

# Asthma

## Asthma: diagnosis and monitoring of asthma in adults, children and young people

*Clinical Guideline*

*Appendices A - R*

*July 2017*

*Draft for consultation*

*Commissioned by the National Institute for  
Health and Care Excellence*

**Disclaimer**

Healthcare professionals are expected to take NICE clinical guidelines fully into account when exercising their clinical judgement. However, the guidance does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of each patient, in consultation with the patient and/or their guardian or carer.

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**Funding**

National Institute for Health and Care Excellence

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# Appendices

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## Appendix A: Scope

FINAL SCOPE

### NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

#### SCOPE

##### **1 Guideline title**

Asthma: diagnosis and monitoring of asthma in adults, children and young people

##### **1.1 Short title**

Asthma: diagnosis and monitoring

##### **2 The remit**

The Department of Health has asked NICE: 'to prepare a guideline on the diagnosis and management of asthma'.

##### **3 Clinical need for the guideline**

##### **3.1 Epidemiology**

- a) Asthma is a chronic inflammatory respiratory disease that can affect people of any age but often starts in childhood. It is characterised by attacks of breathlessness and wheezing, with the severity and frequency of attacks varying from person to person. The attacks are associated with variable airflow obstruction within the lung, which is often reversible with or without treatment.
- b) The World Health Organization estimates that worldwide 235 million people suffer from asthma and that it is the most common chronic condition affecting children. In the UK 5.4 million people are receiving treatment for asthma, including 1.1 million children.
- c) Studies of adults diagnosed with asthma suggest that up to 30% do not have clear evidence of asthma. Some may have had asthma in

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the past, but it is likely that many have been given an incorrect diagnosis.

- d) The causes of asthma are not well understood. A combination of risk factors is associated with the condition. Risk factors include both genetic (the condition clusters in families) and environmental (such as inhalation of allergens or chemical irritants) influences. Occupational causes of asthma in adults are often unrecognised.

### **3.2 *Current practice***

- a) Asthma is diagnosed principally on the basis of a careful history taken by an experienced clinician. Initial clinical assessment includes questions about symptoms (wheezing, cough, breathing and chest problems) and any personal or family history of allergies, atopic disorders or asthma. Various tests can be used to support a diagnosis, but there is no single test that serves as a gold standard.
- b) A number of methods and assessments are available to determine the likelihood of asthma. These include measures of airflow obstruction (spirometry and peak flow) and measures of reversibility with bronchodilators, both of which are widely used in current practice. However, normal results do not exclude asthma and abnormal results could be indicators of other respiratory diseases.
- c) Testing for airway inflammation is increasingly used as a diagnostic strategy in clinical practice. This includes measuring sputum eosinophil counts and fractional exhaled nitric oxide (FeNO). However, there is some uncertainty about both the sensitivity and specificity of FeNO, particularly whether it can distinguish general atopy from asthma.
- d) Other diagnostic strategies include blood or skin prick tests to detect allergic reactions to environmental influences, exercise tests to detect evidence of bronchoconstriction, and measures of airway

hyper-reactivity, such as histamine/methacholine PC20 and mannitol challenge. However, it is debatable which test or measure, or combination- of them, is the most effective to accurately diagnose asthma.

- e) It is recognised that asthma control is suboptimal in many people with asthma. This has an impact on their quality of life, their use of healthcare services and the associated costs. Asthma control can be monitored by measuring airway inflammation and by using validated questionnaires, but the most effective monitoring strategy is uncertain.

#### **4 The guideline**

The guideline development process is described in detail on the NICE website (see section 6, 'Further information').

This scope defines what the guideline will (and will not) examine, and what the guideline developers will consider.

It is based on the referral from the Department of Health, but now covers the diagnosis and monitoring of asthma and excludes other aspects of management. This is because there is evidence that incorrect diagnosis is a significant problem whereas management of correctly diagnosed asthma is straightforward in most cases. Also, NICE technology appraisal guidance covers some of the available asthma therapies. In the future NICE will consider whether further guidance on asthma covering the aspects omitted from the current scope is needed.

The areas that will be addressed by the current guideline are described in the following sections.

#### **4.1 Population**

##### **4.1.1 Groups that will be covered**

- a) Adults, children and young people who are being investigated for suspected asthma, or who have been diagnosed with asthma and are having their condition monitored.
- b) Specific consideration will be given to subgroups based on age, broadly divided into younger children, older children, and older people (aged over 75 years).

#### **4.2 Healthcare setting**

- a) Primary, secondary and community care settings in which NHS-funded care is provided.

#### **4.3 Diagnosis and monitoring**

##### **4.3.1 Key clinical issues that will be covered**

###### **Diagnosis**

###### *Initial clinical assessment*

- a) The value of specific signs and symptoms in making a diagnosis of asthma. For example, wheezing, cough, breathlessness and other respiratory symptoms including diurnal and seasonal variations; symptoms in response to exercise; and symptoms after taking drugs such as aspirin, other non-steroidal anti-inflammatory drugs and beta-blockers.
- b) The value of a family or personal history of atopic disorders in making a diagnosis of asthma.
- c) Case identification of occupational asthma.

###### *Objective tests*

The value of the following tests in making a diagnosis of asthma:

- d) Measures of lung function and airway obstruction including spirometry/flow volume loop, peak expiratory flow (PEF) variability,

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bronchodilator response (using PEF or forced expiratory volume in 1 second), and measures of airway hyper-reactivity, such as histamine/methacholine PC20 and mannitol challenge.

- e) Biomarkers of airway inflammation and allergy: skin tests for the common aero-allergens, serum total IgE, peripheral blood eosinophil count and FeNO.
- f) Measures of exercise-induced bronchoconstriction.

**Monitoring**

- g) Assessment of asthma control using self- or parental reports such as symptom scores or diaries, and validated asthma control questionnaires such as the asthma control test (ACT), the children's asthma control test (CACT), the asthma control questionnaire-7 (ACQ-7), and the Royal College of Physicians 3 (RCP3) questions.
- h) Use of tele-healthcare as a route for assessment.
- i) Monitoring adherence.
- j) Inhaler technique.
- k) Assessment of asthma control using tests such as measures of pulmonary function (for example, spirometry and peak expiratory flow meters) and measures of airway hyper-reactivity.
- l) Assessments of asthma control using tests or measures such as FeNO.

**4.3.2 Clinical issues that will not be covered**

- a) Tertiary care setting.
- b) Severe, difficult to control asthma.
- c) Sputum cell counts.



- d) Treating asthma.

#### **4.4 Main outcomes**

- a) Objective response to treatment.
- b) Accuracy of diagnostic tests.
- c) Frequency of asthma attacks.
- d) Need for oral corticosteroids and short-acting beta-agonists.
- e) Unscheduled use of healthcare services.
- f) Health-related quality of life.
- g) Time off school or work.

#### **4.5 Economic aspects**

Developers will take into account both clinical and cost effectiveness when making recommendations involving a choice between interventions. A review of the economic evidence will be conducted and analyses will be carried out as appropriate. The preferred unit of effectiveness is the quality-adjusted life year (QALY), and the costs considered will usually only be from an NHS and personal social services (PSS) perspective. Further detail on the methods can be found in 'The guidelines manual' (see 'Further information').

#### **4.6 Status**

##### **4.6.1 Scope**

This is the final version of the scope.

##### **4.6.2 Timing**

The development of the guideline recommendations will begin in August 2013.

## 5 Related NICE guidance

### 5.1 *Published guidance and quality standards*

- [Omalizumab for the treatment of severe persistent allergic asthma in children aged 6 and over and adults](#) (review of TA133 and TA201) NICE technology appraisal guidance TA278 (2013).
- [Quality standard for asthma](#). NICE quality standard 25 (2013).
- [Bronchial thermoplasty for severe asthma](#). NICE interventional procedure guidance 419 (2012).
- [Roflumilast for the management of severe chronic obstructive pulmonary disease](#). NICE technology appraisal guidance 244 (2012).
- [Chronic obstructive pulmonary disease \(updated\)](#). NICE clinical guideline 101 (2009).
- [Respiratory tract infections](#). NICE clinical guideline 69 (2008).
- [Inhaled corticosteroids for the treatment of chronic asthma in adults and in children aged 12 years and over](#). NICE technology appraisal guidance 138 (2008).
- [Inhaled corticosteroids for the treatment of chronic asthma in children under the age of 12 years](#). NICE technology appraisal guidance 131 (2007).
- [Inhaler devices for routine treatment of chronic asthma in older children \(aged 5–15 years\)](#). NICE technology appraisal guidance 38 (2002).
- [Guidance on the use of inhaler systems \(devices\) in children under the age of 5 years with chronic asthma](#). NICE technology appraisal guidance 10 (2000).

### 5.2 *Guidance under development*

NICE is currently developing the following related guidance (details available from the NICE website).

- Measuring fractional exhaled nitric oxide concentration in asthma – NIOX MINO, NIOX VERO and NObreath. NICE diagnostic assessment programme. Publication expected April 2014.

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- Bronchiolitis: diagnosis and management of bronchiolitis in children. NICE clinical guideline. Publication expected April 2015.

## **6 Further information**

Information on the guideline development process is provided in the following documents, available from the NICE website:

- How NICE clinical guidelines are developed: an overview for stakeholders' the public and the NHS
- [The guidelines manual](#).

Information on the progress of the guideline will also be available from the [NICE website](#).

## Appendix B: Declarations of interest

The 2007 version of the NICE code of practice for declaring and dealing with conflicts of interest policy was applied to this guideline.

### Andrew Menzies-Gow (GDG Chair)

Date	Item declared	Classification	Action taken
GDG1 (29.7.13)	Received payment for attending advisory boards for Roche, NAPP, Boehringer Ingelheim and Novartis.	Non-specific personal pecuniary	Declare and participate
	Received lecture fees for presenting and chairing education meetings from Novartis, Glaxo SmithKline and NAPP.		
	Royal Brompton and Harefield NHS Foundation Trust received payment from Glaxo SmithKline, Novartis and Roche for participation in phase II and III studies on severe asthma where Andrew Menzies-Gow is the principal investigator.	Non-specific non-personal pecuniary – (monitoring questionnaires review) ACT and CACT developed by GSK but both are freely available (non-profit making).	Declare and participate
	Holds one current grant from Asthma UK.		
	Member of the BTS severe asthma network and BTS asthma SAG.	Personal non-pecuniary	Declare and participate
	Andrew Menzies-Gow resigned position on the BTS/SIGN asthma guidelines.		
GDG2 (3.9.13)	Received payment for advisory board attendance for Amgen who are trialling a novel monoclonal antibody for use in severe asthma, October 2013.	Non-specific personal pecuniary	Declare and participate
GDG3 (8.10.13)	No change to existing declarations.	n/a	n/a
GDG4 (19.11.13)	No change to existing declarations.	n/a	n/a
GDG5&6 (27.1.14 & 28.1.14)	Attended advisory boards for Roche on Lebrikizumab in severe asthma, January and February 2014.	Non-specific personal pecuniary	Declare and participate
GDG7 (3.3.14)	Presented on specialist commissioning of severe asthma at 4 meetings for	Non-specific personal pecuniary	Declare and participate

Date	Item declared	Classification	Action taken
	Novartis. Presented at 2 meetings in Denmark on severe asthma for Novartis. Attended Gulf Thoracic Society in UAE, sponsored by Novartis.		
GDG8 (8.4.14)	No change to existing declarations.	n/a	n/a
GDG9 (13.5.14)	Two presentations to primary care on the use of Flutiform in asthma, sponsored by NAPP. One presentation on specialist commissioning of severe asthma services sponsored by Novartis.	Non-specific personal pecuniary	Declare and participate
GDG10 (16.6.14)	No change to existing declarations.	n/a	n/a
GDG11 (22.7.14)	Attended one advisory board for Boehringer Ingelheim discussing the use of Tiotropium in severe asthma.  Received lecture fees from NAPP for talking about the use of Flutiform in asthma.  Received lecture fees from Glaxo SmithKline for talking about Real Life clinical trials and the Salford Lung Study  Received lecture fees from Chiesi for talking about the Management of Severe Asthma	Non-specific personal pecuniary  Non-specific personal pecuniary  Non-specific personal pecuniary  Non-specific personal pecuniary	Declare and participate
GDG12 (2.9.14)	Filmed for Boehringer Ingelheim on the use of Tiotropium in severe asthma.	Non-specific personal pecuniary	Declare and participate
GDG13 (7.10.14)	Lecture fees for a presentation on severe asthma for Boehringer Ingelheim Lecture fees for a pro con debate on severe asthma for Novartis Lecture fees for a presentation on treatment options for severe asthma and severe asthma workshop for severe asthma for Boehringer-Ingelheim	Non-specific personal pecuniary	Declare and participate
GDG14 (30.3.15)	Received speaker fees from Glaxo SmithKline, Novartis, Astra Zeneca and Boehringer Ingelheim for speaking about new treatment options for asthma. Attended an advisory board for Roche discussing novel therapies for severe asthma	Non-specific personal pecuniary	Declare and participate
GDG15 (9.5.17)	Attended advisory boards and or received lecture fees from: Astra Zeneca, Glaxo SmithKline, Teva, Napp, Mundi Pharma, Novartis, Boehringer	Non-specific personal pecuniary	Declare and participate

Date	Item declared	Classification	Action taken
	<p>Ingelheim, Vectura and Hoffman La Roche.</p> <p>Attended international conferences with Napp and Boehringer Ingelheim.</p> <p>Participated in clinical studies for which my institution has been reimbursed with Glaxo SmithKline, Hoffman La Roche and Boehringer Ingelheim.</p> <p>Consultancy agreements with Astra Zeneca and Vectura.</p>		

**John Alexander**

Date	Item declared	Classification	Action taken
GDG1 (29.7.13)	None	n/a	n/a
GDG2 (3.9.13)	No change to existing declarations.	n/a	n/a
GDG3 (8.10.13)	No change to existing declarations.	n/a	n/a
GDG4 (19.11.13)	No change to existing declarations.	n/a	n/a
GDG5&6 (27.1.14 & 28.1.14)	Received lecture fee from GSK for lecture to GPs.	Non-specific personal pecuniary – (monitoring questionnaires review) ACT and CACT developed by GSK but both are freely available (non-profit making).	Declare and participate
GDG7 (3.3.14)	No change to existing declarations.	n/a	n/a
GDG8 (8.4.14)	No change to existing declarations.	n/a	n/a
GDG9 (13.5.14)	No change to existing declarations.	n/a	n/a
GDG10 (16.6.14)	No change to existing declarations.	n/a	n/a
GDG11 (22.7.14)	<p>Paid lecture on RSV for Abbvie.</p> <p>Paid advisory board on preventing RSV admissions by Abbvie.</p>	<p>Non-specific personal pecuniary</p> <p>Non-specific personal pecuniary</p>	Declare and participate
GDG12 (2.9.14)	No change to existing declarations.	n/a	n/a

Date	Item declared	Classification	Action taken
GDG13 (7.10.14)	No change to existing declarations.	n/a	n/a
GDG14 (30.3.15)	No change to existing declarations.	n/a	n/a
GDG15 (9.5.17)	No change to existing declarations.	n/a	n/a

**Tara Burn**

Date	Item declared	Classification	Action taken
GDG1 (29.7.13)	None	n/a	n/a
GDG2 (3.9.13)	No change to existing declarations.	n/a	n/a
GDG3 (8.10.13)	No change to existing declarations.	n/a	n/a
GDG4 (19.11.13)	No change to existing declarations.	n/a	n/a
GDG5&6 (27.1.14 & 28.1.14)	No change to existing declarations.	n/a	n/a
GDG7 (3.3.14)	No change to existing declarations.	n/a	n/a
GDG8 (8.4.14)	No change to existing declarations.	n/a	n/a
GDG9 (13.5.14)	No change to existing declarations.	n/a	n/a
GDG10 (16.6.14)	No change to existing declarations.	n/a	n/a
GDG11 (22.7.14)	No change to existing declarations.	n/a	n/a
GDG12 (2.9.14)	No change to existing declarations.	n/a	n/a
GDG13 (7.10.14)	No change to existing declarations.	n/a	n/a
GDG14 (30.3.15)	No change to existing declarations.	n/a	n/a
GDG15 (9.5.17)	Did not participate.	n/a	n/a

**Erol Gaillard**

Date	Item declared	Classification	Action taken
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Date	Item declared	Classification	Action taken
GDG1 (29.7.13)	One research grant for £3000 from Novartis.	Non-personal pecuniary	Declare and participate
	Newly appointed member to the SIGN/BTS Asthma Guideline Development Group.	Personal non-pecuniary	
GDG2 (3.9.13)	No change to existing declarations.	n/a	n/a
GDG3 (8.10.13)	No change to existing declarations.	n/a	n/a
GDG4 (19.11.13)	No change to existing declarations.	n/a	n/a
GDG5&6 (27.1.14 & 28.1.14)	No change to existing declarations.	n/a	n/a
GDG7 (3.3.14)	Research collaboration with MedImmune a biotech firm with links to AstraZeneca. No direct payments to Erol Gaillard or his research group.	Personal non-pecuniary	Declare and participate
	Member of the SIGN/BTS Asthma Guideline Development Group.	Personal non-pecuniary	
GDG8 (8.4.14)	No change to existing declarations.	n/a	n/a
GDG9 (13.5.14)	No change to existing declarations.	n/a	n/a
GDG10 (16.6.14)	No change to existing declarations.	n/a	n/a
GDG11 (22.7.14)	No change to existing declarations.	n/a	n/a
GDG12 (2.9.14)	No change to existing declarations.	n/a	n/a
GDG13 (7.10.14)	No change to existing declarations.	n/a	n/a
GDG14 (30.3.15)	No change to existing declarations.	n/a	n/a
GDG15 (9.5.17)	Received grants and consultancy paid to his institution from Vertex and Boehringer Ingelheim.	Specific non-personal pecuniary	Declare and withdraw for FeNO and the HE model but can answer questions on request by the Chair.
	Has research grants from Astra Zeneca and Circassia.		



**Catherine Lawlor**

Date	Item declared	Classification	Action taken
GDG1 (29.7.13)	<p>Paid honoraria by Teva for position on “Integrated Care advisory board” May 2013.</p> <p>Paid honoraria by British Lung Foundation for development of “Train the Trainer COPD and Self Management” programme May / June 2013.</p> <p>PCRS-UK executive and PCRS-UK Nurse committee and receive Loss of Earnings payment plus travel expenses.</p>	Non-specific personal pecuniary	Declare and participate
	<p>Pending fee from British Lung Foundation for providing COPD training to GPs and Nurses in Hertfordshire.</p> <p>Honoraria received from TEVA for attending advisory meeting.</p> <p>Honoraria received from Almirall for attending nurse group meeting.</p> <p>Pending fee from RTA training for asthma update presentation for school nurses.</p>	Non-specific personal pecuniary	Declare and participate
GDG2 (3.9.13)	No change to existing declarations.	n/a	n/a
GDG3 (8.10.13)	No change to existing declarations.	n/a	n/a
GDG4 (19.11.13)	No change to existing declarations.	n/a	n/a
GDG5&6 (27.1.14 & 28.1.14)	No change to existing declarations.	n/a	n/a
GDG7 (3.3.14)	No change to existing declarations.	n/a	n/a
GDG8 (8.4.14)	No change to existing declarations.	n/a	n/a
GDG9 (13.5.14)	No change to existing declarations.	n/a	n/a
GDG10 (16.6.14)	No change to existing declarations.	n/a	n/a
GDG11 (22.7.14)	No change to existing declarations.	n/a	n/a
GDG12 (2.9.14)	No change to existing declarations.	n/a	n/a
GDG13 (7.10.14)	No change to existing declarations.	n/a	n/a

Date	Item declared	Classification	Action taken
GDG14 (30.3.15)	No change to existing declarations.	n/a	n/a
GDG15 (9.5.17)	Did not participate.	n/a	n/a

**Val Hudson**

Date	Item declared	Classification	Action taken
GDG1 (29.7.13)	None	n/a	n/a
GDG2 (3.9.13)	Husband was commissioned by North Durham Clinical Commissioning Group (in shadow form) to carry out a piece of work on developing public and patient involvement in the CCG. This has now finished.	Personal family interest	Declare and participate
GDG3 (8.10.13)	No change to existing declarations.	n/a	n/a
GDG4 (19.11.13)	No change to existing declarations.	n/a	n/a
GDG5&6 (27.1.14 & 28.1.14)	No change to existing declarations.	n/a	n/a
GDG7 (3.3.14)	No change to existing declarations.	n/a	n/a
GDG8 (8.4.14)	Attended a 1-hour Boehringer Ingelheim training event for their medical and marketing staff in Berlin. Received accommodation and travel expenses but no other reimbursements	Reasonable travel expenses	Declare and participate
GDG9 (13.5.14)	No change to existing declarations.	n/a	n/a
GDG10 (16.6.14)	No change to existing declarations.	n/a	n/a
GDG11 (22.7.14)	No change to existing declarations.	n/a	n/a
GDG12 (2.9.14)	No change to existing declarations.	n/a	n/a
GDG13 (7.10.14)	No change to existing declarations.	n/a	n/a
GDG14 (30.3.15)	No change to existing declarations.	n/a	n/a
GDG15 (9.5.17)	No change to existing declarations.	n/a	n/a

### Angela Key

Date	Item declared	Classification	Action taken
GDG1 (29.7.13)	None	n/a	n/a
GDG2 (3.9.13)	No change to existing declarations.	n/a	n/a
GDG3 (8.10.13)	No change to existing declarations.	n/a	n/a
GDG4 (19.11.13)	No change to existing declarations.	n/a	n/a
GDG5&6 (27.1.14 & 28.1.14)	No change to existing declarations.	n/a	n/a
GDG7 (3.3.14)	No change to existing declarations.	n/a	n/a
GDG8 (8.4.14)	No change to existing declarations.	n/a	n/a
GDG9 (13.5.14)	No change to existing declarations.	n/a	n/a
GDG10 (16.6.14)	No change to existing declarations.	n/a	n/a
GDG11 (22.7.14)	No change to existing declarations.	n/a	n/a
GDG12 (2.9.14)	No change to existing declarations.	n/a	n/a
GDG13 (7.10.14)	No change to existing declarations.	n/a	n/a
GDG14 (30.3.15)	No change to existing declarations.	n/a	n/a
GDG15 (9.5.17)	Did not participate.	n/a	n/a

### Matthew Masoli

Date	Item declared	Classification	Action taken
GDG1 (29.7.13)	None	n/a	n/a
GDG2 (3.9.13)	Received support from GSK to attend the EACCI conference in Milan (June 2013) and with Novartis for the ERS annual conference (Sept 2012). Support included registration and accommodation.  In June 2013 received payment from GSK to do a talk on 'asthma control' as part of an allergy study day for GPs and practice nurses.	Non-specific personal pecuniary – (monitoring questionnaires review) ACT and CACT developed by GSK but both are freely available (non-profit making).	Declare and participate
GDG3 (8.10.13)	No change to existing declarations.	n/a	n/a

Date	Item declared	Classification	Action taken
GDG4 (19.11.13)	No change to existing declarations.	n/a	n/a
GDG5&6 (27.1.14 & 28.1.14)	No change to existing declarations.	n/a	n/a
GDG7 (3.3.14)	No change to existing declarations.	n/a	n/a
GDG8 (8.4.14)	Speaker fee for an educational talk and workshop to healthcare professionals on 'reducing emergency asthma admissions' for a severe asthma study day sponsored by Novartis. March 2014.	Non-specific personal pecuniary	Declare and participate
GDG9 (13.5.14)	Spoken presentation at a severe asthma symposium sponsored by Novartis in March 2014.	Non-specific personal pecuniary	Declare and participate
GDG10 (16.6.14)	No change to existing declarations.	n/a	n/a
GDG11 (22.7.14)	No change to existing declarations.	n/a	n/a
GDG12 (2.9.14)	No change to existing declarations.	n/a	n/a
GDG13 (7.10.14)	No change to existing declarations.	n/a	n/a
GDG14 (30.3.15)	No change to existing declarations.	n/a	n/a
GDG15 (9.5.17)	No change to existing declarations.	n/a	n/a

### Melanie McFeeters

Date	Item declared	Classification	Action taken
GDG1 (29.7.13)	<p>Received speaker fees, expenses and hospitality from the pharmaceutical industry for both speaking and attending meetings in the past 12 months and which are planned but have not taken place yet. This includes fees for presenting educational talks to other healthcare professionals and hospitality for attending meetings and conferences related to the diagnosis and management of asthma. The companies include Abbott, Abbvie, AstraZeneca, GlaxoSmithKline, Novartis, Roche and Schering Plough.</p> <p>Member of the British Thoracic Society (BTS) and committee member of the BTS Nurse Advisory Group.</p> <p>Member of the BTS/SIGN 101 British Guideline on the Management of Asthma</p>	<p>Non-specific personal pecuniary – (monitoring questionnaires review) ACT and CACT developed by GSK but both are freely available (non-profit making).</p> <p>Personal non-pecuniary</p>	Declare and participate

Date	Item declared	Classification	Action taken
	Guideline Development Group – Organisation and Delivery of Care. RCN Member.		
GDG2 (3.9.13)	No change to existing declarations.	n/a	n/a
GDG3 (8.10.13)	No change to existing declarations.	n/a	n/a
GDG4 (19.11.13)	No change to existing declarations.	n/a	n/a
GDG5&6 (27.1.14 & 28.1.14)	No change to existing declarations.	n/a	n/a
GDG7 (3.3.14)	Speaker fee received for educational talk to Healthcare Professionals (GP & PNs) on 30/1/14. Meeting sponsored by GSK. Talk presented - Asthma management in children.  Steering committee/Advisory board meeting attended on 3/2/14 for AbbVie in preparation for the EMBRACE 2014 meeting – Prophylaxis for RSV.	Non-specific personal pecuniary	Declare and participate
GDG8 (8.4.14)	No change to existing declarations.	n/a	n/a
GDG9 (13.5.14)	No change to existing declarations.	n/a	n/a
GDG10 (16.6.14)	No change to existing declarations.	n/a	n/a
GDG11 (22.7.14)	No change to existing declarations.	n/a	n/a
GDG12 (2.9.14)	No change to existing declarations.	n/a	n/a
GDG13 (7.10.14)	No change to existing declarations.	n/a	n/a
GDG14 (30.3.15)	No change to existing declarations.	n/a	n/a
GDG15 (9.5.17)	No change to existing declarations.	n/a	n/a

## Tahmina Siddiqui

Date	Item declared	Classification	Action taken
GDG1 (29.7.13)	None	n/a	n/a
GDG2 (3.9.13)	Member of iCOPD template development group in conjunction with PCRS UK, funded by Kendle Healthcare.	Non-specific personal non-pecuniary	Declare and participate

Date	Item declared	Classification	Action taken
	Attended ERS in September 2102, also to attend a iCOPD meeting funded by Kendle Healthcare.	Non-specific personal pecuniary	
	Lead GP for COPD in Milton Keynes. Long term intervention team (LIT) chairperson Milton Keynes.	Non-specific personal non-pecuniary	
GDG3 (8.10.13)	No change to existing declarations.	n/a	n/a
GDG4 (19.11.13)	Chaired a GP study day COPD Master class on September 2013 sponsored by Almirral.  Attended 1 <sup>st</sup> COPD world Summit conference in Lisbon Sponsored by Almirral.	Non-specific personal pecuniary	Declare and participate
GDG5&6 (27.1.14 & 28.1.14)	No change to existing declarations.	n/a	n/a
GDG7 (3.3.14)	No change to existing declarations.	n/a	n/a
GDG8 (8.4.14)	No change to existing declarations.	n/a	n/a
GDG9 (13.5.14)	No change to existing declarations.	n/a	n/a
GDG10 (16.6.14)	No change to existing declarations.	n/a	n/a
GDG11 (22.7.14)	No change to existing declarations.	n/a	n/a
GDG12 (2.9.14)	No change to existing declarations.	n/a	n/a
GDG13 (7.10.14)	No change to existing declarations.	n/a	n/a
GDG14 (30.3.15)	No change to existing declarations.	n/a	n/a
GDG15 (9.5.17)	No change to existing declarations.	n/a	n/a

**Mike Thomas**

Date	Item declared	Classification	Action taken
GDG1 (29.7.13)	<p>Received honoraria for attending advisory panels from the following companies manufacturing respiratory products in the past 12 months: GlaxoSmithKline Almirall Novartis.</p> <p>Received sponsorship to attend the European Respiratory Society meeting from Napp (standard travel and hotel).</p> <p>Holds a research study funded by GSK.</p>	<p>Non-specific personal pecuniary – (monitoring questionnaires review) ACT and CACT developed by GSK but both are freely available (non-profit making).</p> <p>Non-specific non-personal pecuniary</p>	<p>Declare and participate</p>
	<p>Received an honorarium for speaking at the ERS at the Aerocrine sponsored symposium.</p>	<p>Specific personal pecuniary</p>	<p>Declare and withdraw for FeNO</p>
	<p>Received speaker’s honoraria for speaking at sponsored meetings from the following companies marketing respiratory and allergy products: Aerocrine, Astra Zeneca, Boehringer Ingelheim, GSK, MSD, Napp, Schering-Plough, Teva.</p> <p>Received honoraria for attending advisory panels with; Aerocrine, Almirall, Astra Zeneca, BI, Chiesi, GSK, MSD, Merck Respiratory, Schering-Plough, Teva, Novartis.</p> <p>Received sponsorship to attend international scientific meetings from: GSK, MSD, Astra Zeneca, Mundipharma.</p> <p>Received funding for research projects from: GSK, Almirall.</p> <p>Michael Thomas is chief medical adviser to the charity Asthma UK, a member of the BTS SIGN Asthma guideline group and a member of the EPOS Rhinosinusitis guideline group.</p>	<p>Specific personal pecuniary</p> <p>Non-specific non-personal pecuniary</p> <p>Personal non-pecuniary</p>	<p>Declare and withdraw for FeNO</p>

Date	Item declared	Classification	Action taken
	Spoke at the ERS on the use of exhaled nitric oxide in the diagnosis and management of asthma and spoke to the NICE team on this topic as an expert witness.		
	Department has received an honorarium for Michael Thomas speaking at the ERS at the Aerocrine sponsored symposium; department also received honoraria for Michael Thomas to attend an advisory board and for giving a talk at a GP educational meeting.	Specific non-personal pecuniary interest	Declare and withdraw for FeNO and the HE model but can answer questions on request by the Chair.
	Department received honoraria for producing a research study protocol for Novartis.	Non-specific non-personal pecuniary	
GDG2 (3.9.13)	No change to existing declarations.	n/a	n/a
GDG3 (8.10.13)	No change to existing declarations.	n/a	n/a
GDG4 (19.11.13)	No change to existing declarations.	n/a	n/a
GDG5&6 (27.1.14 & 28.1.14)	No change to existing declarations.	n/a	n/a
GDG7 (3.3.14)	No change to existing declarations.	n/a	n/a
GDG8 (8.4.14)	No change to existing declarations.	n/a	n/a
GDG9 (13.5.14)	No change to existing declarations.	n/a	n/a
GDG10 (16.6.14)	No change to existing declarations.	n/a	n/a
GDG11 (22.7.14)	Department received an honorarium from Aerocrine (makers of a FENO monitor) for Michael Thomas's attendance at an advisory meeting to discuss research needs in the FENO evidence, and there is discussion of a possible Horizon 2020 grant application for a multinational collaborative EU-Industry funded project.	Specific non-personal pecuniary interest	Declare and withdraw for FeNO and the HE model but can answer questions on request by the Chair.
	Department received funding from GSK as Michael Thomas is the Chief Investigator and chair of the steering committee of an international study investigating inhaler device errors.	Non-specific non-personal pecuniary	
	Received an honorarium from Boehringer Ingelheim for attendance at a meeting	Non-specific personal pecuniary	



Date	Item declared	Classification	Action taken
	organising a collaborative project with the University of Nottingham/PRIMIS to create an asthma electronic audit tool for use in general practice, and from Novartis for speaking at meeting on COPD.		
GDG12 (2.9.14)	No change to existing declarations.	n/a	n/a
GDG13 (7.10.14)	No change to existing declarations.	n/a	n/a
GDG14 (30.3.15)	No change to existing declarations.	n/a	n/a
GDG15 (9.5.17)	No change to existing declarations and previously declared conflict of interest with Aerocrine now expired.	n/a	Declare and participate

#### 1 2 NCGC team

Date	Item declared	Classification	Action taken
GDG1 (29.7.13)	In receipt of NICE commissions.  Bernard Higgins is Chair of the British Thoracic Society.	n/a  Non-specific personal non-pecuniary	n/a  Declare and participate
GDG2 (3.9.13)	No change to existing declarations.	n/a	n/a
GDG3 (8.10.13)	No change to existing declarations.	n/a	n/a
GDG4 (19.11.13)	No change to existing declarations.	n/a	n/a
GDG5&6 (27.1.14 & 28.1.14)	No change to existing declarations.	n/a	n/a
GDG7 (3.3.14)	No change to existing declarations.	n/a	n/a
GDG8 (8.4.14)	No change to existing declarations.	n/a	n/a
GDG9 (13.5.14)	No change to existing declarations.	n/a	n/a
GDG10 (16.6.14)	No change to existing declarations.	n/a	n/a
GDG11 (22.7.14)	No change to existing declarations.	n/a	n/a
GDG12 (2.9.14)	No change to existing declarations.	n/a	n/a

Date	Item declared	Classification	Action taken
GDG13 (7.10.14)	No change to existing declarations.	n/a	n/a
GDG14 (30.3.15)	No change to existing declarations.	n/a	n/a
GDG15 (9.5.17)	No change to existing declarations.	n/a	n/a

**Cochrane team**

Date	Item declared	Classification	Action taken
Initial declaration (Dec 13)	None	n/a	n/a
GDG10 (16.6.14)	No change to existing declarations.	n/a	n/a

**NIHR team**

Date	Item declared	Classification	Action taken
Initial declaration (May 14)	None	n/a	n/a
GDG12 (2.9.14)	No change to existing declarations.	n/a	n/a

# 1 Appendix C: Review protocols

## 2 C.1 Diagnosis: Signs and symptoms

3 **Table 1: Review protocol: Signs and symptoms for asthma diagnosis**

Component	Description
Review question	In people under investigation for asthma, what is the diagnostic accuracy of each of the following signs and symptoms? <ul style="list-style-type: none"> <li>• wheezing</li> <li>• cough</li> <li>• breathlessness</li> <li>• nocturnal symptoms</li> <li>• diurnal and seasonal variations</li> </ul>
Objectives	To evaluate the diagnostic accuracy of signs and symptoms in diagnosing asthma
Study design	Cross sectional studies, cohort studies, case series (including both retrospective and prospective analyses)
Population / Target condition	People with suspected asthma (presenting with respiratory symptoms). All ages, stratified into the following 3 different groups: <ul style="list-style-type: none"> <li>• Children (1-&lt;5 years old)</li> <li>• Children/young people (5-16 years old)</li> <li>• Adults (&gt;16 years old)</li> </ul>
Setting	Primary, secondary and community care settings
Index test	Signs and symptoms of asthma Each of the following symptoms alone or in combination: <ul style="list-style-type: none"> <li>• Wheezing (current or persistent or triggered)</li> <li>• Cough (including nocturnal cough)</li> <li>• Breathlessness</li> <li>• Nocturnal symptoms</li> <li>• Diurnal and seasonal variations</li> </ul>
Reference standard	Physician diagnosis of asthma based on symptoms plus an objective test from any one of the following: <ul style="list-style-type: none"> <li>• peak flow variability (cut-off value of more than 20% variability as indication of a positive test);</li> <li>• bronchodilator reversibility (cut-off value of an improvement in FEV1 of more than or equal to 12%, and an increase in volume of more than or equal to 200mls as indication of a positive test);</li> <li>• bronchial hyper-responsiveness (histamine or methacholine challenge test, cut-off value of PC20 less than or equal to 8mg/ml as indication of a positive test)</li> </ul> <p>Where no evidence is available using the cut-off values specified above, evidence will be included from studies using a reference standard of physician diagnosis with an objective test using an alternative threshold.</p> <p>Where no evidence is available from studies using physician diagnosis and an objective test, evidence will be included from studies using physician diagnosis based on symptoms alone, or patient report of a previous physician diagnosis.</p>

	In children 1-<5 years, objective tests cannot be performed so the reference standard will be physician diagnosis based on recurrent and persistent wheezing.
Outcomes	<ul style="list-style-type: none"> <li>Diagnostic accuracy (sensitivity and specificity)</li> </ul>
Other exclusions	<ul style="list-style-type: none"> <li>Not looking at occupational asthma /allergens</li> <li>Not looking at factors which influence signs/symptoms</li> <li>Due to anticipation of there being a large amount of studies retrieved from the search, the inclusion criteria was limited to studies which only look at populations in the UK, USA, Australia, Canada, New Zealand and Western Europe*. These countries were expected to be similar to the UK in terms of how people report symptoms and the impact of language. If relevant studies were identified from other review questions reporting populations outside these countries then these were included. *Western Europe = Austria, Belgium, France, Germany, Liechtenstein, Luxembourg, Monaco, Netherlands, Switzerland</li> </ul>
Search Strategy	The database to be searched are Medline, Embase, The Cochrane Library
Review Strategy	<p>Appraisal of methodological quality</p> <ul style="list-style-type: none"> <li>The methodological quality of each study will be assessed using the QUADAS-II checklist.</li> </ul> <p>Synthesis of data</p> <ul style="list-style-type: none"> <li>Diagnostic meta-analysis will be conducted where appropriate.</li> </ul> <p>If no/insufficient evidence is found we will (in order of preference):</p> <ul style="list-style-type: none"> <li>Consider unpublished or partially published studies (including abstracts – and contact the authors for more information)</li> <li>Move to GDG consensus</li> </ul>
Analysis-subgroups to investigate heterogeneity	<ul style="list-style-type: none"> <li>Different test thresholds</li> <li>Different reference standards</li> <li>Combinations of symptoms</li> </ul>

## 1 C.2 Diagnosis: History of atopic disorders

2 **Table 2: Review protocol: History of atopic disorders for asthma diagnosis**

Component	Description
Review question	In people under investigation for asthma, what is the diagnostic accuracy of taking a personal/family history of atopic disorders?
Objectives	To evaluate the diagnostic test value of taking a personal/family history of atopic disorders in diagnosing asthma
Study design	Cross sectional studies, cohort studies, case series (including both retrospective and prospective analyses)
Population / Target condition	<p>People with suspected asthma (presenting with respiratory symptoms). All ages, stratified into the following 3 different groups:</p> <ul style="list-style-type: none"> <li>Children (1-&lt;5 years old)</li> <li>Children/young people (5-16 years old)</li> <li>Adults (&gt;16 years old)</li> </ul>
Setting	Primary, secondary and community care settings

Index test	<p>Personal/family history of atopic disorders.</p> <ul style="list-style-type: none"> <li>This is likely to be ascertained by a questionnaire.</li> </ul> <p>NOTE: personal history is defined as an individual who has had one of the atopic disorders listed below</p> <p>NOTE: family history is defined as: 1<sup>st</sup> degree relatives.</p> <p>NOTE: atopic disorders are defined as: eczema, hay fever, allergic rhinitis, food allergy, asthma.</p>
Reference standard	<p>Physician diagnosis of asthma based on symptoms plus an objective test from any one of the following:</p> <ul style="list-style-type: none"> <li>peak flow variability (cut-off value of more than 20% variability as indication of a positive test);</li> <li>bronchodilator reversibility (cut-off value of an improvement in FEV1 of more than or equal to 12%, and an increase in volume of more than or equal to 200mls as indication of a positive test);</li> <li>bronchial hyper-responsiveness (histamine or methacholine challenge test, cut-off value of PC20 less than or equal to 8mg/ml as indication of a positive test)</li> </ul> <p>Where no evidence is available using the cut-off values specified above, evidence will be included from studies using a reference standard of physician diagnosis with an objective test using an alternative threshold.</p> <p>Where no evidence is available from studies using physician diagnosis and an objective test, evidence will be included from studies using physician diagnosis based on symptoms alone, or patient report of a previous physician diagnosis.</p> <p>In children 1-&lt;5 years, objective tests cannot be performed so the reference standard will be physician diagnosis based on recurrent and persistent wheezing.</p>
Outcomes	<ul style="list-style-type: none"> <li>Diagnostic accuracy (sensitivity and specificity)</li> </ul>
Other exclusions	<ul style="list-style-type: none"> <li>Not looking at occupational asthma /allergens</li> <li>Not looking at other factors which influence this</li> </ul>
Search Strategy	<p>The database to be searched are Medline, Embase, The Cochrane Library</p>
Review Strategy	<p>Appraisal of methodological quality</p> <ul style="list-style-type: none"> <li>The methodological quality of each study will be assessed using the QUADAS-II checklist.</li> </ul> <p>Synthesis of data</p> <ul style="list-style-type: none"> <li>Diagnostic meta-analysis will be conducted where appropriate.</li> </ul> <p>If no/insufficient evidence is found we will (in order of preference):</p> <ul style="list-style-type: none"> <li>Consider unpublished or partially published studies (including abstracts – and contact the authors for more information)</li> <li>Move to GDG consensus</li> </ul>
Analysis-subgroups to investigate heterogeneity	<ul style="list-style-type: none"> <li>Different reference standards</li> </ul>

## 1 C.3 Diagnosis: Symptoms after exercise

2 **Table 3: Review protocol: Symptoms after exercise for asthma diagnosis**

Component	Description
Review question	In people under investigation for asthma, what is the diagnostic accuracy of a clinical history of symptoms in response to exercise?
Objectives	To evaluate the diagnostic test value of taking a clinical history of symptoms in response to exercise in diagnosing asthma
Study design	Cross sectional studies, cohort studies, case series (including both retrospective and prospective analyses)
Population / Target condition	People with suspected asthma (presenting with respiratory symptoms). All ages, stratified into the following 3 different groups: <ul style="list-style-type: none"> <li>• Children (1- &lt;5 years old)</li> <li>• Children/young people (5-16 years old)</li> <li>• Adults (&gt;16 years old)</li> </ul>
Setting	Primary, secondary and community care settings
Index test	Clinical history of symptoms in response to exercise. NOTE: symptoms would be a combination of the following, or individual symptoms – wheezing, cough, breathlessness
Reference standard	Physician diagnosis of asthma based on symptoms plus an objective test from any one of the following: <ul style="list-style-type: none"> <li>• peak flow variability (cut-off value of more than 20% variability as indication of a positive test);</li> <li>• bronchodilator reversibility (cut-off value of an improvement in FEV1 of more than or equal to 12%, and an increase in volume of more than or equal to 200mls as indication of a positive test);</li> <li>• bronchial hyper-responsiveness (histamine or methacholine challenge test, cut-off value of PC20 less than or equal to 8mg/ml as indication of a positive test)</li> </ul> <p>Where no evidence is available using the cut-off values specified above, evidence will be included from studies using a reference standard of physician diagnosis with an objective test using an alternative threshold.</p> <p>Where no evidence is available from studies using physician diagnosis and an objective test, evidence will be included from studies using physician diagnosis based on symptoms alone, or patient report of a previous physician diagnosis.</p> <p>In children 1-&lt;5 years, objective tests cannot be performed so the reference standard will be physician diagnosis based on recurrent and persistent wheezing.</p>
Statistical measures	Diagnostic accuracy (sensitivity, specificity)
Other exclusions	<ul style="list-style-type: none"> <li>• Not occupational asthma /allergens</li> <li>• Not looking at other factors which influence signs/symptoms (this includes seasonal variation)</li> <li>• Not looking at tests in athletes or professional / specialist sports</li> <li>• Not looking at validation studies, or studies comparing different methods of measuring clinical history of symptoms after exercise.</li> </ul>

	Not looking at 'case-control' type studies where the index test is applied in people with confirmed asthma and healthy controls, and where there is no uncertainty about whether the patient has asthma or not. Such studies only include a spectrum of the disease and non-diseased patients and the diagnostic test accuracy may not be applicable to the clinical question.
Search Strategy	The database to be searched are Medline, Embase, The Cochrane Library
Review Strategy	Appraisal of methodological quality <ul style="list-style-type: none"> <li>The methodological quality of each study will be assessed using the QUADAS-II checklist.</li> </ul> Synthesis of data <ul style="list-style-type: none"> <li>Diagnostic meta-analysis will be conducted where appropriate.</li> </ul> If no/insufficient evidence is found we will (in order of preference): <ul style="list-style-type: none"> <li>Consider unpublished or partially published studies (including abstracts – and contact the authors for more information)</li> <li>Move to GDG consensus</li> </ul>
Analysis-subgroups to investigate heterogeneity	None

## 1 C.4 Diagnosis: Symptoms after using medication

2 **Table 4: Review protocol: Symptoms after using medication for asthma diagnosis**

Component	Description
Review question	In people under investigation for asthma, what is the diagnostic accuracy of a clinical history of symptoms after taking the following drugs: a) in adults - beta blockers, aspirin, or other NSAIDs b) in children – ibuprofen?
Objectives	To evaluate the diagnostic test value of taking a clinical history of worsening asthma symptoms after taking drugs (aspirin or other NSAIDs and beta blockers)?
Study Design	Cross sectional studies, cohort studies, case series (including both retrospective and prospective analyses)
Population/Target condition	People with suspected asthma (presenting with respiratory symptoms). All ages, stratified into the following 3 different groups: <ul style="list-style-type: none"> <li>Children (1-&lt;5 years old) - for ibuprofen only</li> <li>Children/young people (5-16 years old) – for ibuprofen only</li> <li>Adults (&gt;16 years old) – for beta blockers, aspirin or other NSAIDs</li> </ul>
Setting	Primary, secondary and community care settings
Index test	Clinical history of symptoms after taking drugs. NOTE: drugs of interest for the adult population are aspirin and NSAIDs, beta blockers. For children – ibuprofen. NOTE: symptoms would be a combination of the following, or individual symptoms – wheezing, cough, breathlessness, nocturnal symptoms, diurnal and seasonal variations.
Reference standard	Physician diagnosis of asthma based on symptoms plus an objective test from any one of the following: <ul style="list-style-type: none"> <li>peak flow variability (cut-off value of more than 20% variability as indication of a positive test);</li> <li>bronchodilator reversibility (cut-off value of an improvement in FEV1 of more than or equal to 12%, and an increase in volume of more than or equal to 200mls as indication of a positive test);</li> </ul>

Component	Description
	<ul style="list-style-type: none"> <li>• bronchial hyper-responsiveness (histamine or methacholine challenge test, cut-off value of PC20 less than or equal to 8mg/ml as indication of a positive test)</li> </ul> <p>Where no evidence is available using the cut-off values specified above, evidence will be included from studies using a reference standard of physician diagnosis with an objective test using an alternative threshold.</p> <p>Where no evidence is available from studies using physician diagnosis and an objective test, evidence will be included from studies using physician diagnosis based on symptoms alone, or patient report of a previous physician diagnosis.</p>
Outcomes	Diagnostic accuracy (sensitivity, specificity)
Other exclusions	Not occupational asthma /allergens Not looking at other factors which influence signs/symptoms
Search strategy	The database to be searched are Medline, Embase, The Cochrane Library
Review strategy	<p>Appraisal of methodological quality</p> <ul style="list-style-type: none"> <li>• The methodological quality of each study will be assessed using the QUADAS-II checklist.</li> </ul> <p>Synthesis of data</p> <ul style="list-style-type: none"> <li>• Diagnostic meta-analysis will be conducted where appropriate.</li> </ul> <p>If no/insufficient evidence is found we will (in order of preference):</p> <ul style="list-style-type: none"> <li>• Consider unpublished or partially published studies (including abstracts – and contact the authors for more information)</li> <li>• Move to GDG consensus</li> </ul>
Analysis-subgroups to investigate heterogeneity	None

## 1 C.5 Diagnosis: Occupational asthma

2 **Table 5: Review protocol: Occupational asthma diagnosis**

Component	Description
Review question	In adults under investigation for occupational asthma, what is the diagnostic accuracy for case identification, of asking whether their symptoms are better away from work?
Objectives	To evaluate the diagnostic test value (for identifying occupational asthma), of asking whether symptoms are better away from work?
Study design	Cross sectional studies, cohort studies, case series (including both retrospective and prospective analyses)
Population / Target condition	Adults (>16 years old) with suspected occupational asthma.
Setting	Primary, secondary and community care settings
Index test	Symptoms are better away from work.  NOTE: symptoms are defined as – wheezing, cough, breathlessness, nocturnal symptoms, diurnal variations
Reference standard	Physician’s diagnosis of occupational asthma supported by an objective test (e.g. specific inhalation challenge)



Outcomes	Diagnostic accuracy (sensitivity, specificity)
Other exclusions	
Search Strategy	The database to be searched are Medline, Embase, The Cochrane Library
Review Strategy	<p>Appraisal of methodological quality</p> <ul style="list-style-type: none"> <li>• The methodological quality of each study will be assessed using the QUADAS-II checklist.</li> </ul> <p>Synthesis of data</p> <ul style="list-style-type: none"> <li>• Diagnostic meta-analysis will be conducted where appropriate.</li> </ul> <p>If no/insufficient evidence is found we will (in order of preference):</p> <ul style="list-style-type: none"> <li>• Consider unpublished or partially published studies (including abstracts – and contact the authors for more information)</li> <li>• Move to GDG consensus</li> </ul>
Analysis-subgroups to investigate heterogeneity	Occupational differences (different causal agents)

## 1 C.6 Diagnosis: Spirometry

2 **Table 6: Review protocol: Spirometry for asthma diagnosis**

Component	Description
Review question	In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of spirometry / flow volume loop measures?
Objectives	To evaluate the diagnostic test value of spirometry / flow volume loop measures in diagnosing asthma
Study design	Cross sectional studies, cohort studies, case series (including both retrospective and prospective analyses)
Population / Target condition	People with suspected asthma (presenting with respiratory symptoms). Ages stratified into the following 2 groups: <ul style="list-style-type: none"> <li>• Children/young people (5-16 years old)</li> <li>• Adults (&gt;16 years old)</li> </ul>
Setting	Primary, secondary and community care settings
Index test	<p>Spirometry measures (report separately)</p> <ul style="list-style-type: none"> <li>• FEV1/FVC ratio (&lt;70%)</li> <li>• Flow volume loop (graph)</li> <li>• FEV1 (&lt;80%) – if limited evidence from the above two measures</li> </ul> <p>Pre bronchodilator values (applies for all above measures) FEV1 and FVC should be performed using the following criteria:</p> <ul style="list-style-type: none"> <li>• Forced expiratory volume (FEV1) - patients perform manoeuvre until 3 readings are within 5% of each other (maximum 8 attempts) the measured value being the best of these 3 readings.</li> <li>• Forced vital capacity (FVC) - patients perform manoeuvre until 3 readings are within 5% of each other (maximum 8 attempts) the measured value being the best of these 3 readings.</li> </ul>
Reference standard	<p>Physician diagnosis of asthma based on symptoms plus an objective test from any one of the following:</p> <ul style="list-style-type: none"> <li>• peak flow variability (cut-off value of more than 20% variability as indication of a positive test);</li> <li>• bronchodilator reversibility (cut-off value of an improvement in FEV1 of more than or equal to 12%, and an increase in volume of more than or equal to 200mls as indication of a positive test);</li> <li>• bronchial hyper-responsiveness (histamine or methacholine challenge test, cut-off value of PC20 less than or equal to 8mg/ml as indication of a positive test)</li> </ul> <p>Where no evidence is available using the cut-off values specified above, evidence will be included from studies using a reference standard of physician diagnosis with an objective test using an alternative threshold.</p> <p>Where no evidence is available from studies using physician diagnosis and an objective test, evidence will be included from studies using physician diagnosis based on symptoms alone, or patient report of a previous physician diagnosis.</p>
Outcomes	<ul style="list-style-type: none"> <li>• Diagnostic accuracy (sensitivity and specificity)</li> </ul>

Other exclusions	<ul style="list-style-type: none"><li>• Not looking at occupational asthma /allergens</li><li>• Not looking at validation studies, or studies comparing different spirometry or flow volume loop measures</li><li>• Not looking at factors which influence measurements</li></ul>
Search Strategy	The database to be searched are Medline, Embase, The Cochrane Library
Review Strategy	Appraisal of methodological quality <ul style="list-style-type: none"><li>• The methodological quality of each study will be assessed using the QUADAS-II checklist.</li></ul> Synthesis of data <ul style="list-style-type: none"><li>• Diagnostic meta-analysis will be conducted where appropriate.</li></ul> If no/insufficient evidence is found we will (in order of preference): <ul style="list-style-type: none"><li>• Consider unpublished or partially published studies (including abstracts – and contact the authors for more information)</li><li>• Move to GDG consensus</li></ul>
Analysis-subgroups to investigate heterogeneity	<ul style="list-style-type: none"><li>• Different reference standards</li></ul>

## 1 C.7 Diagnosis: Bronchodilator reversibility

2 **Table 7: Review protocol: Bronchodilator reversibility for asthma diagnosis**

Component	Description
Review question	In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of bronchodilator response (using PEF or FEV1)?
Objectives	To evaluate the diagnostic test value of bronchodilator response (using PEF or FEV1) in diagnosing asthma
Study design	Cross sectional studies, cohort studies, case series (including both retrospective and prospective analyses)
Population / Target condition	People with suspected asthma (presenting with respiratory symptoms). Ages stratified into the following 2 groups: <ul style="list-style-type: none"> <li>• Children/young people (5-16 years old)</li> <li>• Adults (&gt;16 years old)</li> </ul>
Setting	Primary, secondary and community care settings
Index test	Bronchodilator response, measured using the following <ul style="list-style-type: none"> <li>• PEF</li> <li>• FEV1 <ul style="list-style-type: none"> <li>○ change in FEV1 % initial and change in FEV1 litres</li> </ul> </li> </ul> <p>Exclusions:</p> <ul style="list-style-type: none"> <li>• Change in FEV1 % initial alone</li> <li>• Change in absolute litres alone</li> <li>• Change in FEV1 % predicted (<math>\Delta</math>FEV1 %pred)</li> <li>• Standardised residual (SR)-FEV1</li> <li>• Change in FEV1 % of possible maximal response (<math>\Delta</math>FEV1 %max)</li> </ul>
Reference standard	Physician diagnosis of asthma based on symptoms plus an objective test from any one of the following: <ul style="list-style-type: none"> <li>• peak flow variability (cut-off value of more than 20% variability as indication of a positive test);</li> <li>• bronchial hyper-responsiveness (histamine or methacholine challenge test, cut-off value of PC20 less than or equal to 8mg/ml as indication of a positive test)</li> </ul> <p>Where no evidence is available using the cut-off values specified above, evidence will be included from studies using a reference standard of physician diagnosis with an objective test using an alternative threshold.</p> <p>Where no evidence is available from studies using physician diagnosis and an objective test, evidence will be included from studies using physician diagnosis based on symptoms alone, or patient report of a previous physician diagnosis.</p>
Outcomes	<ul style="list-style-type: none"> <li>• Diagnostic accuracy (sensitivity and specificity)</li> </ul>
Other exclusions	<ul style="list-style-type: none"> <li>• Not occupational asthma /allergens</li> <li>• Not looking at validation studies, or studies comparing different methods of measuring the same test</li> </ul>

	<ul style="list-style-type: none"> <li>• Not looking at factors which influence measurements</li> </ul>
Search Strategy	The database to be searched are Medline, Embase, The Cochrane Library
Review Strategy	<p>Appraisal of methodological quality</p> <ul style="list-style-type: none"> <li>• The methodological quality of each study will be assessed using the QUADAS-II checklist.</li> </ul> <p>Synthesis of data</p> <ul style="list-style-type: none"> <li>• Diagnostic meta-analysis will be conducted where appropriate.</li> </ul> <p>If no/insufficient evidence is found we will (in order of preference):</p> <ul style="list-style-type: none"> <li>• Consider unpublished or partially published studies (including abstracts – and contact the authors for more information)</li> <li>• Move to GDG consensus</li> </ul>
Analysis-subgroups to investigate heterogeneity	<ul style="list-style-type: none"> <li>• Different test thresholds</li> <li>• Different reference standards</li> </ul>

## 1 C.8 Diagnosis: PEF variability

2 **Table 8: Review protocol: Peak expiratory flow (PEF) variability for asthma diagnosis**

Component	Description
Review question	In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of peak expiratory flow (PEF) variability?
Objectives	To evaluate the diagnostic test value of PEF variability in diagnosing asthma
Study design	Cross sectional studies, cohort studies, case series (including both retrospective and prospective analyses)
Population / Target condition	<p>People with suspected asthma (presenting with respiratory symptoms). All ages, stratified into the following 2 different groups:</p> <ul style="list-style-type: none"> <li>• Children/young people (5-16 years old)</li> <li>• Adults (&gt;16 years old)</li> </ul>
Setting	Primary, secondary and community care settings
Index test	PEF variability (diurnal variability usually expressed as amplitude (highest – lowest reading) as a percentage of the mean or the highest reading). PEFv values should be recorded as the mean over a period of at least 3 days)
Reference standard	<p>Physician diagnosis of asthma based on symptoms plus an objective test from any one of the following:</p> <ul style="list-style-type: none"> <li>• bronchodilator reversibility (cut-off value of an improvement in FEV1 of more than or equal to 12%, and an increase in volume of more than or equal to 200mls as indication of a positive test);</li> <li>• bronchial hyper-responsiveness (histamine or methacholine challenge test, cut-off value of PC20 less than or equal to 8mg/ml as indication of a positive test)</li> </ul> <p>Where no evidence is available using the cut-off values specified above, evidence will be included from studies using a reference standard of physician diagnosis with an</p>

	<p>objective test using an alternative threshold.</p> <p>Where no evidence is available from studies using physician diagnosis and an objective test, evidence will be included from studies using physician diagnosis based on symptoms alone, or patient report of a previous physician diagnosis.</p>
Outcomes	<ul style="list-style-type: none"> <li>• Diagnostic accuracy (sensitivity, specificity)</li> </ul>
Other exclusions	<ul style="list-style-type: none"> <li>• Not occupational asthma /allergens</li> <li>• Not looking at validation studies, or studies comparing different PEF measures</li> <li>• Not looking at factors which influence measurements</li> </ul>
Search Strategy	The database to be searched are Medline, Embase, The Cochrane Library
Review Strategy	<p>Appraisal of methodological quality</p> <ul style="list-style-type: none"> <li>• The methodological quality of each study will be assessed using the QUADAS-II checklist.</li> </ul> <p>Synthesis of data</p> <ul style="list-style-type: none"> <li>• Diagnostic meta-analysis will be conducted where appropriate.</li> </ul> <p>If no/insufficient evidence is found we will (in order of preference):</p> <ul style="list-style-type: none"> <li>• Consider unpublished or partially published studies (including abstracts – and contact the authors for more information)</li> <li>• Move to GDG consensus</li> </ul>
Analysis-subgroups to investigate heterogeneity	<ul style="list-style-type: none"> <li>• Different test thresholds</li> <li>• Different reference standards</li> </ul>

## 1 C.9 Diagnosis: Skin prick tests

2 **Table 9: Review protocol: Skin prick tests for asthma diagnosis**

Component	Description
Review question	In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of skin prick tests?
Objectives	To evaluate the diagnostic test value of skin prick tests in diagnosing asthma
Study design	Cross sectional studies, cohort studies, case series (including both retrospective and prospective analyses)
Population / Target condition	<p>People with suspected asthma (presenting with respiratory symptoms). All ages, stratified into the following 3 different groups:</p> <ul style="list-style-type: none"> <li>• Children (1-&lt;5 years old)</li> <li>• Children/young people (5-16 years old)</li> <li>• Adults (&gt;16 years old)</li> </ul>
Setting	Primary, secondary and community care settings
Index test	<p>Skin prick tests for the most common allergens (reported separately)</p> <ul style="list-style-type: none"> <li>• House dust mites</li> <li>• Cat</li> <li>• Dog</li> <li>• Grass pollen* (native UK grasses)</li> <li>• Tree pollen* (native UK trees)</li> </ul>

	<ul style="list-style-type: none"> <li>• Mixed pollens* (native UK species)</li> <li>• <i>Aspergillus</i></li> <li>• <i>Alternaria</i></li> <li>• <i>Cladosporium</i></li> </ul> <p>Cut off values: 3mm WHEAL (skin reaction) greater than the negative control in the presence of a positive control</p> <p>* Mainland Europe (including Denmark; excluding Norway, Sweden, Finland, Iceland, Russia, Greece), North America (USA + Canada), Australia, New Zealand (as trees/grasses/pollen similar to UK in included countries but not in other countries)</p>
Reference standard	<p>Physician diagnosis of asthma based on symptoms plus an objective test from any one of the following:</p> <ul style="list-style-type: none"> <li>• peak flow variability (cut-off value of more than 20% variability as indication of a positive test);</li> <li>• bronchodilator reversibility (cut-off value of an improvement in FEV1 of more than or equal to 12%, and an increase in volume of more than or equal to 200mls as indication of a positive test);</li> <li>• bronchial hyper-responsiveness (histamine or methacholine challenge test, cut-off value of PC20 less than or equal to 8mg/ml as indication of a positive test)</li> </ul> <p>Where no evidence is available using the cut-off values specified above, evidence will be included from studies using a reference standard of physician diagnosis with an objective test using an alternative threshold.</p> <p>Where no evidence is available from studies using physician diagnosis and an objective test, evidence will be included from studies using physician diagnosis based on symptoms alone, or patient report of a previous physician diagnosis.</p> <p>In children 1-&lt;5 years, objective tests cannot be performed so the reference standard will be physician diagnosis based on recurrent and persistent wheezing.</p>
Outcomes	<ul style="list-style-type: none"> <li>• Diagnostic accuracy (Sensitivity and specificity)</li> </ul>
Other exclusions	<ul style="list-style-type: none"> <li>• Not occupational asthma /allergens</li> <li>• Not looking at validation studies, or studies comparing different skin prick methods</li> <li>• Not looking at factors which influence skin prick measurements</li> <li>• Studies in which we are unable to calculate sensitivity and specificity (unless sensitivity/specificity has been reported by the study).</li> </ul>
Search Strategy	<p>The database to be searched are Medline, Embase, The Cochrane Library</p>
Search terms	
Review Strategy	<p>Appraisal of methodological quality</p> <ul style="list-style-type: none"> <li>• The methodological quality of each study will be assessed using the QUADAS-II checklist.</li> </ul> <p>Synthesis of data</p> <ul style="list-style-type: none"> <li>• Diagnostic meta-analysis will be conducted where appropriate.</li> </ul> <p>If no/insufficient evidence is found we will (in order of preference):</p> <ul style="list-style-type: none"> <li>• Consider unpublished or partially published studies (including abstracts – and contact the authors for more information)</li> </ul>

	<ul style="list-style-type: none"> <li>• Move to GDG consensus</li> </ul>
Analysis-subgroups to investigate heterogeneity	<ul style="list-style-type: none"> <li>• Different test thresholds</li> <li>• Different reference standards</li> <li>• Age groups</li> <li>• People with eczema</li> <li>• Personal or family history of atopy</li> </ul>

## 1 C.10 Diagnosis: IgE

2 **Table 10: Review protocol: Serum IgE for asthma diagnosis**

Component	Description
Review question	In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of total and specific serum IgE measures?
Objectives	To evaluate the diagnostic test value of serum IgE in diagnosing asthma
Study design	Cross sectional studies, cohort studies, case series (including both retrospective and prospective analyses)
Population / Target condition	<p>People with suspected asthma (presenting with respiratory symptoms). All ages, stratified into the following 3 different groups:</p> <ul style="list-style-type: none"> <li>• Children (1-&lt;5 years old)</li> <li>• Children/young people (5-16 years old)</li> <li>• Adults (&gt;16 years old)</li> </ul>
Setting	Primary, secondary and community care settings
Index test	<p>Serum IgE</p> <ul style="list-style-type: none"> <li>• Total IgE</li> <li>• Specific IgE* (including RAST test)</li> </ul> <p>*Reported separately t for the most common aero-allergens (dust mites, grass pollen, tree pollen, dog, cat, <i>Aspergillus</i>, <i>Alternaria</i>, <i>Cladosporium</i>).</p> <p>NOTE: serum IgE must have been assessed using ELISA (apart from RAST) as other techniques are not current/no longer used.</p>
Reference standard	<p>Physician diagnosis of asthma based on symptoms plus an objective test from any one of the following:</p> <ul style="list-style-type: none"> <li>• peak flow variability (cut-off value of more than 20% variability as indication of a positive test);</li> <li>• bronchodilator reversibility (cut-off value of an improvement in FEV1 of more than or equal to 12%, and an increase in volume of more than or equal to 200mls as indication of a positive test);</li> <li>• bronchial hyper-responsiveness (histamine or methacholine challenge test, cut-off value of PC20 less than or equal to 8mg/ml as indication of a positive test)</li> </ul> <p>Where no evidence is available using the cut-off values specified above, evidence will be included from studies using a reference standard of physician diagnosis with an objective test using an alternative threshold.</p> <p>Where no evidence is available from studies using physician diagnosis and an objective test, evidence will be included from studies using physician diagnosis based on symptoms alone, or patient report of a previous physician diagnosis.</p>



	In children 1-<5 years, objective tests cannot be performed so the reference standard will be physician diagnosis based on recurrent and persistent wheezing.
Outcomes	<ul style="list-style-type: none"> <li>• Diagnostic accuracy (Sensitivity and specificity)</li> </ul>
Other exclusions	<ul style="list-style-type: none"> <li>• POPULATION: <ul style="list-style-type: none"> <li>○ Occupational asthma /allergens</li> <li>○ Mixed populations of asthma with other groups such as rhinitis (unless the results for the subgroup of asthma patients have been reported separately).</li> </ul> </li> <li>• TESTS: <ul style="list-style-type: none"> <li>○ Validation studies, or studies comparing different methods of measuring IgE.</li> <li>○ Studies that do not use ELISA for determining presence of IgE.</li> </ul> </li> <li>• ANALYSIS/RESULTS: <ul style="list-style-type: none"> <li>○ Studies that look at levels of IgE</li> <li>○ Studies that assess factors that may influence IgE measurements (eg. smoking, age, gender)</li> <li>○ Studies that use IgE predict the development of asthma at a later follow-up time</li> <li>○ Studies that look at correlations or agreement between tests, but not numbers of patients who were positive and negative</li> <li>○ Studies that look at IgE to in relation to asthma severity</li> </ul> </li> <li>• STUDY TYPES: <ul style="list-style-type: none"> <li>○ Case-control studies will be excluded if there are few 'true' diagnostic studies</li> </ul> </li> </ul>
Search Strategy	The database to be searched are Medline, Embase, The Cochrane Library
Review Strategy	<p>Appraisal of methodological quality</p> <ul style="list-style-type: none"> <li>• The methodological quality of each study will be assessed using the QUADAS-II checklist.</li> </ul> <p>Synthesis of data</p> <ul style="list-style-type: none"> <li>• Diagnostic meta-analysis will be conducted where appropriate.</li> </ul> <p>If no/insufficient evidence is found we will (in order of preference):</p> <ul style="list-style-type: none"> <li>• Consider unpublished or partially published studies (including abstracts – and contact the authors for more information)</li> <li>• Move to GDG consensus</li> </ul>
Analysis-subgroups to investigate heterogeneity	<ul style="list-style-type: none"> <li>• Different test thresholds</li> <li>• Different reference standards</li> </ul>

## 1 C.11 Diagnosis: FeNO

2 **Table 11: Review protocol: FeNO for asthma diagnosis**

Component	Description
Review question	In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of fractional exhaled nitric oxide (FeNO) measures?
Objectives	To evaluate the diagnostic test value of FeNO in diagnosing asthma
Study design	Cross sectional studies, cohort studies, case series (including both retrospective and prospective analyses) Case-control studies were included for the comparison of FeNO levels only
Population / Target condition	People with suspected asthma (presenting with respiratory symptoms). All ages, stratified into the following 3 different groups: <ul style="list-style-type: none"> <li>• Children (1-&lt;5 years old)</li> <li>• Children/young people (5-16 years old)</li> <li>• Adults (&gt;16 years old)</li> </ul>
Setting	Primary, secondary and community care settings
Index test	Fractional exhaled nitric oxide (FeNO) with a cut-off threshold between 20-50ppb and a flow rate of 50ml/s or equivalent
Reference standard	Physician diagnosis of asthma based on symptoms plus an objective test from any one of the following: <ul style="list-style-type: none"> <li>• peak flow variability (cut-off value of more than 20% variability as indication of a positive test);</li> <li>• bronchodilator reversibility (cut-off value of an improvement in FEV1 of more than or equal to 12%, and an increase in volume of more than or equal to 200mls as indication of a positive test);</li> <li>• bronchial hyper-responsiveness (histamine or methacholine challenge test, cut-off value of PC20 less than or equal to 8mg/ml as indication of a positive test)</li> </ul> <p>Where no evidence is available using the cut-off values specified above, evidence will be included from studies using a reference standard of physician diagnosis with an objective test using an alternative threshold.</p> <p>Where no evidence is available from studies using physician diagnosis and an objective test, evidence will be included from studies using physician diagnosis based on symptoms alone, or patient report of a previous physician diagnosis.</p> <p>In children 1-&lt;5 years, objective tests cannot be performed so the reference standard will be physician diagnosis based on recurrent and persistent wheezing.</p>
Outcomes	<ul style="list-style-type: none"> <li>• Diagnostic accuracy (Sensitivity and specificity)</li> <li>• FeNO levels</li> </ul>
Other exclusions	<ul style="list-style-type: none"> <li>• Studies in which &gt;50% of people are on corticosteroid treatment</li> <li>• Not looking at occupational asthma /allergens</li> <li>• Not looking at validation studies, or studies comparing different methods of measuring FeNO.</li> <li>• Cross-sectional studies were included if they reported sensitivity or specificity, or the sensitivity and specificity could be calculated.</li> <li>• Case-control studies were only included if they reported levels of FeNO, but they had to have a sample size of N&gt;50.</li> </ul>

Search Strategy	The database to be searched are Medline, Embase, The Cochrane Library
Review Strategy	<p>Appraisal of methodological quality</p> <ul style="list-style-type: none"> <li>The methodological quality of each study will be assessed using the QUADAS-II checklist.</li> </ul> <p>Synthesis of data</p> <ul style="list-style-type: none"> <li>Diagnostic meta-analysis will be conducted where appropriate.</li> </ul> <p>If no/insufficient evidence is found we will (in order of preference):</p> <ul style="list-style-type: none"> <li>Consider unpublished or partially published studies (including abstracts – and contact the authors for more information)</li> <li>Move to GDG consensus</li> </ul>
Analysis-subgroups to investigate heterogeneity	<p>Are there any subgroups to consider?</p> <ul style="list-style-type: none"> <li>Different test thresholds</li> <li>Sequence step of the test (eg, first test, second test etc)</li> <li>Commercially available meters</li> </ul>

## 1 C.12 Diagnosis: Peripheral blood eosinophils

2 **Table 12: Review protocol: Peripheral blood eosinophil count for asthma diagnosis**

Component	Description
Review question	In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of eosinophil blood count measures?
Objectives	To evaluate the diagnostic test value of eosinophil blood count in diagnosing asthma
Study design	<p>Cross sectional studies, cohort studies, case series (including both retrospective and prospective analyses)</p> <p>Case-control studies were included for the comparison of blood eosinophil levels only</p>
Population / Target condition	<p>People with suspected asthma (presenting with respiratory symptoms). All ages, stratified into the following 3 different groups:</p> <ul style="list-style-type: none"> <li>Children (1- &lt;5 years old)</li> <li>Children/young people (5-16 years old)</li> <li>Adults (&gt;16 years old)</li> </ul>
Setting	Primary, secondary and community care settings
Index test	Peripheral blood eosinophil count (may be part of FBC)
Reference standard	<p>Physician diagnosis of asthma based on symptoms plus an objective test from any one of the following:</p> <ul style="list-style-type: none"> <li>peak flow variability (cut-off value of more than 20% variability as indication of a positive test);</li> <li>bronchodilator reversibility (cut-off value of an improvement in FEV1 of more than or equal to 12%, and an increase in volume of more than or equal to 200mls as indication of a positive test);</li> <li>bronchial hyper-responsiveness (histamine or methacholine challenge test, cut-off value of PC20 less than or equal to 8mg/ml as indication of a positive test)</li> </ul> <p>Where no evidence is available using the cut-off values specified above, evidence will be included from studies using a reference standard of physician diagnosis with an objective test using an alternative threshold.</p>

	<p>Where no evidence is available from studies using physician diagnosis and an objective test, evidence will be included from studies using physician diagnosis based on symptoms alone, or patient report of a previous physician diagnosis.</p> <p>In children 1-&lt;5 years, objective tests cannot be performed so the reference standard will be physician diagnosis based on recurrent and persistent wheezing.</p>
Outcomes	<ul style="list-style-type: none"> <li>• Diagnostic accuracy (sensitivity, specificity)</li> <li>• Eosinophil levels</li> </ul>
Other exclusions	<ul style="list-style-type: none"> <li>• Not looking at occupational asthma /allergens</li> <li>• Not looking at validation studies, or studies comparing different methods of measuring eosinophil blood counts.</li> <li>• Not looking at factors which influence eosinophil measurements</li> <li>• Cross-sectional studies were included if they reported sensitivity or specificity, or the sensitivity and specificity could be calculated. If they reported levels of blood eosinophils, then they were excluded.</li> <li>• Case-control studies were only included if they reported levels of blood eosinophils, but they had to have a sample size of N&gt;50.</li> </ul>
Search Strategy	The database to be searched are Medline, Embase, The Cochrane Library
Review Strategy	<p>Appraisal of methodological quality</p> <ul style="list-style-type: none"> <li>• The methodological quality of each study will be assessed using the QUADAS-II checklist.</li> </ul> <p>Synthesis of data</p> <ul style="list-style-type: none"> <li>• Diagnostic meta-analysis will be conducted where appropriate.</li> </ul> <p>If no/insufficient evidence is found we will (in order of preference):</p> <ul style="list-style-type: none"> <li>• Consider unpublished or partially published studies (including abstracts – and contact the authors for more information)</li> <li>• Move to GDG consensus</li> </ul>
Analysis-subgroups to investigate heterogeneity	<ul style="list-style-type: none"> <li>• Different test thresholds</li> <li>• Different reference standards</li> <li>• Sequence step of the test (eg, first test, second test etc)</li> <li>• Eosinophil counts: &gt;1, 0.4-0.9, 0.2-0.4</li> </ul>

## 1 C.13 Diagnosis: Histamine and methacholine

2 **Table 13: Review protocol: Histamine and methacholine challenge tests for asthma diagnosis**

Component	Description
Review question	In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of airway hyper-reactivity (non-specific bronchial challenge) with histamine and methacholine?
Objectives	To evaluate the diagnostic test value of histamine and methacholine PC20 in diagnosing asthma
Study design	Cross sectional studies, cohort studies, case series (including both retrospective and prospective analyses)
Population / Target condition	People with suspected asthma (presenting with respiratory symptoms). Ages stratified into the following 2 different groups: <ul style="list-style-type: none"> <li>• Children/young people (5-16 years old)</li> <li>• Adults (&gt;16 years old)</li> </ul>
Setting	Primary, secondary and community care settings
Index test	<ul style="list-style-type: none"> <li>• Histamine PC20 and PD20</li> <li>• Methacholine PC20 and PD20</li> </ul> Cut-off threshold of 8mg/ml or a cut-off threshold identified from a ROC curve
Reference standard	Physician diagnosis of asthma based on symptoms plus an objective test from any one of the following: <ul style="list-style-type: none"> <li>• peak flow variability (cut-off value of more than 20% variability as indication of a positive test);</li> <li>• bronchodilator reversibility (cut-off value of an improvement in FEV1 of more than or equal to 12%, and an increase in volume of more than or equal to 200mls as indication of a positive test).</li> </ul> <p>Where no evidence is available using the cut-off values specified above, evidence will be included from studies using a reference standard of physician diagnosis with an objective test using an alternative threshold.</p> <p>Where no evidence is available from studies using physician diagnosis and an objective test, evidence will be included from studies using physician diagnosis based on symptoms alone, or patient report of a previous physician diagnosis.</p>
Statistical measures	<ul style="list-style-type: none"> <li>• Diagnostic accuracy (sensitivity and specificity)</li> </ul>
Other exclusions	<ul style="list-style-type: none"> <li>• Not occupational asthma /allergens</li> <li>• Not looking at validation studies, or studies comparing different methods of measuring the same test</li> <li>• Not looking at factors which influence measurements</li> <li>• Not looking at 'case-control' type studies where the index test is applied in people with confirmed asthma and healthy controls, and where there is no uncertainty about whether the patient has asthma or not. Such studies only include a spectrum of the disease and non-diseased patients and the diagnostic test accuracy may not be applicable to the clinical question.</li> </ul>
Search Strategy	The database to be searched are Medline, Embase, The Cochrane Library
Review Strategy	Appraisal of methodological quality <ul style="list-style-type: none"> <li>• The methodological quality of each study will be assessed using the QUADAS-II</li> </ul>

	<p>checklist.</p> <p>Synthesis of data</p> <ul style="list-style-type: none"> <li>• Diagnostic meta-analysis will be conducted where appropriate.</li> </ul> <p>If no/insufficient evidence is found we will (in order of preference):</p> <ul style="list-style-type: none"> <li>• Consider unpublished or partially published studies (including abstracts – and contact the authors for more information)</li> <li>• Move to GDG consensus</li> </ul>
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## 1 C.14 Diagnosis: Mannitol

2 **Table 14: Review protocol: Mannitol challenge test for asthma diagnosis**

Component	Description
Review question	In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of airway hyper-reactivity (non-specific bronchial challenge) with mannitol?
Objectives	To evaluate the diagnostic test value of mannitol in diagnosing asthma
Study design	Cross sectional studies, cohort studies, case series (including both retrospective and prospective analyses)
Population / Target condition	<p>People with suspected asthma (presenting with respiratory symptoms). Ages stratified into the following 2 different groups:</p> <ul style="list-style-type: none"> <li>• Children/young people (5-16 years old)</li> <li>• Adults (&gt;16 years old)</li> </ul>
Setting	Primary, secondary and community care settings
Index test	<ul style="list-style-type: none"> <li>• Mannitol</li> </ul>
Reference standard	<p>Physician diagnosis of asthma based on symptoms plus an objective test from any one of the following:</p> <ul style="list-style-type: none"> <li>• peak flow variability (cut-off value of more than 20% variability as indication of a positive test);</li> <li>• bronchodilator reversibility (cut-off value of an improvement in FEV1 of more than or equal to 12%, and an increase in volume of more than or equal to 200mls as indication of a positive test);</li> <li>• bronchial hyper-responsiveness (histamine or methacholine challenge test, cut-off value of PC20 less than or equal to 8mg/ml as indication of a positive test)</li> </ul> <p>Where no evidence is available using the cut-off values specified above, evidence will be included from studies using a reference standard of physician diagnosis with an objective test using an alternative threshold.</p> <p>Where no evidence is available from studies using physician diagnosis and an objective test, evidence will be included from studies using physician diagnosis based on symptoms alone, or patient report of a previous physician diagnosis.</p>
Statistical measures	Diagnostic accuracy (sensitivity, specificity)
Other exclusions	<ul style="list-style-type: none"> <li>• Not occupational asthma /allergens</li> <li>• Not looking at validation studies, or studies comparing different methods of measuring the same test</li> <li>• Not looking at factors which influence measurements</li> </ul>

Search Strategy	The database to be searched are Medline, Embase, The Cochrane Library
Review Strategy	<p>Appraisal of methodological quality</p> <ul style="list-style-type: none"> <li>The methodological quality of each study will be assessed using the QUADAS-II checklist.</li> </ul> <p>Synthesis of data</p> <ul style="list-style-type: none"> <li>Analyse mannitol challenge methods and kits separately (split)</li> <li>Diagnostic meta-analysis will be conducted where appropriate.</li> </ul> <p>If no/insufficient evidence is found we will (in order of preference):</p> <ul style="list-style-type: none"> <li>Consider unpublished or partially published studies (including abstracts – and contact the authors for more information)</li> <li>Move to GDG consensus</li> </ul>
Analysis-subgroups to investigate heterogeneity	<ul style="list-style-type: none"> <li>Different test thresholds</li> <li>Different reference standards</li> </ul>

## 1 C.15 Diagnosis: Exercise challenge test

2 **Table 15: Review protocol: Exercise challenge test for asthma diagnosis**

Component	Description
Review question	In people under investigation for asthma, what is the diagnostic accuracy of bronchoconstriction in response to an exercise challenge?
Objectives	To evaluate the diagnostic test value of bronchoconstriction in response to an exercise challenge, in diagnosing asthma
Study design	Cross sectional studies, cohort studies, case series (including both retrospective and prospective analyses)
Population / Target condition	<p>People with suspected asthma (presenting with respiratory symptoms). Ages stratified into the following 2 different groups:</p> <ul style="list-style-type: none"> <li>Children/young people (5-16 years old)</li> <li>Adults (&gt;16 years old)</li> </ul>
Setting	Primary, secondary and community care settings
Index test	<p>Exercise challenge test (&gt;10% FEV1 bronchoconstriction in response to exercise – within 15 mins)</p> <ol style="list-style-type: none"> <li>Change in FEV1 <math>\geq</math>10% post-exercise</li> <li>If the study has used a cut-off based on performing a ROC</li> </ol> <p>NOTE: usually this is a 6 minute exercise challenge test.</p>
Reference standard	<p>Physician diagnosis of asthma based on symptoms plus an objective test from any one of the following:</p> <ul style="list-style-type: none"> <li>peak flow variability (cut-off value of more than 20% variability as indication of a positive test);</li> <li>bronchodilator reversibility (cut-off value of an improvement in FEV1 of more than or equal to 12%, and an increase in volume of more than or equal to 200mls as indication of a positive test);</li> <li>bronchial hyper-responsiveness (histamine or methacholine challenge test, cut-off value of PC20 less than or equal to 8mg/ml as indication of a positive test)</li> </ul>

	<p>Where no evidence is available using the cut-off values specified above, evidence will be included from studies using a reference standard of physician diagnosis with an objective test using an alternative threshold.</p> <p>Where no evidence is available from studies using physician diagnosis and an objective test, evidence will be included from studies using physician diagnosis based on symptoms alone, or patient report of a previous physician diagnosis.</p>
Outcomes	<ul style="list-style-type: none"> <li>• Diagnostic accuracy (sensitivity and specificity)</li> </ul>
Other exclusions	<ul style="list-style-type: none"> <li>• Not occupational asthma /allergens</li> <li>• Not looking at tests in athletes</li> <li>• Not looking at other factors which influence signs/symptoms</li> </ul>
Search Strategy	The database to be searched are Medline, Embase, The Cochrane Library
Review Strategy	<p>Appraisal of methodological quality</p> <ul style="list-style-type: none"> <li>• The methodological quality of each study will be assessed using the QUADAS-II checklist.</li> </ul> <p>Synthesis of data</p> <ul style="list-style-type: none"> <li>• Diagnostic meta-analysis will be conducted where appropriate.</li> </ul> <p>If no/insufficient evidence is found we will (in order of preference):</p> <ul style="list-style-type: none"> <li>• Consider unpublished or partially published studies (including abstracts – and contact the authors for more information)</li> <li>• Move to GDG consensus</li> </ul>
Analysis-subgroups to investigate heterogeneity	<ul style="list-style-type: none"> <li>• Different test thresholds</li> <li>• Different reference standards</li> </ul>

## 1 C.16 Monitoring: Questionnaires

2 **Table 16: Review protocol: Symptom scores/diaries or validated questionnaires to monitor**  
3 **asthma control**

Component	Description
Review question	In people with asthma, what is the clinical and cost-effectiveness of using symptom scores / diaries or validated questionnaires measuring symptom control (eg ACT, ACQ, CACT, RCP 3 questions) and/or health related quality of life (eg AQLQ, PAQLQ) to monitor asthma?
Objectives	To evaluate the clinical and cost-effectiveness of using symptom scores / diaries or validated questionnaires that measure symptoms or HRQoL to monitor asthma? Questionnaires that measure current disease impact and future risk of exacerbation; does measuring symptom control and QoL in asthma patients, improve patient outcomes?
Study design	<ul style="list-style-type: none"> <li>• RCTs</li> <li>• Validation studies (in different age groups) – summarise these narratively.</li> </ul>
Population / Target condition	<p>People with asthma (defined as physician Dx with objective test or recurrent persistent wheeze in &lt;5 years). If insufficient evidence is found we will consider evidence from studies where asthma is defined as physician Dx only or on asthma treatment (give details of how Dx was made). Not including severe asthma.</p> <p>All ages, stratified into the following 3 different groups:</p> <ul style="list-style-type: none"> <li>• Children (1-&lt;5 years old)</li> </ul>



	<ul style="list-style-type: none"> <li>• Children/young people (5-16 years old)</li> <li>• Adults (&gt;16 years old)</li> </ul>
Intervention	<p>Monitoring the following, and using the outcomes of scores/questionnaires to adjust management/therapy according to physician decision or personalised treatment plan (use of other interventions to be included if equal access in each group, eg both groups receive education in addition to monitoring):</p> <ul style="list-style-type: none"> <li>• Symptom scores or diaries</li> <li>• Symptom/control questionnaires <ul style="list-style-type: none"> <li>○ Asthma Control Test, ACT (including caregivers or paediatric version, CACT)</li> <li>○ Asthma Control Questionnaire, ACQ (including mini ACQ or paediatric ACQ)</li> <li>○ RCP 3 questions</li> </ul> </li> <li>• Quality of life questionnaires (asthma specific) <ul style="list-style-type: none"> <li>○ HS QoL</li> <li>○ Asthma Quality of Life Questionnaire, AQLQ (including paedics version, PAQLQ)</li> </ul> </li> </ul>
Comparison	<p>Comparison of adjustment of asthma therapy based on symptom scores or questionnaires to:</p> <ul style="list-style-type: none"> <li>• Usual care: eg clinical symptoms (with/without spirometry/PEF) according to guidelines (including BTS/SIGN, GINA)</li> </ul> <p>Comparison of adjustment of asthma therapy based on:</p> <ul style="list-style-type: none"> <li>• Symptom scores or diaries vs questionnaires</li> <li>• Control questionnaire vs other control questionnaire</li> <li>• QoL questionnaire vs control questionnaire</li> </ul>
Outcomes	<p>Critical outcomes:</p> <ul style="list-style-type: none"> <li>• Mortality</li> <li>• Unscheduled healthcare utilisation (ED/A&amp;E visit; hospital admissions; GP out of hours or walk-in centre)</li> <li>• Exacerbations (defined as need for course of oral steroids)</li> <li>• Asthma control questionnaires (ACT; CACT; ACQ; PACQ; RCP-3)</li> <li>• QoL (AQLQ; pAQLQ; St George's respiratory questionnaire)</li> </ul> <p>Important outcomes:</p> <ul style="list-style-type: none"> <li>• Lung function (FEV1, PEF)</li> <li>• Symptoms (annual symptom free days)</li> <li>• Dose of regular asthma therapy / preventer medication (ICS dose)</li> <li>• Rescue medication (SABA use)</li> <li>• Time off school or work</li> </ul>
Exclusions	<ul style="list-style-type: none"> <li>• Exclude observational cohort studies and NRS unless limited evidence from RCTs</li> <li>• Studies not in English</li> <li>• Not occupational asthma /allergens</li> </ul>
Search Strategy	The database to be searched are Medline, Embase, The Cochrane Library
Review Strategy	<p>Stratify by age group</p> <p>Appraisal of methodological quality</p> <ul style="list-style-type: none"> <li>• The methodological quality of each study will be assessed using NICE checklists and the quality of the evidence will be assessed by GRADE for each outcome.</li> </ul> <p>Synthesis of data</p> <ul style="list-style-type: none"> <li>• Meta-analysis will be conducted where appropriate</li> <li>• Outcomes will be grouped into the following categories based on time-points:</li> </ul>

	<ul style="list-style-type: none"> <li>○ &lt;6 months (or the one nearest to 6 months if multiple time-points are given)</li> <li>○ ≥6 months (or the longest one if multiple time-points are given)</li> </ul> <p>Default MIDs will be used where no MIDs are established: 0.75 and 1.25 for dichotomous outcomes; 0.5 times SD for continuous outcomes</p> <p>If no/insufficient evidence is found we will (in order of preference):</p> <ul style="list-style-type: none"> <li>• Consider unpublished or partially published studies (including abstracts – and contact the authors for more information)</li> <li>• Consider observational studies and NRS</li> <li>• Consider prognostic studies</li> <li>• Move to GDG consensus</li> </ul>
Analysis-subgroups to investigate heterogeneity	<ul style="list-style-type: none"> <li>• Ethnic groups (e.g. south Asians, African Americans, Hispanics)</li> <li>• Education levels</li> <li>• Language (non English speaking)</li> </ul>

## 1 C.17 Monitoring: Lung function tests

2 **Table 17: Review protocol: Lung function tests to monitor asthma control**

Component	Description
Review question	In people with asthma, what is the clinical and cost-effectiveness of using measures of pulmonary function assessing asthma control (for example, spirometry and peak expiratory flow) to monitor asthma?
Objectives	To evaluate the clinical and cost-effectiveness of using measures of pulmonary function assessing asthma control (for example, spirometry and peak expiratory flow) to monitor asthma.
Study design	<ul style="list-style-type: none"> <li>• RCTs</li> </ul>
Population / Target condition	<p>People with asthma (defined as physician Dx with objective test). If insufficient evidence is found we will consider evidence from studies where asthma is defined as physician Dx only or on asthma treatment (give details of how Dx was made). Not including severe asthma.</p> <p>All ages, stratified into the following 2 different groups:</p> <ul style="list-style-type: none"> <li>• Children/young people (5-16 years old)</li> <li>• Adults (&gt;16 years old)</li> </ul>
Intervention	<p>Monitoring lung function using the following tests, and using the outcomes to adjust management/therapy according to physician decision or personalised treatment plan (use of other interventions to be included if equal access in each group, eg both groups receive education in addition to monitoring):</p> <ul style="list-style-type: none"> <li>• Spirometry (FEV1; FEV1/FVC; Flow loop measures)</li> <li>• PEF</li> </ul>
Comparison	<p>Comparison of adjustment of asthma therapy based on lung function tests to:</p> <ul style="list-style-type: none"> <li>• Usual care: eg clinical symptoms according to guidelines (including BTS/SIGN, GINA)</li> <li>• Asthma control or QOL questionnaires</li> </ul> <p>Comparison of adjustment of asthma therapy based on:</p> <ul style="list-style-type: none"> <li>• Spirometry versus PEF</li> </ul>
Outcomes	<p>Critical outcomes:</p> <ul style="list-style-type: none"> <li>• Mortality</li> <li>• Unscheduled healthcare utilisation (ED/A&amp;E visit; hospital admissions; GP out of</li> </ul>

	<p>hours or walk-in centre)</p> <ul style="list-style-type: none"> <li>• Exacerbations (defined as need for course of oral steroids)</li> <li>• Asthma control questionnaires (ACT; CACT; ACQ; PACQ; RCP-3)</li> <li>• QoL (AQLQ; pAQLQ; St George’s respiratory questionnaire)</li> </ul> <p>Important outcomes:</p> <ul style="list-style-type: none"> <li>• Lung function (FEV1, PEF)</li> <li>• Symptoms (annual symptom free days)</li> <li>• Dose of regular asthma therapy / preventer medication (ICS dose)</li> <li>• Rescue medication (SABA use)</li> <li>• Time off school or work</li> </ul>
Exclusions	<ul style="list-style-type: none"> <li>• Exclude observational cohort studies and NRS unless limited evidence from RCTs</li> <li>• Studies not in English</li> <li>• Not occupational asthma /allergens</li> </ul>
Search Strategy	The database to be searched are Medline, Embase, The Cochrane Library
Review Strategy	<p>Stratify by age group</p> <p>Appraisal of methodological quality</p> <ul style="list-style-type: none"> <li>• The methodological quality of each study will be assessed using NICE checklists and the quality of the evidence will be assessed by GRADE for each outcome.</li> </ul> <p>Synthesis of data</p> <ul style="list-style-type: none"> <li>• Meta-analysis will be conducted where appropriate</li> <li>• Outcomes will be grouped into the following categories based on time-points: <ul style="list-style-type: none"> <li>○ &lt;6 months (or the one nearest to 6 months if multiple time-points are given)</li> <li>○ ≥6 months (or the longest one if multiple time-points are given)</li> </ul> </li> </ul> <p>Default MIDs will be used where no MIDs are established: 0.75 and 1.25 for dichotomous outcomes; 0.5 times SD for continuous outcomes</p> <p>If no/insufficient evidence is found we will (in order of preference):</p> <ul style="list-style-type: none"> <li>• Consider unpublished or partially published studies (including abstracts – and contact the authors for more information)</li> <li>• Consider observational studies and NRS</li> <li>• Consider prognostic studies</li> <li>• Move to GDG consensus</li> </ul>
Analysis-subgroups	
Key papers	

## 1 C.18 Monitoring: FeNO

2 **Table 18: Review protocol: FeNO to monitor asthma control**

Component	Description
Review question	In people with asthma, what is the clinical and cost-effectiveness of using fractional exhaled nitric oxide (FeNO) measures for monitoring asthma control?
Objectives	To evaluate the clinical and cost-effectiveness of using fractional exhaled nitric oxide (FeNO) for monitoring asthma control?
Study design	<ul style="list-style-type: none"> <li>• RCTs</li> </ul>
Population / Target condition	People with asthma (defined as physician Dx with objective test). If insufficient evidence is found we will consider evidence from studies where asthma is defined as

	<p>physician Dx only or on asthma treatment (give details of how Dx was made). Not including severe asthma.</p> <p>All ages, stratified into the following 2 different groups:</p> <ul style="list-style-type: none"> <li>• Children/young people (5-16 years old)</li> <li>• Adults (&gt;16 years old)</li> </ul> <p>The following groups will be included/combined in the analysis (do not subgroup, would not make separate recommendations for these groups):</p> <ul style="list-style-type: none"> <li>• Smokers</li> <li>• Atopic asthma</li> </ul>
Intervention	<p>Monitoring FeNO and adjustment of management/therapy according to physician decision or personalised treatment plan (use of other interventions to be included if equal access in each group, eg both groups receive education in addition to monitoring)</p> <p>Only use validated methods of measuring FeNO (eg 50ml/s flow rate).</p>
Comparison	<p>Comparison of adjustment of asthma therapy based on FeNO to:</p> <ul style="list-style-type: none"> <li>• Usual care: eg clinical symptoms (with or without PEF) according to guidelines (including BTS/SIGN, GINA)</li> <li>• Asthma control questionnaires or QOL questionnaires</li> <li>• Lung function tests (spirometry or PEFv)</li> <li>• Blood eosinophils</li> <li>• Challenge tests</li> </ul> <p>Comparison of different frequencies of monitoring using FeNO.</p>
Outcomes	<p>Critical outcomes:</p> <ul style="list-style-type: none"> <li>• Mortality</li> <li>• Unscheduled healthcare utilisation (ED/A&amp;E visit; hospital admissions; GP out of hours or walk-in centre)</li> <li>• Exacerbations (defined as need for course of oral steroids)</li> <li>• Asthma control questionnaires (ACT; CACT; ACQ; PACQ; RCP-3)</li> <li>• QoL (AQLQ; pAQLQ; St George's respiratory questionnaire)</li> </ul> <p>Important outcomes:</p> <ul style="list-style-type: none"> <li>• Lung function (FEV1, PEF)</li> <li>• Symptoms (annual symptom free days)</li> <li>• Dose of regular asthma therapy / preventer medication (ICS dose)</li> <li>• Rescue medication (SABA use)</li> <li>• Time off school or work</li> </ul>
Exclusions	<ul style="list-style-type: none"> <li>• Exclude observational cohort studies and NRS unless limited evidence from RCTs</li> <li>• Studies not in English</li> <li>• Not occupational asthma /allergens</li> </ul>
Search Strategy	The database to be searched are Medline, Embase, The Cochrane Library
Review Strategy	<p>Stratify by age group</p> <p>Appraisal of methodological quality</p> <ul style="list-style-type: none"> <li>• The methodological quality of each study will be assessed using NICE checklists and the quality of the evidence will be assessed by GRADE for each outcome.</li> </ul> <p>Synthesis of data</p> <ul style="list-style-type: none"> <li>• Meta-analysis will be conducted where appropriate</li> <li>• Outcomes will be grouped into the following categories based on time-points:</li> </ul>

	<ul style="list-style-type: none"> <li>○ &lt;6 months (or the one nearest to 6 months if multiple time-points are given)</li> <li>○ ≥6 months (or the longest one if multiple time-points are given)</li> </ul> <p>Default MIDs will be used where no MIDs are established: 0.75 and 1.25 for dichotomous outcomes; 0.5 times SD for continuous outcomes</p> <p>Sensitivity analysis:</p> <ul style="list-style-type: none"> <li>● SUBGROUP: if heterogeneity, subgroup according to the aim of the treatment in the study. Would expect different directions of effect in studies aiming to decrease ICS in controlled patients and studies aiming to increase ICS in uncontrolled patients.</li> </ul> <p>If no/insufficient evidence is found we will (in order of preference):</p> <ul style="list-style-type: none"> <li>● Consider unpublished or partially published studies (including abstracts – and contact the authors for more information)</li> <li>● Consider observational studies and NRS</li> <li>● Consider prognostic studies</li> <li>● Move to GDG consensus</li> </ul>
Analysis-subgroups to investigate heterogeneity	<ul style="list-style-type: none"> <li>● SUBGROUP: if heterogeneity, subgroup according to the aim of the treatment in the study. Would expect different directions of effect in studies aiming to decrease ICS in controlled patients and studies aiming to increase ICS in uncontrolled patients.</li> </ul>
Key papers	

## 1 C.19 Monitoring: Peripheral blood eosinophils

2 **Table 19: Review protocol: Peripheral blood eosinophils to monitor asthma control**

Component	Description
Review question	In people with asthma, what is the clinical and cost-effectiveness of using the peripheral blood eosinophil count for monitoring asthma control?
Objectives	To evaluate the clinical and cost-effectiveness of using peripheral blood eosinophil count for monitoring asthma control?
Study design	<ul style="list-style-type: none"> <li>● RCTs</li> </ul>
Population / Target condition	<p>People with asthma (defined as physician Dx with objective test or recurrent persistent wheeze in &lt;5 years). If insufficient evidence is found we will consider evidence from studies where asthma is defined as physician Dx only or on asthma treatment (give details of how Dx was made). Not including severe asthma.</p> <p>All ages, stratified into the following 3 different groups:</p> <ul style="list-style-type: none"> <li>● Children (1-&lt;5 years old)</li> <li>● Children/young people (5-16 years old)</li> <li>● Adults (&gt;16 years old)</li> </ul> <p>The following groups will be included/combined in the analysis (do not subgroup, would not make separate recommendations for these groups):</p> <ul style="list-style-type: none"> <li>● Smokers</li> <li>● Atopic asthma</li> </ul>
Intervention	Monitoring peripheral blood eosinophil count and adjustment of management/therapy according to physician decision or personalised treatment plan (use of other interventions to be included if equal access in each group, eg both groups receive education in addition to monitoring).

