 5 items and 0.81 for 3 and 4 items. |
| Kelly et al. Is severity assessment after one hour of treatment better for predicting the need for admission in acute asthma? <i>Respir Med</i> 2004; 98(8):777–781. (Commonwealth Department of Health and Aged Care, Australia) | To determine if severity assessment after 1 hour of treatment is better than assessment at presentation for predicting the requirement for hospital admission for ED patients presenting with acute asthma | | Less than 20% mild at either time were admitted. Initial assessment as moderate was poor predictor of need for admission (57% admitted, 43% discharged); 84% assessed as moderate at 1 hour required admission. More than 85% assessed as severe at either time required admission. Only 25% initially severe but 42% severe at 1 hour required ICU admission. | | |

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| <p>Tierney et al. Assessing symptoms and peak expiratory flow rate as predictors of asthma exacerbations. J Gen Intern Med 2004;19(3): 237–242. (Agency for Healthcare Research and Quality)</p> | <p>To investigate ability of peak expiratory flow rate (PEFR) and asthma-related quality of life questionnaire (AQLQ) scores to predict asthma-related ED visits and hospitalizations.</p> | | | <p>Neither PEFR nor predicted maximum PEFR were significant univariate predictors of exacerbations within either 4 months or 12 months of baseline. PEFR <50% was a significant predictor of exacerbations within 12 months of enrollment (p=0.027) in univariate, but not multivariate analysis.</p> <p>In multivariate analysis, lower overall score on AQLQ predicted exacerbation within 4 months (p=0.005) and 12 months (p<0.001). Exacerbation in months prior to enrollment was predictor of subsequent exacerbation within 4 months (p<0.001) and 12 months (p<0.001).</p> <p>Patient with overall AQLQ >5.0 was almost 3 times more likely to have exacerbation during the 12 months than a patient with a score of <4.0 (p<0.001).</p> | |

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| <p>Yurk et al. Predicting patient-reported asthma outcomes for adults in managed care. Am J Manag Care 2004;10(5): 321–328. (Managed Health Care Association Outcomes Management System Asthma Project)</p> | <p>To develop a brief set of patient-reported questions that could be used to predict a broad array of outcomes, including severe symptoms, reduced activities, ED use, and hospitalization</p> | <p>Potential predictors were identified from the literature and clinical judgment: demographic characteristics, generic health status, asthma-specific health status, asthma treatment, asthma service use, and access to care. Outcome indicators were (1) hospitalization, (2) ED treatment, (3) reduced activities for ≥7 days due to asthma or missed work ≥5 days in past month and (4) ≥ five asthma attacks/week in past month or symptoms most of time between attacks.</p> | | | <p>Twenty-one items were retained in the final 5 risk models with between 4 and 11 predictors significant in various 1-year outcomes. Strongest predictors were comorbidity and prior ED use. Areas under the ROC curve ranged from 0.67 to 0.78 with no significant variation for sex, race, and education for those younger than 65 years of age.</p> <p>A scoring system to capture patient risk includes: non-White race, < college education, younger than 34 years of age or older than 65 years of age, female gender, history of myocardial infarction or emphysema or chronic bronchitis, history of ulcer or gastrointestinal bleeding, ED visit for asthma in past 12 months, physician visit within past 6 months, asthma affected activities in past 4 weeks, asthma attacks >1/week in past 4 weeks, symptoms some days between asthma attacks, self-rated general health as poor or fair, and methylxanthine treatment in past 4 weeks.</p> |

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| Dennis et al. Increase in daytime symptoms is a sensitive and specific criterion for predicting corticosteroid-treated exacerbations in a clinical asthma trial. Clin Exp Allergy 2005;35(3): 308–312. | To determine which diary card variables are the most predictive for administration of additional courses of corticosteroids using The Regular Use of Salbutamol Trial (TRUST) data set | Patients were randomized to receive salbutamol or placebo and were followed for 12 months with an average followup of 8.5 months. Patients recorded morning and evening PEF, daytime and night-time symptoms, use of rescue inhaled beta ₂ -agonists, additional corticosteroid usage, visits to the doctor or hospital for asthma and days off work/school for asthma. | | <p>(OR adjusted for age, sex, inhaled steroid level, baseline values and accounted for clustering within patient.)</p> <p>Increase in daytime symptoms of 2 to 5 units over baseline associated with increase in odds of starting course of oral corticosteroids (OR 4.34 to 60.62) and increase of 1 to 5 units for inhaled corticosteroids (OR 2.52 to 26.1).</p> <p>Increase in night-time symptoms and increase in rescue beta₂-agonist use not associated with oral corticosteroid use.</p> <p>Increase in starting oral corticosteroids with fall in evening PEF of more than 20% vs. no change in PEF (OR 4.85, 95% CI 1.56–20.3, p<0.05) but no relationship to starting inhaled corticosteroids.</p> <p>No relationship to starting either oral or inhaled corticosteroids in response to fall of 20% or more in morning PEF.</p> | |