Comparison	<p>Comparison of adjustment of asthma therapy based on peripheral blood eosinophil count to:</p> <ul style="list-style-type: none"> <li>• Usual care: eg clinical symptoms (with or without PEF) according to guidelines (including BTS/SIGN, GINA)</li> <li>• Asthma control questionnaires or QOL questionnaires</li> <li>• Lung function tests (spirometry or PEFv)</li> <li>• Challenge tests</li> </ul> <p>Comparison of different frequencies of monitoring using blood eosinophil count.</p>
Outcomes	<p>Critical outcomes:</p> <ul style="list-style-type: none"> <li>• Mortality</li> <li>• Unscheduled healthcare utilisation (ED/A&amp;E visit; hospital admissions; GP out of hours or walk-in centre)</li> <li>• Exacerbations (defined as need for course of oral steroids)</li> <li>• Asthma control questionnaires (ACT; CACT; ACQ; PACQ; RCP-3)</li> <li>• QoL (AQLQ; pAQLQ; St George’s respiratory questionnaire)</li> </ul> <p>Important outcomes:</p> <ul style="list-style-type: none"> <li>• Lung function (FEV1, PEF)</li> <li>• Symptoms (annual symptom free days)</li> <li>• Dose of regular asthma therapy / preventer medication (ICS dose)</li> <li>• Rescue medication (SABA use)</li> <li>• Time off school or work</li> </ul>
Exclusions	<ul style="list-style-type: none"> <li>• Exclude observational cohort studies and NRS unless limited evidence from RCTs</li> <li>• Studies not in English</li> <li>• Not occupational asthma /allergens</li> </ul>
Search Strategy	<p>The database to be searched are Medline, Embase, The Cochrane Library</p>
Review Strategy	<p>Stratify by age group</p> <p>Appraisal of methodological quality</p> <ul style="list-style-type: none"> <li>• The methodological quality of each study will be assessed using NICE checklists and the quality of the evidence will be assessed by GRADE for each outcome.</li> </ul> <p>Synthesis of data</p> <ul style="list-style-type: none"> <li>• Meta-analysis will be conducted where appropriate</li> <li>• Outcomes will be grouped into the following categories based on time-points: <ul style="list-style-type: none"> <li>○ &lt;6 months (or the one nearest to 6 months if multiple time-points are given)</li> <li>○ ≥6 months (or the longest one if multiple time-points are given)</li> </ul> </li> </ul> <p>Default MIDs will be used where no MIDs are established: 0.75 and 1.25 for dichotomous outcomes; 0.5 times SD for continuous outcomes</p> <p>If no/insufficient evidence is found we will (in order of preference):</p> <ul style="list-style-type: none"> <li>• Consider unpublished or partially published studies (including abstracts – and contact the authors for more information)</li> <li>• Consider observational studies and NRS</li> <li>• Consider prognostic studies</li> <li>• Move to GDG consensus</li> </ul>
Analysis-subgroups to	

investigate heterogeneity	
Key papers	

## 1 C.20 Monitoring: Challenge tests

2 **Table 20: Review protocol: Challenge tests to monitor asthma control**

Component	Description
Review question	In people with asthma, what is the clinical and cost-effectiveness of using indirect challenge tests with mannitol or direct challenge tests with histamine or methacholine for monitoring asthma control?
Objectives	To evaluate the clinical and cost-effectiveness of using indirect challenge tests with mannitol, or direct challenge tests with histamine or methacholine PC20 for monitoring asthma control?
Study design	<ul style="list-style-type: none"> <li>• RCTs</li> </ul>
Population / Target condition	<p>People with asthma (defined as physician Dx with objective test). If insufficient evidence is found we will consider evidence from studies where asthma is defined as physician Dx only or on asthma treatment (give details of how Dx was made). Not including severe asthma.</p> <p>All ages, stratified into the following 2 different groups:</p> <ul style="list-style-type: none"> <li>• Children/young people (5-16 years old)</li> <li>• Adults (&gt;16 years old)</li> </ul>
Intervention	<p>Monitoring using indirect or direct challenge tests and using the outcomes to adjust management/therapy according to physician decision or personalised treatment plan (use of other interventions to be included if equal access in each group, eg both groups receive education in addition to monitoring):</p> <ul style="list-style-type: none"> <li>• Indirect challenge test with mannitol</li> <li>• Direct challenge test with methacholine or histamine</li> </ul>
Comparison	<p>Comparison of adjustment of asthma therapy based on indirect or direct challenge tests to:</p> <ul style="list-style-type: none"> <li>• Usual care: eg clinical symptoms according to guidelines (including BTS/SIGN, GINA)</li> <li>• Asthma control questionnaires or QOL questionnaires</li> <li>• Lung function tests (spirometry or PEFv)</li> </ul> <p>Comparison of adjustment of asthma therapy based on:</p> <ul style="list-style-type: none"> <li>• Indirect vs direct challenge tests</li> <li>• Comparison of different frequencies of monitoring using challenge tests</li> </ul>
Outcomes	<p>Critical outcomes:</p> <ul style="list-style-type: none"> <li>• Mortality</li> <li>• Unscheduled healthcare utilisation (ED/A&amp;E visit; hospital admissions; GP out of hours or walk-in centre)</li> <li>• Exacerbations (defined as need for course of oral steroids)</li> <li>• Asthma control questionnaires (ACT; CACT; ACQ; PACQ; RCP-3)</li> <li>• QoL (AQLQ; pAQLQ; St George's respiratory questionnaire)</li> </ul> <p>Important outcomes:</p> <ul style="list-style-type: none"> <li>• Lung function (FEV1, PEF)</li> <li>• Symptoms (annual symptom free days)</li> </ul>

	<ul style="list-style-type: none"> <li>• Dose of regular asthma therapy / preventer medication (ICS dose)</li> <li>• Rescue medication (SABA use)</li> <li>• Time off school or work</li> </ul>
Exclusions	<ul style="list-style-type: none"> <li>• Exclude observational cohort studies and NRS unless limited evidence from RCTs</li> <li>• Studies not in English</li> <li>• Not occupational asthma /allergens</li> </ul>
Search Strategy	The database to be searched are Medline, Embase, The Cochrane Library
Review Strategy	<p>Stratify by age group</p> <p>Appraisal of methodological quality</p> <ul style="list-style-type: none"> <li>• The methodological quality of each study will be assessed using NICE checklists and the quality of the evidence will be assessed by GRADE for each outcome.</li> </ul> <p>Synthesis of data</p> <ul style="list-style-type: none"> <li>• Meta-analysis will be conducted where appropriate</li> <li>• Outcomes will be grouped into the following categories based on time-points: <ul style="list-style-type: none"> <li>○ &lt;6 months (or the one nearest to 6 months if multiple time-points are given)</li> <li>○ ≥6 months (or the longest one if multiple time-points are given)</li> </ul> </li> </ul> <p>Default MIDs will be used where no MIDs are established: 0.75 and 1.25 for dichotomous outcomes; 0.5 times SD for continuous outcomes</p> <p>If no/insufficient evidence is found we will (in order of preference):</p> <ul style="list-style-type: none"> <li>• Consider unpublished or partially published studies (including abstracts – and contact the authors for more information)</li> <li>• Consider observational studies and NRS</li> <li>• Consider prognostic studies</li> <li>• Move to GDG consensus</li> </ul>
Analysis-subgroups to investigate heterogeneity	
Key papers	

## 1 C.21 Monitoring: Adherence to treatment

2 **Table 21: Review protocol: Monitoring adherence to treatment**

Component	Description
Review question	In people with asthma, what is the clinical and cost-effectiveness of monitoring adherence to treatment?
Objectives	To evaluate the clinical and cost-effectiveness of monitoring adherence to treatment? Adherence with repeat therapies
Study design	<ul style="list-style-type: none"> <li>• RCTs</li> </ul>
Population / Target condition	<p>People with asthma (defined as physician Dx with objective test or recurrent persistent wheeze in &lt;5 years). If insufficient evidence is found we will consider evidence from studies where asthma is defined as physician Dx only or on asthma treatment (give details of how Dx was made). Not including severe asthma.</p> <p>All ages, stratified into the following 3 different groups:</p> <ul style="list-style-type: none"> <li>• Children (1-&lt;5 years old)</li> <li>• Children/young people (5-16 years old)</li> </ul>



	<ul style="list-style-type: none"> <li>• Adults (&gt;16 years old)</li> </ul>
Intervention	<p>Monitoring adherence/compliance/concordance using the following methods and provide patient feedback or intervention to improve adherence (use of other interventions to be included if equal access in each group, eg both groups receive education in addition to monitoring):</p> <ul style="list-style-type: none"> <li>• Adherence with repeat therapy (using prescription and refill data)</li> <li>• Electronic monitoring inhalers (to monitor inhaler use)</li> <li>• Prednisolone levels (serum and urine – when on prednisolone)</li> <li>• MARS questionnaire (medication adherence rating scale)</li> <li>• FeNO levels (comes down if patients are taking their inhalers)</li> <li>• Theophylline levels (when on theophylline)</li> </ul>
Comparison	<ul style="list-style-type: none"> <li>• No monitoring of adherence</li> <li>• Usual care</li> <li>• Comparison of different frequencies of monitoring adherence</li> </ul>
Outcomes	<p>Critical outcomes:</p> <ul style="list-style-type: none"> <li>• Mortality</li> <li>• Unscheduled healthcare utilisation (ED/A&amp;E visit; hospital admissions; GP out of hours or walk-in centre)</li> <li>• Exacerbations (defined as need for course of oral steroids)</li> <li>• Asthma control questionnaires (ACT; CACT; ACQ; PACQ; RCP-3)</li> <li>• QoL (AQLQ; pAQLQ; St George’s respiratory questionnaire)</li> <li>• Adherence</li> </ul> <p>Important outcomes:</p> <ul style="list-style-type: none"> <li>• Lung function (FEV1, PEF)</li> <li>• Symptoms (annual symptom free days)</li> <li>• Dose of regular asthma therapy / preventer medication (ICS dose)</li> <li>• Rescue medication (SABA use)</li> <li>• Time off school or work</li> </ul>
Exclusions	<ul style="list-style-type: none"> <li>• Exclude observational cohort studies and NRS unless limited evidence from RCTs</li> <li>• Studies not in English</li> <li>• Not occupational asthma /allergens</li> </ul>
Search Strategy	The database to be searched are Medline, Embase, The Cochrane Library
Search terms	<ul style="list-style-type: none"> <li>• Adherence</li> <li>• Compliance</li> <li>• Concordance</li> </ul>
Review Strategy	<p>Stratify by age group</p> <p>Appraisal of methodological quality</p> <ul style="list-style-type: none"> <li>• The methodological quality of each study will be assessed using NICE checklists and the quality of the evidence will be assessed by GRADE for each outcome.</li> </ul> <p>Synthesis of data</p> <ul style="list-style-type: none"> <li>• Meta-analysis will be conducted where appropriate</li> <li>• Outcomes will be grouped into the following categories based on time-points: <ul style="list-style-type: none"> <li>○ &lt;6 months (or the one nearest to 6 months if multiple time-points are given)</li> <li>○ ≥6 months (or the longest one if multiple time-points are given)</li> </ul> </li> </ul> <p>Default MIDAs will be used where no MIDAs are established: 0.75 and 1.25 for dichotomous outcomes; 0.5 times SD for continuous outcomes</p> <p>If no/insufficient evidence is found we will (in order of preference):</p>

	<ul style="list-style-type: none"> <li>• Consider unpublished or partially published studies (including abstracts – and contact the authors for more information)</li> <li>• Consider observational studies and NRS</li> <li>• Consider prognostic studies</li> <li>• Move to GDG consensus</li> </ul>
Analysis-subgroups to investigate heterogeneity	<ul style="list-style-type: none"> <li>• Socio economic disadvantage</li> <li>• Cognitive function</li> <li>• Some ethnic groups</li> <li>• Disability (esp. use of inhalers)</li> <li>• Near fatal asthma attacks (associated with psychological effects etc)</li> </ul>

## 1 C.22 Monitoring: Inhaler technique

2 **Table 22: Review protocol: Monitoring inhaler technique**

Component	Description
Review question	In people with asthma, what is the optimal frequency and method for monitoring inhaler technique?
Objectives	To evaluate the clinical and cost-effectiveness of the optimal frequency and method for monitoring inhaler technique?
Study design	<ul style="list-style-type: none"> <li>• RCTs</li> </ul>
Population / Target condition	<p>People with asthma (defined as physician Dx with objective test or recurrent persistent wheeze in &lt;5 years). If insufficient evidence is found we will consider evidence from studies where asthma is defined as physician Dx only or on asthma treatment (give details of how Dx was made). Not including severe asthma.</p> <p>All ages, stratified into the following 3 different groups:</p> <ul style="list-style-type: none"> <li>• Children (1-&lt;5 years old)</li> <li>• Children/young people (5-16 years old)</li> <li>• Adults (&gt;16 years old)</li> </ul>
Intervention	<p>Monitoring inhaler technique using the following methods and provide patient feedback or intervention to improve inhaler technique (use of other interventions to be included if equal access in each group, eg both groups receive education in addition to monitoring):</p> <ul style="list-style-type: none"> <li>• Electronic devices to monitor inhaler technique (devices check the inhaler is being used correctly but this will still be face-to-face monitoring)</li> <li>• Visual monitoring by doctor, nurse or pharmacist (may include use of a checklist to monitor inhaler technique)</li> </ul>
Comparison	<ul style="list-style-type: none"> <li>• No monitoring of inhaler technique</li> <li>• Comparison of different frequencies of monitoring inhaler technique</li> <li>• Monitoring using electronic devices vs monitoring by visual inspection</li> </ul>
Outcomes	<p>Critical outcomes:</p> <ul style="list-style-type: none"> <li>• Mortality</li> <li>• Unscheduled healthcare utilisation (ED/A&amp;E visit; hospital admissions; GP out of hours or walk-in centre)</li> <li>• Exacerbations (defined as need for course of oral steroids)</li> <li>• Asthma control questionnaires (ACT; CACT; ACQ; PACQ; RCP-3)</li> <li>• QoL (AQLQ; pAQLQ; St George's respiratory questionnaire)</li> </ul> <p>Important outcomes:</p> <ul style="list-style-type: none"> <li>• Lung function (FEV1, PEF)</li> </ul>

	<ul style="list-style-type: none"> <li>• Symptoms (annual symptom free days)</li> <li>• Dose of regular asthma therapy / preventer medication (ICS dose)</li> <li>• Rescue medication (SABA use)</li> <li>• Time off school or work</li> </ul>
Exclusions	<ul style="list-style-type: none"> <li>• Exclude observational cohort studies and NRS unless limited evidence from RCTs</li> <li>• Studies not in English</li> <li>• Not occupational asthma /allergens</li> </ul>
Search Strategy	The database to be searched are Medline, Embase, The Cochrane Library
Review Strategy	<p>Stratify by age group</p> <p>Appraisal of methodological quality</p> <ul style="list-style-type: none"> <li>• The methodological quality of each study will be assessed using NICE checklists and the quality of the evidence will be assessed by GRADE for each outcome.</li> </ul> <p>Synthesis of data</p> <ul style="list-style-type: none"> <li>• Meta-analysis will be conducted where appropriate</li> <li>• Outcomes will be grouped into the following categories based on time-points: <ul style="list-style-type: none"> <li>○ &lt;6 months (or the one nearest to 6 months if multiple time-points are given)</li> <li>○ ≥6 months (or the longest one if multiple time-points are given)</li> </ul> </li> </ul> <p>Default MIDs will be used where no MIDs are established: 0.75 and 1.25 for dichotomous outcomes; 0.5 times SD for continuous outcomes</p> <p>If no/insufficient evidence is found we will (in order of preference):</p> <ul style="list-style-type: none"> <li>• Consider unpublished or partially published studies (including abstracts – and contact the authors for more information)</li> <li>• Consider observational studies and NRS</li> <li>• Consider prognostic studies</li> <li>• Move to GDG consensus</li> </ul>
Analysis-subgroups to investigate heterogeneity	
Key papers	

## 1 C.23 Monitoring: Tele-healthcare

2 **Table 23: Review protocol: Tele-healthcare to monitor asthma control**

Component	Description
Review question	In people with asthma, what is the clinical and cost-effectiveness of tele-healthcare to monitor asthma control?
Objectives	To review the efficacy and effectiveness of tele-healthcare to monitor asthma control.
Study design	Full reports of randomised controlled trials which compared a tele-healthcare intervention with usual care or any other control intervention.
Population	Children and adults with clinician-diagnosed asthma. We included studies conducted in both primary and secondary care settings. We focused on studies which looked exclusively at people with asthma. There were no exclusions on the basis of age, gender, ethnicity or language spoken.
Intervention and comparison	<p>Focus on the proactive use of ICT to provide the information the health professional requires to make their decisions and then feedback of their advice to the patient. The study of technology needed to be central and its use sustained. These interventions included the following.</p> <ul style="list-style-type: none"> <li>• Video or telephone links between patient and healthcare professionals in real time or using store-and-forward technologies.</li> <li>• Systems of care using Internet-based telecommunication; these could be synchronous or asynchronous (e.g. Skype®, messaging, email) with healthcare professionals.</li> <li>• Systems of care using both wired and wireless telemetry for monitoring of Peak Expiratory Flow (PEF), spirometry (Forced Expiratory Volume in 1 second (FEV1); Forced Vital Capacity (FVC) respiratory rate, chest movement and oxygen saturations involving feedback to the patient, which had been processed or authorised by a healthcare professional.</li> <li>• Other systems of remote healthcare incorporating patient self-reporting of symptoms on a questionnaire and information exchange with a professional.</li> <li>• Complex intervention studies, if it was possible to tease out the individual tele-healthcare elements.</li> </ul> <p>Professional involvement in care was considered fundamentally important; we thus excluded the following types of interventions.</p> <ul style="list-style-type: none"> <li>• Remote interventions that were merely educational and so did not include the input of a professional, e.g. electronic information provision in an emergency waiting room. Although this type of passive information provision was excluded, education could have been part of a more complex interactive intervention that might fit the inclusion criteria, e.g. if it included feedback from a professional.</li> <li>• Decision support which functioned without the active input of a healthcare professional.</li> <li>•</li> </ul>
Outcomes	<p>Critical outcomes:</p> <ul style="list-style-type: none"> <li>• Mortality</li> <li>• Unscheduled healthcare utilisation (ED/A&amp;E visit; hospital admissions; GP out of hours or walk-in centre)</li> <li>• Exacerbations (defined as need for course of oral steroids)</li> <li>• Asthma control questionnaires (ACT; CACT; ACQ; PACQ; RCP-3)</li> <li>• QoL (AQLQ; pAQLQ; St George's respiratory questionnaire)</li> </ul> <p>Important outcomes:</p> <ul style="list-style-type: none"> <li>• Lung function (FEV1, PEF)</li> </ul> <p>Symptoms (annual symptom free days)</p>

Search	<p>Trials were identified using the Cochrane Airways Group Specialised Register of trials, which is derived from systematic searches of bibliographic databases including the Cochrane Register of Controlled Trials (CENTRAL), MEDLINE, EMBASE, CINAHL, AMED, and PsycINFO, and hand-searching of respiratory journals and meeting abstracts. All records coded as 'asthma' were searched using the following terms:</p> <p>Telehealth* or tele-health* or telemedicine*- or tele-medicine* or internet* or computer* or web* or interactive* or telecommunication* or telephone or phone or SMS or tele-monitor* or telemonitor* or telemanagement or tele-management- or teleconsultation or tele-consultation or telecare* or tele-care* or telematic* or telepharmacy or tele-pharmacy or telenurs* or tele-nurs* or video or email or e-mail or "remote consult*" or wireless or Bluetooth or tele-homecare or telehomecare or "remote care" or tele-support or telesupport or "mobile healthcare" or "computer mediated therapy" or ehealth or e-health or mhealth or m-health</p>
Review strategy	<p>Stratify by age group</p> <p>Appraisal of methodological quality</p> <ul style="list-style-type: none"> <li>• The methodological quality of each study will be assessed using NICE checklists and the quality of the evidence will be assessed by GRADE for each outcome.</li> </ul> <p>Synthesis of data</p> <ul style="list-style-type: none"> <li>• Meta-analysis will be conducted where appropriate</li> </ul> <p>Sources of potential heterogeneity will be assessed with subgroup analyses for device (phonecalls, SMS, email, internet software) and study length (&lt;6 months and &gt; 6 months), or summarised narratively where insufficient numbers of studies are found.</p> <p>Default MIDs will be used where no MIDs are established: 0.75 and 1.25 for dichotomous outcomes; 0.5 times SD for continuous outcomes</p>

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## 2 C.24 Health economic review protocols for all review questions

Review question	All questions – health economic evidence
Objectives	To identify economic evaluations relevant to the review questions set out above.
Criteria	<ul style="list-style-type: none"> <li>• Populations, interventions and comparators must be as specified in the individual review protocols above.</li> <li>• Studies must be of a relevant economic study design (cost–utility analysis, cost–benefit analysis, cost-effectiveness analysis, cost–consequence analysis, comparative cost analysis).</li> <li>• Studies must not be an abstract only, a letter, editorial or commentary, or a review of economic evaluations.<sup>(a)</sup> Unpublished reports will not be considered unless submitted as part of a call for evidence.</li> <li>• Studies must be in English.</li> </ul>
Search strategy	An economic study search will be undertaken using population-specific terms and an economic study filter – see Appendix F.
Review strategy	<p>Each study fulfilling the criteria above will be assessed for applicability and methodological limitations using the NICE economic evaluation checklist which can be found in Appendix G of the NICE guidelines manual (2012).<sup>1204</sup></p> <p><b>Inclusion and exclusion criteria</b></p> <ul style="list-style-type: none"> <li>• If a study is rated as both 'Directly applicable' and with 'Minor limitations' then it will be included in the guideline. An economic evidence table will be completed and it will be included in the economic evidence profile.</li> <li>• If a study is rated as either 'Not applicable' or with 'Very serious limitations' then it will</li> </ul>

usually be excluded from the guideline. If it is excluded then an economic evidence table will not be completed and it will not be included in the economic evidence profile.

- If a study is rated as 'Partially applicable', with 'Potentially serious limitations' or both then there is discretion over whether it should be included.

#### **Where there is discretion**

The health economist will make a decision based on the relative applicability and quality of the available evidence for that question, in discussion with the GDG if required. The ultimate aim is to include studies that are helpful for decision-making in the context of the guideline and the current NHS setting. If several studies are considered of sufficiently high applicability and methodological quality that they could all be included, then the health economist, in discussion with the GDG if required, may decide to include only the most applicable studies and to selectively exclude the remaining studies. All studies excluded on the basis of applicability or methodological limitations will be listed with explanation as excluded economic studies in Appendix H.

The health economist will be guided by the following hierarchies.

#### *Setting:*

- UK NHS
- OECD countries with predominantly public health insurance systems (for example, France, Germany, Sweden)
- OECD countries with predominantly private health insurance systems (for example, USA, Switzerland)
- non-OECD settings (always 'Not applicable').

#### *Economic study type:*

- cost–utility analysis
- other type of full economic evaluation (cost–benefit analysis, cost-effectiveness analysis, cost–consequence analysis)
- comparative cost analysis
- non-comparative cost analyses including cost-of-illness studies (always 'Not applicable').
- Year of analysis:
  - The more recent the study, the more applicable it is.

#### *Quality and relevance of effectiveness data used in the economic analysis:*

- The more closely the effectiveness data used in the economic analysis matches with the outcomes of the studies included in the clinical review the more useful the analysis will be for decision-making in the guideline.

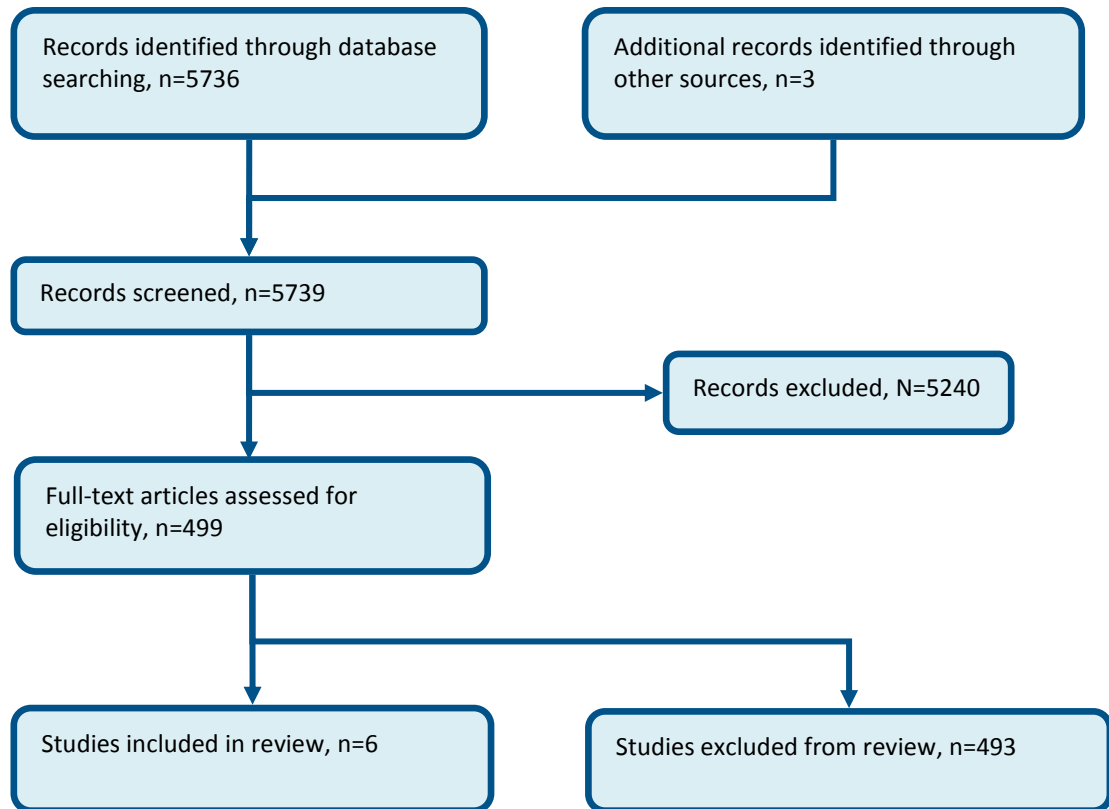
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(a) Recent reviews will be ordered although not reviewed. The bibliographies will be checked for relevant studies, which will then be ordered.

# 1 Appendix D: Clinical article selection

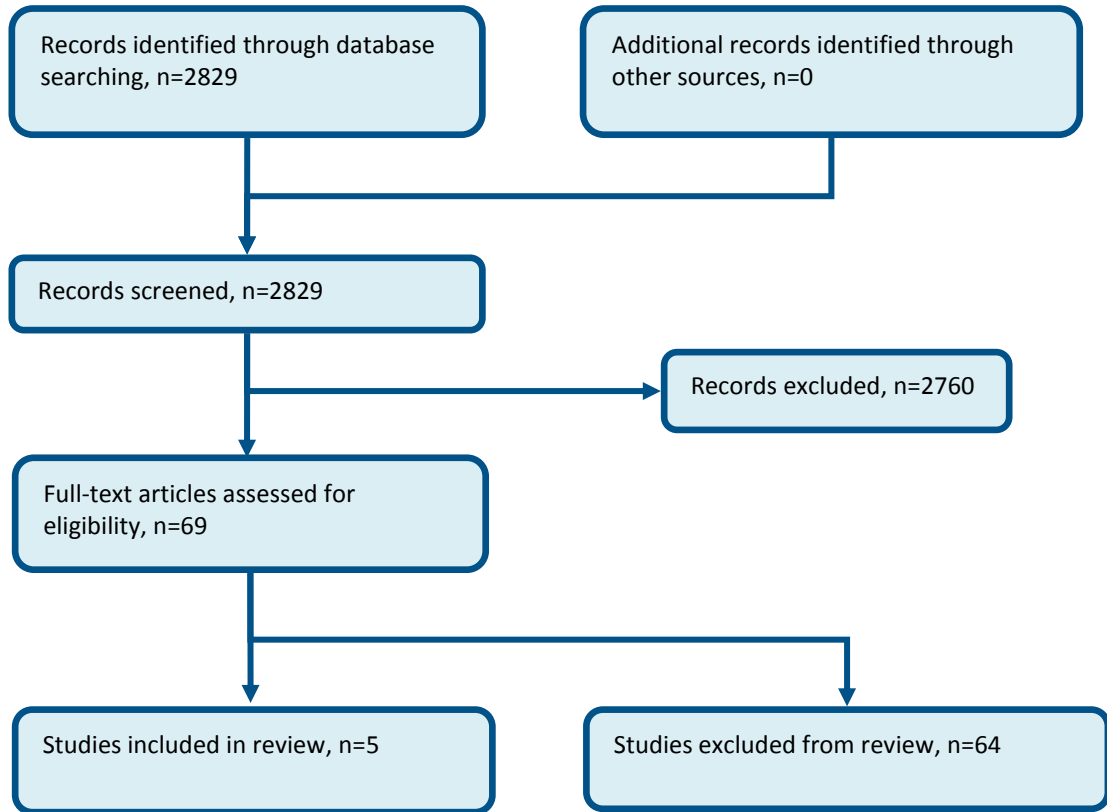
## 2 D.1 Diagnosis: Signs and symptoms

Figure 1: Flow diagram of article selection for the review of signs and symptoms



## 1 D.2 Diagnosis: History of atopic disorders

Figure 2: Flow diagram of clinical article selection for the review of history of atopic disorders

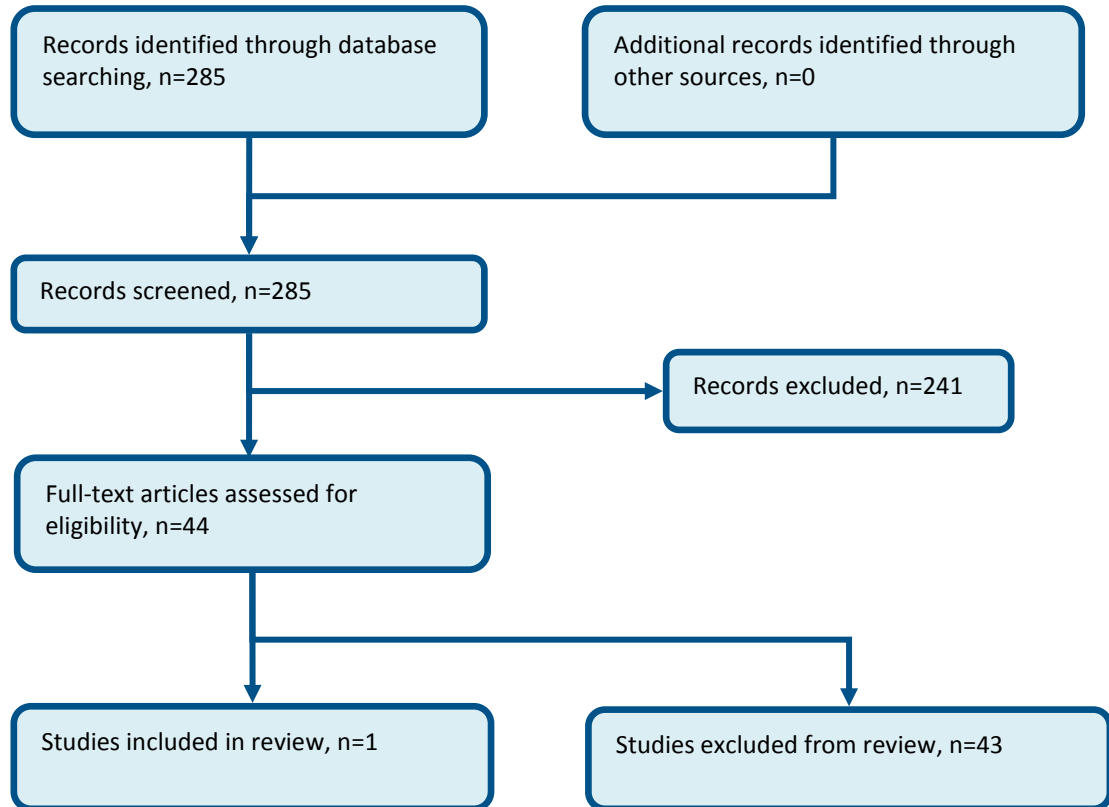


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### 1 D.3 Diagnosis: Symptoms after exercise

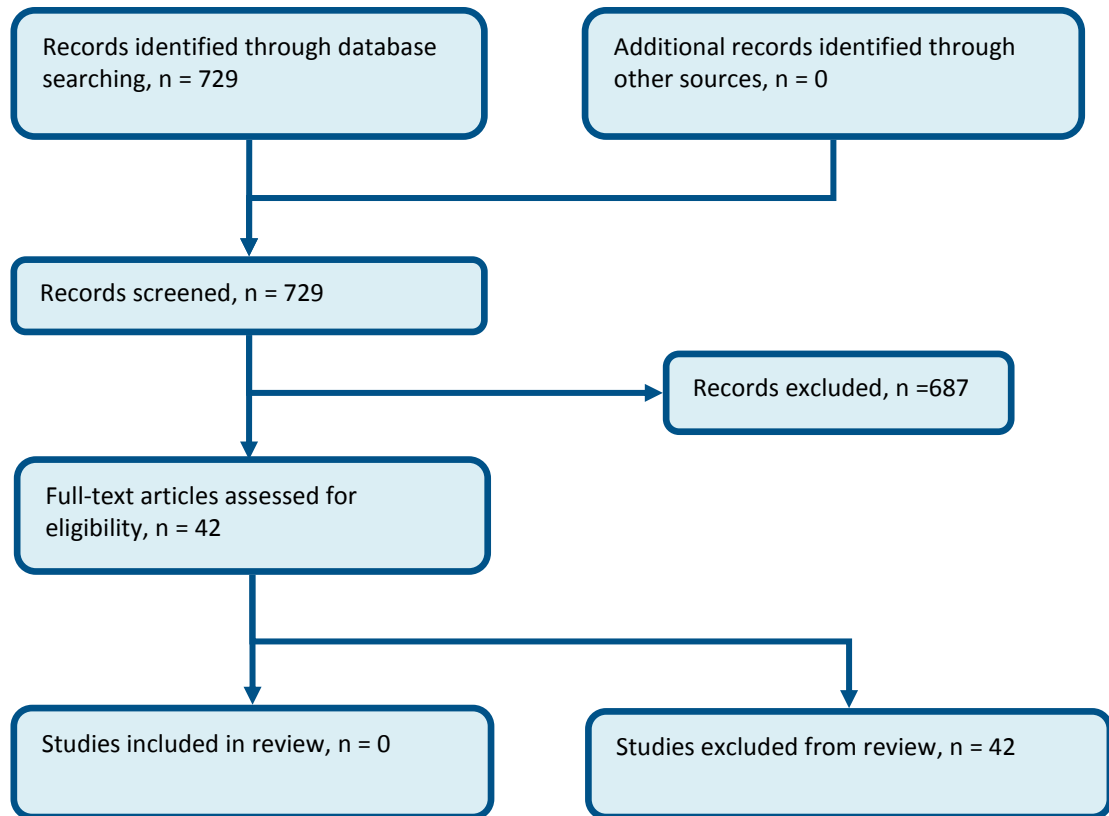
Figure 3: Flow diagram of clinical article selection for the review of symptoms after exercise



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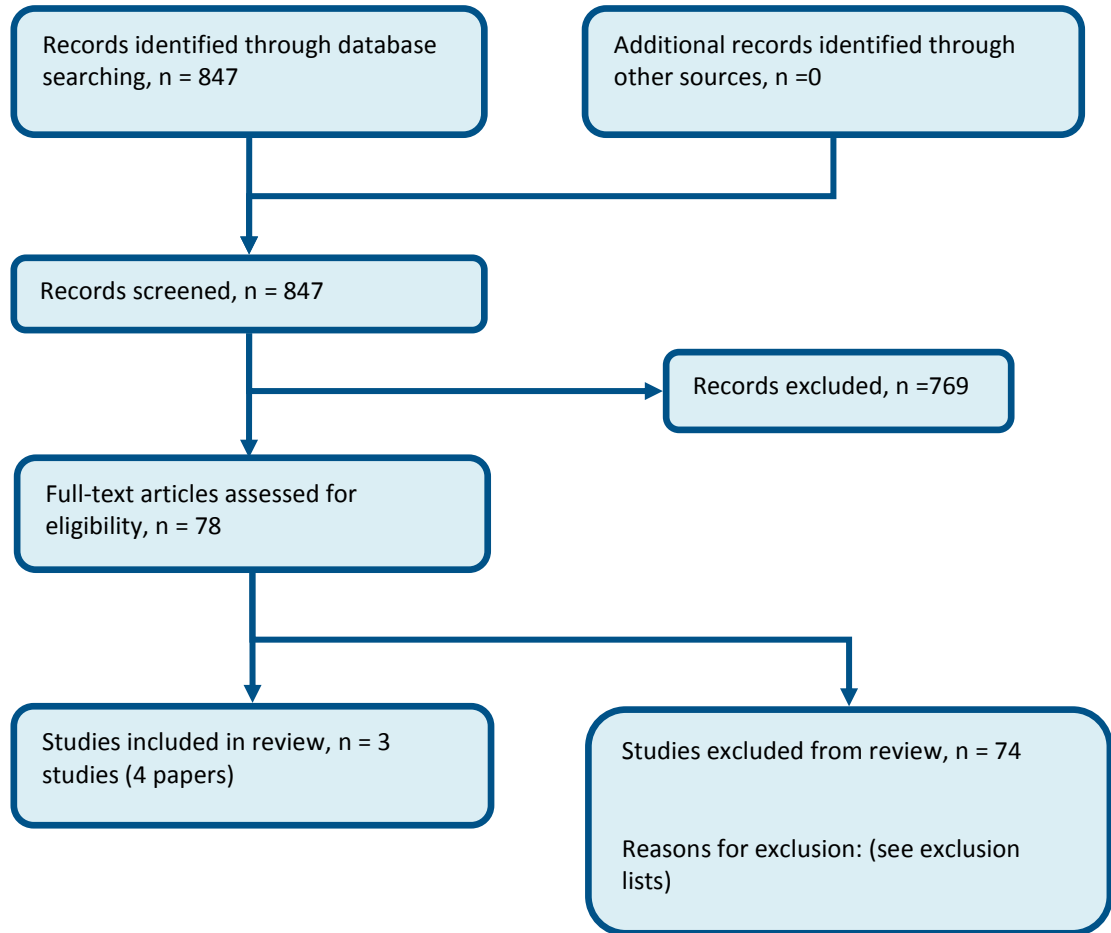
## 1 D.4 Diagnosis: Symptoms after using medication

Figure 4: Flow diagram of clinical article selection for the review of symptoms after using medication



1 **D.5 Diagnosis: Occupational asthma**

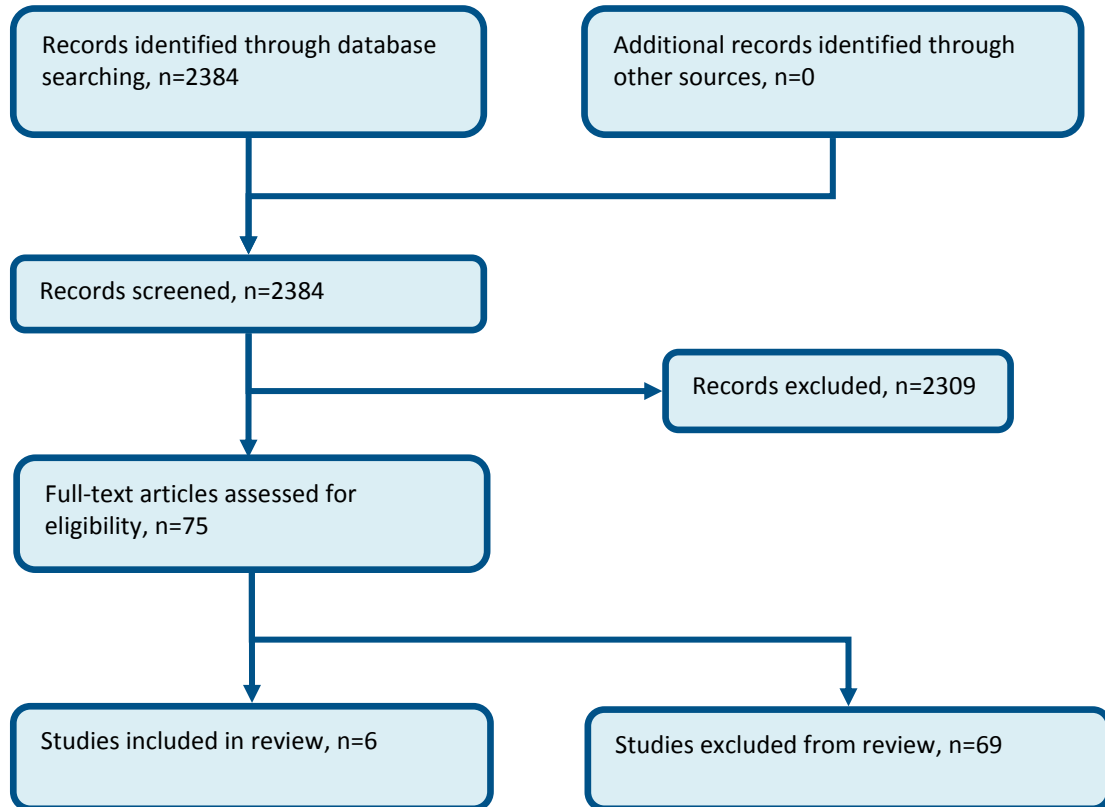
2 **Figure 5: Flow diagram of clinical article selection for the review of occupational asthma**



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## 1 D.6 Diagnosis: Spirometry

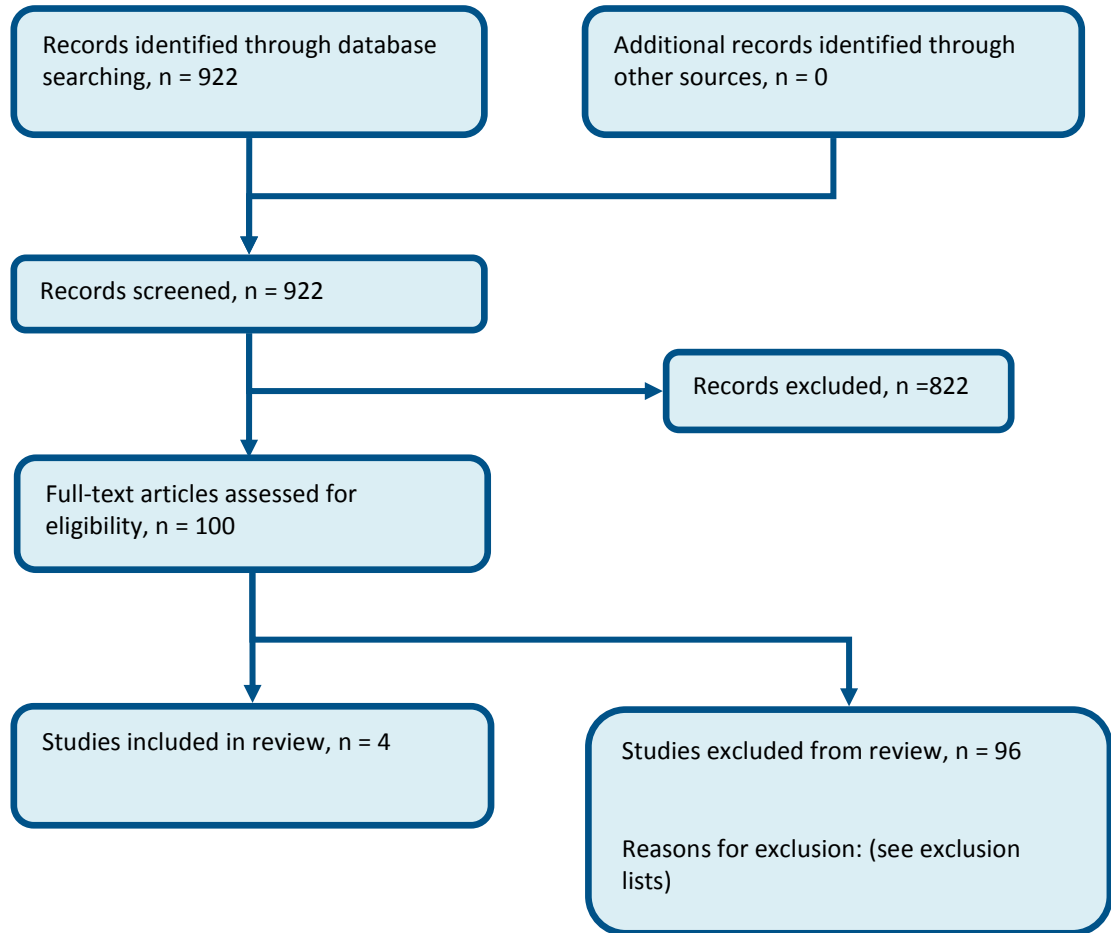
Figure 6: Flow diagram of clinical article selection for the review of spirometry



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1 **D.7 Diagnosis: Bronchodilator reversibility**

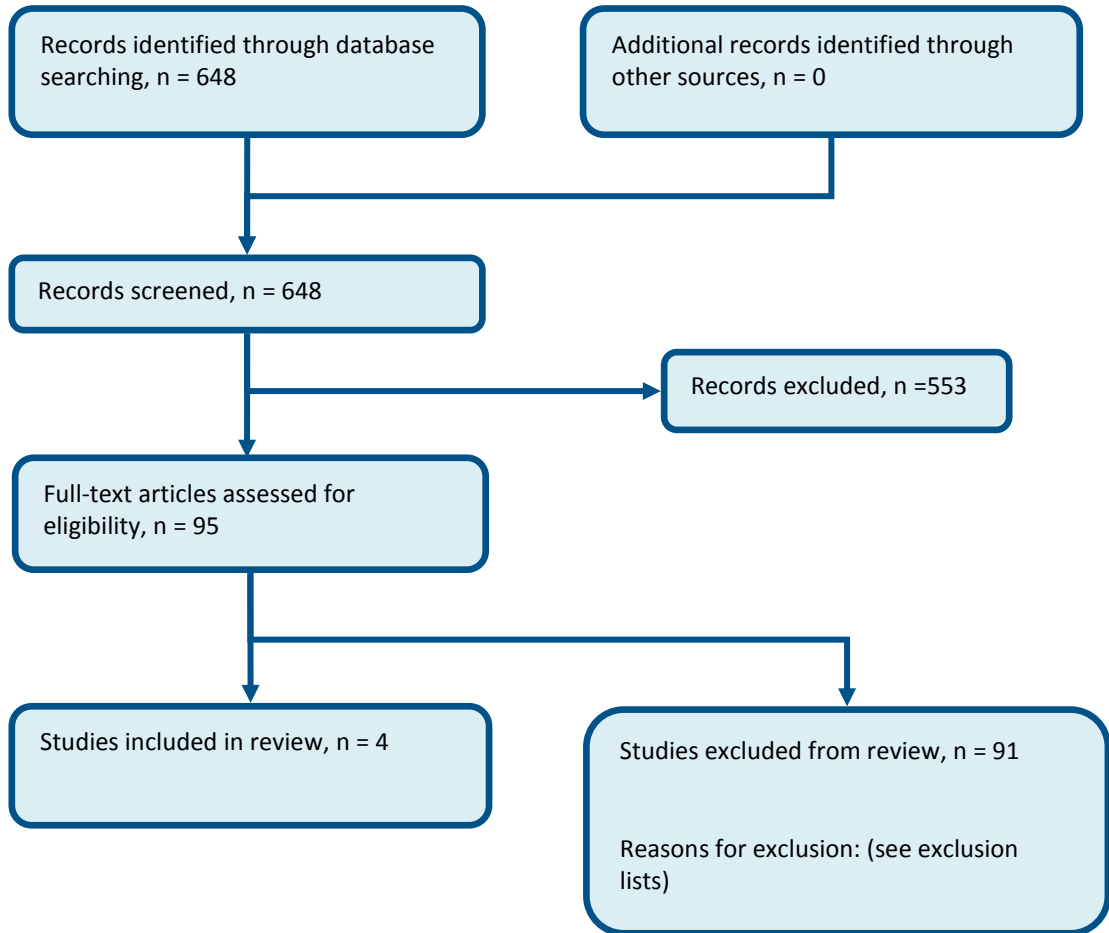
2 **Figure 7: Flow diagram of clinical article selection for the review of bronchodilator reversibility**



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1 **D.8 Diagnosis: PEF variability**

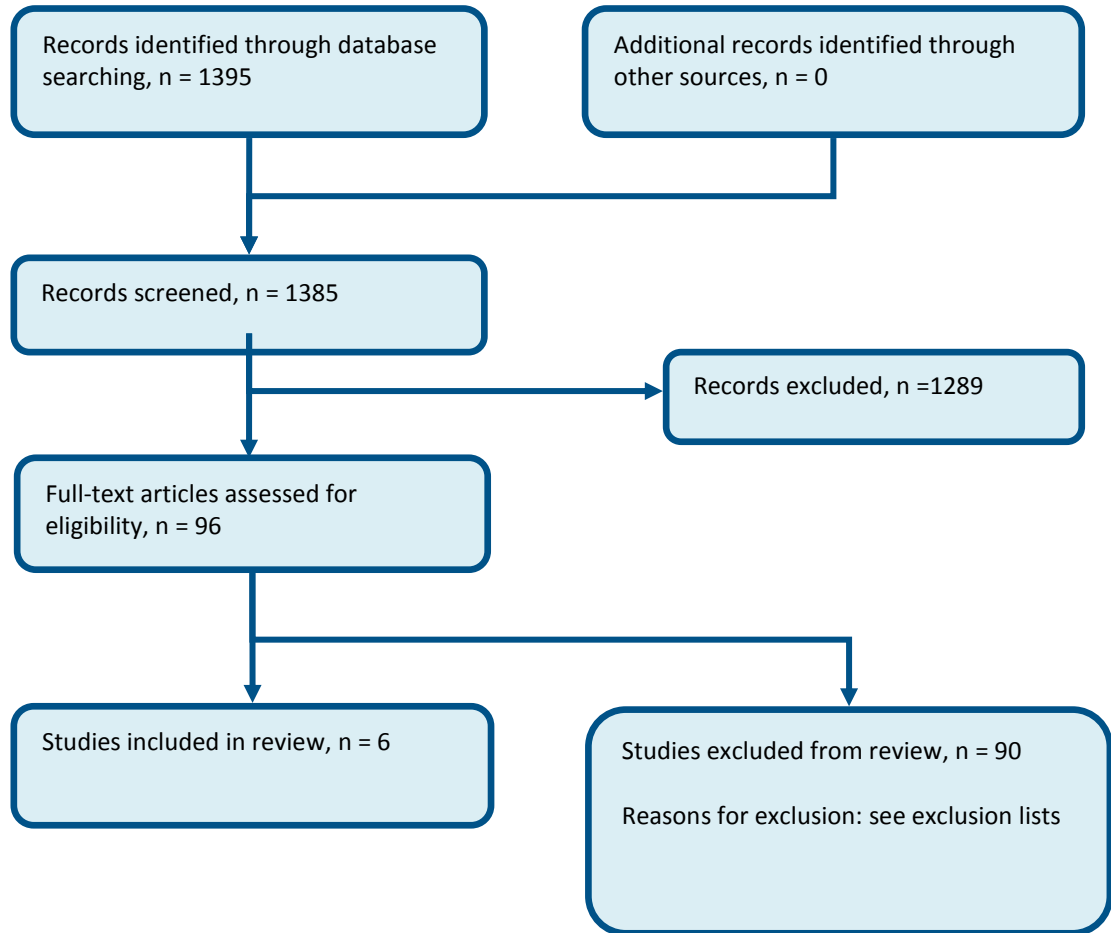
2 **Figure 8: Flow diagram of clinical article selection for the review of PEF variability**



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1 **D.9 Diagnosis: Skin prick tests**

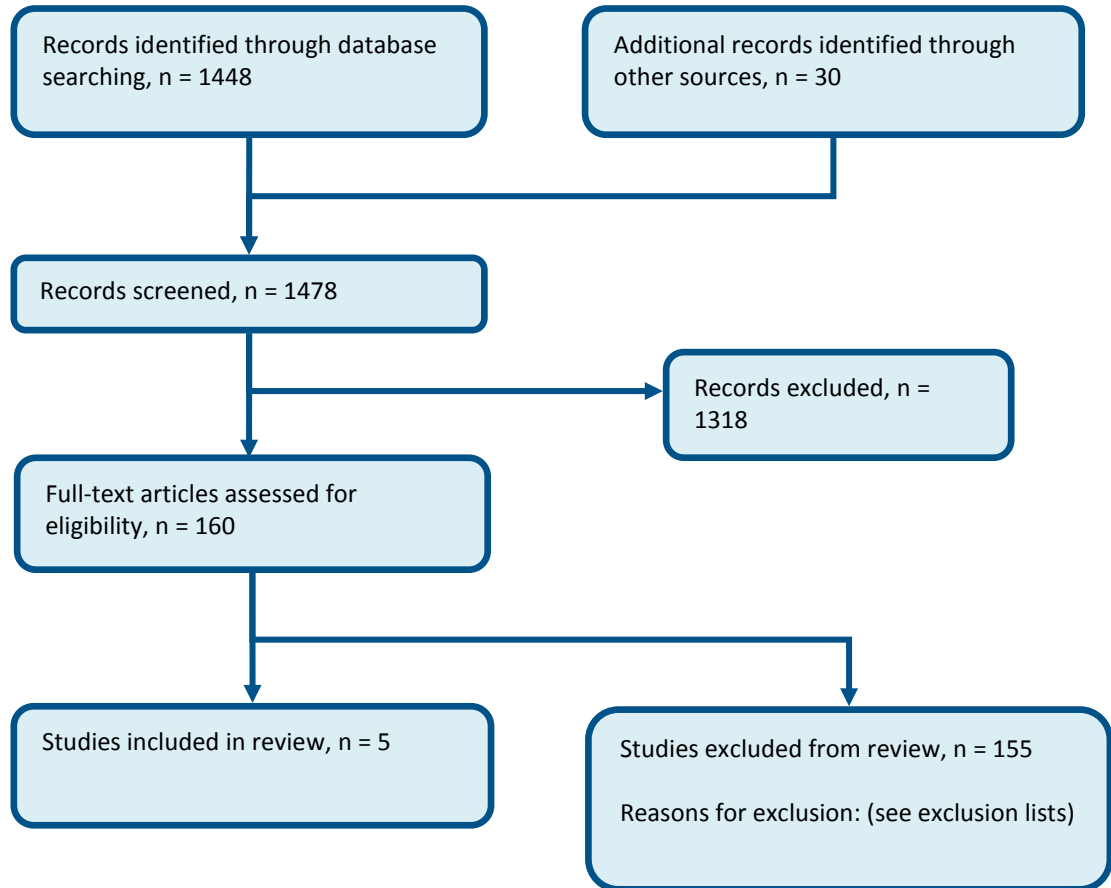
2 **Figure 9: Flow diagram of clinical article selection for the review of skin prick tests**



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1 **D.10 Diagnosis: IgE**

2 **Figure 10: Flow diagram of clinical article selection for the review of IgE**

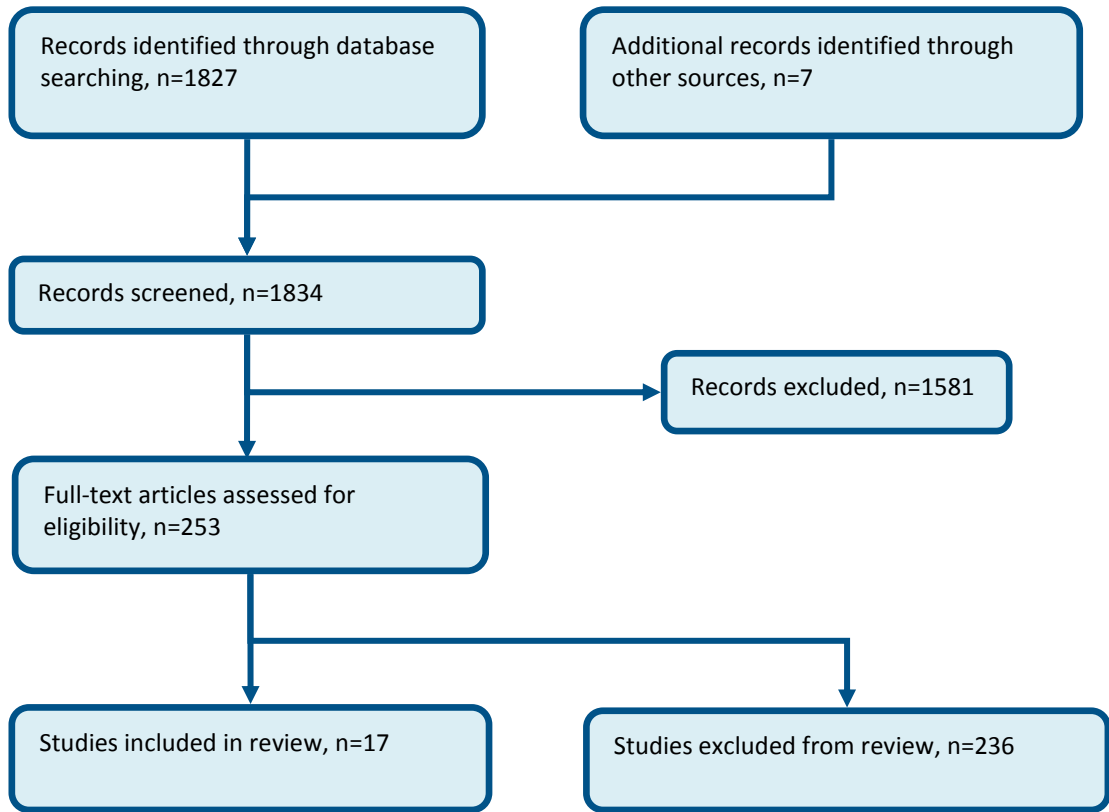


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## 1 D.11 Diagnosis: FeNO

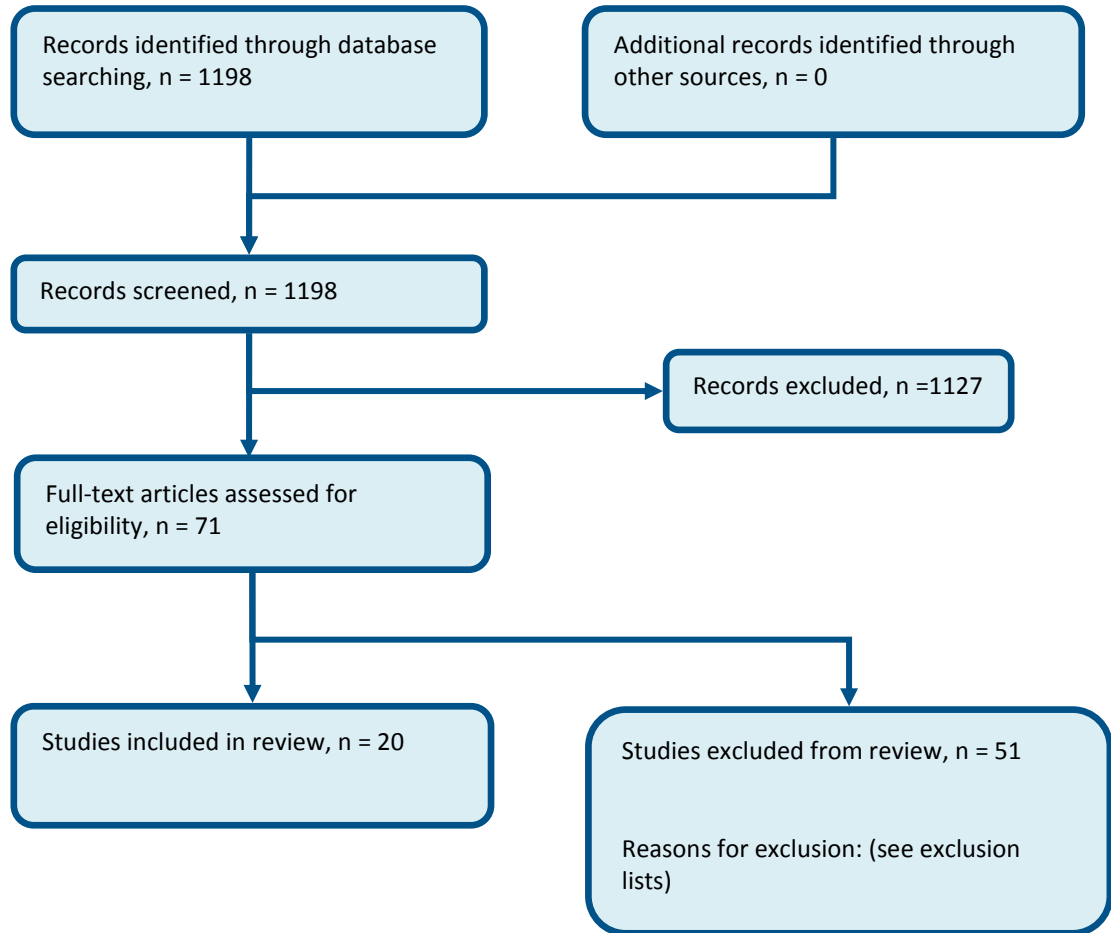
Figure 11: Flow diagram of article selection for the review of FeNO



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1 **D.12 Diagnosis: Eosinophils**

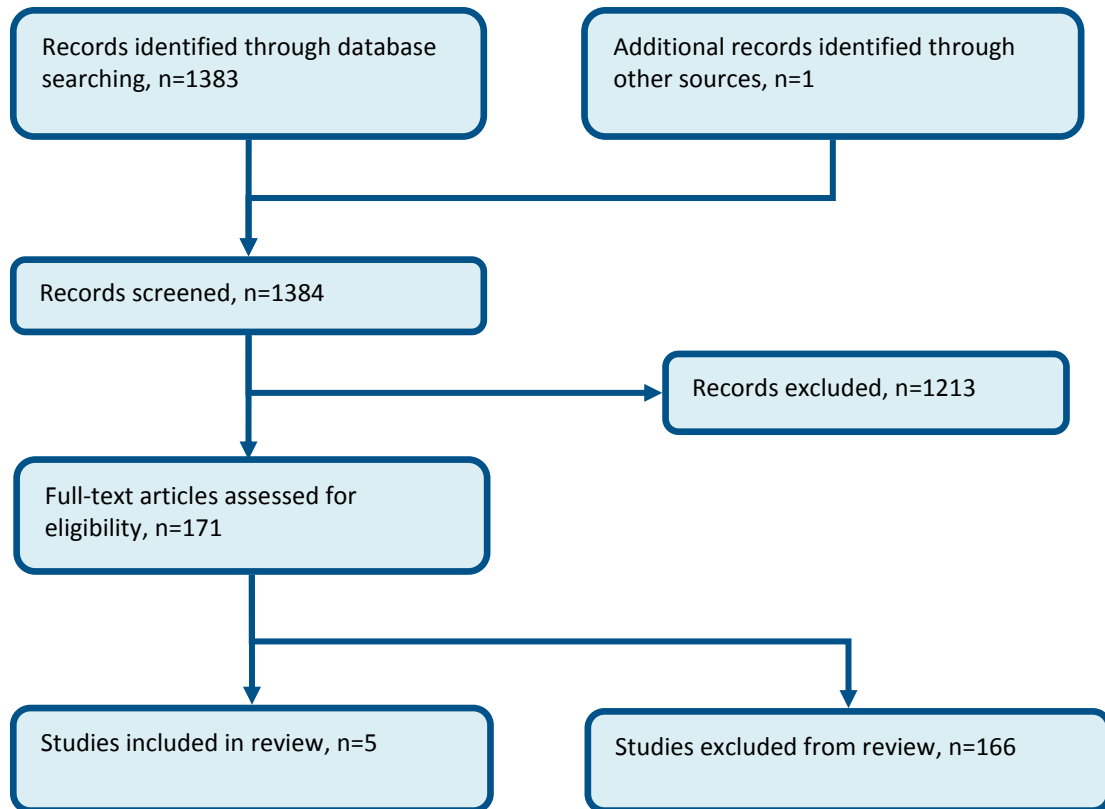
2 **Figure 12: Flow diagram of clinical article selection for the review of peripheral blood eosinophils**



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## 1 D.13 Diagnosis: Histamine and methacholine

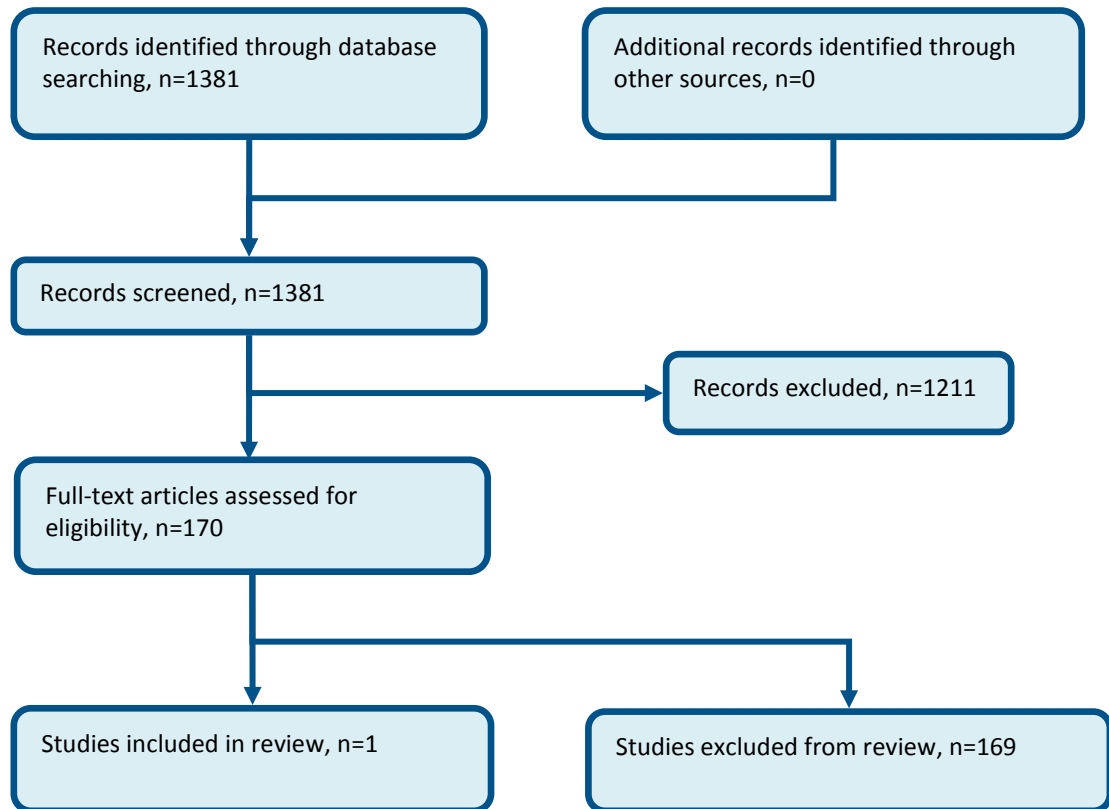
**Figure 13: Flow diagram of clinical article selection for the review of histamine and methacholine challenge tests**



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## 1 D.14 Diagnosis: Mannitol

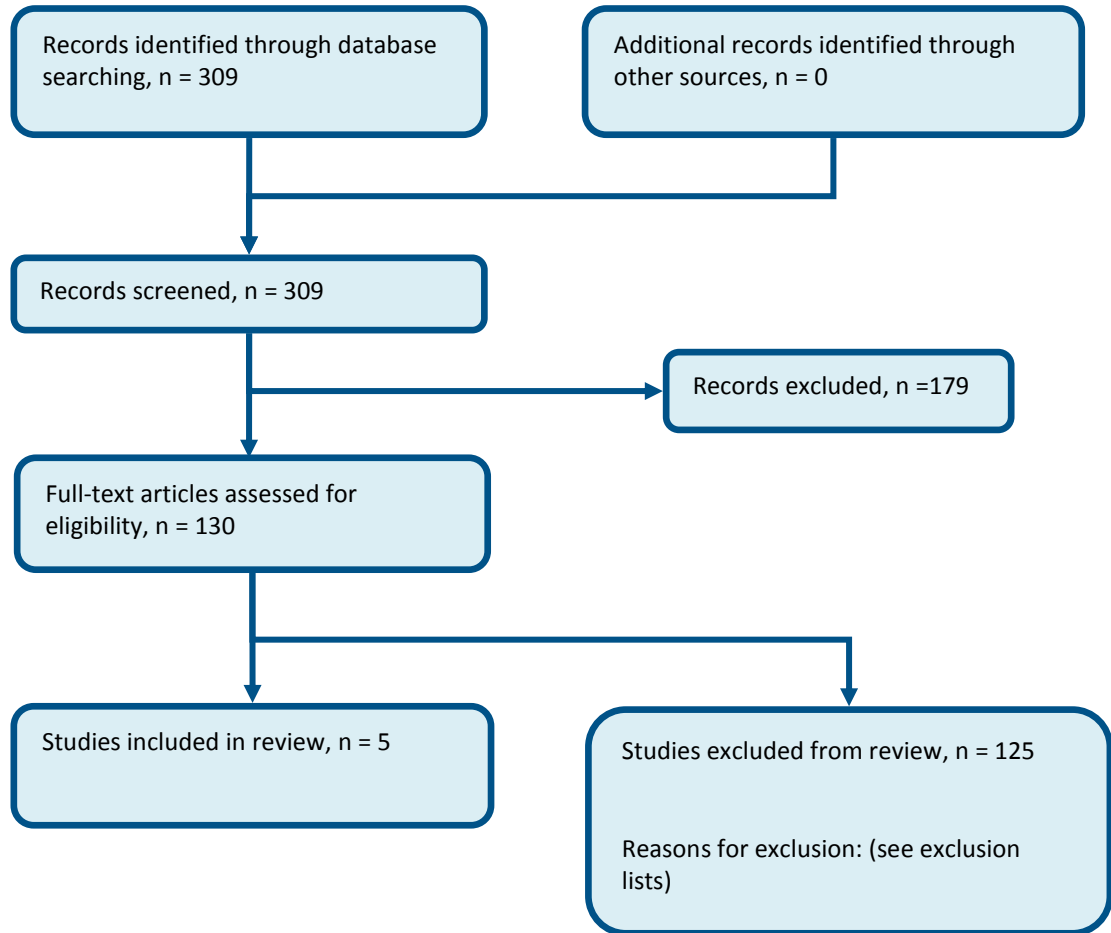
Figure 14: Flow diagram of clinical article selection for the review of mannitol challenge test



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1 **D.15 Diagnosis: Exercise**

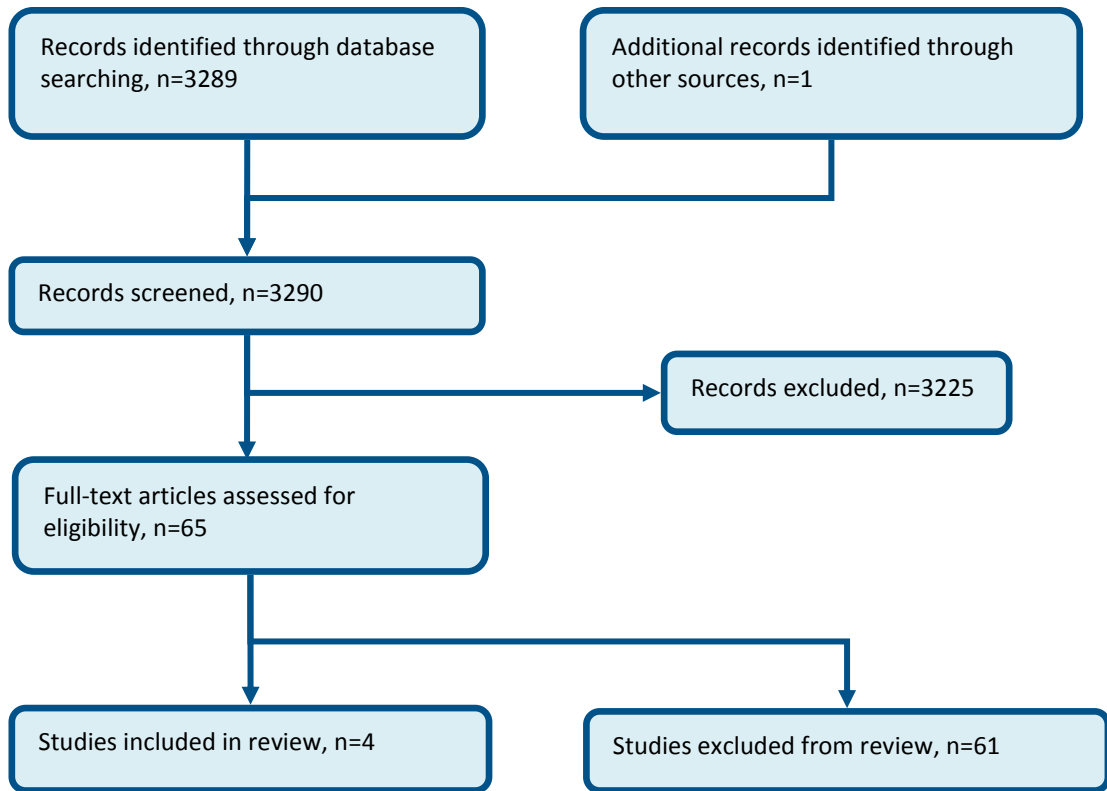
2 **Figure 15: Flow diagram of clinical article selection for the review of exercise challenge test**



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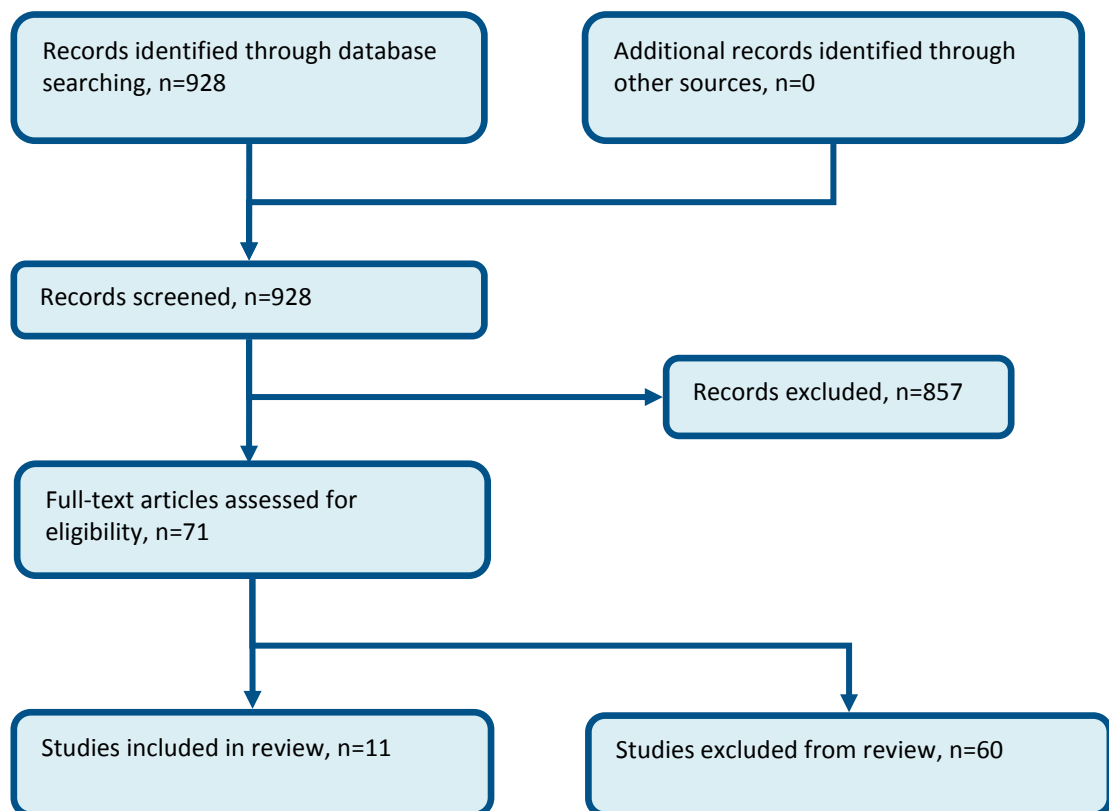
## 1 D.16 Monitoring: Questionnaires

2 **Figure 16: Flow chart of clinical article selection for the review of symptom scores/diaries or**  
3 **validated questionnaires to monitor asthma control**



## 1 D.17 Monitoring: Lung function tests

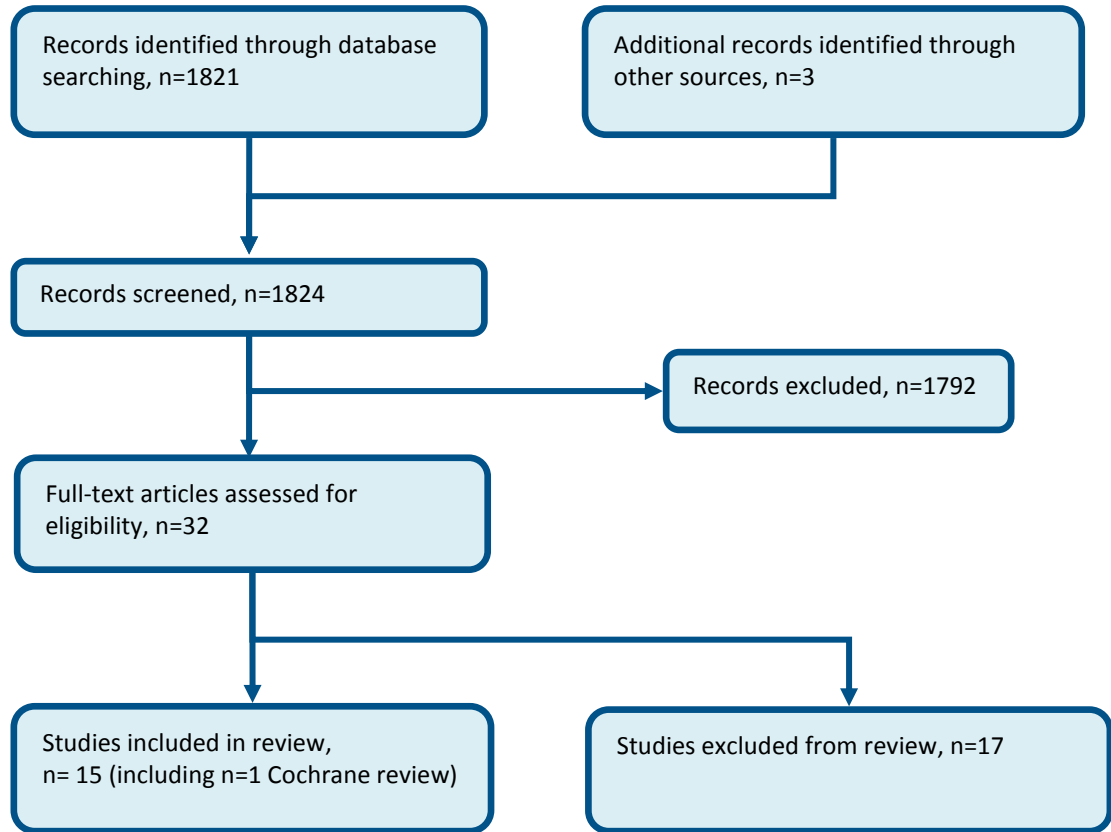
Figure 17: Flow chart of clinical article selection for the review of lung function tests to monitor asthma control



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1 **D.18 Monitoring: FeNO**

2 **Figure 18: Flow chart of clinical article selection for the review of FeNO to monitor asthma control**

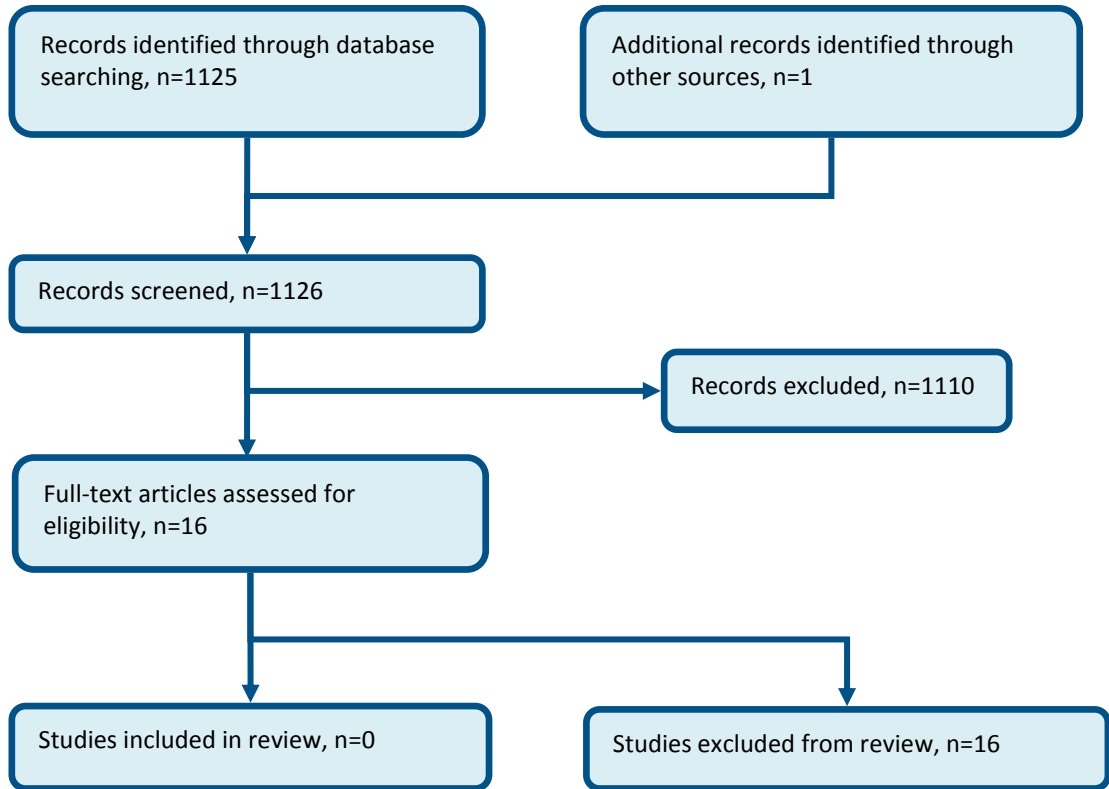


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1 **D.19 Monitoring: Peripheral blood eosinophils**

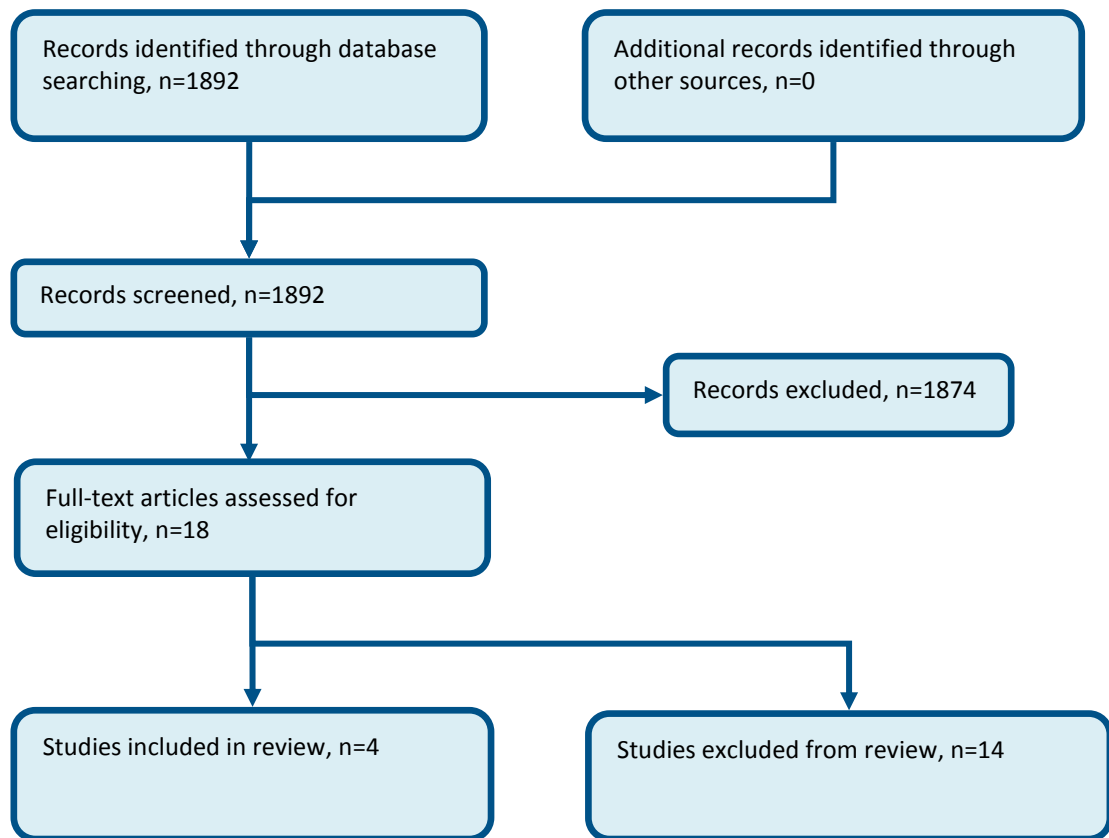
2 **Figure 19: Flow chart of clinical article selection for the review of peripheral blood eosinophils to**  
3 **monitor asthma control**



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## 1 D.20 Monitoring: Challenge tests

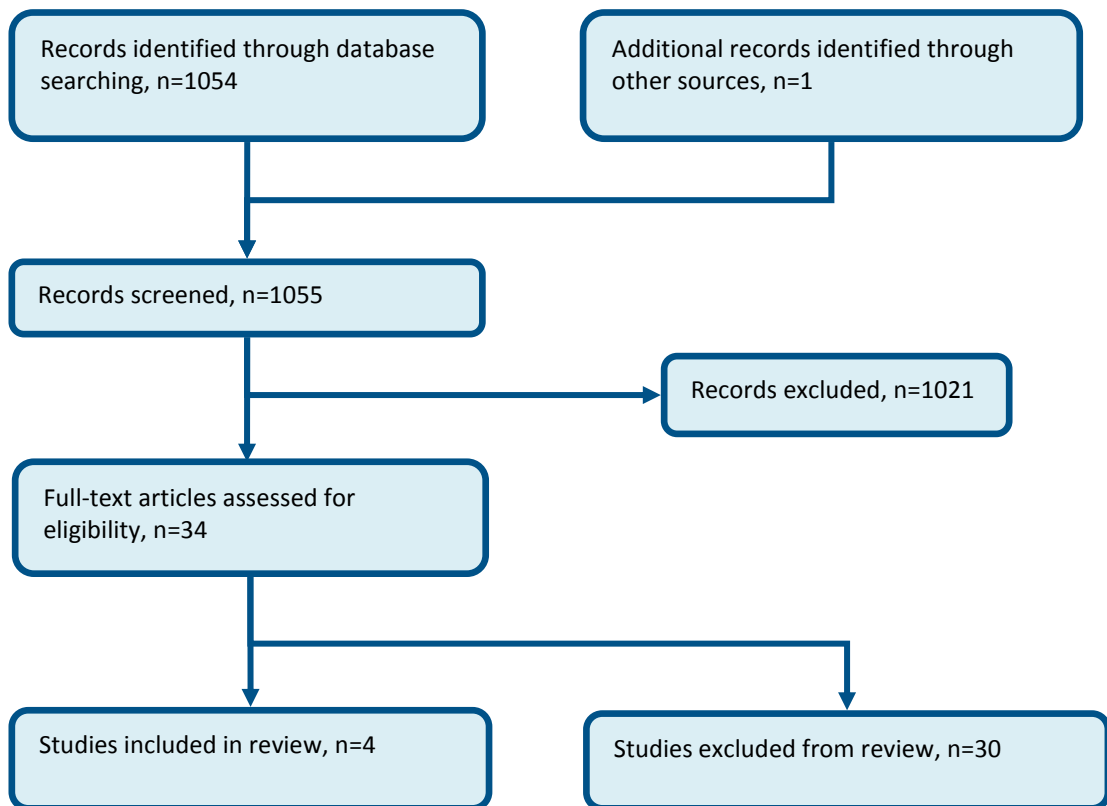
**Figure 20: Flow chart of clinical article selection for the review of challenge tests to monitor asthma control**



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## 1 D.21 Monitoring: Adherence to treatment

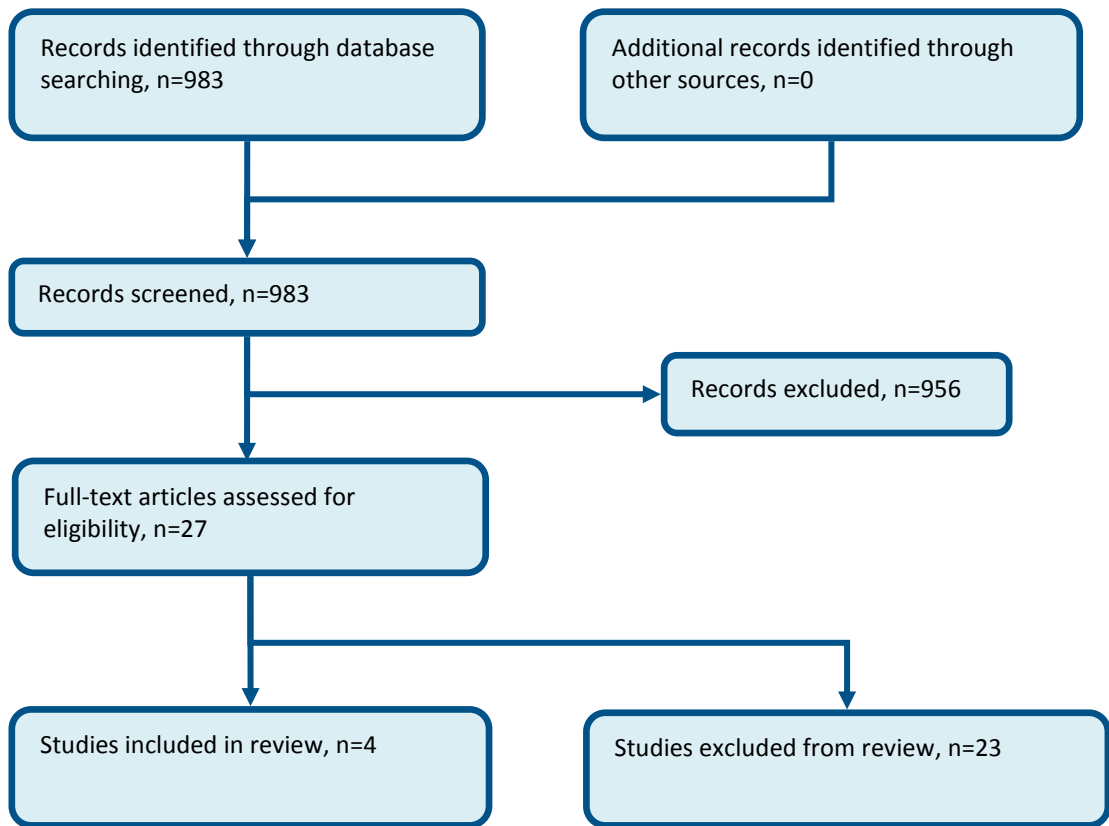
**Figure 21: Flow chart of clinical article selection for the review of monitoring adherence to treatment**



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## 1 D.22 Monitoring: Inhaler technique

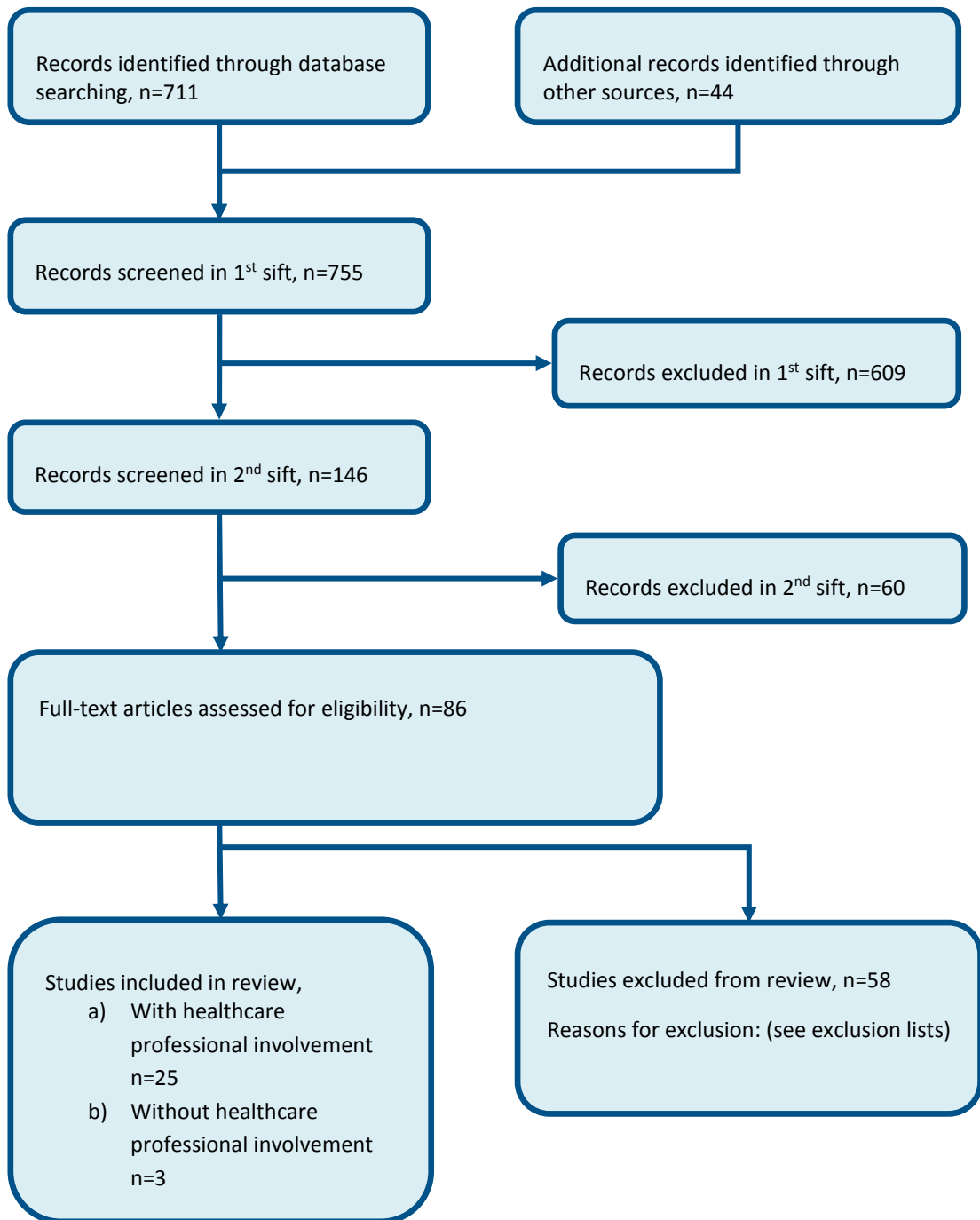
Figure 22: Flow chart of clinical article selection for the review of monitoring inhaler technique



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## 1 D.23 Monitoring: Tele-healthcare

2 **Figure 23: Flow chart of clinical article selection for the review of tele-healthcare to monitor**  
3 **asthma control**

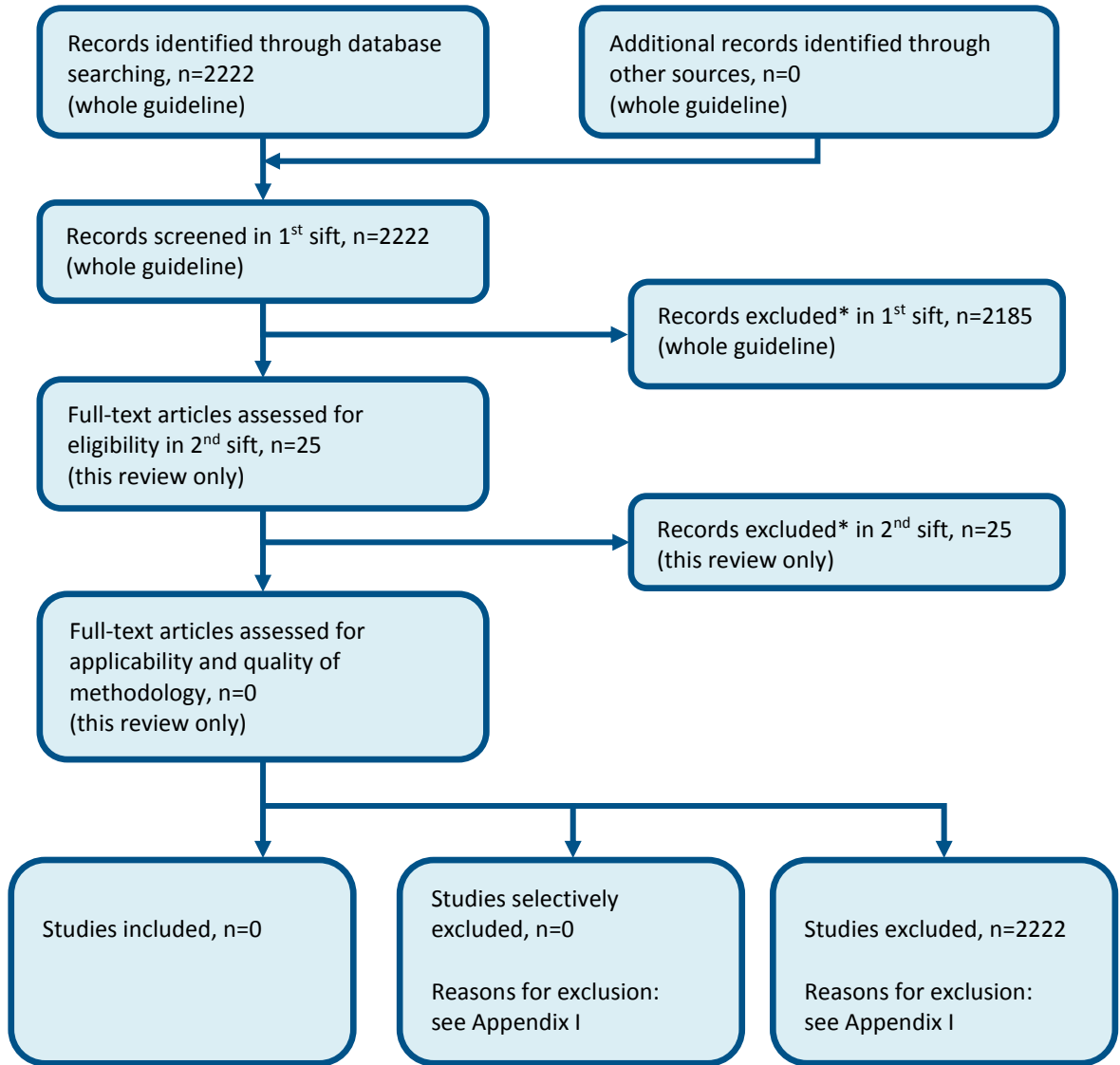


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# 1 Appendix E: Economic article selection

## 2 E.1 Diagnosis: Signs and symptoms

Figure 24: Flow chart of economic article selection for the review of signs and symptoms

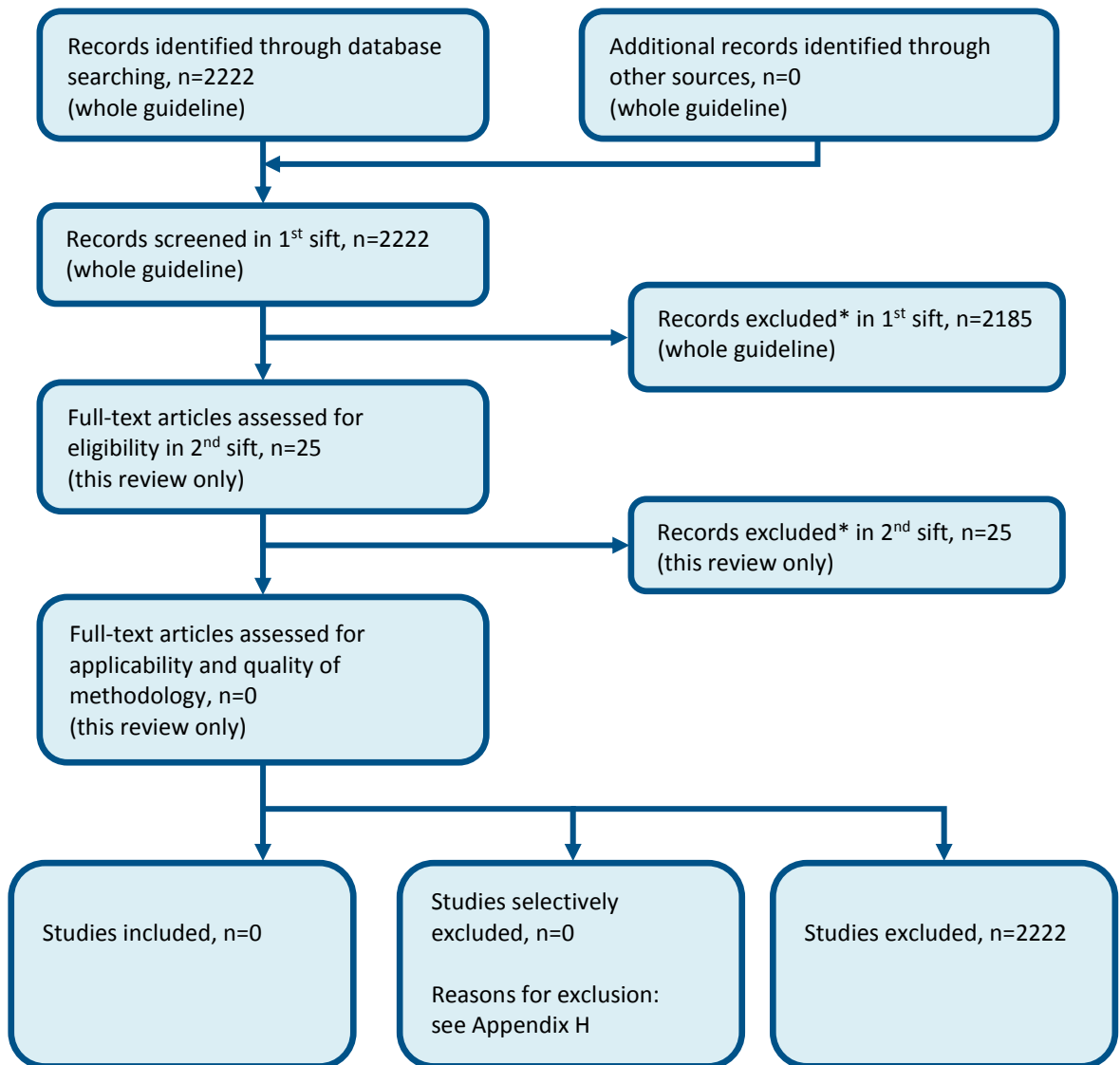


\* Non-relevant population, intervention, comparison, design or setting; non-English language

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## 1 E.2 Diagnosis: History of atopic disorders

Figure 25: Flow diagram of economic article selection for the review of history of atopic disorders

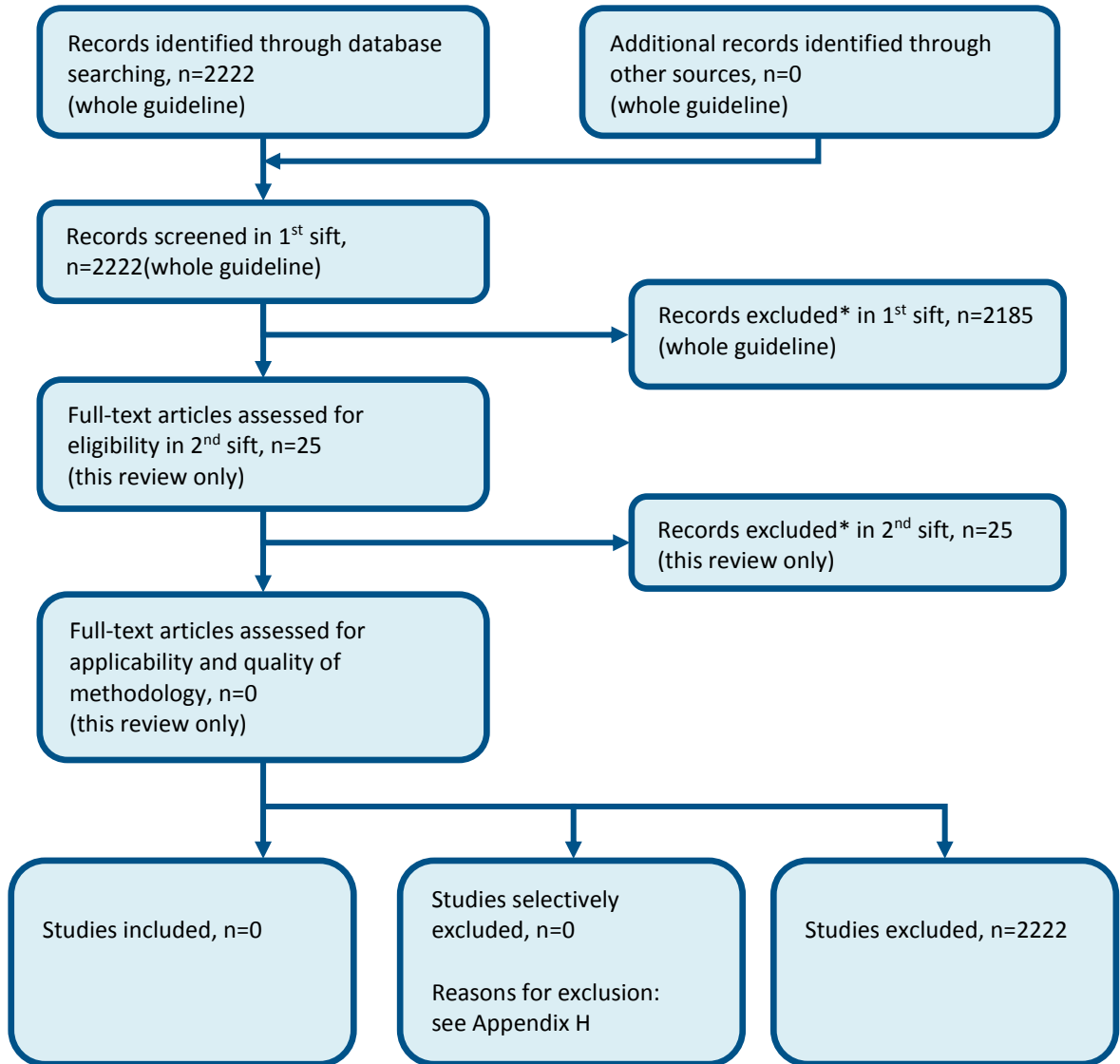


\* Non-relevant population, intervention, comparison, design or setting; non-English language

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### 1 E.3 Diagnosis: Symptoms after exercise

Figure 26: Flow diagram of economic article selection for the review of symptoms in response to exercise



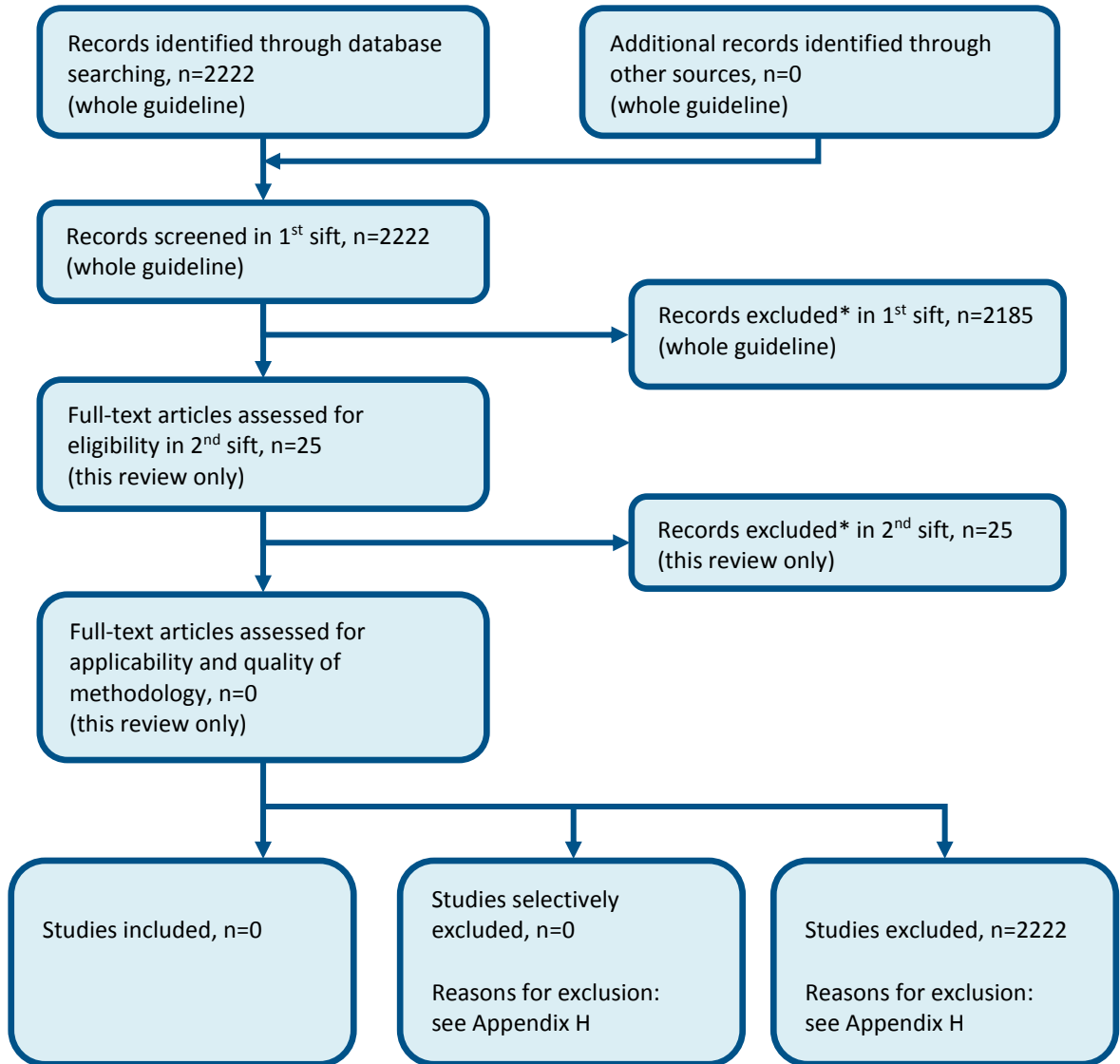
\* Non-relevant population, intervention, comparison, design or setting; non-English language

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## 1 E.4 Diagnosis: Symptoms after using medication

Figure 27: Flow diagram of economic article selection for the review of history of symptoms after using medication

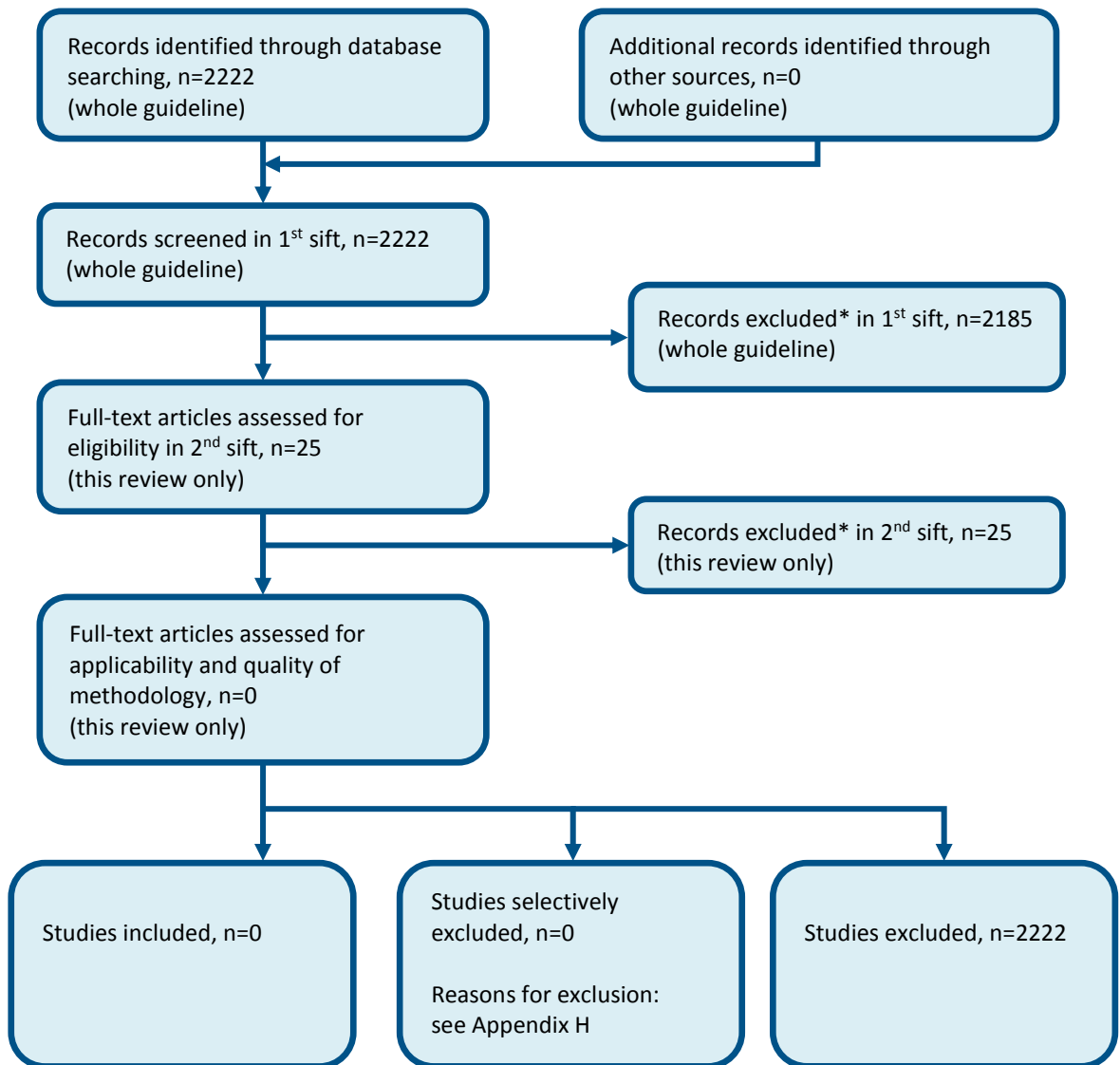


\* Non-relevant population, intervention, comparison, design or setting; non-English language

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## 1 E.5 Diagnosis: Occupational asthma

Figure 28: Flow diagram of economic article selection for the review of occupational asthma

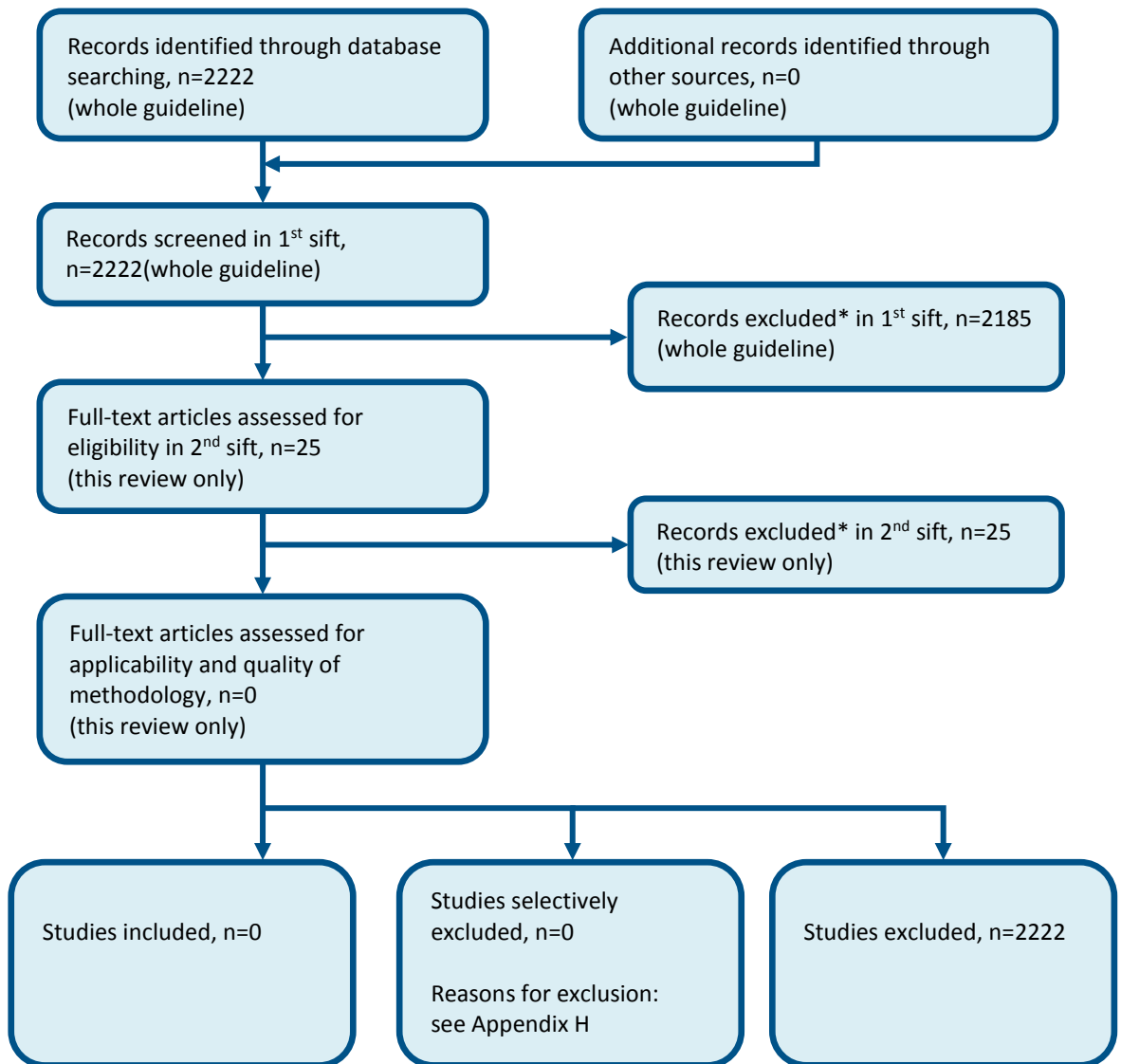


\* Non-relevant population, intervention, comparison, design or setting; non-English language

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## 1 E.6 Diagnosis: Spirometry

Figure 29: Flow diagram of economic article selection for the review of spirometry

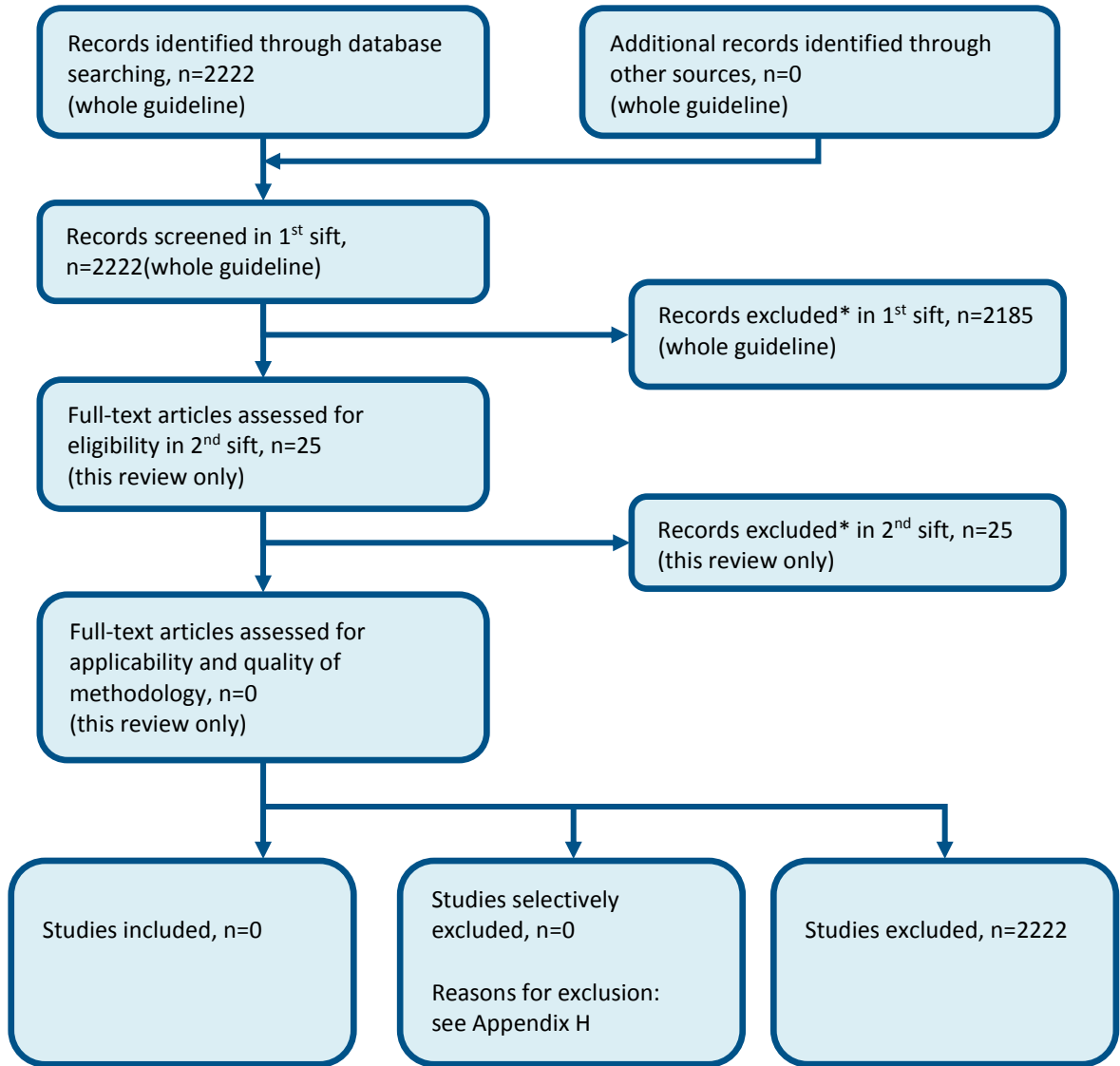


\* Non-relevant population, intervention, comparison, design or setting; non-English language

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## 1 E.7 Diagnosis: Bronchodilator reversibility

Figure 30: Flow diagram of economic article selection for the review of bronchodilator reversibility

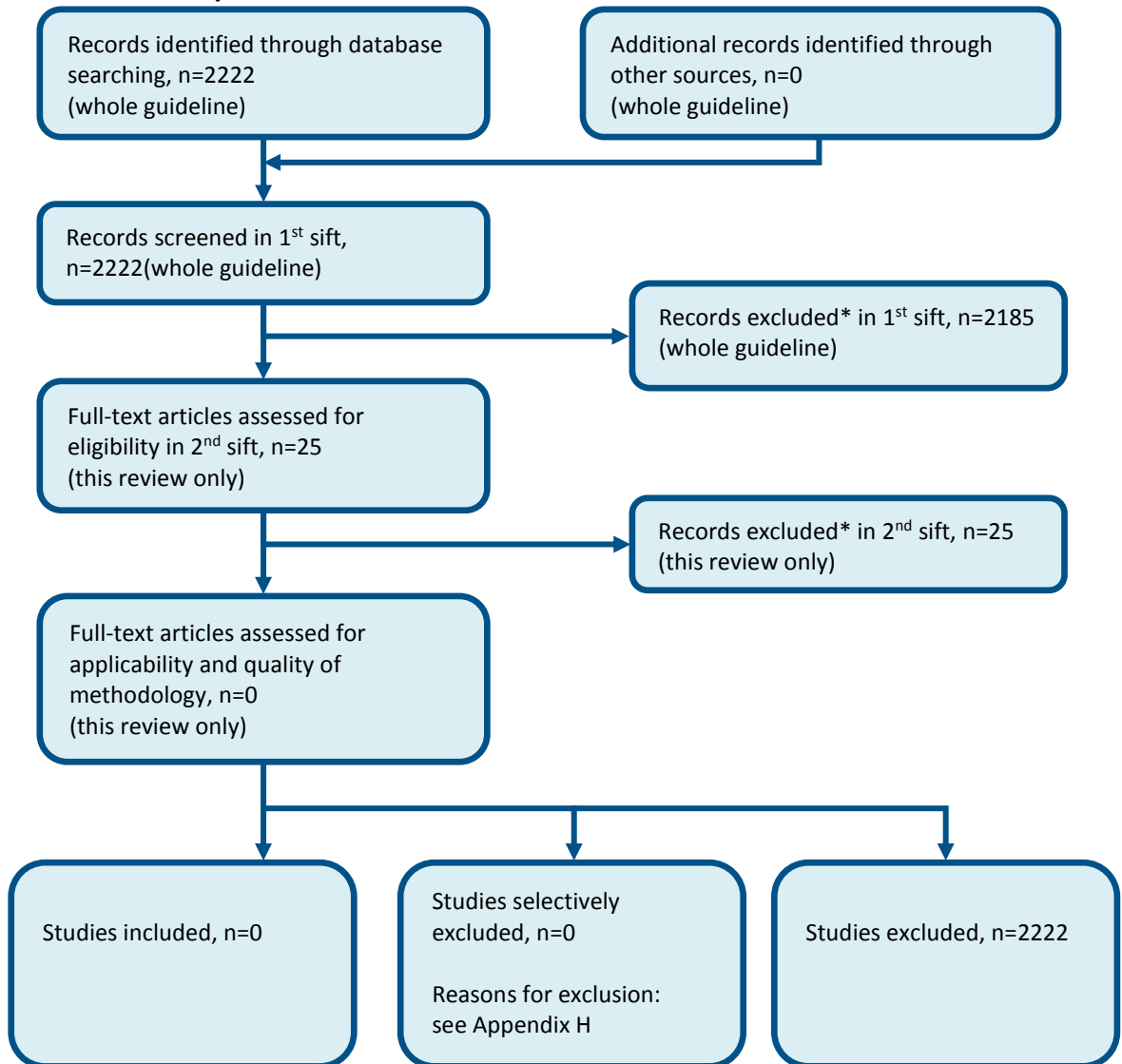


\* Non-relevant population, intervention, comparison, design or setting; non-English language

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## 1 E.8 Diagnosis: PEF variability

Figure 31: Flow chart of economic article selection for the review of peak expiratory flow variability

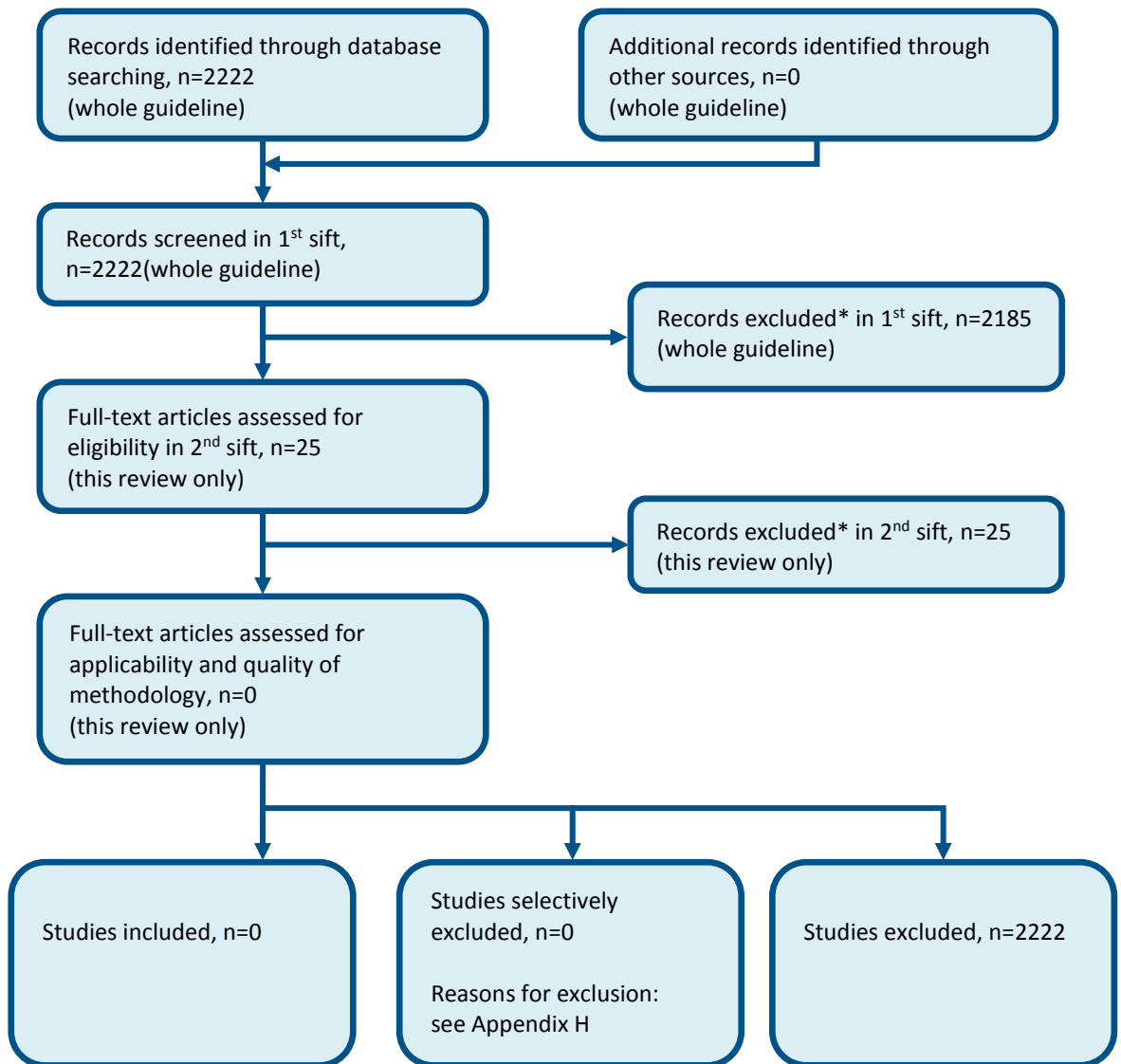


\* Non-relevant population, intervention, comparison, design or setting; non-English language

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## 1 E.9 Diagnosis: Skin prick tests

Figure 32: Flow diagram of economic article selection for the review of skin prick tests

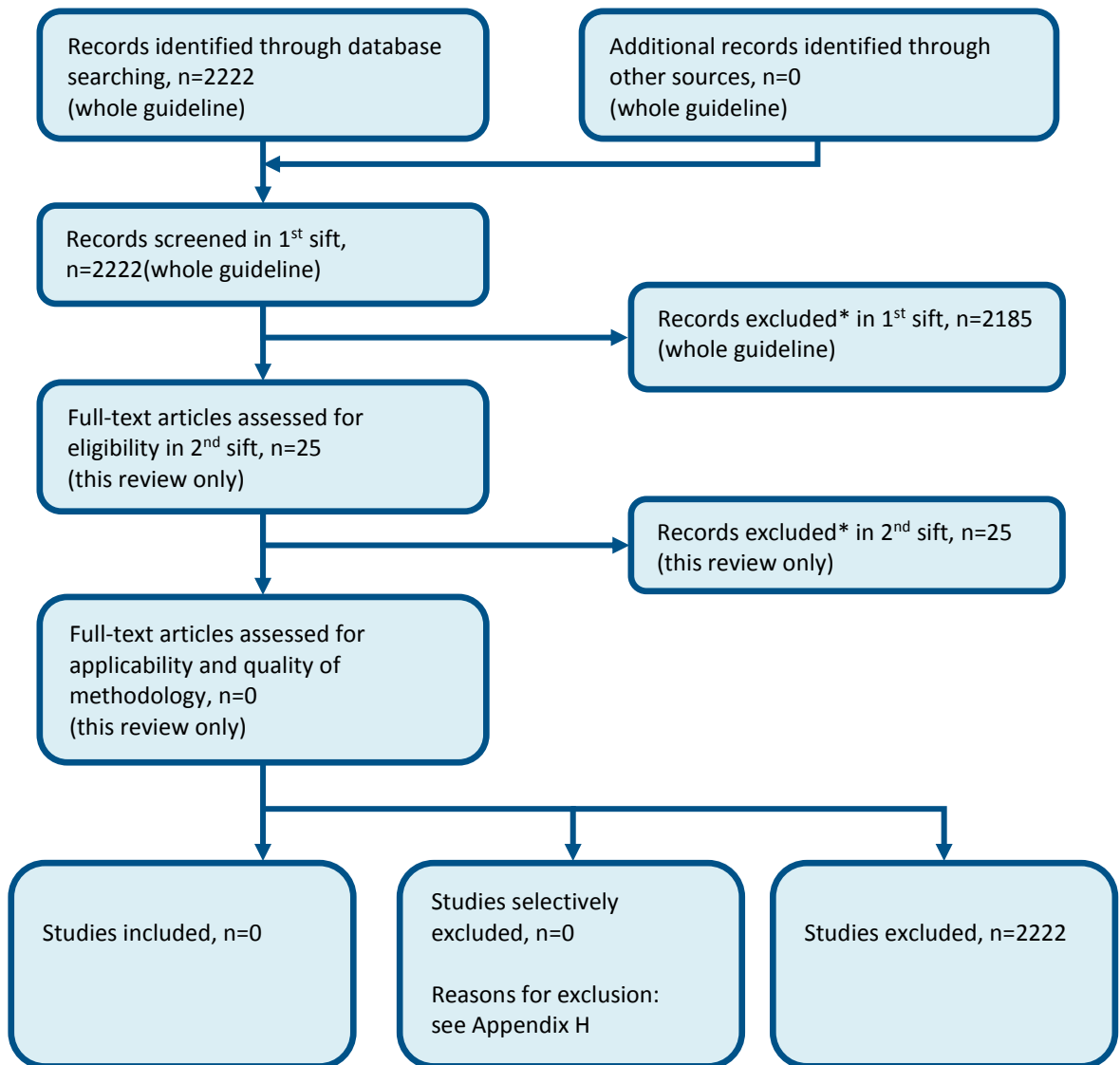


\* Non-relevant population, intervention, comparison, design or setting; non-English language

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## 1 E.10 Diagnosis: IgE

Figure 33: Flow diagram of economic article selection for the review of IgE

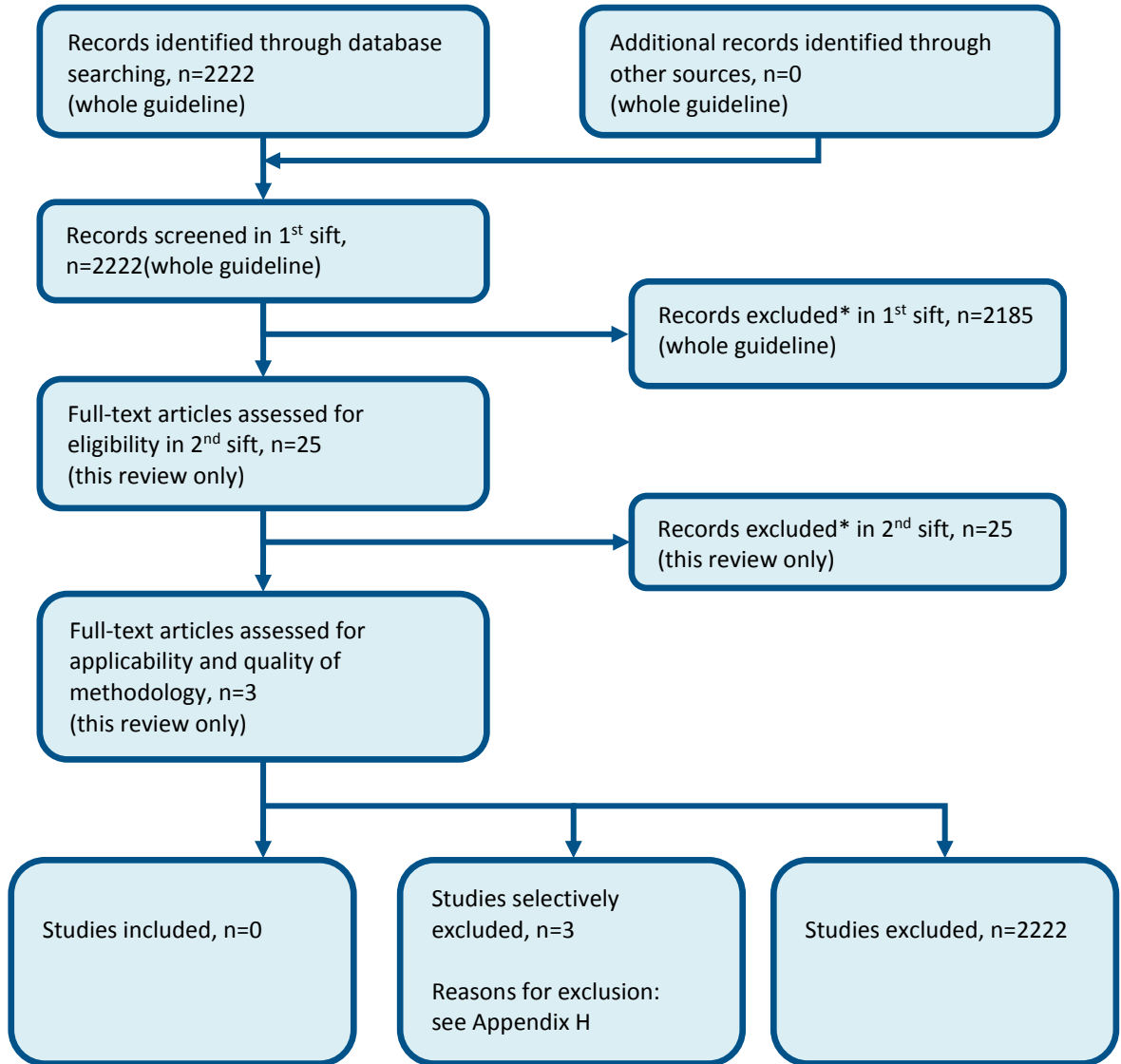


\* Non-relevant population, intervention, comparison, design or setting; non-English language

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## 1 E.11 Diagnosis: FeNO

Figure 34: Flow chart of economic article selection for the review of FeNO for asthma diagnosis



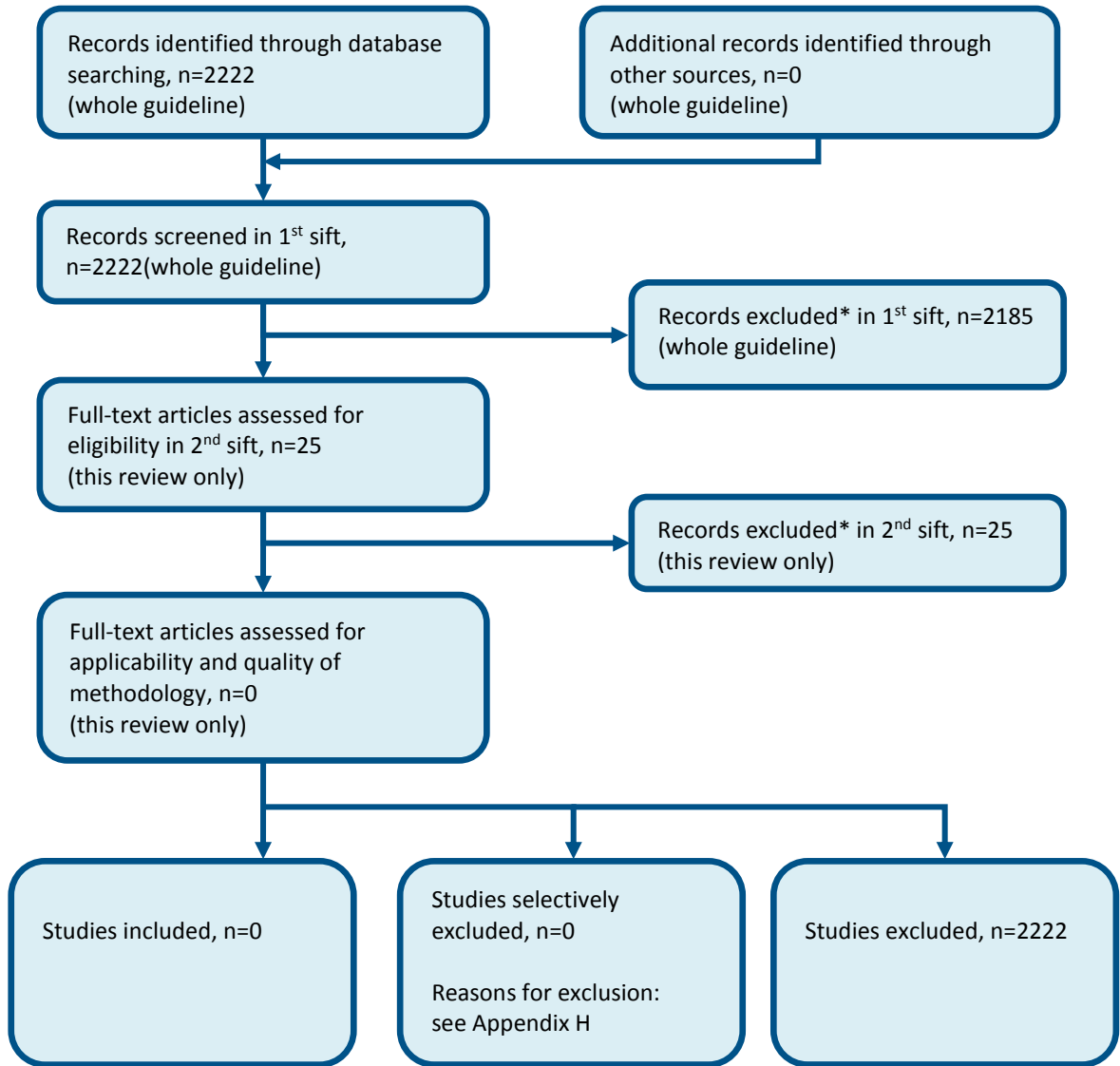
\* Non-relevant population, intervention, comparison, design or setting; non-English language

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## 1 E.12 Diagnosis: Eosinophils

2 **Figure 35: Flow diagram of economic article selection for the review of eosinophils**

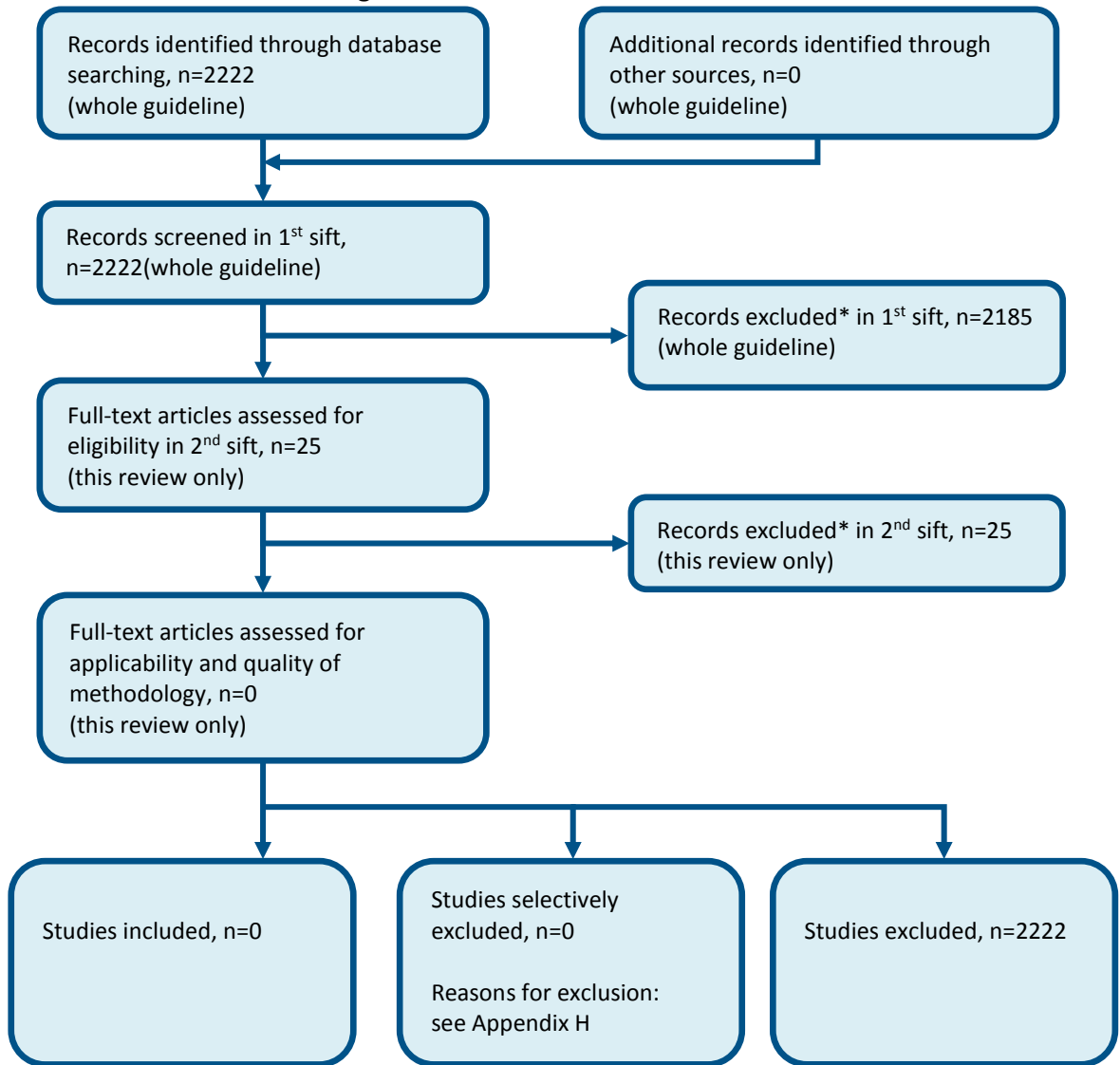


\* Non-relevant population, intervention, comparison, design or setting; non-English language

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## 1 E.13 Diagnosis: Histamine and methacholine

Figure 36: Flow diagram of economic article selection for the review of histamine and methacholine challenge tests

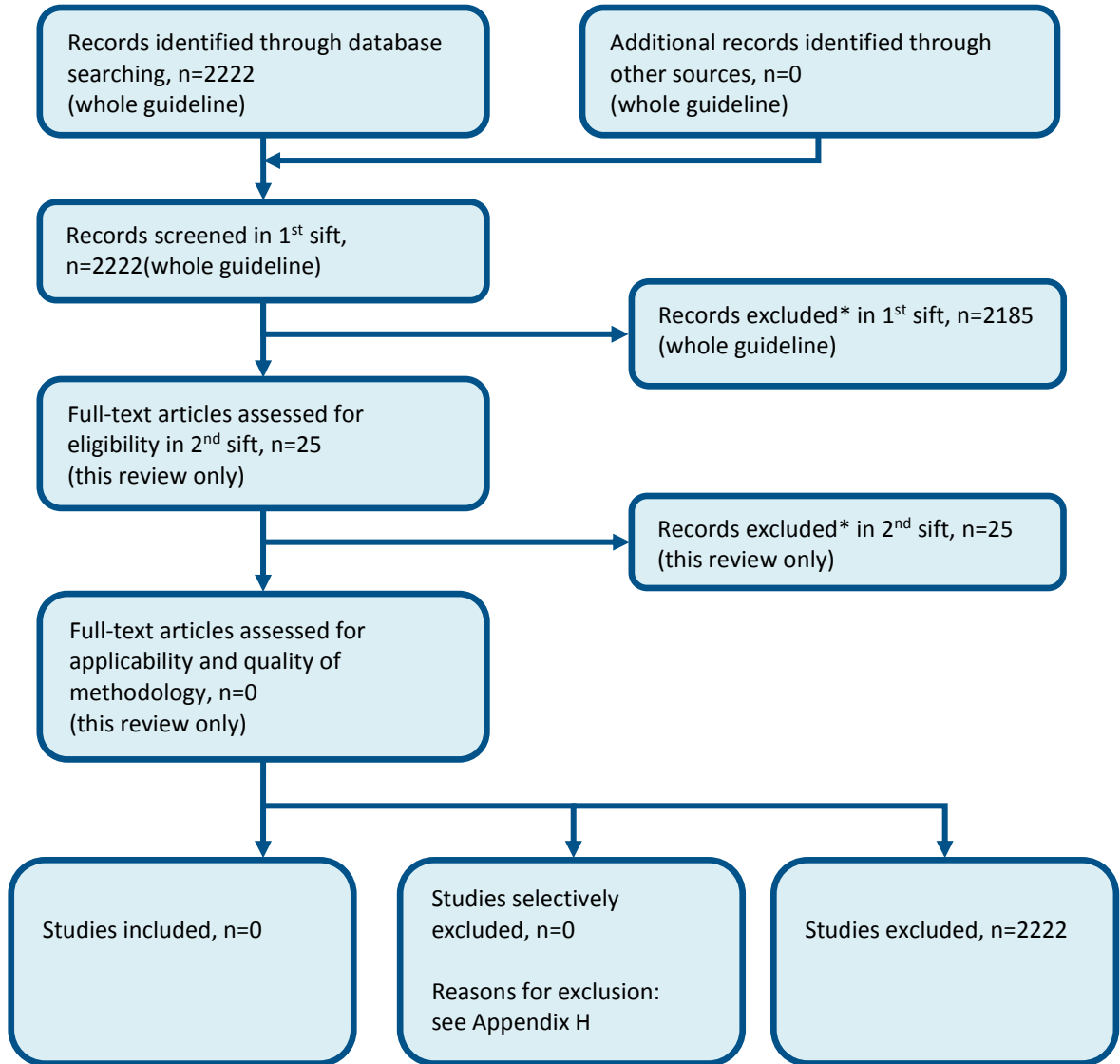


\* Non-relevant population, intervention, comparison, design or setting; non-English language

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## 1 E.14 Diagnosis: Mannitol

Figure 37: Flow chart of economic article selection for the review of mannitol challenge test

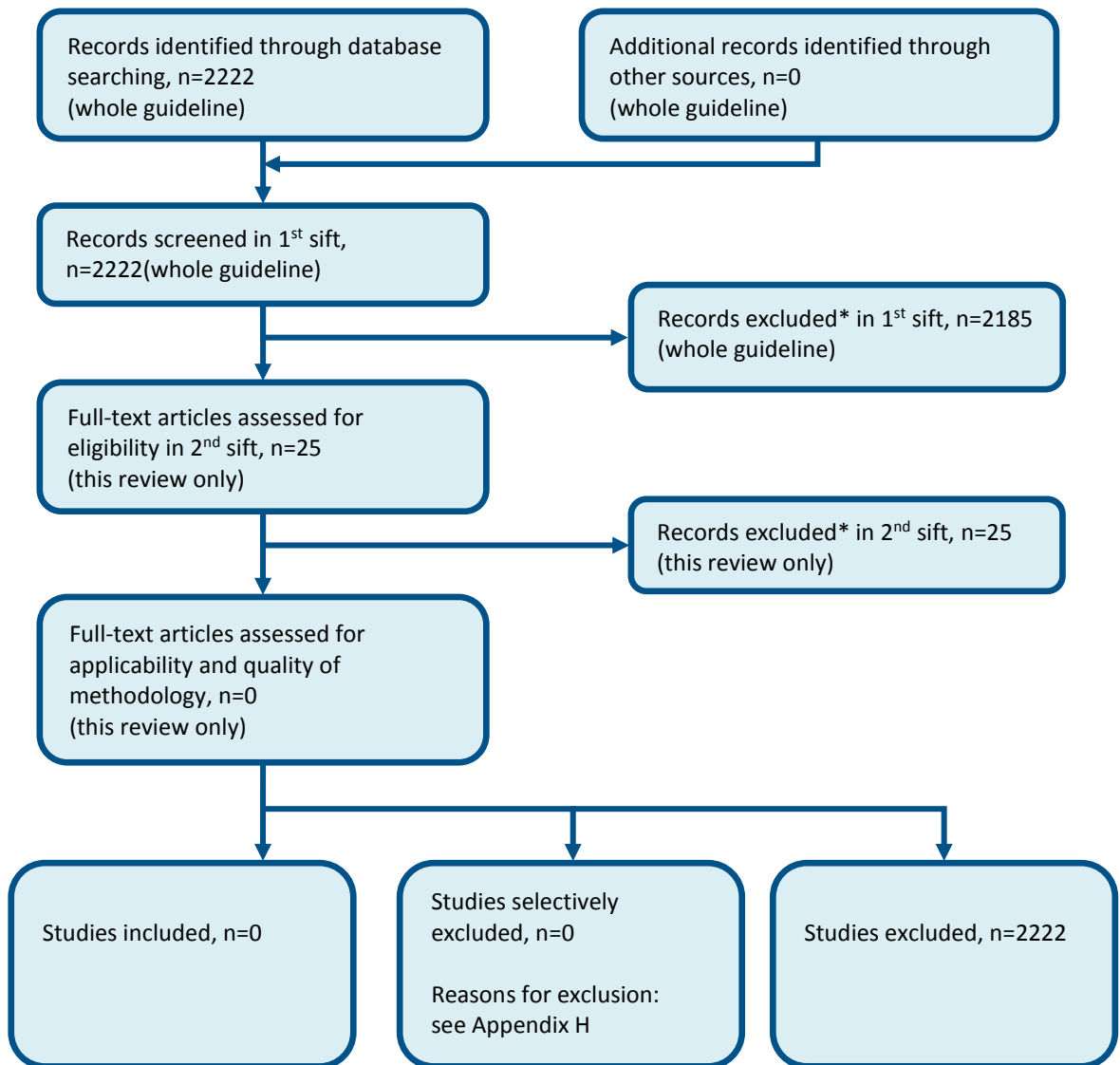


\* Non-relevant population, intervention, comparison, design or setting; non-English language

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## 1 E.15 Diagnosis: Exercise challenge test

Figure 38: Flow diagram of economic article selection for the review of exercise challenge tests

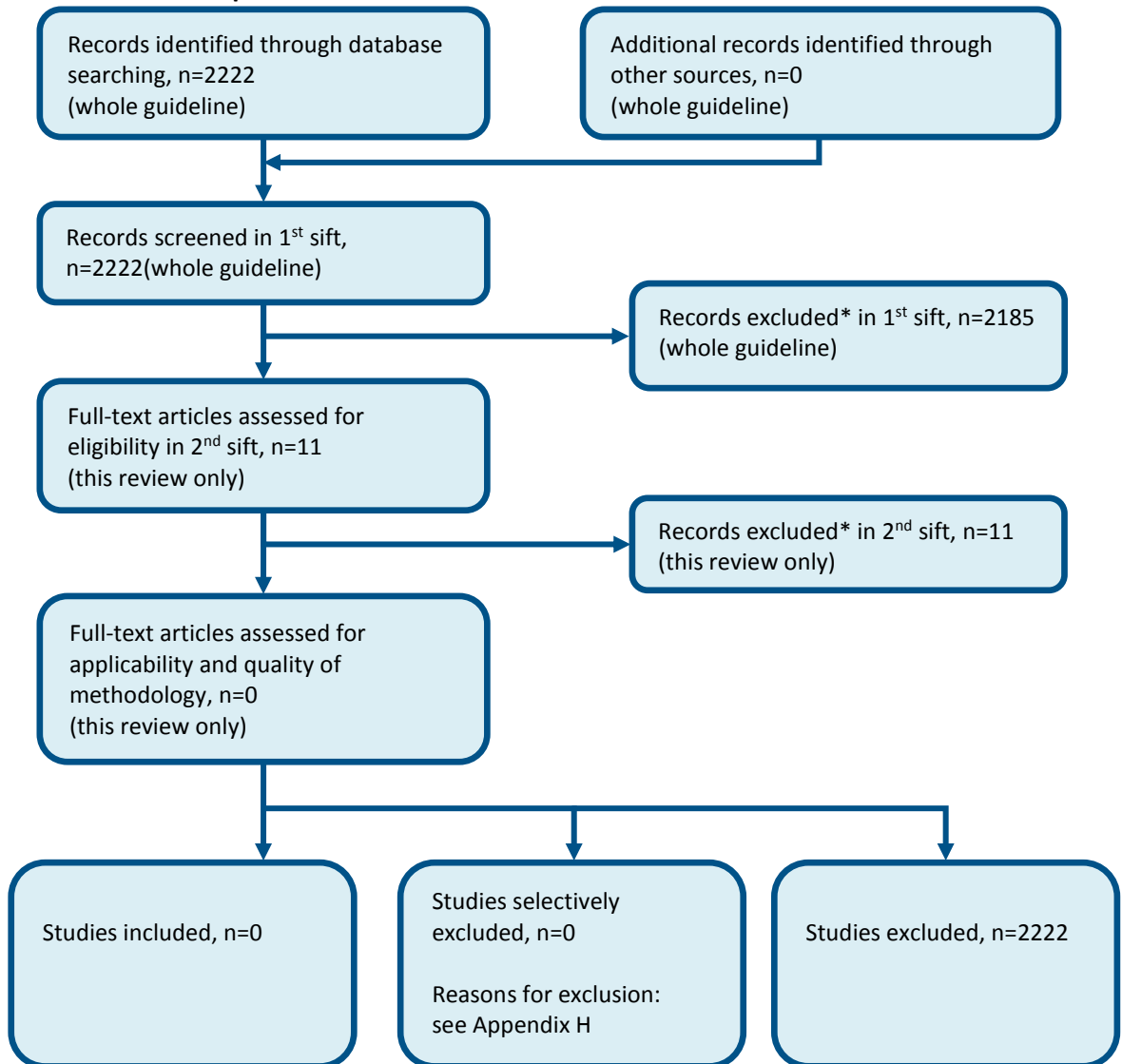


\* Non-relevant population, intervention, comparison, design or setting; non-English language

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## 1 E.16 Monitoring: Questionnaires

**Figure 39: Flow chart of economic article selection for the review of symptom scores/diaries or validated questionnaires to monitor asthma control**

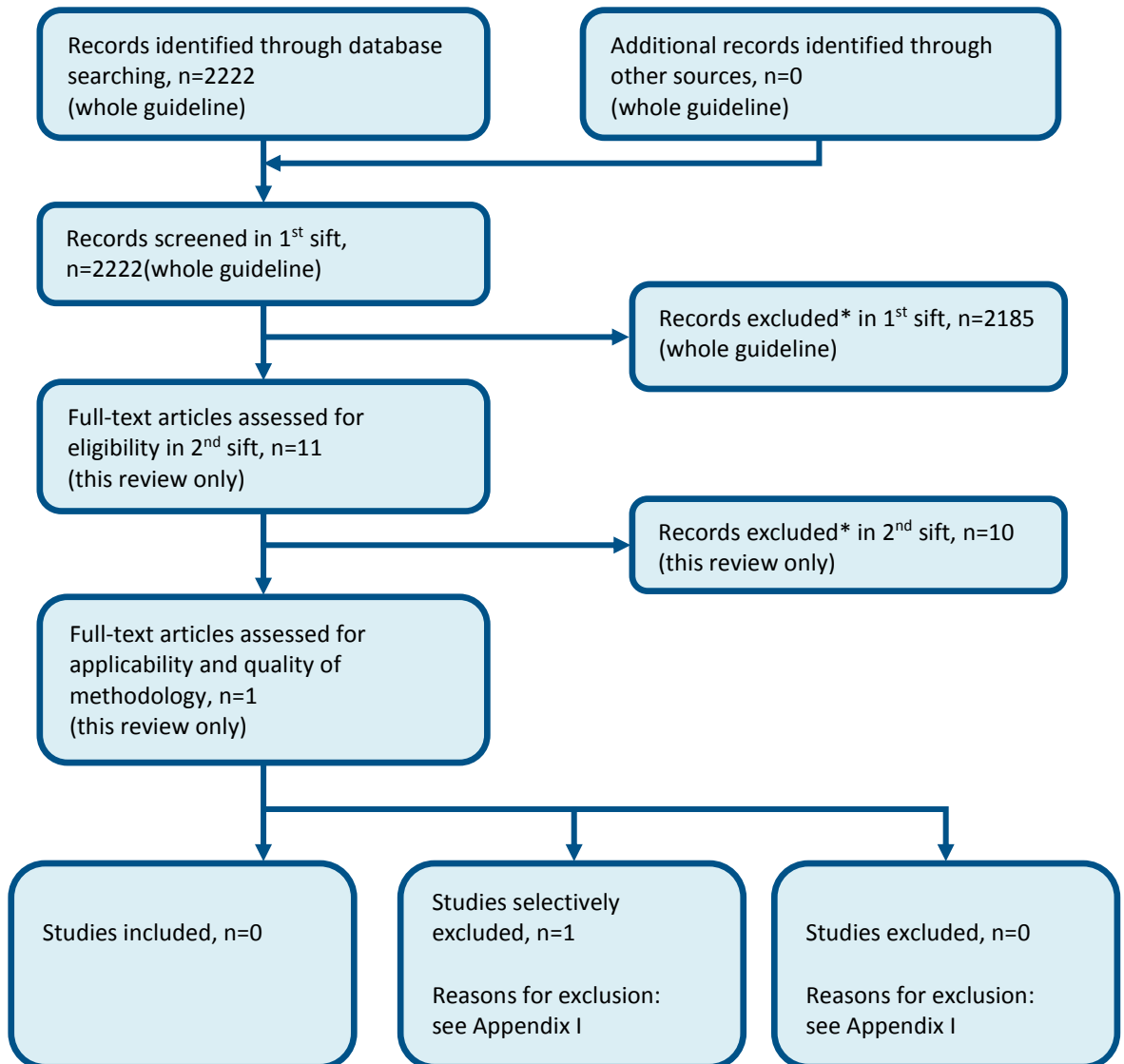


\* Non-relevant population, intervention, comparison, design or setting; non-English language

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## 1 E.17 Monitoring: Lung function tests

**Figure 40: Flow chart of economic article selection for the review of lung function tests to monitor asthma control**

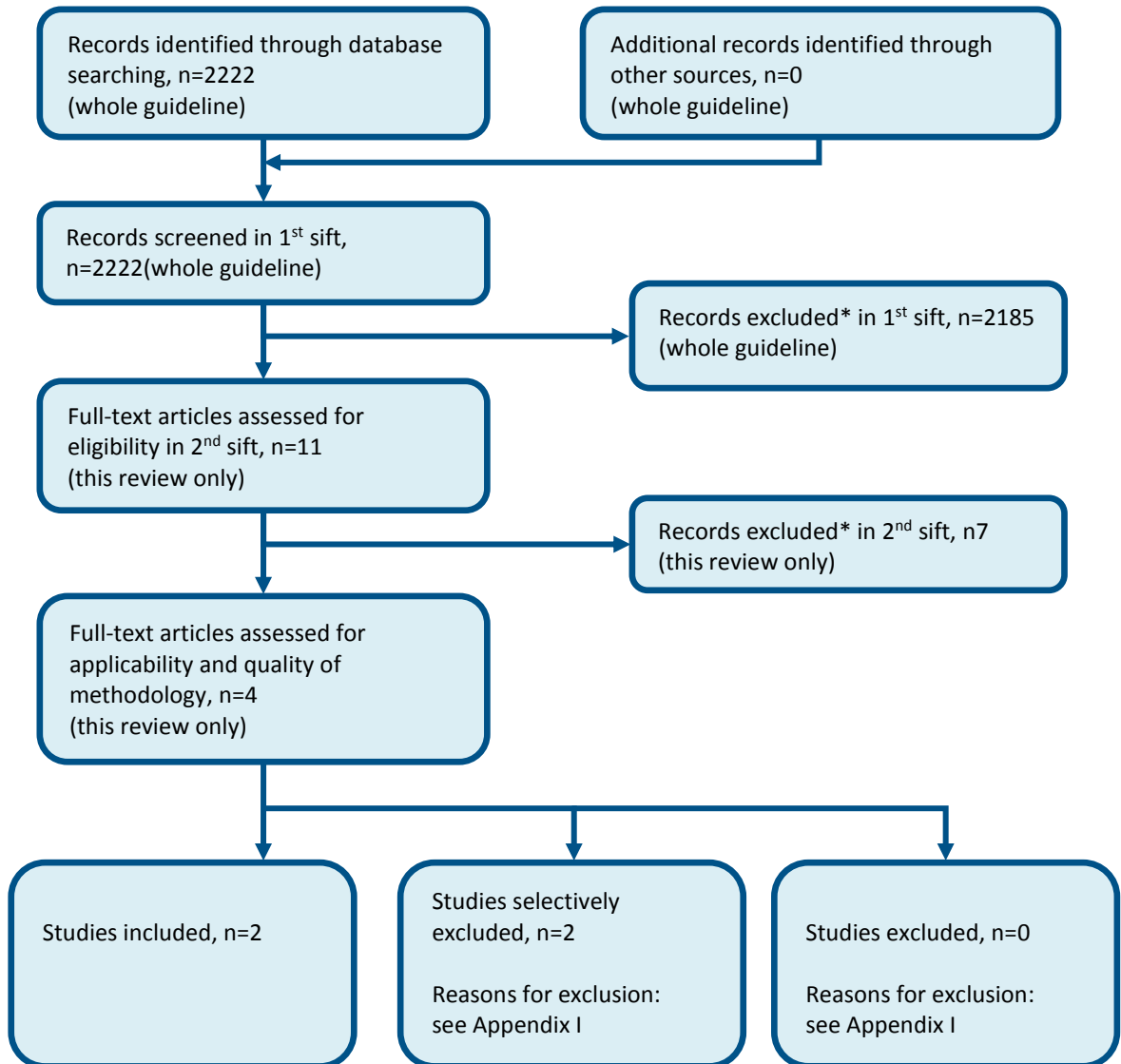


\* Non-relevant population, intervention, comparison, design or setting; non-English language

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## 1 E.18 Monitoring: FeNO

**Figure 41: Flow chart of economic article selection for the review of FeNO to monitor asthma control**

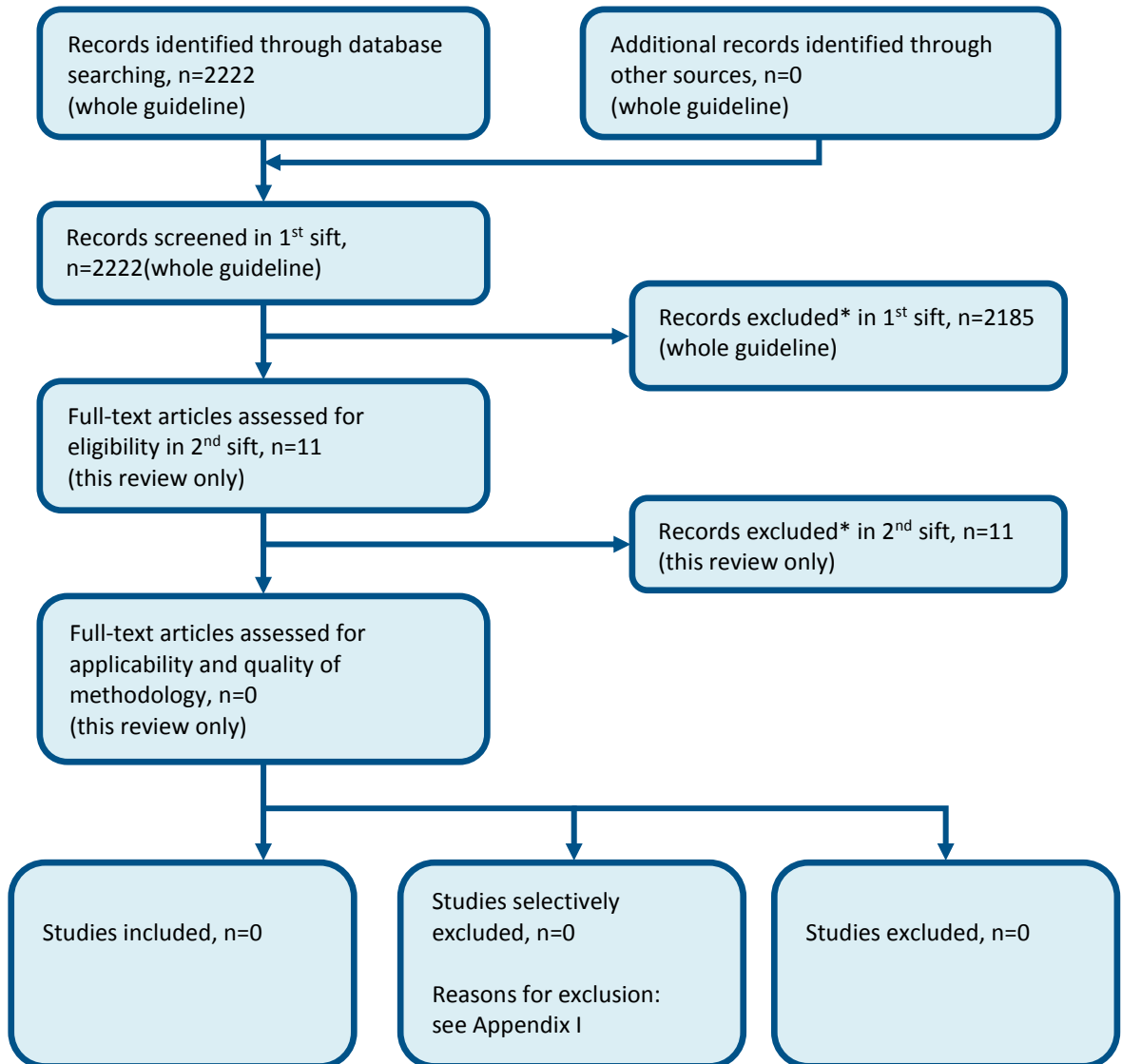


\* Non-relevant population, intervention, comparison, design or setting; non-English language

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## 1 E.19 Monitoring: Peripheral blood eosinophils

Figure 42: Flow chart of economic article selection for the review of peripheral blood eosinophils to monitor asthma control



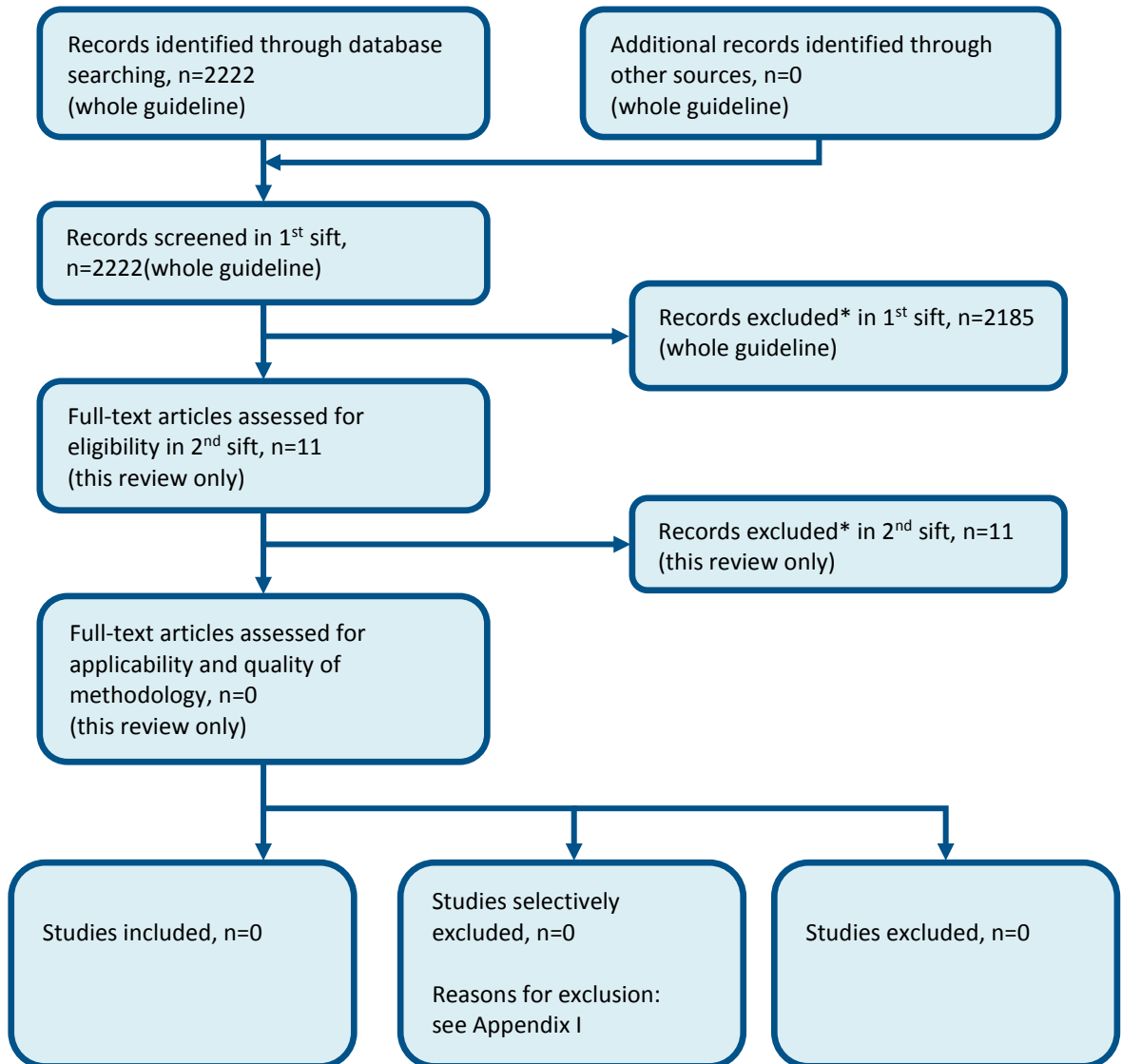
\* Non-relevant population, intervention, comparison, design or setting; non-English language

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## 1 E.20 Monitoring: Challenge tests

**Figure 43: Flow chart of economic article selection for the review of challenge tests to monitor asthma control**

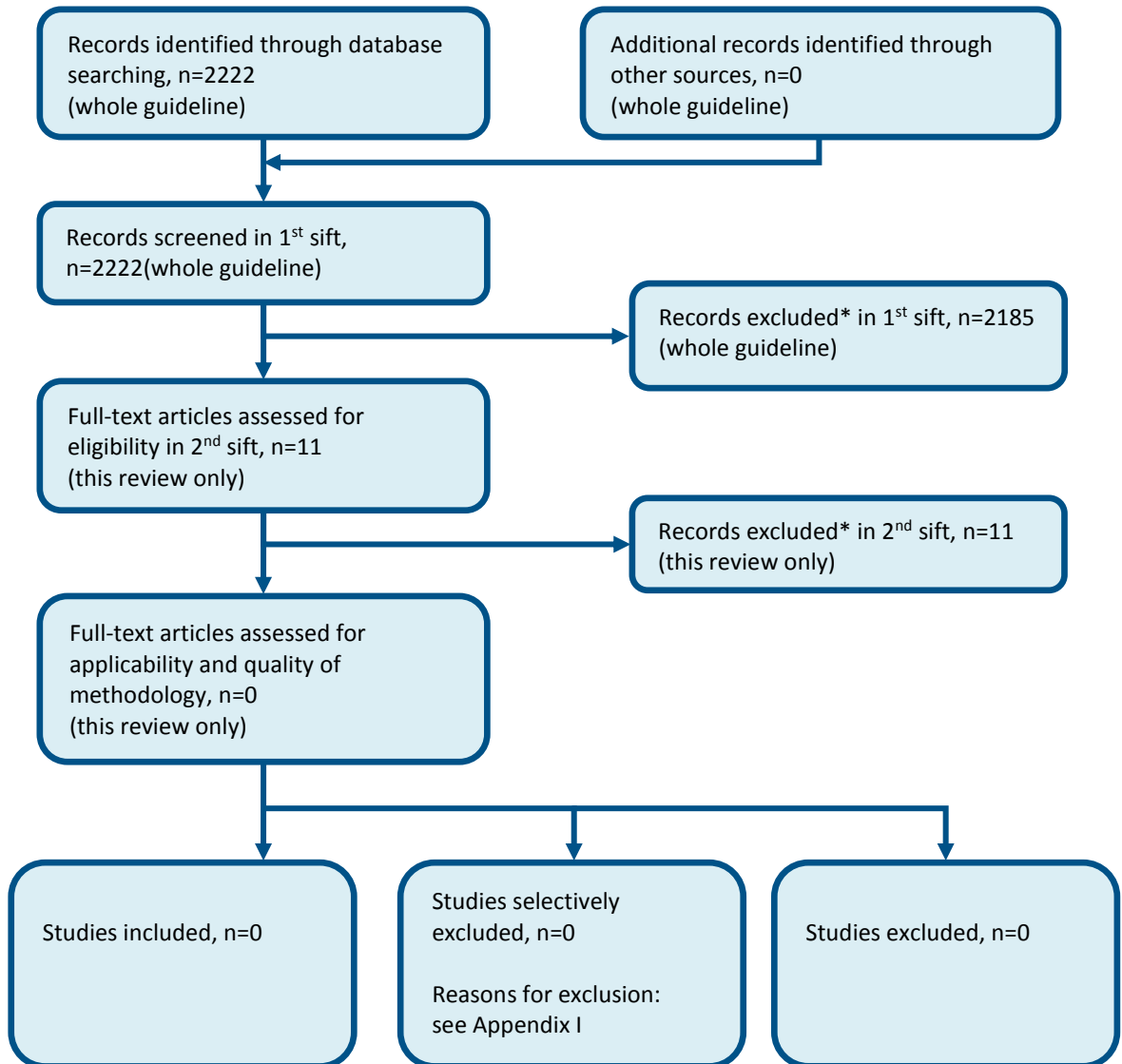


\* Non-relevant population, intervention, comparison, design or setting; non-English language

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## 1 E.21 Monitoring: Adherence to treatment

Figure 44: Flow chart of economic article selection for the review of monitoring adherence to treatment

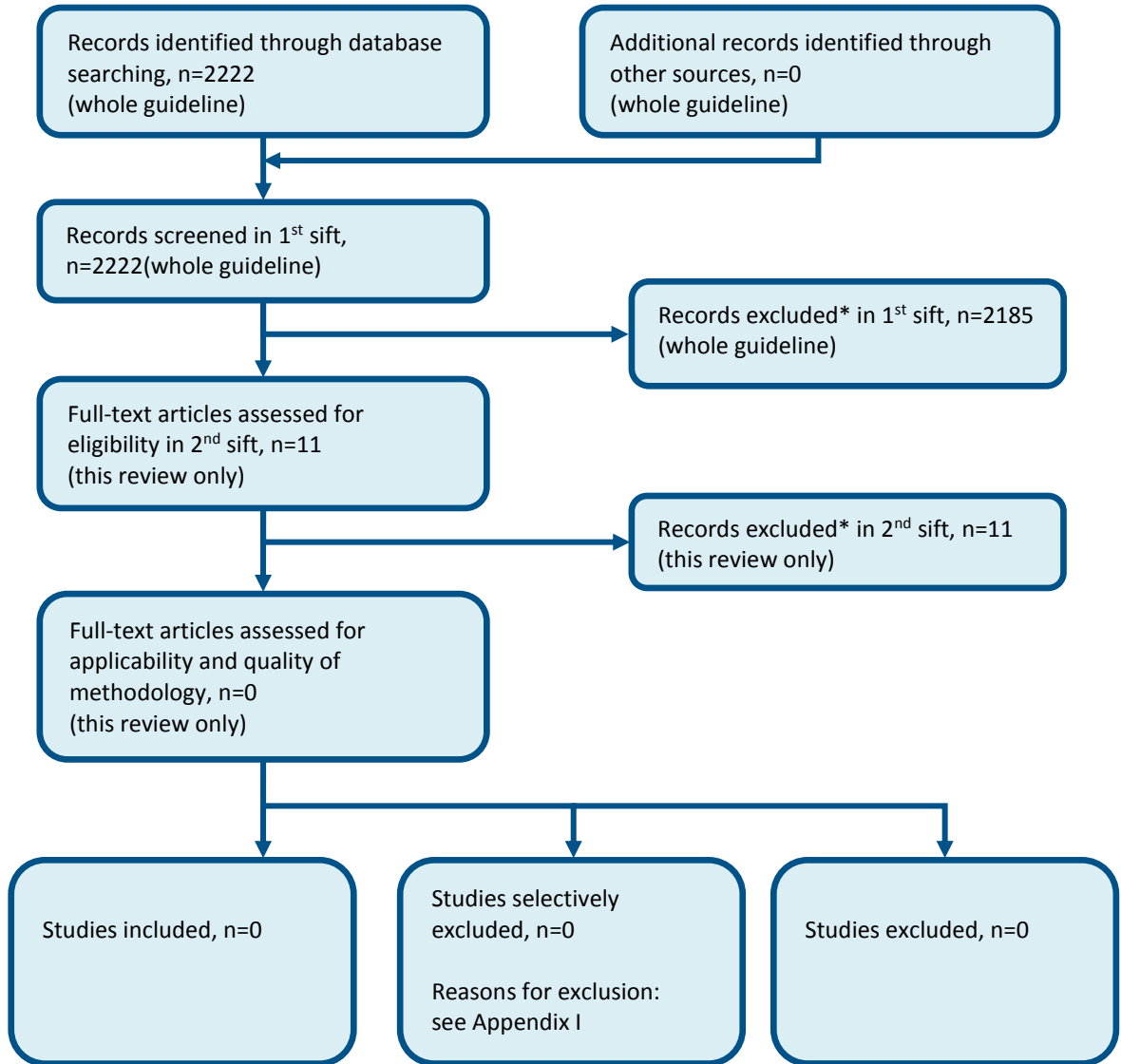


\* Non-relevant population, intervention, comparison, design or setting; non-English language

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## 1 E.22 Monitoring: Inhaler technique

Figure 45: Flow chart of economic article selection for the review of monitoring inhaler technique

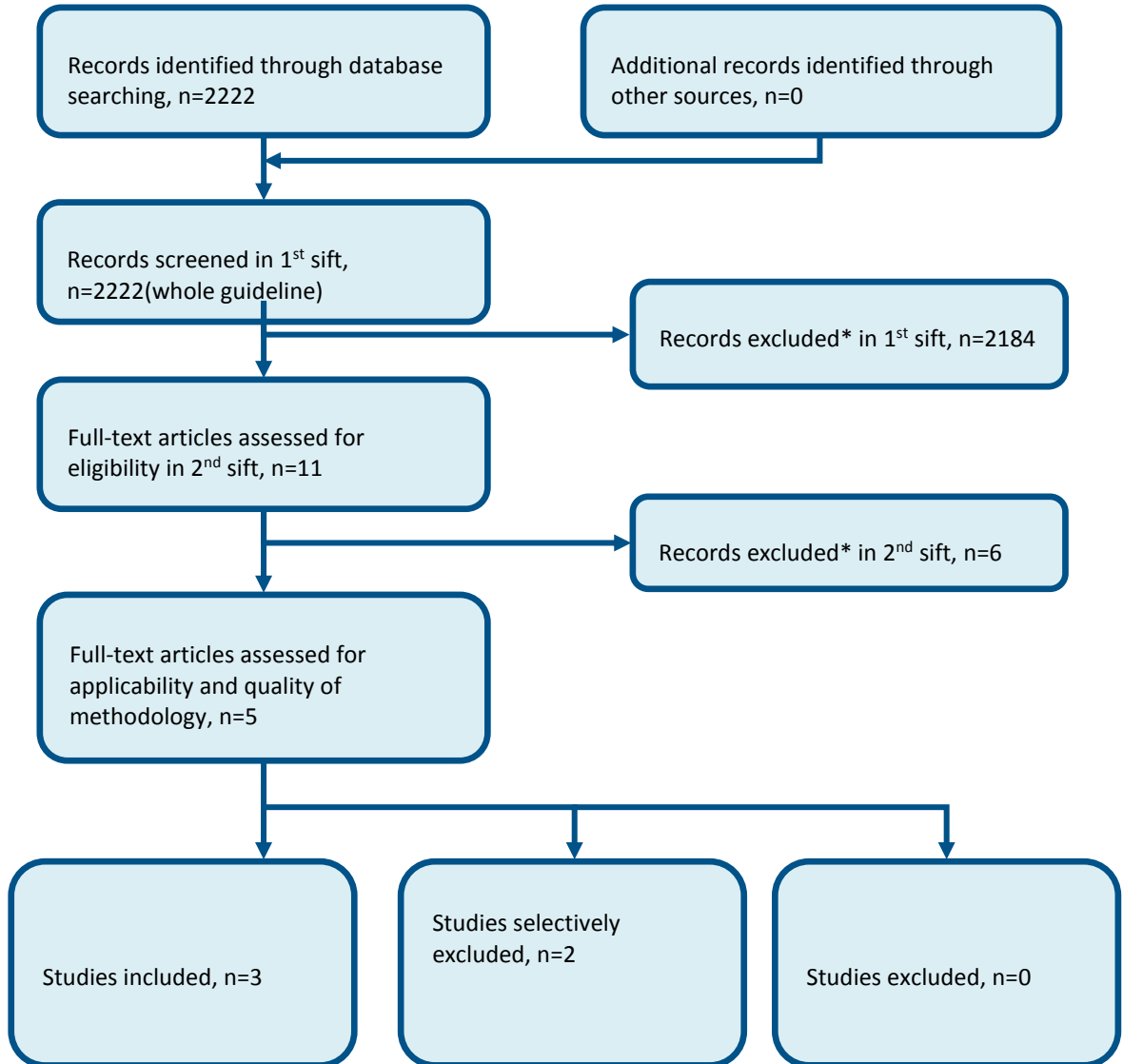


\* Non-relevant population, intervention, comparison, design or setting; non-English language

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## 1 E.23 Monitoring: Tele-healthcare

Figure 46: Flow chart of economic article selection for the review of tele-healthcare to monitor asthma control



\* Non-relevant population, intervention, comparison, design or setting; non-English language

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1

# Appendix F: Literature search strategies

2

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F.2.2	Randomised controlled trials (RCT)
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<b>Appendix P:</b>	<b>References</b>

1 Search strategies used for the asthma guideline are outlined below and were run in accordance with  
 2 the methodology in the NICE guidelines manual 2012.<sup>1204</sup> All searches were run up to 1 October 2014  
 3 unless otherwise stated. Any studies added to the databases after this date (even those published  
 4 prior to this date) were not included unless specifically stated in the text. We do not routinely search  
 5 for electronic, ahead of print or “online early” publications. Where possible searches were limited to  
 6 retrieve material published in English.

7 **Table 24: Database date parameters**

Database	Dates searched
Medline	1946—1 October 2014
Embase	1980 – 1 October 2014 (week 39)
The Cochrane Library	Cochrane Reviews to 2014 Issue 10 of 12 CENTRAL to 2014 Issue 9 of 12 DARE, HTA and NHSEED to 2014 Issue 3 of 4

8 Searches for the **clinical reviews** were run in Medline (OVID), Embase (OVID) and the Cochrane  
 9 Library (Wiley).

10 Searches for **intervention and diagnostic studies** were usually constructed using a PICO format  
 11 where population (P) terms were combined with Intervention (I) and sometimes Comparison (C)  
 12 terms. An intervention can be a drug, a procedure or a diagnostic test. Outcomes (O) are rarely used  
 13 in search strategies for interventions. Search filters were also added to the search where  
 14 appropriate.

15 Searches for **prognostic studies** were usually constructed combining population terms with  
 16 prognostic variable terms and sometimes outcomes. Search filters were added to the search where  
 17 appropriate.

18 Searches for the **health economic reviews** were run in Medline (OVID), Embase (OVID), the NHS  
 19 Economic Evaluations Database (NHS EED), the Health Technology Assessment (HTA) database and  
 20 the Health Economic Evaluation Database (HEED). Searches in NHS EED and HEED were constructed  
 21 using population terms only. For Medline and Embase an economic filter (instead of a study type  
 22 filter) was added to the same clinical search strategy.

## 23 **F.1 Population search strategies**

### 24 **F.1.1 Standard population**

25 This population was used in all clinical questions except F.3.5 occupational asthma.

#### 26 **Medline and Embase search terms**

1.	exp asthma/
2.	asthma*.ti.

3.	or/1-2
----	--------

1 **Cochrane search terms**

#1.	MeSH descriptor: [Asthma] explode all trees
#2.	asthma*:ti
#3.	{or #1-#2}

2 **F.2 Study filter search terms**

3 **F.2.1 Systematic review (SR) search terms**

4 **Medline search terms**

1.	meta-analysis/
2.	meta-analysis as topic/
3.	(meta analy* or metanaly* or metaanaly*).ti,ab.
4.	((systematic* or evidence*) adj2 (review* or overview*)).ti,ab.
5.	(reference list* or bibliograph* or hand search* or manual search* or relevant journals).ab.
6.	(search strategy or search criteria or systematic search or study selection or data extraction).ab.
7.	(search* adj4 literature).ab.
8.	(medline or pubmed or cochrane or embase or psychlit or psyclit or psychinfo or psycinfo or cinahl or science citation index or bids or cancerlit).ab.
9.	cochrane.jw.
10.	((multiple treatment* or indirect or mixed) adj2 comparison*).ti,ab.
11.	or/1-10

5 **Embase search terms**

1.	systematic review/
2.	meta-analysis/
3.	(meta analy* or metanaly* or metaanaly*).ti,ab.
4.	((systematic or evidence) adj2 (review* or overview*)).ti,ab.
5.	(reference list* or bibliograph* or hand search* or manual search* or relevant journals).ab.
6.	(search strategy or search criteria or systematic search or study selection or data extraction).ab.
7.	(search* adj4 literature).ab.
8.	(medline or pubmed or cochrane or embase or psychlit or psyclit or psychinfo or psycinfo or cinahl or science citation index or bids or cancerlit).ab.
9.	cochrane.jw.
10.	((multiple treatment* or indirect or mixed) adj2 comparison*).ti,ab.
11.	or/1-10

6 **F.2.2 Randomised controlled trials (RCTs) search terms**

7 **Medline search terms**

1.	randomized controlled trial.pt.
2.	controlled clinical trial.pt.
3.	randomi#ed.ab.
4.	placebo.ab.
5.	randomly.ab.
6.	clinical trials as topic.sh.

7.	trial.ti.
8.	or/1-7

1 **Embase search terms**

1.	random*.ti,ab.
2.	factorial*.ti,ab.
3.	(crossover* or cross over*).ti,ab.
4.	((doubl* or singl*) adj blind*).ti,ab.
5.	(assign* or allocat* or volunteer* or placebo*).ti,ab.
6.	crossover procedure/
7.	double blind procedure/
8.	single blind procedure/
9.	randomized controlled trial/
10.	or/1-9

2 **F.2.3 Observational studies (OBS) search terms**

3 **Medline search terms**

1.	epidemiologic studies/
2.	exp case control studies/
3.	exp cohort studies/
4.	cross-sectional studies/
5.	case control.ti,ab.
6.	(cohort adj (study or studies or analys*)).ti,ab.
7.	((follow up or observational or uncontrolled or non randomi#ed or nonrandomi#ed or epidemiologic*) adj (study or studies)).ti,ab.
8.	((longitudinal or retrospective or prospective or cross sectional) and (study or studies or review or analys* or cohort*)).ti,ab.
9.	or/1-8

4 **Embase search terms**

1.	clinical study/
2.	exp case control study/
3.	family study/
4.	longitudinal study/
5.	retrospective study/
6.	prospective study/
7.	cross-sectional study/
8.	cohort analysis/
9.	follow-up/
10.	cohort*.ti,ab.
11.	9 and 10
12.	case control.ti,ab.
13.	(cohort adj (study or studies or analys*)).ti,ab.
14.	((follow up or observational or uncontrolled or non randomi#ed or nonrandomi#ed or epidemiologic*) adj (study or studies)).ti,ab.
15.	((longitudinal or retrospective or prospective or cross sectional) and (study or studies or review or analys* or cohort*)).ti,ab.



16.	or/1-8,11-15
-----	--------------

1

### Cochrane search terms

#1.	case control:ti,ab,kw
#2.	(cohort near/2 (study or studies or analys*)):ti,ab,kw
#3.	((follow up or observational or uncontrolled or non randomi?ed or nonrandomi?ed or epidemiologic*) near/2 (study or studies)):ti,ab,kw
#4.	((longitudinal or retrospective or prospective or cross sectional) and (study or studies or review or analys* or cohort*)):ti,ab,kw
#5.	{or #1-#4}

## 2 F.2.4 Diagnostic test accuracy studies (DIAG1) search terms

3

### Medline search terms

1.	exp "sensitivity and specificity"/
2.	(sensitivity or specificity).ti,ab.
3.	((pre test or pretest or post test) adj probability).ti,ab.
4.	(predictive value* or PPV or NPV).ti,ab.
5.	likelihood ratio*.ti,ab.
6.	likelihood function/
7.	(ROC curve* or AUC).ti,ab.
8.	(diagnos* adj2 (performance* or accurac* or utilit* or value* or efficien* or effectiveness)).ti,ab.
9.	gold standard.ab.
10.	or/1-9

4

### Embase search terms

1.	exp "sensitivity and specificity"/
2.	(sensitivity or specificity).ti,ab.
3.	((pre test or pretest or post test) adj probability).ti,ab.
4.	(predictive value* or PPV or NPV).ti,ab.
5.	likelihood ratio*.ti,ab.
6.	(ROC curve* or AUC).ti,ab.
7.	(diagnos* adj2 (performance* or accurac* or utilit* or value* or efficien* or effectiveness)).ti,ab.
8.	diagnostic accuracy/
9.	diagnostic test accuracy study/
10.	gold standard.ab.
11.	or/1-10

5

### Cochrane search terms

#1.	diagnos*:ti,ab,kw
#2.	(sensitivity or specificity):ti,ab,kw
#3.	((pre test or pretest or post test) near probability):ti,ab,kw
#4.	(predictive value* or PPV or NPV):ti,ab,kw
#5.	likelihood ratio*:ti,ab,kw
#6.	(ROC or AUC):ti,ab,kw
#7.	gold standard:ti,ab,kw

#8.	Any MeSH descriptor with qualifier(s): [Diagnosis - DI]
#9.	{or #1-#8}

### 1 F.2.5 Diagnostic studies (DIAG2) search terms

2 The following terms were added to the diagnostic test accuracy search terms in F.2.4 to create a  
3 more sensitive search in Medline and Embase only.

#### 4 Medline and Embase search terms

1.	sensitiv*.mp.
2.	diagnos*.mp.
3.	di.fs.
4.	or/1-3

### 5 F.2.6 Prognostic studies (PROG) search terms

#### 6 Medline search terms

1.	predict.ti.
2.	(validat* or rule*).ti,ab.
3.	(predict* and (outcome* or risk* or model*)).ti,ab.
4.	((history or variable* or criteria or scor* or characteristic* or finding* or factor*) and (predict* or model* or decision* or identif* or prognos*)).ti,ab.
5.	decision*.ti,ab. and Logistic models/
6.	(decision* and (model* or clinical*)).ti,ab.
7.	(prognostic and (history or variable* or criteria or scor* or characteristic* or finding* or factor* or model*)).ti,ab.
8.	(stratification or discrimination or discriminate or c statistic or "area under the curve" or AUC or calibration or indices or algorithm or multivariable).ti,ab.
9.	ROC curve/
10.	or/1-9

#### 7 Embase search terms

1.	predict.ti.
2.	(validat* or rule*).ti,ab.
3.	(predict* and (outcome* or risk* or model*)).ti,ab.
4.	((history or variable* or criteria or scor* or characteristic* or finding* or factor*) and (predict* or model* or decision* or identif* or prognos*)).ti,ab.
5.	decision*.ti,ab. and statistical model/
6.	(decision* and (model* or clinical*)).ti,ab.
7.	(prognostic and (history or variable* or criteria or scor* or characteristic* or finding* or factor* or model*)).ti,ab.
8.	(stratification or discrimination or discriminate or c statistic or "area under the curve" or auc or calibration or indices or algorithm or multivariable).ti,ab.
9.	receiver operating characteristic/
10.	or/1-9
11.	predict.ti.

#### 8 Cochrane search terms

#1.	predict:ti,ab,kw
-----	------------------

#2.	(validat* or rule*):ti,ab,kw
#3.	((history or variable* or criteria or scor* or characteristic* or finding* or factor*) and (model* or decision* or identif* or prognos*)):ti,ab,kw
#4.	(decision* and (model* or clinical*)):ti,ab,kw
#5.	(prognostic and (history or variable* or criteria or scor* or characteristic* or finding* or factor* or model*)):ti,ab,kw
#6.	(stratification or discrimination or discriminate or c statistic or "area under the curve" or calibration or indices or algorithm or multivariable):ti,ab,kw
#7.	{or #1-#6}

## 1 F.2.7 Validation (VAL) studies search terms

### 2 Medline search terms

1.	validation studies/
2.	reproducibility of results/
3.	(valid* or reliab*):ti,ab.
4.	observer variation/
5.	((inter* or intra* or observer* or rater*) adj3 (bias* or variation* or agree* or concordan*)):ti,ab.
6.	or/1-5

### 3 Embase search terms

1.	(valid* or reliab*):ti,ab.
2.	((inter* or intra* or observer* or rater*) adj3 (bias* or variation* or agree* or concordan*)):ti,ab.
3.	validation study/
4.	exp reliability/
5.	exp reproducibility/
6.	exp observer variation/
7.	or/1-6

## 4 F.2.8 Health economics (HE) search terms

### 5 Medline search terms

1.	economics/
2.	value of life/
3.	exp "costs and cost analysis"/
4.	exp economics, hospital/
5.	exp economics, medical/
6.	economics, nursing/
7.	economics, pharmaceutical/
8.	exp "fees and charges"/
9.	exp budgets/
10.	budget*.ti,ab.
11.	cost*.ti.
12.	(economic* or pharmaco?economic*).ti.
13.	(price* or pricing*):ti,ab.
14.	(cost* adj2 (effective* or utilit* or benefit* or minimi* or unit* or estimat* or variable*)):ab.

15.	(financ* or fee or fees).ti,ab.
16.	(value adj2 (money or monetary)).ti,ab.
17.	or/1-16

1 **Embase search terms**

1.	health economics/
2.	exp economic evaluation/
3.	exp health care cost/
4.	exp fee/
5.	budget/
6.	funding/
7.	budget*.ti,ab.
8.	cost*.ti.
9.	(economic* or pharmaco?economic*).ti.
10.	(price* or pricing*).ti,ab.
11.	(cost* adj2 (effective* or utilit* or benefit* or minimi* or unit* or estimat* or variable*)).ab.
12.	(financ* or fee or fees).ti,ab.
13.	(value adj2 (money or monetary)).ti,ab.
14.	or/1-13

2 **F.2.9 Quality of life (QOL) search terms**

3 **Medline search terms**

1.	(euroqol* or eq5d* or eq 5d*).ti,ab.
----	--------------------------------------

4 **Embase search terms**

1.	(euroqol* or eq5d* or eq 5d*).ti,ab.
----	--------------------------------------

5 **F.2.10 Excluded study designs and publication types**

6 The following study designs and publication types were removed from retrieved results using the  
7 NOT operator.

8 **Medline search terms**

1.	letter/
2.	editorial/
3.	news/
4.	exp historical article/
5.	anecdotes as topic/
6.	comment/
7.	case report/
8.	(letter or comment*).ti.
9.	or/1-8
10.	randomized controlled trial/ or random*.ti,ab.
11.	9 not 10
12.	animals/ not humans/
13.	exp animals, laboratory/
14.	exp animal experimentation/

15.	exp models, animal/
16.	exp rodentia/
17.	(rat or rats or mouse or mice).ti.
18.	or/11-17

1

### Embase search terms

1.	letter.pt. or letter/
2.	note.pt.
3.	editorial.pt.
4.	case report/ or case study/
5.	(letter or comment*).ti.
6.	or/1-5
7.	randomized controlled trial/ or random*.ti,ab.
8.	6 not 7
9.	animal/ not human/
10.	nonhuman/
11.	exp animal experiment/
12.	exp experimental animal/
13.	animal model/
14.	exp rodent/
15.	(rat or rats or mouse or mice).ti.
16.	or/8-15

## 2 F.3 Searches for specific questions

### 3 F.3.1 Signs and Symptoms

4 6. In people under investigation for asthma, what is the diagnostic accuracy of each of the following  
5 signs and symptoms?

- 6 • wheezing
- 7 • cough
- 8 • breathlessness
- 9 • nocturnal symptoms
- 10 • diurnal and seasonal variations.

11 Search constructed by combining the columns in the following table using the AND Boolean operator.  
12 Exclusion filter applied using NOT Boolean operator.

Population	Intervention or exposure	Comparison	Study design filter	Date parameters and other limits
People of all ages with asthma or suspected asthma	Signs and symptoms of asthma as listed in the question	n/a	The following filters were used in all databases: DIAG1, OBS, PROG	See Table 24 English only Exclusion filter applied in Medline and Embase

13

### Medline search terms

1.	*respiratory sounds/
----	----------------------

2.	*cough/
3.	*dyspnea/
4.	exp *periodicity/
5.	(wheez* or rhonchi or cough* or breathless* or dyspn?ea).ti,ab.
6.	((difficult* or labo?r* or short*) adj2 breath*).ti,ab.
7.	((24h* or 24 hour* or 24 hr*) adj2 (rhythm* or varia* or change* or pattern* or symptom* or sign or signs)).ti,ab.
8.	((season* or diurnal or circadian or nyctohemeral or night* or nocturnal) adj3 (wheez* or rhonchi or cough* or breathless* or dyspn?ea or symptom or symptoms or sign or signs or asthma*)).ti,ab.
9.	or/1-8

1 **Embase search terms**

1.	*wheezing/
2.	*irritative coughing/
3.	*chronic cough/
4.	*coughing/
5.	*dyspnea/
6.	*abnormal respiratory sound/
7.	*seasonal variation/
8.	exp *periodicity/
9.	((difficult* or labo?r* or short*) adj2 breath*).ti,ab.
10.	((24h* or 24 hour* or 24 hr*) adj2 (rhythm* or varia* or change* or pattern* or symptom* or sign or signs)).ti,ab.
11.	((season* or diurnal or circadian or nyctohemeral or night* or nocturnal) adj3 (wheez* or rhonchi or cough* or breathless* or dyspn?ea or symptom or symptoms or sign or signs or asthma*)).ti,ab.
12.	(wheez* or rhonchi or cough* or breathless* or dyspn?ea).ti,ab.
13.	or/1-12

2 **Cochrane search terms**

#1.	MeSH descriptor: [Respiratory Sounds] this term only
#2.	MeSH descriptor: [Cough] this term only
#3.	MeSH descriptor: [Dyspnea] this term only
#4.	MeSH descriptor: [Periodicity] explode all trees
#5.	(wheez* or rhonchi or cough* or breathless* or dyspn?ea):ti,ab,kw
#6.	((difficult* or labo?r* or short*) near/2 breath*):ti,ab,kw
#7.	((24h* or 24 hour* or 24 hr*) near/2 (rhythm* or varia* or change* or pattern* or symptom* or sign or signs):ti,ab,kw
#8.	((season* or diurnal or circadian or nyctohemeral or night* or nocturnal) near/3 (wheez* or rhonchi or cough* or breathless* or dyspn?ea or symptom or symptoms or sign or signs or asthma*)):ti,ab,kw
#9.	{or #1-#8}

3 **F.3.2 Personal/family history of atopic disorders**

- 4 7. In people under investigation for asthma, what is the diagnostic accuracy of taking a  
5 personal/family history of atopic disorders?

- 1 Search constructed by combining the columns in the following table using the AND Boolean operator.  
2 Exclusion filter applied using NOT Boolean operator.

Population	Intervention or exposure	Comparison	Study design filter	Date parameters and other limits
People of all ages with asthma or suspected asthma	Personal/family history of atopic disorders	n/a	The following filters were used in all databases: DIAG1, PROG	See Table 24 English only Exclusion filter applied in Medline and Embase

3 **Medline search terms**

1.	medical history taking/
2.	(histories or history).ti,ab.
3.	exp questionnaires/
4.	question?aire*.ti,ab.
5.	or/1-4
6.	(atopic or atopy).ti,ab.
7.	(histor* adj2 (hypersensitiv* or allerg*)).ti,ab.
8.	((family or familial or relative? or kin or kinship or brother? or sister? or mother? or father? or son? or daughter? or parent?) adj3 (hypersensitiv* or allerg*)).ti,ab.
9.	rhinitis, allergic, seasonal/
10.	rhinitis, allergic, perennial/
11.	dermatitis, atopic/
12.	exp food hypersensitivity/
13.	((hypersensitiv* or allerg*) adj2 asthma*).ab.
14.	(hay fever or hayfever or pollinosis).ti,ab.
15.	(pollen* adj2 (sensitiv* or hypersensitiv* or allerg*)).ti,ab.
16.	allergic rhinitis.ti,ab.
17.	eczema.ti,ab.
18.	((food* or wheat or nut* or peanut* or milk or dairy or egg* or soy* or sesame or seed* or pecan* or pistachio* or walnut* or coconut* or fish or shellfish or seafood* or cereal* or gluten* or barley or corn* or maize) adj2 (sensitiv* or hypersensitiv* or allerg*)).ti,ab.
19.	or/6-18
20.	5 and 19

4 **Embase search terms**

1.	exp *anamnesis/
2.	(histories or history).ti,ab.
3.	exp *questionnaire/
4.	question?aire*.ti,ab.
5.	or/1-4
6.	(atopic or atopy).ti,ab.
7.	(histor* adj2 (hypersensitiv* or allerg*)).ti,ab.
8.	((family or familial or relative? or kin or kinship or brother? or sister? or mother? or father? or son? or daughter? or parent?) adj3 (hypersensitiv* or allerg*)).ti,ab.
9.	((hypersensitiv* or allerg*) adj2 asthma*).ab.
10.	(hay fever or hayfever or pollinosis).ti,ab.

11.	(pollen* adj2 (sensitiv* or hypersensitiv* or allerg*)).ti,ab.
12.	allergic rhinitis.ti,ab.
13.	eczema.ti,ab.
14.	((food* or wheat or nut* or peanut* or milk or dairy or egg* or soy* or sesame or seed* or pecan* or pistachio* or walnut* or coconut* or fish or shellfish or seafood* or cereal* or gluten* or barley or corn* or maize) adj2 (sensitiv* or hypersensitiv* or allerg*)).ti,ab.
15.	*atopic dermatitis/
16.	*atopy/
17.	exp *allergic rhinitis/
18.	exp *food allergy/
19.	or/6-18
20.	5 and 19

1

### Cochrane search terms

#1.	(histories or history or question*):ti,ab,kw
#2.	(atopic or atopy):ti,ab,kw
#3.	(histor* near/2 (hypersensitiv* or allerg*)):ti,ab,kw
#4.	((family or familial or relative? or kin or kinship or brother? or sister? or mother? or father? or son? or daughter? or parent?) near/3 (hypersensitiv* or allerg*)):ti,ab,kw
#5.	((hypersensitiv* or allerg*) near/2 asthma*):ti,ab,kw
#6.	(hay fever or hayfever or pollinosis):ti,ab,kw
#7.	(pollen* near/2 (sensitiv* or hypersensitiv* or allerg*)):ti,ab,kw
#8.	allergic rhinitis:ti,ab,kw
#9.	eczema:ti,ab,kw
#10.	((food* or wheat or nut* or peanut* or milk or dairy or egg* or soy* or sesame or seed* or pecan* or pistachio* or walnut* or coconut* or fish or shellfish or seafood* or cereal* or gluten* or barley or corn* or maize) near/2 (sensitiv* or hypersensitiv* or allerg*)):ti,ab,kw
#11.	{or #2-#10}
#12.	#1 and #11

### 2 F.3.3 Symptoms in response to exercise

3 8. In people under investigation for asthma, what is the diagnostic accuracy of a clinical history of  
4 symptoms in response to exercise?