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| <p>Frey et al. Risk of severe asthma episodes predicted from fluctuation analysis of airway function. <i>Nature</i> 2005;438(7068): 667–670.</p> <p>(Swiss National Science Foundation and U.S. National Science Foundation)</p> | <p>To examine whether the statistical and correlation properties of the time series of PEF recordings can be used to predict the risk of subsequent exaggeration of airway instability</p> | <p>Twice daily, PEFs were obtained in 3 t-month treatment periods comparing regular short-acting beta₂-agonist (albuterol 400 mcg 4 times daily; SA) and regular long-acting beta₂-agonist (salmeterol, 50 mcg twice daily; LA) with those of matching placebo (PL) period.</p> | | | <p>Time series of PEF show substantial fluctuations, especially in SA period. Compared with PL, the distribution of PEF in LA period shifts to higher values consistent with improved airway function.</p> <p>Means of individual PEF series averages are higher ($p<0.001$) in LA than either SA or PL period, and those in SA are higher than in PL period. Variability of PEF series is higher in SA than either LA or PL period ($p<0.005$) and lower in LA than in PL period ($p=0.001$).</p> <p>Detrended fluctuation function indicates SA fails to increase the mean PEF, increases variability of PEF, and alters correlations of PEF to become more random.</p> <p>Probability that moderate airflow obstruction occurs within 30 days decreases from almost 100% at initial PEF values <200 L/min to 10–30% for initial PEF values >550 L/min depending on treatment period. For any PEF, LA decreases the risk as compared with PL ($p<0.004$) and SA ($p<0.02$).</p> <p>Albuterol increases risk of future moderate or severe airflow obstruction beyond that with PL especially for near normal values of PEF.</p> |
| <p>Sturdy et al. Deaths certified as asthma and use of medical services: a national case-control study. <i>Thorax</i> 2005;60: 909–915.</p> <p>(National Research and Development Asthma Management Programme, United Kingdom; National Asthma Campaign, United Kingdom, through grant from GlaxoSmithKline)</p> | <p>To examine the use of health services in previous 5 years of cases (asthma deaths) and controls</p> | <p>Cases identified as asthma death from death certificate; live hospital controls discharged with primary diagnosis of asthma matched on admission date (index date) and age selected from hospitals where asthma deaths occurred.</p> | | | <p>Length of time between last general practice contact and index data was 86.5 days for cases and 48.3 days for controls ($p<0.001$).</p> <p>Cases had significantly fewer general practice contacts (OR 0.90, 95% CI 0.84 to 0.98, $p=0.009$ per 5 contacts) and respiratory consultations (OR 0.85, 95% CI 0.75 to 0.96, $p=0.006$ per 5 consultations) in past year.</p> <p>Cases had more home visits in past year for respiratory illness (OR 1.12, 95% CI 1.04 to 1.20, $p<0.001$ per visit) and for nonrespiratory illness (OR 1.19, 95% CI 1.09 to 1.32, $p<0.001$ per visit).</p> <p>(Adjusted for gender and mutual adjustment) In the year before index data, 5 additional general practice contacts were associated with 18% lower risk of asthma death, an additional home visit with a 14% higher risk, and an additional PEF taken in last 3 months associated with 17% lower risk.</p> |

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| <p>Boychuk et al. Correlation of initial emergency department pulse oximetry values in asthma severity classes (steps) with the risk of hospitalization. Am J Emerg Med 2006;24(1):8–52. (The Robert Wood Johnson Foundation)</p> | <p>To determine whether the predictive value of pulse oximetry is enhanced by the stratification of the NIH severity class groups (steps)</p> | <p>Phase I (12-month period) formed baseline study group; during phase 2 (10-month period) an active intervention consisted of an educational video to most participants while in ED and provided written asthma action plan specific for the severity classification (step) to “nearly all” patients discharged from ED.</p> | <p>From 95% to 100% oxygen saturation, hospitalization rates are similar between severity groups.</p> <p>In 93% to 94% oxygen saturation group, hospitalization rate is 43% in step 4 compared with 27%, 24%, and 13% for steps 1, 2, and 3, respectively, but differences are not significant.</p> <p>At values of 90% and below, hospitalization rates are higher, number of patients in each step category is smaller, and there is no significant difference between categories.</p> | | |