5 Search constructed by combining the columns in the following table using the AND Boolean operator.  
6 Exclusion filter applied using NOT Boolean operator.

Population	Intervention or exposure	Comparison	Study design filter	Date parameters and other limits
People of all ages with asthma or suspected asthma	History of symptoms following exercise	n/a	The following filter was used in all databases: DIAG1	See Table 24 English only Exclusion filter applied in Medline and Embase

7

### Medline search terms

1.	medical history taking/
2.	(histories or history).ti,ab.
3.	exp questionnaires/



4.	question*.ti,ab.
5.	exp "signs and symptoms, respiratory"/
6.	(symptom or symptoms).ti,ab.
7.	or/1-6
8.	exp exercise/
9.	exp sports/
10.	(exercise* or sport*).ti,ab.
11.	(physical* adj (train* or exert* or activit*)).ti,ab.
12.	or/8-11
13.	7 and 12

1 **Embase search terms**

1.	exp *anamnesis/
2.	(histories or history).ti,ab.
3.	exp *questionnaire/
4.	question*.ti,ab.
5.	(symptom or symptoms).ti,ab.
6.	exp *breathing disorder/
7.	exp *coughing/
8.	or/1-7
9.	exp *exercise/
10.	exp *sport/
11.	(exercise* or sport*).ti,ab.
12.	(physical* adj (train* or exert* or activit*)).ti,ab.
13.	or/9-12
14.	8 and 13

2 **Cochrane search terms**

#1.	(histories or history or question*):ti,ab,kw
#2.	(symptom or symptoms):ti,ab,kw
#3.	{or #1-#2}
#4.	(exercise* or sport*):ti,ab,kw
#5.	(physical* near/1 (train* or exert* or activit*)):ti,ab,kw
#6.	#4or #5
#7.	#3 and #6

3 **F.3.4 Symptoms after using medication**

4 9. In people under investigation for asthma, what is the diagnostic accuracy of a clinical history of  
5 symptoms after taking the following drugs:

- 6
- in adults - beta blockers, aspirin, or other NSAIDs
  - in children – ibuprofen?
- 7

8 Search constructed by combining the columns in the following table using the AND Boolean operator.  
9 Exclusion filter applied using NOT Boolean operator.

Population	Intervention or exposure	Comparison	Study design filter	Date parameters and other limits
People of all	Drugs as listed in	n/a	The following filter was	See Table 24

Population	Intervention or exposure	Comparison	Study design filter	Date parameters and other limits
ages with asthma or suspected asthma	the question		used in all databases: DIAG1 The following filter was used in Medline and Embase only: DIAG2	English only Exclusion filter applied in Medline and Embase

1

### Medline search terms

1.	((anti inflamm* or antiinflam* or anti-inflamm*) adj2 (non- steroid* or nonsteroid* or non-steroid*) adj2 agent*).ti,ab.
2.	((cox2 or cox-2 or coxii or cox-ii) adj2 inhibitor*).ti,ab.
3.	((cyclo-oxygenase2 or cyclo-oxygenase-2 or cyclooxygenase-2 or cyclooxygenase2) adj2 inhibitor*).ti,ab.
4.	((cyclo-oxygenase-ii or cyclo-oxygenaseii or cyclooxygenase-ii or cyclooxygenaseii) adj2 inhibitor*).ti,ab.
5.	(arcoxia or Iodine or eccoxolac or mobic or prexige).ti,ab.
6.	(diclofenac or naproxen or tolmetin or ketoprofen or aceclofenac).ti,ab.
7.	(fenbufen or tenoxicam or nabumetone or osmosin or benoxaprofen).ti,ab.
8.	(fenoprofen or azapropazone or aceclofenac or mefenamic acid or dexketoprofen).ti,ab.
9.	(ibuprofen or ibuprofen).ti,ab.
10.	(indometacin or indomethacin).ti,ab.
11.	(parecoxib or deracoxib or cimicoxib or tilmacoxib).ti,ab.
12.	(piroxicam or flurbiprofen or niflumic acid or diflunisal).ti,ab.
13.	(sulindac or meclofenamate or meclofenamic acid).ti,ab.
14.	exp anti-inflammatory agents, non-steroidal/
15.	celebrex.ti,ab.
16.	celecoxib.ti,ab.
17.	coxib*.ti,ab.
18.	etodolac.ti,ab.
19.	etoricoxib.ti,ab.
20.	exp aspirin/
21.	aspirin.ti,ab.
22.	exp cyclooxygenase 2 inhibitors/
23.	exp diclofenac/
24.	exp diflunisal/
25.	exp etodolac/
26.	exp fenoprofen/
27.	exp flurbiprofen/
28.	exp ibuprofen/
29.	exp indomethacin/
30.	exp ketoprofen/
31.	exp meclofenamic acid/
32.	exp mefenamic acid/
33.	exp naproxen/
34.	exp niflumic acid/

35.	exp piroxicam/
36.	exp sulindac/
37.	exp tolmetin/
38.	flosulide.ti,ab.
39.	iguratimod.ti,ab.
40.	meloxicam.ti,ab.
41.	nimesulide.ti,ab.
42.	nsaid*.ti,ab.
43.	tiaprofenic acid.ti,ab.
44.	(isoxicam or zomepirac or carprofen or proquazone or lornoxicam).ti,ab.
45.	(propranolol or angilol or angilol or inderal-1a or half-inalderal or inderal or bedranol or prograne or slo-pro or acebutolol or setral or atenolol or tenormin or bisoprolol or cardicor or emcor or carvedilol or eucardic or celiprolol or celectol or co-tenidone or tenoret or tenoretic or esmolol or brevbloc or labetalol or trandate or metoprolol or betaloc or lopresor or nadolol or corgard or nebivolol or nebilet or hypoloc or oxprenolol or trasicor or slow-trasicor or pindolol or visken or sotalol or beta-cardone or sotacor or timolol or betim).ti,ab.
46.	(beta adj3 block*).ti,ab.
47.	(b adj3 block*).ti,ab.
48.	(beta adj2 antagonist*).ti,ab.
49.	((beta-adrenoceptor or b-adrenoceptor or beta-adrenergic) adj3 (blockade or blocker* or blocking or antagonist*).ti,ab.
50.	exp adrenergic beta-antagonists/
51.	or/1-50
52.	medical history taking/
53.	(histories or history).ti,ab.
54.	exp drug hypersensitivity/
55.	((drug or medication* or medicine*) adj2 (allerg* or hypersensitivity or sensitivity or intolerance)).ti,ab.
56.	exp questionnaires/
57.	question*.ti,ab.
58.	exp "signs and symptoms, respiratory"/
59.	(symptom or symptoms).ti,ab.
60.	or/52-59
61.	51 and 60

1

#### Embase search terms

1.	((anti inflamm* or antiinflamm* or anti-inflamm*) adj2 (non-steroid* or nonsteroid* or non-steroid*) adj2 agent*).ti,ab.
2.	((cox2 or cox-2 or coxii or cox-ii) adj2 inhibitor*).ti,ab.
3.	((cyclooxygenase-2 or cyclooxygenase2 or cyclooxygenase 2) adj2 inhibitor*).ti,ab.
4.	((cyclooxygenase-ii or cyclooxygenaseii or cyclooxygenase ii) adj2 inhibitor*).ti,ab.
5.	(arcoxia or lodine or eccoxolac or prexige or mobic).ti,ab.
6.	(diclofenac or naproxen or tolmetin or ketoprofen or aceclofenac).ti,ab.
7.	(fenbufen or tenoxicam or nabumetone or osmosin or benoxaprofen).ti,ab.
8.	(fenoprofen or azapropazone or aceclofenac or mefenamic acid or dexketoprofen).ti,ab.
9.	(ibuprofen or ibuprufen).ti,ab.
10.	(indometacin or indomethacin).ti,ab.

11.	(isoxicam or zomepirac or carprofen or proquazone or lornoxicam).ti,ab.
12.	(parecoxib or deracoxib or cimicoxib or tilmacoxib).ti,ab.
13.	(piroxicam or flurbiprofen or niflumic acid or diflunisal).ti,ab.
14.	(sulindac or meclofenamate or meclofenamic acid).ti,ab.
15.	celebrex.ti,ab.
16.	celecoxib.ti,ab.
17.	coxib*.ti,ab.
18.	etodolac.ti,ab.
19.	etoricoxib.ti,ab.
20.	exp *aceclofenac/
21.	exp *aspirin/
22.	exp *azapropazone/
23.	exp *benoxaprofen/
24.	exp *carprofen/
25.	exp *celecoxib/
26.	exp *cyclooxygenase 2 inhibitor/
27.	exp *dexketoprofen/
28.	exp *diclofenac/
29.	exp *diflunisal/
30.	exp *etodolac/
31.	exp *etoricoxib/
32.	exp *fenbufen/
33.	exp *fenoprofen/
34.	exp *flosulide/
35.	exp *flurbiprofen/
36.	exp *ibuprofen/
37.	exp *iguratimod/
38.	exp *indomethacin/
39.	exp *ketoprofen/
40.	exp *lornoxicam/
41.	exp *lumiracoxib/
42.	exp *meclofenamic acid/
43.	exp *mefenamic acid/
44.	exp *meloxicam/
45.	exp *nabumetone/
46.	exp *naproxen/
47.	exp *niflumic acid/
48.	exp *nimesulide/
49.	exp *parecoxib/ or exp *tilmacoxib/
50.	exp *piroxicam/
51.	exp *proquazone/
52.	exp *sulindac/
53.	exp *tenoxicam/
54.	exp *tiaprofenic acid/
55.	exp *tolmetin/

56.	exp *zomepirac/
57.	flosulide.ti,ab.
58.	iguratimod.ti,ab.
59.	lumiracoxib.ti,ab.
60.	meloxicam.ti,ab.
61.	nimesulide.ti,ab.
62.	exp *nonsteroid antiinflammatory agent/
63.	nsaid*.ti,ab.
64.	tiaprofenic acid.ti,ab.
65.	aspirin.ti,ab.
66.	exp *beta adrenergic receptor blocking agent/
67.	exp *bisoprolol/ or exp *bisoprolol fumarate/ or exp *bisoprolol fumarate plus hydrochlorothiazide/ or exp *carvedilol/ or exp *metoprolol/ or exp*metoprolol fumarate/ or exp *metoprolol succinate/ or exp *metoprolol tartrate/ or exp *nebivolol/
68.	(propranolol or angilol or angilol or inderal-la or half-inalderal or inderal or bedranol or prograne or slo-pro or acebutolol or sectral or atenolol or tenormin or bisoprolol or cardicor or emcor or carvedilol or eucardic or celiprolol or celectol or co-tenidone or tenoret or tenoretic or esmolol or brevbloc or labetalol or trandate or metoprolol or betaloc or lopresor or nadolol or corgard or nebivolol or nebilet or hypoloc or oxprenolol or trasicor or slow-trasicor or pindolol or visken or sotalol or beta-cardone or sotacor or timolol or betim).ti,ab.
69.	(beta adj3 block*).ti,ab.
70.	(b adj3 block*).ti,ab.
71.	(beta adj2 antagonist*).ti,ab.
72.	((beta-adrenoceptor or b-adrenoceptor or beta-adrenergic) adj3 (blockade or blocker* or blocking or antagonist*).ti,ab.
73.	or/1-72
74.	exp *anamnesis/
75.	(histories or history).ti,ab.
76.	exp *questionnaire/
77.	question*.ti,ab.
78.	exp *drug hypersensitivity/
79.	((drug or medication* or medicine*) adj2 (allerg* or hypersensitivity or sensitivity or intolerance)).ti,ab.
80.	(symptom or symptoms).ti,ab.
81.	exp *breathing disorder/
82.	exp *coughing/
83.	or/74-82
84.	73 and 83

1

### Cochrane search terms

#1.	((anti inflamm* or antiinflamm* or anti-inflamm*) near/2 (non- steroid* or nonsteroid* or non-steroid*)):ti,ab,kw
#2.	((cox2 or cox-2 or coxii or cox-ii) near/2 (inhibitor*)):ti,ab,kw
#3.	((cyclooxygenase-2 or cyclooxygenase2 or cyclooxygenase 2) near/2 (inhibitor*)):ti,ab,kw
#4.	((cyclo-oxygenase2 or cyclo-oxygenase-2 or cyclooxygenase-2 or cyclooxygenase2) near/2 (inhibitor*)):ti,ab,kw
#5.	((cyclooxygenase-ii or cyclooxygenaseii) near/2 (inhibitor*)):ti,ab,kw
#6.	((cyclo-oxygenase-ii or cyclo-oxygenaseii or cyclooxygenase-ii or cyclooxygenaseii) near/2

	(inhibitor*):ti,ab,kw
#7.	(aceclofenac or arcoxia or aspirin or azapropazone or benoxaprofen or carprofen or celebrex or celecoxib or cimicoxib or coxib* or deracoxib or dexketoprofen or diclofenac or diflunisal or eccoxolac or etodolac or etoricoxib or fenbufen or fenoprofen or flosulide or flurbiprofen or ibuprofen or ibuprofen or iguratimod or indometacin or indomethacin or isoxicam or ketoprofen or lodine or lornoxicam or lumiracoxib or meclofenam* or mefenamic acid or meloxicam or mobic or nabumetone or naproxen or niflumic acid or nimesulide or nsaid* or osmosin or parecoxib or piroxicam or prexige or proquazone or sulindac or tenoxicam or tiaprofenic acid or tilmacoxib or tolmetin or zomepirac):ti,ab,kw
#8.	(propranolol or angilol or angilol or inderal-1a or half-inalderal or inderal or bedranol or prograne or slo-pro or acebutolol or sectral or atenolol or tenormin or bisoprolol or cardiacor or emcor or carvedilol or eucardic or celiprolol or celectol or co-tenidone or tenoret or tenoretic or esmolol or brevibloc or labetalol or trandate or metoprolol or betaloc or lopresor or nadolol or corgard or nebivolol or nebilet or hypoloc or oxprenolol or trasicor or slow-trasicor or pindolol or visken or sotalol or beta-cardone or sotacor or timolol or betim):ti,ab,kw
#9.	(beta or b) near/3 (block* or antagonist*):ti,ab,kw
#10.	((beta-adrenoceptor or b-adrenoceptor or beta-adrenergic) near/3 (blockade or blocker* or blocking or antagonist*)):ti,ab,kw
#11.	{or #1-#10}
#12.	(histories or history or question*):ti,ab,kw
#13.	((drug or medication* or medicine*) near/2 (allerg* or hypersensitivity or sensitivity or intolerance)):ti,ab,kw
#14.	(symptom or symptoms):ti,ab,kw
#15.	{or #12-#14}
#16.	#11 and #15

### 1 F.3.5 Occupational asthma

2 10. In adults under investigation for occupational asthma, what is the diagnostic accuracy for case  
3 identification, of asking whether their symptoms are better away from work?

4 Search constructed by combining the columns in the following table using the AND Boolean operator.  
5 Exclusion filter applied using NOT Boolean operator.

Population	Intervention or exposure	Comparison	Study design filter	Date parameters and other limits
Adults under investigation for occupational asthma	Symptom history	n/a	The following filters were used in Medline and Embase only: DIAG1, OBS, RCT, SR	See Table 24 English only Exclusion filter applied in Medline and Embase

### 6 Medline search terms

1.	asthma, occupational/
2.	((occupation* or work* or job* or employ*) adj2 asthma*).ti,ab
3.	or/1-2
4.	*occupational diseases/
5.	exp asthma/
6.	4 and 5
7.	3 or 6
8.	medical history taking/
9.	(histories or history).ti,ab.

10.	questionnaires/
11.	question*.ti,ab.
12.	(holiday* or weekend* or vacation*).ti,ab.
13.	((away or absent* or leave*) adj3 (work* or job* or employ* or occupation*)).ti,ab.
14.	or/8-13
15.	7 and 14

1

#### Embase search terms

1.	((occupation* or work* or job* or employ*) adj2 asthma*).ti,ab.
2.	*occupational asthma/
3.	or/1-2
4.	*occupational disease/
5.	exp *asthma/
6.	4 and 5
7.	3 or 6
8.	exp *anamnesis/
9.	(histories or history).ti,ab.
10.	exp *questionnaire/
11.	question*.ti,ab.
12.	(holiday* or weekend* or vacation*).ti,ab.
13.	((away or absent* or leave*) adj3 (work* or job* or employ* or occupation*)).ti,ab.
14.	or/8-13
15.	7 and 14

2

#### Cochrane search terms

#1.	((occupation* or work* or job* or employ*) near/2 asthma*):ti,ab,kw
#2.	(histories or history or question* or holiday* or weekend* or vacation*):ti,ab,kw
#3.	((away or absent* or leave*) near/3 (work* or job* or employ* or occupation*):ti,ab,kw
#4.	#2 or #3
#5.	#1 and #4

### 3 F.3.6 Spirometry/flow volume loop measures

4 11. In people under investigation for asthma, what is the diagnostic test accuracy and cost-  
5 effectiveness of spirometry / flow volume loop measures?

6 Search constructed by combining the columns in the following table using the AND Boolean operator.  
7 Exclusion filter applied using NOT Boolean operator.

Population	Intervention or exposure	Comparison	Study design filter	Date parameters and other limits
People of all ages with asthma or suspected asthma	Spirometry / flow volume loop measures	n/a	The following filter was used in all databases: DIAG1	See Table 24 English only Exclusion filter applied in Medline and Embase

8

#### Medline search terms

1.	vital capacity/
----	-----------------

2.	forced expiratory volume/
3.	(FEV1 or FEV 1 or FVC).ti,ab.
4.	(flow volume adj (loop* or curve* or graph*)).ti,ab.
5.	(forced expiratory volume* adj6 ("1" or one)).ti,ab.
6.	((force* or time*) adj vital capacit*).ti,ab.
7.	spirometry.ti.
8.	or/1-7

1 **Embase search terms**

1.	vital capacity/
2.	forced expiratory volume/
3.	lung flow volume curve/
4.	(FEV1 or FEV 1 or FVC).ti,ab.
5.	(flow volume adj (loop* or curve* or graph*)).ti,ab.
6.	(forced expiratory volume* adj6 ("1" or one)).ti,ab.
7.	((force* or time*) adj vital capacit*).ti,ab.
8.	spirometry.ti.
9.	or/1-8

2 **Cochrane search terms**

#1.	MeSH descriptor: [Vital Capacity] this term only
#2.	MeSH descriptor: [Forced Expiratory Volume] this term only
#3.	(FEV1 or "FEV 1" or FVC):ti,ab
#4.	(flow volume near/2 (loop* or curve* or graph*)):ti,ab
#5.	(forced expiratory volume* near/6 ("1" or one)):ti,ab
#6.	((force* or time*) near/2 vital capacit*):ti,ab
#7.	spirometry:ti
#8.	{or #1-#7}

3 **F.3.7 Bronchodilator response**

4 12.In people under investigation for asthma, what is the diagnostic test accuracy and cost-  
5 effectiveness of bronchodilator response (using PEF or FEV1)?

6 Search constructed by combining the columns in the following table using the AND Boolean operator.  
7 Exclusion filter applied using NOT Boolean operator.

Population	Intervention or exposure	Comparison	Study design filter	Date parameters and other limits
People of all ages with asthma or suspected asthma	Bronchodilator response	n/a	The following filter was used in Medline and Cochrane: DIAG1 The following filter was used in Medline only: DIAG2	See Table 24 English only Exclusion filter applied in Medline and Embase

8 **Medline search terms**

1.	exp bronchodilator agents/du
2.	bronchoreversibility.ti,ab.
3.	((bronchodilator* or bronchial dilat* or broncholytic*) adj3 (test* or revers* or respons* or



	respond*)).ti,ab.
4.	(BDR or BDT).ti,ab.
5.	or/1-4

1

### Embase search terms

1.	bronchoreversibility.ti,ab.
2.	((bronchodilator* or bronchial dilat* or broncholytic*) adj3 (test* or revers* or respons* or respond*)).ti,ab.
3.	(BDR or BDT).ti,ab.
4.	bronchoreversibility.ti,ab.
5.	or/1-4
6.	exp "sensitivity and specificity"/
7.	(sensitivity or specificity).ti,ab.
8.	((pre test or pretest or post test) adj probability).ti,ab.
9.	(predictive value* or PPV or NPV).ti,ab.
10.	likelihood ratio*.ti,ab.
11.	(ROC curve* or AUC).ti,ab.
12.	(diagnos* adj2 (performance* or accurac* or utilit* or value* or efficien* or effectiveness)).ti,ab.
13.	diagnostic accuracy/
14.	diagnostic test accuracy study/
15.	gold standard.ab.
16.	sensitiv*.mp.
17.	diagnos*.mp.
18.	di.fs.
19.	or/6-18
20.	5 and 19
21.	exp *bronchodilating agent/
22.	or/6-15
23.	21 and 22
24.	20 or 23

2

### Cochrane search terms

#1.	((bronchodilator* or bronchial dilat* or broncholytic*) near/3 (test* or revers* or respons* or respond*)):ti,ab,kw
#2.	bronchoreversibility:ti,ab,kw
#3.	(BDR or BDT):ti,ab,kw
#4.	MeSH descriptor: [Bronchodilator Agents] explode all trees and with qualifiers: [Diagnostic use - DU]
#5.	{or #1-#4}

### 3 F.3.8 Peak expiratory flow

4 13.In people under investigation for asthma, what is the diagnostic test accuracy and cost-  
5 effectiveness of peak expiratory flow (PEF) variability?

6 Search constructed by combining the columns in the following table using the AND Boolean operator.  
7 Exclusion filter applied using NOT Boolean operator.

Population	Intervention or exposure	Comparison	Study design filter	Date parameters and other limits
People of all ages with asthma or suspected asthma	Peak expiratory flow (PEF) variability	n/a	The following filter was used in all databases: DIAG1 The following filter was used in Medline and Embase only: DIAG2	See Table 24 English only Exclusion filter applied in Medline and Embase

1 **Medline search terms**

1.	PEFV.ti,ab.
2.	((diurnal* or circadian or variation* or variability or fluctuat* or alter* or increas* or decreas* or chang*) adj3 (PEF or PEFR or PFR or peak expiratory flow* or peak flow*)).ti,ab.
3.	peak expiratory flow rate/
4.	exp circadian rhythm/
5.	3 and 4
6.	1 or 2 or 5

2 **Embase search terms**

1.	PEFV.ti,ab.
2.	((diurnal* or circadian or variation* or variability or fluctuat* or alter* or increas* or decreas* or chang*) adj3 (PEF or PEFR or PFR or peak expiratory flow* or peak flow*)).ti,ab.
3.	peak expiratory flow/
4.	circadian rhythm/
5.	3 and 4
6.	1 or 2 or 5

3 **Cochrane search terms**

#1.	pefv:ti,ab,kw
#2.	((diurnal* or circadian or variation* or variability or fluctuat* or alter* or increas* or decreas* or chang*) near/3 (PEFR or PFR or peak expiratory flow* or peak flow*)):ti,ab,kw
#3.	{or #1-#2}

4 **F.3.9 Skin prick test**

5 14. In people under investigation for asthma, what is the diagnostic test accuracy and cost-  
6 effectiveness of skin prick tests?

7 Search constructed by combining the columns in the following table using the AND Boolean operator.  
8 Exclusion filter applied using NOT Boolean operator.

Population	Intervention or exposure	Comparison	Study design filter	Date parameters and other limits
People of all ages with asthma or suspected asthma	Skin prick test	n/a	The following filter was used in Medline and Embase only: DIAG1	See Table 24 English only Exclusion filter applied in Medline and Embase

9 **Medline search terms**

1.	((dust or housedust) adj mite*).ti,ab.
----	--

2.	(dermatophagoides or euroglyphus).ti,ab.
3.	pyroglyphidae/
4.	(cat or cats or feline*).ti,ab.
5.	cats/
6.	(dog or dogs or canine*).ti,ab.
7.	dogs/
8.	pollen*.ti,ab.
9.	pollen/
10.	exp aspergillus/
11.	aspergillus.ti,ab.
12.	alternaria/
13.	alternaria.ti,ab.
14.	cladosporium/
15.	cladosporium.ti,ab.
16.	((air* or aero*) adj allergen*).ti,ab.
17.	aeroallergen*.ti,ab.
18.	or/1-17
19.	exp skin tests/
20.	skin prick*.ti,ab.
21.	skin scratch*.ti,ab.
22.	prick* test*.ti,ab.
23.	scratch* test*.ti,ab.
24.	skin test*.ti,ab.
25.	or/19-24
26.	18 and 25

1

**Embase search terms**

1.	((dust or housedust) adj mite*).ti,ab.
2.	(dermatophagoides or euroglyphus).ti,ab.
3.	(cat or cats or feline*).ti,ab.
4.	(dog or dogs or canine*).ti,ab.
5.	pollen*.ti,ab.
6.	aspergillus.ti,ab.
7.	alternaria.ti,ab.
8.	cladosporium.ti,ab.
9.	exp *dermatophagoides/
10.	*cat/
11.	*dog/
12.	*grass pollen/
13.	*pollen/
14.	exp *aspergillus/
15.	exp *alternaria/
16.	exp *cladosporium/
17.	((air* or aero*) adj allergen*).ti,ab.
18.	aeroallergen*.ti,ab.

19.	or/1-18
20.	exp *skin test/
21.	skin prick*.ti,ab.
22.	skin scratch*.ti,ab.
23.	prick* test*.ti,ab.
24.	scratch* test*.ti,ab.
25.	skin test*.ti,ab.
26.	or/20-25
27.	19 and 26

1 **Cochrane search terms**

#1.	(skin prick* or skin scratch* or prick* test* or scratch* test* or skin test*):ti,ab,kw
#2.	((dust or housedust) near/1 mite*):ti,ab,kw
#3.	(dermatophagoides or euroglyphus or cat or cats or feline* or dog or dogs or canine* or pollen or aspergillus or alternaria or cladosporium or pyroglyphidae):ti,ab,kw
#4.	((air* or aero*) near/1 allergen*):ti,ab
#5.	aeroallergen*:ti,ab
#6.	{or #2-#5}
#7.	#1 and #6

2 **F.3.10 IgE**

3 15. In people under investigation for asthma, what is the diagnostic test accuracy and cost-  
4 effectiveness of total and specific serum IgE measures?

5 Search constructed by combining the columns in the following table using the AND Boolean operator.  
6 Exclusion filter applied using NOT Boolean operator.

Population	Intervention or exposure	Comparison	Study design filter	Date parameters and other limits
People of all ages with asthma or suspected asthma	Serum IgE	n/a	The following filters were used in Medline and Embase only: DIAG1, OBS, RCT, SR	See Table 24 English only Exclusion filter applied in Medline and Embase

7 **Medline and Embase search terms**

1.	*radioallergosorbent test/
2.	(RAST or radioallergosorbent).ti.
3.	*immunoglobulin E/
4.	(immunoglobulin E or IgE).ti.
5.	or/1-4

8 **Cochrane search terms**

#1.	(immunoglobulin E or IgE or RAST or radioallergosorbent):ti,kw
-----	--

9 **F.3.11 FeNO**

10 16. In people under investigation for asthma, what is the diagnostic test accuracy and cost-  
11 effectiveness of fractional exhaled nitric oxide (FeNO) measures?

- 1 Search constructed by combining the columns in the following table using the AND Boolean operator.  
2 Exclusion filter applied using NOT Boolean operator.

Population	Intervention or exposure	Comparison	Study design filter	Date parameters and other limits
People of all ages with asthma or suspected asthma	Fractional exhaled nitric oxide (FeNO)	n/a	The following filter was used in Medline and Embase only: DIAG1	See Table 24 English only Exclusion filter applied in Medline and Embase

3 **Medline search terms**

1.	FeNO.ti,ab.
2.	((Fe or exhal* or fraction*) adj2 (NO or nitric or nitrogen)).ti,ab.
3.	or/1-2
4.	nitric oxide/
5.	biological markers/
6.	breath tests/
7.	exhalation/
8.	or/5-7
9.	4 and 8
10.	3 or 9

4 **Embase search terms**

1.	FeNO.ti,ab.
2.	((Fe or exhal* or fraction*) adj2 (NO or nitric or nitrogen)).ti,ab.
3.	or/1-2
4.	*nitric oxide/
5.	*breath analysis/
6.	*expired air/
7.	*biological marker/
8.	*exhalation/
9.	or/5-8
10.	4 and 9
11.	3 or 10

5 **Cochrane search terms**

#1.	FeNO:ti,ab,kw
#2.	((Fe or exhal* or fraction*) near/2 (NO or nitric or nitrogen)):ti,ab,kw
#3.	((NO or nitric or nitrogen) near/2 (marker* or biomarker* or breath* or
#4.	{or #1-#3}
#5.	test* or exhal* or expir*)):ti,ab,kw
#6.	MeSH descriptor: [Nitric Oxide] explode all trees
#7.	MeSH descriptor: [Biological Markers] explode all trees
#8.	MeSH descriptor: [Breath Tests] explode all trees
#9.	MeSH descriptor: [Exhalation] explode all trees
#10.	{or #6-#9}
#11.	#5 and #10

#12.	#4 or #11
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### 1 F.3.12 Peripheral blood eosinophil count

2 17. In people under investigation for asthma, what is the diagnostic test accuracy and cost-  
3 effectiveness of eosinophil blood count measures?

4 Search constructed by combining the columns in the following table using the AND Boolean operator.  
5 Exclusion filter applied using NOT Boolean operator.

Population	Intervention or exposure	Comparison	Study design filter	Date parameters and other limits
People of all ages with asthma or suspected asthma	Eosinophil blood count measures	n/a	The following filter was used in Medline and Embase only: DIAG1	See Table 24 English only Exclusion filter applied in Medline and Embase

#### 6 Medline search terms

1.	*eosinophils/
2.	*eosinophilia/
3.	(blood* adj2 (eosinophil* or acidophil*)):ti,ab.
4.	or/1-3

#### 7 Embase search terms

1.	*eosinophil/
2.	*eosinophil count/
3.	*eosinophilia/
4.	(blood* adj2 (eosinophil* or acidophil*)):ti,ab.
5.	or/1-4

#### 8 Cochrane search terms

#1.	eosinophil*:kw
#2.	(blood* near/2 (eosinophil* or acidophil*)):ti,ab
#3.	{or #1-#2}

### 9 F.3.13 Bronchial challenge test: histamine, methacholine, mannitol

10 Searches for the following two questions were run as one search:

11 18. In people under investigation for asthma, what is the diagnostic test accuracy and cost-  
12 effectiveness of airway hyper-reactivity (non-specific bronchial challenge) with histamine and  
13 methacholine?

14 19. In people under investigation for asthma, what is the diagnostic test accuracy and cost-  
15 effectiveness of airway hyper-reactivity (non-specific bronchial challenge) with mannitol?

16 Search constructed by combining the columns in the following table using the AND Boolean operator.  
17 Exclusion filter applied using NOT Boolean operator.

Population	Intervention or exposure	Comparison	Study design filter	Date parameters and other limits
People of all ages with asthma or	Bronchial challenge tests using histamine and	n/a	The following filter was used in all databases: DIAG1	See Table 24 English only Exclusion filter

Population	Intervention or exposure	Comparison	Study design filter	Date parameters and other limits
suspected asthma	methacholine or mannitol			applied in Medline and Embase

1

### Medline search terms

1.	exp mannitol/
2.	exp histamine/
3.	methacholine chloride/
4.	(mannitol* or histamine* or methacholine*).ti,ab.
5.	or/1-4
6.	bronchial provocation tests/
7.	(inhalation or provocation or provoke* or challenge*).ti,ab.
8.	(hyperresponsiv* or hyperreactiv*).ti,ab.
9.	bronchial hyperreactivity/
10.	or/6-9
11.	5 and 10

2

### Embase search terms

1.	mannitol/
2.	histamine/
3.	methacholine/
4.	(mannitol* or histamine* or methcholine*).ti,ab.
5.	or/1-4
6.	inhalation test/
7.	provocation test/
8.	bronchus hyperreactivity/
9.	(inhalation or provocation or provoke* or challenge*).ti,ab.
10.	(hyperresponsiv* or hyperreactiv*).ti,ab.
11.	or/6-10
12.	5 and 11

3

### Cochrane search terms

#1.	MeSH descriptor: [Mannitol] explode all trees
#2.	MeSH descriptor: [Histamine] explode all trees
#3.	MeSH descriptor: [Methacholine Chloride] explode all trees
#4.	(mannitol or histamine or methacholine):ti,ab
#5.	{or #1-#4}
#6.	MeSH descriptor: [Bronchial Provocation Tests] explode all trees
#7.	MeSH descriptor: [Bronchial Hyperreactivity] explode all trees
#8.	(inhalation or provocation or provoke* or challenge*).ti,ab
#9.	(hyperresponsiv* or hyperreactiv*).ti,ab
#10.	{or #6-#9}
#11.	5 and 10

1 **F.3.14 Bronchial challenge test: exercise**

2 20. In people under investigation for asthma, what is the diagnostic accuracy of bronchoconstriction  
3 in response to an exercise challenge?

4 Search constructed by combining the columns in the following table using the AND Boolean operator.  
5 Exclusion filter applied using NOT Boolean operator.

Population	Intervention or exposure	Comparison	Study design filter	Date parameters and other limits
People of all ages with asthma or suspected asthma	Clinical history of symptoms in response to exercise	n/a	The following filter was used in all databases: DIAG1	See Table 24 English only Exclusion filter applied in Medline and Embase

6 **Medline search terms**

1.	exp exercise/
2.	exp sports/
3.	(exercise* or sport*).ti,ab.
4.	(physical* adj (train* or exert* or activit*)).ti,ab.
5.	or/1-4
6.	medical history taking/
7.	(histories or history).ti,ab.
8.	exp questionnaires/
9.	question*.ti,ab.
10.	exp "signs and symptoms, respiratory"/
11.	(symptom or symptoms).ti,ab.
12.	or/6-11
13.	5 and 12

7 **Embase search terms**

1.	exp *exercise/
2.	exp *sport/
3.	(exercise* or sport*).ti,ab.
4.	(physical* adj (train* or exert* or activit*)).ti,ab.
5.	or/1-4
6.	exp *anamnesis/
7.	(histories or history).ti,ab.
8.	exp *questionnaire/
9.	question*.ti,ab.
10.	(symptom or symptoms).ti,ab.
11.	exp *breathing disorder/
12.	exp *coughing/
13.	or/6-12
14.	5 and 13

8 **Cochrane search terms**

#1.	(exercise* or sport*):ti,ab,kw
-----	--------------------------------



#2.	(physical* near/1 (train* or exert* or activit*)):ti,ab,kw
#3.	{or #1-#2}
#4.	(histories or history or question*):ti,ab,kw
#5.	(symptom or symptoms):ti,ab,kw
#6.	#4 or #5
#7.	#3 and #6

### 1 F.3.15 Questionnaires

2 21. In people with asthma, what is the clinical and cost-effectiveness of using symptom scores/diaries  
3 or validated questionnaires measuring symptom control (e.g. ACT, ACQ, cACT, RCP 3 questions)  
4 and/or health related quality of life (e.g. AQLQ, pAQLQ) to monitor asthma?

5 Search constructed by combining the columns in the following table using the AND Boolean operator.  
6 Exclusion filter applied using NOT Boolean operator.

Population	Intervention or exposure	Comparison	Study design filter	Date parameters and other limits
People of all ages with asthma or suspected asthma	Validated questionnaires	n/a	The following filters were used in Medline and Embase only: OBS, RCT, VAL	See Table 24 English only Exclusion filter applied in Medline and Embase

### 7 Medline search terms

1.	(diary or diaries).ti,ab.
2.	(symptom* adj2 scor*).ti,ab.
3.	or/1-2
4.	(measur* or assess* or monitor* or evaluat*).ti,ab.
5.	3 and 4
6.	(CACT or ACQ 6 or ACQ 7 or ACQ6 or ACQ7 or PACQ or RCP-3 or RCP3 or PAQLQ or AQLQ or PACQLQ).ti,ab.
7.	asthma control test*.ti,ab.
8.	asthma control questionnaire*.ti,ab.
9.	(rcp3 question* or rcp 3 question* or rcp three question* or royal college of physician*3 question* or royal college of physician* three question*).ti,ab.
10.	asthma quality of life questionnaire*.ti,ab.
11.	((p?ediatric or caregiver* or care giver* or carer*) adj3 quality of life questionnaire*).ti,ab.
12.	or/6-11
13.	5 or 12

### 8 Embase search terms

1.	(diary or diaries).ti,ab.
2.	(symptom* adj2 scor*).ti,ab.
3.	or/1-2
4.	(measur* or assess* or monitor* or evaluat*).ti,ab.
5.	3 and 4
6.	(CACT or ACQ 6 or ACQ 7 or ACQ6 or ACQ7 or PACQ or RCP-3 or RCP3 or PAQLQ or AQLQ or PACQLQ).ti,ab.
7.	asthma control test*.ti,ab.

8.	asthma control questionnaire*.ti,ab.
9.	(rcp3 question* or rcp 3 question* or rcp three question* or royal college of physician*3 question* or royal college of physician* three question*).ti,ab.
10.	asthma quality of life questionnaire*.ti,ab.
11.	((p?ediatric or caregiver* or care giver* or carer*) adj3 quality of life questionnaire*).ti,ab.
12.	or/6-11
13.	5 or 12

1

### Cochrane search terms

#1.	(diary or diaries):ti,ab
#2.	(symptom* near/2 scor*):ti,ab
#3.	{or #1-#2}
#4.	(measur* or assess* or monitor* or evaluat*):ti,ab
#5.	#3 and #4
#6.	(CACT or ACQ 6 or ACQ 7 or ACQ6 or ACQ7 or PACQ or RCP-3 or RCP3 or PAQLQ or AQLQ or PACQLQ):ti,ab
#7.	asthma control test*:ti,ab
#8.	asthma control questionnaire*:ti,ab
#9.	(rcp3 question* or rcp 3 question* or rcp three question* or royal college of physician*3 question* or royal college of physician* three question*):ti,ab
#10.	asthma quality of life questionnaire*:ti,ab
#11.	((p?ediatric or caregiver* or care giver* or carer*) near/3 "quality of life questionnaire*"):ti,ab
#12.	{or #6-#11}
#13.	#5 or #12

### 2 F.3.16 Lung functions tests

3 22.In people with asthma, what is the clinical and cost-effectiveness of using measures of pulmonary  
4 function assessing asthma control (for example, spirometry and peak expiratory flow) to monitor  
5 asthma?

6 Search constructed by combining the columns in the following table using the AND Boolean operator.  
7 Exclusion filter applied using NOT Boolean operator.

Population	Intervention or exposure	Comparison	Study design filter	Date parameters and other limits
People of all ages with asthma or suspected asthma	Lung function tests	n/a	The following filter was used in Medline and Embase only: RCT	See Table 24 English only Exclusion filter applied in Medline and Embase

8

### Medline search terms

1.	vital capacity/
2.	forced expiratory volume/
3.	(FEV1 or FEV 1 or FVC).ti,ab.
4.	(flow volume adj (loop* or curve* or graph*)):ti,ab.
5.	(forced expiratory volume* adj6 ("1" or one)).ti,ab.
6.	((force* or time*) adj vital capacit*).ti,ab.
7.	spirometry.ti.

8.	or/1-7
9.	PEFV.ti,ab.
10.	(PEF or PEFR or PFR or peak expiratory flow* or peak flow*).ti,ab.
11.	peak expiratory flow rate/
12.	or/9-11
13.	8 or 12
14.	monitoring, physiologic/
15.	monitor*.ti,ab.
16.	self care/
17.	plan*.ti,ab.
18.	or/14-17
19.	13 and 18

1

### Embase search terms

1.	vital capacity/
2.	forced expiratory volume/
3.	lung flow volume curve/
4.	(FEV1 or FEV 1 or FVC).ti,ab.
5.	(flow volume adj (loop* or curve* or graph*)).ti,ab.
6.	(forced expiratory volume* adj6 ("1" or one)).ti,ab.
7.	((force* or time*) adj vital capacit*).ti,ab.
8.	spirometry.ti.
9.	or/1-8
10.	PEFV.ti,ab.
11.	(PEF or PEFR or PFR or peak expiratory flow* or peak flow*).ti,ab.
12.	peak expiratory flow/
13.	or/10-12
14.	(monitor* or plan*).ti,ab.
15.	exp monitoring/
16.	self care/
17.	or/14-16
18.	9 or 13
19.	17 and 18

2

### Cochrane search terms

#1.	MeSH descriptor: [Vital Capacity] this term only
#2.	MeSH descriptor: [Forced Expiratory Volume] this term only
#3.	(FEV1 or "FEV 1" or FVC):ti,ab
#4.	(flow volume near/2 (loop* or curve* or graph*)):ti,ab
#5.	(forced expiratory volume* near/6 ("1" or one)):ti,ab
#6.	((force* or time*) near/2 vital capacit*):ti,ab
#7.	spirometry:ti
#8.	{or #1-#7}
#9.	PEFV:ti,ab
#10.	(PEF or PEFR or PFR or peak expiratory flow* or peak flow*):ti,ab,kw
#11.	#9 or #10

#12.	#8 or #11
#13.	(monitor* or plan*):ti,ab,kw
#14.	MeSH descriptor: [Self Care] explode all trees
#15.	#13 or #14
#16.	#12 and #15

### 1 F.3.17 FeNO (monitoring)

2 For search terms see F.3.11

3 23.In people with asthma, what is the clinical and cost-effectiveness of using fractional exhaled nitric  
4 oxide (FeNO) measures for monitoring asthma control?

5 Search constructed by combining the columns in the following table using the AND Boolean operator.  
6 Exclusion filter applied using NOT Boolean operator.

Population	Intervention or exposure	Comparison	Study design filter	Date parameters and other limits
People of all ages with asthma or suspected asthma	Fractional exhaled nitric oxide (FeNO)	n/a	The following filters were used in Medline and Embase only: OBS, RCT, SR	See Table 24 English only Exclusion filter applied in Medline and Embase

### 7 F.3.18 Peripheral blood eosinophil count (monitoring)

8 For search terms see F.3.12

9 24.In people with asthma, what is the clinical and cost-effectiveness of using the peripheral blood  
10 eosinophil count for monitoring asthma control?

11 Search constructed by combining the columns in the following table using the AND Boolean operator.  
12 Exclusion filter applied using NOT Boolean operator.

Population	Intervention or exposure	Comparison	Study design filter	Date parameters and other limits
People of all ages with asthma or suspected asthma	Eosinophil blood count measures	n/a	The following filters were used in Medline and Embase only: OBS, RCT	See Table 24 English only Exclusion filter applied in Medline and Embase

### 13 F.3.19 Airway hyper-reactivity measures

14 For search terms see F.3.13

15 25.In people with asthma, what is the clinical and cost-effectiveness of using indirect challenge tests  
16 with mannitol or direct challenge tests with histamine or methacholine for monitoring asthma  
17 control?

18 Search constructed by combining the columns in the following table using the AND Boolean operator.  
19 Exclusion filter applied using NOT Boolean operator.

Population	Intervention or exposure	Comparison	Study design filter	Date parameters and other limits
People of all	Bronchial challenge	n/a	The following filter was	See Table 24

Population	Intervention or exposure	Comparison	Study design filter	Date parameters and other limits
ages with asthma or suspected asthma	tests using histamine and methacholine or mannitol		used in Medline and Embase only: RCT	English only Exclusion filter applied in Medline and Embase

1 **F.3.20 Adherence to treatment**

2 26.In people with asthma, what is the clinical and cost-effectiveness of monitoring adherence to  
3 treatment?

4 Search constructed by combining the columns in the following table using the AND Boolean operator.  
5 Exclusion filter applied using NOT Boolean operator.

Population	Intervention or exposure	Comparison	Study design filter	Date parameters and other limits
People of all ages with asthma or suspected asthma	Strategies to monitor or interventions to increase adherence	n/a	The following filters were used in Medline and Embase only: OBS, RCT	See Table 24 English only Exclusion filter applied in Medline and Embase

6 **Medline search terms**

1.	(adheren* or complian* or concordan* or nonadheren* or noncomplian*).ti,ab.
2.	exp patient compliance/
3.	or/1-2
4.	FeNO.ti,ab.
5.	nitric oxide/
6.	biological markers/
7.	breath tests/
8.	exhalation/
9.	or/6-8
10.	5 and 9
11.	((Fe or exhal* or fraction*) adj2 (NO or nitric or nitrogen)).ti,ab.
12.	4 or 10 or 11
13.	prescription*.ti,ab.
14.	exp pharmaceutical services/
15.	or/13-14
16.	((electronic adj2 inhaler*) or smartinhaler* or smart inhaler*).ti,ab.
17.	prednisolone.ti,ab.
18.	theophylline.ti,ab.
19.	(MARS or (medication adherence adj2 scale*)).ti,ab.
20.	exp adrenal cortex hormones/
21.	administration, inhalation/
22.	20 and 21
23.	(inhal* and (corticosteroid* or steroid* or corticoid* or glucocorticoid* or glucocortico*)).ti,ab.

24.	22 or 23
25.	or/12,15-19,24
26.	exp monitoring, physiologic/
27.	monitor*.ti,ab.
28.	or/26-27
29.	25 or 28
30.	3 and 29

1

#### Embase search terms

1.	(adheren* or complian* or concordan* or nonadheren* or noncomplian*).ti,ab.
2.	exp *patient compliance/
3.	or/1-2
4.	FeNO.ti,ab.
5.	((Fe or exhal* or fraction*) adj2 (NO or nitric or nitrogen)).ti,ab.
6.	*nitric oxide/
7.	*breath analysis/
8.	*expired air/
9.	*biological marker/
10.	*exhalation/
11.	or/7-10
12.	6 and 11
13.	4 or 5 or 12
14.	prescription*.ti,ab.
15.	*pharmacy/
16.	*prescription/
17.	((electronic adj2 inhaler*) or smartinhaler* or smart inhaler*).ti,ab.
18.	prednisolone.ti,ab.
19.	theophylline.ti,ab.
20.	*prednisolone/
21.	*theophylline blood level/
22.	(MARS or (medication adherence adj2 scale*)).ti,ab.
23.	exp *corticosteroid/ih
24.	(inhal* and (corticosteroid* or steroid* or corticoid* or glucocorticoid* or glucocortico*)).ti,ab.
25.	or/13-24
26.	exp *monitoring/
27.	monitor*.ti,ab.
28.	or/26-27
29.	3 and (25 or 28)

2

#### Cochrane search terms

#1.	(adheren* or complian* or concordan* or nonadheren* or noncomplian*).ti,ab
#2.	[mh ^"patient compliance"]
#3.	{or #1-#2}
#4.	FeNO:ti,ab
#5.	((Fe or exhal* or fraction*) near/2 (NO or nitric or nitrogen)):ti,ab

#6.	((NO or nitric or nitrogen) near/2 (marker* or biomarker* or breath* or test* or exhal* or expir*)):ti,ab
#7.	[mh ^"Nitric Oxide"]
#8.	[mh ^"Biological Markers"]
#9.	[mh ^"Breath Tests"]
#10.	[mh ^Exhalation]
#11.	{or #8-#10}
#12.	#7 and #11
#13.	{or #4-#6, #12}
#14.	prescription*:ti,ab
#15.	[mh ^"pharmaceutical services"]
#16.	((electronic near/2 inhaler*) or smartinhaler* or smart inhaler*):ti,ab
#17.	prednisolone:ti,ab
#18.	theophylline:ti,ab
#19.	(MARS or medication adherence):ti,ab
#20.	[mh ^"adrenal cortex hormones"]
#21.	[mh "administration, inhalation"]
#22.	(inhal* and (corticosteroid* or steroid* or corticoid* or glucocorticoid* or glucocortico*)):ti,ab
#23.	#20 and #21
#24.	{or #13-#19, #22-#23}
#25.	[mh ^"Monitoring, Physiologic"]
#26.	monitor*:ti,ab
#27.	{or #25-#36}
#28.	#3 and (#24 or #27)

1 **F.3.21 Inhaler technique**

2 27.In people with asthma, what is the optimal frequency and method for monitoring inhaler  
3 technique?

4 Search constructed by combining the columns in the following table using the AND Boolean operator.  
5 Exclusion filter applied using NOT Boolean operator.

Population	Intervention or exposure	Comparison	Study design filter	Date parameters and other limits
People of all ages with asthma or suspected asthma	Monitoring inhaler technique	n/a	The following filters were used in Medline and Embase only: OBS, RCT	See Table 24 English only Exclusion filter applied in Medline and Embase

6 **Medline search terms**

1.	((nebuliser* or nebulizer* or vaporiser* or vaporizer* or atomiser* or atomizer* or inhal* or aerosol* or device*) adj5 (technique* or competen* or efficien* or inefficien* or misuse* or check* or correct* or incorrect* or evaluat* or adher*)):ti,ab.
----	--

7 **Embase search terms**

1.	((nebuliser* or nebulizer* or vaporiser* or vaporizer* or atomiser* or atomizer* or inhal* or aerosol* or device*) adj5 (technique* or competen* or efficien* or inefficien* or misuse* or
----	--

	check* or correct* or incorrect* or evaluat* or adher*)):ti,ab.
--	---

1 **Cochrane search terms**

#1.	((nebuliser* or nebulizer* or vaporiser* or vaporizer* or atomiser* or atomizer* or inhal* or aerosol* or device*) near/5 (technique* or competen* or efficien* or inefficien* or misuse* or check* or correct* or incorrect* or evaluat* or adher*)):ti,ab
-----	---

2 **F.3.22 Tele-healthcare**

3 Searches for the following question were undertaken by the Cochrane Airways Group using the  
4 Cochrane Airways Group Specialised Register of trials. Full search methodology is provided in the  
5 published Cochrane review.<sup>1111</sup>

6 28.In people with asthma, what is the clinical and cost-effectiveness of tele-healthcare to monitor  
7 asthma control?

8 **F.4 Health economics search**

9 **F.4.1 Health economic reviews**

10 Economic searches were conducted in Medline, Embase, HEED and CRD for NHS EED and HTA.

Population	Intervention or exposure	Comparison	Study design filters	Date parameters and other limits
People of all ages with asthma or suspected asthma	n/a	n/a	The following filters were used in Medline and Embase only: HE	Medline and Embase 2012–1 October 2014 CRD EED and HTA All dates to 1 October 2014 English only

11 **Medline and Embase search terms**

4.	exp asthma/
5.	asthma*.ti,ab.
6.	or/1-2

12 **Cochrane search terms**

#4.	MeSH descriptor: [Asthma] explode all trees
#5.	asthma*:ti,ab.
#6.	{or #1-#2}

13 **CRD search terms**

#1.	MeSH DESCRIPTOR Asthma EXPLODE ALL TREES
#2.	(asthma*)
#3.	#1 OR #2

14 **HEED search terms**

1.	AX=asthma*
----	------------

15 **F.4.2 Quality of life reviews**

16 Quality of life searches were conducted in Medline and Embase only



<b>Population</b>	<b>Intervention or exposure</b>	<b>Comparison</b>	<b>Study design filters</b>	<b>Date parameters and other limits</b>
People of all ages with asthma or suspected asthma	n/a	n/a	The following filters were used in Medline and Embase only: QOL	Medline 1948-02/10/2014 Embase 1980-02/10/2014 English only

1

# Appendix G: Clinical evidence tables

## G.1 Signs and symptoms for diagnosis

**Table 25: CHOI 2007<sup>315</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments			
Choi et al., 2007. Easy diagnosis of asthma: computer-assisted, symptom-based diagnosis. Journal of Korean Medical Science: 22: 832-838.  REF ID: CHOI2007	<u>Study type:</u> Diagnostic cross sectional study  <u>Setting:</u> Hospital outpatient dept.  <u>Country:</u> Korea  <u>Recruitment:</u> Consecutive or random patient selection	N = 302 Adults <u>Inclusion criteria:</u> • Respiratory symptoms such as dyspnoea, cough or wheezing  <u>Exclusion criteria:</u>	<u>Male:Female</u> 127:175  <u>Mean age:</u> Asthma: 46.8 (16.8) Non-asthma: 47.8 (15.6)  Medications: Not reported  Smokers: Asthma: 36.7% Non-asthma: 21.4%	<u>Index test</u> Questionnaire consisting of 11 questions regarding symptoms within 1 year: Q1 = Have you had wheezing associated with dyspnoea? (score 2) Provoking factors: • Nocturnal aggravation (score 1) • Cold air (score 1) • Exercise (score 1) • Upper respiratory infection (score 1) • Smoke or air pollution (score 1) • Concurrently with coughing (score 1) Q2 = Have you had paroxysmal coughing? (score 1) Q3 = Have you had dyspnoea without wheezing? (score 1) Q4 = Have you had wheezing without dyspnoea? (score 1) Q5 = Have you had fluctuation of	a) only sn/sp values reported, not number of TN, FN, TP and FP. Cut-off ≥3: Sn = 92.4%; Sp = 3.3% Cut-off ≥4: Sn = 85.2%; Sp = 25.0% Cut-off ≥5: Sn = 74.3%; Sp = 47.8% Cut-off ≥6: Sn = 59.5%; Sp = 66.3% Cut-off ≥7: Sn = 40.0%; Sp = 83.7% Cut-off ≥8: Sn = 21.4%; Sp = 89.1% Cut-off ≥9: Sn = 14.3%; Sp = 95.7% Cut-off ≥10: Sn = 8.6%; Sp = 96.7% Cut-off ≥11: Sn = 4.3%; Sp = 98.9%  AUC total symptom score: 0.647 (0.033)	<u>Source of funding:</u> Korea Asthma Allergy Foundation Research Grant and Korea Health 21 R&D Project, Ministry of Health  <u>Limitations:</u> • No drop-outs • Consecutive or random patient selection not mentioned • time between IT and RS unclear but same time			
					b)		Ref std +	Ref std -	Total
					Index test +		86	71	157
					Index test -		124	21	145
Total	210	92	302						

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
	not reported			<p>exacerbation and improvement? (score 2)</p> <p>a) Total symptom score                      b) Responded yes to Q1 (all provoking factors)                      c) Responded yes to Q2                      d) Responded yes to Q3                      e) Responded yes to Q4                      f) Responded yes to Q5</p> <p>Cut-off: various total symptom score cut-off scores reported. ROC analysis of total symptom scores. With an increase in cut-off, sensitivity decreased and specificity increased. Cut-off value of <math>\geq 4</math> associated with highest combination of sn and sp. Even within a total symptom score of <math>\geq 4</math>, the sn/sp varied with the combination of symptoms (reported in paper Table 6)</p> <p><u>Reference standard</u>                      Physician Dx with objective test (patients with an FEV1 &gt;70% had MCT, all other patients had BDR to short-acting beta2-agonist). Definite Dx of asthma made using test (MCh PC20 &lt;16mg/ml or BDR FEV1 increase &gt;12% and 200ml)</p>	Sensitivity Specificity PPV / NPV		41.0% 22.8% 54.8% / 14.5%		<p>suggested</p> <p><u>Additional data:</u>                      Symptoms and provoking factors with high prevalence in those Dx with asthma: wheezing with dyspnoea (86%); nocturnal aggravation (64%); fluctuation (64%); upper respiratory infection (50%); cold air (44%); exercise (40%).</p>
c)		Ref std +	Ref std -	Total					
Index test +		34	53	87					
Index test -		176	39	215					
Total		210	92	302					
Sensitivity Specificity PPV / NPV		16.2% 42.4% 39.1% / 18.1%							
d)		Ref std +	Ref std -	Total					
Index test +		24	27	51					
Index test -		186	65	251					
Total		210	92	302					
Sensitivity Specificity PPV / NPV		11.4% 70.7% 47.1% / 25.9%							
e)		Ref std +	Ref std -	Total					
Index		18	19	37					

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
				Time between index test and reference standard: unclear	test +				
					Index test -	192	73	265	
					Total	210	92	302	
				<u>Target condition</u> Asthma	Sensitivity		9.0%		
					Specificity		79.3%		
					f)	Ref std +	Ref std -	Total	
					Index test +	64	59	123	
					Index test -	146	33	179	
					Total	210	92	302	
					Sensitivity		30.5%		
					Specificity		35.9%		
					PPV / NPV		52.0% / 18.4%		

**Table 26: SCHLEICH 2012<sup>1514</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
Schleich FN, Asandei R, Manise M, Sele J, Seidel L, Louis R. Is FENO50	<u>Study type:</u> Prospective study  <u>Data source:</u> Collected for study	N = 174  <u>Inclusion criteria:</u> Patients referred to chest physicians for methacholine challenge for asthma diagnosis;	<u>Male: Female</u> 72: 102  <u>Mean (SD) age:</u> 41 (16) yrs	<u>Index test</u> Questionnaire concerning symptoms: a) diurnal cough b) nocturnal cough c) diurnal wheezing d) nocturnal wheezing e) dyspnoea	a)	Ref std +	Ref std -	Total	<u>Source of funding:</u> Interuniversity Attraction Poles Project  <u>Limitations:</u>
					Index test +	54	68	122	
					Index test -	28	24	52	
					Total	82	92	174	

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
useful diagnostic tool in suspected asthma? International Journal of Clinical Practice. 2012; 66(2):158-165. (Guideline Ref ID SCHLEICH 2012)	<u>Setting:</u> Department of Pulmonary Medicine  <u>Country:</u> Belgium  <u>Recruitment:</u> March 13, 2009 to December 30, 2009	bronchodilator test failed to show reversible airway obstruction or baseline spirometry normal  <u>Exclusion criteria:</u> Patients already receiving inhaled corticosteroids		<u>Reference standard</u> Methacholine challenge  Cut off PC20 <16mg/mL Time between index test and reference standard: same time  <u>Target condition</u> Asthma (methacholine challenge positive) vs. methacholine negative  FeNO levels: methacholine challenge positive vs. methacholine negative	Sensitivity		65.9		<u>Additional data:</u> None
					Specificity		26.1		
					PPV / NPV		44.3 / 46.2		
					b)	Ref std +	Ref std -	Total	
					Index test +	30	32	62	
					Index test -	52	60	112	
					Total	82	92	174	
					Sensitivity		36.6		
					Specificity		65.2		
					PPV / NPV		48.4 / 53.4		
					c)	Ref std +	Ref std -	Total	
					Index test +	47	35	82	
					Index test -	35	57	92	
					Total	82	92	174	
Sensitivity		57.3							
Specificity		62.0							
PPV / NPV		57.3 / 62.0							
d)	Ref std +	Ref std -	Total						
Index test +	46	19	65						
Index test -	36	73	109						

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
					Total	82	92	174	
					Sensitivity	56.1			
					Specificity	79.3			
					PPV / NPV	70.8 / 67.0			
					e)	Ref std +	Ref std -	Total	
					Index test +	60	41	101	
					Index test -	22	51	73	
					Total	82	92	174	
					Sensitivity	73.2			
					Specificity	55.4			
					PPV / NPV	59.4 / 69.9			

**Table 27: SCHNEIDER 2009A<sup>1519</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
Schneider A et al. 2009. Diagnostic accuracy of spirometry in primary	<u>Study type:</u> Cross-sectional study <u>Setting:</u> Index test in primary care, 14 GPs in 10 practices	N = 219 Adults <u>Inclusion criteria:</u> • Visiting GP for the first time with complaints of suggested obstructive airway disease (OAD).	<u>Male: Female</u> 92:127  <u>Mean (SD) age:</u> 43.8 (15.6)  <u>% of symptomatic</u>	<u>Index test:</u> Medical history taken with a structured questionnaire: a) 'Do you sometimes suffer from shortness of breath?' b) 'Have you suffered from wheezing in your chest?' c) 'Do you often suffer from cough?'	a)	Ref st +	Ref st -	Total	<u>Source of funding:</u> Federal ministry of education and research (BMBF), Germany. <u>Limitations:</u>
					Index test +	55	80	135	
					Index test -	35	49	84	
					Total	90	129	219	

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
care. BMC Pulmonary Medicine: 9: 31.  REF ID: SCHNEIDER2009A	<u>Country:</u> Germany  <u>Recruitment:</u> Consecutive recruitment	<ul style="list-style-type: none"> <li>Symptoms such as dyspnoea, coughing, or expectoration</li> </ul> <u>Exclusion criteria:</u> <ul style="list-style-type: none"> <li>Previous Dx for OAD</li> <li>Previous anti-obstructive medicine</li> <li>Contraindications for BDR of challenge testing (untreated hyperthyreosis, unstable coronary artery disease, cardiac arrhythmia)</li> <li>Pregnancy</li> </ul>	<u>patients with positive/abnormal spirometry:</u> 35.6%  <u>Medications:</u> None prior to spirometry at GP. If necessary, therapy initiated by GP for asthma or COPD but stopped 12 hours prior to lung function lab.	d) 'Do you often suffer from expectoration?' e) 'Have you been woken up with a feeling of tightness in your chest?' f) 'Have you been woken up by an attack of shortness of breath?'  <u>Reference standard</u> LUNG FUNCTION LAB: Dx by pneumologist based on whole-body plethysmography (FEV1/VC ≤70% or FEV1 <80%) followed by either BDR if obstruction is present (FEV1 ≥12% and ≥200ml) or methacholine if obstruction is not present (PC20 ≤16mg/ml or extreme increase in airway resistance accompanied by clinical symptoms in two patients)  Time between index test and reference standard: unclear  <u>Target condition</u> OAD: Asthma or COPD	Sensitivity		61.1		<u>Additional data:</u> 3 lost to follow-up
					Specificity		38.0		
					PPV/NPV		40.7/58.3		
					b)	Ref st +	Ref st -	Total	
					Index test +	47	60	107	
					Index test -	43	69	112	
					Total	90	129	219	
					Sensitivity		52.2		
					Specificity		53.5		
					PPV/NPV		43.9 / 61.6		
c)	Ref st +	Ref st -	Total						
Index test +	39	87	126						
Index test -	51	42	93						
Total	90	129	219						
Sensitivity		43.3							
Specificity		32.6							
PPV / NPV		31.0 / 45.2							
d)	Ref st +	Ref st -	Total						

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
					Index test +	22	52	74	
					Index test -	68	77	145	
					Total	90	129		
					Sensitivity	24.4			
					Specificity	59.7			
					PPV/NPV	29.7 / 53.1			
					e)	Ref st +	Ref st -	Total	
					Index test +	27	22	49	
					Index test -	63	107	170	
					Total	90	129		
					Sensitivity	30.0			
					Specificity	82.9			
					PPV/NPV	55.1 / 62.9			
					f)	Ref st +	Ref st -	Total	
					Index test +	27	24	51	
					Index test -	63	105	168	
					Total	90	129		
					Sensitivity	30.0			
					Specificity	81.4			



Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables		Comments
					PPV / NPV	52.9 / 62.5	

**Table 28: SCHNEIDER 2012<sup>1517</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments
Antonius Schneider, Mehtap Ay, Bernhard Faderl, Klaus Linde, and Stefan Wagenpfeil. Diagnostic accuracy of clinical symptoms in obstructive airway diseases varied within different health care sectors.	<p><u>Study type:</u> Cross-sectional study</p> <p><u>Setting:</u> 3 parts /settings: 1. GPs 2. Referral practice (pneumologists) • Hospital (Pts in rehab after long-term respiration, or after weaning from artificial respiration, or pts with severe COPD)</p>	<p>N = 778 adults (GP: n=219; pneumologists: n=259; hospital: n=300).</p> <p><u>Inclusion criteria:</u> <b>1. GPs:</b> • first time visit with complaints of suggested OAD or RAD • symptoms for &gt;2 months <b>2. Pneumologists:</b> • 1<sup>st</sup> visit for Dx work-up to include or exclude OAD or RAD • Other criteria as for GPs <b>3. Hospital</b> • Pts with suspected OAD who were hospitalised for the</p>	<p><u>Female</u> GP: 58% Referral: 60% Hospital: 36%</p> <p><u>Mean age:</u> GP: 43.8 Referral: 46.3 Hospital: 65.3</p> <p><u>% of symptomatic patients Dx with asthma:</u> GP: 90 (41%) Referral: 84 (32%) Hospital: 25 (8.3%)</p> <p><u>Medications:</u> Not mentioned.</p>	<p><u>Index test:</u> Medical history taken with a structured questionnaire: a) Self-reported wheezing b) Coughing c) Dyspnoea attacks d) Dyspnoea going upstairs e) Dyspnoea when walking f) Dyspnoea on minimal exercise g) Expectoration h) Tightness of chest</p> <p><u>Reference standard</u> Symptoms + LUNG FUNCTION LAB: Dx by pneumologist based on whole-body plethysmography (FEV1/VC ≤70% or FEV1 &lt;80%) followed by either BDR if obstruction is</p>	<p><b>GP (sens/spec)</b> NOTE: some outcome data was previously reported in Schneider 2009A. a) Self-reported wheezing (52.2 / 53.1) b) Coughing (43.8 / 31.5) c) Dyspnoea attacks (40.0 / 78.4) d) Dyspnoea going upstairs (47.1 / 49.6) e) Dyspnoea when walking (4.8 / 93.2) f) Dyspnoea on minimal exercise (2.5 / 94.1) g) Expectoration (25.3 / 58.7) h) Tightness of chest (31.4 / 82.7)</p> <p><b>Pneumologists (sens/spec)</b> a) Self-reported wheezing (52.4 / 65.6) b) Coughing (52.5 / 63.9) c) Dyspnoea attacks (8.9 / 88.2) d) Dyspnoea going upstairs (54.6 / 40.6) e) Dyspnoea when walking (25.0 / 78.4) f) Dyspnoea on minimal exercise (14.5 / 84.9) g) Expectoration (40.0 / 74.1) h) Tightness of chest (31.7 / 74.7)</p>	<p><u>Source of funding:</u> Federal ministry of education and research (BMBF), Germany.</p> <p><u>Limitations:</u></p> <p><u>Additional data:</u> None.</p>

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments
<p><i>J.Clin.Epidemiol.</i> 65 (8):846-854, 2012.</p> <p>REF ID: SCHNEIDER2012</p>	<p>needing respiration at home or severe asthma)</p> <p><u>Country:</u> Germany (multicentre)</p> <p><u>Recruitment:</u> Consecutive recruitment</p>	<p>first time.</p> <p><u>Exclusion criteria:</u></p> <p><b>1. GPs:</b></p> <ul style="list-style-type: none"> <li>Respiratory infections in prior 6 wks</li> <li>Previous Dx of OAD.</li> </ul> <p><b>2. Pneumologists:</b></p> <ul style="list-style-type: none"> <li>As above.</li> </ul> <p><b>3. Hospital</b></p> <ul style="list-style-type: none"> <li>None reported.</li> </ul>		<p>present (FEV1 <math>\geq</math>12% and <math>\geq</math>200ml) or methacholine if obstruction is not present (PC20 <math>\leq</math>16mg/ml). Most asthma pts were identified by the BPT.</p> <p><u>Time between index test and reference standard:</u> unclear</p> <p><u>Target condition</u> OAD: Asthma or COPD</p>	<p><b>Hospital (sens/spec)</b></p> <p>a) Self-reported wheezing (76.0 / 33.6)</p> <p>b) Coughing (48.0 / 51.8)</p> <p>c) Dyspnoea attacks (32.0 / 81.6)</p> <p>d) Dyspnoea going upstairs (88.0 / 6.7)</p> <p>e) Dyspnoea when walking (36.0 / 32.3)</p> <p>f) Dyspnoea on minimal exercise (32.0 / 42.9)</p> <p>g) Expectoration (41.7 / 51.1)</p> <p>h) Tightness of chest (44.0 / 53.5)</p>	

**Table 29: TOMITA 2013<sup>1753</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
<p>Tomita et al., 2013. A scoring algorithm for predicting the presence of adult asthma: a prospective</p>	<p><u>Study type:</u> Cross-sectional study</p> <p><u>Setting:</u> Outpatient clinic, University Hospital</p> <p><u>Country:</u> Japan</p>	<p>N = 566</p> <p>Adults</p> <p><u>Inclusion criteria:</u></p> <ul style="list-style-type: none"> <li>Adult outpatients with non-specific respiratory symptoms including wheeze, shortness of breath, and cough.</li> </ul> <p><u>Exclusion criteria:</u></p>	<p><u>Male: Female</u> 221:345</p> <p>Median (range) age: 52 years (18-88)</p> <p>Medications: Could be</p>	<p><u>Index test</u></p> <p>Five additional questions at routine interview, including:</p> <p>a) 'Have you ever had any experiences of wheezing?'</p> <p>b) 'Did your symptoms occur in the early morning or at night (diurnal variation)?'</p> <p>c) 'Have you had similar episodes of respiratory symptoms (recurrent episodes)?'</p>	a)	Ref st +	Ref st -	Total	<p><u>Source of funding:</u> None. None of the authors had a financial relationship with a commercial entity</p> <p><u>Limitations:</u></p> <ul style="list-style-type: none"> <li>Time</li> </ul>
					Index test +	110	26	136	
					Index test -	257	173	430	
					Total	367	199	566	

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
derivation study. Primary care respiratory journal: 22: 51-58  REF ID: TOMITA2013	<u>Recruitment:</u> All eligible patients between Jan 2008 and Sept 2011 (unclear)	<ul style="list-style-type: none"> <li>Abnormal x-ray findings and other causes</li> <li>Pregnant/breastfeeding</li> <li>Current Dx of pneumonia, pneumothorax, atelectasis, pulmonary fibrotic disease, chronic bronchitis, other lower respiratory abnormality.</li> <li>Systemic or inhaled CS, beta-blockers or angiotensin converting enzyme inhibitors</li> <li>Symptoms of chest pain or haemosputum.</li> </ul>	started on ICS at first visit before MCT	<u>Reference standard</u> Relevant symptom history (all patients) and BDR (FEV1 <200ml and 12%) and/or BHR (methacholine PC20 <8mg/ml)  NB. 64/367 patients Dx had clinically Dx asthma (responsive to ICS with neither BDR or BHR)  Time between index test and reference standard: within 8 weeks  <u>Target condition</u> Asthma	Sensitivity		30.0%		between tests 8 weeks, but could be started on ICS at first visit  • 813 consented but only 566 performed MCT (others declined participation or no AHR)  <u>Additional data:</u>
					Specificity		86.9%		
					PPV / NPV		80.9% / 40.2%		
					b)	Ref std +	Ref std -	Total	
					Index test +	198	62	260	
					Index test -	169	137	306	
					Total	367	199	566	
					Sensitivity		54.0%		
					Specificity		68.8%		
					PPV / NPV		76.2% / 44.8%		
c)	Ref std +	Ref std -	Total						
Index test +	107	18	125						
Index test -	260	181	441						
Total	367	199	566						
Sensitivity		29.2%							
Specificity		91.0%							

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables		Comments
					PPV / NPV	85.6% / 41.0%	

**Table 30: WEVERHESS 1999<sup>1887</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
					a)	Ref st +	Ref st -	Total	
Weverhess et al., 1999. Prognostic characteristics of asthma diagnosis in early childhood in clinical practice. Acta Paediatrica: 88: 827-834.  REF ID: WEVERHESS1999	<u>Study type:</u> Longitudinal prognostic study  <u>Setting:</u> Outpatient department, Children's Hospital  <u>Country:</u> Netherlands  <u>Recruitment:</u> All children from Jan 1991 to Jan 1993	N = 188 (including aged 2-4yr subgroup only)  <u>Inclusion criteria:</u> Aged 0-4 years with symptoms that were suggestive of asthma  <u>Exclusion criteria:</u> Symptoms that could be explained by other respiratory disorders, such as respiratory syncytial virus bronchiolitis, cystic fibrosis, gastro-oesophageal reflux	<u>Male: Female</u> 108:80  <u>Mean (SD) age:</u> 37 (8.4) months  Medications at initial visit: Beta-agonists 42%, depropine 10%, anticholinergics 3%, antihistamines 20%, anti-inflammatory 5%, antibiotics 49%.	<u>Index test</u> Symptoms (visit and questionnaire): a) cough b) wheeze c) cough and wheeze d) shortness of breath  <u>Reference standard</u> Dx taken from medical notes at follow-up (2 years later). Dx made by a paediatrician on clinical grounds, based on recurrence of symptoms and need for and response to therapy according to the guidelines for diagnosis of asthma in young children (follow up statement from the International Paediatric Asthma Consensus Group).	Index test +	127	41	168	<u>Source of funding:</u> Supported financially by Stichting Astmabestrijding, Amsterdam  <u>Limitations:</u> Follow up at 2 years, prognostic design  <u>Additional data:</u> Data provided from children aged 0-1 year separately but does not match protocol.
					Index test -	17	3	20	
					Total	144	44	188	
					Sens / Spec PPV / NPV		88.2% / 6.8% 75.6% / 15.0%		
					b)	Ref std +	Ref std -	Total	
					Index test +	78	19	97	
					Index test -	66	25	91	
					Total	144	44	188	
					Sens / Spec PPV / NPV		54.2% / 56.8% 80.4% / 27.5%		

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments																																																
				<p><u>Time between index test and reference standard:</u> 2 years</p> <p><u>Target condition</u></p>	<table border="1"> <tr> <td>c)</td> <td>Ref std +</td> <td>Ref std -</td> <td>Total</td> </tr> <tr> <td>Index test +</td> <td>70</td> <td>18</td> <td>88</td> </tr> <tr> <td>Index test -</td> <td>74</td> <td>26</td> <td>100</td> </tr> <tr> <td>Total</td> <td>144</td> <td>44</td> <td>188</td> </tr> <tr> <td colspan="2">Sens / Spec</td> <td colspan="2">48.6% / 59.1%</td> </tr> <tr> <td colspan="2">PPV / NPV</td> <td colspan="2">79.5% / 26.0%</td> </tr> </table> <table border="1"> <tr> <td>d)</td> <td>Ref std +</td> <td>Ref std -</td> <td>Total</td> </tr> <tr> <td>Index test +</td> <td>109</td> <td>21</td> <td>130</td> </tr> <tr> <td>Index test -</td> <td>35</td> <td>23</td> <td>58</td> </tr> <tr> <td>Total</td> <td>144</td> <td>44</td> <td>188</td> </tr> <tr> <td colspan="2">Sens / Spec</td> <td colspan="2">75.7% / 52.3%</td> </tr> <tr> <td colspan="2">PPV / NPV</td> <td colspan="2">83.8% / 39.7%</td> </tr> </table> <p><b>PROGNOSTIC DATA (multivariate):</b>  <b>Predictors of Asthma Dx 2 years later (n=188)</b></p> <ul style="list-style-type: none"> <li>• Shortness of breath was a prognostic factor (OR 3.10, 95% CI 1.49-6.47)</li> <li>• Wheeze was not a prognostic factor</li> </ul>	c)	Ref std +	Ref std -	Total	Index test +	70	18	88	Index test -	74	26	100	Total	144	44	188	Sens / Spec		48.6% / 59.1%		PPV / NPV		79.5% / 26.0%		d)	Ref std +	Ref std -	Total	Index test +	109	21	130	Index test -	35	23	58	Total	144	44	188	Sens / Spec		75.7% / 52.3%		PPV / NPV		83.8% / 39.7%		
c)	Ref std +	Ref std -	Total																																																			
Index test +	70	18	88																																																			
Index test -	74	26	100																																																			
Total	144	44	188																																																			
Sens / Spec		48.6% / 59.1%																																																				
PPV / NPV		79.5% / 26.0%																																																				
d)	Ref std +	Ref std -	Total																																																			
Index test +	109	21	130																																																			
Index test -	35	23	58																																																			
Total	144	44	188																																																			
Sens / Spec		75.7% / 52.3%																																																				
PPV / NPV		83.8% / 39.7%																																																				

## G.2 History of atopic disorders

**Table 31: CORDIERO 2011<sup>360</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
					Ref st +	Ref st -	Total		
Cordiero et al., 2011. Utility of nitric oxide for the diagnosis of asthma in an allergy clinic population. Allergy and Asthma Proceedings: 32: 119-126.  REF ID: CORDIERO 2011	<u>Study type:</u> Cross-sectional observational study  <u>Setting:</u> General outpatient allergy clinic  <u>Country:</u> The Netherlands  <u>Recruitment:</u> All from January 2007 to September 2007	N = 114 Adults and children/young people  <u>Inclusion criteria:</u> <ul style="list-style-type: none"> <li>New referrals to outpatient allergy clinic</li> <li>Symptoms of nasal or ocular complaints; pulmonary complaints; skin complaints and general complaints.</li> </ul> <u>Exclusion criteria:</u> <ul style="list-style-type: none"> <li>Patients using inhaled corticosteroids or oral corticosteroids within 6 weeks</li> </ul>	<u>Male: Female</u> 43:71  <u>Median (range) age:</u> 38.5 (7-87)  Medications: Treatment with short acting bronchodilators allowed up to 8 hours before and long acting bronchodilators and antihistamines up to 48 hours before.	<u>Index test</u> Family history (unclear if first degree relatives and if history of asthma or atopy)  <u>Reference standard</u> History of typical respiratory symptoms and FEV1 improvement >12% and >200mL with salbutamol 400µg or PC20 histamine ≤8mg/mL according to GINA.  Time between index test and reference standard: 6 weeks  <u>Target condition</u> Asthma diagnosis vs. non-asthma (Allergic rhinitis, non-allergic rhinitis, eczema, urticarial, other analysed all together)					<u>Source of funding:</u> Not stated  <u>Limitations:</u> <ul style="list-style-type: none"> <li>Family history (unclear if first degree relatives and if history of asthma or atopy).</li> </ul> <u>Additional data:</u>
					Index test +	25	32	57	
					Index test -	17	40	57	
					Total	42	72	114	
					Sensitivity		59.5%		
					Specificity		55.6%		
					PPV		43.9%		
					NPV		70.2%		

**Table 32: DEILAMI 2009**<sup>408</sup>

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
					Ref st +	Ref st -	Total		
Deilami et al., 2009. Evaluation of methacholine challenge test results in chronic cough patients referring to clinic of pulmonary disease. Acta Medica Iranica: 47: 175-179.  REF ID: DEILAMI2009	<u>Study type:</u> Cross sectional study <u>Setting:</u> Hospital pulmonary disease clinic <u>Country:</u> Iran <u>Recruitment:</u> All patients who were not excluded (unclear)	N = 81  <u>Inclusion criteria:</u> <ul style="list-style-type: none"> <li>Suffering from cough for at least 8 weeks and went to the pulmonary disease clinic.</li> <li>Normal spirometry</li> </ul> <u>Exclusion criteria:</u> <ul style="list-style-type: none"> <li>Patients with PND</li> <li>Patients of GERD who were untreated</li> <li>Respiratory infection within the last 3 weeks or contraindication to methacholine.</li> </ul>	<u>Male: Female</u> 45:36  <u>Mean age:</u> 32.5 (13.1)  Medications: n=7 smokers	<u>Index test</u> Personal history of allergy  NB Family history of asthma sens/spec data was not extracted as was not first class relatives only  <u>Reference standard</u> Methacholine challenge test: concentrations of 0.03, 0.06, 0.125, 0.25, 0.5, 1, 2, 4, 8 and 16mg/ml, until FEV1 drop of 20% or more.  Cut-off: PC20 ≤4mg/ml  Time between index test and reference standard:  <u>Target condition</u> Asthma					<u>Source of funding:</u> Not reported <u>Limitations:</u> <ul style="list-style-type: none"> <li></li> <li></li> </ul> <u>Additional data:</u>
					Index test +	13	15	28	
					Index test -	11	42	53	
					Total	24	57	80	
					Sensitivity		54.2%		
					Specificity		73.7%		
					PPV		46.4%		
					NPV		20.8%		

**Table 33: TOMITA 2013**<sup>1753</sup>

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments
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Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
					a)	Ref st +	Ref st -	Total	
<p>Tomita et al., 2013. A scoring algorithm for predicting the presence of adult asthma: a prospective derivation study. Primary care respiratory journal: 22: 51-58</p> <p>REF ID: TOMITA2013</p>	<p><u>Study type:</u> Cross-sectional study</p> <p><u>Setting:</u> Outpatient clinic, University Hospital</p> <p><u>Country:</u> Japan</p> <p><u>Recruitment:</u> All eligible patients between Jan 2008 and Sept 2011 (unclear)</p>	<p>N = 566 Adults</p> <p><u>Inclusion criteria:</u></p> <ul style="list-style-type: none"> <li>Adult outpatients with non-specific respiratory symptoms including wheeze, shortness of breath, and cough.</li> </ul> <p><u>Exclusion criteria:</u></p> <ul style="list-style-type: none"> <li>Abnormal x-ray findings and other causes</li> <li>Pregnant/breastfeeding</li> <li>Current Dx of pneumonia, pneumothorax, atelectasis, pulmonary fibrotic disease, chronic bronchitis, other lower respiratory abnormality.</li> <li>Systemic or inhaled CS, beta-blockers or angiotensin converting enzyme inhibitors</li> <li>Symptoms of chest pain or</li> </ul>	<p><u>Male: Female</u> 221:345</p> <p>Median (range) age: 52 years (18-88)</p> <p>Medications: Could be started on ICS at first visit before MCT</p>	<p><u>Index test</u> Routine interview including following questions: a) Personal history: 'Have you had any medical history of allergic diseases such as asthma, atopic dermatitis, and allergic rhinitis?' b) Family history: 'Do you have any close relatives with allergic disease?'</p> <p><u>Reference standard</u> Relevant symptom history (all patients) and BDR (FEV1 &lt;200ml and 12%) and/or BHR (methacholine PC20 &lt;8mg/ml)</p> <p>NB. 64/367 patients Dx had clinically Dx asthma (responsive to ICS with neither BDR or BHR)</p> <p>Time between index test and reference standard: within 8 weeks</p> <p><u>Target condition</u> Asthma</p>	a)	Ref st +	Ref st -	Total	<p><u>Source of funding:</u> None. None of the authors had a financial relationship with a commercial entity</p> <p><u>Limitations:</u></p> <ul style="list-style-type: none"> <li>Time between tests 8 weeks, but could be started on ICS at first visit</li> <li>813 consented but only 566 performed MCT (others declined participation or no AHR)</li> </ul> <p><u>Additional data:</u></p>
					Index test +	202	64	266	
					Index test -	165	135	300	
					Total	367	199	566	
					Sensitivity		55.0%		
					Specificity		67.8%		
					PPV		75.9%		
					NPV		45.0%		
					b)	Ref std +	Ref std -	Total	
					Index test +	95	34	129	
Index test -	272	165	437						
Total	367	199	566						



Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables		Comments
		haemosputum.			Sensitivity	25.9%	
					Specificity	82.9%	
					PPV	73.6%	
					NPV	37.8%	

**Table 34: WEVERHESS 1999<sup>1887</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
Weverhess et al., 1999. Prognostic characteristics of asthma diagnosis in early childhood in clinical practice.	<u>Study type:</u> Longitudinal prognostic study <u>Setting:</u> Outpatient department, Children's Hospital <u>Country:</u> Netherlands	N = 188 (including aged 2-4yr subgroup only)  <u>Inclusion criteria:</u> • Aged 0-4 years with symptoms that were suggestive of asthma <u>Exclusion criteria:</u>	<u>Male: Female</u> 108:80  <u>Mean (SD) age:</u> 37 (8.4) months  Medications at initial visit: Beta-agonists 42%,	<u>Index test</u> History taken at initial visit: a) Past or present rhinitis b) past or present eczema c) family history  <u>Reference standard</u> Dx taken from medical notes at follow-up (2 years later). Dx made by a paediatrician on clinical	a)	Ref st +	Ref st -	Total	<u>Source of funding:</u> Supported financially by Stichting Astmabestrijding, Amsterdam  <u>Limitations:</u>
					Index test +	89	35	124	
					Index test -	55	9	64	
					Total	144	44	188	

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
Acta Paediatrica: 88: 827-834.  REF ID: WEVERHESS1999	<u>Recruitment:</u> All children from Jan 1991 to Jan 1993	<ul style="list-style-type: none"> <li>Symptoms that could be explained by other respiratory disorders, such as respiratory syncytial virus bronchiolitis, cystic fibrosis, gastro-oesophageal reflux</li> </ul>	depropine 10%, anticholinergics 3%, antihistamines 20%, anti-inflammatory 5%, antibiotics 49%.	<p>grounds, based on recurrence of symptoms and need for and response to therapy according to the guidelines for diagnosis of asthma in young children (follow up statement from the International Paediatric Asthma Consensus Group).</p> <p>Time between index test and reference standard: 2 years</p> <p><u>Target condition</u></p>	Sensitivity Specificity		61.8% 20.5%		<u>Additional data:</u> Data provided from children aged 0-1 year separately but does not match protocol.
PPV NPV		71.8% 14.1%							
b)	Ref std +	Ref std -	Total						
Index test +	67	11	78						
Index test -	77	33	110						
Total	144	44	188						
Sensitivity Specificity		46.5% 75.0%							
PPV NPV		85.9% 30.0%							
c)	Ref std +	Ref std -	Total						
Index test +	63	19	82						

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
					Index test -	81	25	106	
					Total	144	44	188	
					Sensitivity		43.8%		
					Specificity		56.8%		
					PPV		76.8%		
					NPV		23.6%		

**Table 35: VANDERMARK 2014<sup>1802</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
Predicting asthma in preschool children at high risk presenting in primary care: development of a clinical asthma prediction score.	<u>Study type:</u> Longitudinal prognostic study (demographic data and clinical history obtained from questionnaire. Sensitivity and specificity calculated from for Dx	N = 771 (438 had information for diagnosis at age 6 years)  <u>Inclusion criteria:</u> Aged 1-5 years. Presented in primary care in the previous 12 months with current coughing (≥2 visits), wheezing (≥1 visits), and/or shortness of breath (≥1 visits) (only those	<u>Male: Female</u> 249:189  <u>Mean (SD) age:</u> At baseline for study: 3.0 (1.3). Note: diagnosis made at aged 6 years  Medications: unclear	<u>Index test</u> Questionnaire administered at baseline and at 6 years: a) Family history of asthma (parents and/or siblings)  <u>Reference standard</u> At age 6 years, spirometry and BHR obtained in children with wheezing, shortness of breath, recurrent coughing or use of asthma medication during the previous 12	a)	Ref st +	Ref st -	Total	<u>Source of funding:</u> Not reported  <u>Limitations:</u>  <u>Additional data:</u>
					Index test +	80	76	156	
					Index test -	107	175	282	
					Total	187	251	438	
					Sens	43.8%			
					Spec	69.7%			

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments
<p>Primary Care Respiratory Journal. 2014; 68(1):52-59.</p> <p>REF ID: VANDERM ARK2014</p>	<p>at 6 years of age)</p> <p><u>Setting:</u> Primary care</p> <p><u>Country:</u> Netherlands</p> <p><u>Recruitment:</u> Children participating in the ARCADE prospective cohort study</p>	<p>with symptoms in the past year included in asthma Dx at age 6 years).</p> <p><u>Exclusion criteria:</u></p>		<p>months.</p> <p>Dx defined as having persistent symptoms and/or using asthma medication in the last year in combination with BHR (methacholine &lt;8mg.ml) or BDR (&gt;10% increase in FEV1).</p> <p><u>Time between index test and reference standard:</u> Unclear if index test (clinical history) was taken at baseline or at 6 years.</p> <p><u>Target condition</u> Asthma</p>		

## G.3 Symptoms after exercise

**Table 36: Choi 2007<sup>315</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments	
					Ref std +	Ref std -	Total			
Choi et al., 2007. Easy diagnosis of asthma: computer-assisted, symptom-based diagnosis. Journal of Korean Medical Science: 22: 832-838.  REF ID: CHOI2007	<u>Study type:</u> Diagnostic cross sectional study  <u>Setting:</u> Hospital outpatient dept.  <u>Country:</u> Korea  <u>Recruitment:</u> Consecutive or random patient selection not reported	N = 302 Adults <u>Inclusion criteria:</u> <ul style="list-style-type: none"> <li>Respiratory symptoms such as dyspnoea, cough or wheezing</li> </ul> <u>Exclusion criteria:</u>	<u>Male:Female</u> 127:175  <u>Mean age:</u> Asthma: 46.8 (16.8) Non-asthma: 47.8 (15.6)  Medications: Not reported  Smokers: Asthma: 36.7% Non-asthma: 21.4%	<u>Index test</u> Questionnaire consisting of 11 questions regarding symptoms. Q3 = Have you had wheezing associated with dyspnoea (provoking factor – exercise)?  Cut-off: affirmative answer to Q3  <u>Comparator test</u> n/a  <u>Reference standard</u> Physician Dx with objective test (patients with an FEV1 >70% had MCT, all other patients had BDR to short-acting beta2-agonist). Definite Dx of asthma made using test (MCh PC20 <16mg/ml or BDR FEV1 increase >12% and 200ml)  Time between index test and reference standard: unclear					<u>Source of funding:</u> Korea Asthma Allergy Foundation Research Grant and Korea Health 21 R&D Project, Ministry of Health  <u>Limitations:</u> <ul style="list-style-type: none"> <li>No drop-outs</li> <li>Consecutive or random patient selection not mentioned</li> <li>time between IT and RS unclear but same time suggested</li> </ul> <u>Additional data:</u>	
					Index test +	84	20	104		
					Index test -	126	72	198		
					Total	210	92	302		
					Sensitivity		40.0%			
					Specificity		78.3%			
					PPV		80.8%			
					NPV		36.4%			
						Ref std +	Ref std -	Total		
					Index test +					

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
				<u>Target condition</u> Asthma	Index test -				
					Total				
					Sensitivity				
					Specificity				
					PPV				
					NPV				

## G.4 Occupational asthma

Table 37: BAUR 1998<sup>130</sup>

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures		Effect sizes		Comments
Baur X et al. Relation between occupatio	<u>Study type:</u> Diagnostic Cross-sectional study	N = 62 healthcare workers (airborne latex; 12 asthma)	<u>Male: Female</u> <u>Not stated</u>  <u>Mean age:</u>	<u>Index test</u> Asking whether their symptoms are better away from work	<b>Occupational asthma: health care workers (latex)</b>	Ref std +	Ref std -	Total	<u>Source of funding:</u> None stated

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures		Effect sizes		Comments
Occupational asthma case history, bronchial methacholine challenge, and specific challenge test in patients with suspected occupational asthma. Am J Industr Med 1998; 33: 114-122.  BAUR1998	<u>Data source:</u> Industrial medicine institute  <u>Setting:</u> Symptomatic  <u>Country:</u> Germany  <u>Recruitment:</u> 1992 to 1997	28 bakers (flour, baking enzymes; 7 asthma)  114 isocyanate workers (isocyanates; 21 asthma)  <u>Inclusion criteria:</u> Healthcare workers with contact with latex gloves, bakers or isocyanate workers presenting with suspected occupational asthma  <u>Exclusion criteria:</u> Challenge tests contraindicated or declined	Healthcare workers 31 (8.1); bakers 32 (11.9); isocyanate workers 39 (11.1) years  Time between index test and reference standard: same time	<b>CUT-OFF:</b> positive = Reversible airways narrowing (SOB, wheeze) causally related to exposure in the working environment occurred repeatedly  <u>Reference standard</u> <b>Clinical Dx</b> including objective test: Specific conductance (sG <sub>aw</sub> ) dropped ≥40% from baseline and absolute value ≤0.5(kPa*s) <sup>-1</sup>  <u>Target condition</u> Occupational asthma	Question +	11	34	45	<u>Limitations:</u>  <u>Additional data:</u> Sensitivity etc calculated
					Question -	1	16	17	
					Total	12	50	62	
					Sensitivity		92%		
					Specificity		32%		
					PPV		24%		
					NPV		94%		
					<b>Occupational asthma: bakers (flour/enzyme)</b>	Ref std +	Ref std -	Total	
					Question +	7	8	15	
					Question -	0	13	13	
					Total	7	21	28	
					Sensitivity		100%		
					Specificity		62%		
					PPV		47%		
					NPV		100%		
<b>Occupational asthma: isocyanate workers</b>	Ref std +	Ref std -	Total						
Question	14	32	46						

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments	
					+			
					Question	7	61	68
					-			
					Total	21	93	114
					Sensitivity		67%	
					Specificity		66%	
					PPV		30%	
					NPV		90%	

**Table 38: Malo 1991<sup>1067</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
Malo J-L et al. Is the clinical history a satisfactory means of diagnosing occupational asthma? Am Rev Respir Dis 1991; 143: 528-532.	<u>Study type:</u> Diagnostic Cross-sectional study  <u>Data source:</u> Chest clinic  <u>Setting:</u> Symptomatic  <u>Country:</u> Canada	N = 162  <u>Inclusion criteria:</u> Consecutive cases referred for possible occupational asthma  <u>Exclusion criteria:</u> None given	<u>Male:</u> <u>Female</u> 125:37  <u>Mean age:</u> 39.6 (11.8) years	<u>Index test</u> Asking whether their symptoms are better away from work  <b>CUT-OFF:</b> positive = Whether symptoms worse during or after work and improved during weekends and holidays – history “very likely” or “likely”  <u>Reference standard</u> <b>Clinical Dx</b> including objective test: Final diagnosis including specific inhalation challenges, serial monitoring of peak flow at work and away from work or both. Fall in FEV1 > 20% (or ≥15% in late component of dual reactions) on specific challenge	<b>Occupational asthma</b> Ref std +  Question + Question - Total  Sensitivity Specificity PPV NPV	Ref std + –  65 10 75  87% 55% 63% 83%	Total 104 58 162  87% 55% 63% 83%  <u>Source of funding:</u> Not stated  <u>Limitations:</u>  <u>Additional data:</u> PPV and NPV reported; sensitivity and specificity calculated



Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
MALO 1991	<u>Recruitment:</u> 1987 to 1989			<p>or patterns suggestive of work-related asthma using graphs of individual, mean, maximum and minimum daily values using Burge criteria</p> <p>Time between index test and reference standard: same time</p> <p><u>Target condition</u> Occupational asthma (isocyanates, flour, grain dust, red and white cedar, pharmaceutical products, sawmills, laboratory animals)</p>			

**Table 39: Vandenplas 2001<sup>1821</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes		Comments	
Vandenplas O et al. Occupational asthma in symptomatic workers exposed to natural rubber latex:	<u>Study type:</u> Diagnostic Cross-sectional study  <u>Data source:</u> Chest clinic  <u>Setting:</u> Symptomatic	N = 45  <u>Inclusion criteria:</u> Consecutive patients referred for investigation of possible OA caused by latex; exposed at work to airborne natural rubber latex (NRL) allergens from NRL gloves.	<u>Male: Female</u> 2:43  <u>Mean age:</u> 33.6 years	<u>Index test:</u> Asking whether their symptoms are better away from work  <b>CUT-OFF:</b> positive = Symptoms present only on work days  <u>Reference standard:</u> <b>Clinical Dx</b> including objective test: SICs with NRL gloves; FEV1 fell by more than 20%	<b>Occupational asthma (latex)</b>	Ref std +	Ref std -	<u>Source of funding:</u> Programme d'appui scientifique à la protection des travailleurs, Services fédéraux des affaires scientifiques, techniques et	
					Question +	15	4		19
					Question -	16	10		26
					Total	31	14		45
					Sensitivity	48%			
Specificity	71%								

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
Evaluation of diagnostic procedures. J Allergy Clin Immunol 2001; 107(3): 542-547.  VANDENPLAS 2001	<u>Country:</u> Belgium  <u>Recruitment:</u> 1993 to 1998	<u>Exclusion criteria:</u> None given		Time between index test and reference standard: same time  <u>Target condition</u> Occupational asthma (latex)	PPV NPV	79% 38%	culturelles  <u>Limitations:</u>  <u>Additional data:</u> Sensitivity and specificity etc calculated

**Table 40: Vandenas 2005<sup>1821</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments		
What are the questionnaire items most useful in identifying subjects with occupational asthma? European Respirator	<u>Study type:</u> Diagnostic Cross-sectional study  <u>Data source:</u> Chest clinic  <u>Setting:</u> Symptomatic	N = 212  <u>Inclusion criteria:</u> Prospectively assessed in outpatient clinics of four hospital centres and who underwent objective testing with specific inhalation challenges.	<u>Male: Female</u> 125:87  <u>Mean age:</u> 38.8 (10.7) years	<u>Index test:</u> Asking whether their symptoms are better away from work  • <b>CUT-OFF:</b> positive = a) Improvement or disappearance of symptoms at weekends • b) Improvement or disappearance of symptoms during vacations  <u>Reference standard</u> <b>Clinical Dx</b>	<b>Occupational asthma – Question a</b>	Ref std +	Ref std	Total	<u>Source of funding:</u> <u>Actions de Recherche Concertées, Communauté Française de Belgique, Belgium.</u>
					Question +	55	64	119	
					Question -	17	76	93	
					Total	72	140	212	
					Sensitivity	76%		<u>Limitations:</u>	
Specificity	54%								

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments		
y Journal. 2005; 26(6):1056-1063  VANDENP LAS 2005	<u>Country:</u> Belgium, Canada, Italy, Spain  <u>Recruitment:</u> not stated	<u>Exclusion criteria:</u> None given		including objective test: specific inhalation challenge; a sustained fall in forced expiratory volume in one second of 20%  Time between index test and reference standard: same time  <u>Target condition</u> Occupational asthma (flour and cereals, latex, isocyanates, other chemicals, wood dust, laboratory animals, persulfate, resins and glues, various proteins, metals)	PPV	41%	<u>Additional data:</u> Sensitivity and specificity etc reported; raw data calculated		
					NPV	80%			
					<b>Occupational asthma – question b</b>	Ref std +		Ref std –	Total
					Question +	53		60	113
					Question -	19		80	99
					Total	72		140	212
					Sensitivity	74%			
Specificity	57%								
PPV question	57%								
NPV	74%								

## G.5 Spirometry/flow volume loop measures

Table 41: FORTUNA 2007<sup>505</sup>

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables			Comments	
Fortuna et al., 2007. Diagnostic utility of inflammatory	<u>Study type:</u> Cross sectional study <u>Setting:</u> Referred to	N = 50 Adults <u>Inclusion criteria:</u> • Referred with a clinical history suggestive of	<u>Male: Female</u> 21:29  <u>Age range:</u> 18-68	<u>Index test</u> Spirometry was performed following international guidelines with a Datospir 120 (Sibelmed, Barcelona, Spain). A FEV1 ≥80% of predicted and/or a ratio of		Ref st +	Ref st -	Total	<u>Source of funding:</u> Not reported <u>Limitations:</u> • RS objective MCT is
					Index test +	5	0	5	
					Index test -	17	22	39	

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
					Total	22	22	44	
biomarkers in asthma: exhaled nitric oxide and induced sputum eosinophil count. Respiratory Medicine: 101: 2416-2421  REF ID: FORTUNA	hospital based outpatient clinic <u>Country:</u> Spain <u>Recruitment:</u> Consecutive	asthma (dry cough, wheezing, and shortness of breath) <u>Exclusion criteria:</u> <ul style="list-style-type: none"> <li>Conditions that could affect FENO or Eos% measurement for reasons other than asthma: subjects with symptoms of respiratory tract infection in the previous 6 weeks or with systemic manifestations of atopy (rash, digestive</li> </ul>	<u>% of symptomatic patients with positive/abnormal spirometry (FEV1/FVC&lt;75% or FEV1 &lt;80%):</u> 10%  <u>Medications:</u> no CS within the last 4 weeks	FEV1/FVC ≥75% were considered to lie within normal limits.  Cut-off: Obstruction: FEV1 <80%  <u>Comparator test</u> n/a  <u>Reference standard</u> Methacholine challenge test (PD20 ≤16mg/ml) following guidelines of the GINA  Time between index test and reference standard: 1 day	Sensitivity	22.7%	100%  100%  56.4%  0.64 (95% CI, 0.49–0.77; p<0.008)  0.63 (95% CI, 0.48–0.76; p<0.006)	44	16mg/ml <ul style="list-style-type: none"> <li>Unclear why 6 patients not included in analysis of sn/sp</li> <li>Suggests IT is FEV1&lt;80% and unclear if also includes FEV1/FVC</li> </ul> <u>Additional data:</u> 7 of original 57 patients excluded as on CS treatment  6 out of the 50
					Specificity	100%			

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments
2007		symptoms, etc.) <ul style="list-style-type: none"> <li>Received treatment with inhaled or oral corticosteroids in the last 4 weeks</li> </ul>		<u>Target condition</u> Asthma		patients not included in analysis of sn/sp for spirometry and not mentioned

**Table 42: PINO 1996<sup>1351</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables			Comments
Pino et al., 1996.	<u>Study type:</u> Cross-	N = 84 Adults	<u>Male: Female</u> 53:31	<u>Index test</u> Spirometry: Pneumoscreen II	Ref st +	Ref st -	Total	<u>Source of funding:</u>

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
Value of the peak expiratory flow in bronchodynamic tests. Allergologia et Immunopathologia: 24: 54-57  REF ID: PINO1996	sectional study  <u>Setting:</u> University hospital  <u>Country:</u> Spain  <u>Recruitment:</u> Not stated	<u>Inclusion criteria:</u> <ul style="list-style-type: none"> <li>Clinically suspected of bronchial asthma</li> </ul> <u>Exclusion criteria:</u> <ul style="list-style-type: none"> <li>Worsening of symptoms in the preceding 2 months</li> <li>A respiratory infection in the lower or upper tract in the preceding 6 weeks</li> <li>Vaccination with live attenuated virus 6 weeks prior to the test</li> <li>The existence of a recurrent pathology</li> <li>Cases of whistling in observed in pulmonary auscultation were excluded from the bronchial provocation test.</li> </ul>	<u>Mean age:</u> 46.5 (13.7)  Medications: Smoking prohibited 2 hours before the study; discontinuation 48 hours in advance of beta-agonists; theophyllines; anticholinergics; antihistamines; nedochromil; chromoglicate.	(Jagger) according to ATS criteria  Cut-off: FEV1/FVC<70% and FEV1<80%  <u>Comparator test</u> n/a  <u>Reference standard</u> If obstructive spirometry: performed BDR (400µg salbutamol; FEV1 >15% initial) If normal spirometry: methacholine challenge test five breaths of 5mg/ml and five breaths of 25mg/ml, test positive if a 20% drop in FEV1  Time between index test and reference standard:  <u>Target condition</u>	Index test +	20	24	44	Not reported  <u>Limitations:</u> <ul style="list-style-type: none"> <li>Unclear of the directness of the population as few details reported</li> <li>Unclear time between RS and IT</li> <li>Random or consecutive recruitment not reported</li> <li>Patients have different RS objective tests depending on if they were negative or positive to IT</li> <li>Unclear if suitable cut-off used for MCT</li> </ul> <u>Additional data:</u>
					Index test -	23	17	40	
					Total	43	41	84	
					Sensitivity		46.5%		
					Specificity		41.5%		
					PPV		45.5%		
					NPV		42.5%		
						Ref std +	Ref std -	Total	
					Index test +				
					Index test -				
Total									

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables		Comments
					Sensitivity Specificity		
					PPV NPV		

**Table 43: POPOVIC 2012<sup>1367</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
Popovic-Grle et al., 2002. Clinical validation of bronchial hyperresponsiveness, allergy tests and lung	<u>Study type:</u> Cross-sectional study <u>Setting:</u> Outpatient department, University Hospital <u>Country:</u> Croatia	N = 195 Adults <u>Inclusion criteria:</u> <ul style="list-style-type: none"> <li>Referred by GP with suspected asthma and symptoms of breathlessness / dyspnoea.</li> </ul> <u>Exclusion criteria:</u> <ul style="list-style-type: none"> <li>Serious diseases of</li> </ul>	<u>Male, %</u> 51% of those given an asthma Dx  <u>Mean age:</u> 36.5 (6.2) in those given an asthma Dx (n=141)	<u>Index test</u> Spirometry: measured at least 3 times by forced expiration on Vitalograph apparatus with a pneumotachograph. Best attempt recorded.  Cut-off: FEV1 <80% predicted  <u>Comparator test</u> n/a		Ref st +	Ref st -	Total	<u>Source of funding:</u> Not reported <u>Limitations:</u> <ul style="list-style-type: none"> <li>Details of reference standard objective test not given</li> <li>Unclear if RS results</li> </ul>
					Index test +	63	37	100	
					Index test -	78	17	95	
					Total	141	54	195	

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables		Comments
function in the diagnosis of asthma in persons with dyspnoea. Collegium Antropologicum: 26 Suppl: 119-127  REF ID: POPOVIC 2002	<u>Recruitment:</u> Random	other organ systems or the lungs (apart from those of an obstructive and/or allergic nature)	Medications: Not reported	<u>Reference standard</u> Dx made on the basis of questionnaire, with typical medical history data of occasional asthma attacks with wheezing and nocturnal awakening because of dyspnoea, and reversible bronchial obstruction after salbutamol test (no further details stated)  Time between index test and reference standard: same time  <u>Target condition</u> Asthma	Sensitivity Specificity  PPV NPV	44.7% 31.5%	interpreted without knowledge of the IT results  • Unclear if IT results interpreted without knowledge of the RS results (but objective)  <u>Additional data:</u>



Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments

**Table 44: SCHNEIDER 2009A<sup>1519</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables			Comments	
Schneider A et al. 2009. Diagnostic accuracy of spirometry in primary care. BMC Pulmonary Medicine: 9: 31.  REF ID: SCHNEIDER2009A	<u>Study type:</u> Cross-sectional study <u>Setting:</u> Index test in primary care, 14 GPs in 10 practices <u>Country:</u> Germany <u>Recruitment:</u> Consecutive recruitment	N = 219 Adults <u>Inclusion criteria:</u> <ul style="list-style-type: none"> <li>• Visiting GP for the first time with complaints of obstructive airway disease (OAD).</li> <li>• Symptoms such as dyspnoea, coughing, or expectoration</li> </ul> <u>Exclusion criteria:</u> <ul style="list-style-type: none"> <li>• Previous Dx for OAD</li> <li>• Previous anti-obstructive medicine</li> <li>• Contraindications</li> </ul>	<u>Male: Female</u> 92:127  <u>Mean (SD) age:</u> 43.8 (15.6)  <u>% of symptomatic patients with positive/abnormal spirometry:</u> 35.6%  <u>Medications:</u> None prior to spirometry at GP. If necessary, therapy initiated by GP for asthma or	<u>Index test: Spirometry at GP</u> Electronic spirometer (Medikro Spirostar USB). Best of 3 consecutive spirometric values used in accordance with European Respiratory Society (ERS). Max inspiratory and expiratory flow volume curves generated by forced deep inspiration and expiration with intervening periods of tidal breathing.  Cut-off: OAD if FEV1/VC ≤70% and/or FEV1 <80%  <u>Comparator test</u> None  <u>Reference standard</u> LUNG FUNCTION LAB: Dx by		Ref st +	Ref st -	Total	<u>Source of funding:</u> Federal ministry of education and research (BMBF), Germany. <u>Limitations:</u> <ul style="list-style-type: none"> <li>• Spirometry performed with full adherence to ERS guidelines in 39.8% of cases and moderate adherence in 38% of cases. ERS criteria</li> </ul>
					Index test +	26	52	78	
					Index test -	63	75	138	
					Total	89	127	216	
					Sensitivity	29.2%			
					Specificity	59.1%			
PPV	33.3%								
NPV	54.3%								

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments																								
		for BDR of challenge testing (untreated hyperthyreosis, unstable coronary artery disease, cardiac arrhythmia) <ul style="list-style-type: none"> <li>• Pregnancy</li> </ul>	COPD but stopped 12 hours prior to lung function lab.	pneumologist based on whole-body plethysmography (FEV1/VC $\leq 70\%$ or FEV1 $< 80\%$ ) followed by either BDR if obstruction is present (FEV1 $\geq 12\%$ and $\geq 200\text{ml}$ ) or methacholine if obstruction is not present (PC20 $\leq 16\text{mg/ml}$ or extreme increase in airway resistance accompanied by clinical symptoms in two patients)	<table border="1"> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="2"></td> <td colspan="2"></td> </tr> <tr> <td colspan="4"></td> </tr> </table>																									not fulfilled in 22.2% of cases. <ul style="list-style-type: none"> <li>• Unclear time between IT and RS; 74 patients from original 293 only wanted the IT and did not have RS</li> <li>• RS objective MCT is 16mg/ml</li> </ul> Additional data: 3 lost to follow-up
				Time between index test and reference standard: unclear		Gives sn/sp of spirometry for asthma and COPD separately (data combined here to include all patients presenting with respiratory symptoms regardless of their final Dx)																								
				<u>Target condition</u> OAD: Asthma or COPD																										

**Table 45: SIVAN 2009<sup>1602</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments	
					Ref st +	Ref st -	Total			
Sivan et al., 2009. The use of exhaled nitric oxide in the diagnosis of asthma in school children. Journal of Pediatric s: 155: 211-216  REF ID: SIVAN2009	<u>Study type:</u> Cross-sectional study  <u>Setting:</u> Outpatient paediatric pulmonary clinic, Children's Hospital  <u>Country:</u> Israel  <u>Recruitment</u> : Consecutive	N = 150 (113 excluding those on ICS from analysis) Children  <u>Inclusion criteria:</u> <ul style="list-style-type: none"> <li>Non-specific respiratory symptoms suggestive of asthma for at least 3 months, including cough, wheezing and shortness of breath with or without trials of treatment with bronchodilators and ICS.</li> <li>Follow-up for at least 1 year</li> </ul> <u>Exclusion criteria:</u> <ul style="list-style-type: none"> <li>Symptoms of unresolved respiratory tract infection</li> <li>Systemic clinical manifestations of atopy such as anaphylaxis, angioedema, food allergy, urticarial, systemic or inflammatory disease</li> </ul>	<u>Male: Female</u> ~56% male  <u>Age range:</u> 5-18yrs (mean 12)  Medications: Withheld bronchodilators for 24 hours. Unclear if on medications for 18 months between IT and RS.	<u>Index test</u> Spirometry: hand-held spirometer (Micro-lab ML3500/S, Micro-Medical, UK).  Cut-off: FEV1 <80%  <u>Reference standard</u> Made by paediatric pulmonologist after 18 months follow-up. Based on history of 2 or more clinical exacerbations of wheezing documented by a physician; dyspnoea or cough relived by bronchodilators; documented variability in FEV1 ≥15% in response to bronchodilators at any time during the follow-up period; OR documented variability in FEV1 ≥15% over time with or without controller medications (ICS or montelukast). Results of provocation tests included when available.  Time between index test and reference standard: 18 months		Ref st +	Ref st -	Total	<u>Source of funding:</u> Not reported  <u>Limitations:</u> <ul style="list-style-type: none"> <li>Recruited 150 patients but excluded 37 on ICS from analysis</li> <li>Time between IT and RS = 18 months</li> <li>Unclear if all had objective test with RS</li> <li>Interpretation of RS not done blinded to results of spirometry IT</li> </ul> <u>Additional data:</u>	
					Index test +	36	12	48		
					Index test -	33	32	65		
					Total	69	44	113		
					Sensitivity		52%			
					Specificity		72%			
					PPV		75%			
					NPV		48%			

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments
				<u>Target condition</u> Asthma		

**Table 46: SMITH 2004<sup>1613</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments		
Smith et al., 2004. Clinical usefulness of fractional exhaled nitric	<u>Study type:</u> Cross-sectional study  <u>Setting:</u> Referred to hospital pulmonary	N = 47 Adults and children (8-75 years)  <u>Inclusion criteria:</u> <ul style="list-style-type: none"> <li>Referred to hospital pulmonary function lab by GP for possible asthma</li> </ul>	<u>Male: Female</u>   <u>Mean age:</u>   Medications:	<u>Index test</u> Spirometry	<b>FEV1/FVC &lt;70%</b>	<u>Source of funding:</u> Supported by Otago Medical Research Foundation and the Otago respiratory		
					Ref st +		Ref st -	Total
				Index test +	6		0	6
				Index test -	11		30	41
				Total	17	30	47	

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
oxide for diagnosis of prolonged cough. Respiratory Medicine: 102: 1452-1459.  REF ID: SMITH2004	function lab <u>Country:</u> New Zealand <u>Recruitment:</u> Consecutive	<ul style="list-style-type: none"> <li>Respiratory symptoms for a minimum of 6 weeks</li> </ul> <u>Exclusion criteria:</u> <ul style="list-style-type: none"> <li>Used ICS in the preceding 4 weeks</li> <li>Typical respiratory tract infection in the preceding 6 weeks</li> </ul>	Short-acting beta-agonists and anticholinergic inhalers permitted during the study period but withheld for a minimum of 6 hours before the study visit.	FEV1/FVC <70%  <u>Comparator test</u> n/a  <u>Reference standard</u> Relevant symptom history (all patients) and a positive hypertonic saline challenge test (PD15<20ml) or BDR increase in FEV1 ≥12%	Sensitivity 35.3% Specificity 100% PPV 100% NPV 73.2%  AUC FEV1/FVC 0.678				research trust. GSK personal education grant to one author. <u>Limitations:</u> <ul style="list-style-type: none"> <li></li> <li></li> </ul> <u>Additional data:</u> 4 of the original 51 patients withdrew after first study visit due to time commitments.
				Time between index test and reference standard: 2 weeks	Sensitivity 47.1% Specificity 80.0% PPV 57.1% NPV 72.7%				
				<u>Target condition</u> Asthma					

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
					AUC FEV1%pred		0.804		
					<b>FEV1 &lt;90% pred</b>	Ref st +	Ref st -	Total	
					Index test +	6	2	8	
					Index test -	11	28	39	
					Total	17	30	47	
					Sensitivity		35.3%		
					Specificity		93.3%		
					PPV		75%%		
					NPV		71.8%		

## G.6 Bronchodilator reversibility

Table 47: BRAND 1992<sup>213</sup>

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures		Effect sizes		Comments
Brand PLP et al. Interpretation of bronchodilator response	<u>Study type</u> : Diagnostic cross-sectional study	N = 150  <u>Inclusion criteria</u> : • Adults with chronic respiratory symptoms (asthma)	<u>Male: Female</u> Not stated  <u>Mean age</u> : 18-60 years; mean not stated	<u>Index test</u> Bronchodilator reversibility: Response to inhaled terbutaline 1000µg a) change [Δ]FEV1 % init; b) ΔFEV1[l] i.e. absolute value in litres; c) ΔFEV1 % init and ΔFEV1[l]; d) ΔFEV1 %pred; e) standardised residual [SR]-FEV1;	<b>Asthma</b>	Ref std +	Ref std -	Total	<u>Source of funding</u> : Not stated  <u>Limitations</u> : Some
					Bronchodilator reversibility	68	24	92	

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments		
in patients with obstructive airways disease. Thorax 1992; 47: 429-436.  BRAND1992	<u>Data source:</u> University hospital outpatients departments  <u>Setting:</u> Secondary care  <u>Country:</u> The Netherlands  <u>Recruitment:</u> Not stated.	or COPD) in university hospital outpatients departments; baseline FEV1 >1.2 litres and 1.64-4.5 residual standard deviations below predicted value, or FEV1/inspiratory vital capacity ratio >1.64 RSD below predicted; hyperresponsive to inhaled histamine  <u>Exclusion criteria:</u> Pregnant women; history of occupational asthma or other serious diseases (e.g. TB, MI, malignancy); oral corticosteroids, beta-blockers, nitrates or anticoagulants; continuous antibiotics.	Tx was withdrawn for 14days and BD Tx for 12 days.	f) FEV1 post-bronchodilator [pb] %pred  <b>CUT-OFF:</b> positive = a) ΔFEV1 % init >15%; b) ΔFEV1[I] > 0.200; <b>c) ΔFEV1 % init &gt;15% and ΔFEV1[I] &gt; 0.200;</b> d) ΔFEV1 %pred >9%; e) SR-FEV1 > 0.5; f) FEV1 pb %pred >80%  <u>Reference standard</u> <b>Clinical Dx</b> Standardised history using criteria of American Thoracic Society: asthma = attacks of breathlessness and wheeze (asthma attacks) without chronic (>3 months/year) cough or sputum production; COPD = Current or former smokers without a history of asthma attacks reporting either chronic cough +/- sputum production, or dyspnoea when walking quietly on level ground, or both  Plus hyper-responsiveness to inhaled histamine  Time between index test and reference standard: same time  <u>Target condition</u> Asthma	(a) +			exclusions may limit generalisability  <u>Additional data:</u> Raw data not stated; calculated from sensitivity and specificity	
					Br. rev. (b) +	31	27		58
					Br. rev. (b) -				
					Total	99	51		150
					Sensitivity (a)		68.7%		
					Specificity (a)		52.9%		
					Likelihood ratio (a)		1.459		
					<b>Asthma</b>	Ref std +	Ref std -		Total
					Br. rev. (b) +	87	33		120
					Br. rev. (b) -	12	18		30
					Total	99	51		150
					Sensitivity (b)		87.9%		
					Specificity (b)		35.3%		
Likelihood ratio (b)		1.359							
<b>Asthma</b>	Ref std +	Ref std -	Total						
Br. rev. (c) +	68	23	91						

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments		
					Br. rev. (c) -	31	28	59	
					Total	99	51	150	
					Sensitivity (c)		68.7%		
					Specificity (c)		54.9%		
					Likelihood ratio (c)		1.523		
					<b>Asthm a</b>	Ref std +	Ref std -	Total	
					Br. rev. (d) +	73	22	95	
					Br. rev. (d) -	26	29	55	
					Total	99	51	150	
					Sensitivity (d)		73.7%		
					Specificity (d)		56.9%		
					Likelihood ratio (d)		1.710		
					<b>Asthm a</b>	Ref std +	Ref std -	Total	
					Br. rev. (e) +	80	28	108	
					Br. rev. (e) -	19	23	42	
					Total	99	51	150	
					Sensitivity(e)		80.8%		
					Specificity (e)		45.1%		
					Likelihood ratio (e)		1.472		



Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures		Effect sizes		Comments
					Asthm a	Ref std +	Ref std -	Total	
					Br. rev. (f) +	45	16	61	
					Br. rev. (f) -	54	35	89	
					Total	99	51	150	
					Sensitivity (f)	45.5%			
					Specificity (f)	68.6%			
					Likelihood ratio (f)	1.449			

**Table 48: CHHABRA 2005<sup>310</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures		Effect sizes		Comments
					Asthm a	Ref std +	Ref std -	Total	
Chhabra SK. Acute bronchodilator response has limited value in differentiating bronchial asthma from COPD. J Asthma 2005; 42:	<u>Study type:</u> Diagnostic cross-sectional study  <u>Data source:</u> Outpatient clinic  <u>Setting:</u> Secondary care  <u>Country:</u>	N = 354  <u>Inclusion criteria:</u> • Clinical diagnosis of asthma (non-smokers) or COPD; stable clinical state with no history of acute exacerbation in previous 4 weeks; acceptable performance of spirometry; FEV1/FVC ratio 70% or less	<u>Male: Female</u> Asthma: 122:78; COPD: 149:5  <u>Mean age:</u> Asthma mean 35.60 (12.47); COPD mean 56.28 (9.57) years  Participants were already on (and remained on)	<u>Index test:</u> Bronchodilator reversibility: Response to inhaled salbutamol 200µg: a) absolute change in FEV1 (ΔFEV1); b) ΔFEV1%init; c) ΔFEV1%pred; d) ΔFEV1≥0.2l and ΔFEV1%init ≥12%  <u>CUT-OFF:</u> positive = a) absolute change in FEV1 (ΔFEV1) a1: 0.2l; a2: 0.3l; a3: 0.4l; b) ΔFEV1%init b1: 12%; b2: 15%; b3: 20%; c) ΔFEV1%pred c1: 9%; c2: 15%; <b>d) ΔFEV1≥0.2l and ΔFEV1%init ≥12%</b>  <u>Reference standard:</u> <b>Clinical Dx</b>	Bronchodilator reversibility (a1) +	146	31	177	<u>Source of funding:</u> Not stated  <u>Limitations:</u> Time between index test and reference standard: unclear. Some exclusions may limit generalisability  <u>Additional data:</u>
					Bronchodilator reversibility (a1) -	54	123	177	
					Total	200	154	354	

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments																																
367-372.  CHHABRA 2005	India  <u>Recruitment:</u> Not stated.	<u>Exclusion criteria:</u> Smokers with asthma; any other concurrent pulmonary or systemic disease	corticosteroid treatment. BD Tx was withdrawn for 12 hrs.	Physician diagnosis based on clinical criteria suggested by the National Institute of Health Global Strategy for Asthma Management and Prevention (asthma = recurrent episodes of breathlessness and wheezing, with or without cough and phlegm, with seasonal and diurnal variations and any identifiable trigger factors) and the Global Initiative for Chronic Obstructive Lung Disease (COPD = history of smoking >10 pack-years, cough with expectoration for at least 3 consecutive months in a year for 2 years or more and progressive dyspnoea on exertion).  Time between index test and reference standard: unclear  <u>Target condition</u> Asthma	Sensitivity (a1) Specificity (a1) PPV (a1) NPV (a1) Likelihood ratio (a1) <table border="1"> <tr> <td><b>Asthm a</b></td> <td>Ref std +</td> <td>Ref std -</td> <td>Total</td> </tr> <tr> <td>Br. rev. (a2) +</td> <td>106</td> <td>20</td> <td>126</td> </tr> <tr> <td>Br. rev. (a2) -</td> <td>94</td> <td>134</td> <td>228</td> </tr> <tr> <td>Total</td> <td>200</td> <td>154</td> <td>354</td> </tr> </table> Sensitivity(a2) Specificity (a2) PPV (a2) NPV (a2) Likelihood ratio (a2) <table border="1"> <tr> <td><b>Asthm a</b></td> <td>Ref std +</td> <td>Ref std -</td> <td>Total</td> </tr> <tr> <td>Br. rev. (a3) +</td> <td>68</td> <td>8</td> <td>76</td> </tr> <tr> <td>Br. rev. (a3) -</td> <td>132</td> <td>146</td> <td>278</td> </tr> <tr> <td>Total</td> <td>200</td> <td>154</td> <td>354</td> </tr> </table> Sensitivity (a3) Specificity (a3)	<b>Asthm a</b>	Ref std +	Ref std -	Total	Br. rev. (a2) +	106	20	126	Br. rev. (a2) -	94	134	228	Total	200	154	354	<b>Asthm a</b>	Ref std +	Ref std -	Total	Br. rev. (a3) +	68	8	76	Br. rev. (a3) -	132	146	278	Total	200	154	354	73% 80% 82% 69% 3.60 53% 87% 84% 59% 4.08 34% 95%	Raw data not stated; calculated from sensitivity and specificity
<b>Asthm a</b>	Ref std +	Ref std -	Total																																				
Br. rev. (a2) +	106	20	126																																				
Br. rev. (a2) -	94	134	228																																				
Total	200	154	354																																				
<b>Asthm a</b>	Ref std +	Ref std -	Total																																				
Br. rev. (a3) +	68	8	76																																				
Br. rev. (a3) -	132	146	278																																				
Total	200	154	354																																				

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
					PPV (a3) NPV (a3) Likelihood ratio (a3)	91% 53% 7.37	
					<b>Asthm a</b>	Ref std + Ref std - Total	
					Br. rev. (b1) +	150 62 212	
					Br. rev. (b1) -	50 92 142	
					Total	200 154 354	
					Sensitivity (b1) Specificity (b1)	75% 60%	
					PPV (b1) NPV (b1) Likelihood ratio (b1)	71% 65% 1.88	
					<b>Asthm a</b>	Ref std + Ref std - Total	
					Br. rev. (b2) +	132 48 170	
					Br. rev. (b2) -	68 106 174	
					Total	200 154 354	
					Sensitivity (b2) Specificity (b2)	66% 69%	
					PPV (b2) NPV (b2) Likelihood ratio	73% 61% 2.12	

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
					(b2)		
					<b>Asthm a</b>	Ref std + Ref std -	Total
					Br. rev. (b3) +	106 34	140
					Br. rev. (b3) -	94 120	214
					Total	200 154	354
					Sensitivity (b3)	53%	
					Specificity (b3)	78%	
					PPV (b3)	76%	
					NPV (b3)	56%	
					Likelihood ratio (b3)	2.42	
					<b>Asthm a</b>	Ref std + Ref std -	Total
					Br. rev. (c1) +	126 25	151
					Br. rev. (c1) -	74 129	203
					Total	200 154	354
					Sensitivity (c1)	63%	
					Specificity (c1)	84%	
					PPV (c1)	84%	
					NPV (c1)	64%	
					Likelihood ratio (c1)	4.03	
					<b>Asthm a</b>	Ref std + Ref std -	Total

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments		
					Br. rev. (c2) +	76	8	84	
					Br. rev. (c2) -	124	146	270	
					Total	200	154	354	
					Sensitivity (c2)	38%			
					Specificity (c2)	95%			
					PPV (c2)	92%			
					NPV (c2)	54%			
					Likelihood ratio (c2)	8.36			
					<b>Asthma</b>	Ref std +	Ref std -	Total	
					Br. rev. (d) +	130	29	159	
					Br. rev. (d) -	70	125	195	
					Total	200	154	354	
					Sensitivity (d)	65%			
					Specificity (d)	81%			
					PPV (d)	81%			
					NPV (d)	64%			
					Likelihood ratio (d)	3.34			

**Table 49: KIM 2012<sup>861</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
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Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures		Effect sizes		Comments
					Asthma	Ref std +	Ref std -	Total	
Kim T-B et al. The reality of an intermediate type between asthma and COPD in practice. Respir Care 2012; 57: 1248-1253.  KIM2012	<u>Study type:</u> Diagnostic cross-sectional study  <u>Data source:</u> Disease cohorts  <u>Setting:</u> Secondary care  <u>Country:</u> Republic of Korea  <u>Recruitment:</u> Not stated	N = 514  <u>Inclusion criteria:</u> • Adults with chronic obstructive airways disorders included in an asthma cohort or a COPD cohort; all had at least one chronic persistent respiratory symptom (dyspnoea, cough, sputum production or wheeze) for >3 months or repetition of the symptom for >3 months  <u>Exclusion criteria:</u> Patients with tuberculous destroyed lungs, bronchiectasis or lung resection	<u>Male: Female</u> 49% male in asthma group and 91.7% in COPD group  <u>Mean age:</u> 48 (16) years for asthma and 65 (8) years for COPD	<u>Index test</u> Bronchodilator reversibility: Bronchodilator response to albuterol 400µg  <b>CUT-OFF:</b> positive = Increase in FEV1 >200mL and >12% above baseline  <u>Reference standard</u> <b>Clinical Dx</b> Clinical decision (no definite diagnostic criteria) by specialists in allergy or pulmonary departments  Time between index test and reference standard: same time  <u>Target condition</u> Asthma	Asthma	Ref std +	Ref std -	Total	<u>Source of funding:</u>  Korea Healthcare Technology Research and Development Project, Ministry of Health and Welfare, Republic of Korea  <u>Limitations:</u> No definite diagnostic criteria used; unclear if index test could be part of diagnostic criteria. Some exclusions may limit generalisability  <u>Additional data:</u> None
					Bronchodilator reversibility +	62	56	118	
					Bronchodilator reversibility -	307	89	396	
					Total	369	145	514	
					Sensitivity		16.8%		
					Specificity		61.4%		
PPV		52%							
NPV		22%							

**Table 50: QUADRELLI 1999<sup>1402</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures		Effect sizes		Comments				
					Asthm a	Ref std +	Ref std -	Total					
Quadrelli SA et al. Evaluation of bronchodilator response in patients with airway obstruction. Respir Med 1999; 93: 630-636.  QUADRELLI 1999	<u>Study type:</u> Diagnostic cross-sectional study  <u>Data source:</u> University hospital  <u>Setting:</u> Secondary care  <u>Country:</u> Argentina  <u>Recruitment:</u> Not stated	N = 119 (subset of 61 patients with asthma with FEV1<55% from overall sample 142 asthma patients, plus all 58 patients with COPD)  <u>Inclusion criteria:</u> • Patients with previously diagnosed airways obstruction; present baseline spirometry: FEV1/FVC relationship 1.64 SEE below predicted value or lower; people with asthma had FEV1 <55% predicted (to match with COPD patients' baseline lung function)  <u>Exclusion criteria:</u>	<u>Male: Female</u> Overall: asthma 74:68; COPD 46:12  <u>Mean age:</u> Overall asthma: 55.4 (19.0) years; COPD 67.3 (7.0) years	• <u>Index test</u> Bronchodilator reversibility: Response to inhaled salbutamol 200µg a) ΔFEV1[L]; b) ΔFEV1%init; c) ΔFEV1[L] plus ΔFEV1%init; d) ΔFEV1%pred; e) ΔFEV1%max (% of maximal possible response)  <b>CUT-OFF:</b> positive = a) ΔFEV1[L]: 200mL; b) ΔFEV1%init: 15%; <b>c) ΔFEV1[L] &gt;200mL plus ΔFEV1%init &gt;15%</b> ; d) ΔFEV1%pred: 9%; e) ΔFEV1%max (% of maximal possible response): 50%  Positive and negative predictive values calculated for two arbitrary prevalences of asthma A] prevalence of asthma 30% and B] prevalence of asthma 70%  <u>Reference standard</u> <b>Clinical Dx</b> Clinical diagnosis: asthma = attacks of breathlessness or wheeze according to ATS criteria (smokers excluded) and at least 2 of: 1;	Br. rev. (a) +	43	17	60	<u>Source of funding:</u> Not stated  <u>Limitations:</u> Time between index test and reference standard: unclear. Some exclusions may limit generalisability				
					Br. rev. (a) -	18	41	59					
					Total	61	58	119					
					Sensitivity (a)		70.4%		Specificity(a)		70.6%		<u>Additional data:</u> Raw data not stated; calculated from sensitivity and specificity
					PPV(a) [A]		50.5%		[B]		84.8%		
					NPV (a) [A]		84.7%		[B]		50.6%		
					Total		61		58		119		
					Sensitivity (b)		85.2%		Specificity(b)		50.0%		
					PPV(b) [A]		39.4%		Total		119		

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments																																
		Those mentioned in inclusion and reference standard sections, plus patients not clearly classified as either asthma or COPD, or those under current treatment with systemic steroids		<p>history of symptoms since childhood or adolescence; 2. symptomatic-free periods of &gt;3 months; 3. spontaneous variations in FEV1 during the year of &gt;20% of baseline value; 4. histamine challenge test &lt;8mg/mL. COPD = heavy current or ex-smokers with no history of asthma reporting chronic cough or sputum (non-smokers excluded)</p> <p>Time between index test and reference standard: unclear</p> <p><u>Target condition</u> Asthma</p>	<p>[B] NPV (b) [A] [B]</p> <table border="1"> <thead> <tr> <th>Asthm a</th> <th>Ref std +</th> <th>Ref std -</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>Br. rev. (c) +</td> <td>42</td> <td>17</td> <td>59</td> </tr> <tr> <td>Br. rev. (c) -</td> <td>19</td> <td>41</td> <td>60</td> </tr> <tr> <td>Total</td> <td>61</td> <td>58</td> <td>119</td> </tr> </tbody> </table> <p>Sensitivity (c) Specificity(c)</p> <p>PPV(c) [A] [B] NPV(c) [A] [B]</p> <table border="1"> <thead> <tr> <th>Asthm a</th> <th>Ref std +</th> <th>Ref std -</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>Br. rev. (d) +</td> <td>41</td> <td>17</td> <td>58</td> </tr> <tr> <td>Br. rev. (d) -</td> <td>20</td> <td>41</td> <td>61</td> </tr> <tr> <td>Total</td> <td>61</td> <td>58</td> <td>119</td> </tr> </tbody> </table> <p>Sensitivity (d) Specificity(d)</p> <p>PPV(d) [A] [B] NPV (d) [A]</p>	Asthm a	Ref std +	Ref std -	Total	Br. rev. (c) +	42	17	59	Br. rev. (c) -	19	41	60	Total	61	58	119	Asthm a	Ref std +	Ref std -	Total	Br. rev. (d) +	41	17	58	Br. rev. (d) -	20	41	61	Total	61	58	119	<p>78.0% 82.9% 47.3%</p> <p>68.8% 70.6%</p> <p>48.1% 83.5% 81.9% 45.5%</p> <p>67.2% 70.6%</p> <p>49.2% 84.1% 83.1%</p>	
Asthm a	Ref std +	Ref std -	Total																																				
Br. rev. (c) +	42	17	59																																				
Br. rev. (c) -	19	41	60																																				
Total	61	58	119																																				
Asthm a	Ref std +	Ref std -	Total																																				
Br. rev. (d) +	41	17	58																																				
Br. rev. (d) -	20	41	61																																				
Total	61	58	119																																				



Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
					[B]	47.5%	
					<b>Asthma</b>	Ref std + -	Total
					Br. rev. (e) +	4	1 5
					Br. rev. (e) -	57	57 114
					Total	61	58 119
					Sensitivity (e)	6.5%	
					Specificity(e)	98.2%	
					PPV(e) [A]	75.5%	
					[B]	94.5%	
					NPV (e) [A]	72.3%	
					[B]	32.4%	

## G.7 PEF variability

Table 51: BROUWER 2010<sup>233</sup>

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
Brouwer AFJ, Visser CAN, Duiverman EJ,	<u>Study type</u> :DiagnosticCross-sectional study	N = 61  <u>Inclusion criteria</u> : Children with non-specific respiratory	<u>Male: Female</u> 27:34  <u>Mean age</u> : 6 to 16 years;	<u>Index test</u> PEF variation amp%mean <b>CUT-OFF</b> : positive = >95 <sup>th</sup> centile for healthy children i.e. ≥12.3%	<b>Asthma</b> PEF + PEF -	Ref std + 10 10 Ref std - 11 28 Total 21 38	<u>Source of funding</u> : AstraZeneca NL  <u>Limitations</u> :

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments																							
Roorda RJ, and Brand PLP. Is home spirometry useful in diagnosing asthma in children with nonspecific respiratory symptoms? Pediatric Pulmonology 2010; 45: 326-332 REF ID: <b>BROUWER2010.</b>	<p><u>Data source:</u> Paediatric asthma clinic</p> <p><u>Setting:</u> Secondary care</p> <p><u>Country:</u> The Netherlands</p> <p><u>Recruitment:</u> Not stated.</p>	<p>symptoms such as cough and breathlessness in whom GP uncertain of diagnosis referred to hospital-based paediatric asthma clinic</p> <p><u>Exclusion criteria:</u> Straightforward diagnosis of asthma based on classical respiratory symptoms; referred for poorly controlled asthma; systemic corticosteroids or long-acting beta-2 agonists in last 4 weeks</p>	<p>mean 10.4 years</p>	<p><u>Reference standard</u> <b>Clinical Dx</b> including objective test: Asthma diagnosed by paediatric pulmonologist including history, physical examination and lung function tests including methacholine challenge</p> <p>Time between index test and reference standard: same time</p> <p><u>Target condition</u> Asthma</p>	<table border="1"> <tr> <td>Total</td> <td>20</td> <td>39</td> <td>59</td> </tr> <tr> <td>Sensitivity</td> <td></td> <td>50%</td> <td></td> </tr> <tr> <td>Specificity</td> <td></td> <td>72%</td> <td></td> </tr> <tr> <td>PPV</td> <td></td> <td>48%</td> <td></td> </tr> <tr> <td>NPV</td> <td></td> <td>74%</td> <td></td> </tr> <tr> <td>Likelihood ratio</td> <td></td> <td>1.77</td> <td></td> </tr> </table>	Total	20	39	59	Sensitivity		50%		Specificity		72%		PPV		48%		NPV		74%		Likelihood ratio		1.77		<p>Home spirometry data lost for 2 patients due to battery failure of the device</p> <p><u>Additional data:</u> <u>None</u></p>
Total	20	39	59																											
Sensitivity		50%																												
Specificity		72%																												
PPV		48%																												
NPV		74%																												
Likelihood ratio		1.77																												

**Table 52: DEN OTTER 1997<sup>417</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments								
den Otter JJ, Reijnen GM, van den Bosch	<p><u>Study type:</u> Diagnostic Cross-sectional</p>	<p>N = 323</p> <p><u>Inclusion criteria:</u> adults between 25</p>	<p><u>Male: Female</u> 135:188</p> <p><u>Mean age:</u></p>	<p><u>Index test</u> PEF variability = <math>(PEF_{highest} - PEF_{lowest}) / PEF_{mean} \times 100\%</math> (mean over 21 days' readings)</p>	<table border="1"> <tr> <td><b>Asthma</b></td> <td>Ref std +</td> <td>Ref std -</td> <td>Total</td> </tr> <tr> <td>PEF var &gt;15%</td> <td>6</td> <td>4</td> <td>10</td> </tr> </table>	<b>Asthma</b>	Ref std +	Ref std -	Total	PEF var >15%	6	4	10	<p>Ref std -</p> <p>Total</p>	<p><u>Source of funding:</u> Not stated.</p>
<b>Asthma</b>	Ref std +	Ref std -	Total												
PEF var >15%	6	4	10												

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments		
WJ, van Schayck CP, Molema J, Van Weel C. Testing bronchial hyper-responsiveness: provocation or peak expiratory flow variability? British Journal of General Practice. 1997; 47(421):487-492 DENOTTE R1997	study  <u>Data source:</u> Population screening  <u>Setting:</u> General population  <u>Country:</u> The Netherlands <u>Recruitment:</u> Not stated.	and 70 years old with signs or symptoms indicating asthma (persistent or recurrent respiratory symptoms or signs of reversible bronchial obstruction)  <u>Exclusion criteria:</u> None given	43 (12) years	<b>CUT-OFF:</b> positive = >5% or 10% or 15%  <u>Reference standard</u> <b>Clinical Dx</b> including objective test: Reference standard = BHR, defined as a PC20 histamine of ≤8 mg/ml  Time between index test and reference standard: unclear  <u>Target condition</u> Asthma	PEF var ≤15%	124	184	308	<u>Limitations:</u> None  <u>Additional data:</u> None
					Total	130	188	318	
					Sensitivity	5%			
					Specificity	97%			
					PPV	60%			
					NPV	60%			
					PLR and NLR				
						Ref std +	Ref std -	Total	
					PEF var >10%	18	8	26	
					PEF var ≤10%	112	180	292	
					Total	130	188	318	
					Sensitivity	14%			
					Specificity	96%			
					PPV	69%			
					NPV	62%			
PLR and NL									
	Ref std +	Ref std -	Total						
PEF var >5%	73	58	131						
PEF var ≤5%	57	130	187						
Total	130	188	318						
Sensitivity	56%								

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
					Specificity	69%	
					PPV	56%	
					NPV	66%	
					PLR and NL		

**Table 53: THIADENS 1998<sup>1727</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments		
Thiadens HA, De Bock GH, Dekker FW, Huysman JA, Van Houwelingen JC, Springer MP et al. Value of measuring diurnal peak flow variability in the recognition of asthma: a study in general practice.	<u>Study type:</u> Diagnostic Cross-sectional study  <u>Data source:</u> Community  <u>Setting:</u> Primary care  <u>Country:</u> The Netherlands  <u>Recruitment:</u> January 1994 – March 1995	N = 170  <u>Inclusion criteria:</u> 18–75 yrs of age, who consulted their GP with coughing that had lasted for at least 2 weeks  <u>Exclusion criteria:</u> Already had a diagnosis of asthma or COPD, pregnant, or had a cardiovascular or concomitant pulmonary disease	<u>Male:</u> Female 61: 109  <u>Mean age:</u> 44 (16) years	<u>Index test:</u> PEF variability (DPV) = $(PEF_{highest} - PEF_{lowest}) / PEF_{highest} \times 100\%$ = amplitude % highest (a) MDPV = mean over 2 week period (b) DPV more than threshold on 4 days or more (c) DPV more than threshold on 3 days or more  <u>CUT-OFF:</u> (a) MDPV > 10% and MDPV >15% (b) DPV >15% on 4 days or more (c) DPV >20% on 3 days or more  <u>Reference standard</u> <b>Clinical Dx</b> including objective test: A patient was considered to have asthma if there had been a		Ref std +	Ref std –	Total	<u>Source of funding:</u> GlaxoWellcome BV, Medical Division, The Netherlands.  <u>Limitations:</u> Sensitivity etc calculated  <u>Additional data:</u> None
					MDPV (a) >10% +	10	3	13	
					MDPV -	59	98	157	
					Total	69	101	170	
					Sensitivity		14.5%		
					Specificity		97.0%		
					PPV		76.9%		
					NPV		62.4%		
					PLR and NL				
						Ref std +	Ref std –	Total	
MDPV (a) 15% +	2	1	3						

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments		
European Respiratory Journal. 1998; 12(4):842-847  THIADENS 1998				previous period of respiratory symptoms for >3 weeks in the last year, accompanied by a provocative dose causing a 20% fall in FEV1 (PD20) ≤15.6 μmol methacholine and/or reversibility ≥9% of predicted  Time between index test and reference standard: same time  <u>Target condition</u> Asthma	MDPV	67	100	167	
					-				
					Total	69	101	170	
					Sensitivity		2.9%		
					Specificity		99.0%		
					PPV		66.7%		
					NPV		59.9%		
					PLR and NL				
						Ref std +	Ref std -	Total	
					DPV(b) >15% ≥4 days +	14	3	17	
					PEF -	55	98	153	
					Total	69	101	170	
Sensitivity		20.3%							
Specificity		97.0%							
PPV		82.4%							
NPV		64.1%							
PLR and NL									
	Ref std +	Ref std -	Total						
DPV (c)	8	1	9						

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments		
					>20% on ≥3 days +				
					PEF -	61	100	161	
					Total	69	101	170	
					Sensitivity		11.6%		
					Specificity		99.0%		
					PPV		88.9%		
					NPV		62.1%		
					PLR and NL				

**Table 54: ULRIK 2005<sup>1789</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments		
Ulrik CS, Postma DS, Backer V. Recognition of asthma in adolescents and young adults: which objective measure is best? Journal of	<u>Study type:</u> Diagnostic Cross-sectional study  <u>Data source:</u> Community survey  <u>Setting:</u> Community  <u>Country:</u>	N = 74 people with asthma out of sample of 609 adolescents and young adults in survey  <u>Inclusion criteria:</u> Children and adolescents born between 1969 and 1979 in central Copenhagen  <u>Exclusion criteria:</u> None given	<u>Male: Female</u> 37:37  <u>Mean age:</u> 18.5 (2.8) years	<u>Index test</u> PEF variability (amp%mean)  <b>CUT-OFF:</b> positive = PEF amp%mean ≥20%  <u>Reference standard</u> <b>Clinical Dx</b> including objective test: 1) Histamine challenge test; cut off PC20 <16.0mg/mL histamine (airways hyper-responsiveness) 2) Bronchodilator reversibility: change in FEV1 (ΔFEV1%post) >10%	<b>Asthma</b>	Ref std (1) +	Ref std (1) –	Total	<u>Source of funding:</u> Danish Lung Association  <u>Limitations:</u> Asthma patients only  <u>Additional data:</u> <u>None</u>
					PEF +	32	1	33	
					PEF -	37	4	41	
					Total	69	5	74	
					Sensitivity		46.4%		
					Specificity		80.0%		
					PPV		97.0%		
					NPV		9.8%		
					PLR and NLR				
AUC									

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments		
Asthma. 2005; 42(7):549-554  ULRIK2005	Denmark  <u>Recruitment:</u> 1992.			Time between index test and reference standard: same time  <u>Target condition</u> Asthma	Diagnostic yield				
						Ref std (2) +		Ref std (2) -	Total
					PEF +	5		28	33
					PEF -	2		39	41
					Total	7		67	74
					Sensitivity			71.4%	
					Specificity			58.2%	
					PPV			15.2%	
					NPV			95.1%	
					PLR and NL				
AUC									
Diagnostic yield									

## G.8 Skin prick tests

Table 55: DRKULEC 2013<sup>451</sup>

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments		
Sensitization profile in differential diagnosis: allergic	<u>Study type:</u> Diagnostic Cross-sectional study  <u>Data source:</u>	N = 131 (N=71 asthma)  <u>Inclusion criteria:</u> • 1-15 year olds in Zagreb	<u>Male: Female</u> 89:32  <u>Mean age:</u> 7.5 years	<u>Index test SPT</u> • Allergopharma (Croatia) • Allergens: • SPT for <i>Dermatophagoides pteronyssinus</i> (house dust)	Der P	Asthma	Chronic cough	Total	<u>Source of funding:</u> Departmental sources
					SPT +	59	17	76	
					SPT -	12	43	55	
					Total	71	60	131	

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments		
asthma vs. chronic (nonspecific) cough syndrome. Medical science monitor: 19: 409-415 Drkulec V, Nogalo B, Perica M, Plavec D, Pezer M, and Turkalj M 2013. REF ID: DRKULEC2013.	Clinic  <u>Setting:</u> Patients attending Department of Allergology  <u>Country:</u> Croatia  <u>Recruitment:</u> 6 month period (date not stated)	<ul style="list-style-type: none"> <li>Respiratory symptoms</li> <li>Sent to department for diagnosis</li> </ul> <u>Exclusion criteria:</u> None given		mite) <ul style="list-style-type: none"> <li><i>Ambrosia artemisifoliae</i> (common ragweed)</li> <li><i>Phleum pratense</i> (timothy grass)</li> </ul> <b>CUT-OFF:</b> not stated.  <u>Reference standard Clinical Dx</u> At least 3 episodes of wheezing and/or positive bronchodilatation test  Time between index test and reference standard: same time  <u>Target condition</u> Allergic asthma (vs. chronic cough, i.e. <3 episodes of wheezing, with persistent cough >6 weeks)	<b>Der P</b> Sensitivity Specificity	83.6% (72.4, 90.8) 71.4% (59.9, 80.7)	<u>Limitations:</u> none  <u>Additional data:</u> Raw data calculated not presented		
					PPV NPV Likelihood + test Likelihood - test	71.8% (60.5, 80.9) 83.3% (71.9, 90.7) 2.9 (2.6, 3.3) 0.23 (0.19, 0.28)			
					Diagnostic accuracy	77.1% (69.2, 83.5)			
					Diagnostic odds	12.8 (5.4, 29.9)			
					<b>Amb A</b>	Asthma	Chronic cough	Total	
					SPT +	47	31	78	
					SPT -	24	29	53	
					Total	71	60	131	
					<b>Amb A</b> Sensitivity Specificity	66.7% (46.7, 82.0) 48.6% (39.3, 57.9)			
					PPV NPV Likelihood + test Likelihood - test	22.5% (14.4, 33.5) 86.7% (75.8, 93.1) 1.30 (1.18, 1.4) 0.69 (0.52, 0.91)			
					Diagnostic accuracy	51.9% (43.4, 60.3)			
					Diagnostic odds	1.89 (0.75, 4.8)			
					<b>Phl P</b>	Asthma	Chronic cough	Total	



Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments		
					SPT +	47	30	77	
					SPT -	24	30	54	
					Total	71	60	131	
					<b>Phl P</b>		66.7% (48.8, 80.8)		
					Sensitivity		49.5% (39.9, 59.1)		
					Specificity				
					PPV		28.2% (19.0, 39.5)		
					NPV		83.3% (71.9, 90.7)		
					Likelihood + test		1.3 (1.2, 1.4)		
					Likelihood - test		0.67 (0.53, 0.85)		
					Diagnostic accuracy		53.4% (44.9, 61.8)		
					Diagnostic odds		1.96 (0.84, 4.60)		
					<b>≥1 allergens</b>	Asthma	Chronic cough	Total	
					SPT +	56	5	61	
					SPT -	15	55	70	
					Total	71	60	131	
					<b>SPT to ≥1 allergen</b>		78.8% (68.9, 86.2)		
					Sensitivity		91.3% (79.7, 96.6)		
					Specificity				
					PPV		94.4% (86.4, 97.8)		
					NPV		70% (57.5, 80.1)		
					Likelihood + test		9.1 (5.5, 14.9)		
					Likelihood - test		0.23 (0.21, 0.26)		

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
					Diagnostic accuracy	83.21% (75.88, 88.64)	
					Diagnostic odds	39.1 (12.4, 123.4)	

**Table 56: Gaig 1999<sup>533</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures		Effect sizes		Comments
					Der P/ Der F	Asthma	Rhinitis	Total	
Asthma, mite sensitization, and sleeping in bunks. Annals of allergy, asthma and immunology: 82: 531-533 Gaig P, Enrique E, Garcia-Ortega P, Olona M, del Mar San Miguel M, and Richart C 1999.	<u>Study type:</u> Cross-sectional study  <u>Data source:</u> Clinic  <u>Setting:</u> Outpatient allergy clinic  <u>Country:</u> Spain  <u>Recruitment:</u> Consecutive patients, date not stated	N = 94 (47 sibling pairs); (N=41 asthma)  <u>Inclusion criteria:</u> Patients attending outpatient allergy clinic who had been sharing a bunk with a sibling for >6 months, occupying always the same position (top or bottom bunk)  <u>Exclusion criteria:</u> not stated	<u>Male: Female</u> 43:51  <u>Mean age:</u> 16 years	<u>Index test</u> <b>SPT</b> • ALK Abelló (Madrid, Spain) • Allergens: • <i>Dermatophagoides pteronyssinus</i> and <i>Dermatophagoides farinae</i> <b>CUT-OFF:</b> skin wheal diameter to at least one of the two mites 3mm larger than control  <u>Reference standard</u> <b>Clinical Dx</b> Clinical history and current symptoms (asthma or rhinitis)  Time between index test and reference standard: not stated  <u>Target condition</u> Allergic asthma (vs. rhinitis)	Der P/ Der F	Asthma	Rhinitis	Total	<u>Source of funding:</u> ALK Abelló (Madrid, Spain) supported antibody testing  <u>Limitations:</u> No mention of objective test for asthma; study not designed to assess diagnostic test  <u>Additional data:</u> Sensitivity etc calculated from 2 x 2 table
					SPT +	35	17	52	
					SPT -	6	9	15	
					Total	41	26	67	
					Mite Sensitivity		85.4%		
					Specificity		34.6%		
PPV		67.3%							
NPV		60%							

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
REF ID: GAIG1999							

**Table 57: May 1990<sup>1096</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments					
Allergy to <i>Artemisia vulgaris</i> in the region of Warsaw. <i>Allergologia et Immunopathologia</i> : 18: 57-60 May KL 1990. REF ID: MAY1990.	<u>Study type:</u> Diagnostic Cross-sectional study  <u>Data source:</u> Clinic  <u>Setting:</u> Allergology clinic  <u>Country:</u> Poland  <u>Recruitment:</u> consecutive patients, date not stated	N = 446 (N=190 asthma)  <u>Inclusion criteria:</u> Consecutive unselected patients for allergological consultation for conjunctivitis, rhinitis and/or asthma which appeared or deteriorated in late spring and summer  <u>Exclusion criteria:</u> None stated	<u>Male: Female</u> 256:190  <u>Mean age:</u> Range 6 to 56 years, mean not stated	<u>Index test SPT</u> <ul style="list-style-type: none"> <li>• Haarlem-Holland</li> <li>• Allergens:                             <ul style="list-style-type: none"> <li>• <i>Gramineae</i> (grasses both wild and cultivated)</li> <li>• <i>Artemisia vulgaris</i> (weed: mugwort)</li> </ul> </li> </ul> <b>CUT-OFF:</b> 3+ or 4+  <u>Reference standard Clinical Dx</u> Clinically evident bronchial symptoms  Time between index test and reference standard: not stated  <u>Target condition</u> Asthma with or without	<b>Gramineae</b>	Asthma with or without rhinitis and with or without conjunctivitis	Rhinitis with or without conjunctivitis	Total	<u>Source of funding:</u> Not stated  <u>Limitations:</u> No mention of objective test for asthma  <u>Additional data:</u> Sensitivity etc calculated from 2 x 2 table			
					SPT +	170	228	398				
					SPT -	20	28	48				
					Total	190	256	446				
					<b>Gramineae</b>		Sensitivity			89.5%		
							Specificity			10.9%		
							PPV			42.7%		
							NPV			58.3%		
					<b>Artemisia vulgaris</b>	Asthma	Rhinitis	Total				
					SPT +	92	95	187				
SPT -	98	161	259									

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
				rhinitis and with or without conjunctivitis (vs. rhinitis with or without conjunctivitis.)	Total 190	256 446	
					<b>Artemisia vulgaris</b> Sensitivity Specificity	48.4% 62.9%	
					PPV NPV	49.2% 62.2%	

**Table 58: Miraglia del Giudice 2002<sup>1144</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments		
Atopy and house dust mite sensitization as risk factors for asthma in children. Allergy: 57: 169-172 Miraglia Del Giudice M, Pedulla M, Piacentini GL,	<u>Study type:</u> Diagnostic Cross-sectional study  <u>Data source:</u> Clinic  <u>Setting:</u> Paediatric Asthma and Allergy clinic  <u>Country:</u> Italy	N = 1426 (N=925 asthma)  <u>Inclusion criteria:</u> Children referred to our Paediatric Asthma and Allergy Centre because of allergic symptoms (see reference standard)  <u>Exclusion criteria:</u> Children without a confirmed	<u>Male: Female</u> 814:612  <u>Mean age:</u> Range 0 to 12 years, mean not stated	<u>Index test SPT</u> <ul style="list-style-type: none"><li>Bayer DHS Diagnostics, Epernon Cedex-France</li><li>Allergens:</li><li>house dust mites (HDM) (<i>Dermatophagoides pteronyssinus</i>, <i>D. farinae</i>), <i>Parietaria officinalis</i> (lichwort, in the nettle family), grasses (<i>Dactylis glomerata</i>, <i>Lolium perenne</i>, <i>Phaleum pratense</i>), moulds (<i>Alternaria</i>, <i>Aspergillus</i>, <i>Cladosporium</i>), dog fur, cat fur, egg albumin, and cow's milk</li></ul> <b>CUT-OFF:</b> wheal was at least 3 mm in diameter  <u>Reference standard Clinical Dx</u> Clinical diagnosis: asthma, allergic	<b>≥1 test +ve</b>	Asthma	Chronic cough	Total	<u>Source of funding:</u> None stated
					SPT +	411	218	629	
					SPT -	514	283	797	
					Total	925	501	1426	
					<b>≥1 test +ve</b>	Sensitivity		44%	<u>Limitations:</u> No mention of objective test for asthma  <u>Additional data:</u> Sensitivity,
						Specificity		56%	
	PPV	65%							
		NPV	36%						

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
<p>Capristo C, Brunese FP, Decimo F, Maiello N, and Capristo AF 2002. REF ID: MIRAGLIA DELGIUDI CE2002.</p>	<p><u>Recruitment:</u> January–December 1998</p>	<p>diagnosis</p>		<p>rhinoconjunctivitis, atopic dermatitis and food allergy was confirmed by a paediatric allergologist.</p> <p><b>Bronchial asthma</b> defined as <math>\geq 3</math> episodes of wheezing &lt; 2 years of age, or 1 episode from 2 years of age, or any episode of wheezing independent of age, if combined with atopic symptoms in the family or other atopic symptoms in the child.</p> <p><b>Allergic rhino-conjunctivitis:</b> sneezing, nasal obstruction, watery rhinorrhea, nasal itching, conjunctival hyperemia and photophobia at least twice after exposure to a particular allergen and unrelated to infection.</p> <p><b>Food allergy:</b> acute onset of symptoms e.g. skin reactions, wheezing, oral allergic symptoms, vomiting or diarrhoea on &gt;1 occasion after ingestion of, or oral contact with, a particular type of food.</p> <p><b>Atopic dermatitis:</b> defined according to Hanifin and assessed with the Scrad index</p> <p>Time between index test and reference standard: not stated</p> <p><u>Target condition</u> Allergic asthma (vs. allergic rhinoconjunctivitis, atopic dermatitis or</p>			<p>specificity calculated</p>

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
				food allergy)			

**Table 59: Popovic 2002<sup>1367</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments				
S. Popovic-Grle, M. Mehulic, F. Pavicic, I. Babic, and Z. Beg-Zec. Clinical validation of bronchial hyperresponsiveness, allergy tests and lung function in the diagnosis of asthma in persons with dyspnea. <i>Coll. Antro</i>	<u>Study type:</u> Cross-sectional study	N = 195 (N=141 asthma, n=17 COPD, n=29 rhinitis/sinusitis, n=8 unsolved)  <u>Inclusion criteria:</u> • Pts with dyspnoea • Treated for breathlessness in the Outpt dept of Allergology • Referred by GPs due to suspected asthma  <u>Exclusion criteria:</u> • All serious diseases of other organ systems or the lungs (apart from those of an obstructive and/or	<b>ASTHMA PTS:</b>  <u>Male: Female</u> 51%:49%  <u>Mean age:</u> 36.5 years	<u>Index test</u> <b>SPT</b> • House dust • <i>D. pteronyssinus</i> • Grass pollen • Weed pollen • Tree pollen • Animal dander • Cat fur • Dog fur • Feathers • Fungi mixture • Insect antigens <b>CUT-OFF:</b> skin wheal diameter ≥3mm.  <u>Reference standard</u> <b>Clinical Dx (with obj test)</b> Questionnaire of clinical history of occasional asthma attacks with wheezing and nocturnal awakening because of dyspnoea, and BDR test with salbutamol.	≥1 <b>aeroallergen</b>	Asthma	Non-asthma	Total	<u>Source of funding:</u> None reported  <u>Limitations:</u> No major ones identified  <u>Additional data:</u> n/a		
					SPT +	87				20	1074
					SPT -	54				34	88
					Total	141				54	195
					Sensitivity	62%					
					Specificity	63%					
					PPV	81%					
	NPV	61%									

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
pol. 26 Suppl:119-127, 2002.  REF ID: POPOVIC 2002.		allergic nature)		Time between index test and reference standard: not stated  <u>Target condition</u> Allergic asthma (vs. rhinitis/sinusitis, COPD or unsolved)			

**Table 60: Soriano 1999A<sup>1628</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments		
JB Soriano, JM. Anto, J. Sunyer, A. Tobias, M. Kogevinas, E. Almar, N. Muniozgueren, JL. Sanchez, L. Palenciano, P. Burney, J. Martinez-Moratalla et al. Risk of asthma in the general Spanish	<u>Study type:</u> Cross-sectional study  <u>Data source:</u> Sub sample of general population reporting respiratory symptoms  <u>Setting:</u> General population	N = 1816 (N=136 asthma)  <u>Inclusion criteria:</u> • Subsample of pts from a general population, who reported respiratory symptoms in a screening questionnaire.  <u>Exclusion criteria:</u> • Already selected in	<u>Male: Female</u> 48%:52%  <u>Mean age:</u> 32 years	<u>Index test SPT</u> • <i>D. pteronyssinus</i> • <i>Cladosporium</i> • <i>Alternaria</i> • Timothy grass • Olive • Birch • Parieta or ragweed <b>CUT-OFF:</b> skin wheal diameter ≥3mm.  <u>Reference standard Clinical Dx with objective test</u> Clinical history and current symptoms (woken up by attack of	≥1 allergen +ve	Asthma	Non-asthma	Total	<u>Source of funding:</u> Fondo de Investigaciones Sanitarias, Madrid and Generalitat de Catalunya.
					SPT +	60.7% (n=83)	31.4% (n=528)	611	
					SPT -	39.3% (n=53)	68.6% (n=1152)	1205	
					Total	136	1680	1816	
					Sensitivity	60.7%			
					Specificity	68.6%			
					PPV	-			
NPV	-								
<b>Alternaria</b>	Asthma	Non-asthma	Total						

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes		Comments
population attributable to specific immunoresponse. <i>Int.J.Epidemiol.</i> 28 (4):728-734, 1999.  REF ID: SORIANO 1999A.	<u>Country:</u> Spain  <u>Recruitment:</u> date not stated	an earlier random sample		shortness of breath during last 12 months, or having an attack of asthma during last 12 months, or currently taking medication for asthma) – using questionnaire, plus methacholine challenge for bronchoresponsiveness (BR).  Asthma defined as symptomatic BR.  Time between index test and reference standard: not stated  <u>Target condition</u> Allergic asthma	SPT +	6.7% (n=9)	1.4% (n=24)	33
					SPT -	93.3% (n=127)	98.6% (n=1656)	1783
					Total	136	1680	1816
					Sensitivity		6.7%	
					Specificity		98.6%	
					<b>Birch</b>	Asthma	Non-asthma	Total
					SPT +	5.9% (n=8)	1.6% (n=27)	35
					SPT -	94.1% (n=128)	98.4% (n=1653)	1781
					Total	136	1680	1816
					Sensitivity		5.9%	
					Specificity		98.4%	
					<b>Cat</b>	Asthma	Non-asthma	Total
					SPT +	20.7% (n=28)	6.3% (n=106)	134
					SPT -	79.3% (n=108)	93.7% (n=1574)	1682
					Total	136	1680	1816
Sensitivity		20.7%						
Specificity		93.7%						
<b>Cladosporium</b>	Asthma	Non-asthma	Total					



Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes		Comments	
					SPT +	7.4% (n=10)	2.8% (n=47)	57	
					SPT -	92.6% (n=126)	97.2% (n=1633)	1759	
					Total	136	1680	1816	
					Sensitivity	7.4%			
					Specificity	97.2%			
					<b>Dust mite</b>	Asthma	Non-asthma	Total	
					SPT +	39.3% (n=53)	20.0% (n=336)	389	
					SPT -	60.7% (n=83)	80.0% (n=1344)	1427	
					Total	136	1680	1816	
					Sensitivity	39.3%			
					Specificity	80.0%			
					<b>Timothy grass</b>	Asthma	Non-asthma	Total	
					SPT +	31.9% (n=43)	13.3% (n=223)	266	
					SPT -	68.1% (n=93)	86.7% (n=1457)	1550	
					Total	136	1680	1816	
					Sensitivity	31.9%			
					Specificity	86.7%			

## G.9 IgE

**Table 61: ABRAHAM 2007<sup>8</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures		Effect sizes		Comments
CM. Abraham, DR Ownby, EL Peterson, G Wegienka, EM Zoratti, LK Williams, CLM Joseph, and C Cole Johnson. The relationship between seroatopy and symptoms of either allergic rhinitis or asthma. <i>J.Allergy Clin.Immunol.</i> 119 (5):1099-1104, 2007.	<u>Study type:</u> Diagnostic Cross-sectional study  <u>Data source:</u> Information from a regional survey of pregnant women in a primary care practice, and subsequent interview and blood test.  <u>Setting:</u> Primary care  <u>Country:</u> USA  <u>Recruitment:</u> Dates not	N = 702  <u>Inclusion criteria:</u> • Pregnant women in second trimester or later • Age 21-49 years  <u>Exclusion criteria:</u> None given	<u>Male: Female</u> 0 : 100%  <u>Mean age:</u> 29 years  <u>Dx of asthma:</u> N=140 self-reported, N=138 physician provided Dx.	<u>Index test</u> <b>Specific IgE</b> • Pharmacia UniCAP system • Allergens: ○ Dust mite (American) <i>D. farinae</i> ○ Dust mite (European) <i>D. pteronyssinus</i> ○ Cat ○ Dog ○ Cockroach ○ Ragweed ○ Grass (timothy) ○ Egg ○ <i>Alternaria</i>  <b>CUT-OFF:</b> positive = $\geq 0.35$ kU/l.  <u>Reference standard</u> <b>Clinical Dx</b> Physician Dx of asthma (by answer to questionnaire).  <u>Time between index test</u>	<b>Dust mite (Ameri) asthma</b>	Ref std +	Ref std –	Total	<u>Source of funding:</u> National Institute of Allergy and Infectious Diseases and by the Fund for Henry Ford Health System, Detroit.  <u>Limitations:</u> High IgE cut off, pregnant women only, consecutive recruitment; Unclear time between Ref standard and Index test
					IgE +				
					IgE -				
					Total				
					Sensitivity				
					Specificity				
					<b>Dust mite (Euro) asthma</b>	Ref std +	Ref std –	Total	
					IgE +	37.9% (~n=47)	21.8% (~n=90)		
					IgE -	62.1% (~n=77)	78.2% (~n=403)		
					Total	N=124	N=493	N=617	
Sensitivity		37.9 (47/124)							
Specificity		78.2 (97/493)							
<b>Grass (tim)</b>	Ref std +	Ref std –	Total						

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments			
ABRAHAM 2007	given			<p><u>and reference standard:</u>Index done much later (because physican Dx was determined by people answering a questionnaire, so the Dx could have been made any previous time)</p> <p><u>Target condition</u> Allergic asthma</p>	<b>asthma</b>			<u>Additional data:</u>		
					IgE +	33.3% (~n=41)	19.5% (~n=96)			
					IgE -	66.7% (~n=83)	80.5% (~n=397)			
					Total	N=124	N=493		N=617	
					Sensitivity		33.3 (41/124)			
					Specificity		80.5 (397/493)			
					<b>Alternariaasthma</b>	Ref std +	Ref std -		Total	
					IgE +	33.9% (~n=42)	14.4% (~n=71)			
					IgE -	66.1% (~n=82)	85.6% (~n=422)			
					Total	N=124	N=493		N=617	
					Sensitivity		33.9 (167/124)			
					Specificity		85.6 (106/493)			
					<b>Cat asthma</b>		Ref std +		Ref std -	Total
					IgE +	39.8% (~n=49)	12.2% (~n=60)			
IgE -	(~n=75)	87.8% (~n=433)								
Total	N=124	N=493	N=617							
Sensitivity		39.8%								
Specificity		87.87%								
<b>Dog asthma</b>		Ref std +	Ref std -	Total						
IgE +	33.9%	12.3%								

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
						(~n=42) (n=61)	
					IgE -	66.1% (n=82) (n=432)	
					Total	N=124 N=493	
					Sensitivity	33.9%	
					Specificity	88%	

**Table 62: LINNEBERG 2006<sup>1015</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments		
A. Linneberg, L. Husemoen, N. Nielsen, F. Madsen, L. Frolund, and N. Johansen. Screening for allergic respiratory disease in the general population with the ADVIA Centaur Allergy Screen Assay. <i>Allergy</i> 61 (3):344-348, 2006.	<u>Study type</u> : Diagnostic Cross-sectional study  <u>Data source</u> : Random sample from a prospective cohort study (Copenhagen Allergy Study).  <u>Setting</u> : General population  <u>Country</u> : Denmark	N = 709  <u>Inclusion criteria</u> : • 15-69 year olds in Copenhagen • Participants in the study who responded at follow-up • Random group and a respiratory symptom group were used for analysis	<u>Male: Female</u> Not reported  <u>Mean age</u> : Not reported	<u>Index test</u> <b>Specific IgE</b> • ADIVA Centaur immunoassay • Allergens: ○ Birch ○ Grass (timothy) ○ Mugwort ○ Mammals (includes dog, cat, horse, hamster and others) ○ Dust mite <b>CUT-OFF</b> : positive = >0.35 kU/l.  <u>Reference standard</u> <b>Clinical Dx</b> Allergic asthma clinical Dx by presence of positive symptoms (via questionnaire) and positive SPT.  Time between index test and	<b>Pollen asthma</b>	Ref std +	Ref std -	Total	<u>Source of funding</u> : Not stated  <u>Limitations</u> : Unclear time between Ref standard and Index test
					IgE +	49	238	287	
					IgE -	2	420	422	
					Total	51	658	709	
					Sensitivity	96.1 (49/51)			
					Specificity	63.8 (420/658)			
					PPV	17.1 (49/287)			
					NPV	99.5 (420/658)			
					PLR and NLR	-			
					<b>Dust mite asthma</b>	Ref std +	Ref std -	Total	
IgE +	27	260	287						
IgE -	5	417	422						
Total	32	677	709						

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments		
LINNEBERG 2006	<u>Recruitment:</u> Oct 1997-Nov 1998	<u>Exclusion criteria:</u> None given		reference standard: unclear  <u>Target condition</u> Allergic asthma	Sensitivity		84.4 (27/32)		<u>Additional data:</u>
					Specificity		62.0 (417/677)		
					PPV		9.4 (27/287)		
					NPV		61.5 (417/677)		
					<b>ALL allergic asthma</b>	Ref std +	Ref std -	Total	
					IgE +	79	208	287	
					IgE -	6	416	422	
					Total	85	624	709	
Sensitivity		92.9 (79/85)							
Specificity		66.7 (416/624)							
PPV		27.5 (79/287)							
NPV		98.6 (416/422)							
PLR and NLR		-							

**Table 63: PLASCHKE 1999A<sup>1354</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments		
P. Plaschke, C. Janson, E. Norrman, E. Björnsson, S. Ellbjär, and B. Järholm. Association between atopic sensitization	<u>Study type:</u> Diagnostic Cross-sectional study  <u>Data source:</u> Random sample (1800 men, 1800 women) from population registers.	N = 1572 in final analysis.  <u>Inclusion criteria:</u> • Aged 20-44 years • Responded to questionnaire and agreed to	<u>Male:</u> Female 46: 54%  <u>Mean age:</u> 33 years  <u>Current smokers:</u> 30%	<u>Index test</u> Specific IgE • Pharmacia CAP system • Allergens: ○ Cat ○ Dust mite <i>D. pteronyssinus</i> ○ Grass ○ Birch	<b>Dust mite (Euro) asthma</b>	Ref std +	Ref std -	Total	<u>Source of funding:</u> Fondo de Investigaciones Sanitarias, Madrid and Generalitat de Catalunya.
					IgE +	18.8% (~n=16)	5.8% (~n=86)	102	
					IgE -	81.2% (~n=68)	94.2% (~n=1402)	1470	
					Total	N=84	N=1488	N=1572	

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments		
and asthma and bronchial hyperresponsiveness in Swedish adults: pets, and not mites, are the most important allergens. <i>J. Allergy Clin. Immunol.</i> . 104 (1):58-65, 1999.  PLASCHKE 1999A	Postal questionnaire (modified ECRHS) was sent and had an 86% response rate. 89.2% of those who answered, agreed to participate in clinical examinations.  <u>Setting:</u> General population  <u>Country:</u> Sweden  <u>Recruitment:</u> Feb 1991 – June 1992	have clinical examination and perform SPT, RAST and bronchial methacholine challenge.  <u>Exclusion criteria:</u> None given	<u>Dx of asthma:</u> N=84 (according to symptoms and previous Dx ascertained by questionnaire).	<ul style="list-style-type: none"> <li>o <i>Cladosporium</i></li> </ul> <b>CUT-OFF:</b> positive = class $\geq 2$ ( $\geq 0.7$ kU/l).  <u>Reference standard</u> <b>Clinical Dx</b> Dx of asthma (by answer to questionnaire)  <u>Time between index test and reference standard:</u> Not mentioned.  <u>Target condition</u> Allergic asthma	Sensitivity	18.8 (16/84)			<u>Limitations:</u> High IgE cut off; Unclear time between Ref standard and Index test  <u>Additional data:</u>
					Specificity	94.2 (1402/1488)			
					<b>Grass asthma</b>	Ref std +	Ref std –	Total	
					IgE +	35.3% (~n=30)	12.6% (~n=187)	217	
					IgE -	64.7% (~n=54)	87.3% (~n=1301)	1355	
					Total	N=84	N=1488	N=1572	
					Sensitivity	35.3 (30/84)			
					Specificity	87.3 (1301/1572)			
					<b>Birch asthma</b>	Ref std +	Ref std –	Total	
					IgE +	29.4% (~n=25)	10.4% (~n=155)	180	
					IgE -	70.6% (~n=59)	89.6% (~n=1333)	1392	
					Total	N=84	N=1488	N=1572	
Sensitivity	29.4 (25/84)								
Specificity	89.6 (1333/1488)								
<b>Cladosporium asthma</b>	Ref std +	Ref std –	Total						
IgE +	3.5% (~n=3)	1.0% (~n=15)	18						
IgE -	96.5% (~n=81)	99.0% (~n=1473)	1554						

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments		
					Total	N=84	N=1488	N=1572	
					Sensitivity		3.5 (3/84)		
					Specificity		99.0 (1473/1488)		
					<b>Cat asthma</b>	Ref std +	Ref std -	Total	
					IgE +	40% (~n=34)	9.4% (~n=140)		
					IgE -	60% (~n=50)	90.6% (~n=1348)		
					Total	N=84	N=1488		
					Sensitivity		40%		
					Specificity		90.6%		

**Table 64: SORIANO 1999<sup>1627</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments		
J. B. Soriano, J. M. Anto, J. Sunyer, A. Tobias, et al. Risk of asthma in the general Spanish population attributable to	<u>Study type:</u> Diagnostic Cross-sectional study  <u>Data source:</u> Info from a 20% random subsample of a questionnaire	N = 1816  <u>Inclusion criteria:</u> • Aged 20-44 years • Responded to questionnaire and provided blood samples, had SPTs and spirometry as	<u>Male:</u> <u>Female</u> 48 : 52%  <u>Mean age:</u> 32 years  <u>Current smokers:</u> 52%	<u>Index test:</u> Specific IgE or SPT • Pharmacia CAP system • Allergens: ○ Cat ○ <i>Cladosporium</i> ○ Dust mite <i>D. pteronyssinus</i> ○ Grass (timothy) ○ <i>Parietaria</i> ○ <i>Alternaria</i> (SPT only)	<b><i>Cladosporium</i> asthma</b> IgE + IgE - Total Sensitivity / Specificity <b>Dust mite asthma</b>	Ref std + 7.4% (~n=10) 92.6% (~n=126) N=136 Ref std +	Ref std - 2.8% (~n=47) 97.2% (~n=1633) N=1680 Ref std -	Total 57 1759 N=1816 7.0 and 97.2 Total	<u>Source of funding:</u> Fondo de Investigaciones Sanitarias, Madrid and Generalitat de Catalunya.

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments		
specific immunoresponse. Spanish Group of the European Community Respiratory Health Survey. <i>Int.J.Epidemiol.</i> 28 (4):728-734, 1999.  SORIANO 1999	given to a random sample (N=16844) of general population aged 20-44 yrs in 5 areas of Spain.  <u>Setting:</u> General population  <u>Country:</u> Spain  <u>Recruitment:</u> Dates not given	well as methacholine challenge test.  <u>Exclusion criteria:</u> None given	<u>Dx of asthma:</u> N=136 (according to symptoms and BR results) performed by the study and questionnaire. N=1689 (not asthma).	<ul style="list-style-type: none"> <li>o Birch (SPT only)</li> <li>o Olive Ragweed (SPT only)</li> </ul> <b>CUT-OFF:</b> positive = >0.35 kU/l.  <u>Reference standard</u> Clinical Dx of asthma (by answer to questionnaire and BR results).  <u>Time between index test and reference standard:</u> Index done same time as BR tests  <u>Target condition</u> Allergic asthma	IgE +	39.3% (~n=53)	20.0% (~n=336)	389	<u>Limitations:</u> Unclear time between Ref standard and Index test; results mix of IgE + SPT.  <u>Additional data:</u>
					IgE -	60.7% (~n=83)	80.0% (~n=1344)	1427	
					Total	N=136	N=1680	N=1816	
					Sensitivity		39.3 (53/136)		
					Specificity		80.0 (1344/1680)		
					<b>Grass timothy asthma</b>	Ref std +	Ref std -	Total	
					Index test +	31.9% (~n=93)	13.3% (~n=223)	316	
					Index test -	68.1% (~n=43)	86.7% (~n=1457)	1500	
					Total	N=136	N=1680	N=1816	
					Sensitivity		68.0 (93/136)		
Specificity		86.7 (1457/1680)							
<b>Cat asthma</b>	Ref std +	Ref std -	Total						
IgE +	20.7% (~n=27)	6.3% (~n=106)							
IgE -	79.3% (~n=109)	93.7% (~n=1574)							
Total	136	1680							
Sensitivity		20.7%							
Specificity		94%							



**Table 65: TSCHOPP 1998<sup>1768</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures		Effect sizes		Comments
					Current allergic asthma	Ref std +	Ref std -	Total	
J. M. Tschopp, D. Sistek, C. Schindler, P. Leuenberger, A. P. Perruchoud, B. Wuthrich, M. Brutsche, J. P. Zellweger, W. Karrer, and O. Brandli. Current allergic asthma and rhinitis: diagnostic efficiency of three commonly used atopic markers (IgE, skin prick tests, and Phadiatop). Results from 8329 randomized adults from the SAPALDIA Study. Swiss Study on	<p><u>Study type:</u> Diagnostic Cross-sectional study</p> <p><u>Data source:</u> Information from a random sample of residents (part of the SAPALDIA study) from the general population aged 18-60 yrs.</p> <p><u>Setting:</u> General population</p>	<p>N = 8329</p> <p><u>Inclusion criteria:</u></p> <ul style="list-style-type: none"> <li>Aged 18-60</li> <li>Undertaken the 3 atopic tests (total IgE, SPT and Phadiatop)</li> </ul> <p><u>Exclusion criteria:</u></p> <ul style="list-style-type: none"> <li>Not done the 3 atopic</li> </ul>	<p><u>Male: Female</u></p> <p>Data in another publication – ON ORDER</p> <p><u>Mean age:</u></p> <p>Data in another publication – ON ORDER</p> <p><u>Current smokers:</u></p> <p>Data in another publication – ON ORDER</p> <p><u>Dx of asthma (in N=8329):</u></p> <p>DA (DrDx): N=566, CA (current asthma): N=208, CAA (current allergic asthma): N=153, CAR (current allergic</p>	<p><u>Index test Total IgE</u></p> <ul style="list-style-type: none"> <li>Pharmacia CAP FEIA technology</li> </ul> <p><b>CUT-OFF:</b> positive = <math>\geq 100</math> kU/l.</p> <p><u>Index test Specific IgE</u></p> <ul style="list-style-type: none"> <li>Phadiatop fluoroenzyme immunoassay</li> <li>Allergens:                             <ul style="list-style-type: none"> <li>Pollens</li> <li>House dust mite</li> <li>Moulds</li> <li>Cat – total IgE only</li> </ul> </li> </ul> <p><b>NOT USING DATA AS RESULTS ARE COMBINED</b></p> <p><b>CUT-OFF:</b> positive = above the reference serum value.</p> <p><u>Reference standard Clinical Dx</u></p> <p>Dx of current allergic asthma (by qu'aire results: CA + respiratory symptoms related to common allergy exposure in the last 12 mths asthma.</p>	Current allergic asthma	Ref std +	Ref std -	Total	<p><u>Source of funding:</u></p> <p>Swiss National Science Foundation and Federal Office of Education and Science.</p> <p><u>Limitations:</u></p> <p>High cut off; Unclear time between Ref standard and Index test</p>
					Total IgE +	87	1807	1894	
					Total IgE -	66	6369	6435	
					Total	153	8176	8329	
					Sensitivity	56.9			
					Specificity	77.9			
					PPV, NPV	4.6, 99.0			
					Current allergic asthma (all allergens)	Ref std +	Ref std -	Total	
					Sp IgE +	NR	NR	NR	
					Sp IgE -	NR	NR	NR	
					Total	NR	NR	8329	
					Sensitivity	72.5			
					Specificity	71.9			
PPV, NPV	4.6, 99.3								
PLR and NLR	-								

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
Air Pollution and Lung Diseases in Adults. <i>Allergy</i> 53 (6):608-613, 1998.  TSCHOPP 1998	<u>Country:</u> Switzerland  <u>Recruitment:</u> 1 year period	tests.	rhinitis): N=1361, CAA and/or CAR: N=1422, Phadiatop: N=2410, SPT+: N=1912, IgE+: N=1890.	<u>Time between index test and reference standard:</u> not reported (likely to be different time as one was based on questionnaire results).  <u>Target condition</u> Current allergic asthma. DATA NOT GIVEN FOR DA (Dr Dx asthma).			<u>Additional data:</u>

1 **G.10 FeNO for diagnosis**

**Table 66: BERLYNE 2000<sup>161</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments
G. S. Berlyne, K. Parameswaran, D. Kamada, A. Efthimiadis, and F. E. Hargreave. A comparison of exhaled nitric oxide and induced sputum as markers of airway inflammation. <i>J.Allergy Clin.Immunol.</i> 106 (4):638-644, 2000.	<p><u>Study type:</u> Case-control study</p> <p><u>Data source:</u> clinic pts</p> <p><u>Setting:</u> Chest allergy clinic pts</p> <p><u>Country:</u> Canada</p> <p><u>Recruitment:</u> Not reported</p>	<p>N = 131 adults</p> <ul style="list-style-type: none"> <li>- n=38 asthma – steroid naive (1)</li> <li>- n=35 asthma – steroid Tx (2)</li> <li>- n=8 eosinophilic bronchitis (3)</li> <li>- n=28 healthy controls - atopic (4)</li> <li>- n=22 healthy controls – nonatopic (5)</li> </ul> <p><u>Inclusion criteria:</u></p> <p>(1): Asthma (steroid naive). Symptoms of wheeze, breathlessness or cough in past year plus MCT PC20 &lt;8 mg/ml if the FEV1/VC &gt;70%; or a post-BD FEV1 &gt;15% if the FEV1/VC was &lt;70%. Not received ICS in previous month.</p> <p>(2): Asthma (steroid-Tx). As above but receiving regular ICS Tx.</p> <p>(3): Eosinophilic bronchitis without asthma. Cough in the past yr, FEV1/VC &gt;80%, MCT PC20 &gt;16 mg/ml, and induced sputum eos count &gt;5% of total squamous cell count (above the 90<sup>th</sup> percentile for sputum eos).</p> <p>(4): Healthy controls - atopic. No symptoms. FEV1/VC &gt;70% and MCT PC20 &gt;16 mg/ml. Positive SPT to at least 1 common allergen.</p> <p>(5): Healthy controls -nonatopic. As</p>	<p><u>Male: Female</u> 43%/57%</p> <p><u>Mean age:</u> 39 years</p>	<p><u>Index test</u></p> <p>FeNO: chemiluminescence analyser; fixed flow rate 45 ml/s. Sievers 240 device.</p> <p><u>Target condition</u></p> <p>FeNO levels asthma vs. healthy vs. eosinophilic bronchitis (separately)</p>	<p><b>Median (IQR) FeNO levels:</b></p> <ol style="list-style-type: none"> <li>1. Asthma – steroid naive: 39 (43) ppb</li> <li>2. Asthma – steroid Tx: 17 (12) ppb</li> <li>3. Eosinophilic bronchitis: 65 (92) ppb</li> <li>4. Healthy - atopic: 11 (6) ppb</li> <li>5. Healthy - nonatopic: 9 (7) ppb</li> </ol> <p>- median of healthy = 10</p> <p>The median FeNO was SS different between the groups.</p> <p>Median FeNO was SS higher in the group with asthma (steroid naive) vs. healthy controls (p&lt;0.001)</p> <p>Median FeNO was SS lower in the group with asthma (steroid Tx) vs. steroid naive (p&lt;0.001)</p> <p>Median FeNO was SS lower in the group with asthma (steroid Tx) vs. Eosinophilic bronchitis.</p>	<p><u>Source of funding:</u> Not reported</p> <p><u>Limitations:</u> -</p> <p><u>Additional data:</u> None</p>

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments
BERLYNE 2000		<p>above but negative SPT to at least 1 common allergen.</p> <p><u>Exclusion criteria:</u></p> <ul style="list-style-type: none"> <li>• Current smokers (as reduces ENO levels)</li> <li>• Ex-smokers &lt;1 year</li> <li>• Symptoms of RTI in 4 wks before study or other complicating respiratory disease</li> </ul>				There was NS difference in median FeNO levels between the control groups (ie. atopic status does not matter).

**Table 67: CARDINALE 2005<sup>270</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments
F.	<u>Study type:</u>	N = 175 children (mean 10 years)	<u>Male: Female</u>	<u>Index test</u>	<b>Median (IQR) FeNO levels:</b>	<u>Source of</u>

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments
<p>Cardinale, F. M. De Benedictis, V. Muggeo, P. Giordano, M. S. Loffredo, G. Iacoviello, and L. Armenio. Exhaled nitric oxide, total serum IgE and allergic sensitization in childhood asthma and allergic rhinitis. <i>Pediatr. Allergy Immunol.</i> 16 (3):236-242, 2005.</p>	<p>Case-control study</p> <p><u>Data source:</u> Pts from clinic</p> <p><u>Setting:</u> Paediatric allergy clinic</p> <p><u>Country:</u> Italy</p> <p><u>Recruitment:</u> No detail if consecutive. Nov 2002 - Sept 2003.</p>	<p>- n=109 asthma (83.4% were allergic – SPT+; 51% of all asthma had additional allergic rhinitis (1a and 1b = atopic/nonatopic asthma)</p> <p>- n=41 allergic rhinitis, moderate persistent (2)</p> <p>- n=25 healthy controls (3)</p> <p><u>Inclusion criteria:</u> (1): mild intermittent asthma. History of symptoms, pulmonary function tests and response to inhaled beta-adrenergic agents according to international guidelines. History of at least 1 episode of asthma in past year and stable at time of study. (2): moderate persistent allergic rhinitis. Clinical history and positive SPT to common allergens. None had ever had wheezing or received asthma medication. Steroid Tx or antihistamine had to be withdrawn &gt;3 months before study. (3): Healthy controls. Non-atopic (absence of allergic symptoms in history and negative SPT), no history of airway disease, allergy or significant medical illness and not taking any medication.</p> <p><u>Exclusion criteria:</u></p>	<p>1:2 (overall)</p> <p><u>Mean age:</u> 10 years (overall)</p>	<p>FeNO: chemiluminescence analyser; flow rate 50 ml/s. NOA Tm280 Sievers device</p> <p><u>Target condition</u> FeNO levels asthma vs. allergic rhinitis vs. healthy controls (separately)</p>	<p>1. All asthma: 22.7 (9.1 - 48) ppb 1a. n=91 Asthma atopic: 25.6 (11.4 – 56.2) ppb 1b. n=18 Asthma non-atopic: 11.5 (5.4 - 15.5) ppb 2. Allergic rhinitis: 15.3 (9.4 – 31.0) 3. Healthy: 5.9 (3.4 – 9.3)</p> <p>Asthma pts and allergic rhinitis has SS higher FeNO levels than controls (p=0.0001 and p=0.016)</p> <p>The mean eNO was SS higher in allergic vs. non-allergic asthma (p&lt;0.001)</p> <p>There was NS difference in eNO between the non-allergic asthma pts vs. healthy controls.</p> <p>There was NS difference in eNO between all asthma pts vs. allergic rhinitis.</p> <p>The median FeNO level was SS higher in allergic asthma vs. allergic rhinitis. (p=0.03)</p>	<p><u>funding:</u> Not reported</p> <p><u>Limitations:</u> -</p> <p><u>Additional data:</u> None</p>

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments
CARDINAL E 2005		History of significant medical illness, previous or current allergen hyposensitisation, history or signs of RTI in 4 wks before study, tobacco smoke exposure in the family.				

**Table 68: CHATKIN 1999<sup>304</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables			Comments	
Chatkin JM, Ansarin K, Silkoff PE, McClean P, Gutierrez C, Zamel N et al. Exhaled	<u>Study type:</u> Cross-sectional observational study  <u>Data source:</u>	N = 38 chronic cough + 23 healthy controls  <u>Inclusion criteria:</u> Chronic cough (>3 weeks) of unknown cause referred for	<u>Male: Female</u> 11:27 chronic cough plus 8:15 controls  <u>Mean age:</u> Adult: asthma:	<u>Index test</u> FeNO: chemiluminescence analyser (Sievers 280 device); mouth pressure 20mm Hg. Flow rate 45ml/s Optimal cut-off 30ppb		Ref std +	Ref std -	Total	<u>Source of funding:</u> Dr Chatkin recipient of a grant from CAPES
					Index test +	6	4	10	
					Index test -	2	26	28	
					Total	8	30	38	

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables		Comments
nitric oxide as a noninvasive assessment of chronic cough. American Journal of Respiratory and Critical Care Medicine. 1999; 159(6):1810-1813. (Guideline Ref ID CHATKIN19 99)	<p>Data collected for this study</p> <p><u>Setting:</u> Asthma centre (tertiary referral centre) or affiliated community respiratory clinics</p> <p><u>Country:</u> Canada</p> <p><u>Recruitment:</u> Not stated</p>	<p>diagnosis; normal CXR and FEV1 &gt;80% predicted</p> <p><u>Exclusion criteria:</u> Use of codeine or any other medication for chronic cough, upper respiratory infection within 4 weeks; use of corticosteroids within 6 weeks; current smoking; any significant medical conditions; contra-indications to methacholine challenge.</p>	<p>41 (12) yr; chronic cough non-asthma: 47 (15) yr; healthy controls: 38 (8)</p> <p>Non-asthma = chronic cough (mean 53.8 weeks) but methacholine negative</p>	<p><u>Reference standard</u> Positive to methacholine challenge (PC20 ≤8mg/mL) Tests done within 24 hours</p> <p><u>Target condition</u> Asthma diagnosis vs. chronic cough non-asthma FeNO levels asthma vs. chronic cough non-asthma or vs. healthy controls</p>	Sensitivity	75%	<p><u>Limitations:</u> None</p> <p><u>Additional data:</u> None</p>
					Specificity	87%	
					PPV NPV PLR / NLR	60% 93% 5.8 / 0.3	
					AUC	Not stated	
					<p>Median (25<sup>th</sup> to 75<sup>th</sup> percentile) FeNO levels: asthma (chronic cough and methacholine positive): 75.0 (34.1 to 104.0) ppb n=8, p=0.0014 vs. non-asthma, p=0.007 vs. controls</p> <p>Non-asthma (chronic cough and methacholine negative): 16.7 (11.0 to 21.7) ppb n=30</p> <p>Healthy controls: 28.3 (23 to 30) ppb, n=23</p>		

**Table 69: CIPRANDI 2013<sup>334</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments
Giorgio	<u>Study type:</u>	N = 330 children (median 12 years)	<u>Male: Female</u>	<u>Index test</u>	<b>Median (IQR) FeNO levels:</b>	<u>Source of</u>

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments
<p>Ciprandi, Maria Angela Tosca, and Michele Capasso. High exhaled nitric oxide levels may predict bronchial reversibility in allergic children with asthma or rhinitis. <i>J.Asthma</i> 50 (1):33-38, 2013.</p> <p>CIPRANDI 2013</p>	<p>Case-control study</p> <p><u>Data source:</u> Hospital pts</p> <p><u>Setting:</u> Hospital</p> <p><u>Country:</u> Italy</p> <p><u>Recruitment:</u> Not reported</p>	<p>- n=180 allergic intermittent asthma (1) - n=150 allergic rhinitis (2)</p> <p><u>Inclusion criteria:</u> (1): allergic asthma. Paediatrician using validated criteria (GINA). Consistent symptoms and signs, lung function impairment and BDR. BDR FEV1&gt;12%. Allergy by SPT for common aeroallergens. (2): rhinitis. Paediatrician using validated criteria (GINA).</p> <p><u>Exclusion criteria:</u> Negative SPT Acute or chronic uRTI Anatomical or nasal disorders Previous or current immunotherapy Use of CS, nasal or oral vasoconstrictors, LABA anti-leukotrienes or antihistamines in previous 4 weeks.</p>	<p>56%/44%</p> <p><u>Median age:</u> (1) children 13 yrs (2) children 10 yrs</p>	<p>FeNO: chemiluminescence analyser; flow rate 50 ml/s. Sievers 280 device.</p> <p><u>Target condition</u> FeNO levels allergic asthma vs. rhinitis (separately)</p>	<p>1. Asthma allergic: 34 (29 - 381) ppb 2. Rhinitis: 27 (21 - 35)</p> <p>The median FeNO was SS higher in the allergic asthma vs. rhinitis group (p&lt;0.001)</p>	<p><u>funding:</u> No sponsorship.</p> <p><u>Limitations:</u> -</p> <p><u>Additional data:</u> None</p>



**Table 70: CORDEIRO 2011**<sup>360</sup>

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables			Comments	
					Ref std +	Ref std -	Total		
<p>Cordeiro D, Rudolphus A, Snoey E, Braunstahl GJ. Utility of nitric oxide for the diagnosis of asthma in an allergy clinic population. Allergy and Asthma Proceedings. 2011; 32(2):119-126. (Guideline Ref ID CORDEIRO2011)</p> <p><u>Data source:</u> Routine prospective database</p> <p><u>Setting:</u> General outpatient allergy clinic</p> <p><u>Country:</u> The Netherlands</p> <p><u>Recruitment:</u> January 2007 to September 2007</p>	<p><u>Study type:</u> Cross-sectional observational study</p>	<p>N = 114</p> <p><u>Inclusion criteria:</u> New referrals to outpatient allergy clinic</p> <p><u>Exclusion criteria:</u> Patients using inhaled corticosteroids or oral corticosteroids within 6 weeks</p>	<p><u>Male:</u> <u>Female:</u> 43: 71</p> <p><u>Median age:</u> Asthma: 39 (range 7-83); non-asthma 38 (7-87)</p>	<p><u>Index test</u> FeNO: measured online at constant flow rate 50mL/s (Niox-Flex device) Optimal cut off 27ppb. Flow rate 50ml/s</p> <p><u>Reference standard</u> History of typical respiratory symptoms and FEV1 improvement &gt;12% and &gt;200mL with salbutamol 400µg or PC20 histamine ≤8mg/mL</p> <p>Time between index test and reference standard: within 6 weeks</p> <p><u>Target condition</u> Asthma diagnosis vs. non-asthma (Allergic rhinitis, non-allergic rhinitis, eczema, urticarial, other analysed all together); raw data calculated from sensitivity/ specificity</p> <p>FeNO levels: Asthma vs. Allergic rhinitis, non-allergic rhinitis, eczema, urticarial, other analysed all together Asthma vs. allergic rhinitis</p>				<p><u>Source of funding:</u> Not stated</p> <p><u>Limitations:</u> Unclear if pts treated with asthma medication apart from corticosteroids (steroid-naive)</p> <p><u>Additional data:</u> None</p>	
					Index test +	33	6		39
					Index test -	9	66		75
					Total	42	72		114
					Sensitivity Specificity	78% 92%			
					PPV / NPV	86% / 87%			
					AUC	0.88			
					Median (range) FeNO levels: Asthma: 44 (6-290) ppb, n=42	Non-asthma (all diagnoses): 17 (5-45) ppb, n=72 p<0.001 Allergic rhinitis only (sub-group of above): 21 ppb, n=32 p<0.001			

**Table 71: DEYKIN 2002<sup>429</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables			Comments	
					Ref std +	Ref std -	Total		
Deykin et al., 2002. Exhaled nitric oxide as a diagnostic test for asthma: online versus offline techniques and effect of flow rate. American Journal of Respiratory and Critical Care Medicine: 165: 1597-1601  REF ID: DEYKIN2002	<u>Study type:</u> Prospective case-control study  <u>Data source:</u> Collected for study  <u>Setting:</u> Pulmonary and Critical Care Division, Department of Medicine  <u>Country:</u> US  <u>Recruitment:</u> Not stated	N = 62  <u>Inclusion criteria:</u> <ul style="list-style-type: none"> <li>• Adult nonsmokers with and without asthma</li> <li>• Those with asthma had a history of asthma, with either a 12% improvement in FEV1 after inhalation of a beta-agonist or a methacholine PC20 of 8 mg/ml or less</li> <li>• Those without asthma had no history of asthma, normal spirometry, and a methacholine PC20 more than 8 mg/ml.</li> <li>• Free of upper respiratory infection for at least 6 weeks</li> </ul> <u>Exclusion criteria:</u> Systemic or inhaled corticosteroids used within 8 weeks	<u>Male: Female</u> 26:36  <u>Mean (SEM)</u> <u>age:</u> People with asthma (n=34) 29.6 (1.6) Healthy (n=28) 27.3 (1.3)  Medications: No asthma medications except for short-acting bronchodilators, which were withheld for at least 8 hours before all testing	<u>Index test</u> FeNO: chemiluminescence analyser (NOA 280 Sievers device); triplicate recordings.  <u>Target condition</u> FeNO levels asthma vs. healthy controls				<u>Source of funding:</u> Supported by the National Institutes of Health (P50-HL-56383) and an educational grant from Merck USHH  <u>Limitations:</u>  <u>Additional data:</u> Other flow rates reported but not relevant	
					Index test +	-	-		-
					Index test -	-	-		-
					Total	-	-		-
					Sensitivity		-		
					Specificity		-		

Various flow rates reported:  
 50ml/s: Asthma: 57.9 (6.5) Healthy: 26.3 (2.2);  
 (p<0.001 for comparison)

**Table 72: FUKUHARA 2011**<sup>529</sup>

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments				
					Ref st +	Ref st -	Total						
Fukuhara et al., 2011. Validation study of asthma screening criteria based on subjective symptoms and fractional exhaled nitric oxide. Annals of Allergy, Asthma and Immunology: 107: 480-486  REF ID: FUKUHAR A2011	<u>Study type:</u> Cross-sectional study  <u>Setting:</u> Outpatients, Dept. of Pulmonary Medicine, University Hospital  <u>Country:</u> Japan  <u>Recruitment:</u> Not reported	N = 61 Adults  <u>Inclusion criteria:</u> <ul style="list-style-type: none"> <li>At least 1 of the subjective symptoms: recurrent cough, wheezing or dyspnoea (including chest tightness)</li> </ul> <ul style="list-style-type: none"> <li><u>Exclusion criteria:</u> <ul style="list-style-type: none"> <li>Prior history of asthma</li> <li>Taking oral or inhaled steroids or anti-leukotriene agents</li> </ul> </li> </ul>	<u>Male: Female</u> 31:30  <u>Mean age (range):</u> 55.6 (17-81)  Medications:  6 current smokers and 13 former smokers	<u>Index test</u> FeNO level: measured using online method in accordance with American Thoracic Society/European Respiratory Society and a chemiluminescence analyser (NA623N, Chest MI, Japan). Information on the compatibility with other NO analysers provided. FeNO level measured 3 times with differences within 10%, mean of 3 measurements used. Flow rate 50ml/s.  Cut-off: ≥40ppb  <u>Comparator test</u> n/a  <u>Reference standard</u> At least 2 of the following: induced sputum eosinophilia, airway hyperresponsiveness, reversible airway obstruction. Airway reversibility defined as a change in FEV1 of 200ml or ≥12% after short-acting β-agonist or after 2-4 weeks treatment with ICS or bronchodilator. Airway					<u>Source of funding:</u> Not reported  <u>Limitations:</u> <ul style="list-style-type: none"> <li>Consecutive or random recruitment not reported</li> <li>97 patients with symptoms gave consent but 36 were unable to undergo testing (reasons not reported)</li> </ul> <u>Additional data:</u>				
					Index test +	33	2	35					
					Index test -	9	17	26					
					Total	42	19	61					
					Sensitivity	78.6%							
					Specificity	89.5%							
					PPV	94.3%							
					NPV	65.4%							
					FeNO levels, mean (95% CI), ppb								
					Asthma 90.1 (65.9 -114.3)								
Non-asthma (with symptoms): 40.1 (21.8 – 58.5)													

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments
				<p>hyperresponsiveness defined as dose of MCh at which airway resistance began to rise (cut-off &lt;12.5U). And other diseases ruled out using chest radiography, computed tomography and other lab tests.</p> <p>Time between index test and reference standard: FeNO measured before other pulmonary function tests</p> <p><u>Target condition</u> Asthma</p>		

**Table 73: HEFFLER 2006<sup>648</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments			
Heffler E, Guida G, Marsico P, Bergia R, Bommarito L, Ferrero N et al.	<p><u>Study type:</u> Prospective study</p> <p><u>Data source:</u> Collected for study</p>	<p>N = 48 symptomatic + 30 healthy controls</p> <p><u>Inclusion criteria:</u> Patients referred to allergy department for diagnostic evaluation of</p>	<p><u>Male: Female</u> 21:27</p> <p><u>Mean age:</u> Asthma: 42.33 (range 17-69) yr; non-asthma: 38.73 (11-75) yr</p>	<p><u>Index test</u> FeNO: chemiluminescence analyser (Niox device); mouth pressure 10 cm H<sub>2</sub>O; exhalation rate 50mL/s; mean of 3 recordings.</p> <p>Different cut offs used: optimal cut off for highest combination of</p>		<p><u>Source of funding:</u> Regione Piemonte-Ricerca Sanitaria Finalizzata 2003</p>			
							Ref std +	Ref std -	Total
					Index test +		14	12	26
					Index test -		4	18	22
Total	18	30	48						

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables		Comments
Exhaled nitric oxide as a diagnostic test for asthma in rhinitic patients with asthmatic symptoms . Respirator Y Medicine. 2006; 100(11):1981-1987. (Guideline Ref ID HEFFLER2006)	<u>Setting:</u> Allergy outpatients clinic	persistent rhinitis and asthma-like lower airways symptoms (cough, dyspnoea, chest tightness and wheezing) during the last 2 months		sensitivity and specificity was 36ppb  <u>Reference standard</u> Typical symptoms and significant response to bronchodilator ( $\geq 12\%$ improvement in FEV1 with salbutamol) or airway hyper-responsiveness to methacholine (PD20 FEV1 $\leq 800\mu\text{g}$ )  Time between index test and reference standard: same time  <u>Target condition</u> Asthma vs. no asthma (not meeting criteria for diagnosis of asthma but final diagnoses not reported); raw data calculated from sensitivity/specificity  FeNO levels: asthma vs. no asthma (symptomatic) or healthy controls	Sensitivity	77.8%	<u>Limitations:</u> None
	Specificity				60.0%	<u>Additional data:</u> None	
	PPV / NPV				54.0% / 81.8%		Geometric mean (95% CI) FeNO levels: asthma 59.7 (50.2 to 89.0) ppb, n=18
	Accuracy				66.67%	Non-asthma (symptomatic): 30.4 (28.1 to 45.1) ppb, n=30, p=0.001 vs. asthma  Healthy controls: 12.2 (11.1 to 15.1) ppb, n=30, p<0.001 vs. asthma	
	<u>Country:</u> Italy				AUC	0.78	
	<u>Recruitment:</u> Not stated	<u>Exclusion criteria:</u> Use of steroids or any other anti-inflammatory medications in last 2 months, current smoking (in previous 12 months), previous diagnosis of asthma, respiratory infection in last 6 weeks					

**Table 74: KOSTIKAS 2008<sup>906</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables			Comments	
Kostikas K, Papaioannou AI, Tanou K, Koutsoker	<u>Study type:</u> Prospective study	N = 149 symptomatic + 70 healthy controls	<u>Male: Female</u> 76: 73 symptomatic + 37:33 controls	<u>Index test</u> FeNO: exhalation flow rate 50mL/s (NIOX MINO device)		Ref std +	Ref std -	Total	<u>Source of funding:</u> Not stated
	<u>Data source:</u>								

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
					Index test +	Index test -	Total	Sensitivity Specificity	
a A, Papala M, Gourgouli anis Kl. Portable exhaled nitric oxide as a screening tool for asthma in young adults during pollen season. Chest. 2008; 133(4):90 6-913. (Guideline Ref ID KOSTIKAS 2008)	Collected for the study  <u>Setting:</u> University students  <u>Country:</u> Greece  <u>Recruitment:</u> Spring 2006	one asthma symptom on a screening questionnaire among students  <u>Exclusion criteria:</u> Previous diagnosis of asthma or rhinitis treated with anti-inflammatory medication (inhaled or nasal corticosteroids, long-acting $\beta$ -agonists, leukotriene modifiers, antihistamines or methylexanthines); respiratory tract infection in past 6 weeks; recent smoking cessation (<2 months prior to study)	<u>Mean age:</u> Asthma: 21.6 (2.7) yr; allergic rhinitis: 21.8 (3.0) yr; non-specific symptoms: 22.1 (3.1) yr; healthy controls: 21.4 (2.3) yr	<u>Reference standard</u> History + significant bronchodilator reversibility, positive methacholine challenge test, or clinical or spirometric response to a 4-week trial of inhaled corticosteroids  Time between index test and reference standard: same time  <u>Target condition</u> Asthma vs. Allergic rhinitis (raw data calculated from sensitivity/specificity)  FeNO levels: Asthma vs. Allergic rhinitis or non-specific respiratory symptoms or healthy controls (separately)	Index test +				Population symptomatic but had not presented to healthcare professionals  <u>Additional data:</u> None
					Index test -				
					Total				
					PPV NPV PLR NLR	Not used as calculated including healthy control group			
					AUC	0.544			
					Median (IQR) FeNO levels: Asthma: 20.0 (14.0 to 31.0), n=63	Allergic rhinitis: 17.0 (12.5 to 23.0), n=57, p=0.28 vs. asthma Non-specific symptoms: 11.0 (8.5 to 12.5), n=29, p<0.0001 vs. asthma Healthy controls: 10.5 (7.0 to 13.0), n=70,			

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments
					p<0.0001 vs. asthma	

**Table 75: KOWAL 2009<sup>914</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments																
Kowal K, Bodzenta-Lukaszyk A, Zukowski S. Exhaled nitric oxide in evaluation of young adults with chronic cough. Journal of Asthma 2009; 46(7):692-698. (Guideline Ref ID KOWAL2009)	<u>Study type:</u> Prospective study  <u>Data source:</u> Collected for study  <u>Setting:</u> Asthma clinic  <u>Country:</u> Poland  <u>Recruitment:</u> September 2000 to November 2006	N = 540 symptomatic + 100 healthy controls  <u>Inclusion criteria:</u> Young adult patients with chronic cough (at least 8 weeks) referred to asthma clinic for evaluation  <u>Exclusion criteria:</u> Use of any anti-asthma medication, treatment with angiotensin converting enzyme inhibitors, use of codeine or other cough suppressant, upper respiratory tract infection within 4 weeks before study, presence of any systemic disease, contra-indications to	<u>Male: Female</u> Not stated  <u>Mean age:</u> Symptomatic: 26.5 (range 18-45) years; healthy controls: 24 (18-39) years	<u>Index test</u> FeNO: chemiluminescence analyser (NOA 280 Sievers device); fixed expiratory resistance 16cm H <sub>2</sub> O; exhalation flow rate 50mL/s; mean of 3 recordings  Optimal cut off 40ppb  <u>Reference standard</u> Significant diurnal changes in PEF or significant improvement of FEV1 with 200µg salbutamol over next 6 months  Time between index test and reference standard: up to 6 months  <u>Target condition</u> Asthma vs. Rhinitis/sinusitis or gastroesophageal reflux; raw data calculated from sensitivity/specificity  FeNO levels: Asthma vs.	<table border="1"> <tr> <td></td> <td>Ref std +</td> <td>Ref std -</td> <td>Total</td> </tr> <tr> <td>Index test +</td> <td>157</td> <td>63</td> <td>220</td> </tr> <tr> <td>Index test -</td> <td>21</td> <td>299</td> <td>320</td> </tr> <tr> <td>Total</td> <td>178</td> <td>362</td> <td>540</td> </tr> </table>		Ref std +	Ref std -	Total	Index test +	157	63	220	Index test -	21	299	320	Total	178	362	540	<u>Source of funding:</u> Medical University of Bialystok  <u>Limitations:</u> None  <u>Additional data:</u> None
						Ref std +	Ref std -	Total														
					Index test +	157	63	220														
					Index test -	21	299	320														
					Total	178	362	540														
					Sensitivity	88.3%																
					Specificity	82.6%																
					PPV	72.6%																
					NPV	94%																
					PLR	5.08																
NLR	0.14																					
AUC	0.924																					
Median (95% CI) FeNO levels: asthma: 86ppb (95% CI 72 to 94.5), n=178	Rhinitis/sinusitis: 37ppb (95% CI 35.6 to 42.9), n=211, p<0.0001 Gastroesophageal reflux: 14.8ppb (95% CI 13.3 to 16.2),																					

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments
		bronchial histamine test; people with seasonal allergies if cough appeared in pollen season or up to 4 weeks after the season		Rhinitis/sinusitis; gastroesophageal reflux; healthy controls (separately)		n=108, p<0.0001 vs. asthma Healthy controls: 13ppb (95% CI 11 to 15), n=100, p<0.0001 vs. asthma

**Table 76: LOUHELAINEN 2008<sup>1029</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments
Louhelainen N, Ryttilä P, Obase Y, Makela M, Haahtela T, Kinnula VL et al. The value of sputum 8-isoprostan e in detecting oxidative stress in mild asthma. Journal of	<u>Study type:</u> Prospective study	N = 37 asthma + 11 COPD + 28 healthy controls	<u>Male: Female</u> Asthma: 17:20 COPD: 7:4 Healthy controls: 11:17	<u>Index test</u> FeNO: chemiluminescence analyser (Niox device); exhalation flow rate 50mL/s; mean of 3 recordings	Ref std +	<u>Source of funding:</u> Finnish Tuberculosis Association Foundation, funding of the Helsinki University Hospital (EVO), the Sigrid Juselius Foundation, the Ida Montin Foundation, an unrestricted research grant from GSK
	<u>Data source:</u> Collected for study	<u>Inclusion criteria:</u> Patients with newly-diagnosed asthma (wheezing, prolonged cough and shortness of breath plus significant bronchial reversibility i.e. reduction in post-exercise PEF and/or FEV1 ≥15% or improvement in FEV1 ≥12% after bronchodilator or PD15 of histamine	<u>Mean age:</u> Patients with asthma and healthy controls grouped by age (adult asthma mean 38 yr, range 16-72 yrs; adult control mean 40, range 19 to 56 yr; asthma child mean 10, range	<u>Reference standard</u> BDR ≥12%, Exercise challenge test ≥15% or histamine challenge test PD15 <0.4mg	Ref std -	
	<u>Setting:</u> Division of Pulmonary Medicine			<u>Target condition</u> FeNO levels: Asthma vs. healthy controls (COPD not reported)	Total	
	<u>Country:</u> Finland				Index test +	
	<u>Recruitment:</u> Not stated				Index test -	
					Total	
					Sensitivity	
					Specificity	



Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables		Comments
Asthma. 2008; 45(2):149-154. (Guideline Ref ID LOUHELAI NEN2008 A)		<p>&lt;0.4mg or ≥20% diurnal variation in PEF values and/or ≥15% improvement in PEF after bronchodilator at home)</p> <p>COPD exacerbation</p> <p>Healthy controls</p> <p><u>Exclusion criteria:</u> Not stated</p>	7-14 yr; healthy child mean 11, range 8-14 yrs); COPD all adult (mean 72, range 54 to 85)		PPV	-	<p><u>Limitations:</u> None</p> <p><u>Additional data:</u> None</p>
					NPV		
					PLR		
					NLR		
					AUC	-	
					<p>Median FeNO levels:</p> <p>Asthma children: 35.5ppb, n unclear – between 19 and 23</p> <p>Asthma adults: 81.8ppb, n unclear – between 5 and 14</p>	<p>Healthy children: 11.9ppb, n unclear – between 9 and 13, p&lt;0.001 vs. children with asthma</p> <p>Healthy adults: 16.6ppb, n unclear – between 6 and 15, p=0.025 vs. adults with asthma</p>	

**Table 77: SATO 2008<sup>1499</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables			Comments	
					Ref std +	Ref std -	Total		
Sato S, Saito J, Sato Y, Ishii T, Xintao W, Tanino Y et al. Clinical usefulness of fractional exhaled nitric oxide for diagnosis of prolonged cough. Respirator Y Medicine. 2008; 102(10):1452-1459. (Guideline Ref ID SATO2008)	<u>Study type:</u> Prospective	N = 71	<u>Male: Female</u> Bronchial asthma: 20:10	<u>Index test</u> FeNO: chemiluminescence analyser (Device from Kimoto, Japan - no further details given); exhalation flow rate 50mL/s; mouth pressure 16 cm H <sub>2</sub> O; mean of 3 recordings				<u>Source of funding:</u> Not stated	
	<u>Data source:</u> Collected for study	<u>Inclusion criteria:</u> Prolonged cough or wheezing >3 weeks attending	Cough variant asthma: 7:11	Optimal cut off 38.8ppb	Index test +	38	2	40	<u>Limitations:</u> None
	<u>Setting:</u> Department of Pulmonary Medicine	Department of Pulmonary Medicine; age 20-78 years; no abnormalities on CXR or CT scan; no prior history of treatment for pulmonary disease; never used oral or inhaled corticosteroids	Eosinophilic bronchitis without asthma: 4:4		Index test -	10	21	31	
	<u>Country:</u> Japan		Others: 8:7	<u>Reference standard</u> Bronchial asthma (BA): cough and wheezing for 3 weeks or longer, sputum eosinophilia and positive airway hyper-responsiveness (methacholine <12.5 units) or reversible airflow limitation (improvement in FEV1 of 200mL and ≥12% from baseline after salbutamol 200µg or long-acting β <sub>2</sub> -agonist).	Total	48 (BA + CVA)	23 (EB + other)	71	<u>Additional data:</u> None
	<u>Recruitment:</u> January 2004 to January 2007	<u>Exclusion criteria:</u> None apart from above		<u>Mean (95% CI) age:</u> Bronchial asthma: 55.5 (48.9 to 62.5)	Sensitivity	79.2%			Eosinophilic bronchitis without asthma: 16.4 (10.9 to 24.8) ppb, n=8, NS vs. others  Other = post-infectious cough, post-nasal drip, COPD, chronic bronchitis, cough with GERD or ino-bronchial syndrome: 21.2 (15.1 to 29.7) ppb, n=15
			Cough variant asthma: 48.2 (39.4 to 57.0)	Cough variant asthma (CVA): As above except without wheezing	Specificity	91.3%			
			Eosinophilic bronchitis without asthma: 45.3 (33.3 to 57.2)	Time between index test and reference standard: same time					
			Others: 55.5 (47.5 to 63.5)	<u>Target condition</u> Asthma group = bronchial asthma + cough variant asthma together; compared with non-asthma group = eosinophilic bronchitis without asthma (EB), post-infectious cough, post-nasal drip, COPD, chronic bronchitis, cough	Mean (95% CI) FeNO levels: Bronchial asthma: 93.5 (72.5 to 120.7) ppb, n=30, p=0.001 vs. CVA group, p<0.001 vs. EB group, p<0.001 vs. others				
					Cough variant asthma: 46.7 (33.6 to 64.8) ppb, n=18, p<0.001 vs. EB				

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments
				with GERD or sino-bronchial syndrome (i.e. one comparator group); raw data calculated from sensitivity/ specificity  FeNO levels: Bronchial asthma and cough variant asthma (separately); compared with a) eosinophilic bronchitis without asthma, and b) other = post-infectious cough, post-nasal drip, COPD, chronic bronchitis, cough with GERD or sino-bronchial syndrome (i.e. two comparator groups)	group, p<0.001 vs. others	

**Table 78: SHIMODA 2013<sup>1563</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments		
Shimoda T, Obase Y, Kishikawa R, Iwanaga T, Miyatake A, Kasayama S. The fractional exhaled nitric oxide and	<u>Study type:</u> Prospective study, case-control  <u>Data source:</u> Collected for study  <u>Setting:</u> Department of respiratory	N = 90 cough variant asthma + 92 bronchial asthma + 90 healthy controls  <u>Inclusion criteria:</u> Both patients with cough variant asthma and bronchial asthma were to be free of attacks and newly diagnosed. The diagnoses of cough variant asthma	<u>Male: Female</u> Bronchial asthma: 44:48 Cough variant asthma: 32:58 Controls: 47:43  <u>Mean age:</u> Bronchial asthma: 38.6 (13.8) yr Cough variant asthma: 44.7	<u>Index test</u> FeNO: chemiluminescence analyser (NOA 280 Sievers device); mouth pressure 16 cm H <sub>2</sub> O; flow rate 50mL/s; mean of 3 recordings  Cut off: n/a (case-control study for levels only)  <u>Reference standard</u> Newly diagnosed asthma (bronchial or cough variant) using GINA guidelines: Cough variant asthma: chronic cough	Ref std +	Ref std -	Total	<u>Source of funding:</u> Not stated  <u>Limitations:</u> Patient groups not comparable at baseline  <u>Additional data:</u> None
					Index test +			
					Index test -			
					Total			
					Sensitivity			
					Specificity			

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables			Comments
serum high sensitivity C-reactive protein levels in cough variant asthma and typical bronchial asthma. Allergology International. 2013; 62(2):251-257. (Guideline Ref ID SHIMODA 2013)	medicine  <u>Country:</u> Japan  <u>Recruitment:</u> Not stated	and bronchial asthma were based on the GINA guidelines  Healthy subjects had no past history of asthma, atopic diseases, or other respiratory diseases and had no current respiratory symptoms  <u>Exclusion criteria:</u> Treated with any type of steroid; concurrent hypertension, diabetes mellitus, hyperlipidaemia; cough too severe to measure bronchial hypersensitivity	(14.7) yr Controls: 37.4 (11.5) yr; p=0.004 between groups  Symptom duration: bronchial asthma: 6.0 (8.8) yr; cough variant asthma: 2.5 (4.4) yr, p=0.001	persisting for longer than 8 weeks but without wheezing or dyspnoea; no past history of asthma or other respiratory diseases; wheeze or rhonchi not audible on chest auscultation; BHR to inhaled acetylcholine; bronchodilators effective against their coughs; normal chest radiograph results.  Bronchial asthma: history of episodic dyspnoea, wheezing and cough; at least 15% reversibility in FEV1 after inhalation of 200 µg of salbutamol and/or BHR to acetylcholine.  Time between index test and reference standard: n/a  <u>Target condition</u> Bronchial asthma vs. cough variant asthma  FeNO levels: Each type of asthma compared separately with healthy controls.	Mean (SD) FeNO levels: bronchial asthma: 92.6 (85.5) ppb, n=92, p<0.001 vs. controls	Healthy controls: 18.0 (6.4) ppb, n=90  Cough variant asthma: 35.6 (43.3) ppb, n=90,  p<0.001 vs. bronchial asthma, p<0.001 vs. controls		

**Table 79: SHOME 2006<sup>1568</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables			Comments	
Shome GP, Starnes III	<u>Study type:</u> Prospective study	N = 19 asthma (11 mild; 8 moderate to severe) + 17 healthy	<u>Male: Female</u> Not stated	<u>Index test</u> FeNO: 10cm H2O resistance; flow rate 50mL/s (CLD 88sp, EcoPhysics)		Ref std +	Ref std -	Total	<u>Source of funding:</u> Department of
					Index	-	-	-	

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments			
JD, Shearer M, Kennedy R, Way A, Arif A et al. Exhaled nitric oxide in asthma: Variability, relation to asthma severity, and peripheral blood lymphocyte cytokine expression. Journal of Asthma. 2006; 43(2):95-99. (Guideline Ref ID SHOME2006)	<u>Data source:</u> Collected for study  <u>Setting:</u> Division of Allergy and Immunology  <u>Country:</u> USA  <u>Recruitment:</u> Not stated	controls  <u>Inclusion criteria:</u> Patients with newly-diagnosed asthma (symptoms, signs and spirometry according to National Heart, Lung and Blood Institute) plus increase $\geq 12\%$ after albuterol 2.5mg; untreated at baseline  <u>Exclusion criteria:</u> COPD, CF, lupus pneumonitis, sepsis, respiratory infection in previous 6 weeks, congestive heart failure, smoking, other systemic diseases with pulmonary symptoms	<u>Mean (SEM) age:</u> Mild asthma: 52.36 (17.10) yr; moderate to severe asthma: 38.25 (8.52) yr; controls: 38.71 (13.04) yr, mild vs. control: $p < 0.05$	device)  <u>Reference standard</u> BDR $\geq 12\%$  <u>Target condition</u> FeNO levels: asthma vs. healthy controls. Patients with asthma grouped by mild versus moderate/severe disease	test +				Internal Medicine, Texas Tech University Health Sciences Center  <u>Limitations:</u> Groups not comparable at baseline  <u>Additional data:</u> None
					Index test -	-	-	-	
					Total	-	-		
					Sensitivity Specificity		-		
					Mean (SEM) FeNO levels: Moderate to severe asthma: 18.53 (2.00) ppb, $n=8$ , $p < 0.001$ vs. controls Mild asthma: 6.27 (3.79) ppb, $n=11$ , NS vs. controls  MEDIAN OF BOTH ASTHMA = 24.8ppb  Healthy controls: 5.90 (0.90) ppb, $n=17$				

**Table 80: VOUTILAINEN 2013<sup>1858</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables			Comments
					Ref std +	Ref std -	Total	
Voutilainen M, Malmberg LP, Vasankari T, Haahtela T. Exhaled nitric oxide indicates poorly athlete's asthma. Clinical Respiratory Journal. 2013; 7(4):347-353. (Guideline Ref ID VOUTILAINE N2013)	<u>Study type:</u> Cross-sectional observational study  <u>Setting:</u> Allergy and asthma clinic  <u>Country:</u> Finland  <u>Recruitment:</u> Not stated	N = 87 (study also included a group of elite athletes N=87, not included in this review)  <u>Inclusion criteria:</u> Sedentary patients referred to an allergy and asthma clinic because of respiratory symptoms (cough, dyspnoea or wheeze)  <u>Exclusion criteria:</u> History of sports at a competitive level	<u>Male:</u> <u>Female</u> 26:61  <u>Mean age:</u> 23 (14-31)  <u>Medications:</u> No subjects on ICS at the time of the study and beta-agonists withheld accordingly	<u>Index test</u> FeNO: measured using online single exhalation method recommended by ATS (Niox device) Cut off 30ppb.  <u>Reference standard</u> Based on general guidelines including typical symptoms and the objective confirmation of variable airway obstruction documented in hospital records. Such evidence was based either on BDR ≥12%, PEFv ≥20%, BDR of PEF ≥15%, exercise challenge test ≥15% or BHR MCh PD20 or hist PD15 ≤0.4mg  Time between index test and reference standard: 1 day  <u>Target condition</u> Asthma  FeNO levels: Asthma vs. non-asthma dx (final dx not stated)				<u>Source of funding:</u> Supported by the Vaino and Laina Kivi foundation (study sponsors did not have involvement in study design, collection, analysis or interpretation of data).  <u>Limitations:</u> Random or consecutive recruitment of patients not stated  <u>Additional data:</u> study also included a group of elite athletes N=87, not included in this review
					Index test +			
					Index test -			
					Total			
					Sensitivity		43%	
					Specificity		89%	
					PPV / NPV		-	
					AUC		0.79	
					FeNO levels: Asthma: 29.7ppb Non-asthma: 14.6ppb P<0.001			

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments
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**Table 81: WOO 2012<sup>1914</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments			
Woo SI, Lee JH, Kim H, Kang JW, Sun YH, Hahn YS. Utility of fractional exhaled nitric oxide (F(E)NO) measurements in diagnosing asthma. Respiratory Medicine. 2012; 106(8):1103-1109.	<u>Study type:</u> Prospective study  <u>Data source:</u> Collected for study  <u>Setting:</u> Department of Paediatrics  <u>Country:</u> Korea  <u>Recruitment:</u> Not stated	N = 245  <u>Inclusion criteria:</u> Children 8- 16 years old, presenting with non-specific respiratory symptoms e.g. cough, wheezing, shortness of breath, referred to paediatric outpatients for evaluation of asthma  <u>Exclusion criteria:</u> Receiving inhaled short-acting $\beta_2$ agonist in previous 8 hours; receiving regular treatment with controller medications for 3	<u>Male: Female</u> Overall: 163:82 Atopic asthma: 92:37; atopic non-asthma: 42:18; non-atopic asthma: 20:18; non-atopic non-asthma: 9:9  <u>Mean age:</u> Atopic asthma: 11.7 (2.4) yr; atopic non-asthma: 12.6 (2.6) yr; non-atopic asthma: 11.6 (2.7) yr; non-atopic non-asthma 11.4 (2.0) yr	<u>Index test</u> FeNO: chemiluminescence (NIOX MINO device); flow rate 50mL/s; mean of 2 values.  Optimal cut off 22ppb  <u>Reference standard</u> History + reversible airflow obstruction ( $\geq 12\%$ improvement in FEV1 with inhaled $\beta$ -agonist) and/or airway hyper-responsiveness (methacholine PC20 $\leq 8$ mg/mL)  Time between index test and reference standard: same time  <u>Target condition</u> Asthma vs. non-asthma (not airway hyper-responsiveness (cut off for	Total study population	Ref std +	Ref std -	Total	<u>Source of funding:</u> Basic Science Research Program through the National Research Foundation of Korea funded by the Ministry of Education, Science and Technology  <u>Limitations:</u> Unclear if treatment naive  <u>Additional data:</u> None
					Index test +	95	10	105	
					Index test -	72	68	140	
					Total	167	78	245	
					Sensitivity		56.9%		
					Specificity		87.2%		
					PPV	90.5%			
NPV	48.6%								
PLR									
NLR									
Accuracy	64.5%								

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
(Guideline Ref ID WOO2012 )		month or more before enrolment		methacholine PC20 of 8mg/mL) or reversible airflow obstruction (12% improvement in FEV1 with inhaled β-agonist); final diagnoses not stated. Asthma and non-asthma groups also sub-divided by atopic vs. non-atopic	AUC		0.76, p<0.001		
					Atopic only	Ref std +	Ref std -	Total	
					Index test +	93	9	102	
					Index test -	36	51	87	
					Total	129	60	189	
					Sensitivity		72.1%		
					Specificity		85.0%		
					PPV	91.2%			
					NPV	58.6%			
PLR									
NLR									
Accuracy									
AUC		0.85, p<0.001							
Geometric mean FeNO levels: asthma: 23.4 ppb (95% CI 20.9 to 26.2), n=167		Non-asthma: 12.6 ppb (95% CI 10.9 to 14.5), n=78, p<0.001							



Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments
					<p>Atopic asthma sub-group: 29.6 (26.6 to 32.8) ppb, n=129, p&lt;0.001 vs. atopic non-asthma, non-atopic asthma and non-atopic non-asthma</p> <p>Non-atopic asthma sub-group: 10.6 (8.6 to 13.0) ppb, n=38</p>	<p>vs. asthma</p> <p>Atopic non-asthma sub-group: 13.6 (11.6 to 15.9) ppb, n=60, p&lt;0.05 vs. non-atopic asthma and non-atopic no asthma</p> <p>Non-atopic non-asthma sub-group: 9.7 (7.1 to 13.3) ppb, n=18</p>

**Table 82: ZIETKOWSKI 2006A<sup>1957</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments
Zietkowski et al., 2006. Comparison of exhaled nitric oxide measurement	<p><u>Study type:</u> Case-control study</p> <p><u>Data source:</u> Collected for this study</p> <p><u>Setting:</u> Medical</p>	<p>N = 140 (inc. 39 healthy controls)</p> <p><u>Inclusion criteria:</u></p> <ul style="list-style-type: none"> <li>• Steroid-naïve patients with mild to moderate asthma (56 allergic and 45 nonallergic)</li> <li>• Asthma Dx according to GINA</li> <li>• Stable condition free from</li> </ul>	<p><u>Male: Female</u> 57:83</p> <p><u>Mean ( ) age:</u> Allergic asthma (n=56) 32 (12)</p> <p>Non-allergic</p>	<p><u>Index test</u> FeNO: chemiluminescence analyser; measurements were performed at an expiratory flow of 50 mL/s. Repeat measurements were performed until the 3 values agreed to within 10% of the mean. The mean value of the 3 measurements was recorded</p>	<p><b>FeNO levels</b></p> <p>Allergic asthma: 84.0±51.4 Non-allergic asthma: 45.8±32.6 MEDIAN OF BOTH ASTHMA = 64.9ppb</p> <p>Healthy controls: 12.9 ±4.6</p>	<p><u>Source of funding:</u> Not reported</p> <p><u>Limitations:</u></p> <p><u>Additional data:</u></p>



Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
<p>Backer V, Nepper-Christensen S, Ulrik CS, von Linstow ML, Porsbjerg C. Factors associated with asthma in young Danish adults. Ann Allergy Asthma Immunol. 2002 Aug;89(2):148-54.</p> <p>BACKER2002</p>	<p><u>Study type:</u> Cross-sectional</p> <p><u>Data source:</u> Registry</p> <p><u>Setting:</u> General population</p> <p><u>Country:</u> Denmark</p> <p><u>Recruitment:</u> Children and adolescents living in the area surrounding Rigshospitalet were drawn from the civil registration list who were born between 1969 and 1979.</p>	<p>N = 624</p> <p>103 people with asthma and 521 people who do not have asthma</p> <p><u>Inclusion criteria:</u> Children and adolescents</p> <p><u>Exclusion criteria:</u> Not to use theophylline or antihistamine for at least 24 hours before the test, not to use astemizole for 6 weeks before testing, oral beta-2-agonist for 12 hours before the tests. Pregnant women and breast feeding mothers were excluded from the histamine challenge and pregnant women did not undergo skin prick testing.</p>	<p><u>Male</u> N=279 <u>Female</u> N=345</p> <p><u>Age:</u> 19 to 29 years</p> <p><u>Severity of asthma:</u> Current asthma vs. those who do not have asthma.</p> <p><u>Current smokers:</u> 35 to 53%</p> <p><u>Current anti-asthma:</u> Inhaled or oral corticosteroid</p> <p><u>Drop-outs/missing values:</u> 940 were eligible; 624 participated.</p>	<p><u>Index test</u> <b>Peripheral blood eosinophils</b></p> <ul style="list-style-type: none"> <li>• Venous blood sample and put into a tube containing EDTA, and the number of eosinophil leukocytes was counted in billions per litre.</li> </ul> <p><u>Reference standard</u> N/A</p> <p><u>Target condition</u> NA</p>	<p><b>Blood eosinophil count. (Factor associated with asthma in young adults).</b> Billions per litre.</p>	<p><b>Non-asthma:</b> 0.19 (0.1) <b>versus.</b> <b>Asthma</b> 0.26 (0.2)</p> <ul style="list-style-type: none"> <li>• P&lt;0.01 different between two groups.</li> </ul>	<p><u>Source of funding:</u> Danish Lung Association. Glaxo Wellcome and ALK-Abello.</p> <p><u>Limitations:</u> Overall - LOW/UNCLEAR RISK OF BIAS.</p> <p><u>Additional data</u> Those that had asthma had higher eosinophil counts.</p>

**Table 84: HALVANI 2012**<sup>627</sup>

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments						
Abolhasan Halvani, Fatemeh Tahghighi, and Hossein Hadi Nadooshan. Evaluation of correlation between airway and serum inflammatory markers in asthmatic patients. <i>Lung India</i> 29 (2):143-146, 2012.  HALVANI 2012	<u>Study type:</u> Case-control	N = 98 (includes 37 healthy)  <u>Inclusion criteria:</u> <ul style="list-style-type: none"> <li>Mild to moderate persistent asthma (GINA criteria)</li> <li>Non-smokers without history of RTI or exacerbation of asthma during previous 6 weeks.</li> <li>Healthy: no history of smoking, heart disease or other diseases; normal pulmonary function tests.</li> </ul> <u>Exclusion criteria:</u> <ul style="list-style-type: none"> <li>Heart disease</li> <li>Diabetes</li> <li>Cancer</li> <li>Obesity</li> <li>Systemic inflammatory disorders.</li> </ul>	<u>Male: Female</u> 55%/45%  <u>Mean age:</u> 37.8 years.  <u>Diagnoses:</u> <ul style="list-style-type: none"> <li>1. Healthy controls: n=37</li> <li>2. Asthma ICS user: n=31</li> <li>3. Asthma non-ICS user: n=30.</li> </ul> <u>Current smokers:</u> None reported.  <u>Current anti-asthma Tx:</u> N=31 ICS users.  <u>Drop-outs/missing values:</u> None reported.	<u>Index test</u> <b>Peripheral blood eosinophils</b> <ul style="list-style-type: none"> <li>Not reported.</li> </ul> <b>CUT-OFF:</b> N/A  <u>Reference standard</u> N/A  <u>Time between index test and reference standard:</u> N/A  <u>Target condition</u> <ul style="list-style-type: none"> <li>Asthma.</li> </ul>	<b>Population (baseline)</b>	<b>Eosinophils, median</b>  <b>No./μL</b>	<u>Source of funding:</u> None reported.  <u>Limitations:</u> Overall - LOW/UNCLEAR RIK OF BIAS.  <u>Additional data:</u> N/A						
	<u>Data source:</u> Asthma pts from clinic – details not reported, and age and sex matched healthy controls.							<u>Setting:</u> Outpatients (secondary care).	<u>Country:</u> Iran	<u>Recruitment:</u> Not reported.	Healthy controls	<b>211</b>	<ul style="list-style-type: none"> <li><b>Asthma non-ICS user group: SS more PBE than asthma ICS users and healthy controls.</b></li> </ul>
										Asthma – ICS user	<b>402</b>		
										Asthma – non-ICS user	<b>517</b>		

**Table 85: HUNTER 2002<sup>713</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments	
<p>C. J. Hunter, C. E. Brightling, G. Woltmann, A. J. Wardlaw, and I. D. Pavord. A comparison of the validity of different diagnostic tests in adults with asthma. <i>Chest</i> 121 (4):1051-1057, 2002.</p> <p>HUNTER 2002</p>	<p><u>Study type:</u> Case-control</p>	<p>N = 110 (includes n=21 healthy controls)</p> <p><u>Inclusion criteria:</u></p> <ul style="list-style-type: none"> <li>• Asthma: consistent clinical features, symptomatic, FEV1 &gt;65% predicted, and one or more of other criteria.</li> <li>• Healthy controls: no symptoms suggesting past or current asthma, non-smokers.</li> <li>• Pseudoasthma: people referred to hospital with Dx of asthma by GP, clinical features considered atypical and symptoms not deteriorate upon withdrawal of Tx. Symptoms improved after Tx of underlying condition.</li> </ul> <p><u>Exclusion criteria:</u> None reported.</p>	<p><u>Male: Female</u> 47%:53%</p> <p><u>Mean age:</u> 39 years (range 14-76).</p> <p><u>Diagnoses:</u></p> <ul style="list-style-type: none"> <li>• Asthma: n=69</li> <li>• Pseudoasthma: n=20</li> <li>• Healthy control: n=21</li> </ul> <p><u>Current smokers:</u> 8%</p> <p><u>Current anti-asthma Tx:</u> 28%. Mean Tx time = 2 years (0-29 yrs).</p> <p><u>Drop-outs/missing values:</u> None reported.</p>	<p><u>Index test</u> <b>Peripheral blood eosinophils</b></p> <ul style="list-style-type: none"> <li>• Standard haematological techniques.</li> </ul> <p><b>CUT-OFF:</b> N/A</p> <p><u>Reference standard</u> N/A</p> <p><u>Time between index test and reference standard:</u> N/A</p> <p><u>Target condition</u></p> <ul style="list-style-type: none"> <li>• Asthma.</li> <li>• Physician Dx based on clinical features and tests.</li> </ul>	<p><b>Population</b></p>	<p><b>Eosinophils, mean (SEM)</b> %</p>	<p><u>Source of funding:</u> None reported.</p> <p><u>Limitations:</u> Overall - LOW/UNCLEAR RIK OF BIAS.</p> <p><u>Additional data:</u> N/A</p>	
	<p><u>Data source:</u> Patients attending Dept of Respiratory medicine, staff, and volunteers.</p>				<p><u>Setting:</u> Patients (secondary care) and general population.</p>	<p>Healthy controls</p>		<p>1.9 (0.6)</p>
	<p><u>Country:</u> UK</p>				<p><u>Recruitment:</u> Dates not reported.</p>	<p>Pseudoasthma</p>		<p>2.0 (0.3)</p>
						<p>Asthma</p>		<p>4.3 (0.6)</p>
					<p><b>Test results for eosinophil vs. healthy controls:</b></p> <ul style="list-style-type: none"> <li>• Normal range = &lt;6.3%</li> <li>• sens 21% (11-31)</li> <li>• spec 100</li> </ul>			
					<p><b>Most tests were less specific when the reference population consisted of people with pseudoasthma.</b></p>			

**Table 86: KHAKZAD 2009<sup>847</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
M. R. Khakzad, M. Mirsadraee, M. Sankian, A. Varasteh, and M. Meshkat. Is serum or sputum eosinophil cationic protein level adequate for diagnosis of mild asthma? <i>Iran.J.Allergy Asthma Immunol.</i> 8 (3):155-160, 2009.  KHAKZAD 2009	<u>Study type:</u> Case-control	N = 62 (includes 12 healthy)  <u>Inclusion criteria:</u> <ul style="list-style-type: none"> <li>• Asthma: history of cough, dyspnoea, wheeze and airway hyperresponsiveness; symptoms increased during nights and some seasons; Spirometry showing obstructive pattern with &gt;12% increase with bronchodilator or PC20 &lt;8 mg/ml.</li> <li>• All were new cases or pts who had withheld their drugs for a long time.</li> <li>• Healthy: no history of asthma or other allergic disorders; PC20 &gt;8 mg/ml.</li> </ul> <u>Exclusion criteria:</u> <ul style="list-style-type: none"> <li>• Healthy people with : evidence of peripheral blood eosinophilia, abnormal chest X-ray, history of smoking, systemic or ICS usage, recent infection.</li> </ul>	<u>Male: Female</u> 40%/60%  <u>Mean age:</u> 39.5 years (range 9-76).  <u>Diagnoses (GINA criteria):</u> <ul style="list-style-type: none"> <li>• 1. Healthy controls: n=12</li> <li>• 2. Asthma Mild intermittent: n=6.</li> <li>• 3. Asthma mild persistent: n=16.</li> <li>• 4. Asthma moderate persistent: n=13</li> <li>• 5. Asthma severe: n=15</li> </ul> <u>Current smokers:</u> None reported.  <u>Current anti-asthma Tx:</u> None reported.  <u>Drop-outs/missing values:</u> None reported.	<u>Index test</u> <b>Peripheral blood eosinophils</b> <ul style="list-style-type: none"> <li>• Automated cell counter (Sysmex).</li> </ul> <b>CUT-OFF:</b> N/A  <u>Reference standard</u> N/A  <u>Time between index test and reference standard:</u> N/A  <u>Target condition</u> <ul style="list-style-type: none"> <li>• Asthma.</li> </ul>	<b>Population (baseline)</b>	<b>Eosinophils, median %</b>	<u>Source of funding:</u> Islamic Azad University.  <u>Limitations:</u> Overall - LOW/UNCLEAR RIK OF BIAS.  <u>Additional data:</u> N/A
	Healthy controls		1.2				
	All asthma		1.0				
	Asthma Mild intermittent		2.0				
	Asthma mild persistent		3.6				
	Asthma moderate persistent		3.2				
	Asthma severe		3.2				
<ul style="list-style-type: none"> <li>• Asthma: SS higher PBE than healthy controls.</li> </ul>							

**Table 87: KOTANIEMI 2002<sup>907</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
Anne Kotaniemi-Syrjanen, Tiina M. Reijonen, Kaj Korhonen, and Matti Korppi. Wheezing requiring hospitalization in early childhood: predictive factors for asthma in a six-year follow-up. <i>Pediatr.Allergy Immunol.</i> 13 (6):418-425, 2002.  KOTANIEMI 2002	<p><u>Study type:</u> Case series (prospective)</p> <p><u>Data source:</u> Prospective study: 6-year follow-up of children with infection-related wheeze; data used for 6 years only to see at 6 years the % who have asthma.</p> <p><u>Setting:</u> Outpatients (secondary care)</p> <p><u>Country:</u> Finland</p> <p><u>Recruitment:</u> 6 year follow-up data January to March 1999 (original baseline study December 1992-1993)</p>	<p>N = 82 <b>(FINAL Dx: N=33 asthma; N=49 non-asthma)</b></p> <p><u>Inclusion criteria:</u></p> <ul style="list-style-type: none"> <li>Children from previous study who were available for follow-up.</li> </ul> <p><u>Exclusion criteria:</u> None reported.</p>	<p><u>Male: Female</u> 74%:26%</p> <p><u>Median age:</u> 7.2 (5.6 - 8.8 years)</p> <p><u>Current smokers:</u> N/A</p> <p><u>Current anti-asthma Tx:</u> 30/33 asthma pts used cromones (n=18) or inhaled steroids (n=12) for maintenance medication for asthma.</p> <p><u>Drop-outs/missing values:</u> N=18 from the original 100</p>	<p><u>Index test</u> <b>Peripheral blood eosinophils</b></p> <ul style="list-style-type: none"> <li>Method not reported.</li> </ul> <p><b>CUT-OFF:</b> <math>\geq 0.45 \times 10^9/l</math>.</p> <p><u>Reference standard</u> <b>Clinical Dx – clinical history and questionnaire (symptoms), and exercise challenge test</b> (pulmonary testing before and after exercise using flow-volume spirometry and FEV<sub>1</sub> – positive = auscultatory wheezing post-exercise and/or <math>\geq 15\%</math> fall in FEV<sub>1</sub>).</p> <p><b>Asthma diagnosed if:</b></p> <ol style="list-style-type: none"> <li>On continuous maintenance Tx-asthma</li> <li>suffered from repeated (<math>\geq 2</math>) episodes of wheezing and/or prolonged cough (<math>\geq 4</math> wks) apart from infection during previous 12 months reported by parents.</li> <li>positive exercise challenge test.</li> </ol> <p><b>Non-Asthma diagnosed if:</b> wheezing or prolonged cough but negative exercise challenge OR positive exercise test but no asthma symptoms.</p> <p>Time between index test and reference standard: unclear</p> <p><u>Target condition:</u> Asthma.</p>	<p><b>Population</b></p> <p>False positives: 8, false negatives: 15, true positives: 18, true negatives: 41</p> <p>Sensitivity: 18/33 Specificity: 41/49 PPV: 18/26 (69% reported in the paper) NPV: 41/56</p>	<p><b>% with Eosinophil counts <math>\geq 0.45 \times 10^9/l</math></b></p>	<p><u>Source of funding:</u> Ida Montin Foundation, Kerttu and kale Viik Fund, Kuopio University Hospital.</p> <p><u>Limitations:</u> Overall - LOW/UNCLEAR RISK OF BIAS.</p> <p><u>Additional data:</u> N/A</p>

**Table 88: KROEGEL 1998<sup>920</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
C. Kroegel, M. Schuler, M. Forster, R. Braun, and P. R. Grahmann. Evidence for eosinophil activation in bronchiectasis unrelated to cystic fibrosis and bronchopulmonary aspergillosis: discrepancy between blood eosinophil counts and serum eosinophil cationic protein levels. <i>Thorax</i> 53 (6):498-500, 1998.	<p><u>Study type:</u> Case-control</p> <p><u>Data source:</u> Consecutive pts with bronchiectasis, plus age and sex matched control groups (allergic asthma, COPD and healthy).</p> <p><u>Setting:</u> Secondary care.</p> <p><u>Country:</u> Germany</p> <p><u>Recruitment:</u> Jan 1992 – August 1994.</p>	<p>N = 56 (n=14 asthma)</p> <p><u>Inclusion criteria:</u></p> <ul style="list-style-type: none"> <li>• Proven or new bronchiectasis (persistent cough, recurrent pneumonias and frequent haemoptysis, large quantities of partially foul purulent sputum production, positive sputum cultures &gt;3 years, and radiological evidence of bronchiectasis)</li> <li>• COPD or asthma (diagnostic criteria previously published)</li> <li>• All pts without clinical signs of current infectious exacerbation in previous 4 weeks</li> <li>• Healthy controls – no pulmonary disease.</li> <li>• No family history of similar lung disease.</li> </ul> <p><u>Exclusion criteria:</u></p> <ul style="list-style-type: none"> <li>• None reported.</li> </ul>	<p><u>Male: Female</u> N=8/N=6</p> <p><u>Mean age:</u> 54.8 years (range 31-78).</p> <p><u>Diagnoses:</u></p> <ul style="list-style-type: none"> <li>• 1. Healthy controls: n=14</li> <li>• 2. Bronchiectasis: n=14</li> <li>• 3. COPD: n=14</li> <li>• 4. Allergic asthma: n=14.</li> </ul> <p><u>Current smokers:</u> None reported.</p> <p><u>Current anti-asthma Tx:</u> Not reported.</p> <p><u>Drop-outs/missing values:</u> None reported.</p>	<p><u>Index test</u> <b>Peripheral blood eosinophils</b></p> <ul style="list-style-type: none"> <li>• Standard cytometry.</li> </ul> <p><b>CUT-OFF:</b> N/A</p> <p><u>Reference standard</u> N/A</p> <p><u>Time between index test and reference standard:</u> N/A</p> <p><u>Target condition</u></p> <ul style="list-style-type: none"> <li>• Allergic asthma.</li> </ul>	<p><b>Population (baseline)</b></p>	<p><b>Eosinophils, median</b> <b>x10<sup>7</sup>/l</b></p>	<p><u>Source of funding:</u> County of Thuringia, Germany.</p> <p><u>Limitations:</u> Overall - LOW/UNCLEAR RISK OF BIAS.</p> <p><u>Additional data:</u> N/A</p>
					<p>Healthy controls</p> <p>Bronchiectasis</p> <p>COPD</p> <p>Allergic asthma</p>		
KROEGEL 1998					<ul style="list-style-type: none"> <li>• <b>Allergic asthma: SS more PBE than all other groups</b></li> <li>• <b>NS difference in PBE count between bronchiectasis and healthy controls or COPD.</b></li> </ul>		



**Table 89: LABBE 2001<sup>943</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
A. Labbe, B. Aublet-Cuvelier, L. Jouaville, G. Beaugeon, L. Fiani, I. Petit, L. Ouchchane, and M. Doly. Prospective longitudinal study of urinary eosinophil protein X in children with asthma and chronic cough. <i>Pediatr.Pulmonol.</i> 31 (5):354-362, 2001.	<u>Study type:</u> Case-control	N = 143 (N=88 asthma, N=22 severe)	<u>Male: Female</u> 64%/36%	<u>Index test</u> <b>Peripheral blood eosinophils</b>  • Method not reported.	<b>Population (baseline)</b>	<b>Eosinophils, median</b>  x10 <sup>9</sup> /L	<u>Source of funding:</u> Pharmacia.
	<u>Data source:</u> Children seen in outpts by paediatric pulmonologist .	<u>Inclusion criteria:</u>  • Asthma: a) recent onset, not receiving any Tx except B-2 agonists if needed. b) severe asthma, taking ICS regularly for at least 12 months.  • Healthy: admitted to dept for non-infectious, non-respiratory disorder. No history of asthma or atopic disease.  • Chronic cough: referred for chronic cough (>3months duration/year), or recurrent cough (>3 episodes/year, each lasting >15 days).	<u>Mean age:</u> 7.0 years (range 1.1 - 16.5).	<u>CUT-OFF:</u> N/A	Healthy controls	<b>0.25</b>	<u>Limitations:</u> Overall - LOW/UNCLEAR RIK OF BIAS.
	<u>Setting:</u> Outpatients (secondary care).		<u>Diagnoses (GINA criteria):</u>  • 1. Healthy controls: n=34.  • 2. Chronic cough: n=21.  • 3. Asthma: n=88	<u>Reference standard</u> N/A	Chronic cough	<b>0.21</b>	
	<u>Country:</u> France		<u>Current smokers:</u> N/A.	<u>Time between index test and reference standard:</u> N/A	Asthma	<b>0.40</b>	<u>Additional data:</u> N/A
LABBE 2001	<u>Recruitment:</u> Feb 1997- March 1999.	<u>Exclusion criteria:</u>  • None reported.	<u>Current anti-asthma Tx:</u> Some pts.	<u>Target condition</u>  • Asthma.			
			<u>Drop-outs/missing values:</u> None reported.				

**Table 90: METSO 2000<sup>1127</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
Metso T, Kilpiö K, Björkstén F, Kiviranta K, Haahtela T. Detection and treatment of early asthma. Allergy. 2000 May;55(5):505-9.  METSO 2000	<p><u>Study type:</u> Case-control study (pt groups within this were randomly assigned to Tx groups for 6 weeks)).</p> <p><u>Data source:</u> Hospital staff recruited patients</p> <p><u>Setting:</u> Hospital</p> <p><u>Country:</u> Finland</p> <p><u>Recruitment:</u> 80 consecutive patients</p>	<p>N = 190 (N=30 control and N=160 asthma – N=39 budesonide, N=39 terbutaline).</p> <p><u>Inclusion criteria:</u> Subjective symptoms for &lt;1 year. At least one of the following lung-function test outside the reference range: FEV1 improvement &gt;15% after inhaled beta2 agonist PEF diurnal variation &gt;15% and PEF increase of &gt;15% after inhaled beta2-agonist at least once during a 2 week period</p> <p><u>Exclusion criteria:</u> treatment with anti-inflammatory medication, lung diseases other than asthma, and respiratory tract infection in the previous 4 weeks. Past and present long-term respiratory diseases including asthma, respiratory tract infections and preceding 4 weeks and hyper responsiveness to histamine.</p>	<p><u>Male: Female</u> Budesonide 32/7 Terbutaline 31/10 Controls 28/2</p> <p><u>Age:</u> 16-60</p> <p><u>Severity of asthma:</u> Mild/Moderate Budesonide 31/8 Terbutaline 30/11 Controls 0/0</p> <p><u>Current smokers:</u> Budesonide 14 Terbutaline 9 Controls 0</p> <p><u>Current a-asthma Tx:</u></p> <p><u>Drop-outs/missing values:</u> NA</p>	<p><u>Index test</u> <b>Peripheral blood eosinophils</b></p> <p><b>CUT-OFF: NA</b></p> <p><u>Reference standard</u> N/A</p> <p><u>Target condition</u> <u>NA</u></p>	<b>Blood eosinophils 10<sup>9</sup>/L</b>	<p><b>Control:</b> 0.13</p> <p><b><u>Budesonide group:</u></b> <b>Pre-Tx:</b>0.20 <b>Post-Tx (6 wks):</b> 0.11**</p> <p><b><u>Terbutaline group</u></b> <b>Pre-Tx:</b> 0.16 <b>Post-Tx (6 wks):</b> 0.14</p> <p><b>Post-Tx (6 wks terbutaline + 2 ks budesonide):</b> 0.12**</p> <p>** p&lt;0.05 vs baseline</p>	<p><u>Source of funding:</u> Research institute of Helsinki University Central Hospital and the Finnish Allergy Research Foundation.</p> <p><u>Limitations:</u> Overall - LOW/UNCLEAR RISK OF BIAS.</p> <p><u>Additional data:</u> N/A</p>

**Table 91: NORDLUND 2012<sup>1245</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
<p>Nordlund B, Konradsen JR, Kull I, Borres MP, Önell A, Hedlin G, Grönlund H. IgE antibodies to animal-derived lipocalin, kallikrein and secretoglobulin are markers of bronchial inflammation in severe childhood asthma. Allergy. 2012 May;67(5):661-9.</p> <p>NORDLUND 2012</p>	<p><u>Study type:</u> Case-series</p> <p><u>Data source:</u> Hospital based paediatric clinics</p> <p><u>Setting:</u> Outpatients (secondary care)</p> <p><u>Country:</u> Denmark</p> <p><u>Recruitment:</u> Hospital based paediatric clinics</p>	<p>N = 39 (mild to moderate)</p> <p><u>Inclusion criteria:</u> Children from 7 to 18 years of age with diagnosed asthma according to the Global initiative for asthma (GINA). At least 6months of regular treatment with ICS, min 800 microgram of budesonide or equivalent for problematic severe asthma and 100-400 microgram budesonide or equivalent for children with mild to moderate asthma. Physician diagnosed asthma.</p> <p><u>Exclusion criteria:</u> children with lung or neurological diseases, as well as those born prematurely (gestational age &lt;36 weeks) were excluded.</p>	<p><u>Male:female</u> 59: 41</p> <p><u>Age:</u> 13.8±2.9 years</p> <p><u>Severity of asthma:</u> Controlled mild to moderate. And severe patients were included.</p> <p><u>Current smokers:</u> 35 to 53%</p> <p><u>Current anti-asthma</u> Inhaled or oral corticosteriod</p> <p><u>Drop-outs/missing values:</u> Unclera</p>	<p><u>Index test</u> <b>Peripheral blood eosinophils</b></p> <ul style="list-style-type: none"> <li>• Venous blood sample and the number of eosinophil were measured.</li> </ul> <p><u>Reference standard</u> N/A</p> <p><u>Target condition</u> NA</p>	<p><b>Blood count of eosinophils (10<sup>9</sup> x 1<sup>-1</sup>, mean SD)</b></p>	<ul style="list-style-type: none"> <li>• Mild to moderate asthma 0.25± 0.19</li> </ul>	<p><u>Source of funding:</u> Freemason Child House Foundation Swedish Asthma and Allergy Associations Research Fund and Swedish Heart and Lung Foundation</p> <p><u>Limitations:</u> Overall - LOW/UNCLEAR RISK OF BIAS.</p> <p><u>Additional data:</u> N/A</p>

**Table 92: PIIPPOSAVOLAINEN 2007<sup>1344</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
E Piippo-Savolainen, S Remes, and M Korppi. Does blood eosinophilia in wheezing infants predict later asthma? A prospective 18-20-year follow-up. <i>Allergy Asthma Proc.</i> 28 (2):163-169, 2007.  PIIPPOSAVOLAINEN 2007	<u>Study type:</u> Case-series (prospective)  <u>Data source:</u> Infants hospitalised for bronchiolitis.  <u>Setting:</u> Hospital (secondary care).  <u>Country:</u> Finland.  <u>Recruitment:</u> 1981-1982.	N = 83  <u>Inclusion criteria:</u> <ul style="list-style-type: none"> <li>• Infants (&lt;2 years) hospitalised for bronchiolitis</li> <li>• Bronchiolitis: respiratory wheezing and/or prolonged expirum during lower respiratory infection.</li> </ul> <u>Exclusion criteria:</u> None reported.	<u>Male: Female</u> Not reported.  <u>Mean age:</u> <2 years (mean or range not given).  <u>Diagnoses:</u> N/A at baseline.  <u>Current smokers:</u> N/A  <u>Current anti-asthma Tx:</u> Not reported.  <u>Drop-outs/missing values:</u> None reported.	<u>Index test</u> <b>Peripheral blood eosinophils</b> <ul style="list-style-type: none"> <li>• Fuchs-Rosenthal counting chamber.</li> </ul> <b>CUT-OFF:</b> N/A  <u>Reference standard</u> N/A  <u>Time between index test and reference standard:</u> N/A  <u>Target condition</u> <ul style="list-style-type: none"> <li>• Asthma</li> </ul>	<b>BASELINE VALUES</b> <b>Population: wheezing</b>  Wheezing (all 83 pts)	<b>Eosinophils, median (25<sup>th</sup>-75<sup>th</sup> percentile)</b> <small>counts</small> 0.1 x 10 <sup>9</sup> /L (0.028 – 0.321)	<u>Source of funding:</u> None reported.  <u>Limitations:</u> Overall - LOW/UNCLEAR RISK OF BIAS.  <u>Additional data:</u> N/A

**Table 93: POPOVIC 2002<sup>1367</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
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Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures		Effect sizes		Comments
					Asthma	Ref std +	Ref std -	Total	
S. Popovic-Grle, M. Mehulic, F. Pavicic, I. Babic, and Z. Beg-Zec. Clinical validation of bronchial hyperresponsiveness, allergy tests and lung function in the diagnosis of asthma in persons with dyspnea. <i>Coll. Antropol.</i> 26 Suppl:119-127, 2002.  POPOVIC 2002	<u>Study type:</u> Diagnostic Cross-sectional study  <u>Data source:</u> Outpatients with dyspnoea, treated for breathlessness; referred by GP due to suspected asthma.  <u>Setting:</u> Outpatients (secondary care)  <u>Country:</u> Croatia  <u>Recruitment:</u> Not reported	N =195 <b>(FINAL Dx:</b> N=141 asthma, N=17 COPD, N=29 rhinitis/sinusitis, N=8 unsolved so further examined)  <u>Inclusion criteria:</u> • Outpatients treated for breathlessness  <u>Exclusion criteria:</u> • None reported.	<b>ASTHMA pts</b>  <u>Male: Female</u> 48%:52%  <u>Mean age:</u> 39 years  <u>Current smokers:</u> 20%  <u>Current anti-asthma Tx:</u> Not mentioned  <u>Drop-outs/missing values:</u> None	<u>Index test</u> <b>Peripheral blood eosinophils</b>  • Method not mentioned  <b>CUT-OFF:</b> positive = not reported.  <u>Reference standard</u> <b>Physician Dx (pulmonologist)</b> Based on questionnaire (medical history of occasional asthma attacks with wheezing and nocturnal waking due to dyspnoea), and on the basis of bronchodilation test (reversible obstruction) with salbutamol.  Time between index test and reference standard: unclear  <u>Target condition</u> Asthma. N=141 were people with diagnosed asthma.	Asthma	Ref std +	Ref std -	Total	<u>Source of funding:</u> Not reported.  <u>Limitations:</u> Overall - LOW/UNCLEAR RIK OF BIAS.  <u>Additional data:</u> N/A
					Eosin +	21	33	54	
					Eosin -	120	21	141	
					Total	141	54	195	
					Sensitivity	15% (21/141)			
					Specificity	39% (21/54)			
					PPV	64% (21/33)			
					NPV	74% (120/162)			
					PLR and NLR	-			
					AUC	-			
% eosinophils in asthma pts, mean (SD)	Not reported								

**Table 94: POSTMA 1995<sup>1370</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures		Effect sizes		Comments
					Asthma	Ref std +	Ref std	Total	
D. S. Postma and M. D. Lebowitz. Persistence and new onset of asthma and chronic bronchitis evaluated longitudinally in a community population sample of adults. <i>Arch. Intern. Med.</i> 155 (13):1393-1399, 1995.  POSTMA 1995	<u>Study type:</u> Diagnostic Cross-sectional study  <u>Data source:</u> Adults from an epidemiologic study of obstructive airway disease.  <u>Setting:</u> General population  <u>Country:</u> USA  <u>Recruitment:</u> Original study: 1972-1985	N =2169 (N=2130 had Dx data) ( <b>FINAL Dx:</b> N=345 any asthma, N=303 emphysema and/or chronic bronchitis, N=124 Low 1 <sup>st</sup> FEV1, N=1358 none)  <u>Inclusion criteria:</u> Age ≥20 years  <u>Exclusion criteria:</u> None reported.	<b>Reported in a separate publication (Lebowitz 1989)</b>  <u>Male: Female</u> -  <u>Mean age:</u> Adults (details not reported)  <u>Current smokers:</u> -  <u>Current anti-asthma Tx:</u> -  <u>Drop-outs/missing values:</u> -	<u>Index test</u> <b>Peripheral blood eosinophils</b>  Stained slides counted from the 1st and 6 <sup>th</sup> surveys.  <b>CUT-OFF:</b> eosinophilia (positive) = ≥5% 1st survey, or ≥3% 6 <sup>th</sup> survey. Based on distribution of all values in either survey.  <u>Reference standard</u> <b>Physician Dx</b>  Based on questionnaire (symptoms) and clinical evaluations (including FVC, and reversibility of airways obstruction (FEV1 before and after 5 mins after inhalation of 2 puffs of isoproterenol hydrochloride from a metered dose inhaler).  Time between index test and reference standard: unclear  <u>Target condition</u> Asthma. N=345 were people with diagnosed asthma.	Asthma	Ref std +	Ref std	Total	<u>Source of funding:</u>  Dutch Asthma fund and National Heart, Lung and Blood Institute, USA.  <u>Limitations:</u> Overall - LOW/UNCLEAR RISK OF BIAS.  <u>Additional data:</u> N/A
					Eosin +	103	-	-	
					Eosin -	242	-	-	
					Total	345	1989	2130	
					Sensitivity		30% (103/345)		
					Specificity		-		
					PPV		-		
					NPV		-		
					PLR and NLR		-		
					AUC		-		
% eosinophils in asthma pts, mean (SD)		Not reported							

**Table 95: RYTILA 2000<sup>1481</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments	
P. Ryttila, T. Metso, K. Heikkinen, P. Saarelainen, I. J. Helenius, and T. Haahtela. Airway inflammation in patients with symptoms suggesting asthma but with normal lung function. <i>Eur.Respir.J.</i> 16 (5):824-830, 2000.  RYTILA 2000	<u>Study type:</u> Case-control	N = 68 (includes n=43 healthy controls)	<u>Male: Female</u> 41%: 59%	<u>Index test</u> <b>Peripheral blood eosinophils</b> <ul style="list-style-type: none"> <li>Method not reported.</li> </ul>	<b>Population (baseline)</b>	<b>Eosinophils mean</b> x10 <sup>9</sup> /l	<u>Source of funding:</u> None reported.  <u>Limitations:</u> Overall - LOW/UNCLEAR RISK OF BIAS.  <u>Additional data:</u> N/A	
	<u>Data source:</u> Consecutive pts with respiratory symptoms, and healthy controls.		<u>Inclusion criteria:</u> <ul style="list-style-type: none"> <li>Pts with respiratory symptoms suggestive of asthma.</li> <li>At least 2/6 respiratory symptoms for &gt;2 months and &lt;1 year.</li> <li>Healthy – no respiratory symptoms or history of chronic pulmonary diseases.</li> </ul>	<u>Mean age:</u> 37.7 years (range 15-75).	<b>CUT-OFF:</b> N/A	Healthy controls		<b>0.11</b>
	<u>Setting:</u> Outpatients (secondary care).		<u>Exclusion criteria:</u> <ul style="list-style-type: none"> <li>Pts treated with anti-inflammatory asthma medication.</li> </ul>	<u>Diagnoses:</u> <ul style="list-style-type: none"> <li>1. Healthy controls (normal lung function tests): n=43</li> <li>2. Respiratory symptoms (no significant airflow variability, and not hyperresponsive): n=36</li> <li>3. Asthma (FEV1 increase ≥12% 15 mins after SABA, or PEF varied by &gt;12% from morning to evening for ≥3 days during 2-week follow-up. Had increased bronchial responsiveness to inhaled histamine): n=25</li> </ul>	<u>Reference standard</u> N/A	Respiratory Symptoms		<b>0.17</b>
	<u>Country:</u> Finland		<u>Recruitment:</u> Oct 1996-March 1997.	<u>Current smokers:</u> 31% <u>Current anti-asthma Tx:</u> Not reported.	<u>Time between index test and reference standard:</u> N/A	Asthma		<b>0.41</b>
				<u>Drop-outs/missing values:</u> None reported.	<u>Target condition</u> <ul style="list-style-type: none"> <li>Asthma.</li> </ul>	Atopic asthma		0.51
								Non-atopic asthma

**Table 96: SHIELDS 1999<sup>1562</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
Shields MD, Brown V, Stevenson EC, Fitch PS, Schock BC, Turner G, Taylor R, Ennis M. Serum eosinophilic cationic protein and blood eosinophil counts for the prediction of the presence of airways inflammation in children with wheezing. Clin Exp Allergy. 1999 Oct;29(10):1382-9.  SHIELDS1999	<u>Study type:</u> Cross sectional study  <u>Data source:</u> Wheezing children undergoing an elective surgical procedure for a non-inflammatory condition at the Hospital  <u>Setting:</u> Hospital  <u>Country:</u> Northern Ireland  <u>Recruitment:</u> -	N = 137  <u>Inclusion criteria:</u> <ul style="list-style-type: none"> <li>History of wheezing in the previous year</li> <li>Free from recent respiratory infection.</li> </ul> <u>Exclusion criteria:</u> Alternative causes of wheezing.	Male N=48 Female N=29  <u>Age:</u> 1-15 years (mean not reported)  <u>Severity of asthma:</u> Atopic asthma  <u>Current smokers:</u> N/A  <u>Current anti-asthma Tx:</u> 43 were taking anti-inflammatory therapy, however there was no effect on blood eosinophil counts.  <u>Drop-outs/missing values:</u>	<u>Index test</u> <b>blood eosinophils</b> <ul style="list-style-type: none"> <li>Blood sample taken pre-surgery. Eosinophil counts obtained from blood smears by routine methods.</li> </ul> <b>CUTOFF positive</b> = 4% and 8% (elevated).  <u>Reference standard</u> <b>Physican Dx</b> Detailed asthma and allergy history.  Diagnoses: 1. Atopic asthma – symptoms triggered by known aeroallergens, who had other personal atopic features, strong family background of atopy or elevated serum IgE compared to normal values. 2. Viral-associated wheezing – no personal or family background of atopy, wheezing predominantly in winter and solely in association with viral upper RTI.  <u>Target condition</u> Asthma (N=60 atopic asthma diagnosed).	<b>Blood eosinophil %</b>  <b>Area under curve for predicting airways inflammation</b>  <b>Blood eosinophils</b> >4% >8%	<b>All patients</b> N=77 4 (0-25) <b>People with atopic asthma</b> n=60 4.10 (1-25)  <b>Log serum ECP concentration</b> = 0.75 <b>Log blood eosinophil %</b> = 0.76  >4% <b>Sensitivity</b> 62% <b>Specificity</b> 67% <b>PPV %</b> 56% <b>PLR</b> 1.9  >8% <b>Sensitivity</b> 38% <b>Specificity</b> 93% <b>PPV %</b> 78% <b>PLR</b> 5.4	<u>Source of funding:</u> National Asthma Campaign and the Northern Ireland Chest Heart and Stroke Association.  <u>Limitations:</u> Overall - LOW/UNCLEAR RIK OF BIAS.  <u>Additional data:</u> Serum eosinophil percentages in BAL and blood were lowest (NS) when last symptoms occurred more than 12 weeks previously



**Table 97: SILVESTRI 2001A<sup>1583</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments	
M. Silvestri, F. Sabatini, D. Spallarossa, L. Fregonese, E. Battistini, M. G. Biraghi, and G. A. Rossi. Exhaled nitric oxide levels in non-allergic and allergic mono- or polysensitised children with asthma. <i>Thorax</i> 56 (11):857-862, 2001.  SILVESTRI 2001A	<p><u>Study type:</u> Case-control</p> <p><u>Data source:</u> Children with asthma referred to outpatient department.</p> <p><u>Setting:</u> Outpatients (secondary care)</p> <p><u>Country:</u> Italy</p> <p><u>Recruitment:</u> Dates not reported.</p>	<p>N = 112 (N=26 additional healthy controls, but data not given).</p> <p><u>Inclusion criteria:</u></p> <ul style="list-style-type: none"> <li>• Children</li> <li>• History of mild asthma</li> <li>• Positive response to methacholine challenge</li> <li>• Stable clinical condition</li> <li>• Not taken inhaled steroids at least in the year before the study</li> </ul> <p><u>Exclusion criteria:</u> None reported.</p>	<p><u>Male: Female</u> 58%:42%</p> <p><u>Mean age (SD):</u> 10.6 (0.3), range 0-18 years.</p> <p><u>Types of asthma:</u></p> <ul style="list-style-type: none"> <li>• Non-allergic: n=56</li> <li>• Sensitised: n=56                             <ul style="list-style-type: none"> <li>○ Monosensitised (dust mites): n=23</li> <li>○ Polysensitised (dust mites and at least one other allergen class): n=33</li> </ul> </li> </ul> <p><u>Current smokers:</u> N/A</p> <p><u>Current anti-asthma Tx:</u> None reported.</p> <p><u>Drop-outs/missing values:</u> None reported.</p>	<p><u>Index test</u> <b>Peripheral blood eosinophils</b></p> <ul style="list-style-type: none"> <li>• Technicon H6000.</li> </ul> <p><b>CUT-OFF:</b> N/A</p> <p><u>Reference standard</u> N/A</p> <p><u>Time between index test and reference standard:</u> N/A</p> <p><u>Target condition</u> Asthma.</p>	<b>Population: asthma</b>	<b>Eosinophils, % and median (IQR)</b>		<p><u>Source of funding:</u> None reported.</p> <p><u>Limitations:</u> Overall - LOW/UNCLEAR RISK OF BIAS.</p> <p><u>Additional data:</u> N/A</p>
							<b>%</b>	
					All allergic	7.5 (5.0-11.8)	500 (370-855)	
					Mono-sensitised	6.9 (5.3-13.7)	500 (370-893)	
					Poly-sensitised	8.3 (4.9-10.0)	500 (263-750)	
					Non-allergic	2.5 (1.6-4.2)	125 (100-300)	
					<p><b>Children with allergic asthma had SS higher blood eosinophilia - % and absolute numbers:</b></p> <ul style="list-style-type: none"> <li>• median difference %: 4.6, 95% CI 3.2-5.9; p=0.0001</li> <li>• median difference cells/mm<sup>3</sup>: 375, 95% CI 237.9 – 512.1, p=0.0001</li> </ul> <p><b>There was NS difference between mono- and poly-sensitised children (p&gt;0.1).</b></p>			

**Table 98: SILVESTRI 2003<sup>1586</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
M Silvestri, F Sabatini, R Sale, AC Defilippi, L Fregonese, E Battistini, MG Biraghi, and GA Rossi. Correlations between exhaled nitric oxide levels, blood eosinophilia, and airway obstruction reversibility in childhood asthma are detectable only in atopic individuals. <i>Pediatr.Pulmonol.</i> 35 (5):358-363, 2003.  SILVESTRI 2003	<u>Study type:</u> Case-control	N = 92	<u>Male: Female</u> 65%:35%	<u>Index test</u> <b>Peripheral blood eosinophils</b> • Technicon H6000.	<b>Population: asthma</b>	<b>% eosinophils, Median (IQR)</b> %	<u>Source of funding:</u> None reported.
	<u>Data source:</u> Children with atopic asthma and age/gender matched children with non-atopic asthma referred to outpatient department.	<u>Inclusion criteria:</u> • Children • History of mild asthma • Atopic or non-atopic • Not have upper or lower RTIs 2 months before study	<u>Mean age (SD):</u> 10.7 (0.3) years.	<u>CUT-OFF:</u> N/A	All	5.5 (3.0-9.8)	<u>Limitations:</u> Overall - LOW/UNCLEAR RIK OF BIAS.
	<u>Setting:</u> Outpatients (secondary care)	• Atopic or non-atopic • Not taken anti-asthma Tx (except for $\beta_2$ -agonists as necessary – which were avoided 12hrs before study).	<u>Types of asthma:</u> • Atopic: n=66 • Non-atopic: n=26	<u>Reference standard</u> N/A	Atopic	6.7 (4.6-10.7)	<u>Additional data:</u> N/A
	<u>Country:</u> Italy	• Not taken anti-asthma Tx (except for $\beta_2$ -agonists as necessary – which were avoided 12hrs before study).	<u>Current smokers:</u> N/A	<u>Time between index test and reference standard:</u> N/A	Non-atopic	3.0 (1.8-4.3)	
<u>Recruitment:</u> Dates not reported.	<u>Exclusion criteria:</u> None reported.	<u>Current anti-asthma Tx:</u> None reported.	<u>Target condition</u> • Asthma. • Atopic/non-atopic diagnosed according to SPT to common aeroallergens (those sensitised to pollen were tested outside of the pollen season)	<b>Children with atopic asthma had SS higher blood eosinophilia than non-atopic (p=0.001).</b>			
			<u>Drop-outs/missing values:</u> None reported.	<b>Within the atopic group, there was NS difference between mono- and poly-sensitised children (p&gt;0.05).</b>			

**Table 99: TILEMANN 2011<sup>1737</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures		Effect sizes		Comments
					Asthma	Ref std +	Ref std -	Total	
L Tilemann, L Gindner, F Meyer, J Szecsenyi, and A Schneider. Differences in local and systemic inflammatory markers in patients with obstructive airways disease. <i>Prim. care respir. j.</i> 20 (4):407-414, 2011.  TILEMANN 2011	<u>Study type:</u> Diagnostic Cross-sectional study  <u>Data source:</u> Consecutive pts with suspected obstructive airways disease (OAD).  <u>Setting:</u> Primary care  <u>Country:</u> Germany  <u>Recruitment:</u> Dates not mentioned.	N = 210 <b>(FINAL Dx:</b> N=86 asthma, N=36 COPD, N=13 partial reversibility, N=75 No OAD)  <u>Inclusion criteria:</u> <ul style="list-style-type: none"> <li>• Pts presenting for first time to GP with complaints suggestive of OAD</li> <li>• Symptoms: dyspnoea, coughing and/or expectoration persisting for at least 2 months.</li> </ul> <u>Exclusion criteria:</u> <ul style="list-style-type: none"> <li>• Respiratory tract infections in the previous 6 weeks</li> <li>• Well-known contraindications for bronchodilator reversibility testing or bronchial provocation – pregnancy, untreated hyperthyroidism, unstable coronary artery disease, and cardiac arrhythmia.</li> </ul>	<u>Male: Female</u> 45%:55%  <u>Mean age:</u> 49 years  <u>Current smokers:</u> 39%  <u>Current anti-asthma Tx:</u> 5.2% (inhaled corticosteroids)  <u>Drop-outs/missing values:</u> <ul style="list-style-type: none"> <li>• Eosinophils: N=13</li> <li>• FeNO: N=54</li> </ul> Pts were instructed not to use any bronchodilator or inhaled steroid and to stop smoking 12 hrs before assessments.	<u>Index test. Peripheral blood eosinophils</u> <ul style="list-style-type: none"> <li>• Flow cytometry (ADVIA system)</li> </ul> <b>OPTIMAL CUT-OFF:</b> positive = 4.15%.  <u>Reference standard Bronchodilation test (salbutamol)</u> Pts with FEV <sup>1</sup> <80% predicted received BDT with additional whole body plethysmography 20 mins after inhaling 400µg salbutamol. If no obstruction in the first lung function test, a BPT with methacholine was performed.  Diagnoses: <ul style="list-style-type: none"> <li>• COPD (irreversible OAD): FEV<sup>1</sup> &lt;12% and &lt;200mL compared to baseline).</li> <li>• Asthma: (fully reversible OAD): reversibility in FEV<sup>1</sup> &gt;12% and &gt;200mL</li> </ul>	Eosin +	Ref std +	Ref std -	Total	<u>Source of funding:</u> Federal Ministry of Education and Research, Germany.  <u>Limitations:</u> Overall - LOW/UNCLEAR RISK OF BIAS.  <u>Additional data:</u> N/A
					≥4.15%	-	-	-	
					Eosin -	-	-	-	
					≥4.15%	-	-	-	
					Total	86	124	210	
					Sensitivity	36%			
					Specificity	83%			
					PPV	59%			
					NPV	65%			
					PLR and NLR	-			
AUC	0.602 (95% CI 0.50–0.68)								
% eosinophils in asthma pts, mean (SD)	4.1 (3.1); 95% CI 3.3-4.7. Median 3.2								

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
				<p>compared to baseline).</p> <p>Time between index test and reference standard: unclear</p> <p><u>Target condition</u> Asthma. N=86 were diagnosed with asthma.</p>			

**Table 100: TOMASIAKLOZOWSKA 2012<sup>1751</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
MM Tomasiak-Lozowska, Z Zietkowski, K Przeslaw, M Tomasiak, R Skiepkowski, and A Bodzenta-Lukaszyk. Inflammatory markers and	<u>Study type:</u> Case-control	110 (N=91 asthma)  <u>Inclusion criteria:</u> <ul style="list-style-type: none"> <li>Asthma (mild allergic – all atopic and sensitised to common inhaled allergens by SPT).</li> <li>Healthy controls:</li> </ul>	<u>Male: Female:</u> 50%/50% <u>Mean age:</u> 38 years <u>Current smokers:</u> None.  <u>Diagnoses (GINA criteria):</u> <ul style="list-style-type: none"> <li>1. Healthy controls: n=19.</li> <li>2. Stable* asthma, steroid naïve (no ICS Tx in past 3 mths): n=22.</li> <li>3. Stable* asthma, ICS Tx (mild to</li> </ul>	<u>Index test</u> <b>Peripheral blood eosinophils</b> <ul style="list-style-type: none"> <li>Haematological analyser (Coulter).</li> </ul> <b>CUT-OFF:</b> N/A	<b>Population (baseline)</b>	<b>Eosinophils, mean</b>  cells/mm <sup>3</sup>	<u>Source of funding:</u> Grant number given but details not specified.  <u>Limitations:</u> Overall - LOW/UNCLEAR
	<u>Data source:</u> Pts and healthy volunteers.				Healthy controls	<b>32.0</b>	
	<u>Setting:</u> Not				Stable asthma (no ICS)	<b>29.5</b>	

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments	
acid-base equilibrium in exhaled breath condensate of stable and unstable asthma patients. <i>Int.Arch.Allergy Immunol.</i> 159 (2):121-129, 2012.  TOMASIAKLO ZOWSKA 2012	reported.  <u>Country:</u> Poland.  <u>Recruitment:</u> Not reported.	free of RTIs within past 3 months and other significant illness known to affect FeNO mmmts.  <u>Exclusion criteria:</u> <ul style="list-style-type: none"> <li>• Asthma exacerbation</li> <li>• Respiratory disease</li> <li>• Concomitant heart, renal, liver or collagen disease</li> <li>• RTI in the mouth.</li> </ul>	moderate, low to medium ICS dose at constant dose for $\geq 3$ mths): n=35. <ul style="list-style-type: none"> <li>• 4. Severe, unstable asthma, ICS Tx (required <math>\geq 1</math> hospitalisations for asthma and <math>&gt;3</math> oral steroid bursts in previous year. Taking high doses of ICS and LABA <math>\geq 6</math> mths): n=34.</li> </ul> <p>*stable asthma = minimal need for rescue medication (SABA), no exacerbations and no use of systemic steroids in past 12 mths.</p> <p><u>Current anti-asthma Tx:</u> Mild to moderate asthma pts had been Tx with constant low to medium doses of ICS for <math>\geq 3</math> mths.</p> <p><u>Drop-outs/missing values:</u> None reported.</p>	<u>Reference standard</u> N/A  <u>Time between index test and reference standard:</u> N/A  <u>Target condition</u> <ul style="list-style-type: none"> <li>• Asthma.</li> </ul>	Stable asthma (ICS)	<b>42.4</b>	RIK OF BIAS.  <u>Additional data:</u> N/A	
						Unstable asthma (ICS)	<b>49.8</b>	
						No other details of results reported for eosinophil counts.		

**Table 101: TUCHINDA 1987<sup>1777</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
M. Tuchinda, S. Habananada, J. Vareenil, N. Srimaruta,	<u>Study type:</u> Case series (prospective)  <u>Data source:</u>	N = 1000 measured for blood eosinophils (N=2000 whole study)	<u>Male: Female</u> 61%:39%  <u>Age:</u> <13 years	<u>Index test</u> Peripheral blood eosinophils <ul style="list-style-type: none"> <li>• Method not reported.</li> </ul> <p><b>CUT-OFF:</b> Not reported.</p>	Eosinophil counts (cells/mm <sup>3</sup> )	%	<u>Source of funding:</u> None reported.
					0 - 500	39.8	

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
and K. Piromrat. Asthma in Thai children: a study of 2000 cases. <i>Ann.Allergy</i> 59 (3):207-211, 1987.  TUCHINDA 1987	Prospective study of 2000 children with asthma	<u>Inclusion criteria:</u> <ul style="list-style-type: none"> <li>Age &lt;13 years</li> <li>Diagnosis of bronchial asthma.</li> </ul> <u>Exclusion criteria:</u> None reported.	<u>Severity of asthma:</u> <ul style="list-style-type: none"> <li>Mild: 29%</li> <li>Moderate: 61%</li> <li>Severe: 9.6%</li> </ul> <u>Current smokers:</u> N/A	<u>Reference standard :</u> N/A  Time between index test and reference standard: unclear  <u>Target condition</u> Asthma. 63% of pts had other allergic diseases.	501 - 1000	29.4	<u>Limitations:</u> Overall - LOW/UNCLEAR RISK OF BIAS.  <u>Additional data:</u> N/A
	<u>Setting:</u> Outpatients (secondary care)				1001 - 1500	15.7	
	<u>Country:</u> Thailand				1501 - 2000	8.6	
	<u>Recruitment:</u> December 1972-1985				>2000	6.5	

**Table 102: VILA-INDURAIN 1999<sup>1844</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
B. Vila-Indurain, F. Munoz-Lopez, and M. Martin-	<u>Study type:</u> Case-control	N = 57 (includes n=21 healthy controls)	<u>Male:</u> Female Not reported.	<u>Index test</u> <b>Peripheral blood eosinophils</b> <ul style="list-style-type: none"> <li>Flow cytometry.</li> </ul>	<b>Population (baseline – pre BPT)</b>	<b>Eosinophils, mean (SD)</b>	<u>Source of funding:</u> None reported.  <u>Limitations:</u>
	<u>Data source:</u>		<u>Mean age:</u>		Healthy controls	<b>Cells/mm<sup>3</sup></b> 161 (77)	

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
Mateos. Evaluation of blood eosinophilia and the eosinophil cationic protein (ECP) in the serum of asthmatic children with varying degree of severity. <i>Allergol.Immunopathol.(Madrid)</i> . 27 (6):304-308, 1999.  VILA-INDURAIN 1999	Selection of children with asthma and control healthy children.  <u>Setting:</u> Not reported.  <u>Country:</u> Spain  <u>Recruitment:</u> Dates not reported.	<u>Inclusion criteria:</u> • Children age 8-18 years with asthma or healthy controls.  <u>Exclusion criteria:</u> None reported.	Range 8-18 years.  <u>Diagnoses:</u> • 1. Healthy controls (negative allergy and respiratory function tests): n=21 • 2. Asthma (favourably evolving, with normal FEV <sub>1</sub> ): n=19 • 3. Asthma (below normal FEV <sub>1</sub> that normalised with salbutamol): n=13 • 4. Asthma (below normal FEV <sub>1</sub> that did not recover after bronchodilation test): n=14  <u>Current smokers:</u> N/A <u>Current anti-asthma Tx:</u> Not reported. <u>Drop-outs/missing values:</u> None reported.	<u>CUT-OFF:</u> N/A  <u>Reference standard</u> N/A  <u>Time between index test and reference standard:</u> N/A  <u>Target condition</u> • Asthma.	1. Asthma – normal FEV <sub>1</sub>	509 (311)	Overall - LOW/UNCLEAR RIK OF BIAS.  <u>Additional data:</u> N/A
					2. Asthma – below normal FEV <sub>1</sub> normalised with SABA	397 (230)	
					3. Asthma – below normal FEV <sub>1</sub> not normalise after SABA	319 (152)	

1 **Table 103: ZIETKOWSKI 2006A<sup>1957</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
Z. Zietkowski,	<u>Study type:</u>	140 (N=101 asthma)	<u>Male: Female</u>	<u>Index test</u>	<b>Population</b>	<b>Eosinophils,</b>	<u>Source of</u>

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
A. Bodzenta-Lukaszyk, M. Tomasiak, R. Skiepmo, and M. Szmitkowski. Comparison of exhaled nitric oxide measurement with conventional tests in steroid-naive asthma patients. <i>J. Investig. Allergol. Clin. Immunol.</i> 16 (4):239-246, 2006.  ZIETKOWSKI 2006A	Case-control  <u>Data source:</u> Asthma pts and healthy volunteers.  <u>Setting:</u> Not reported.  <u>Country:</u> Poland.  <u>Recruitment:</u> Not reported.	<u>Inclusion criteria:</u> <ul style="list-style-type: none"> <li>• Asthma: stable condition, free from acute exacerbations and RTIs in previous 2 mths.</li> <li>• Healthy: FEV1 &gt; 80% predicted. Free of RTIs for 2 mths before study and from other significant illnesses known to affect FeNO mmts.</li> </ul> <u>Exclusion criteria:</u> <ul style="list-style-type: none"> <li>• Factors that could alter FeNO (such as smoking and nitrate rich diet, but not asthma)</li> <li>• Features of atopy or allergic rhinitis</li> <li>• Tx with ICS in the past.</li> </ul>	41%/59%  <u>Mean age:</u> 35.2 years.  <u>Diagnoses (GINA criteria and history of symptoms and SPT for allergic rhinitis):</u> <ul style="list-style-type: none"> <li>• 1. Healthy controls: n=39.</li> <li>• 2. Allergic asthma: n=56.</li> <li>• 3. Non-allergic asthma: n=45.</li> </ul> <u>Current smokers:</u> Not reported.  <u>Current anti-asthma Tx:</u> Prior to study, pts allowed to take SABA and LABA.  <u>Drop-outs/missing values:</u> None reported.	<u>Peripheral blood eosinophils</u> <ul style="list-style-type: none"> <li>• Haematologic analyser (Coulter).</li> </ul> <u>CUT-OFF:</u> N/A  <u>Reference standard</u> N/A  <u>Time between index test and reference standard:</u> N/A  <u>Target condition</u> <ul style="list-style-type: none"> <li>• Asthma.</li> </ul>	(baseline)	<u>mean</u> cells/mm <sup>3</sup>	<u>funding:</u> None reported.  <u>Limitations:</u> Overall - LOW/UNCLEAR RISK OF BIAS.  <u>Additional data:</u> N/A
					Healthy controls	119	
					Allergic asthma	247	
					Non-allergic asthma	211	
					<ul style="list-style-type: none"> <li>• Asthma: SS higher PBE than healthy controls (P&lt;0.05)</li> <li>• Allergic asthma: NS higher PBE than non-allergic asthma.</li> </ul>		



1 **G.12 Histamine and methacholine challenge tests for diagnosis**

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**Table 104: ANDERSON 2009<sup>48</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments	
					Ref std +	Ref std -	Total			
Anderson et al. 2009. Comparison of mannitol and methacholine to predict exercise-induced bronchoconstriction and a clinical diagnosis of asthma. Resp Res 10: 4.	<u>Study type:</u> Diagnostic cross sectional study  <u>Recruitment:</u> Not mentioned	N = 391 (16 not included in PP analysis reported N=375)  Adults and children/youngpeople. Sn/sp given for: • all ages • <18 yrs only  <u>Inclusion criteria:</u> Aged 6-50 yrs (BMI<35) with signs and symptoms suggestive of asthma according to the NIH questionnaire. • At least step 1 symptoms according to the NAEPPII asthma severity grading (symptoms ≤2 times per week; asymptomatic between exacerbations; exacerbations of only a few hrs to a few days; night time symptoms ≤2 times	<u>Male: Female</u> 182/193  <u>Mean age:</u> 24.3 (10.2) range 6-50 Children n=96 Adults n=279  Medications: Withholding periods of medications summarised in table in paper for inhaled agents, oral BD, CS, other medications, foods, strenuous exercise and tobacco.	<u>Index test</u> MCT – methacholine (Provocholine, CA) delivered from a nebulizer (DeVilbiss 646) by the dosimeter method. Concentrations were 0.0312, 0.0625, 0.125, 0.25, 0.5, 1, 2, 4, 8, 16mg/ml administered (each conc required 5 inhalations and spirometry performed within 3 minutes). PC20 calculated  Cut-off: 16mg/ml  <u>Comparator test</u> Mannitol: mannitol test kit as per standard protocol (Aridol or Osmohale Pharmaxis Ltd). FEV1 measured 60s after each dose: 0, 5, 10, 20, 40, 80, 160, 160, 160mg). 60s after the 0mg capsule, the FEV1 was measured in duplicate at the highest value taken as baseline. PD15 calculated  Cut-off: ≥15% fall in FEV1 ≤635mg					<u>Source of funding:</u> Phase III clinical trial funded by Pharmaxis Ltd and involved in the design and statistics  <u>Limitations:</u> • Indirect population: reported ages 6-50 yrs together. Children reported separately but age 6-18, not age 5-16 as in protocol. • Not all patients included in analysis. • Consecutive or random patient selection not reported.	
					Index test +	122	34	156		
					Index test -	118	101	219		
					Total	240	135	375		
					Sensitivity		50.8%			
					Specificity		74.8%			
					PPV		78.2%			
					NPV		46.1%			
						Mann +	Mann -	Total		
					Index test +	104	52	156		
Index test -	64	155	219							
Total	168	207	375							

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments
		<p>per month)</p> <ul style="list-style-type: none"> <li>• FEV1 <math>\geq</math>70% predicted at screening</li> </ul> <p><u>Exclusion criteria:</u></p> <ul style="list-style-type: none"> <li>• Firm diagnosis of asthma or an exclusion of the Dx of asthma</li> <li>• Other pulmonary disease</li> <li>• Smoked &gt;1 cigarette per week in the past yr or a <math>\geq</math>10pack year smoking history</li> <li>• Respiratory tract infection within the last 4 weeks</li> <li>• Skin test positive to aeroallergens present in the environment during enrolment or reported worsening symptoms when exposed to these during the study</li> <li>• Dx at screening visit as definitively having asthma (95-100% likelihood) or not having asthma (0-5% likelihood)</li> <li>• Abnormal chest x-ray or ECG</li> </ul>		<p>or 10% fall between consecutive doses.</p> <p><u>Reference standard</u></p> <p>Clinical Dx with objective test: made by respiratory physician at visit 5 with access to data on exercise challenge, history, examination, skin tests and BDR but not methacholine and mannitol challenge tests.</p> <p>Time between index test and reference standard: unclear</p> <p><u>Target condition</u></p> <p>Asthma</p>	<p>Sensitivity 62%</p> <p>Specificity 75%</p> <p>PPV 66.7%</p> <p>NPV 70.8%</p> <p><b>Children &lt;18 yrs (n=115)</b></p> <p>MCT vs reference standard</p> <ul style="list-style-type: none"> <li>• Sensitivity = 66.2%</li> <li>• Specificity = 62.9%</li> </ul>	<ul style="list-style-type: none"> <li>• Unclear time between IT and RS</li> </ul> <p><u>Additional data:</u></p> <p>Consisted of 5 study visits. Objective tests performed on first visit and physician assigned one of 6 asthma likelihood – those with 5-95% likelihood included. Visit 2 and 3 confirmed spirometry at screening and an exercise test. Visit 4 and 5 was randomised crossover of either mannitol or methacholine. Likelihood of asthma determined again after visit 5 – but Dx of asthma for ref standard determined by physician blinded to challenge tests.</p>

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments
		<ul style="list-style-type: none"> <li>Failure to observe washout of medications</li> </ul>				

**Table 105: HEDMAN 1998<sup>647</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
Hedman et al. 1998. A rapid dosimetric methacholine challenge in asthma diagnostic : a clinical study of 230 patients with dyspnoea, wheezing or a cough of unknown cause.	<u>Study type:</u> Diagnostic cross sectional study  <u>Setting:</u> Hospital pulmonary department <u>Country:</u> Finland <u>Recruitment:</u> Consecutive patients tested with the MCT from May to Sept 1994	N = 230 Adults <u>Inclusion criteria:</u> Referred due to dyspnoea, wheezing or a cough of unknown cause  <u>Exclusion criteria:</u> Previous asthma Dx; use of inhaled steroids during the preceding 4 weeks  FEV1 of at least 65% before challenge test and no respiratory infection during previous 4 weeks.	<u>Male: Female</u> 90/140  <u>Mean age:</u> 44.3 (16) Current smokers n=39  Medications: - Beta2-agonist used by 58% patients with a positive MCT and 32% of patients with a negative MCT - anticholinergic drug used by 5% patients with a	<u>Index test</u> RAPID dosimetric MCT performed with a pocket turbine spirometer (MicroSpirometer, Micro Medical Instruments). An automatic, inhalation synchronised dosimeter jet nebuliser (Spira Elektro 2, Respiratory Care Centre, Finland)used for MCh delivery. After nebulisation of 33g isotonic saline, MCh delivered in four doses 80, 400, 1700, 6900µg. FEV1 measured 90s after each dose. The concentrations were 2.5, 10, 40 and 160 mg/ml. PD20 calculated  Cut-off PD20≤6900µg  <u>Comparator test</u> None		Ref std +	Ref std -	Total	<u>Source of funding:</u> Not reported  <u>Limitations:</u> <ul style="list-style-type: none"> <li>Unclear time between IT and RS</li> </ul> <u>Additional data:</u>
					Index test +	47	31	78	
					Index test -	14	138	152	
					Total	61	169	230	
					Sensitivity		77.0%		
					Specificity		81.7%		
					PPV	60.3%			
NPV	90.8%								
PLR									
NLR									

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables		Comments
Resp Med 92: 32-39.			<p>positive MCT and 21% of patients with a negative MCT</p> <p>No use of beta2-agonists for 12hrs prior to MCT, or any other asthma or antihistamine drug for 48hrs (terfenadine for 1 week and astemitsole for 4 weeks)</p>	<p><u>Reference standard</u> Physician Dx with objective test (according to guidelines of the American Thoracic Society). The person who classified the patients as having or not having asthma was blinded to MCT results. Patients had to have a documented variation in FEV or PEF of 15% or greater after medication, or repeatedly a 20% or greater spontaneous daily variation in PEF monitoring during a period of 2 weeks. In addition, a 15% or greater decrease in FEV, after a specific allergen provocation or during an exercise test was a criterion for diagnosing bronchial asthma.</p> <p>Time between index test and reference standard: unclear</p> <p><u>Target condition</u> Bronchial asthma</p>	AUC		

1 **Table 106: KOSKELA 2003** <sup>905</sup>

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables			Comments	
Koskela et al.	<u>Study type:</u>	N=42	<u>Male: Female</u>	<u>Index test</u>	PD15 ≤1mg/ml	Ref std +	Ref std -	Total	<u>Source of funding:</u>

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
					Index test +	Index test -	Total	Sensitivity Specificity	
Responsiveness to three bronchial provocation tests in patients with asthma. Chest 2003; 124(6):21-71.	Comparative test vs test study <u>Data source:</u>  <u>Setting:</u> Outpatient clinic <u>Country:</u> Finland <u>Recruitment:</u> Consecutive patients with a new diagnosis of asthma over an 18 month period	Consecutive patients with a new Dx of asthma over a 18 month period <u>Inclusion criteria:</u> Asthma Dx based on patient history and clinical examination, including objective evidence of reversible airway obstruction (positive exercise challenge; BDR; PEFV or PEF improvement with BD) according to the Finnish Social Insurance Institute criteria.  <u>Exclusion criteria:</u> Previous usage of inhaled or oral CS; febrile respiratory tract infection within 4 weeks; FEV1<50% predicted; if staff physician considered COPD the most probable diagnosis.	21/16 <u>Mean age:</u> 49 (44-54)  Current smokers n=6  Medications: subjects refrained from taking short-acting beta2-agonists for 6 hrs, inhaled anti-cholinergic drugs for 8 hrs, and theophylline for 24 hrs prior to HCT.	HCT – administered using Spiro Elektro 2 dosimeter nebuliser (Respiratory Care Centre, Finland) . Nebulisation time 0.4s, set to start 100ms after beginning of inspiration. Starting dose 25µg with 4-fold increases until the FEV1 fallen by 15% or max dose of 1600µg administered  Cut-off: PD15 ≤1mg and PD15 ≤0.4mg  <u>Reference standard</u> Mannitol – spray dried powder packed in gelatin capsules containing 5, 10, 20 and 40mg (inhaled in doubling doses up to 160mg and repeated 3 times using an Inhalator). Test until 15% fall in FEV1 or cumulative dose of 635mg reached  Cut-off: >15% fall in FEV1 regardless of dose  Time between index test and reference standard: 2 days to 2 weeks.  <u>Target condition</u> Asthma (with +ve mannitol	19	11	30	Not reported  <u>Limitations:</u> Comparator test used as reference standard as all people had asthma  <u>Additional data:</u> Mannitol, cold air and histamine tests given in random order within 2 weeks and at least 2 days before challenges (within 3 weeks of asthma Dx).	
					0	7	7		100% 38.9%
					19	18	37		
					PPV NPV		63.3% 100%		
					PD15 ≤0.4mg/ml	Ref std +	Ref std -		Total
					Index test +	16	2		18
					Index test -	3	16		19
					Total	19	18		37
					Sensitivity Specificity PPV NPV		84.2% 88.9% 88.9% 84.2%		

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables			Comments
				response)				

**Table 107: KOWAL 2009<sup>914</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
Kowal et al. Exhaled Nitric Oxide in Evaluation of Young Adults with Chronic Cough. 2009. Journal of Asthma 46: 692-698.	<u>Study type:</u> Diagnostic cross sectional study  <u>Data source:</u> (if it comes from records for instance)  <u>Setting:</u> Asthma Clinic  <u>Country:</u> Poland  <u>Recruitment:</u> Patients referred by family doctors to the clinic between Sept 2000	N = 540  <u>Inclusion criteria:</u> Patients referred to the asthma clinic for evaluation of chronic cough  Non smokers with non-productive cough of at least 8 weeks in duration, no abnormality on chest radiograph and baseline lung function within normal limits  <u>Exclusion criteria:</u> Use of anti-asthma medication before the study; treatment with ACE inhibitors; use of codeine or other cough	<u>Male: Female</u>  <u>Mean age:</u> 26.5 range 18-45 years  Other Dx made were rhinitis; GERD	<u>Index test</u> HCT – doubling concentrations of histamine (aerosol generated using a DeVilbis 646 nebuliser attached to a Rosenthal French dosimeter). Five inspiratory capacity breaths of each conc. FEV1 measured 90s after each fifth inhalation. Starting at 0.62mg/ml until 20% decrease or concentration of 32mg/ml reached.  Cut-off: 8mg/ml  <u>Comparator test</u> FENO  <u>Reference standard</u> Significant diurnal changes in PEF or significant improvement of FEV1 on administration of 200µg of		Ref std +	Ref std -	Total	<u>Source of funding:</u>  <u>Limitations:</u> <ul style="list-style-type: none"> <li>• Consecutive or random patient selection not reported</li> <li>• RS 6 months after IT</li> <li>• Unclear if reference standard performed without knowledge of the results of the Index test</li> </ul> <u>Additional data:</u> Data provided on a healthy
					Index test +	166	0	166	
					Index test -	12	362	374	
					Total	178	362	540	
					Sensitivity		93.3%		
					Specificity		100%		
					PPV	100%			
					NPV	96.8%			
PLR									
NLR									
AUC									

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments
	and Nov2006	suppressant; upper respiratory tract infection within 4 weeks of the study; presence of any systemic disease; contradictions to HCT.		salbutamol according to the Global Initiative of Asthma (GINA) guidelines.  Time between index test and reference standard: 6 months (observed for 6 months after HCT before Dx)  <u>Target condition</u> Bronchial asthma		control group but not included here for calculation of sn/sp

**Table 108: NIEMINEN 1992<sup>1229</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments			
Nieminen M.M. Unimodal Distribution of Bronchial Hyperresponsiveness to Methacholine in Asthmatic Patients. Chest: 102 (5): 1537-	<u>Study type:</u> Diagnostic cross sectional study  <u>Data source:</u>  <u>Setting:</u> Pulmonary Department, University Hospital	N = 791 Adults <u>Inclusion criteria:</u> dyspnoea, wheezing, prolonged cough, or a history of asthma. referred to the clinic and tested with methacholine challenge <u>Exclusion criteria:</u>	<u>Male: Female</u> 319/472 <u>Mean age:</u> 43.2 (SD 14.0)  179 current smokers  Oral beta-agonists and inhaled anti-cholinergic drugs were withheld for 12	<u>Index test</u> MCT performed using a dosimeter technique with tidal breathing. An automatic, inhalation synchronised dosimeter jet nebuliser (Spira Elektro 2, Respiratory Care Centre, Finland) used for MCh delivery. Nebulisation time 0.5s, set to start 100ms after beginning of inspiration. After nebulisation of saline, MCh delivered in five cumulative doses of 18, 72, 270, 810, and 2,600 µg (concentration of MCh was 2.5 mg/ml for the doses 18 to 270µg and 25 mg/ml	Ref std +	Ref std -	Total	<u>Source of funding:</u> Supported by a grant from Suomen Astra Ltd.  <u>Limitations:</u> • Unclear if reference standard performed without knowledge of	
					Index test +	283	114		397
					Index test -	36	358		394
					Total	319	472		791
					Sensitivity Specificity	88.7% 75.8%			

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables		Comments
1543	<p><u>Country:</u> Finland</p> <p><u>Recruitment:</u> consecutive patients referred to pulmonary department with respiratory symptoms. March 1988 – Sept 1989</p>		hours, inhaled beta-agonists for 8 hours and theophylline compounds for 48 hours before the MCT	<p>for the doses 810 to 2,600µg). FEV1 PD20 calculated</p> <p>Cut-off: 2,600µg</p> <p><u>Comparator test</u> None</p> <p><u>Reference standard</u> Clinical Dx according to the guidelines defined by the American Thoracic Society, a typical history with chronic or repeated symptoms, and a documented variation in FEV1 or in PEFr of more than 15 percent after medication, or repeatedly 20 percent spontaneous daily variation in PEFr monitoring during a period of two weeks. In addition, a 15 percent decrease in air flow after specific allergen provocation or in an exercise test was a criterion for diagnosing bronchial asthma.</p> <p>Time between index test and reference standard: unclear</p> <p><u>Target condition</u> Bronchial asthma</p>	<p>PPV 71.3%</p> <p>NPV 90.9%</p> <p>PLR</p> <p>NLR</p>		<p>the results of the Index test.</p> <ul style="list-style-type: none"> <li>Unclear time between IT and RS</li> </ul> <p><u>Additional data:</u> Data provided on a healthy control group but not included here for calculation of sn/sp</p>



**Table 109: POPOVIC 2012<sup>1367</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
					Ref st +	Ref st -	Total		
Popovic-Grle et al., 2002. Clinical validation of bronchial hyperresponsiveness, allergy tests and lung function in the diagnosis of asthma in persons with dyspnea. Collegium Antropologicum: 26 Suppl: 119-127  REF ID: POPOVIC 2002	<u>Study type:</u> Cross-sectional study  <u>Setting:</u> Outpatient department, University Hospital  <u>Country:</u> Croatia  <u>Recruitment:</u> Random	N = 195 Adults <u>Inclusion criteria:</u> • Referred by GP with suspected asthma and symptoms of breathlessness / dyspnoea.  <u>Exclusion criteria:</u> • Serious diseases of other organ systems or the lungs (apart from those of an obstructive and/or allergic nature)	<u>Male, %</u> 51% of those given an asthma Dx  <u>Mean age:</u> 36.5 (6.2) in those given an asthma Dx (n=141)  Medications: Not reported	<u>Index test</u> Methacholine Challenge test (initial concentration of 0.03mg/ml, increased by doubling concentrations to 8mg/ml)  Cut-off: 8mg/ml suggested as highest concentration given  <u>Comparator test</u> n/a  <u>Reference standard</u> Dx made on the basis of questionnaire, with typical medical history data of occasional asthma attacks with wheezing and nocturnal awakening because of dyspnoea, and reversible bronchial obstruction after salbutamol test (no further details stated)  Time between index test and reference standard: same time  <u>Target condition</u>					<u>Source of funding:</u> Not reported  <u>Limitations:</u> • Details of reference standard objective test not given • Unclear if RS results interpreted without knowledge of the IT results • Unclear if IT results interpreted without knowledge of the RS results (but objective) • Value reported in text for positive MCT result do not match other
					Index test +	137	9	146	
					Index test -	4	45	49	
					Total	141	54	195	
					Sensitivity	97.2%			
					Specificity	83.3%			
					PPV	93.8%			
					NPV	91.8%			

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
				Asthma					results  <u>Additional data:</u>

## G.13 Mannitol challenge test for diagnosis

Table 110: ANDERSON 2009<sup>48</sup>

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
Anderson et al. 2009. Comparison of mannitol and	<u>Study type:</u> Diagnostic cross sectional study	N = 391 (16 not included in PP analysis reported N=375) Adults and children/youngpeo	<u>Male: Female</u> 182/193  <u>Mean age:</u> 24.3 (10.2) range 6-50	<u>Index test</u> Mannitol: mannitol test kit as per standard protocol (Aridol or Osmohale Pharmaxis Ltd). FEV1 measured 60s after each dose: 0, 5, 10, 20, 40, 80, 160, 160, 160mg). 60s after the 0mg capsule, the		Ref std +	Ref std -	Total	<u>Source of funding:</u> Phase III clinical trial funded by Pharmaxis Ltd and involved in the design and
					Index test +	134	34	168	
					Index test -	106	101	207	

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables				Comments
methacholine to predict exercise-induced bronchoconstriction and a clinical diagnosis of asthma. Resp Res 10: 4. <sup>48</sup>	Recruitment: Not mentioned	<p>ple. Sn/sp given for:</p> <ul style="list-style-type: none"> <li>all ages</li> <li>&lt;18 yrs only</li> </ul> <p><u>Inclusion criteria:</u> Aged 6-50 yrs (BMI&lt;35) with signs and symptoms suggestive of asthma according to the NIH questionnaire.</p> <ul style="list-style-type: none"> <li>At least step 1 symptoms according to the NAEPPII asthma severity grading (symptoms ≤2 times per week; asymptomatic between exacerbations; exacerbations of only a few hrs to a few days; night time symptoms ≤2 times per month)</li> <li>FEV1 ≥70% predicted at screening</li> </ul> <p><u>Exclusion criteria:</u></p> <ul style="list-style-type: none"> <li>Firm diagnosis of asthma or an</li> </ul>	<p>Children n=96 Adults n=279</p> <p>Medications: Withholding periods of medications summarised in table in paper for inhaled agents, oral BD, CS, other medications, foods, strenuous exercise and tobacco.</p>	<p>FEV1 was measured in duplicate at the highest value taken as baseline. PD15 calculated</p> <p>Cut-off: ≥15% fall in FEV1 ≤635mg or 10% fall between consecutive doses.</p> <p><u>Comparator test</u> Exercise: running on a treadmill whilst breathing medical grade dry air to 80-90% predicted HR (220-age) and sustained for 6 minutes. FEV1 measured 5, 10, 15 and 30 mins after and % fall in FEV1 calculated by subtracting lowest value after exercise from pre-exercise value</p> <p>Cut-off: positive if fall in FEV1 ≥10%</p> <p><u>Reference standard</u> Clinical Dx with objective test: made by respiratory physician at visit 5 with access to data on exercise challenge, history, examination, skin tests and BDR but not mannitol challenge tests.</p> <p>Time between index test and reference standard: unclear</p>	Total	240	135	375	<p>statistics</p> <p><u>Limitations:</u></p> <ul style="list-style-type: none"> <li>Indirect population: reported ages 6-50 yrs together. Children reported separately but age 6-18, not age 5-16 as in protocol.</li> <li>Not all patients included in analysis.</li> <li>Consecutive or random patient selection not reported.</li> <li>Unclear time between IT and RS</li> </ul> <p><u>Additional data:</u> Consisted of 5 study visits. Objective tests performed on</p>
					Sensitivity		55.8%		
					Specificity		74.8%		
					PPV		79.8%		
					NPV		48.8%		
						Ex +	Ex -	Total	
					Index test +	95	73	168	
					Index test -	68	136	204	
					Total	163	209	372	
					Sensitivity		58.6%		
Specificity		65.2%							
PPV		56.5%							
NPV		66.7%							

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments
		exclusion of the Dx of asthma <ul style="list-style-type: none"> <li>• Other pulmonary disease</li> <li>• Smoked &gt;1 cigarette per week in the past yr or a ≥10pack year smoking history</li> <li>• Respiratory tract infection within the last 4 weeks</li> <li>• Skin test positive to aeroallergens present in the environment during enrolment or reported worsening symptoms when exposed to these during the study</li> <li>• Dx at screening visit as definitively having asthma (95-100% likelihood) or not having asthma (0-5% likelihood)</li> <li>• Abnormal chest x-ray or ECG</li> <li>• Failure to observe washout of</li> </ul>		<u>Target condition</u> Asthma	<b>Children &lt;18 yrs (n=115)</b> Mannitol vs reference standard <ul style="list-style-type: none"> <li>• Sensitivity = 63.2%</li> <li>• Specificity = 81.4%</li> </ul> Mannitol vs Exercise <ul style="list-style-type: none"> <li>• Sensitivity = 60.1%</li> <li>• Specificity = 58.5%</li> </ul>	first visit and physician assigned one of 6 asthma likelihood – those with 5-95% likelihood included. Visit 2 and 3 confirmed spirometry at screening and an exercise test. Visit 4 and 5 was randomised crossover of either mannitol or methacholine. Likelihood of asthma determined again after visit 5 – but Dx of asthma for ref standard determined by physician blinded to challenge tests.

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Statistical measures and 2x2 tables	Comments
		medications				

1  
2  
3

## G.14 Exercise challenge test for diagnosis

Table 111: AVITAL2000<sup>81</sup>

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures		Effect sizes		Comments
					Asthma	Ref std +	Ref std -	Total	
<b>Exercise, methacholine, and adenosine 5'-monophosphate challenge s in children with asthma: relation to severity of the disease.</b>	<u>Study type:</u> Diagnostic Cross-sectional study  <u>Data source:</u> Paediatric pulmonology clinic  <u>Setting:</u> Secondary care  <u>Country:</u>	N = 135  <u>Inclusion criteria:</u> • American Thoracic Society definition of asthma;  <u>Exclusion criteria:</u> Upper or lower respiratory tract infection in last 4 weeks	<u>Male: Female</u> Not stated  <u>Mean age:</u> 12.4 (3.9) range 6 to 25 years	<u>Index test</u> Exercise test 6 minute treadmill  <b>CUT-OFF:</b> positive = minimum fall in FEV1 of 8.2%  <u>Reference standard</u> <b>Clinical Dx</b> Methacholine challenge (PC20 ≤8mg/mL)  Time between index test and reference standard: within 30 days  <u>Target condition</u> Asthma	Asthma	Ref std +	Ref std -	Total	<u>Source of funding:</u> Not stated  <u>Limitations:</u> None  <u>Additional data:</u> None
					Exercise +	95	1	96	
					Exercise -	37	2	39	
					Total	132	3	135	
					Sensitivity	72%			
Specificity	67%								

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
Pediatric Pulmonology: 30: 207-214 Avital A, Godfrey S, and Springer C 2000. REF ID: <b>AVITAL2000.</b>	Israel  <u>Recruitment:</u> Not stated						

**Table 112: EGGLESTON1979<sup>464</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments		
<b>A comparison of the asthmatic response to methacholine and exercise.</b> Journal of Allergy and Clinical Immunology: 63: 104-110	<u>Study type:</u> Diagnostic Cross-sectional study  <u>Data source:</u> University School of Medicine  <u>Setting:</u> Secondary care	N = 45  <u>Inclusion criteria:</u> • Young adults with asthma  <u>Exclusion criteria:</u> None given	<u>Male: Female</u> 27:18  <u>Mean age:</u> Range 16 to 30 years	<u>Index test</u> Exercise test 5 minutes treadmill  <b>CUT-OFF:</b> positive = $\Delta FEV1 \geq 18\%$ (cut off for 2SD from mean normal response)  <u>Reference standard</u> <b>Clinical Dx</b> Methacholine  Time between index test and reference standard: same time  <u>Target condition</u>	<b>Asthma</b>	Ref std +	Ref std -	Total	<u>Source of funding:</u> Not stated  <u>Limitations:</u> No patients were methacholine-negative so specificity cannot be calculated  <u>Additional data:</u> None
					Exercise +	36	0	36	
					Exercise -	9	0	9	
					Total	45	0	45	
					Sensitivity Specificity	80% Not estimable			

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
Eggleston PA 1979. REF ID: <b>EGGLESTON1979.</b>	<u>Country:</u> USA  <u>Recruitment:</u> Not stated			Asthma			

**Table 113: KERSTEN2009<sup>844</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments		
Kersten ETG et al. Mannitol and exercise challenge tests in asthmatic children. Pediatric Pulmonology 2009; 44: 655-661.  KERSTEN2009	<u>Study type:</u> Diagnostic Cross-sectional study  <u>Data source:</u> Outpatients  <u>Setting:</u> Secondary care  <u>Country:</u> The Netherlands  <u>Recruitment:</u>	N = 25  <u>Inclusion criteria:</u> <ul style="list-style-type: none"> <li>Children with a history of allergic asthma and exercise induced bronchoconstriction recruited from outpatient clinic; clinically stable, otherwise healthy; FEV1 at least 70% predicted normal value; able to run on treadmill and perform reproducible spirometry</li> </ul>	<u>Male: Female</u> 17: 8  <u>Mean age:</u> Mean 12.4 (2.0) years	<u>Index test</u> Exercise challenge running with nose clip on treadmill in cold air at ice ring (temperature 1°C) for 6 minutes  <b>CUT-OFF:</b> positive = ΔFEV1%init >15% for both tests  <u>Reference standard</u> Mannitol challenge up to cumulative dose 6.35mg  Time between index test and reference standard: within 4 weeks  <u>Target condition</u> Asthma	<b>Asthma</b>	Ref std +	Ref std -	Total	<u>Source of funding:</u> Pediatric Research Foundation Enschede, The Netherlands  <u>Limitations:</u> None  <u>Additional data:</u> None
					Cold air exercise +	9	1	10	
					Cold air exercise -	4	11	15	
					Total	13	12	25	
					Sensitivity Specificity		69% 92%		

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
	Not stated	<u>Exclusion criteria:</u> None given					

**Table 114: KLEPACPULANIC2004<sup>877</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments		
<b>Exercise and allergic diseases.</b> Arhiv Za Higijenu Rada i Toksikologiju: 55: 197-204 Klepac-Pulanic T, Macan J, Plavec D, and Kanceljak-Macan B 2004. REF ID: <b>KLEPACPU LANIC2004.</b>	<u>Study type:</u> Diagnostic Cross-sectional study  <u>Data source:</u> Institute for Medical Research and Occupational Health  <u>Setting:</u> Secondary care  <u>Country:</u> Croatia  <u>Recruitment:</u>	N = 35  <u>Inclusion criteria:</u> <ul style="list-style-type: none"> <li>GINA definition of asthma; asthma symptoms and/or taking asthma medication; all positive to histamine; all met EAACI definition of allergic asthma and had positive skin prick tests to at least 1 inhalatory allergen. Allergic rhinitis patients met EAACI definition; negative to histamine; positive skin prick tests to at least 1</li> </ul>	<u>Male: Female</u> Not stated  <u>Mean age:</u> Asthma: range 15 to 48 years; allergic rhinitis: range 15 to 45 years	<u>Index test</u> Exercise test (6 minute treadmill)  <b>CUT-OFF:</b> positive = $\Delta$ FVEV1 $\geq$ 10%  <u>Reference standard</u> <b>Clinical Dx</b> GINA definition of asthma; asthma symptoms and/or taking asthma medication; all positive to histamine; all met EAACI definition of allergic asthma and had positive skin prick tests to at least 1 inhalatory allergen. Allergic rhinitis patients met EAACI definition; negative to histamine; positive skin prick tests to at least 1 inhalatory allergen  Time between index test and reference standard: same time  <u>Target condition</u>	<b>Asthma</b>	Ref std +	Ref std -	Total	<u>Source of funding:</u> Not stated  <u>Limitations:</u> None  <u>Additional data:</u> None
					Exercise +	5	0	5	
					Exercise -	14	16	30	
					Total	19	16	35	
					Sensitivity Specificity	26% 100%			



Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
	Not stated	inhalatory allergen  <u>Exclusion criteria:</u> Exercise test or histamine challenge contra-indicated; upper respiratory viral infection within 3 weeks		Asthma			

**Table 115: LIN1991<sup>1006</sup>**

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments		
<b>A bronchial response comparison of exercise and methacholine in asthmatic subjects.</b> Journal of Asthma: 28: 31-40 Lin CC, Wu JL, Huang WC, and	<u>Study type:</u> Diagnostic Cross-sectional study  <u>Data source:</u> Department of Internal Medicine Chest section  <u>Setting:</u> Secondary care  <u>Country:</u>	N = 22  <u>Inclusion criteria:</u> • People with stable unmedicated asthma; FEV1 >75% normal  <u>Exclusion criteria:</u> None given	<u>Male: Female</u> 12:10  <u>Mean age:</u> Range 20 to 40 years	<u>Index test</u> Exercise test (10 minute treadmill)  <b>CUT-OFF:</b> positive = $\Delta$ FEV1%init >20%  <u>Reference standard</u> <b>Clinical Dx</b> Methacholine challenge  Time between index test and reference standard: Up to 3 weeks  <u>Target condition</u> Asthma	<b>Asthma</b>	Ref std +	Ref std -	Total	<u>Source of funding:</u> The National Science Council of China  <u>Limitations:</u> None  <u>Additional data:</u> None
					Exercise +	9	0	9	
					Exercise -	12	1	13	
					Total	21	1	13	
					Sensitivity Specificity	43% 100%			

Reference	Study type	Number of patients	Patient characteristics	Index test(s) and reference standard + target condition	Outcome measures	Effect sizes	Comments
Lin CY 1991. REF ID: <b>LIN1991.</b>	Taiwan  <u>Recruitment:</u> July 1985 to December 1988						

## G.15 Questionnaires to monitor asthma control

**Table 116: MEER 2009<sup>1797,1803</sup>**

Study (subsidiary papers)	SMASHING trial: Van 2009 <sup>1797,1803</sup> (Van der meer 2010 <sup>1114</sup> )
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=200)
Countries and setting	Conducted in Netherlands; Setting: GP and outpatient clinic, multicentre
Line of therapy	Mixed line
Duration of study	Intervention time: 12 months
Method of assessment of guideline condition	Partially adequate method of assessment/diagnosis: Physician Dx asthma, coded according to International Classification of Primary Care
Stratum	Adults and young people overall: Asthma patients 18- 50 years with ICS prescription, not receiving OCS
Subgroup analysis within study	Not stratified but pre-specified: Level of baseline control
Inclusion criteria	age 18-50 years; prescription of ICS for at least 3 months in the previous year; no serious cormorbid conditions interfering with asthma treatment; access to the internet at home; Dutch language.
Exclusion criteria	Receiving maintenance OCS treatment.
Recruitment/selection of patients	September 2005 to September 2006

Age, gender and ethnicity	Age - Range: 18-50 years. Gender (M:F): 61/139. Ethnicity:
Further population details	1. Education level: Moderate/high level of education (>50% with high education level). 2. Language: Non English speaking (Dutch speaking).
Extra comments	Baseline data: age mean (range): Monitoring 36 (19-50); UC 37 (18-50); FEV1%pred Monitoring 88 (34-133); UC 90 (53-118); AQLQ Monitoring 5.73 (3.66-6.94); UC 5.79 (3.03-7.00); ACQ Monitoring 1.12 (0.07-3.22); UC 1.11 (0-3.86); ICS 100%; ICS/LABA 60%.
Indirectness of population	No indirectness
Interventions	<p>(n=101) Intervention 1: Monitoring asthma control + treatment - Monitoring control questionnaires + treatment. Weekly completion of electronic ACQ and instant feedback of asthma control along with advice on how to adjust treatment according to predefined algorithm and treatment plan (treatment steps according to GINA). - Four consecutive scores <math>\leq 0.5</math> : decrease treatment according to plan- Two scores <math>&gt; 0.5</math> but <math>&lt; 1</math>: increase treatment according to plan- One score <math>\geq 1</math> but <math>&lt; 1.5</math>: immediately increase according to plan- One score <math>&gt; 1.5</math>: immediately increase treatment and contact nurse.. Duration 12 months. Concurrent medication/care: Intervention group only - online education, face-to-face group education (two 60 min sessions) and web communications with an asthma nurse Both groups received a prior basic education session about core information on asthma, action of medications and inhaler technique instructions. All trained to measure FEV1 daily and report highest value of 3 measurements before medications. Reported daytime and nighttime symptoms and ACQ weekly. No feedback provided on ACQ or lung function. Further details: 1. Additional education training : Additional education in both groups 2. Duration of study: <math>\geq 6</math> months</p> <p>(n=99) Intervention 2: Usual care. Asthma care according to Dutch guidelines (based on GINA), recommend medical review and treatment adjustment every 2 to 4 weeks in unstable asthma and once or twice yearly for controlled asthma. Control patients had access to the part of the website on which a diary of symptoms and exacerbations was kept, but not ACQ.. Duration 12 months. Concurrent medication/care: Both groups received a prior basic education session about core information on asthma, action of medications and inhaler technique instructions. All trained to measure FEV1 daily and report highest value of 3 measurements before medications. Reported daytime and nighttime symptoms and ACQ weekly. No feedback provided on ACQ or lung function. Further details: 1. Additional education training : Additional education in both groups 2. Duration of study: <math>\geq 6</math> months</p>
Funding	Academic or government funding (Netherlands organisation for health research and development, ZonMw, and Netherland Asthma Foundation)
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: ONGOING MANAGEMENT BASED ON ACQ SCORE versus USUAL CARE	

<p>Protocol outcome 1: Quality of life at End of treatment                      - Actual outcome for Adults and young people overall: AQLQ at 12 months; MD 0.38 (95%CI 0.2 to 0.56) (P&lt;0.001 ) AQLQ 1-7 Top=High is good outcome; Risk of bias: High; Indirectness of outcome: No indirectness</p>	
<p>Protocol outcome 2: Exacerbation (need for OCS) at End of treatment                      - Actual outcome for Adults and young people overall: Emergency treatment, hospitalisation or OCS course at 12 months; HR 1.18 (95%CI 0.51 to 2.74) Reported; Risk of bias: High; Indirectness of outcome: Serious indirectness</p>	
<p>Protocol outcome 3: Asthma control questionnaires at End of Treatment                      - Actual outcome for Adults and young people overall: ACQ at 12 months; MD -0.47 (95%CI -0.64 to -0.3) (P&lt;0.001 ) ACQ 0-6 Top=High is poor outcome; Risk of bias: High; Indirectness of outcome: No indirectness                      - Actual outcome for Adults and young people with uncontrolled asthma: ACQ at 12 months; MD -0.82 (95%CI -1.1 to 0.55) ACQ 0-6 Top=High is poor outcome; Risk of bias: Very high; Indirectness of outcome: No indirectness</p>	
<p>Protocol outcome 4: Dose of regular asthma treatment (SABA, ICS) at End of Treatment                      - Actual outcome for Adults and young people overall: Mean daily ICS use, µg at 12 months; Risk of bias: High; Indirectness of outcome: No indirectness                      - Actual outcome for Adults and young people with controlled asthma: Mean daily ICS use, µg at 12 months; Risk of bias: Very high; Indirectness of outcome: No indirectness                      - Actual outcome for Adults and young people with uncontrolled asthma: Mean daily ICS use, µg at 12 months; Risk of bias: High; Indirectness of outcome: No indirectness</p>	
<p>Protocol outcome 5: Lung Function at End of Treatment                      - Actual outcome for Adults and young people overall: FEV1 L at 12 months; Risk of bias: High; Indirectness of outcome: No indirectness</p>	
<p>Protocol outcome 6: Symptom free days at End of Treatment                      - Actual outcome for Adults and young people overall: % symptom free days in previous 2 weeks at 12 months; Risk of bias: High; Indirectness of outcome: No indirectness</p>	
Protocol outcomes not reported by the study	Mortality at End of Treatment; UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment; Rescue medication at End of Treatment; Time of school/work at End of Treatment

**Table 117: MEHUYS 2008<sup>1116</sup>**

<b>Study</b>	<b>Mehuys 2008<sup>1116</sup></b>
Study type	RCT (Patient randomised; Parallel)

Number of studies (number of participants)	1 (n=201)
Countries and setting	Conducted in Belgium; Setting: Pharmacy, multicentre
Line of therapy	Mixed line
Duration of study	Intervention time: 6 months
Method of assessment of guideline condition	Partially adequate method of assessment/diagnosis: Asthma patients
Stratum	Adults and young people overall: Asthma patients treated for asthma for $\geq 12$ months (not including fully controlled or severely uncontrolled)
Subgroup analysis within study	Not applicable: na
Inclusion criteria	Aged 18-50 years; treated for asthma for $\geq 12$ months; using controller medication; regular visitor to the pharmacy.
Exclusion criteria	Smoking history of $>10$ pack-years; suffering from another severe disease and ACT at screening of $<15$ (indicating seriously uncontrolled asthma) or equalling 25 (complete asthma control).
Recruitment/selection of patients	Consecutive recruitment in 66 pharmacies from Jan 2006 - April 2006.
Age, gender and ethnicity	Age - Range: 18-50. Gender (M:F): 94/107. Ethnicity:
Further population details	1. Education level: Not applicable / Not stated / Unclear 2. Language: Non English speaking (Non English speaking but Dutch version of ACT used).
Extra comments	Baseline data: Mean (range) age: Monitoring: 35.2 (19-51); Usual care: 36.3 (17-51). ACT mean (range): Monitoring: 19.7 (11-25); Usual care: 19.3 (10-25). ICS %: Monitoring: 25%; Usual care: 23.1%; LABA/ICS %: Monitoring: 64.5%; Usual care: 70.8%.
Indirectness of population	No indirectness
Interventions	(n=107) Intervention 1: Monitoring asthma control + treatment - Monitoring control questionnaires + treatment. Pharmacist intervention including initial education on inhaler technique, asthma, medication. Pharmacist advice at 1 month and 3 months based on ACT score of the patient (direct physician feedback). -ACT $<15$ (uncontrolled asthma): immediate referral to GP or specialist-ACT 15-19 (insufficiently controlled asthma): review inhaler technique and check controller adherence-ACT $>19$ (well-controlled): no advice, inform patient asthma is well-controlled. Duration 6 months. Concurrent medication/care: Education session from pharmacist at the start of the intervention in the intervention group Further details: 1. Additional education training : Not applicable / Not stated / Unclear 2. Duration of study: $\geq 6$ months  (n=94) Intervention 2: Usual care. Usual pharmacist care. Duration 6 months. Concurrent medication/care: No education at start of study as in intervention group.

	Further details: 1. Additional education training : Not applicable / Not stated / Unclear 2. Duration of study: >= 6 months
Funding	Funding not stated
<p><b>RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: ONGOING MANAGEMENT BASED ON ACT SCORE versus USUAL PHARMACIST CARE</b></p> <p>Protocol outcome 1: Quality of life at End of treatment          - Actual outcome for Adults and young people overall: AQLQ at 6 months; Group 1: mean 6 (SD 0.7); n=80, Group 2: mean 5.8 (SD 0.9); n=70; Risk of bias: High;          Indirectness of outcome: No indirectness</p> <p>Protocol outcome 2: Exacerbation (need for OCS) at End of treatment          - Actual outcome for Adults and young people overall: Exacerbation (ER visit, hospitalisation or course of OCS) at 6 months; Group 1: 10/80, Group 2: 8/70; Risk of bias: Very high; Indirectness of outcome: Serious indirectness</p> <p>Protocol outcome 3: UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment          - Actual outcome for Adults and young people overall: ER visit or hospitalisation at 6 months; Group 1: 1/80, Group 2: 5/70; Risk of bias: Very high; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 4: Asthma control questionnaires at End of Treatment          - Actual outcome for Adults and young people overall: ACT final values at 3 months; Group 1: mean 20.3 (SD 3.2); n=99, Group 2: mean 20 (SD 3.8); n=84; Risk of bias: Very high; Indirectness of outcome: No indirectness          - Actual outcome for Adults and young people overall: ACT final values at 6 months; Group 1: mean 20.2 (SD 3.5); n=80, Group 2: mean 19.7 (SD 4.8); n=70; Risk of bias: Very high; Indirectness of outcome: No indirectness          - Actual outcome for Adults and young people overall: ACT, no. of patients controlled (score 20-25) at 3 months; Group 1: 61/99, Group 2: 52/84; Risk of bias: Very high; Indirectness of outcome: No indirectness          - Actual outcome for Adults and young people overall: ACT, no. of patients controlled (score 20-25) at 6 months; Group 1: 54/80, Group 2: 42/70; Risk of bias: High; Indirectness of outcome: No indirectness          - Actual outcome for Adults and young people overall: ACT, no. of patients partially controlled (score 15-19) at 3 months; Group 1: 32/99, Group 2: 23/84; Risk of bias: Very high; Indirectness of outcome: No indirectness          - Actual outcome for Adults and young people overall: ACT, no. of patients partially controlled (score 15-19) at 6 months; Group 1: 19/80, Group 2: 17/70; Risk of bias: Very high; Indirectness of outcome: No indirectness          - Actual outcome for Adults and young people overall: ACT, no. of patients uncontrolled (score &lt;15) at 3 months; Group 1: 5/99, Group 2: 9/84; Risk of bias: Very high; Indirectness of outcome: No indirectness          - Actual outcome for Adults and young people overall: ACT, no. of patients uncontrolled (score &lt;15) at 6 months; Group 1: 7/80, Group 2: 11/70; Risk of bias: Very high; Indirectness of outcome: No indirectness</p>	

<p>Protocol outcome 5: Rescue medication at End of Treatment</p> <p>- Actual outcome for Adults and young people overall: puffs/day final values at 3 months; Group 1: mean 0.68 puffs/day (SD 1.16); n=99, Group 2: mean 1.3 puffs/day (SD 2.55); n=84; Risk of bias: High; Indirectness of outcome: No indirectness</p> <p>- Actual outcome for Adults and young people overall: puffs/day final values at 6 months; Group 1: mean 0.67 puffs/day (SD 1.33); n=80, Group 2: mean 0.9 puffs/day (SD 1.36); n=70; Risk of bias: High; Indirectness of outcome: No indirectness</p>	
Protocol outcomes not reported by the study	Mortality at End of Treatment; Dose of regular asthma treatment (SABA, ICS) at End of Treatment; Lung Function at End of Treatment; Symptom free days at End of Treatment; Time of school/work at End of Treatment

**Table 118: RIKKERSMUTSAERTS 2012<sup>1449</sup>**

Study	SMASHING trial: Rijkers-mutsaerts 2012 <sup>1449</sup>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=90)
Countries and setting	Conducted in Netherlands; Setting: Primary and Secondary care
Line of therapy	Mixed line
Duration of study	Intervention time: 12 months
Method of assessment of guideline condition	Partially adequate method of assessment/diagnosis: Doctor Dx of mild to severe persistent asthma; not well controlled asthma as assessed by ACQ>0.75 and/or ATAQ <1.0
Stratum	Children 5 -<16 with uncontrolled asthma: Children 12-18 years, asthma not well controlled asthma as assessed by ACQ>0.75 and/or ATAQ <1.0
Subgroup analysis within study	Not applicable
Inclusion criteria	Aged 12-18 years; prescription of ICS for more than 3 months in the previous year; access to the internet; Dutch language
Exclusion criteria	Receiving maintenance OCS treatment; relevant co-morbidity.
Age, gender and ethnicity	Age - Range: 12-18 years. Gender (M:F): 45/45. Ethnicity:
Further population details	1. Education level: Not applicable / Not stated / Unclear 2. Language: Non English speaking (Dutch speaking).
Extra comments	Baseline data: Age mean (range) Monitoring: 13.4 (12-17), UC: 13.8 (12-17); FEV1%pred Monitoring: 88 (49-151), UC: 92 (49-164); AQLQ Monitoring: 5.6 (3.12-6.97), UC: 5.68 (2.87-7.0); ACQ Monitoring: 1.29 (0.22-3.0), UC: 1.19 (0-3.43); %

	ICS Monitoring: 100%, UC: 100%; % ICS/LABA Monitoring: 60.5%, UC: 65%.
Indirectness of population	Serious indirectness: Age group indirect to protocol (12-18 years); not well controlled asthma includes partially controlled and uncontrolled (not uncontrolled alone)
Interventions	<p>(n=46) Intervention 1: Monitoring asthma control + treatment - Monitoring control questionnaires + treatment. Weekly asthma control monitoring (according to ACQ score) and treatment advice. Monitoring through website, use of internet based treatment plan, online education, web communications with an asthma nurse. Weekly completion of electronic ACQ and instant feedback of asthma control along with advice on how to adjust treatment according to predefined algorithm and treatment plan (treatment steps according to GINA). Patients attended their own physician, as they would normally do, every 3–6 months and extra when needed if their asthma was deteriorating).. Duration 12 months. Concurrent medication/care: Intervention group only: online education, face-to-face group education (two 60 min sessions) and web communications with an asthma nurse. Both groups received prior basic education about asthma, medications and inhaler technique. All trained to measure FEV1 daily and report highest value of 3 measurements before medications. Reported ACQ weekly. No feedback provided on ACQ or lung function. Further details: 1. Additional education training : Additional education in both groups 2. Duration of study: &gt;= 6 months</p> <p>(n=44) Intervention 2: Usual care. Usual care. Adolescents in the usual care group received care by their physician according to the Dutch guidelines on asthma management in children in general practice and in hospitals. Commonly, they visited their general practitioner or paediatrician every 3 months or twice per year once control of asthma had been achieved.. Duration 12 months. Concurrent medication/care: Both groups received prior basic education about asthma, medications and inhaler technique. All trained to measure FEV1 daily and report highest value of 3 measurements before medications. Reported ACQ weekly. No feedback provided on ACQ or lung function. Further details: 1. Additional education training : Additional education in both groups 2. Duration of study: &gt;= 6 months</p>
Funding	Academic or government funding (Netherlands Asthma Foundation)

**RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: ONGOING MANAGEMENT BASED ON ACQ SCORE versus USUAL CARE + TREATMENT**

Protocol outcome 1: Quality of life at End of treatment

- Actual outcome for Children 5 -<16 with uncontrolled asthma: PAQLQ at 3 months; MD 0.4 (95%CI 0.17 to 0.62) (P<0.05 ) PAQLQ 1-7 Top=High is good outcome; Risk of bias: Very high; Indirectness of outcome: No indirectness

- Actual outcome for Children 5 -<16 with uncontrolled asthma: PAQLQ at 12 months; MD -0.05 (95%CI -0.5 to 0.41) (P=0.85 ) PAQLQ 1-7 Top=High is good outcome; Risk of bias: Very high; Indirectness of outcome: No indirectness

Protocol outcome 2: Exacerbation (need for OCS) at End of treatment



- Actual outcome for Children 5 <16 with uncontrolled asthma: Exacerbation requiring OCS for 3 days or more at 12 months; Group 1: 6/35, Group 2: 6/40; Risk of bias: Very high; Indirectness of outcome: No indirectness

Protocol outcome 3: Asthma control questionnaires at End of Treatment

- Actual outcome for Children 5 <16 with uncontrolled asthma: ACQ at 3 months; MD -0.32 (95%CI -0.56 to -0.079) (P<0.01 ) ACQ 0-6 Top=High is poor outcome; Risk of bias: Very high; Indirectness of outcome: No indirectness

- Actual outcome for Children 5 <16 with uncontrolled asthma: ACQ at 12 months; MD -0.05 (95%CI -0.35 to 0.25) (P=0.75 ) ACQ 0-6 Top=High is poor outcome; Risk of bias: Very high; Indirectness of outcome: No indirectness

Protocol outcome 4: Dose of regular asthma treatment (SABA, ICS) at End of Treatment

- Actual outcome for Children 5 <16 with uncontrolled asthma: Mean daily ICS use µg at 3 months; Risk of bias: Very high; Indirectness of outcome: No indirectness

- Actual outcome for Children 5 <16 with uncontrolled asthma: Mean daily ICS use µg at 12 months; Risk of bias: Very high; Indirectness of outcome: No indirectness

Protocol outcome 5: Lung Function at End of Treatment

- Actual outcome for Children 5 <16 with uncontrolled asthma: FEV1 L at 3 months; Risk of bias: Very high; Indirectness of outcome: No indirectness

- Actual outcome for Children 5 <16 with uncontrolled asthma: FEV1 L at 12 months; Risk of bias: Very high; Indirectness of outcome: No indirectness

Protocol outcome 6: Symptom free days at End of Treatment

- Actual outcome for Children 5 <16 with uncontrolled asthma: Proportion of symptom free days in the previous 2 weeks at 3 months; Risk of bias: Very high; Indirectness of outcome: No indirectness

- Actual outcome for Children 5 <16 with uncontrolled asthma: Proportion of symptom free days in the previous 2 weeks at 12 months; Risk of bias: Very high; Indirectness of outcome: No indirectness

Protocol outcomes not reported by the study

Mortality at End of Treatment; UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment; Rescue medication at End of Treatment; Time of school/work at End of Treatment

## 1 G.16 Lung function tests to monitor asthma control

2 **Table 119: Adams 2001<sup>15</sup>**

Study	Adams 2001 <sup>15</sup>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=N=172 (no. randomised to each group not reported and also high attrition from ACA numbers - high ROB))

Countries and setting	Conducted in Australia; Setting: Secondary care (university public teaching hospital)
Line of therapy	Mixed line
Duration of study	Intervention time: 12 months
Method of assessment of guideline condition	Adequate method of assessment/diagnosis: Physician's diagnosis of asthma defined by American Thoracic Society
Stratum	Adults and young people (16 years and over)
Subgroup analysis within study	Not applicable
Inclusion criteria	Age 17 to 70 years; physician's diagnosis of asthma defined by American Thoracic Society; demonstrated ability to use PFM; telephone access at home; could read and sign consent form in English
Exclusion criteria	Previous life-threatening attack of asthma, current or previous written asthma action plan based on symptoms or PEF; pregnancy; poor perception of bronchoconstriction during histamine inhalation test; baseline FEV1 <1.5L preventing histamine inhalation test
Recruitment/selection of patients	Recruited from inpatient and outpatient clinics
Age, gender and ethnicity	Age - Range of means: PFM group 37.3, symptoms group 35.5 years. Gender (M:F): 52:82. Ethnicity: Not stated
Further population details	
Indirectness of population	No indirectness
Interventions	<p>(n=73) Intervention 1: Monitoring lung function + treatment - Monitoring PEF + treatment. Self-management action plan activated by decrease in PEF explained by specialist pulmonologist; reinforced monthly by study coordinator. Duration 12 months. Concurrent medication/care: Started or continued on appropriate dose of inhaled corticosteroids; instructed to use bronchodilator as required Further details: 1. Additional education training : Additional education in both groups</p> <p>(n=61) Intervention 2: No lung function monitoring + treatment - Monitoring symptoms + treatment. Self-management action plan activated by increase in symptoms explained by specialist pulmonologist; reinforced monthly by study coordinator. Duration 12 months. Concurrent medication/care: Started or continued on appropriate dose of inhaled corticosteroids; instructed to use bronchodilator as required Further details: 1. Additional education training : Additional education in both groups</p>
Funding	Academic or government funding (University of Adelaide, The Queen Elizabeth Hospital Research Foundation)

RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: MONITORING PEF + TREATMENT versus MONITORING SYMPTOMS + TREATMENT

<p>Protocol outcome 1: UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment</p> <p>- Actual outcome for Adults and young people (16 years and over): Hospitalisation days at 12 months; Group 1: mean 0.07 days (SD -0.3); n=48, Group 2: mean 0.1 days (SD 0.5); n=40; Risk of bias: High; Indirectness of outcome: No indirectness</p> <p>- Actual outcome for Adults and young people (16 years and over): ED visits at 12 months; Group 1: mean 0.11 (SD 0.4); n=48, Group 2: mean 0.15 (SD 0.4); n=40; Risk of bias: High; Indirectness of outcome: No indirectness</p>	
<p>Protocol outcome 2: Asthma control questionnaires at End of Treatment</p> <p>- Actual outcome for Adults and young people (16 years and over): Severity self-rating at 12 months; Group 1: mean 3.46 None (SD 3.3); n=48, Group 2: mean 3.48 None (SD 2.5); n=40; Self-rating asthma severity 0-10 Top=High is poor outcome; Risk of bias: High; Indirectness of outcome: No indirectness</p>	
<p>Protocol outcome 3: Lung Function at End of Treatment</p> <p>- Actual outcome for Adults and young people (16 years and over): Pre-bronchodilator FEV1 at 12 months; Group 1: mean 2.45 L (SD 0.82); n=48, Group 2: mean 2.71 L (SD 0.86); n=40; Risk of bias: Very high; Indirectness of outcome: No indirectness</p>	
<p>Protocol outcome 4: Time of school/work at End of Treatment</p> <p>- Actual outcome for Adults and young people (16 years and over): Days off work at 12 months; Group 1: mean 5 days (SD 11); n=48, Group 2: mean 2.3 days (SD 4); n=40; Risk of bias: Very high; Indirectness of outcome: No indirectness</p>	
Protocol outcomes not reported by the study	Mortality at End of Treatment; Quality of life at End of treatment; Exacerbation (need for OCS) at End of treatment; Rescue medication at End of Treatment; Dose of regular asthma treatment (SABA, ICS) at End of Treatment; Symptom free days at End of Treatment

**Table 120: Buist 2006<sup>243</sup>**

Study	Buist 2006 <sup>243</sup>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=296)
Countries and setting	Conducted in USA; Setting: Community
Line of therapy	Not applicable
Duration of study	Intervention time: 2 years
Method of assessment of guideline condition	Adequate method of assessment/diagnosis: Physician-diagnosed asthma and had medication use suggestive of moderate-to-severe asthma; bronchodilator reversibility (> 8% of baseline FEV1)

Stratum	Adults and young people (16 years and over)
Subgroup analysis within study	Not applicable
Inclusion criteria	Aged 50 to 92 yr, recruited from a large managed-care organization; physician-diagnosed asthma and medication use suggestive of moderate-to-severe asthma; none was using a peak flow meter; screening criteria included bronchodilator reversibility (>8% of baseline FEV1) and demonstrated ability to keep a daily symptom diary.
Exclusion criteria	None apart from above
Recruitment/selection of patients	Screening criteria included bronchodilator reversibility (> 8% of baseline FEV1) and demonstrated ability to keep a daily symptom diary.
Age, gender and ethnicity	Age - Mean (SD): 66 (9.4) years. Gender (M:F): 142:154. Ethnicity: 94% were white, not of Hispanic origin; others not stated
Further population details	
Indirectness of population	No indirectness
Interventions	<p>(n=149) Intervention 1: Monitoring lung function + treatment - Monitoring PEF + treatment. Peak flow rate (twice daily or “as needed”) for asthma monitoring; four 90-min small-group classes. Development of a personalised action plan and review of the subjects’ asthma diaries; instructed in proper use of metered dose inhalers (MDIs). Interventionists also met with participants semiannually to review MDI and peak flow technique, review daily diaries, and discuss participants’ action plans. In between these meetings, they phoned participants quarterly to review diaries and answer questions . Duration 2 years. Concurrent medication/care: Not stated Further details: 1. Additional education training :</p> <p>(n=147) Intervention 2: No lung function monitoring + treatment - Monitoring symptoms + treatment. Symptoms for asthma monitoring; four 90-min small-group classes. Development of a personalised action plan and review of the subjects’ asthma diaries; instructed in proper use of metered dose inhalers (MDIs). Interventionists also met with participants semiannually to review MDI and peak flow technique, review daily diaries, and discuss participants’ action plans. In between these meetings, they phoned participants quarterly to review diaries and answer questions . Duration 2 years. Concurrent medication/care: Not stated Further details: 1. Additional education training :</p>
Funding	Academic or government funding (National Heart, Lung, and Blood Institute)

RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: MONITORING PEF + TREATMENT versus MONITORING SYMPTOMS + TREATMENT

<p>Protocol outcome 1: Quality of life at End of treatment                      - Actual outcome for Adults and young people (16 years and over): AQLQ increase &gt;0.5 points at 2 years; Group 1: 52/134, Group 2: 50/128; Risk of bias: Very high; Indirectness of outcome: No indirectness                      - Actual outcome for Adults and young people (16 years and over): AQLQ decrease &gt;0.5 points at 2 years; Group 1: 16/134, Group 2: 11/128; Risk of bias: Very high; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 2: UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment                      - Actual outcome for Adults and young people (16 years and over): Total asthma-related health care utilisation at 2 years; Group 1: mean 1.39 Events per person-year of follow-up (SD 1.98); n=148, Group 2: mean 1.5 Events per person-year of follow-up (SD 2.23); n=146; Risk of bias: High; Indirectness of outcome: No indirectness</p>	
Protocol outcomes not reported by the study	Mortality at End of Treatment; Exacerbation (need for OCS) at End of treatment; Asthma control questionnaires at End of Treatment; Rescue medication at End of Treatment; Dose of regular asthma treatment (SABA, ICS) at End of Treatment; Lung Function at End of Treatment; Symptom free days at End of Treatment; Time of school/work at End of Treatment

**Table 121: Charlton 1990<sup>302</sup>**

Study	Charlton 1990 <sup>302</sup>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=115 Patients (46 children and 69 adults))
Countries and setting	Conducted in United Kingdom; Setting: General practice
Line of therapy	Not applicable
Duration of study	Intervention time: 12 months
Method of assessment of guideline condition	Adequate method of assessment/diagnosis: Patients on the repeat prescribing register who were receiving prophylactic treatment for asthma.
Stratum	Adults and young people (16 years and over)

Subgroup analysis within study	Not applicable
Inclusion criteria	Patients on the repeat prescribing register who were receiving prophylactic treatment for asthma.
Exclusion criteria	Not stated
Recruitment/selection of patients	Patients on the repeat prescribing register who were receiving prophylactic treatment for asthma.
Age, gender and ethnicity	Age - --: Not stated. Gender (M:F): Not stated. Ethnicity: Not stated
Further population details	
Indirectness of population	No indirectness
Interventions	<p>(n=51) Intervention 1: Monitoring lung function + treatment - Monitoring PEF + treatment. Peak flow self-management plan. The first interview usually took 45 minutes. One week later the patients were reviewed by the nurse for a further 15 minutes, when spirometry was again performed and inhaler technique checked. Progress with self monitoring and self management were checked and treatment altered, if necessary, after discussion with the patient's general practitioner. Topics such as smoking, holidays, provoking factors, and emergency treatments were discussed in the course of the follow up visits. All the patients were reviewed every eight weeks by the nurse or more often if she considered it necessary.. Duration 12 months. Concurrent medication/care: Not stated Further details: 1. Additional education training : Additional education in both groups</p> <p>(n=64) Intervention 2: No lung function monitoring + treatment - Monitoring symptoms + treatment. Symptoms self-management plan. The first interview usually took 45 minutes. One week later the patients were reviewed by the nurse for a further 15 minutes, when spirometry was again performed and inhaler technique checked. Progress with self monitoring and self management were checked and treatment altered, if necessary, after discussion with the patient's general practitioner. Topics such as smoking, holidays, provoking factors, and emergency treatments were discussed in the course of the follow up visits. All the patients were reviewed every eight weeks by the nurse or more often if she considered it necessary.. Duration 12 months. Concurrent medication/care: Not stated Further details: 1. Additional education training : Additional education in both groups</p>
Funding	Academic or government funding (Clare Wand fund, the Scientific Foundation of the Royal College of General

	Practitioners, and Vitalograph)
<p><b>RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: MONITORING PEF + TREATMENT versus MONITORING SYMPTOMS + TREATMENT</b></p> <p>Protocol outcome 1: Exacerbation (need for OCS) at End of treatment          - Actual outcome for Adults and young people (16 years and over): Receiving oral steroids at 12 months; Group 1: 14/27, Group 2: 7/33; Risk of bias: Very high; Indirectness of outcome: No indirectness          - Actual outcome for Children 5 -&lt;16 : Receiving oral steroids at 12 months; Group 1: 7/19, Group 2: 0/27; Risk of bias: Very high; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 2: Rescue medication at End of Treatment          - Actual outcome for Adults and young people (16 years and over): Requiring nebulised salbutamol at 12 months; Group 1: 3/28, Group 2: 2/37; Risk of bias: Very high; Indirectness of outcome: No indirectness          - Actual outcome for Children 5 -&lt;16 : Requiring nebulised salbutamol at 12 months; Group 1: 2/17, Group 2: 0/27; Risk of bias: Very high; Indirectness of outcome: No indirectness</p>	
Protocol outcomes not reported by the study	Mortality at End of Treatment; Quality of life at End of treatment; UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment; Asthma control questionnaires at End of Treatment; Dose of regular asthma treatment (SABA, ICS) at End of Treatment; Lung Function at End of Treatment; Symptom free days at End of Treatment; Time of school/work at End of Treatment

**Table 122: Cote 1997<sup>364</sup>**

Study	Cote 1997 <sup>364</sup>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=188)
Countries and setting	Conducted in Canada; Setting: Three tertiary care hospitals
Line of therapy	Mixed line
Duration of study	Intervention + follow up: 12 months
Method of assessment of guideline condition	Adequate method of assessment/diagnosis: The diagnosis had to be confirmed by either a documented reversibility greater than 15% in FEV1 or a methacholine PC20<8mg/ml

Stratum	Adults and young people (16 years and over): Aged 16 years or older
Subgroup analysis within study	Not applicable
Inclusion criteria	Presence of moderate to severe asthma; aged 16 years or older; the need to take daily anti-inflammatory agents (ICS, cromoglycate or nedocromil).
Exclusion criteria	Current or ex-smokers 40 years of age or older in whom the best FEV1 after salbutamol was <80% predicted; patients with significant concurrent diseases; those requiring >7.5mg/day of prednisone to control asthma symptoms, those having taken part in an asthma educational program. Subjects in whom regular OCS were needed to obtain good asthma control during the run-in period were excluded.
Recruitment/selection of patients	At time of hospitalisation or visit to the clinic between April and December 1993
Age, gender and ethnicity	Age - Range: ≥16 years. Gender (M:F): 37/58. Ethnicity:
Further population details	
Indirectness of population	No indirectness
Interventions	<p>(n=50) Intervention 1: Monitoring lung function + treatment - Monitoring PEF + treatment. Self-management based on twice daily PEF. - Step 1: green zone, morning PEF ≥85% best, continue maintenance treatment- Step 2: yellow zone, for past 24 hours PEF 60-85% best, increase BDP to 4 puffs twice daily (2000mcg/day) until PEF % best returns, or if there is no increase in PEF within 48 hours proceed to step 3.- Step 3: red zone, for past 12 hours PEF &lt;60% best, inform physician and start OCS- Step 4: red extra zone, PEF &lt;50% best, visit physician or ER.. Duration 12 months. Concurrent medication/care: 2-6 week run-in period when medication adjusted according to the International Consensus on asthma therapy. In patients receiving budesonide, this was replaced by an equivalent dose of inhaled beclomethasone dipropionate (BDP). In patients considered unstable during run-in period (nighttime symptoms, four or more puffs/day of inhaler beta-agonist, PEFv&gt;15%, post-BD FEV1&lt;85%, mean PEF &lt;85%) the dose of BDP could be doubled or theophyllines added. Subjects in whom regular OCS were needed to obtain good asthma control were excluded. Both groups received counselling with an educator during a 1 hour session.</p> <p>Further details: 1. Additional education training : Additional education in both groups</p> <p>(n=45) Intervention 2: No lung function monitoring + treatment - Monitoring symptoms + treatment. Self-management based on symptoms. - Step 1: green zone, not awakened at night, using usual SABA and able to perform usual activities, continue maintenance treatment- Step 2: yellow zone, for previous 24 hours using twice as much SABA, awakened at night and unusual breathlessness with exercise, increase BDP to 4 puffs twice daily (2000mcg/day) until PEF % best returns, or if there is no increase in PEF within 48 hours proceed to step 3.- Step 3: red zone, for past 24 hours SABA relieving symptoms for &lt;4 hours or more than 10puffs/day, inform physician and start OCS- Step 4: red extra zone, SABA relieving symptoms for &lt;2 hours and difficulty talking, inform physician and visit ER.. Duration 12 months. Concurrent</p>



	<p>medication/care: 2-6 week run-in period when medication adjusted according to the International Consensus on asthma therapy. In patients receiving budesonide, this was replaced by an equivalent dose of inhaled beclomethasone dipropionate (BDP). In patients considered unstable during run-in period (nighttime symptoms, four or more puffs/day of inhaler beta-agonist, PEFv&gt;15%, post-BD FEV1&lt;85%, mean PEF &lt;85%) the dose of BDP could be doubled or theophyllines added. Subjects in whom regular OCS were needed to obtain good asthma control were excluded. Both groups received counselling with an educator during a 1 hour session.</p> <p>Further details: 1. Additional education training : Additional education in both groups</p>
Funding	Study funded by industry (Supported by a grant from Glaxo Canada, Mississauga (Ontario))
<p><b>RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: MONITORING PEF + TREATMENT versus MONITORING SYMPTOMS + TREATMENT</b></p> <p>Protocol outcome 1: Exacerbation (need for OCS) at End of treatment          - Actual outcome for Adults and young people (16 years and over): OCS courses at 12 months; Group 1: mean 0.7 number of events (SD 1.4); n=50, Group 2: mean 0.9 number of events (SD 1.3); n=45; Risk of bias: Very high; Indirectness of outcome: Serious indirectness</p> <p>Protocol outcome 2: UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment          - Actual outcome for Adults and young people (16 years and over): Hospitalisation at 12 months; Group 1: mean 0.04 number of events (SD 0.28); n=50, Group 2: mean 0.09 number of events (SD 0.27); n=45; Risk of bias: Very high; Indirectness of outcome: Serious indirectness          - Actual outcome for Adults and young people (16 years and over): ER visits at 12 months; Group 1: mean 0.7 number of events (SD 1.4); n=50, Group 2: mean 0.7 number of events (SD 1.3); n=50; Risk of bias: Very high; Indirectness of outcome: Serious indirectness</p> <p>Protocol outcome 3: Time of school/work at End of Treatment          - Actual outcome for Adults and young people (16 years and over): Mean number of days lost from school or work at 12 months; Group 1: mean 2.2 number of days lost (SD 12.7); n=50, Group 2: mean 2.9 number of days lost (SD 12.7); n=45; Risk of bias: Very high; Indirectness of outcome: No indirectness</p>	
Protocol outcomes not reported by the study	Mortality at End of Treatment; Quality of life at End of treatment; Asthma control questionnaires at End of Treatment; Rescue medication at End of Treatment; Dose of regular asthma treatment (SABA, ICS) at End of Treatment; Lung Function at End of Treatment; Symptom free days at End of Treatment

**Table 123: Cowie 1997<sup>369</sup>**

Study	Cowie 1997 <sup>369</sup>
Study type	RCT (Patient randomised; Parallel)

Number of studies (number of participants)	1 (n=150)
Countries and setting	Conducted in Canada; Setting: Secondary care
Line of therapy	Not applicable
Duration of study	Intervention time: 6 months
Method of assessment of guideline condition	Adequate method of assessment/diagnosis: Adult and adolescent patients who had received urgent treatment for their asthma in the preceding 12 months and used asthma medication
Stratum	Adults and young people (16 years and over)
Subgroup analysis within study	Not applicable
Inclusion criteria	Adult and adolescent patients who had received urgent treatment for their asthma in the preceding 12 months and used asthma medication
Exclusion criteria	Not stated
Recruitment/selection of patients	Subjects were recruited by contacting those who had been treated for an exacerbation of asthma in an emergency department in one of the teaching hospitals in the city of Calgary. Subjects were also recruited from those attending a university asthma clinic when they gave a history of having received urgent treatment for their asthma in the previous 12 months.
Age, gender and ethnicity	Age - Range of means: 36.4 to 39.1 years. Gender (M:F): 56:83. Ethnicity: Not stated
Further population details	
Indirectness of population	No indirectness
Interventions	<p>(n=48) Intervention 1: Monitoring lung function + treatment - Monitoring PEF + treatment. Patients were given a peak flowmeter and brief instructions in its use and in recording the data. Their action plan included peak flow measurements that were estimated from their measured and predicted peak expiratory flows. Peak flow readings at or below which each step should be initiated were written into each subject's action plan. Doubling of their inhaled corticosteroid was recommended when the peak expiratory flow was &lt;70% of their estimated best reading or when the diurnal variation was &gt;20%. Initiation of the third step (prednisone) was advised at &lt;50%, and the fourth step (urgent treatment in an emergency department) at &lt;30% of their estimated best peak expiratory flow.. Duration 6 months. Concurrent medication/care: Not stated</p> <p>Further details: 1. Additional education training :</p> <p>(n=50) Intervention 2: No lung function monitoring + treatment - Monitoring symptoms + treatment. The instructions for the symptom-based plan listed common symptoms of asthma, including waking at night or a persistent cough and</p>

	<p>symptoms of a common cold as indications for doubling their inhaled corticosteroid. The third step required the introduction of prednisone if their relief following the use of a bronchodilator lasted &lt;2 h or if they became short of breath doing their normal daily activities. The fourth step required them to seek urgent treatment if their bronchodilator provided relief for &lt;30 min or if their breathing made it difficult for them to speak.. Duration 6 months. Concurrent medication/care: Not stated</p> <p>Further details: 1. Additional education training :</p>
Funding	Academic or government funding (Foothills Hospital Calgary)
<p><b>RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: MONITORING PEF + TREATMENT versus MONITORING SYMPTOMS + TREATMENT</b></p> <p>Protocol outcome 1: UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment</p> <p>- Actual outcome for Adults and young people (16 years and over): Visits for urgent treatment of asthma at 6 months; Group 1: 5/46, Group 2: 14/45; Risk of bias: High; Indirectness of outcome: No indirectness</p> <p>- Actual outcome for Adults and young people (16 years and over): Hospital admissions at 6 months; Group 1: 2/46, Group 2: 2/45; Risk of bias: High; Indirectness of outcome: No indirectness</p>	
Protocol outcomes not reported by the study	<p>Mortality at End of Treatment; Quality of life at End of treatment; Exacerbation (need for OCS) at End of treatment; Asthma control questionnaires at End of Treatment; Rescue medication at End of Treatment; Dose of regular asthma treatment (SABA, ICS) at End of Treatment; Lung Function at End of Treatment; Symptom free days at End of Treatment; Time of school/work at End of Treatment</p>

**Table 124: Kaya 2009<sup>827</sup>**

Study	Kaya 2009 <sup>827</sup>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=63)
Countries and setting	Conducted in Turkey; Setting: Secondary care
Line of therapy	Not applicable
Duration of study	Intervention time: 12 months
Method of assessment of guideline condition	Adequate method of assessment/diagnosis: Patients with persistent asthma; had been receiving care for at least 1 year in specific asthma clinic; classified by GINA guidelines on illness severity

Stratum	Adults and young people (16 years and over)
Subgroup analysis within study	Not applicable
Inclusion criteria	Patients with persistent asthma; had been receiving care for at least 1 year in specific asthma clinic; classified by GINA guidelines on illness severity
Exclusion criteria	Significant co-morbid conditions; illiteracy; hearing and visual defects; mental retardation; psychotic disorders
Recruitment/selection of patients	Specific asthma clinic
Age, gender and ethnicity	Age - Mean (SD): 43 (10.48) years. Gender (M:F): 13:50. Ethnicity: Not stated
Further population details	
Indirectness of population	No indirectness
Interventions	<p>(n=31) Intervention 1: Monitoring lung function + treatment - Monitoring PEF + treatment. PEF-based self-management. Duration 12 months. Concurrent medication/care: Standard education programme on asthma self-management prepared according to GINA recommendations given to patients with booklet for keeping daily records Further details: 1. Additional education training : Additional education in both groups</p> <p>(n=32) Intervention 2: No lung function monitoring + treatment - Monitoring symptoms + treatment. Symptom-based self-monitoring. Duration 12 months. Concurrent medication/care: Standard education programme on asthma self-management prepared according to GINA recommendations given to patients with booklet for keeping daily records Further details: 1. Additional education training : Additional education in both groups</p>
Funding	Funding not stated

**RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: MONITORING PEF + TREATMENT versus MONITORING SYMPTOMS + TREATMENT**

**Protocol outcome 1: Quality of life at End of treatment**

- Actual outcome for Adults and young people (16 years and over): SF-36 physical score at 3 months; Group 1: mean 58.81 None (SD 21.98); n=31, Group 2: mean 65.3 None (SD 21.31); n=32; SF-36 Physical 0-100 Top=High is good outcome; Risk of bias: Very high; Indirectness of outcome: No indirectness
- Actual outcome for Adults and young people (16 years and over): SF-36 mental score at 3 months; Group 1: mean 62.39 None (SD 19.1); n=31, Group 2: mean 74.17 None (SD 15.51); n=32; SF-36 Mental 0-100 Top=High is good outcome; Risk of bias: Very high; Indirectness of outcome: No indirectness

**Protocol outcome 2: Lung Function at End of Treatment**

- Actual outcome for Adults and young people (16 years and over): FEV1 (%) at 6 months; Group 1: mean 87.74 % (SD 19.02); n=31, Group 2: mean 87.35 % (SD 21.25); n=32; Risk of bias: Very high; Indirectness of outcome: No indirectness

- Actual outcome for Adults and young people (16 years and over): PEF (% personal best) at 6 months; Group 1: mean 84.93 % (SD 14.32); n=31, Group 2: mean 79.62 % (SD 14.92); n=32; Risk of bias: Very high; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Mortality at End of Treatment; Exacerbation (need for OCS) at End of treatment; UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment; Asthma control questionnaires at End of Treatment; Rescue medication at End of Treatment; Dose of regular asthma treatment (SABA, ICS) at End of Treatment; Symptom free days at End of Treatment; Time of school/work at End of Treatment

**Table 125: Letz 2004<sup>985</sup>**

Study	Letz 2004 <sup>985</sup>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=50)
Countries and setting	Conducted in USA; Setting: Allergy, asthma and immunology clinic
Line of therapy	Mixed line
Duration of study	Intervention + follow up: 3 month
Method of assessment of guideline condition	Adequate method of assessment/diagnosis: Diagnosed with mild to severe persistent asthma (symptoms at least 2 times per week, FEV1<80% and FEV1 or PEF variability 12% or greater). Diagnosis made on the basis of history, examination and pre/post-BD lung function testing.
Stratum	Children 5 -<16 : 6-12 years
Subgroup analysis within study	Not applicable
Inclusion criteria	6-12 years, diagnosed with mild to severe persistent asthma (symptoms at least 2 times per week, FEV1<80% and FEV1 or PEF variability 12% or greater), new diagnosis and initiation of daily ICS.
Exclusion criteria	nr
Recruitment/selection of patients	Consecutive recruitment at 2 week follow up after diagnosis and initiation of ICS.
Age, gender and ethnicity	Age - Range of means: 8.9-9.4. Gender (M:F): 32/18. Ethnicity: Caucasian
Further population details	
Indirectness of population	No indirectness
Interventions	(n=26) Intervention 1: Monitoring lung function + treatment - Monitoring PEF + treatment. Action plan based on

	<p>patient's measured and predicted PEF values. Yellow zone recommended when PEF 60-80%, red zone when PEF &lt;60%. Best of 3 consecutive PEF readings recorded daily. Baseline therapy with ICS (green zone), step-up of ICS and beta-agonists used every 4 hours (yellow zone), call office or present to emergency room (red zone). . Duration 3 months. Concurrent medication/care: All provided with asthma education session from a nurse including use of the action plan. Further details: 1. Additional education training : Additional education in both groups</p> <p>(n=25) Intervention 2: No lung function monitoring + treatment - Monitoring symptoms + treatment. Action plan based on symptoms only. Common symptoms including persistent cough, symptoms of common cold, dyspnoea as indications for initiating yellow zone. Red zone if relief following a BD lasted less than 2 hours. Baseline therapy with ICS (green zone), step-up of ICS and beta-agonists used every 4 hours (yellow zone), call office or present to emergency room (red zone).. Duration 3 months. Concurrent medication/care: All provided with asthma education session from a nurse including use of the action plan. Further details: 1. Additional education training : Additional education in both groups</p>
Funding	Funding not stated
<p><b>RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: MONITORING PEF + TREATMENT versus MONITORING SYMPTOMS + TREATMENT</b></p> <p>Protocol outcome 1: Exacerbation (need for OCS) at End of treatment          - Actual outcome for Children 5 -&lt;16 : Required a course of OCS at 3 month; Group 1: 1/12, Group 2: 1/12; Risk of bias: Very high; Indirectness of outcome: No indirectness</p>	
Protocol outcomes not reported by the study	<p>Mortality at End of Treatment; Quality of life at End of treatment; UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment; Asthma control questionnaires at End of Treatment; Rescue medication at End of Treatment; Dose of regular asthma treatment (SABA, ICS) at End of Treatment; Lung Function at End of Treatment; Symptom free days at End of Treatment; Time of school/work at End of Treatment</p>

**Table 126: Lopez-vina 2000<sup>1027</sup>**

<b>Study</b>	<b>Lopez-vina 2000<sup>1027</sup></b>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=150)
Countries and setting	Conducted in Spain

Line of therapy	Mixed line
Duration of study	Intervention + follow up: 12 month
Method of assessment of guideline condition	Adequate method of assessment/diagnosis: Satisfied the ATS definition of asthma, with symptoms of episodic wheezing, cough and shortness of breath responding to bronchodilators, and reversible airflow obstruction documented on at least one previous pulmonary function study (>20% increase in FEV1 or PEF following salbutamol 0.2mg). In patients with normal spirometry and lac of functional assessment of asthma previously, a methacholine test was performed.
Stratum	Adults and young people (16 years and over): 17-65 years of age
Subgroup analysis within study	Not applicable
Inclusion criteria	17-65 years of age; required treatment in an ED of acute-care hospitals over an 18-month period because of an episode of acute asthma exacerbation; symptomatic disease during the previous year; satisfied the ATS definition of asthma with BDR or BHR.
Exclusion criteria	Concurrent chronic diseases (COPD, emphysema, cystic fibrosis, severe rheumatoid arthritis, neoplasia etc)
Recruitment/selection of patients	Consecutive patients who required treatment in an ED over an 18-month period
Age, gender and ethnicity	Age - Range: 17-65. Gender (M:F): 49/51. Ethnicity:
Further population details	
Indirectness of population	No indirectness
Interventions	<p>(n=75) Intervention 1: Monitoring lung function + treatment - Monitoring PEF and symptoms + treatment. Self-management plan with a card of colour codes based on symptoms, medication and PEF. Physician assessment at 15 days, 1 month and then every 3 months at which treatment adjusted according to symptoms, spirometric data and variability in PEF (less than 10% variability considered irrelevant). Duration 12 months. Concurrent medication/care: Medical regimes tailored to each patient and included the administration of beta-agonists when needed in mild asthma; inhaled salbutamol 0.2mg or terbutaline 0.5mg and budesonide 400mcg every 12 hours in moderate to severe asthma with FEV1&gt;80%; and inhaled salbutamol 0.2mg or terbutaline 0.5mg and budesonide 800mcg every 8 hours or when needed and prednisone 40mg/day for 14 days in moderate to severe asthma with FEV1&lt;80%. Patients in both groups received asthma education.</p> <p>Further details: 1. Additional education training : Additional education in both groups</p> <p>(n=75) Intervention 2: No lung function monitoring + treatment - Monitoring symptoms + treatment. Self-management plan based on symptoms only. Physician assessment at 15 days, 1 month and then every 3 months at which treatment adjusted according to symptoms and spirometric data only.. Duration 12 months. Concurrent medication/care: Medical regimes tailored to each patient and included the administration of beta-agonists when needed in mild asthma; inhaled</p>

	salbutamol 0.2mg or terbutaline 0.5mg and budesonide 400mcg every 12 hours in moderate to severe asthma with FEV1>80%; and inhaled salbutamol 0.2mg or terbutaline 0.5mg and budesonide 800mcg every 8 hours or when needed and prednisone 40mg/day for 14 days in moderate to severe asthma with FEV1<80%. Patients in both groups received asthma education. Further details: 1. Additional education training : Additional education in both groups
Funding	Academic or government funding (Supported in part by grant FISS 92/372)
<p><b>RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: MONITORING PEF, MEDICATION AND SYMPTOMS + TREATMENT versus MONITORING SYMPTOMS + TREATMENT</b></p> <p>Protocol outcome 1: UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment                      - Actual outcome for Adults and young people (16 years and over): Number of patients with visits to an emergency ward at 12 months; Group 1: 3/56, Group 2: 0/44; Risk of bias: Very high; Indirectness of outcome: No indirectness                      - Actual outcome for Adults and young people (16 years and over): Number of patients with a hospital admission at 12 months; Group 1: 2/56, Group 2: 0/44; Risk of bias: Very high; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 2: Lung Function at End of Treatment                      - Actual outcome for Adults and young people (16 years and over): FEV1% predicted at 12 months; Group 1: mean 80.9 % (SD 2.3); n=56, Group 2: mean 80.8 % (SD 2.8); n=44; FEV1 %pred 0-100 Top=High is good outcome; Risk of bias: Very high; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 3: Time of school/work at End of Treatment                      - Actual outcome for Adults and young people (16 years and over): Number of patients with absenteeism school/work at 12 months; Group 1: 2/56, Group 2: 0/44; Risk of bias: Very high; Indirectness of outcome: No indirectness</p>	
Protocol outcomes not reported by the study	Mortality at End of Treatment; Quality of life at End of treatment; Exacerbation (need for OCS) at End of treatment; Asthma control questionnaires at End of Treatment; Rescue medication at End of Treatment; Dose of regular asthma treatment (SABA, ICS) at End of Treatment; Symptom free days at End of Treatment

**Table 127: Turner 1998<sup>1783</sup>**

<b>Study</b>	<b>Turner 1998<sup>1783</sup></b>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=117)



Countries and setting	Conducted in Canada; Setting: Primary care
Line of therapy	Not applicable
Duration of study	Intervention time: 6 months
Method of assessment of guideline condition	Adequate method of assessment/diagnosis: PC20 methacholine < 8 mg/ml
Stratum	Adults and young people (16 years and over)
Subgroup analysis within study	Not applicable
Inclusion criteria	Between 18 and 55 yr of age with moderate to moderately severe asthma. The authors defined asthma severity by including only patients with a baseline PC20 methacholine < 8 mg/ml and a daily requirement for inhaled corticosteroids to manage their asthma symptoms. Patients were either newly prescribed inhaled corticosteroids independently by their family physician or were currently using inhaled corticosteroids.
Exclusion criteria	Exclusion criteria included significant comorbid conditions that would impact on QOL measurements, current use of a PFM, inability to use a PFM, and inability to communicate in English.
Recruitment/selection of patients	Potential study patients were identified from the clinic computer database, and the clinic physicians were encouraged to refer patients meeting study criteria. The authors displayed a poster board and flyer advertisements in the clinic to encourage volunteers. All patients had written permission from their physician to participate.
Age, gender and ethnicity	Age - Mean (SD): PEF group: 34.1 (10.5); symptoms group: 34.1 (9.4) years. Gender (M:F): 43:49. Ethnicity: Not stated
Further population details	
Indirectness of population	No indirectness
Interventions	<p>(n=53) Intervention 1: Monitoring lung function + treatment - Monitoring PEF + treatment. The asthma nurse reviewed patients monthly for 6 mo after the initial visit (seven total visits). The self-management plans and use of a PFM were reviewed in detail after randomization. Monthly visits documented morbidity outcomes, reinforced and evaluated use of the self-management plan, and provided ongoing education. Duration 6 months. Concurrent medication/care: Not stated Further details: 1. Additional education training :</p> <p>(n=64) Intervention 2: No lung function monitoring + treatment - Monitoring symptoms + treatment. The asthma nurse reviewed patients monthly for 6 mo after the initial visit (seven total visits). The self-management plans were reviewed in detail after randomization. Monthly visits documented morbidity outcomes, reinforced and evaluated use of the self-management plan, and provided ongoing education. Duration 6 months. Concurrent medication/care: Not stated Further details: 1. Additional education training :</p>

Funding	Study funded by industry (Glaxo Wellcome Canada Inc.)
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: MONITORING PEF + TREATMENT versus MONITORING SYMPTOMS + TREATMENT	
<p>Protocol outcome 1: Quality of life at End of treatment                      - Actual outcome for Adults and young people (16 years and over): Asthma Quality of Life Questionnaire at 6 months; Risk of bias: Very high; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 2: Exacerbation (need for OCS) at End of treatment                      - Actual outcome for Adults and young people (16 years and over): Prednisone treatments at 6 months; Group 1: 3/44, Group 2: 6/48; Risk of bias: Very high; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 3: UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment                      - Actual outcome for Adults and young people (16 years and over): Unscheduled doctor visits at 6 months; Group 1: 17/44, Group 2: 12/48; Risk of bias: High; Indirectness of outcome: No indirectness                      - Actual outcome for Adults and young people (16 years and over): Hospitalisation at 6 months; Group 1: 0/44, Group 2: 1/48; Risk of bias: Very high; Indirectness of outcome: No indirectness                      - Actual outcome for Adults and young people (16 years and over): ED visits at 6 months; Group 1: 6/44, Group 2: 2/48; Risk of bias: Very high; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 4: Lung Function at End of Treatment                      - Actual outcome for Adults and young people (16 years and over): FEV1 % pred at 6 months; Risk of bias: High; Indirectness of outcome: No indirectness                      - Actual outcome for Adults and young people (16 years and over): PEF at 6 months; Risk of bias: High; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 5: Time of school/work at End of Treatment                      - Actual outcome for Adults and young people (16 years and over): Time off school/work at 6 months; Group 1: 9/44, Group 2: 8/48; Risk of bias: Very high; Indirectness of outcome: No indirectness</p>	
Protocol outcomes not reported by the study	Mortality at End of Treatment; Asthma control questionnaires at End of Treatment; Rescue medication at End of Treatment; Dose of regular asthma treatment (SABA, ICS) at End of Treatment; Symptom free days at End of Treatment

**Table 128: Wensley 2004<sup>1885</sup>**

Study	Wensley 2004 <sup>1885</sup>
Study type	RCT (Patient randomised; Parallel)

Number of studies (number of participants)	1 (n=90)
Countries and setting	Conducted in United Kingdom; Setting: Recruitment in primary care and secondary care.
Line of therapy	Not applicable
Duration of study	Intervention time: 12 weeks
Method of assessment of guideline condition	Adequate method of assessment/diagnosis: Physician-diagnosed asthma and at least step 2 of the British Thoracic Society Guidelines for Asthma Management (regular inhaled corticosteroid therapy)
Stratum	Children 5 -<16
Subgroup analysis within study	Not applicable
Inclusion criteria	Inclusion criteria were (1) age 7–14 years, (2) physician-diagnosed asthma, (3) at least step 2 of the British Thoracic Society Guidelines for Asthma Management (regular inhaled corticosteroid therapy), (4) stable treatment for 1 month, (5) no other respiratory problem, (6) competent at spirometry, and (7) a successful 4-week run-in period.
Exclusion criteria	None stated
Recruitment/selection of patients	Withdrawals after run-in phase (n=27) due to refusal, poor comprehension or poor compliance, technical problems, equipment failure or GP advice
Age, gender and ethnicity	Age - Median (range): Symptoms group: 12 (7–14); PEF group: 11 (7–14) years. Gender (M:F): 48:42. Ethnicity: Not stated
Further population details	
Indirectness of population	No indirectness
Interventions	(n=44) Intervention 1: Monitoring lung function + treatment - Monitoring PEF + treatment. Group PF based on symptoms plus PEF. A written symptom diary was completed each morning, and spirometry was performed twice daily. The spirometers of those children randomized to the PF group were reprogrammed so that the PEF value for any maneuver (but not other spirometric values) was visible to them at any time. The child and the main caregiver were taught self-management at a training session, which also included training in spirometry and symptom recording and which lasted 30–90 minutes according to need. A printed plan incorporating the child’s own medication regime was color coded: green, PEF more than 70%, few symptoms (carry on as usual); yellow, PEF 50–70% after beta2 agonist (double-inhaled corticosteroid as well as taking additional beta2-agonist therapy); and red, PEF less than 50% after taking additional inhaled beta2 agonist, severe symptoms (commence oral prednisolone and/or seek medical help). The PEF levels for action were based on the child’s best previous PEF.. Duration 12 weeks. Concurrent medication/care: Not stated Further details: 1. Additional education training :

	(n=46) Intervention 2: No lung function monitoring + treatment - Monitoring symptoms + treatment. Group S based on symptoms alone; the S group did not have access to any lung function results throughout the study.. Duration 12 weeks. Concurrent medication/care: Not stated Further details: 1. Additional education training :
Funding	Study funded by industry (United Kingdom National Asthma Campaign and Glaxo SmithKline, United Kingdom.)
<p><b>RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: MONITORING PEF + TREATMENT versus MONITORING SYMPTOMS + TREATMENT</b></p> <p>Protocol outcome 1: UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment          - Actual outcome for Children 5 &lt;16 : Emergency GP visits at 12 weeks; Group 1: 10/44, Group 2: 11/45; Risk of bias: High; Indirectness of outcome: No indirectness          - Actual outcome for Children 5 &lt;16 : Hospital admissions at 12 weeks; Group 1: 1/44, Group 2: 0/45; Risk of bias: High; Indirectness of outcome: No indirectness          - Actual outcome for Children 5 &lt;16 : Attendance at A&amp;E at 12 weeks; Group 1: 1/44, Group 2: 0/45; Risk of bias: High; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 2: Lung Function at End of Treatment          - Actual outcome for Children 5 &lt;16 : FEV1 at 12 weeks; Group 1: mean 87.3 % of best value (SD 1.33); n=44, Group 2: mean 86.9 % of best value (SD 1.54); n=45; Percentage 0-100% Top=High is good outcome; Risk of bias: Very high; Indirectness of outcome: No indirectness          - Actual outcome for Children 5 &lt;16 : PEF at 12 weeks; Group 1: mean 83.4 % (SD 1.39); n=44, Group 2: mean 80.6 % (SD 1.74); n=45; Percentage 0-100% Top=High is good outcome; Risk of bias: Very high; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 3: Symptom free days at End of Treatment          - Actual outcome for Children 5 &lt;16 : Proportion of symptom-free days at 12 weeks; Risk of bias: High; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 4: Time of school/work at End of Treatment          - Actual outcome for Children 5 &lt;16 : Time off school at 12 weeks; Group 1: 15/44, Group 2: 13/45; Risk of bias: Very high; Indirectness of outcome: No indirectness</p>	
Protocol outcomes not reported by the study	Mortality at End of Treatment; Quality of life at End of treatment; Exacerbation (need for OCS) at End of treatment; Asthma control questionnaires at End of Treatment; Rescue medication at End of Treatment; Dose of regular asthma treatment (SABA, ICS) at End of Treatment

**Table 129: Yoos 2002<sup>1940</sup>**

<b>Study</b>	<b>Yoos 2002<sup>1940</sup></b>
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Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=168)
Countries and setting	Conducted in USA; Setting: 11 primary care settings
Line of therapy	Mixed line
Duration of study	Intervention + follow up: 12 months
Method of assessment of guideline condition	Partially adequate method of assessment/diagnosis: All school-aged children who carried a diagnosis of asthma
Stratum	Children 5 -<16 : Aged 6-19 years
Subgroup analysis within study	Not applicable
Inclusion criteria	Aged 6-19 years with a diagnosis of asthma, more that 3 asthma-related healthcare visits in the previous 12 months, English speaking, the child had not used a PEF meter in the previous 6 months.
Exclusion criteria	Children with mild asthma who were rarely symptomatic (had not had more than 3 asthma related healthcare visits in the previous 12 months).
Recruitment/selection of patients	All school-aged children who carried a diagnosis of asthma identified through computerised data sets.
Age, gender and ethnicity	Age - Range: 6-19 years. Gender (M:F): 99/69. Ethnicity:
Further population details	
Indirectness of population	No indirectness
Interventions	<p>(n=57) Intervention 1: Monitoring lung function + treatment - Monitoring PEF and symptoms + treatment. Personal action plan zones based on symptoms and PEF. Green zone, yellow zone (rescue medication) and red zone (contact healthcare provider).. Duration 3 months. Concurrent medication/care: Both groups received asthma education and a personal action plan. Two week run-in period with allocated self-management method and at the end of this period the nurse established zones based on PEF best and developed a personal action plan based on PEF and symptoms. Further details: 1. Additional education training : Additional education in both groups</p> <p>(n=56) Intervention 2: No lung function monitoring + treatment - Monitoring symptoms + treatment. Personal action plan zones based on symptoms only. Green zone, yellow zone (rescue medication) and red zone (contact healthcare provider).. Duration 3 months. Concurrent medication/care: Both groups received asthma education and a personal action plan. Two week run-in period with allocated self-management method and at the end of this period the nurse established zones based on symptoms and developed a personal action plan based on symptoms. Further details: 1. Additional education training : Additional education in both groups</p>

Funding	Academic or government funding (Supported by NIH grants)
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: MONITORING PEF AND SYMPTOMS + TREATMENT versus MONITORING SYMPTOMS + TREATMENT	
Protocol outcome 1: Lung Function at End of Treatment - Actual outcome for Children 5 <16 : FEV1 % predicted at 3 months; Group 1: mean 88 % (SD 20.6); n=57, Group 2: mean 90 % (SD 21); n=56; FEV1 %pred 0-100 Top=High is good outcome; Risk of bias: Very high; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Mortality at End of Treatment; Quality of life at End of treatment; Exacerbation (need for OCS) at End of treatment; UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment; Asthma control questionnaires at End of Treatment; Rescue medication at End of Treatment; Dose of regular asthma treatment (SABA, ICS) at End of Treatment; Symptom free days at End of Treatment; Time of school/work at End of Treatment

## G.17 FeNO to monitor asthma control

**Table 130: Calhoun 2012<sup>264</sup>**

Study	BASALT trail trial: Calhoun 2012 <sup>264</sup>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=342)
Countries and setting	Conducted in USA; Setting: Secondary - adjustments of inhaled corticosteroids made at outpatient visits
Line of therapy	Mixed line
Duration of study	Intervention time: 9 months
Method of assessment of guideline condition	Adequate method of assessment/diagnosis: All patients had a physician diagnosis of asthma, and either reversible airflow limitation ( $\geq 12\%$ improvement in forced expiratory volume in the first second of expiration [FEV1] after 360 mcg of albuterol), or airway hyperresponsiveness (provocative concentration of methacholine [ $< 8\text{mg/ml}$ ] causing a 20% drop in FEV1)
Stratum	Adults and young people (16 years and over)
Subgroup analysis within study	Not applicable
Inclusion criteria	Mild to moderate persistent asthma, acceptable control of asthma (i.e. a score of 0 or 1 on each of the 3

	questions on the Asthma Evaluation Questionnaire and predicted bronchodilator FEV1 >70%), and patients who demonstrated at least 75% adherence (i.e. those patients that could tolerate 2 puffs twice daily of beclomethasone HFA (40 mcg/puff)) during the run-in period
Exclusion criteria	Poorly controlled, severe asthma
Recruitment/selection of patients	Participants were recruited cooperatively with a concurrent Asthma Clinical Research Network trial
Age, gender and ethnicity	Age - Mean (SD): 35 (11.83). Gender (M:F): 105/237. Ethnicity: White: 216, Black: 69, Hispanic: 38, Asian/Pacific Islander:13, Other: 5, American Indian/Alaska Native: 1
Further population details	
Indirectness of population	No indirectness
Interventions	<p>(n=114) Intervention 1: No FeNO monitoring + treatment - Monitoring symptoms and lung function + treatment. Dose of inhaled corticosteroids was adjusted by an investigator according to a strategy based on National Heart, Lung, and Blood Institute guidelines (PABA). Dose adjustments of inhaled corticosteroids were made at the time of clinic visits (every 6 weeks). Treatment step down - PABA: Physician assessment-based adjustment, inhaler A (1). Fev1 ≥85% at baseline, plus symptoms in past 2 wk ≤2 d/wk (all AEQ of 0); control status: well controlled; inhaler dose change: down 1 level. (2). Fev1 ≥85% at baseline, plus symptoms no worse than mild (AEQ scores of 0 or 1 on each question); control status: controlled; inhaler dose change: maintain current level. (3). Fev1 &lt;85% at baseline, moderate symptoms (any AEQ score of 2 or 3), or meets criteria for treatment failure; control status: under controlled; inhaler dose change: up 1 level. . Duration 9 months. Concurrent medication/care: During the prerandomisation period, patients were given 3 inhalers coded as A, B, and C. Inhaler A contained beclomethasone HFA (40 mcg/puff), and inhalers B and C contained placebo. An albuterol inhaler was provided for use as needed for asthma symptoms. Participants were instructed to use 2 puffs twice daily from inhalers A and B, and to use 2 puffs from inhaler C each time they used 2 puffs of albuterol for symptom relief. Participants who demonstrated 75% adherence were randomised to one of the adjustment strategies (PABA, BBA, or SBA (occurrence of symptoms - data not extracted)). Beclomethasone HFA was provided at a dosage of 2 puffs twice daily (40 mcg/puff) before randomisation, corresponding to level 3 treatment. Hence, inhaled corticosteroid therapy could be intensified or deintensified during the trial. Following randomisation, beclomethasone HFA was contained only in inhaler A for PABA participants, only in inhaler B for BBA patients, and only in inhaler C for SBA participants. Thereafter, inhalers were adjusted according to the strategy assigned (i.e. PABA or BBA). Subsequent visits occurred at 2, 4, 6, 12, 18, 24, 30, and 36 weeks after randomisation.</p> <p>Further details: 1. Additional education training: Not applicable / Not stated / Unclear 2. Aim of intervention: Aim to decrease ICS in controlled patients (To evaluate different approaches to dose adjustment of inhaled corticosteroids in a 3-group trial during 9 months in adults with mild to moderate asthma that was well controlled with low-dose inhaled corticosteroids).</p>

	<p>(n=115) Intervention 2: Monitoring FeNO + treatment. Dose of inhaled corticosteroids was adjusted by an investigator according to exhaled nitric oxide (BBA). Dose adjustments of inhaled corticosteroids were made at the time of clinic visits (every 6 weeks). BBA: Biomarker-based adjustment, inhaler B. Fraction of exhaled nitric oxide, ppb: (1). &lt;22; control status: well controlled; inhaler dose change: down 1 level. (2). 22-35; control status: controlled; inhaler dose change: maintain current level. (3). &gt;35; control status: under controlled; inhaler dose change: up 1 level. Inhaled corticosteroids dose level: (1) none, na; (2) 80 (2 puffs), once daily (am); (3) 160 (2 puffs), twice daily; (4) 320 (4 puffs), twice daily; (5) 640 (8; 4 puffs at double strength), twice daily.. Duration 9 months. Concurrent medication/care: During the prerandomisation period, patients were given 3 inhalers coded as A, B, and C. Inhaler A contained beclomethasone HFA (40 mcg/puff), and inhalers B and C contained placebo. An albuterol inhaler was provided for use as needed for asthma symptoms. Participants were instructed to use 2 puffs twice daily from inhalers A and B, and to use 2 puffs from inhaler C each time they used 2 puffs of albuterol for symptom relief. Participants who demonstrated 75% adherence were randomised to one of the adjustment strategies (PABA, BBA, or SBA (occurrence of symptoms - data not extracted)). Beclomethasone HFA was provided at a dosage of 2 puffs twice daily (40 mcg/puff) before randomisation, corresponding to level 3 treatment. Hence, inhaled corticosteroid therapy could be intensified or deintensified during the trial. Following randomisation, beclomethasone HFA was contained only in inhaler A for PABA participants, only in inhaler B for BBA patients, and only in inhaler C for SBA participants. Thereafter, inhalers were adjusted according to the strategy assigned (i.e. PABA or BBA). Subsequent visits occurred at 2, 4, 6, 12, 18, 24, 30, and 36 weeks after randomisation.</p> <p>Further details: 1. Additional education training : Not applicable / Not stated / Unclear 2. Aim of intervention: Aim to decrease ICS in controlled patients (To evaluate different approaches to dose adjustment of inhaled corticosteroids in a 3-group trial during 9 months in adults with mild to moderate asthma that was well controlled with low-dose inhaled corticosteroids).</p>
Funding	Academic or government funding (Study was conducted with the support of the Institute for Translational Sciences at the University of Texas Medical Branch, supported in part by a Clinical and Translational Science Award from the National Center for Advancing Translational Sciences, National Institutes of Health. The study was also supported by National Institutes of Health grants that were awarded by the National Heart, Lung, and Blood Institute. Teva Pharmaceuticals provided the study drug and matching placebo.)
<p><b>RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: MONITORING FENO + TREATMENT versus MONITORING SYMPTOMS AND LUNG FUNCTION + TREATMENT</b></p> <p>Protocol outcome 1: Quality of life at End of treatment</p>	



- Actual outcome for Adults and young people (16 years and over): AQLQ at 9 months; MD 0.00 (SE 0.11); Risk of bias: Very high; Indirectness of outcome: No indirectness

Protocol outcome 2: Exacerbation (need for OCS) at End of treatment

- Actual outcome for Adults and young people (16 years and over): Asthma exacerbation (including multiple episodes) at 36 weeks; HR InHR -0.095 (SE 0.429); Risk of bias: Very high; Indirectness of outcome: No indirectness

Protocol outcome 3: Asthma control questionnaires at End of Treatment

- Actual outcome for Adults and young people (16 years and over): ACQ at 9 months; MD -0.04 (SE 0.08); Risk of bias: Very high; Indirectness of outcome: No indirectness

Protocol outcome 4: Rescue medication at End of Treatment

- Actual outcome for Adults and young people (16 years and over): Rescue medication - albuterold rescue use (puffs) at 9 months; MD -0.06 (SE 0.034119); Risk of bias: Very high; Indirectness of outcome: No indirectness

Protocol outcome 5: Dose of regular asthma treatment (SABA, ICS) at End of Treatment

- Actual outcome for Adults and young people (16 years and over): Dose of regular asthma therapy (ICS, beclomethasone HFA (40 mcg/puff)) at 36 weeks; Risk of bias: High; Indirectness of outcome: No indirectness

Protocol outcome 6: Lung Function at End of Treatment

- Actual outcome for Adults and young people (16 years and over): Lung function - am peak flow 2-week average prior to visit 4, L/min at 9 months; MD 2.3 (SE 7.2); Risk of bias: Very high; Indirectness of outcome: No indirectness

- Actual outcome for Adults and young people (16 years and over): Lung function - pm peak flow 2-week average prior to visit 4, L/min at 9 months; MD 3.8 (SE 7.04); Risk of bias: Very high; Indirectness of outcome: No indirectness

- Actual outcome for Adults and young people (16 years and over): Lung function - prebronchodilator FEV1 at 9 months; MD 0.98 (SE 0.96); Risk of bias: Very high; Indirectness of outcome: No indirectness

Protocol outcome 7: Time of school/work at End of Treatment

- Actual outcome for Adults and young people (16 years and over): Time off school/work (no. of patients) at 36 weeks; OR InOR 0.693 (SE 0.273); Risk of bias: Very high; Indirectness of outcome: No indirectness

Protocol outcomes not reported by the study

Mortality at End of Treatment; UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment; Symptom free days at End of Treatment

**Table 131: de Jongste 2009<sup>397</sup>**

Study	CHARISM (Children with Asthma subjected to Respiratory Inflammatory Status Monitoring) trial: De jongste 2009 <sup>397</sup>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=151)
Countries and setting	Conducted in Netherlands; Setting: Secondary (clinic visits, data transmitted daily to centre, telephone contact).
Line of therapy	Mixed line
Duration of study	Intervention time: 30 weeks
Method of assessment of guideline condition	Adequate method of assessment/diagnosis: Diagnosed according to GINA guidelines
Stratum	Children 5 -<16
Subgroup analysis within study	Not applicable
Inclusion criteria	Age: 6-18 years; stable mild-moderate atopic asthma, diagnosed according to GINA guidelines; treatment with 200-1000 mcg of inhaled budesonide or equivalent daily for 2 months before randomisation; and RAST class 2 or higher or a positive skin prick test for at least one airborne allergen.
Exclusion criteria	Exclusion criteria were as follows: active smoking, previous admission to an intensive care unit for asthma, and concomitant disease that might affect FeNO.
Recruitment/selection of patients	Participants were recruited from 5 academic centres and 12 general hospitals.
Age, gender and ethnicity	Age - Mean (SD): 11.7 (3.538). Gender (M:F): 100/51. Ethnicity: Not stated
Further population details	
Indirectness of population	No indirectness
Interventions	(n=77) Intervention 1: Monitoring FeNO + treatment - Monitoring FeNO and symptoms + treatment. Children in the FeNO group received an airway inflammation monitor (NIOX MINO; Aerocrine, Solna, Sweden) that measures FeNO. Measurements were performed daily. Measurement time was recorded by the device. Data was transmitted to the coordinating centre. All parents were phoned every 3 weeks between visits, and medication was adapted according to geometric mean FeNO over the preceding 3 weeks and cumulative symptom scores. Algorithm: (a) symptom score, high; FeNO, high; adjustment, increase; (b) symptom score, high; FeNO, low; adjustment, no change; (c) symptom score, low; FeNO, high; adjustment, increase; (d) symptom score, low; FeNO, low; adjustment, decrease or discontinue. Cut-off level for symptom score - high score: >60, low score ≤60 cumulative in 3 weeks. Cut-off levels for FeNO were 20 ppb for children aged 6-10 years and 25 ppb for older children. . Duration 30 weeks. Concurrent medication/care: Monitored children with atopic asthma for 30 weeks. Children were randomised at first visit, stratified by centre. ICS doses were adjusted every 3 weeks on the basis of either FeNO and symptoms, or symptom

	<p>scores alone. All children recorded asthma symptoms in a palmtop diary. Entries were transmitted daily to the coordinating centre. Children in both groups were seen at randomisation and at 3, 12, 21, and 30 weeks. Doses were changed according to predefined steps for each type of inhaled steroid, for example, budesonide at 100, 200, 400, 800, and 1,200 mcg. Maximal allowed dose: 1200 mcg of budesonide or equivalent. If a combination of ICS and long-acting beta-agonist (LABA) was used, the LABA was stopped whenever decrease was required at the lowest ICS dose, before stopping ICS. Steroids were stopped for 6 weeks with low symptom scores at the lowest steroid dose level. Further details: 1. Additional education training: Not applicable / Not stated / Unclear 2. Aim of intervention: Not applicable / Not stated / Unclear</p> <p>(n=74) Intervention 2: No FeNO monitoring + treatment - Monitoring symptoms + treatment. All parents were phoned every 3 weeks between visits. Algorithm: symptom score: above average (adjustment - increase); in range (no change); below range (decrease or discontinue). Cut-off level: the "normal range" was 10-60. Duration 30 weeks. Concurrent medication/care: Monitored children with atopic asthma for 30 weeks. Children were randomised at first visit, stratified by centre. ICS doses were adjusted every 3 weeks on the basis of either FeNO and symptoms, or symptom scores alone. All children recorded asthma symptoms in a palmtop diary. Entries were transmitted daily to the coordinating centre. Children in both groups were seen at randomisation and at 3, 12, 21, and 30 weeks. Doses were changed according to predefined steps for each type of inhaled steroid, for example, budesonide at 100, 200, 400, 800, and 1,200 mcg. Maximal allowed dose: 1200 mcg of budesonide or equivalent. If a combination of ICS and long-acting beta-agonist (LABA) was used, the LABA was stopped whenever decrease was required at the lowest ICS dose, before stopping ICS. Steroids were stopped for 6 weeks with low symptom scores at the lowest steroid dose level. Further details: 1. Additional education training: Not applicable / Not stated / Unclear 2. Aim of intervention: Not applicable / Not stated / Unclear</p>
<p>Funding</p>	<p>Study funded by industry (Supported by a research grant from Aerocrine AB (Solna, Sweden). Conflict of interest statement: authors received travel grants, research grants and lectured at scientific meetings for the following: GlaxoSmithLine, Merck Sharp &amp; Dohme, Altana Pharma, Aerocrine, Abbott, Valeas, Chiesi and Roche. Also note that the Department of Paediatrics/Erasmus MC Holding received research grants from GlaxoSmithKline, AstraZeneca, Aerocrine, Roche, Freisland Foods, Transave, Chiron, and Pfizer.)</p>

**RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: MONITORING FENO AND SYMPTOMS + TREATMENT versus MONITORING SYMPTOMS + TREATMENT**

Protocol outcome 1: Quality of life at End of treatment

- Actual outcome for Children 5 -<16 : PACQLQ(S) - Paediatric Asthma Caregiver Quality of Life Questionnaire with Standardised Activities at 30 weeks; Group 1: mean

6.2 (SD 0.8); n=75, Risk of bias: Very high; Indirectness of outcome: No indirectness	
Protocol outcome 2: Exacerbation (need for OCS) at End of treatment - Actual outcome for Children 5 -<16 : Exacerbation - OCS, prednisone course at 30 weeks; Group 1: 9/75, Group 2: 12/72; Risk of bias: Very high; Indirectness of outcome: No indirectness	
Protocol outcome 3: UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment - Actual outcome for Children 5 -<16 : UHU at 30 weeks; Risk of bias: Very high; Indirectness of outcome: No indirectness	
Protocol outcome 4: Rescue medication at End of Treatment - Actual outcome for Children 5 -<16 : Rescue medication - beta agonist puffs per 3 weeks at 30 weeks; Risk of bias: Very high; Indirectness of outcome: No indirectness	
Protocol outcome 5: Dose of regular asthma treatment (SABA, ICS) at End of Treatment - Actual outcome for Children 5 -<16 : Dose of regular therapy - ICS, budesonide at 30 weeks; Risk of bias: Very high; Indirectness of outcome: No indirectness	
Protocol outcome 6: Lung Function at End of Treatment - Actual outcome for Children 5 -<16 : Lung function - FEV1 at 30 weeks; Group 1: mean 95 % (SD 14); n=75, Group 2: mean 94 % (SD 14); n=72; Risk of bias: Very high; Indirectness of outcome: No indirectness	
Protocol outcome 7: Symptom free days at End of Treatment - Actual outcome for Children 5 -<16 : % symptom free days over last 12 weeks at 30 weeks; MD 0.3 (95%CI -10 to 11); Risk of bias: Very high; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Mortality at End of Treatment; Asthma control questionnaires at End of Treatment; Time of school/work at End of Treatment

**Table 132: Fritsch 2006<sup>522</sup>**

Study	Fritsch 2006 <sup>522</sup>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=47)
Countries and setting	Conducted in Austria; Setting: Secondary care - Paediatric Pulmonology outpatient clinic
Line of therapy	Mixed line
Duration of study	Intervention time: 6 months

Method of assessment of guideline condition	Adequate method of assessment/diagnosis: A paediatrician, trained in paediatric pulmonology and allergology, diagnosed participants asthma according to ATS criteria.
Stratum	Children 5 -<16
Subgroup analysis within study	Not applicable
Inclusion criteria	Patients aged 6-18 years, with mild to moderate persistent asthma. All participants had a positive skin prick test or radioallergosorbent test (RAST >1) to at least one of seven common aeroallergens (cat, dog, house dust mite, alternaria, birch-, hazelnut-, and mixed grass-pollen) in their past medical history or at the time of recruitment.
Exclusion criteria	Participants who had received oral or IV steroid treatment 4 weeks prior to the first visit were excluded from the study.
Recruitment/selection of patients	Recruited from the Paediatric Pulmonology outpatient clinic of the University Children's Hospital Vienna.
Age, gender and ethnicity	Age - Mean (SD): 11.73 (3.121). Gender (M:F): 28/19. Ethnicity: Not stated
Further population details	
Indirectness of population	No indirectness
Interventions	<p>(n=25) Intervention 1: No FeNO monitoring + treatment - Monitoring symptoms and lung function + treatment. Children in the control group were treated considering parameters of asthma control (symptoms, short-acting beta agonist use, and lung function) recommended in current asthma guidelines. A step down in therapy was performed if FEV1 % predicted was <math>\geq 80\%</math> and there was no or mild symptoms over the last 4 weeks and beta agonist use was &lt;6 puffs over the last 12 days. A step up was performed in every other case. . Duration 6 months. Concurrent medication/care: Following a run-in period of 4 weeks participants were randomly assigned to a control group or a FeNO group at the first visit. The trial included five visits (6 weeks intervals) over a period of 6 months. Doses - Low dose ICS: (2X 100 mcg fluticasone or 2x 200 mcg budesonide); Low dose ICS + leukotriene receptor agonists: (2x 100 mcg fluticasone or 2x 200 mcg budesonide + 5 mg montelukast once daily p.o.); Low dose ICS + long acting beta-agonist (2x 100 mcg fluticasone + 2x 50 mcg salmeterol or 2x 200 mcg Budesonide + 2x 12 mcg formeterol); High dose ICS + leukotriene receptor agonist (2x 250 mcg fluticasone or budesonide 2x 400 mcg + 1 daily 5 mg montelukast p.o.); High dose ICS + long acting beta-agonist (2x 250 mcg fluticasone + 2x 50 mcg salmeterol or 2x 400 mcg budesonide + 2x 12 mcg formeterol).</p> <p>Further details: 1. Additional education training: Not applicable / Not stated / Unclear 2. Aim of intervention: Not applicable / Not stated / Unclear</p> <p>(n=22) Intervention 2: Monitoring FeNO + treatment - Monitoring FeNO, symptoms and lung function + treatment. FeNO group therapy was based on symptoms, beta agonist use, lung function, and FeNO. A step down in therapy was performed if FEV1 % predicted was <math>\geq 80\%</math> and there was no or mild symptoms over the last 4 weeks and beta agonist use was &lt;6 puffs over the last 14 days. A step up was performed in every other case. Treatment was further adjusted</p>

	<p>according the FeNO cut-off point, &gt;20 ppb. In participants with stable asthma increased FeNO was considered a sign of insufficient anti-inflammatory treatment. These patients were provided with 2-week diary cards to record daily symptoms, beta agonists use and controller medication requirement, and telephone calls were regularly performed to check adherence to therapy. Asymptomatic patients on therapy with beta-agonist on demand only, with normal lung function but increased FeNO were prescribed low dose steroids. Step up was performed irrespective of FeNO level if FEV1% predicted was &lt;80% and/or there were severe symptoms over the last 4 weeks and/or beta-agonist use was ≥6 puffs over the last 14 days. If FeNO was raised in these patients, they received 2-week diary cards as well. Step down was performed if FEV1% predicted was ≥80% and there were no or mild symptoms over the last 4 weeks and beta-agonist use was &lt;6 puffs over the last 14 days and FeNO was ≤20 ppb.. Duration 6 months. Concurrent medication/care: Following a run-in period of 4 weeks participants were randomly assigned to a control group or a FeNO group at the first visit. The trail included five visits (6 weeks intervals) over a period of 6 months. Doses - Low dose ICS: (2X 100 mcg fluticasone or 2x 200 mcg budesonide); Low dose ICS + leukotriene receptor agonists: (2x 100 mcg fluticasone or 2x 200 mcg budesonide + 5 mg montelukast once daily p.o.); Low dose ICS + long acting beta-agonist (2x 100 mcg fluticasone + 2x 50 mcg salmeterol or 2x 200 mcg Budesonide + 2x 12 mcg formeterol); High dose ICS + leukotriene receptor agonist (2x 250 mcg fluticasone or budesonide 2x 400 mcg + 1 daily 5 mg montelukast p.o.); High dose ICS + long acting beta-agonist (2x 250 mcg fluticasone + 2x 50 mcg salmeterol or 2x 400 mcg budesonide + 2x 12 mcg formeterol).</p> <p>Further details: 1. Additional education training: Not applicable / Not stated / Unclear 2. Aim of intervention: Not applicable / Not stated / Unclear</p>
Funding	Study funded by industry (Aerocine provided technical support and help with data analyses)
<p><b>RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: MONITORING FENO, SYMPTOMS AND LUNG FUNCTION + TREATMENT versus MONITORING SYMPTOMS AND LUNG FUNCTION + TREATMENT</b></p> <p>Protocol outcome 1: Exacerbation (need for OCS) at End of treatment - Actual outcome for Children 5 -&lt;16 : Exacerbation - OCS at 6 months; Group 1: 2/22, Group 2: 2/25; Risk of bias: Very high; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 2: Dose of regular asthma treatment (SABA, ICS) at End of Treatment - Actual outcome for Children 5 -&lt;16 : Dose of regular treatment - ICS dose at 6 months; Other: ; Risk of bias: Very high; Indirectness of outcome: No indirectness</p>	
Protocol outcomes not reported by the study	Mortality at End of Treatment; Quality of life at End of treatment; UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment; Asthma control questionnaires at End of Treatment; Rescue medication at End of Treatment; Lung Function at End of Treatment; Symptom free days at End of Treatment; Time of school/work at End of Treatment

**Table 133: Honkoop 2014<sup>691</sup>**

Study	Asthma Control Cost-Utility Randomised Trial Evaluation (ACCURATE) trial: Honkoop 2014 <sup>691</sup>
Study type	RCT (Cluster randomised; Parallel)
Number of studies (number of participants)	1 (n=647)
Countries and setting	Conducted in Netherlands; Setting: Primary
Line of therapy	Mixed line
Duration of study	Intervention time: 12 months
Method of assessment of guideline condition	Partially adequate method of assessment/diagnosis: Doctor diagnosed asthma according to Dutch national guidelines
Stratum	Adults and young people (16 years and over)
Subgroup analysis within study	Not applicable
Inclusion criteria	18-50 years old, doctor-diagnosed asthma according to the Dutch national guidelines, a prescription for ICSs for at least 3 months in the previous year, and asthma being managed in primary care
Exclusion criteria	Significant comorbidity (at the GPs discretion), inability to understand Dutch, and a prescription for oral corticosteroids in the previous month
Recruitment/selection of patients	General practices from both rural and urban areas in The Netherlands were invited to participate
Age, gender and ethnicity	Age - Mean (SD): 39.42 (9.633). Gender (M:F): 191/420 . Ethnicity: Not specified
Further population details	
Indirectness of population	No indirectness
Interventions	(n=205) Intervention 1: Monitoring FeNO + treatment - Monitoring FeNO and symptoms + treatment. Treatment strategy: aiming at FeNO-driven controlled asthma (FCa strategy). In all strategies, patients visited the practice nurse of their general practice every 3 months over the course of 1 year. During these visits, the practice nurse assessed current medication use and asthma control status by using the 7-item asthma control questionnaire that includes lung function. In addition, FeNO measurement was performed in the FCa strategy. Duration 12 months. Concurrent medication/care: At each visit, a patient's asthma control status was classified based on the ACQ score as controlled (ACQ score $\leq 0.75$ ), partly controlled ( $0.75 < ACQ \leq 1.5$ ), or uncontrolled (ACQ score $> 1.5$ ); and additionally in the FCa strategy as 3 subcategories of FeNO: low/absence of airway inflammation for values at 25 ppb or less, intermediate at 26 to 50 ppb, and high/presence of airway inflammation at greater than 50 ppb. Treatment decisions were based on a dedicated algorithm for each strategy. (1)Strategy aimed at Ca = asthma controlled status Ca (ACQ $\leq 0.75$ ): 3mo: no change, 6mo: step down; asthma controlled status PCa ( $0.75 > ACQ \leq 1.5$ ): step up, treatment choice open; asthma

controlled status uncontrolled (ACQ >1.5): step up, treatment choice open. (2)Strategy aimed at FCa, low FeNO (<25 ppb) = asthma controlled status Ca (ACQ ≤0.75): step down, treatment choice open; asthma controlled status PCa (0.75 > ACQ ≤1.5): 3 mo: no change/change within current step to LABA, 6mo: step down to ICS; asthma controlled status uncontrolled (ACQ >1.5): 3 mo: step up LABA, 6mo: revise asthma diagnosis. (3)Strategy aimed at FCa, intermediate FeNO (25-50 ppb) = asthma controlled status Ca (ACQ ≤0.75): no change; asthma controlled status PCa (0.75 > ACQ ≤1.5): step up, treatment choice open; asthma controlled status uncontrolled (ACQ >1.5): treatment choice open. (4)Strategy aimed at FCa, high FeNO (>50 ppb) = asthma controlled status Ca (ACQ ≤0.75): step up/change within current step to ICS; asthma controlled status PCa (0.75 > ACQ ≤1.5): step up, 1 X ICS; asthma controlled status uncontrolled (ACQ >1.5): step up, 2 X ICS. Current medication use and all measurements were entered into an online decision support tool, which subsequently automatically generated treatment advice based on the appropriate algorithm for each of the treatment strategies. Patients' current medication use was classified as an asthma treatment step ranging from 0 (only short-acting beta agonists) to 5 (oral prednisone) based on the US National Asthma Education and Prevention Programme guideline. When treatment was to be adjusted, in the Ca strategy professionals and patients could choose any (combination of) type or types of asthma medication they preferred within a certain treatment step, whereas the FCa strategy offered more guidance toward adding/removing LABAS or ICSs.

Further details: 1. Additional education training : No education in both groups 2. Aim of intervention: Not applicable / Not stated / Unclear

(n=210) Intervention 2: No FeNO monitoring + treatment - Monitoring symptom control questionnaires + treatment. Treatment strategy: aiming at controlled asthma (Ca strategy). In all strategies, patients visited the practice nurse of their general practice every 3 months over the course of 1 year. During these visits, the practice nurse assessed current medication use and asthma control status by using the 7-item asthma control questionnaire that includes lung function. . Duration 12 months. Concurrent medication/care: At each visit, a patient's asthma control status was classified based on the ACQ score as controlled (ACQ score ≤0.75), partly controlled (0.75 <ACQ ≤1.5), or uncontrolled (ACQ score >1.5); and additionally in the FCa strategy as 3 subcategories of FeNO: low/absence of airway inflammation for values at 25 ppb or less, intermediate at 26 to 50 ppb, and high/presence of airway inflammation at greater than 50 ppb. Treatment decisions were based on a dedicated algorithm for each strategy. (1)Strategy aimed at Ca = asthma controlled status Ca (ACQ ≤0.75): 3mo: no change, 6mo: step down; asthma controlled status PCa (0.75 > ACQ ≤1.5): step up, treatment choice open; asthma controlled status uncontrolled (ACQ >1.5): step up, treatment choice open. (2)Strategy aimed at FCa, low FeNO (<25 ppb) = asthma controlled status Ca (ACQ ≤0.75): step down, treatment choice open; asthma controlled status PCa (0.75 > ACQ ≤1.5): 3 mo: no change/change within current step to LABA, 6mo: step down to ICS; asthma controlled status uncontrolled (ACQ >1.5): 3 mo: step up LABA, 6mo: revise asthma diagnosis. (3)Strategy aimed at FCa, intermediate FeNO (25-50 ppb) = asthma controlled status Ca (ACQ ≤0.75): no change; asthma controlled status PCa (0.75 > ACQ ≤1.5): step up, treatment choice open; asthma controlled status uncontrolled (ACQ >1.5): treatment choice open. (4)Strategy aimed at FCa, high FeNO (>50 ppb) =



	<p>asthma controlled status Ca (ACQ <math>\leq</math>0.75): step up/change within current step to ICS; asthma controlled status PCa (0.75 &gt; ACQ <math>\leq</math>1.5): step up, 1 X ICS; asthma controlled status uncontrolled (ACQ &gt;1.5): step up, 2 X ICS. Current medication use and all measurements were entered into an online decision support tool, which subsequently automatically generated treatment advice based on the appropriate algorithm for each of the treatment strategies. Patients' current medication use was classified as an asthma treatment step ranging from 0 (only short-acting beta agonists) to 5 (oral prednisone) based on the US National Asthma Education and Prevention Programme guideline. When treatment was to be adjusted, in the Ca strategy professionals and patients could choose any (combination of) type or types of asthma medication they preferred within a certain treatment step, whereas the FCa strategy offered more guidance toward adding/removing LABAs or ICSs.</p> <p>Further details: 1. Additional education training: No education in both groups 2. Aim of intervention: Not applicable / Not stated / Unclear</p>
Funding	<p>Study funded by industry (Study was funded by the Netherlands Organisation for Health Research and Development and the Netherlands Asthma Foundation, and nonfinancial support was received from Aerocrine. Author holds stock in Grace Bros and received consultancy fees from Astra-Zeneca, GlaxoSmithKline, and Novartis, as well as grants funding from ACME Pharmaceutical.)</p>

**RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: MONITORING FENO AND SYMPTOMS + TREATMENT versus MONITORING SYMPTOM CONTROL QUESTIONNAIRES + TREATMENT**

**Protocol outcome 1: Exacerbation (need for OCS) at End of treatment**

- Actual outcome for Adults and young people (16 years and over): Exacerbation (severe, defined as hospitalisation, emergency care or use of OCS) at 12 months; Risk of bias: High; Indirectness of outcome: Serious indirectness

**Protocol outcome 2: UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment**

- Actual outcome for Adults and young people (16 years and over): UHU - hospitalisation (from the exacerbation outcome) at 12 months; Group 1: 1/189, Group 2: 2/203; Risk of bias: High; Indirectness of outcome: No indirectness

- Actual outcome for Adults and young people (16 years and over): UHU - ED visit (from the exacerbation outcome) at 12 months; Group 1: 2/189, Group 2: 3/203; Risk of bias: High; Indirectness of outcome: No indirectness

**Protocol outcome 3: Asthma control questionnaires at End of Treatment**

- Actual outcome for Adults and young people (16 years and over): ACQ-7 score at 12 months; Risk of bias: High; Indirectness of outcome: No indirectness

**Protocol outcome 4: Lung Function at End of Treatment**

- Actual outcome for Adults and young people (16 years and over): Lung function (FEV1 % predicted) at 12 months; Risk of bias: High; Indirectness of outcome: No

indirectness	
Protocol outcomes not reported by the study	Mortality at End of Treatment; Quality of life at End of treatment; Rescue medication at End of Treatment; Dose of regular asthma treatment (SABA, ICS) at End of Treatment; Symptom free days at End of Treatment; Time of school/work at End of Treatment

**Table 134: Peirsman 2013<sup>1317</sup>**

Study	Peirsman 2013 <sup>1317</sup>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=99)
Countries and setting	Conducted in Belgium; Setting: Secondary
Line of therapy	Mixed line
Duration of study	Intervention time: 12 months
Method of assessment of guideline condition	Method of assessment /diagnosis not stated: Not stated - children with persistent allergic asthma
Stratum	Children 5 -<16
Subgroup analysis within study	Not applicable
Inclusion criteria	Children with persistent allergic asthma. Mild to severe persistent asthma according to GINA guidelines, for a period of at least 6 months, and allergic sensitisation (i.e., a positive skin prick test and/or specific IgE antibodies against inhalant allergens).
Exclusion criteria	Exclusion criteria comprised significant comorbidity, an acute exacerbation or the administration of experimental medication 4 weeks prior to the screening visit, hospitalisation and/or systematic corticosteroids 12 weeks prior to the screening visit or oral corticosteroids dependence.
Recruitment/selection of patients	Secondary - visits were organised by physicians from seven Belgian hospitals.
Age, gender and ethnicity	Age - Mean (SD): 10.65 (2.151). Gender (M:F): 66/33. Ethnicity: Not stated
Further population details	
Indirectness of population	No indirectness
Interventions	(n=49) Intervention 1: Monitoring FeNO and symptoms + treatment. In the intervention group, FeNO measurements were primarily used to adjust the treatment. Goal was to keep FeNO below 20 ppb, the rounded 95% upper limit of

	<p>FeNO values in healthy children, deduced from previous trials. Controlled asthma = NO ≤20 ppb and controlled; ICS (dosage in budesonide or equivalent) = ICS step down - 100 mcg/day, below 100 mcg/day: stop and add LTRA; LTRA = stay the same; ICS + LTRA = ICS step down: -100 mcg/day, below 100 mcg/day: stop ICS; ICS + LABA = stop LABA. Partly controlled asthma = NO ≤20 ppb and partly controlled or uncontrolled; ICS (dosage in budesonide or equivalent) = consider + LTRA; consider + ICS 100 mcg/day (max 200 mcg/day); ICS + LTRA = consider ICS step up + 100 mcg/day (max 400 mcg/day, then add LABA); ICS + LABA = consider + LTRA. Uncontrolled asthma = NO &gt;20 ppb regardless of symptoms; ICS (dosage in budesonide or equivalent) = +LTRA; LTRA = +ICS 100 mcg/day (max 200 mcg/day); ICS + LTRA = ICS step up: 100 mcg/day, (max 400 mcg/day, then add LABA); ICS + LABA = replace LABA with LTRA.. Duration 12 months. Concurrent medication/care: Five visits, one every 3 months.</p> <p>Further details: 1. Additional education training: Not applicable / Not stated / Unclear 2. Aim of intervention: Not applicable / Not stated / Unclear</p> <p>(n=50) Intervention 2: No FeNO monitoring + treatment - Monitoring symptoms and lung function + treatment. In the control group, control and treatment adjustments during each visit were determined by the reporting of symptoms (i.e., limitation of activities, daytime and nocturnal symptoms), the need for rescue treatment during the two preceding weeks and spirometry (FEV1), based on GINA guidelines.. Duration 12 months. Concurrent medication/care: Five visits, one every 3 months.</p> <p>Further details: 1. Additional education training: Not applicable / Not stated / Unclear 2. Aim of intervention: Not applicable / Not stated / Unclear</p>
<p>Funding</p>	<p>Study funded by industry (Research supported in part by a research grant from the Investigator Initiated Studies Program of Merck &amp; Co., Inc. NO analysers were provided by Aerocrine, Solna, Sweden.)</p>
<p><b>RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: MONITORING FENO + TREATMENT versus MONITORING SYMPTOMS AND LUNG FUNCTION + TREATMENT</b></p> <p>Protocol outcome 1: Exacerbation (need for OCS) at End of treatment          - Actual outcome for Children 5 -&lt;16 : exacerbation (OCS) at 12 months; Group 1: 2/49, Group 2: 3/50; Risk of bias: Very high; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 2: UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment          - Actual outcome for Children 5 -&lt;16 : UHU - number of unscheduled asthma-related contacts at 12 months; Group 1: 6/44, Group 2: 15/43; Risk of bias: Very high; Indirectness of outcome: No indirectness          - Actual outcome for Children 5 -&lt;16 : UHU - number of children with ≥1 hospital admission at 12 months; Group 1: 1/43, Group 2: 1/43; Risk of bias: Very high; Indirectness of outcome: No indirectness          - Actual outcome for Children 5 -&lt;16 : UHU - number of children with ≥1 emergency room admission at 12 months; Group 1: 2/45, Group 2: 4/46; Risk of bias: Very</p>	

<p>high; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 3: Dose of regular asthma treatment (SABA, ICS) at End of Treatment - Actual outcome for Children 5 -&lt;16 : Dose of regular therapy - change in daily ICS dose at 12 months; Risk of bias: Very high; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 4: Lung Function at End of Treatment - Actual outcome for Children 5 -&lt;16 : lung function - FEV1 (mean % predicted) [<math>\geq 6</math>mo] at 12 months; Group 1: mean 93.9 mean % predicted (SD 15.5); n=49, Group 2: mean 91.2 mean % predicted (SD 12.3); n=50; Risk of bias: Very high; Indirectness of outcome: No indirectness - Actual outcome for Children 5 -&lt;16 : lung function - FEV1 (mean % predicted) [<math>&lt; 6</math>mo] at 3 months; Group 1: mean 92.2 (SD 14.1); n=49, Group 2: mean 90.7 (SD 13.2); n=50; Risk of bias: Very high; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 5: Symptom free days at End of Treatment - Actual outcome for Children 5 -&lt;16 : % symptom free days at 12 months; Risk of bias: Very high; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 6: Time of school/work at End of Treatment - Actual outcome for Children 5 -&lt;16 : time off school/work - number of children missed school at 12 months; Group 1: 10/46, Group 2: 12/46; Risk of bias: Very high; Indirectness of outcome: No indirectness</p>	
<p>Protocol outcomes not reported by the study</p>	<p>Mortality at End of Treatment; Quality of life at End of treatment; Asthma control questionnaires at End of Treatment; Rescue medication at End of Treatment</p>

**Table 135: Petsky 2014<sup>1340</sup>**

Study	Petsky 2014 <sup>1340</sup>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=63)
Countries and setting	Conducted in Australia, Hong Kong (China); Setting: Secondary care
Line of therapy	Unclear
Duration of study	Intervention time: 12 months
Method of assessment of guideline condition	Partially adequate method of assessment/diagnosis: Under the care of a paediatrician
Stratum	Children 5 -<16
Subgroup analysis within study	Not applicable
Inclusion criteria	Children aged >4 years with persistent asthma, prescribed anti-inflammatory asthma treatment, and receiving their

	care primarily through the clinical service at Royal Children’s Hospital, Brisbane or Prince of Wales Hospital, Hong Kong.
Exclusion criteria	Children who had underlying cardio-respiratory illness such as bronchiectasis or tracheomalacia, inability to take ICS or long acting beta-2-agonists (LABA) or previous poor adherence to medications (as documented in clinic notes).
Recruitment/selection of patients	Not stated
Age, gender and ethnicity	Age - Median (IQR): 10.17 (6.56,12.69) years FeNO; 10.08 (6.25, 12.44) years controls. Gender (M:F): 31:32. Ethnicity: Not stated
Further population details	
Indirectness of population	No indirectness
Interventions	<p>(n=31) Intervention 1: Monitoring FeNO + treatment. Management based on FeNO levels and atopic status. If FeNO was low for two consecutive visits, medications were stepped down. Elevated FeNO was defined <math>\geq 10</math>ppb in children with no positive skin prick test (SPT), <math>\geq 12</math>ppb in children with one positive SPT, and <math>\geq 20</math>ppb in children with <math>\geq 2</math> positive SPT. Treatment steps were modified from the Australian National Asthma Council guidelines and GINA guidelines.. Duration 1 year. Concurrent medication/care: 2-week run-in period when the children were maintained on their current treatment. If they were unstable (based on clinician review and diary cards) their medications were adjusted by their treating physician and a further run-in period was undertaken Further details: 1. Additional education training: Not applicable / Not stated / Unclear 2. Aim of intervention: Not applicable / Not stated / Unclear</p> <p>(n=32) Intervention 2: No FeNO monitoring + treatment - Monitoring symptoms + treatment. Management based on clinical symptoms. Treatment decisions were made on symptoms as recorded on the asthma symptom diary card. Control was considered inadequate and treatment increased if scores increased by more than or equal to 15% since the previous visit. Treatment was stepped down if the child’s scores totalled <math>&lt; 10</math> in recent week. Treatment steps were modified from the Australian National Asthma Council guidelines and GINA guidelines.. Duration 1 year. Concurrent medication/care: 2-week run-in period when the children were maintained on their current treatment. If they were unstable (based on clinician review and diary cards) their medications were adjusted by their treating physician and a further run-in period was undertaken Further details: 1. Additional education training: Not applicable / Not stated / Unclear 2. Aim of intervention: Not applicable / Not stated / Unclear</p>
Funding	Academic or government funding (Asthma Foundation of Queensland 2008, Royal Children’s Hospital Foundation, NHMRC)

RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: MONITORING FENO + TREATMENT versus MONITORING SYMPTOMS + TREATMENT

<p>Protocol outcome 1: Quality of life at End of treatment - Actual outcome for Children 5 -&lt;16 : Asthma QOL score at 12 months; Risk of bias: High; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 2: Exacerbation (need for OCS) at End of treatment - Actual outcome for Children 5 -&lt;16 : 1 or more exacerbations at 12 months; Group 1: 6/27, Group 2: 15/28; Risk of bias: Low; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 3: UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment - Actual outcome for Children 5 -&lt;16 : Hospitalisation at 12 months; Group 1: 0/27, Group 2: 0/28; Risk of bias: High; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 4: Dose of regular asthma treatment (SABA, ICS) at End of Treatment - Actual outcome for Children 5 -&lt;16 : Fluticasone dose at 12 months; Risk of bias: Low; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 5: Lung Function at End of Treatment - Actual outcome for Children 5 -&lt;16 : FEV1 % predicted at 12 months; Risk of bias: High; Indirectness of outcome: No indirectness</p>	
Protocol outcomes not reported by the study	Mortality at End of Treatment; Asthma control questionnaires at End of Treatment; Rescue medication at End of Treatment; Symptom free days at End of Treatment; Time of school/work at End of Treatment

**Table 136: Pijnenburg 2005<sup>1345</sup>**

Study	Pijnenburg 2005 <sup>1345</sup>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=85)
Countries and setting	Conducted in Netherlands
Line of therapy	Mixed line
Duration of study	Intervention + follow up: 12 months
Method of assessment of guideline condition	Adequate method of assessment/diagnosis: States participants were children with atopic asthma, and fulfilled ATS criteria for asthma.
Stratum	Children 5 -<16
Subgroup analysis within study	Not applicable
Inclusion criteria	Patients had been using inhaled corticosteroids (ICS) at a constant dose for at least 3 months preceding the study. All

	patients were atopic, defined as RAST class 2 or higher for at least 1 airborne allergen ever.
Exclusion criteria	None specified.
Recruitment/selection of patients	Participants were recruited from the outpatient clinic of Erasmus MC - Sophia Children's Hospital.
Age, gender and ethnicity	Age - Mean (SD): 12.28 (2.868). Gender (M:F): 55/30. Ethnicity: Not stated
Further population details	
Indirectness of population	No indirectness
Interventions	<p>(n=42) Intervention 1: Monitoring FeNO + treatment - Monitoring FeNO and symptoms + treatment. In the intervention group, ICS doses were determined by FeNO and symptoms according to the following algorithm: FeNO &gt;30ppb, regardless of symptoms = ICS increased; FeNO ≤30ppb AND symptoms &gt; 14 = ICS stays same; FeNO ≤30 AND symptoms ≤14 = ICS decreased.. Duration 12 months. Concurrent medication/care: After a 2-week run-in period, participants were randomly allocated to one of two groups stratified for baseline FeNO (≥ 30 or &lt;30 ppb) and dose of ICS (≥ 400 or &lt;400 mcg budesonide or equivalent daily dose). Study duration was 12 months, with five visits at 3-month intervals. FeNO was measured at each visit, and the ICS dose was then adapted to FeNO and/or symptom scores recorded during the previous 2 weeks. Throughout the study, 2000 mcg per day budesonide (or equivalent dose of other ICS) was the maximum allowed dose. The study design was such that the patients' physician was allowed to deviate from the recommended ICS dose. Lung function and bronchoprovocation tests with methacholine were performed at visits 1 and 5. At all visits, inhaler technique was checked and optimised. ICS doses: 100 mcg: increase to 200 mcg, decrease to 0 mcg; 200 mcg: increase to 400 mcg, decrease to 100 mcg; 400 mcg: increase to 800 mcg, decrease to 200 mcg; 500 mcg: increase to 1000 mcg, decrease to 250 mcg; 800 mcg: increase to 1200 mcg, decrease to 400 mcg; 1000 mcg: increase to 1500 mcg, decrease to 500 mcg; 1200 mcg: increase to 1600 mcg, decrease to 800 mcg; 1600 mcg: increase to 2000 mcg, decrease to 1200 mcg; 2000 mcg: no further increase, decrease to 1000 mcg.</p> <p>Further details: 1. Additional education training: Not applicable / Not stated / Unclear 2. Aim of intervention: Not applicable / Not stated / Unclear</p> <p>(n=47) Intervention 2: No FeNO monitoring + treatment - Monitoring symptoms + treatment. In the control group, only symptoms influenced ICS dosing. Symptoms &gt;14 = ICS increased; symptoms ≤ 14, first time = ICS stays same; symptoms ≤14, second time = ICS decreased. . Duration 12 months. Concurrent medication/care: After a 2-week run-in period, participants were randomly allocated to one of two groups stratified for baseline FeNO (≥ 30 or &lt;30 ppb) and dose of ICS (≥ 400 or &lt;400 mcg budesonide or equivalent daily dose). Study duration was 12 months, with five visits at 3-month intervals. FeNO was measured at each visit, and the ICS dose was then adapted to FeNO and/or symptom scores recorded during the previous 2 weeks. Throughout the study, 2000 mcg per day budesonide (or equivalent dose of other ICS) was the maximum allowed dose. The study design was such that the patients' physician was allowed to deviate from the recommended ICS dose. Lung function and bronchoprovocation tests with</p>

	<p>methacholine were performed at visits 1 and 5. At all visits, inhaler technique was checked and optimised. ICS doses: 100 mcg: increase to 200 mcg, decrease to 0 mcg; 200 mcg: increase to 400 mcg, decrease to 100 mcg; 400 mcg: increase to 800 mcg, decrease to 200 mcg; 500 mcg: increase to 1000 mcg, decrease to 250 mcg; 800 mcg: increase to 1200 mcg, decrease to 400 mcg; 1000 mcg: increase to 1500 mcg, decrease to 500 mcg; 1200 mcg: increase to 1600 mcg, decrease to 800 mcg; 1600 mcg: increase to 2000 mcg, decrease to 1200 mcg; 2000 mcg: no further increase, decrease to 1000 mcg.</p> <p>Further details: 1. Additional education training: Not applicable / Not stated / Unclear 2. Aim of intervention: Not applicable / Not stated / Unclear</p>
Funding	Other (Supported by grant from the Kroger Foundation/Sophia Children's Hospital Foundation. Authors note in conflict of interest statement that the Department of Paediatrics of Erasmus University received research grants and payments for consultancy services from Aerocine (manufacturer of NO analysers).)
<p><b>RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: MONITORING FENO AND SYMPTOMS + TREATMENT versus MONITORING SYMPTOMS + TREATMENT</b></p> <p>Protocol outcome 1: Exacerbation (need for OCS) at End of treatment          - Actual outcome for Children 5 -&lt;16 : Exacerbation - need for OCS (prednisone course) at 12 months; Group 1: 7/39, Group 2: 10/46; Risk of bias: Very high; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 2: Dose of regular asthma treatment (SABA, ICS) at End of Treatment          - Actual outcome for Children 5 -&lt;16 : Dose of regular treatment (mean daily ICS dose score, at 3 months) at 3 months; Risk of bias: Very high; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 3: Lung Function at End of Treatment          - Actual outcome for Children 5 -&lt;16 : Lung function - FEV1 at 12 months; MD 2.3 (95%CI -1.8 to 6.3); Risk of bias: Very high; Indirectness of outcome: No indirectness</p>	
Protocol outcomes not reported by the study	Mortality at End of Treatment; Quality of life at End of treatment; UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment; Asthma control questionnaires at End of Treatment; Rescue medication at End of Treatment; Symptom free days at End of Treatment; Time of school/work at End of Treatment



**Table 137: Pike 2012<sup>1346</sup>**

Study	Pike 2012 <sup>1346</sup>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=90)
Countries and setting	Conducted in United Kingdom; Setting: Secondary - hospital
Line of therapy	Mixed line
Duration of study	Intervention time: 12 months
Method of assessment of guideline condition	Adequate method of assessment/diagnosis: Asthma diagnosis was based upon a history of typical symptoms, $\geq 15\%$ increase in FEV1 with bronchodilator or diurnal PEF variability of $\geq 15\%$ .
Stratum	Children 5 - <16
Subgroup analysis within study	Not applicable
Inclusion criteria	Participants were age 6-17 years, clinical diagnosis of asthma and treatment with $\geq 400$ mcg/day beclomethasone/budesonide or $\geq 200$ mcg/day fluticasone.
Exclusion criteria	Inability to perform spirometry or FeNO measurement, cigarette smoking, poor treatment adherence, life-threatening exacerbation or need for maintenance oral prednisolone.
Recruitment/election of patients	Participants were recruited from outpatient clinics at Southampton University Hospital; St Mary's Hospital, Portsmouth; St Mary's Hospital, Isle of Wight; and, the Royal Hampshire County Hospital, Winchester.
Age, gender and ethnicity	Age - Mean (SD): 10.98 (2.695). Gender (M:F): 51/39. Ethnicity: Not stated
Further population details	
Indirectness of population	No indirectness
Interventions	(n=44) Intervention 1: No FeNO monitoring + treatment - Monitoring symptoms, BD use and lung function + treatment. Therapy decisions were taken by an independent clinician following a simple algorithm reflecting symptom control for standard management subjects. Under standard management, therapy was increased if symptoms were poorly controlled and decreased if symptoms were well controlled for 3 months as per the SIGN/BTS (Scottish Intercollegiate Guidelines Network/British Thoracic Society) guidelines. Algorithm for managing asthma: Standard management group: (a) poorly controlled asthma - increase inhaled corticosteroids or add LABA and/or LTRA as directed by stepwise approach to therapy SIGN/BTS; (b) asthma controlled – no change in inhaled corticosteroids; (c) well-controlled asthma – if well-controlled for 3 months reduced if inhaled corticosteroids if dose $\leq 400$ mcg, reduce LABA.. Duration 12 months. Concurrent medication/care: Participants asthma was stabilised if necessary over 4-16 weeks prior to randomisation. Participants were assessed 2 monthly for 12 months. Participants' asthma was

categorised as well controlled (symptoms and reliever inhaler <1 per week and FEV1 ≥90% predicted); controlled (symptoms or reliever inhaler use 1-2 days per week or FEV1 ≥80% predicted); or poorly controlled (symptoms or reliever inhaler use >2 days per week or FEV1 <80% predicted). Step 1: no inhaled corticosteroid (option 1); no inhaled corticosteroid (option 2); no inhaled corticosteroid (option 3). Step 2: Beclometasone 50 mcg twice a day via spacer (option 1); Budesonide 50 mcg twice a day via spacer (or tubohaler) (options 2); Fluticasone 50 mcg once a day via spacer (or accuhaler) (option 3). Step 3: Beclometasone 100 mcg twice a day via spacer (option 1); Budesonide 100 mcg twice a day via spacer (or tubohaler) (options 2); Fluticasone 50 mcg twice a day via spacer (or accuhaler) (option 3). Step 4: Beclometasone 200 mcg twice a day via spacer (option 1); Budesonide 200 mcg twice a day via spacer (or tubohaler) (options 2); Fluticasone 100 mcg once a day via spacer (or accuhaler) (option 3). Step 5: Trial of LABA, if ineffective consider trial of LTRA (options 1, 2, 3). Step 6: Fluticasone 125 mcg twice a day via spacer (options 1, 2, 3). Step 7: Fluticasone 250 mcg twice a day via spacer (options 1, 2, 3). Step 8: Consider a short course of prednisolone or other therapeutic options (options 1, 2, 3).

Further details: 1. Additional education training: Not applicable / Not stated / Unclear 2. Aim of intervention: Not applicable / Not stated / Unclear

(n=46) Intervention 2: Monitoring FeNO + treatment - Monitoring FeNO and symptoms + treatment. Therapy decisions were taken by an independent clinician following a simple algorithm reflecting FeNO measurements in addition to symptom control for FeNO group. ICS was decreased if FeNO ≤15 ppb and symptoms were controlled or well controlled for 3 months in similar steps as for the standard management group. Where asthma was poorly controlled and FeNO was <25ppb in the FeNO group, long-acting beta-agonist (LABA) therapy was maximised before ICS was increased. ICS was increased if FeNO ≥25 ppb or FeNO doubled from baseline. If FeNO remained raised after increasing by two SIGN/BTS steps, ICS was not further increased unless participants were poorly controlled. Algorithm for managing asthma: FeNO group: (a) ≥25 ppb or FeNO more than twice baseline: poorly controlled asthma - increase inhaled corticosteroids or add LTRA if already at SIGN/BTS step 4 (if after increasing by two SIGN/BTS steps FeNO remains high do not increase therapy further); asthma controlled/well-controlled asthma – increase inhaled corticosteroids or add LTRA if already at SIGN/BTS step 4. (b) >15 to <25 ppb: poorly controlled asthma - increase LABA therapy (if dose maximal, increase corticosteroids or add LTRA if already at SIGN/BTS step 4); asthma controlled/well-controlled asthma – continue current treatment. (c) ≤15 ppb: poorly controlled asthma – increase LABA (if does maximal, increase corticosteroids or add LTRA if already at SIGN/BTS step 4); asthma controlled/well-controlled asthma – if asthma controlled for 3 months, reduce inhaled corticosteroids (if dose ≤400 mcg, reduce LABA).. Duration 12 months. Concurrent medication/care: Participants asthma was stabilised if necessary over 4-16 weeks prior to randomisation. Participants were assessed 2 monthly for 12 months. Participants' asthma was categorised as well controlled (symptoms and reliever inhaler <1 per week and FEV1 ≥90% predicted); controlled (symptoms or reliever inhaler use 1-2 days per week or FEV1 ≥80% predicted); or poorly controlled (symptoms or reliever inhaler use >2 days per week or FEV1 <80% predicted). Step 1: no inhaled corticosteroid (option 1); no inhaled corticosteroid (option 2); no inhaled corticosteroid (option 3). Step 2: Beclometasone 50 mcg twice a day via spacer

	<p>(option 1); Budesonide 50 mcg twice a day via spacer (or tubohaler) (options 2); Fluticasone 50 mcg once a day via spacer (or accuhaler) (option 3). Step 3: Beclometasone 100 mcg twice a day via spacer (option 1); Budesonide 100 mcg twice a day via spacer (or tubohaler) (options 2); Fluticasone 50 mcg twice a day via spacer (or accuhaler) (option 3). Step 4: Beclometasone 200 mcg twice a day via spacer (option 1); Budesonide 200 mcg twice a day via spacer (or tubohaler) (options 2); Fluticasone 100 mcg once a day via spacer (or accuhaler) (option 3). Step 5: Trial of LABA, if ineffective consider trial of LTRA (options 1, 2, 3). Step 6: Fluticasone 125 mcg twice a day via spacer (options 1, 2, 3). Step 7: Fluticasone 250 mcg twice a day via spacer (options 1, 2, 3). Step 8: Consider a short course of prednisolone or other therapeutic options (options 1, 2, 3). Further details: 1. Additional education training: Not applicable / Not stated / Unclear 2. Aim of intervention: Not applicable / Not stated / Unclear</p>
Funding	Other (Funding was provided by Sparks)
<p><b>RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: MONITORING FENO AND SYMPTOMS + TREATMENT versus MONITORING SYMPTOMS + TREATMENT</b></p> <p>Protocol outcome 1: UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment - Actual outcome for Children 5 -&lt;16 : UHU - severe, requiring ≥8 hr hospital admission at 12 months; Group 1: 5/46, Group 2: 3/44; Risk of bias: High; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 2: Dose of regular asthma treatment (SABA, ICS) at End of Treatment - Actual outcome for Children 5 -&lt;16 : Dose of regular therapy - final inhaled corticosteroid dose at 12 months; Risk of bias: Very high; Indirectness of outcome: No indirectness</p>	
Protocol outcomes not reported by the study	Mortality at End of Treatment; Quality of life at End of treatment; Exacerbation (need for OCS) at End of treatment; Asthma control questionnaires at End of Treatment; Rescue medication at End of Treatment; Lung Function at End of Treatment; Symptom free days at End of Treatment; Time of school/work at End of Treatment

**Table 138: Powell 2011**<sup>1374</sup>

Study	Powell 2011 <sup>1374</sup>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=220)
Countries and setting	Conducted in Australia; Setting: Antenatal clinics
Line of therapy	Mixed line
Duration of study	Intervention time: Patients reviewed monthly until delivery
Method of assessment of guideline condition	Adequate method of assessment/diagnosis: Doctor's diagnosis of asthma and were using inhaled therapy for asthma within the past year
Stratum	Adults and young people (16 years and over)
Subgroup analysis within study	Not applicable
Inclusion criteria	Non-smoking pregnant women (aged >18 years) with asthma attending the antenatal clinics were recruited between weeks 12 and 20 of gestation. Women had a doctor's diagnosis of asthma and were using inhaled therapy for asthma within the past year. The diagnosis was confirmed by a respiratory physician's diagnostic interview.
Exclusion criteria	None specified
Recruitment/selection of patients	Recruited through antenatal clinics, between weeks 12 and 20 of gestation
Age, gender and ethnicity	Age - Other: Mean age (95% CI): control: 28.8 (27.72 - 29.84); intervention: 28.1 (27.12 - 29.09). Gender (M:F): All female sample. Ethnicity: Australian born - control: 94/103 (91.3%); intervention: 96/103 (93.2%)
Further population details	
Indirectness of population	No indirectness
Interventions	(n=111) Intervention 1: Monitoring FeNO + treatment. The FeNO algorithm used a sequential process: first, the FeNO concentration was used to adjust the dose of inhaled corticosteroids; and second the ACQ score was used to adjust the dose of long acting $\beta_2$ agonist. The cut-off points used for the dose reduction was 16 ppb, which was the upper 95% confidence limit of the mean FeNO concentration in pregnant women with asthma that remained controlled (ACQ <1.5) throughout pregnancy. The cut-off point for dose increase was 29 ppb. In terms of FeNO algorithm steps: steroid-naïve patients who needed inhaled corticosteroids started with budesonide 100mg twice per day. If a participant had undergone two dose increases but the FeNO concentration remained greater than 29 ppb, the inhaled corticosteroid was not increased further. If such a participant was symptomatic (ACQ score >1.5), formoterol 6mg twice per day was added. When FeNO concentrations were between 16 ppb and 29 ppb, the inhaled corticosteroid dose was not changed. Symptomatic patients (ACQ score >1.5) with FeNO in the range 16-29 ppb were treated with an increase in the $\beta_2$ agonist step, either with the addition of formoterol 6mg twice per day or an increase in formoterol dose. When FeNO concentrations were less than 16 ppb, inhaled corticosteroid dose was

reduced by 50%. If participants were simultaneously symptomatic, formoterol 6mg per day was added. For participants taking formoterol, the budesonide dose was not reduced to zero, but to 100mg twice per day. Participants who remained uncontrolled and were taking the maximum dose step, were assessed with subsequent treatment decided by the respiratory physician. . Duration 4-6 months. Concurrent medication/care: At visit 1 (baseline characterisation), FeNO and spirometry were measured, and the asthma control questionnaire was administered. Asthma self-management skills were assessed and optimised. Eligible women commenced a 2-week run-in period. Women using inhaled corticosteroids continued with their current dose, delivered as budesonide turbuhaler, with dose equivalence determined from guidelines. Women with uncontrolled asthma who were not using maintenance inhaled corticosteroids (n=31) were started on budesonide (200mg twice per day). At randomisation (visit 2), measurements included asthma symptoms, FeNO, spirometry, ACQ score, and quality-of-life questionnaires. Women were reviewed monthly at the antenatal clinic until delivery. The research assistant collected data and treatment were sent by facsimile to the algorithm keeper. This person applied the relevant algorithm and sent the treatment recommendation to the research assistant in the clinic, who informed the participant. Participants were seen by the investigator in the antenatal clinic if their asthma was uncontrolled and they were at the maximum treatment level of the algorithm. Telephone assessments were done 2 weeks after each clinic visit to assess symptoms and to encourage drug adherence.

Further details: 1. Additional education training : Not applicable / Not stated / Unclear 2. Aim of intervention: Not applicable / Not stated / Unclear

(n=109) Intervention 2: No FeNO monitoring + treatment - Monitoring symptoms + treatment. The clinical algorithm was based on asthma control, which was assessed with the Juniper ACQ with cut-off points defined as: well controlled (ACQ score <0.75), partially controlled (0.75-1.50), and uncontrolled (>1.5). After assessment of asthma control, a woman with uncontrolled asthma had her dose increased by one treatment step. Those with well controlled asthma had their inhaled corticosteroid dose reduced by one treatment step. The intermediate group represents partial loss of control, and no definite treatment change was undertaken. Participants who remained uncontrolled and were taking the maximum allowed dose were assessed and their subsequent treatment decided by the respiratory physician. . Duration 4-6 months. Concurrent medication/care: At visit 1 (baseline characterisation), FeNO and spirometry were measured, and the asthma control questionnaire was administered. Asthma self-management skills were assessed and optimised. Eligible women commenced a 2-week run-in period. Women using inhaled corticosteroids continued with their current dose, delivered as budesonide turbuhaler, with dose equivalence determined from guidelines. Women with uncontrolled asthma who were not using maintenance inhaled corticosteroids (n=31) were started on budesonide (200mg twice per day). At randomisation (visit 2), measurements included asthma symptoms, FeNO, spirometry, ACQ score, and quality-of-life questionnaires. Women were reviewed monthly at the antenatal clinic until delivery. The research assistant collected data and treatment were sent by facsimile to the algorithm keeper. This person applied the relevant algorithm and sent the treatment recommendation to the research assistant in the clinic, who informed the participant. Participants were seen by the

	<p>investigator in the antennal clinic if their asthma was uncontrolled and they were at the maximum treatment level of the algorithm. Telephone assessments were done 2 weeks after each clinic visit to assess symptoms and to encourage drug adherence.</p> <p>Further details: 1. Additional education training : Not applicable / Not stated / Unclear 2. Aim of intervention: Not applicable / Not stated / Unclear</p>
Funding	Academic or government funding (National Health and Medical Research Council of Australia)
<p><b>RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: MONITORING FENO + TREATMENT versus MONITORING SYMPTOMS + TREATMENT</b></p> <p><b>Protocol outcome 1: Quality of life at End of treatment</b>          - Actual outcome for Adults and young people (16 years and over): AQLQ-M total score at 4-6 months; Other: AQLQ-M 0-10 Top=High is poor outcome; Risk of bias: Low; Indirectness of outcome: No indirectness</p> <p><b>Protocol outcome 2: Exacerbation (need for OCS) at End of treatment</b>          - Actual outcome for Adults and young people (16 years and over): Exacerbation - mixed at 4-6 months; Group 1: 28/111, Group 2: 45/109; Risk of bias: ; Indirectness of outcome: No indirectness</p> <p><b>Protocol outcome 3: Asthma control questionnaires at End of Treatment</b>          - Actual outcome for Adults and young people (16 years and over): ACQ (mean ACQ score at exacerbation) at 4-6 months; Group 1: mean 1.97 (SD 0.95); n=111, Group 2: mean 2.02 (SD 0.79); n=109; ACQ 0-6 Top=High is poor outcome; Risk of bias: Low; Indirectness of outcome: No indirectness          - Actual outcome for Adults and young people (16 years and over): ACQ (mean ACQ score at unscheduled doctor visits) at 4-6 months; Group 1: mean 2.03 (SD 0.76); n=111, Group 2: mean 2.01 (SD 0.97); n=109; ACQ 0-6 Top=High is poor outcome; Risk of bias: Low; Indirectness of outcome: No indirectness          - Actual outcome for Adults and young people (16 years and over): ACQ (overall) at 4-6 months; Group 1: mean 0.56 (SD 0.67); n=111, Group 2: mean 0.72 (SD 0.8); n=109; ACQ 0-6 Top=High is poor outcome; Risk of bias: Low; Indirectness of outcome: No indirectness</p> <p><b>Protocol outcome 4: Dose of regular asthma treatment (SABA, ICS) at End of Treatment</b>          - Actual outcome for Adults and young people (16 years and over): Dose of regular asthma treatment - ICS at 4-6 months; Group 1: 200/111, Group 2: 0/109; Risk of bias: Low; Indirectness of outcome: No indirectness          - Actual outcome for Adults and young people (16 years and over): Dose of regular asthma treatment - SABA at 4-6 months; Group 1: 1/111, Group 2: 0/109; Risk of bias: Low; Indirectness of outcome: No indirectness</p> <p><b>Protocol outcome 5: Lung Function at End of Treatment</b>          - Actual outcome for Adults and young people (16 years and over): FEV1 (L) at 4-6 months; Other: ; Risk of bias: Low; Indirectness of outcome: No indirectness</p>	

- Actual outcome for Adults and young people (16 years and over): FEV1 (%) at 4-6 months; Other: ; Risk of bias: Low; Indirectness of outcome: No indirectness

Protocol outcome 6: Symptom free days at End of Treatment

- Actual outcome for Adults and young people (16 years and over): Symptom free days (past week) at 4-6 months; Group 1: 7/111, Group 2: 6/109; Risk of bias: Low; Indirectness of outcome: No indirectness

Protocol outcomes not reported by the study

Mortality at End of Treatment; UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment; Rescue medication at End of Treatment; Time of school/work at End of Treatment

**Table 139: Shaw 2007<sup>1558</sup>**

Study	Shaw 2007 <sup>1558</sup>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=118)
Countries and setting	Conducted in United Kingdom; Setting: Secondary - visits took place at hospital
Line of therapy	Mixed line
Duration of study	Intervention time: 12 months
Method of assessment of guideline condition	Adequate method of assessment/diagnosis: Participants had a diagnosis of asthma recorded in their general practitioner's (GP) notes. Participants attended hospital for tests to characterise their asthma: exhaled nitric oxide levels measured at flow of 50 ml/second, FEV1, and forced vital capacity (FVC), methacholine challenge test to determine the concentration of methacholine required to provoke a 20% fall in FEV1, induced sputum analysis, and skin prick tests.
Stratum	Adults and young people (16 years and over)
Subgroup analysis within study	Not applicable
Inclusion criteria	GP diagnosis of asthma. Participants were eligible if they had received at least one prescription for any antiasthma medication in the last 12 months. Study was restricted to current non-smokers with a past smoking history of less than 10 packs-years.
Exclusion criteria	Participants were excluded if they were considered by their physician to be poorly compliant or had had a severe asthma exacerbation, requiring a course of prednisolone, within 4 weeks of study entry.
Recruitment/selection of patients	Recruited from primary care - all suitable participants on the registers (held in general practices around Leicester, UK) who responded to an invitation from their GP to be contacted by the research team were invited to participate in the study.
Age, gender and ethnicity	Age - Mean (range): Intervention group: 50 (20-75). Control group: 52 (24-81).. Gender (M:F): 54/64. Ethnicity: Not specified
Further population details	
Indirectness of population	No indirectness
Interventions	(n=58) Intervention 1: Monitoring FeNO + treatment - Monitoring FeNO and symptoms + treatment. At each visit, patients asthma control was determined using a validated Juniper asthma control questionnaire, which scores asthma control from 0 to 6; a score of greater than 1.57 was used to identify poorly controlled asthma. Assessment of asthma control was made per protocol by investigators who were unaware of the participants' randomisation status. In the



FeNO group, treatment was adjusted following a set protocol according to both the FeNO and Juniper scores. If the FeNO was greater than 26 ppb, inhaled corticosteroid treatment was increased; if it was less than 16 ppb or less than 26 ppb on two consecutive occasions, treatment was decreased. Bronchodilator therapy was increased if symptoms were uncontrolled, despite a FeNO of less than 26 ppb. \*Hierarchy of Anti-Inflammatory Treatment: 1) Low dose inhaled steroid (100-200µg BDP bd). 2) Moderate dose inhaled steroid (200-800µg BDP bd). 3) High dose inhaled steroid (800-2000µg BDP bd). 4) High dose inhaled steroid (800-2000µg BDP bd) plus leukotriene antagonist. 5) Higher dose inhaled steroid (2000µg BDP bd) plus leukotriene antagonist. 6) Higher dose inhaled steroid (2000µg BDP bd) plus leukotriene antagonist plus oral Prednisolone 30mg. 2/52, then titrating dose reducing by 5mg/week \*\*Hierarchy of Bronchodilator Treatment: 1) PRN short acting β<sub>2</sub>-agonists. 2) Long acting β<sub>2</sub> agonist. 3) Long acting β<sub>2</sub> agonist plus theophylline. 4) Long acting β<sub>2</sub>-agonist plus theophylline plus nebulised bronchodilator.. Duration 12 months. Concurrent medication/care: Participants were seen 2 weeks following characterisation of their asthma, and then every month for 4 months; they were seen every 2 months for a further 8 months. Each visit occurred at the same time of day and consisted of assessment of exhaled nitric oxide, spirometry, and post-bronchodilator FEV<sub>1</sub>, 20 minutes after 400 mcg albuterol at the end of every visit. Peak flow and symptom diaries were analysed and compliance assessed by monitoring adherence to prescription script collection. Participants were issued with self-management plans based on their baseline peak flow from the first 2 weeks of the study; if their peak flow fell to less than 70% of their best peak flow for 48 hours during the study, or their asthma deteriorated, they were asked to attend the hospital where they were assessed by a physician. Further details: 1. Additional education training: Not applicable / Not stated / Unclear 2. Aim of intervention: Aim to decrease ICS in controlled patients

(n=60) Intervention 2: No FeNO monitoring + treatment - Monitoring symptom control questionnaires + treatment. At each visit, patients asthma control was determined using a validated Juniper asthma control questionnaire, which scores asthma control from 0 to 6; a score of greater than 1.57 was used to identify poorly controlled asthma. Assessment of asthma control was made per protocol by investigators who were unaware of the participants' randomisation status. In the control group, treatment was doubled if the score was more than 1.57, and treatment was halved if the score was less than 1.57 for 2 consecutive months. Step 1: SABA as required. Step 2: Add inhaled steroid 200 to 800mcg/day BDP equivalent. Step 3: Add inhaled LABA. Step 4: Increase ICS up to 2000mcg/day and addition of 4th drug, e.g. LTRA, theophylline, LABA. Step 5: Oral prednisolone, high does ICS, refer to specialist care.. Duration 12 months. Concurrent medication/care: Participants were seen 2 weeks following characterisation of their asthma, and then every month for 4 months; they were seen every 2 months for a further 8 months. Each visit occurred at the same time of day and consisted of assessment of exhaled nitric oxide, spirometry, and post-bronchodilator FEV<sub>1</sub>, 20 minutes after 400 mcg albuterol at the end of every visit. Peak flow and symptom diaries were analysed and compliance assessed by monitoring adherence to prescription script collection. Participants were issued with self-management plans based on their baseline peak flow from the first 2 weeks of the study; if their peak flow fell to less than 70% of their best peak flow for 48 hours during the study, or their asthma deteriorated, they

	<p>were asked to attend the hospital where they were assessed by a physician. Further details: 1. Additional education training: Not applicable / Not stated / Unclear 2. Aim of intervention: Aim to decrease ICS in controlled patients</p>
Funding	<p>Academic or government funding (Trial supported by a grant from Asthma UK. Conflict of interest statement: authors received grants (research and travel) from Glaxo SmithKline and lecture fees from Astra eneca.)</p>
<p><b>RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: MONITORING FENO AND SYMPTOMS + TREATMENT versus MONITORING SYMPTOM CONTROL QUESTIONNAIRES + TREATMENT</b></p> <p>Protocol outcome 1: Exacerbation (need for OCS) at End of treatment - Actual outcome for Adults and young people (16 years and over): Exacerbation - course of oral steroids or antibiotics at 12 months; Group 1: 12/58, Group 2: 19/60; Risk of bias: Very high; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 2: Dose of regular asthma treatment (SABA, ICS) at End of Treatment - Actual outcome for Adults and young people (16 years and over): Dose of regular therapy - ICS, expressed as equivalent dose to BDP at 12 months; MD -338 (95%CI - 640 to -37); Risk of bias: Very high; Indirectness of outcome: No indirectness</p>	
Protocol outcomes not reported by the study	<p>Mortality at End of Treatment; Quality of life at End of treatment; UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment; Asthma control questionnaires at End of Treatment; Rescue medication at End of Treatment; Lung Function at End of Treatment; Symptom free days at End of Treatment; Time of school/work at End of Treatment</p>

**Table 140: Smith 2005<sup>1611</sup>**

Study	Smith 2005 <sup>1611</sup>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=110)
Countries and setting	Conducted in New Zealand; Setting: Primary care
Line of therapy	Unclear
Duration of study	Intervention time: Phase 1 stabilisation on optimum therapy (mean 22 and 25 weeks in the 2 groups); phase 2 dose adjustment using FeNO or control: 12 months
Method of assessment of guideline condition	Partially adequate method of assessment/diagnosis: Chronic asthma
Stratum	Adults and young people (16 years and over)
Subgroup analysis within study	Not applicable
Inclusion criteria	12 to 75 years of age with chronic asthma, managed in primary care, regular inhaled corticosteroids for six months or more with no change in dose in last 6 weeks
Exclusion criteria	Four or more courses of oral prednisone in the previous 12 months; admission to the hospital because of asthma in the previous 6 months or to the intensive care unit because of asthma at any time in the past; and cigarette smoking, either current or past, with a history of more than 10 pack-years.
Recruitment/selection of patients	Not stated
Age, gender and ethnicity	Age - Mean (range): 44.8 (12 to 73) years. Gender (M:F): 41:69. Ethnicity: Not stated
Further population details	
Indirectness of population	No indirectness
Interventions	(n=48) Intervention 1: Monitoring FeNO + treatment. Dose adjustment based on FeNO. Visits every 2 months for 1 year. Cut-off 15ppb (at an exhaled flow rate of 250 ml per second), above which an increase in the dose of inhaled corticosteroid was prescribed; this FeNO value is equivalent to 35 ppb at a flow rate of 50 ml per second. Subjects in the FeNO group had a predetermined "safety buffer" by which an upward (one-step) adjustment in the dose was provided to deal with deteriorating asthma in the absence of a rise in measured FeNO. Duration 12 months. Concurrent medication/care: 5 patients on LABA. Two-week run-in period. At the second visit, all patients were started on inhaled fluticasone. During phase 1, the dose of inhaled fluticasone was titrated downward in a stepwise manner until the optimal dose was deemed to have been achieved. Subjects received 750 µg per day to start (or 500 µg per day if their inhaled-corticosteroid requirement before enrolment was less than 200 µg per day of fluticasone or the equivalent).

	<p>Further details: 1. Additional education training : Not applicable / Not stated / Unclear 2. Aim of intervention: Aim to increase ICS in uncontrolled patients</p> <p>(n=49) Intervention 2: No FeNO monitoring + treatment - Monitoring symptoms, BD use and lung function + treatment. Dose adjustments were based on predetermined thresholds in regard to symptoms, bronchodilator use, diurnal peak flows, and spirometry with an algorithm based on Global Initiative for Asthma 2002 criteria. Visits every 2 months for 1 year.. Duration 12 months. Concurrent medication/care: 8 patients on LABA. Two-week run-in period. At the second visit, all patients were started on inhaled. During phase 1, the dose of inhaled fluticasone was titrated downward in a stepwise manner until the optimal dose was deemed to have been achieved. Subjects received 750 µg per day to start (or 500 µg per day if their inhaled-corticosteroid requirement before enrolment was less than 200 µg per day of fluticasone or the equivalent).</p> <p>Further details: 1. Additional education training : Not applicable / Not stated / Unclear 2. Aim of intervention: Aim to increase ICS in uncontrolled patients</p>
<p>Funding</p>	<p>Academic or government funding (Otago Medical Research Foundation, Dunedin School of Medicine, University of Otago)</p>
<p><b>RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: MONITORING FENO + TREATMENT versus MONITORING SYMPTOMS AND LUNG FUNCTION + TREATMENT</b></p> <p>Protocol outcome 1: Exacerbation (need for OCS) at End of treatment          - Actual outcome for Adults and young people (16 years and over): Number of patients requiring at least one course of OCS at 12 months; Group 1: 13/46, Group 2: 15/48; Risk of bias: High; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 2: Rescue medication at End of Treatment          - Actual outcome for Adults and young people (16 years and over): Bronchodilator mean puffs/day (past 7 days) at 12 months; Group 1: mean 0.4 puffs/day (SD 1.04); n=46, Group 2: mean 0.4 puffs/day (SD 0.88); n=48; Risk of bias: High; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 3: Dose of regular asthma treatment (SABA, ICS) at End of Treatment          - Actual outcome for Adults and young people (16 years and over): Dose of fluticasone at 12 months; Group 1: mean 370 microg/day (SD 370); n=46, Group 2: mean 641 microg/day (SD 407); n=48; Risk of bias: High; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 4: Lung Function at End of Treatment          - Actual outcome for Adults and young people (16 years and over): FEV1 % predicted at 12 months; MD 3.8 (SE 4.4); Risk of bias: High; Indirectness of outcome: No indirectness</p>	

<p>- Actual outcome for Adults and young people (16 years and over): PEF am (mean previous 7 days) at 12 months; MD 1.0 (SE 13.2); Risk of bias: High; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 5: Symptom free days at End of Treatment</p> <p>- Actual outcome for Adults and young people (16 years and over): Percentage of symptom-free days at 12 months; Risk of bias: High; Indirectness of outcome: No indirectness</p>	
Protocol outcomes not reported by the study	Mortality at End of Treatment; Quality of life at End of treatment; UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment; Asthma control questionnaires at End of Treatment; Time of school/work at End of Treatment

**Table 141: Syk 2013<sup>1692</sup>**

Study	Syk 2013 <sup>1692</sup>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=181)
Countries and setting	Conducted in Sweden; Setting: Primary care.
Line of therapy	Mixed line
Duration of study	Intervention time: 12 months
Method of assessment of guideline condition	Partially adequate method of assessment/diagnosis: Physician's diagnosis of asthma, had been on prescribed ICS treatment for at least 6 months, and had confirmed IgE sensitisation to at least 1 major airborne perennial allergen (dog, cat, or mite).
Stratum	Adults and young people (16 years and over)
Subgroup analysis within study	Not applicable
Inclusion criteria	Eligible participants had a physician's diagnosis of asthma, had been on prescribed ICS treatment for at least 6 months, and had confirmed IgE sensitisation to at least 1 major airborne perennial allergen (dog, cat, or mite). In addition: age 18-64 years old, non-smokers since at least 1 year earlier and with a smoking history of <10 packs years.
Exclusion criteria	Not stated
Recruitment/selection of patients	Participants recruited from 17 primary health care centres in 7 different autonomous health care regions in central and southern Sweden.
Age, gender and ethnicity	Age - Mean (SD): 41 (12.4). Gender (M:F): 94/87. Ethnicity: Not stated

Further population details	
Indirectness of population	No indirectness
Interventions	<p>(n=93) Intervention 1: Monitoring FeNO + treatment. In the FeNO-guided group, the anti-inflammatory treatment (ICS and leukotriene receptor antagonist [LTRA]) was adjusted according to an algorithm based on exhaled NO levels (FeNO &lt;19ppb (men), &lt;21ppb (women) - decrease one step; FeNO 19-23 (men), 21-25 (women) - no change; FeNO ≥24ppb (men), ≥26ppb (women) - increase one step (no change in treatment step if on step 4 or 5 and using ≤2 inhalations of short-acting beta2 agonist per week); FeNO ≥30ppb (men), ≥32ppb (women)- increase two steps (only if one treatment step 1); grey zone of 5ppb applied to avoid frequent dose changes) and 6 fixed treatment steps (Steps 1-6: Budesonide (mcg/day): 0, 200, 400, 800, 800+LTRA, 1600+LTRA; Fluticasone (mcg/day): 0, 100, 250, 500, 500+LTRA; 1000+LTRA; Mometasone (mcg/day): 0, 100, 200, 400, 400+LTRA, 800+LTRA).. Duration 12 months. Concurrent medication/care: Capillary blood was sampled to confirm perennial allergy by using ImmunoCAP Rapid Wheeze/Rhinitis Child. All participants currently being treated with combination inhalers (corticosteroid plus LABA) were required to switch to the corresponding single corticosteroid inhaler to withdraw the LABA component. All patients switched SABA to a salbutamol inhaler which incorporates a dose counter. Venous blood was sampled for serum IgE All participants received a logbook to take home, in which they noted contacts with health care, changes in drug therapy, sick leave, or other problems between scheduled visits.</p> <p>Further details: 1. Additional education training : Not applicable / Not stated / Unclear 2. Aim of intervention: Aim to decrease ICS in controlled patients (The goal of the asthma treatment was to achieve and maintain clinical control, which implies that the patients should be free from symptoms; maintain normal activity levels, including physical exercise; maintain pulmonary function as close to normal as possible; avoid adverse effects of asthma medication; and have little or no need for reliever medication, all according to the Swedish Medical Product Agency recommendations.).</p> <p>(n=88) Intervention 2: No FeNO monitoring + treatment - Monitoring symptoms, BD use and lung function + treatment. In the control group, FeNO measurement was done but blinded to both operator and patient, and treatment was adjusted according to usual care, that is, based on patient-reported symptoms, SABA use, physical examination, and results of pulmonary function tests. In the control group, only the treatment steps (as described for the intervention group) were allowed, but changes in treatment steps were entirely at the discretion of the treating physician, and immediate changes over several steps were allowed. Permissible treatment steps (as described for the intervention group) basically followed the prevailing national guidelines at the time of the study start, issued in 2002 by the Swedish Medical Product Agency, with the exception that only LTRA was used as an add-on treatment.. Duration 12 months. Concurrent medication/care: Capillary blood was sampled to confirm perennial allergy by using ImmunoCAP Rapid Wheeze/Rhinitis Child. All participants currently being treated with combination inhalers (corticosteroid plus LABA) were required to switch to the corresponding single corticosteroid inhaler to withdraw the LABA component. All patients switched SABA to a salbutamol inhaler which incorporates a dose counter. Venous</p>

	<p>blood was sampled for serum IgE analysis. All participants received a logbook to take home, in which they noted contacts with health care, changes in drug therapy, sick leave, or other problems between scheduled visits. Further details: 1. Additional education training : Not applicable / Not stated / Unclear 2. Aim of intervention: Aim to decrease ICS in controlled patients (The goal of the asthma treatment was to achieve and maintain clinical control, which implies that the patients should be free from symptoms; maintain normal activity levels, including physical exercise; maintain pulmonary function as close to normal as possible; avoid adverse effects of asthma medication; and have little or no need for reliever medication, all according to the Swedish Medical Product Agency recommendations.).</p>
Funding	<p>Academic or government funding (Study was funded by the Stockholm country council (PickUp), Centre for Allergy Research, Korlinska Institutet, and the Research Foundation of the Swedish Asthma and Allergy Association. Support also from Aerocine AB (NIOX MINO instruments), Phadia AB (ImmunoCAP Rapid), Meda AB (Buventol Easyhaler), and MSD Sweden (small grant). Authors not conflicts of interest: grants from Aerocrine AB and Research Council for Working Life and Social Research; stock/stock options as employee and co-founder of Aerocine, etc.)</p>

**RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: MONITORING FENO + TREATMENT versus MONITORING SYMPTOMS AND LUNG FUNCTION + TREATMENT**

**Protocol outcome 1: Exacerbation (need for OCS) at End of treatment**

- Actual outcome for Adults and young people (16 years and over): Exacerbation - severe ( $\geq 1$  event, course of OCS) at 12 months; Group 1: 8/93, Group 2: 6/88; Risk of bias: Very high; Indirectness of outcome: No indirectness

**Protocol outcome 2: Asthma control questionnaires at End of Treatment**

- Actual outcome for Adults and young people (16 years and over): ACQ - clinically important improvement ( $\geq 0.5$ ) at 12 months; Group 1: 29/81, Group 2: 19/74; Risk of bias: Very high; Indirectness of outcome: No indirectness

**Protocol outcome 3: Rescue medication at End of Treatment**

- Actual outcome for Adults and young people (16 years and over): Rescue medication (SABA use per week, at 8-12 months, i.e.  $\geq 6$  months) at 12 months; Risk of bias: Very high; Indirectness of outcome: No indirectness

**Protocol outcome 4: Dose of regular asthma treatment (SABA, ICS) at End of Treatment**

- Actual outcome for Adults and young people (16 years and over): Dose of regular therapy (Budesonide equivalent dose) at 12 months; Risk of bias: Very high; Indirectness of outcome: No indirectness

**Protocol outcome 5: Lung Function at End of Treatment**

- Actual outcome for Adults and young people (16 years and over): Lung function - FEV1 (litres) at 12 months; Group 1: mean -0.034 litres (SD 0.28); n=88, Group 2: mean -0.006 litres (SD 0.28); n=78; Risk of bias: Very high; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Mortality at End of Treatment; Quality of life at End of treatment; UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment; Symptom free days at End of Treatment; Time of school/work at End of Treatment

**Table 142: Szefler 2008<sup>1693</sup>**

Study	Szefler 2008 <sup>1693</sup>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=546)
Countries and setting	Conducted in USA; Setting: 10 centres
Line of therapy	Unclear
Duration of study	Intervention time: 46 weeks
Method of assessment of guideline condition	Adequate method of assessment/diagnosis: Physician diagnosis
Stratum	Children 5 -<16
Subgroup analysis within study	Not applicable
Inclusion criteria	Aged 12 to 20 years, with asthma; residents of urban census tracts in which at least 20 percent of households had incomes below the federal poverty threshold. Individuals receiving long-term control therapy were required to have symptoms of persistent asthma or evidence of uncontrolled disease. Individuals not receiving long-term control therapy were required to have both symptoms of persistent asthma and evidence of uncontrolled disease defined by NAEPP guidelines
Exclusion criteria	Excluded after the run-in if controller adherence was <25%. Participants with a urinary cotinine >100 excluded (active smokers)
Recruitment/selection of patients	Not stated
Age, gender and ethnicity	Age - Mean (SD): 14.4 ± 2.1 years in each group. Gender (M:F): 288:258. Ethnicity: Black: 347/546 (64%); Hispanic: 125/546 (23%); other/mixed: 74/546 (13%)
Further population details	
Indirectness of population	No indirectness
Interventions	(n=276) Intervention 1: Monitoring FeNO, lung function, BD use and symptoms + treatment. Exhaled nitric oxide



	<p>(eNO) added to guideline-based care. FENO was measured for each participant at every visit, but only influenced treatment of the FENO Group. Control level and FENO data were entered into a computer program which generated two treatment options for the blinded physician, one for the Reference Group and another for the FENO Group. The treatment options were derived from protocol-defined treatment steps. Duration 46 weeks. Concurrent medication/care: For safety reasons, FENO was not allowed to increase treatment on the third consecutive visit without elevated symptoms. Also low FENO alone was not allowed to reduce therapy without a corresponding reduction in symptoms.</p> <p>Further details: 1. Additional education training : Not applicable / Not stated / Unclear 2. Aim of intervention: Aim to increase ICS in uncontrolled patients</p> <p>(n=270) Intervention 2: No FeNO monitoring + treatment - Monitoring symptoms, BD use and lung function + treatment. Based on National Asthma Education and Prevention Program (NAEPP) guidelines. Duration 46 weeks. Concurrent medication/care: Not stated</p> <p>Further details: 1. Additional education training : Not applicable / Not stated / Unclear 2. Aim of intervention: Aim to increase ICS in uncontrolled patients</p>
Funding	Academic or government funding (National Institute of Allergy and Infectious Diseases, National Institutes of Health and National Centre for Research Resources, National Institutes of Health)
<p><b>RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: MONITORING FENO + TREATMENT versus MONITORING SYMPTOMS AND LUNG FUNCTION + TREATMENT</b></p> <p>Protocol outcome 1: Exacerbation (need for OCS) at End of treatment          - Actual outcome for Children 5 -&lt;16 : OCS at 46 weeks; Group 1: 89/250, Group 2: 113/244; Risk of bias: Low; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 2: UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment          - Actual outcome for Children 5 -&lt;16 : Hospitalisation at 46 weeks; Group 1: 9/250, Group 2: 11/244; Risk of bias: High; Indirectness of outcome: No indirectness          - Actual outcome for Children 5 -&lt;16 : Unscheduled visits at 46 weeks; Group 1: 59/250, Group 2: 61/244; Risk of bias: Low; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 3: Asthma control questionnaires at End of Treatment          - Actual outcome for Children 5 -&lt;16 : Poor control at &gt;20% of visits at 46 weeks; Group 1: 59/267, Group 2: 63/267; Risk of bias: Low; Indirectness of outcome: No indirectness          - Actual outcome for Children 5 -&lt;16 : Asthma Control Test score in last month at 46 weeks; Group 1: mean 21.89 Not stated (SD 1.9); n=250, Group 2: mean 21.83 Not stated (SD 1.87); n=244; Asthma Control Test Not stated Top=High is good outcome; Risk of bias: Low; Indirectness of outcome: No indirectness</p>	

<p>Protocol outcome 4: Dose of regular asthma treatment (SABA, ICS) at End of Treatment          - Actual outcome for Children 5 -&lt;16 : ICS daily dose (fluticasone) at 46 weeks; MD 118.9 (95%CI 48.5 to 189.3); Risk of bias: Low; Indirectness of outcome: Serious indirectness</p>	
<p>Protocol outcome 5: Lung Function at End of Treatment          - Actual outcome for Children 5 -&lt;16 : FEV1 % pred at 46 weeks; MD 0.8 (95%CI -0.51 to 2.07); Risk of bias: Low; Indirectness of outcome: No indirectness</p>	
<p>Protocol outcome 6: Symptom free days at End of Treatment          - Actual outcome for Children 5 -&lt;16 : Number of symptom-days in last 2 weeks at 46 weeks; Group 1: mean 1.93 days (SD 1.42); n=250, Group 2: mean 1.89 days (SD 1.41); n=244; Risk of bias: Low; Indirectness of outcome: No indirectness</p>	
<p>Protocol outcome 7: Time of school/work at End of Treatment          - Actual outcome for Children 5 -&lt;16 : School days missed in last 2 weeks at 46 weeks; Group 1: mean 0.19 days (SD 0.47); n=250, Group 2: mean 0.23 days (SD 0.47); n=244; Risk of bias: Low; Indirectness of outcome: No indirectness</p>	
Protocol outcomes not reported by the study	Mortality at End of Treatment; Quality of life at End of treatment; Rescue medication at End of Treatment

**Table 143: Verini 2010<sup>1836</sup>**

Study	Verini 2010 <sup>1836</sup>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=64)
Countries and setting	Conducted in Italy; Setting: Secondary care
Line of therapy	Unclear
Duration of study	Intervention time: 12 months
Method of assessment of guideline condition	Adequate method of assessment/diagnosis: Diagnosis was made by a paediatric respiratory physician on the basis of clinical history of repeated episodes of coughing, dyspnoea, and wheezing, according to ATS-ERS criteria
Stratum	Children 5 -<16
Subgroup analysis within study	Not applicable
Inclusion criteria	Children with allergic asthma; age 6-17 years; referred to the Allergological and Pneumological Unity of the Paediatric Department, University of Chieti, Italy, between January 2005 and January 2006.
Exclusion criteria	Not stated

Recruitment/selection of patients	Not stated
Age, gender and ethnicity	Age - Mean (SD): FeNO group: 10.7 ± 2.4 years; GINA group: 11.3 ± 2.1 years, range 6-17 years. Gender (M:F): 36:28. Ethnicity: Caucasian
Further population details	
Indirectness of population	No indirectness
Interventions	<p>(n=32) Intervention 1: Monitoring FeNO + treatment. Therapy was based on symptoms, short acting β2-agonist use, and lung function and FeNO measurements. Duration 12 months. Concurrent medication/care: Not stated Further details: 1. Additional education training : 2. Aim of intervention:</p> <p>(n=32) Intervention 2: No FeNO monitoring + treatment - Monitoring symptoms and lung function + treatment. Therapy was based on symptoms, short acting β2-agonist use, and lung function. Duration 12 months. Concurrent medication/care: ot stated Further details:1. Additional education training : 2. Aim of intervention:</p>
Funding	Funding not stated
<p><b>RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: MONITORING FENO + TREATMENT versus MONITORING SYMPTOMS AND LUNG FUNCTION + TREATMENT</b></p> <p>Protocol outcome 1: Rescue medication at End of Treatment - Actual outcome for Children 5 -&lt;16 : Number of patients with exacerbations (defined as the number of episodes of coughing, dyspnoea, and wheezing, according to ATS-ERS criteria, requiring short-acting β2-adrenergic agonist) at 12 months; Group 1: 16/32, Group 2: 26/32; Risk of bias: Very high; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 2: Dose of regular asthma treatment (SABA, ICS) at End of Treatment - Actual outcome fo Children 5 -&lt;16 : Number of patients not using inhaled corticosteroids or anti-leukotrienes at 12 months; Group 1: 2/32, Group 2: 6/32; Risk of bias: High; Indirectness of outcome: No indirectness</p>	
Protocol outcomes not reported by the study	Mortality at End of Treatment; Quality of life at End of treatment; Exacerbation (need for OCS) at End of treatment; UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment; Asthma control questionnaires at End of Treatment; Lung Function at End of Treatment; Symptom free days at End of Treatment; Time of school/work at End of Treatment

1 **G.18 Challenge tests to monitor asthma control**

**Table 144: Koenig 2008<sup>885</sup>**

Study	Koenig 2008 <sup>885</sup>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=466)
Countries and setting	Conducted in Latvia, Multiple countries, USA; Setting: 50 sites in the US, three sites in Latin American, and two sites in Latvia.
Line of therapy	Mixed line
Duration of study	Intervention time: 40 weeks
Method of assessment of guideline condition	Adequate method of assessment/diagnosis: Either historical documentation of reversible airways disease within the last 24 months or an increase in FEV1 of at least 12% within 30 min of inhalation of 2 puffs (180 mcg) of albuterol.
Stratum	Adults and young people (16 years and over)
Subgroup analysis within study	Not applicable
Inclusion criteria	Male and female patients, 12 years of age and older; asthma for at least 3 months and had been treated during the previous month with short-acting beta2-agonists, anticholinergics, or ICS (p250 mcg daily of fluticasone propionate (FP) or equivalent). At the screening visit, all patients were required to have a forced expiratory volume in 1 s (FEV1) between 60% and 95% of predicted normal
Exclusion criteria	Pregnancy; lifethreatening asthma, hospitalization attributable to asthma within the last 6 months, current smoker or a >10 pack-year history of smoking, a recent (within 2 weeks) upper or lower respiratory tract infection, or significant concurrent diseases. Medications that could confound the evaluation of the study treatments or treatment strategies were prohibited before and throughout the study, including inhaled (up to 250 mcg FP allowed prior to randomization), oral, or parenteral corticosteroids (with the exception of protocol defined use of oral corticosteroids following second consecutive assignment to the highest dose of FP), theophylline or other bronchodilators, leukotriene modifiers, anticholinergics, cromolyn, and nedocromil
Recruitment/selection of patients	Patients underwent physical examination, pulmonary function testing, and other pre-study procedures at the screening visit
Age, gender and ethnicity	Age - Mean (range): 34.8 (12–81), 34.8 (12–81) and 33.2 (12–72) years in the three groups. Gender (M:F): 85:115. Ethnicity: White FSCBHR 124 (79%), FPBHR 120 (77%), FPREF 124 (81%); Black FSCBHR 18 (12%), FPBHR 24 (15%), FPREF 16 (10%); Other FSCBHR 14 (9%), FPBHR 12 (8%), FPREF 14 (9%)

Further population details	
Indirectness of population	No indirectness
Interventions	<p>(n=156) Intervention 1: Monitoring challenge tests + treatment - Monitoring direct challenge tests + treatment. Starting dose of treatment and adjustment of dose (at each 8 week visit for 40 weeks) based on severity class or BHR. Severity class included 4 treatment steps based on control over the past 14 days based on the highest of the following clinical measures (symptoms, BD use, PEFv, FEV1) or BHR. Treatment steps 1-no ICS (placebo); 2-FSC 100/50mcg BID; 3-FSC 250/50mcg BID; 4-500/50mcg BID. For BHR (methacholine PC20) severity class one &gt;4mg/ml; two 1.1-4mg/ml; three 0.25-1mg/ml; four &lt;0.25mg/ml.. Duration 40 weeks. Concurrent medication/care: SABA replaced by albuterol for study duration. ICS was fluticasone propionate using the DISKUS. If patient remained in step 4 for 2 or more visits they were given OCS. Further details: 1. Additional education training : Not applicable / Not stated / Unclear</p> <p>(n=154) Intervention 2: No challenge test monitoring + treatment - Monitoring symptoms, lung function and BD use + treatment. Starting dose of treatment and adjustment of dose (at each 8 week visit for 40 weeks) based on severity class (without BHR as a clinical measure). Severity class included 4 treatment steps based on control over the past 14 days based on the highest of the following clinical measures (symptoms, BD use, PEFv, FEV1). Treatment steps 1-no ICS (placebo); 2-FSC 100/50mcg BID; 3-FSC 250/50mcg BID; 4-500/50mcg BID. . Duration 40 weeks. Concurrent medication/care: SABA replaced by albuterol for study duration. ICS was fluticasone propionate using the DISKUS. If patient remained in step 4 for 2 or more visits they were given OCS. Further details: 1. Additional education training : Not applicable / Not stated / Unclear</p>
Funding	Study funded by industry (GlaxoSmithKline, Research Triangle Park, NC.)

**RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: MONITORING DIRECT CHALLENGE TESTS + TREATMENT versus MONITORING SYMPTOMS, LUNG FUNCTION AND BD USE + TREATMENT**

**Protocol outcome 1: Mortality at End of Treatment**

- Actual outcome for Adults and young people (16 years and over): Death at 40 weeks; Group 1: 1/105, Group 2: 0/107; Risk of bias: Very high; Indirectness of outcome: No indirectness

**Protocol outcome 2: Exacerbation (need for OCS) at End of treatment**

- Actual outcome for Adults and young people (16 years and over): Asthma exacerbation (not defined) at 40 weeks; Group 1: 22/105, Group 2: 26/107; Risk of bias: Very high; Indirectness of outcome: Exacerbations not defined, serious indirectness.

<p>Protocol outcome 3: Rescue medication at End of Treatment                      - Actual outcome for Adults and young people (16 years and over): Albuterol use (puff/day) at 40 weeks; Group 1: mean -0.8 puffs/day (SD 1.8); n=105, Group 2: mean -0.7 puffs/day (SD 1.8); n=107; Risk of bias: High; Indirectness of outcome: No indirectness</p>	
<p>Protocol outcome 4: Dose of regular asthma treatment (SABA, ICS) at End of Treatment                      - Actual outcome for Adults and young people (16 years and over): Mean inhaled corticosteroid daily dose over treatment period (mcg) at 40 weeks; MD 131.2 (95%CI 83.2 to 178.5) (P=0.037 van Elteren tests ); Risk of bias: High; Indirectness of outcome: No indirectness</p>	
<p>Protocol outcome 5: Lung Function at End of Treatment                      - Actual outcome for Adults and young people (16 years and over): AM PEF at 40 weeks; Group 1: mean 16.9 L/min (SD 92.2); n=105, Group 2: mean 25.5 L/min (SD 92.1); n=107; Risk of bias: High; Indirectness of outcome: No indirectness                      - Actual outcome for Adults and young people (16 years and over): PM PEF at 40 weeks; Group 1: mean 16.4 L/min (SD 89.1); n=105, Group 2: mean 22.4 L/min (SD 88.9); n=107; Risk of bias: High; Indirectness of outcome: No indirectness                      - Actual outcome for Adults and young people (16 years and over): Pre-dose FEV1 at 40 weeks; Group 1: mean 0.06 L (SD 0.51); n=105, Group 2: mean 0.11 L (SD 0.52); n=107; Risk of bias: High; Indirectness of outcome: No indirectness</p>	
<p>Protocol outcome 6: Symptom free days at End of Treatment                      - Actual outcome for Adults and young people (16 years and over): % symptom-free days at 40 weeks; Group 1: mean 13 % (SD 56.2); n=105, Group 2: mean 18.1 % (SD 54.9); n=107; Risk of bias: High; Indirectness of outcome: No indirectness</p>	
Protocol outcomes not reported by the study	Quality of life at End of treatment; UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment; Asthma control questionnaires at End of Treatment; Time of school/work at End of Treatment

**Table 145: Lipworth 2012<sup>1018</sup>**

Study	STAMINA trial: Lipworth 2012 <sup>1018</sup>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=157)
Countries and setting	Conducted in United Kingdom; Setting: Primary care
Line of therapy	Mixed line
Duration of study	Intervention time: 12 months
Method of assessment of guideline condition	Partially adequate method of assessment/diagnosis: History of mild to moderate persistent asthma

Stratum	Adults and young people (16 years and over)
Subgroup analysis within study	Not applicable
Inclusion criteria	Between 18 and 65 years of age and with a history of mild to moderate persistent asthma; prebronchodilator FEV <sub>1</sub> was required to be > 60% predicted for the purposes of challenge testing.
Exclusion criteria	Not stated
Recruitment/selection of patients	At the time of patients' entry into the study, AHR was established through a provocative dose of mannitol causing a 10% fall in FEV <sub>1</sub> (PD 10) ≤ 635 mg at the end of the step-down period. Patients initially underwent step-down of their existing treatment with follow-up every 2 weeks. Patients on combination inhalers were switched to an equivalent dose of the same ICS only. The dose of ICS was then halved every 2 weeks until patients were taking 200 mg/d beclomethasone dipropionate equivalent or they became clinically unstable. Once unstable, patients were stepped back up to the last stable dose of ICS. All patients were then converted to an equivalent dose of the reference ICS, namely ciclesonide, to be taken throughout the rest of the study.
Age, gender and ethnicity	Age - Mean (SD): Control 53.7 (1.7); intervention 53.2 (1.6) years. Gender (M:F): Not stated. Ethnicity: Not stated
Further population details	
Indirectness of population	Serious indirectness: Patients initially underwent step-down of their existing treatment. Patients on combination inhalers were switched to an equivalent dose of the same ICS only (unclear whether LABA was continued)
Interventions	<p>(n=80) Intervention 1: Monitoring challenge tests + treatment - Monitoring indirect challenge tests + treatment. Treatment adjusted based on mannitol AHR only, every 2 months for 12 months. ICS dose increased by one step every 2 months until they became unresponsive to mannitol (PD10&gt;635mg). Treatment steps: ciclesonide, step 1: 80mcg once daily, step 2: 160mcg once daily, step 3: 320mcg once daily, step 4: 160mcg and 320mcg BID, step 5: 320mcg BID.. Duration 12 months. Concurrent medication/care: Initial step-down of existing treatment and those on combination inhalers switched to same ICS only. Dose of ICS halved every 2 weeks until taking 200ug/d beclomethasone dipropionate or equivalent or became unstable - put back to last stable ICS dose. All then converted to equivalent ciclesonide. Further details: 1. Additional education training : Not applicable / Not stated / Unclear</p> <p>(n=77) Intervention 2: No challenge test monitoring + treatment - Monitoring symptoms, lung function and BD use + treatment. Treatment adjusted according to BTS guidelines every 2 months for 12 months. ICS dose increased by one step if 1. fall in PEF &gt;20% baseline; 2. fall in FEV<sub>1</sub> &gt;20% baseline; 3. BD use more than 0.5puffs/day; 4. symptom score &gt;0.5. Treatment steps: ciclesonide, step 1: 80mcg once daily, step 2: 160mcg once daily, step 3: 320mcg once daily, step 4: 160mcg and 320mcg BID, step 5: 320mcg BID.. Duration 12 months. Concurrent medication/care: Initial step-down of existing treatment and those on combination inhalers switched to same ICS only. Dose of ICS halved every 2 weeks until taking 200ug/d beclomethasone dipropionate or equivalent or became unstable - put back to last stable ICS dose. All</p>

	then converted to equivalent ciclesonide. Further details: 1. Additional education training : Not applicable / Not stated / Unclear
Funding	Study funded by industry (University Departmental grants as well as by Pharmaxis, who supplied mannitol as a gift and donated an unrestricted educational grant. Nycomed supplied the ciclesonide inhalers as a gift and also provided an unrestricted educational grant.)
<p><b>RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: MONITORING INDIRECT CHALLENGE TESTS + TREATMENT versus MONITORING SYMPTOMS, LUNG FUNCTION AND BD USE + TREATMENT</b></p> <p>Protocol outcome 1: Quality of life at End of treatment - Actual outcome for Adults and young people (16 years and over): mini AQLQ at 12 months; Risk of bias: High; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 2: Exacerbation (need for OCS) at End of treatment - Actual outcome for Adults and young people (16 years and over): Severe exacerbations requiring oral corticosteroids at 12 months; Group 1: 12/61, Group 2: 13/58; Risk of bias: High; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 3: Rescue medication at End of Treatment - Actual outcome for Adults and young people (16 years and over): Reliever use (puffs/day) at 12 months; MD 0.31 (95%CI -0.12 to 0.73) (P=0.16 ) (final value is lower in the intervention group, therefore mean difference analysed as -0.31); Risk of bias: High; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 4: Dose of regular asthma treatment (SABA, ICS) at End of Treatment - Actual outcome for Adults and young people (16 years and over): ciclesonide dose mcg at 12 months; MD 306 (95%CI 241.6 to 370.2); Risk of bias: High; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 5: Lung Function at End of Treatment - Actual outcome for Adults and young people (16 years and over): AM PEF at 12 months; MD 1.5 (95%CI -37.7 to 34.7) (P=0.93 ); Risk of bias: High; Indirectness of outcome: No indirectness - Actual outcome for Adults and young people (16 years and over): FEV1% at 12 months; Group 1: mean 2 % (SD 22.3); n=61, Group 2: mean 1.7 % (SD 24.9); n=58; % 0-100 Top=High is good outcome; Risk of bias: High; Indirectness of outcome: No indirectness - Actual outcome for Adults and young people (16 years and over): PEF% at 12 months; Group 1: mean 3.1 % (SD 25.9); n=61, Risk of bias: High; Indirectness of outcome: No indirectness</p>	
Protocol outcomes not reported by the study	Mortality at End of Treatment; UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment; Asthma control questionnaires at End of Treatment; Symptom free days at End of Treatment; Time of school/work at End of



	Treatment
<b>Table 146: Nuijsink 2007<sup>1248</sup></b>	
<b>Study</b>	<b>Children Asthma Therapy Optimal (CATO) Study trial: Nuijsink 2007<sup>1248</sup></b>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=210)
Countries and setting	Conducted in Netherlands; Setting: 15 centres; secondary care
Line of therapy	Mixed line
Duration of study	Intervention time: 2 years
Method of assessment of guideline condition	Adequate method of assessment/diagnosis: Documented clinical history of moderate persistent asthma, according to GINA guidelines.
Stratum	Children 5 -<16
Subgroup analysis within study	Not applicable
Inclusion criteria	<p>Children with clinically stable asthma living in the Netherlands, aged 6–16 yrs and with a documented clinical history of moderate persistent asthma, according to GINA guidelines. All patients gave a positive, class <math>\geq 1</math>, radioallergosorbent test result for one or more airborne allergens and used <math>\geq 200</math> <math>\mu\text{g}/\text{day}</math> fluticasone or an equivalent dose of other ICS.</p> <p>In children treated with 500 mg/day fluticasone who did not meet the criteria for randomisation after 1 month, the dose of ICS was tapered down to 200 mg/day fluticasone for a further 2 months before randomisation. After run-in, children were randomised into one of two treatment strategy arms if they showed a cumulative symptom score <math>\geq 14</math> during the last 2 weeks of the run-in period and/or a PD20&lt;150mg.</p>
Exclusion criteria	Not stated
Recruitment/selection of patients	Selected on the basis of symptom scores and/or the presence of airway hyper-responsiveness
Age, gender and ethnicity	Age - Mean (SD): Intervention: 10.8+/-2.4 years; control: 10.9+/-2.5 years. Gender (M:F): 117:89. Ethnicity: Not stated
Further population details	
Indirectness of population	Serious indirectness: Patients initially underwent step-down of their existing treatment.
Interventions	(n=102) Intervention 1: Monitoring challenge tests + treatment - Monitoring direct challenge tests + treatment. Treatment adjusted on the basis of AHR and symptom score according to a three step medication level algorithm. AHR methacholine dosimeter method PD20.- Increase by 1: PD20<100mcg and SS<14 or PD20<300mcg and SS>=14- No

	<p>change: PD20 100-300mcg and SS&lt;14 or PD20&gt;=300mcg and SS&gt;=14- Decrease by 1: PD20&gt;300mcg and SS&lt;14.. Duration 2 years. Concurrent medication/care: During run-in patients put on 100 or 250 FP BID depending on equivalent treatment before run-in. Further details: 1. Additional education training : Not applicable / Not stated / Unclear</p> <p>(n=104) Intervention 2: No challenge test monitoring + treatment - Monitoring symptoms + treatment. Treatment adjusted on the basis of symptom score only according to a three step medication level algorithm. Symptoms from diary 2 weeks before visit. - Increase by 1: SS&gt;=14- No change: SS 0-14- Decrease by 1: SS=0. Duration 2 years. Concurrent medication/care: During run-in patients put on 100 or 250 FP BID depending on equivalent treatment before run-in. Further details: 1. Additional education training : Not applicable / Not stated / Unclear</p>
Funding	Funding not stated
<p><b>RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: MONITORING DIRECT CHALLENGE TESTS + TREATMENT versus MONITORING SYMPTOMS + TREATMENT</b></p> <p>Protocol outcome 1: Exacerbation (need for OCS) at End of treatment - Actual outcome for Children 5 -&lt;16 : At least one exacerbation at 2 years; Group 1: 16/102, Group 2: 17/104; Risk of bias: High; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 2: Dose of regular asthma treatment (SABA, ICS) at End of Treatment - Actual outcome for Children 5 -&lt;16 : Mean daily ICS dose for treatment period at 2 years; Group 1: mean 562 mcg/day (SD 239); n=85, Group 2: mean 478 mcg/day (SD 256); n=90; Risk of bias: High; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 3: Lung Function at End of Treatment - Actual outcome for Children 5 -&lt;16 : FEV1 % at 2 years; MD 6.0 (95%CI 1.2 to 10.8); Risk of bias: High; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 4: Symptom free days at End of Treatment - Actual outcome for Children 5 -&lt;16 : % symptom-free days (in last 3 months) at 2 years; Risk of bias: High; Indirectness of outcome: No indirectness</p>	
Protocol outcomes not reported by the study	Mortality at End of Treatment; Quality of life at End of treatment; UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment; Asthma control questionnaires at End of Treatment; Rescue medication at End of Treatment; Time of school/work at End of Treatment

**Table 147: Sont 1999<sup>1625</sup>**

Study	AMPUL trial: Sont 1999 <sup>1625</sup>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=75)
Countries and setting	Conducted in Netherlands; Setting: Secondary care
Line of therapy	Mixed line
Duration of study	Intervention time: 2 years
Method of assessment of guideline condition	Partially adequate method of assessment/diagnosis: History of episodic chest tightness and wheezing in the previous year and visiting a chest physician for their asthma.
Stratum	Adults and young people (16 years and over)
Subgroup analysis within study	Not applicable
Inclusion criteria	Patients who were visiting a chest physician for their asthma at one of the outpatient clinics of four hospitals in the Leiden area; history of episodic chest tightness and wheezing in the previous year; AHR was established through a 20% decrease in FEV1 in response to a provocative concentration of inhaled methacholine (PC20) of < 8 mg/ml; nonsmokers at the time of recruitment (> 1 yr; < 5 pack-yr), and were atopic, between 18 and 50 yr of age, and had had a history of episodic chest tightness and wheezing in the previous year. Atopy was assessed through a positive skin-prick test (> 3 mm wheal) to one or more common airborne allergen extracts. Prebronchodilator FEV1 was more than 50% predicted and > 1.5 L, whereas postbronchodilator FEV1 was within the normal range (> 80% predicted). Subjects were eligible when they had used no other medication than regular inhaled steroids and/or beta-agonists as needed for their asthma during the 6 mo before entry. All subjects gave their written informed consent
Exclusion criteria	Not stated
Recruitment/selection of patients	Outpatient clinics of four hospitals in the Leiden area
Age, gender and ethnicity	Age - Mean (SD): Intervention 31.5 (1.7); control 28.2 (1.3) years. Gender (M:F): 37:38. Ethnicity: Not stated
Further population details	
Indirectness of population	No indirectness
Interventions	(n=34) Intervention 1: Monitoring challenge tests + treatment - Monitoring direct challenge tests + treatment. Treatment adjusted at each 3 month visit based on severity class or AHR. Severity class included 4 treatment steps based on the highest of the following clinical measures (symptoms, BD use, PEFv, FEV1 or BHR). Treatment steps 1-no ICS; 2-low dose ICS; 3-intermediate dose ICS; 4-high dose ICS plus OCS course. For AHR (methacholine PC20) severity class one

	<p>&gt;4mg/ml; two 1.0-4mg/ml; three 0.25-1mg/ml; four &lt;0.25mg/ml.. Duration 2 years. Concurrent medication/care: SABA used as needed</p> <p>Further details: 1. Additional education training : Not applicable / Not stated / Unclear</p> <p>(n=41) Intervention 2: No challenge test monitoring + treatment - Monitoring symptoms, lung function and BD use + treatment. Treatment adjusted at each 3 month visit based on severity class ONLY. Severity class included 4 treatment steps based on the highest of the following clinical measures (symptoms, BD use, PEFv, FEV1). Treatment steps 1-no ICS; 2-low dose ICS; 3-intermediate dose ICS; 4-hig dose ICS plus OCS course. . Duration 2 years. Concurrent medication/care: SABA use as needed</p> <p>Further details: 1. Additional education training : Not applicable / Not stated / Unclear</p>
Funding	Academic or government funding (The Netherlands Asthma Foundation)
<p>RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: MONITORING DIRECT CHALLENGE TESTS + TREATMENT versus MONITORING SYMPTOMS, LUNG FUNCTION AND BD USE + TREATMENT</p> <p>Protocol outcome 1: Lung Function at End of Treatment</p> <p>- Actual outcome for Adults and young people (16 years and over): FEV1 L at 2 years; Group 1: mean 78 mL/year (SD 34); n=32, Group 2: mean -7 mL/year (SD 36); n=35;</p> <p>Risk of bias: High; Indirectness of outcome: No indirectness</p>	
Protocol outcomes not reported by the study	Mortality at End of Treatment; Quality of life at End of treatment; Exacerbation (need for OCS) at End of treatment; UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment; Asthma control questionnaires at End of Treatment; Rescue medication at End of Treatment; Dose of regular asthma treatment (SABA, ICS) at End of Treatment; Symptom free days at End of Treatment; Time of school/work at End of Treatment

## G.19 Monitoring adherence to treatment

**Table 148: BURGESS 2010<sup>246</sup>**

<b>Study</b>	<b>Burgess 2010<sup>246</sup></b>
Study type	RCT (Patient randomised; Parallel)

Number of studies (number of participants)	1 (n=26)
Countries and setting	Conducted in Australia; Setting: Paediatric asthma clinic, outer metropolitan general hospital
Line of therapy	Mixed line
Duration of study	Intervention time: 4 months
Method of assessment of guideline condition	Partially adequate method of assessment/diagnosis: Dx with asthma
Stratum	Children 5 -<16 with uncontrolled asthma: Children 6-14 years, asthma not well controlled despite preventative medication ('unstable asthma')
Subgroup analysis within study	Not applicable:
Inclusion criteria	Aged 6-14 years; asthma not well controlled (based on a reported history of asthma symptoms occurring more than twice a week and requiring reliever medication and/or lung function FEV1 <80%)
Exclusion criteria	nr
Recruitment/selection of patients	nr
Age, gender and ethnicity	Age - Range: 6-14 years. Gender (M:F): 17/9. Ethnicity:
Further population details	1. Cognitive function: Not applicable / Not stated / Unclear 2. Disability: Not applicable / Not stated / Unclear 3. Near fatal asthma attacks: Not applicable / Not stated / Unclear 4. Social economic disadvantage: Not applicable / Not stated / Unclear
Indirectness of population	No indirectness
Interventions	<p>(n=14) Intervention 1: Adherence monitoring + treatment - Adherence monitoring and feedback + treatment. Electronic monitoring device (Smartinhalet, Nexus 6; counts number of doses). Adherence calculated at each monthly review as a % of the number of prescribed doses registered by the smartinhalet. Adherence shared with child and carer and incorporated into the management plan (direct feedback from respiratory physician). Duration 4 months. Concurrent medication/care: In both groups: personalised asthma education and generic written information. Personalised asthma management plan devised, assessment of inhaler technique. Further details: 1. Additional education training : Additional education in both groups</p> <p>(n=12) Intervention 2: Usual care + treatment - Usual care (no adherence feedback) + treatment. Adherence remains unknown to physician. Duration 4 months. Concurrent medication/care: In both groups: personalised asthma education and generic written information. Personalised asthma management plan devised, assessment of inhaler technique. Further details: 1. Additional education training : Additional education in both groups</p>

Funding	Funding not stated
<p><b>RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: ADHERENCE MONITORING AND FEEDBACK + TREATMENT versus USUAL CARE (NO ADHERENCE FEEDBACK) + TREATMENT</b></p> <p><b>Protocol outcome 1: Adherence at End of Treatment</b>                      - Actual outcome for Children 5 -&lt;16 with uncontrolled asthma: % of prescribed doses measured by the electronic inhaler at 4 months; Group 1: mean 84.2 % (SD 26.3); n=14, Group 2: mean 55.3 % (SD 26.3); n=12; % of prescribed doses measured by the electronic inhaler 0-100 Top=High is good outcome; Risk of bias: Very high; Indirectness of outcome: No indirectness</p> <p><b>Protocol outcome 2: Exacerbation (need for OCS) at End of treatment</b>                      - Actual outcome for Children 5 -&lt;16 with uncontrolled asthma: Acute exacerbation at 4 months; Group 1: 3/14, Group 2: 1/12; Risk of bias: Very high; Indirectness of outcome: Serious indirectness</p> <p><b>Protocol outcome 3: Rescue medication at End of Treatment</b>                      - Actual outcome for Children 5 -&lt;16 with uncontrolled asthma: Reliever medication 3 or more times a week at 4 months; Group 1: 2/14, Group 2: 0/12; Risk of bias: Very high; Indirectness of outcome: No indirectness</p>	
Protocol outcomes not reported by the study	Mortality at End of Treatment; Quality of life at End of treatment; UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment; Asthma control questionnaires at End of Treatment; Dose of regular asthma treatment (SABA, ICS) at End of Treatment; Lung Function at End of Treatment; Symptom free days at End of Treatment; Time of school/work at End of Treatment

**Table 149: ONYIRIMBA 2003<sup>1270</sup>**

Study	Onyirimba 2003 <sup>1270</sup>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=30)
Countries and setting	Conducted in USA; Setting: hospital asthma centre
Line of therapy	Mixed line
Duration of study	Intervention time: 10 weeks
Method of assessment of guideline condition	Partially adequate method of assessment/diagnosis: Adults with moderate to severe asthma; referred to hospital asthma centre
Stratum	Adults and young people with uncontrolled asthma: Adults with moderate to severe asthma
Subgroup analysis within study	Not applicable
Inclusion criteria	Adults with moderate to severe asthma; referred to hospital asthma centre; low socioeconomic status; FEV1 <80% predicted and BDR of ≥15%; regular use of ICS (LABA, OCS and theophylline permissible); smokers not excluded.
Exclusion criteria	nr
Recruitment/selection of patients	nr
Age, gender and ethnicity	Age - Range: >18 years. Gender (M:F): 3/16. Ethnicity:
Further population details	1. Cognitive function: Not applicable / Not stated / Unclear 2. Disability: Not applicable / Not stated / Unclear 3. Near fatal asthma attacks: Not applicable / Not stated / Unclear 4. Social economic disadvantage: Low social economic status
Indirectness of population	Serious indirectness: Includes severe asthma
Interventions	(n=15) Intervention 1: Adherence monitoring + treatment - Adherence monitoring and feedback + treatment. Electronic monitoring device (MDI Chronologs and electronic recording of actuations for 10 weeks). Received direct feedback on ICS use from the clinician investigator and discussion of techniques to improve adherence (in addition to standard asthma care). Duration 10 weeks. Concurrent medication/care: In both groups: If necessary, ICS switched to a twice daily regime; 3 week intensive asthma education (four 30-60min sessions) by a nurse and/or respiratory therapist blinded to the patient group (goals of therapy, signs of worsening asthma, medications, importance of prophylactic medication, MDI technique and PEF). Physician input, therapy adjustment and implementation of a management plan based on PEF or symptoms at these sessions Further details: 1. Additional education training : Additional education in both groups

	(n=15) Intervention 2: Usual care + treatment - Usual care (no adherence feedback) + treatment. Adherence data not provided to physician. Standard asthma care only. Duration 10 weeks. Concurrent medication/care: In both groups: If necessary, ICS switched to a twice daily regime; 3 week intensive asthma education (four 30-60min sessions) by a nurse and/or respiratory therapist blinded to the patient group (goals of therapy, signs of worsening asthma, medications, importance of prophylactic medication, MDI technique and PEF). Physician input, therapy adjustment and implementation of a management plan based on PEF or symptoms at these sessions Further details: 1. Additional education training : Additional education in both groups
Funding	Funding not stated
<p><b>RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: ADHERENCE MONITORING AND FEEDBACK + TREATMENT versus USUAL CARE (NO ADHERENCE FEEDBACK) + TREATMENT</b></p> <p>Protocol outcome 1: Quality of life at End of treatment                      - Actual outcome for Adults and young people with uncontrolled asthma: AQLQ at 10 weeks; Group 1: mean change score 1.13 (SD 0.31); n=10, Group 2: mean change score 0.76 (SD 0.33); n=9; AQLQ 1-7 Top=High is good outcome; Risk of bias: Very high; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 2: Lung Function at End of Treatment                      - Actual outcome for Adults and young people with uncontrolled asthma: FEV1 % at 10 weeks; Group 1: mean 0.04 L (SD 0.11); n=10, Risk of bias: Very high; Indirectness of outcome: No indirectness</p>	
Protocol outcomes not reported by the study	Adherence at End of Treatment; Mortality at End of Treatment; Exacerbation (need for OCS) at End of treatment; UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment; Asthma control questionnaires at End of Treatment; Rescue medication at End of Treatment; Dose of regular asthma treatment (SABA, ICS) at End of Treatment; Symptom free days at End of Treatment; Time of school/work at End of Treatment

**Table 150: OTSUKI 2009<sup>1279</sup>**

Study	Otsuki 2009 <sup>1279</sup>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=250)
Countries and setting	Conducted in USA; Setting: Community; recruited from paediatric ED
Line of therapy	Mixed line



Duration of study	Intervention time: 18 months
Method of assessment of guideline condition	Partially adequate method of assessment/diagnosis: Phys Dx asthma
Stratum	Children 5 -<16 with uncontrolled asthma: Children 2-12 years with asthma recruited from ED discharge records; 2 ED visits or 1 hospitalisation for asthma in previous year
Subgroup analysis within study	Not applicable
Inclusion criteria	Children with asthma recruited from ED discharge records; 2-12 years old; had Phys Dx asthma; 2 ED visits or 1 hospitalisation for asthma in previous year; prescribed an asthma controller medication)
Exclusion criteria	nr
Recruitment/selection of patients	2001-2003
Age, gender and ethnicity	Age - Range: 2-12 years. Gender (M:F): 106/61. Ethnicity:
Further population details	1. Cognitive function: Not applicable / Not stated / Unclear 2. Disability: Not applicable / Not stated / Unclear 3. Near fatal asthma attacks: Not applicable / Not stated / Unclear 4. Social economic disadvantage: Not applicable / Not stated / Unclear
Indirectness of population	No indirectness: Mean age within 5-16 year age group
Interventions	<p>(n=83) Intervention 1: Adherence monitoring + treatment - Adherence monitoring and feedback + treatment. Feedback of adherence (electronic medication monitors), goal-setting and reinforcement of adherence goals and strategies for self-monitoring of med use plus home-based education as in the control group. Duration 18 months. Concurrent medication/care: In both groups: Five 30min home visits by trained asthma educators Further details: 1. Additional education training : Additional education in both groups</p> <p>(n=84) Intervention 2: Usual care + treatment - Usual care (no adherence feedback) + treatment. Home-based asthma education programme alone (review of asthma regime; training in inhaler technique; development of asthma action plan and other education materials). Duration 18 months. Concurrent medication/care: In both groups: Five 30min home visits by trained asthma educators Further details: 1. Additional education training : Additional education in both groups</p>
Funding	Academic or government funding (National Heart Lung and Blood Institute)

RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: ADHERENCE MONITORING AND FEEDBACK + TREATMENT versus USUAL CARE (NO ADHERENCE FEEDBACK) + TREATMENT

<p>Protocol outcome 1: Adherence at End of Treatment                      - Actual outcome for Children 5 -&lt;16 with uncontrolled asthma: % self-reported adherence in previous 6 months at 18 months; Group 1: mean 87.33 % (SD 25.24); n=76, Risk of bias: Very high; Indirectness of outcome: No indirectness                      - Actual outcome for Children 5 -&lt;16 with uncontrolled asthma: Number of canister refills (100% adherence = 3.0) at 18 months; Group 1: mean 0.58 (SD 0.86); n=76, Risk of bias: Very high; Indirectness of outcome: No indirectness</p>	
<p>Protocol outcome 2: Exacerbation (need for OCS) at End of treatment                      - Actual outcome for Children 5 -&lt;16 with uncontrolled asthma: Courses of OCS in previous 6 months at 18 months; Group 1: mean 0.96 (SD 1.59); n=76, Risk of bias: High; Indirectness of outcome: Serious indirectness</p>	
<p>Protocol outcome 3: UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment                      - Actual outcome for Children 5 -&lt;16 with uncontrolled asthma: Hospitalisation in previous 6 months at 18 months; Group 1: mean 12 (SD 15.8); n=76, Risk of bias: High; Indirectness of outcome: Serious indirectness</p>	
Protocol outcomes not reported by the study	Mortality at End of Treatment; Quality of life at End of treatment; Asthma control questionnaires at End of Treatment; Rescue medication at End of Treatment; Dose of regular asthma treatment (SABA, ICS) at End of Treatment; Lung Function at End of Treatment; Symptom free days at End of Treatment; Time of school/work at End of Treatment

**Table 151: WILLIAMS 2010<sup>1899</sup>**

Study	Williams 2010 <sup>1899</sup>
Study type	RCT (Cluster randomised; Parallel)
Number of studies (number of participants)	1 (n=2698)
Countries and setting	Conducted in USA; Setting: Primary care
Line of therapy	Mixed line
Duration of study	Intervention time: 12 months
Method of assessment of guideline condition	Partially adequate method of assessment/diagnosis: at least one physician Dx of asthma and no Dx of COPD or congestive heart failure
Stratum	Adults and young people overall: Age 5-56 years with ICS prescription
Subgroup analysis within study	Not applicable
Inclusion criteria	Age 5-56 years; an electronic prescription for an ICS between Jan 2005 and April 2007; at least one physician Dx of asthma and no Dx of COPD or congestive heart failure; at least one visit to primary care provider in the previous year

Exclusion criteria	nr
Recruitment/selection of patients	August 2007 to July 2008
Age, gender and ethnicity	Age - Range: 5-56 years. Gender (M:F): Define. Ethnicity:
Further population details	1. Cognitive function: Not applicable / Not stated / Unclear 2. Disability: Not applicable / Not stated / Unclear 3. Near fatal asthma attacks: Not applicable / Not stated / Unclear 4. Social economic disadvantage: Not applicable / Not stated / Unclear
Indirectness of population	No indirectness: Mean age within adult and young person age group
Interventions	<p>(n=1335) Intervention 1: Adherence monitoring + treatment - Adherence monitoring and feedback + treatment. Physicians provided with adherence information (from refill data) when reviewing and writing prescriptions. Adherence calculated from prescription and refill data and uploaded onto the ePrescribing system every 2 weeks and could be viewed by physicians. General and detailed adherence information could be viewed. Physicians also received specific instructions on how to interpret the adherence data.. Duration 12 months. Concurrent medication/care: GP practices in both groups received information on the most recent asthma guidelines, and methods for discussing nonadherence with their patients. Further details: 1. Additional education training : No education in both groups</p> <p>(n=1363) Intervention 2: Usual care + treatment - Usual care (no adherence feedback) + treatment. GP used e Prescribing system but could not view asthma patient's adherence data.. Duration 12 months. Concurrent medication/care: GP practices in both groups received information on the most recent asthma guidelines, and methods for discussing nonadherence with their patients. Further details: 1. Additional education training : No education in both groups</p>
Funding	Academic or government funding (Grants from National Heart Lung and Blood Institute, National Institute of Allergy and Infectious Diseases, National Institute of Diabetes and Digestive and Kidney Diseases, National Institutes for Health, Fund for Henry Ford Hospital, American Asthma Foundation.)

**RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: ADHERENCE MONITORING AND FEEDBACK + TREATMENT versus USUAL CARE (NO ADHERENCE FEEDBACK) + TREATMENT**

Protocol outcome 1: Adherence at End of Treatment

- Actual outcome for Adults and young people overall: % adherence to prescription refills in previous 3 months at 12 months; Risk of bias: Very high; Indirectness of outcome: No indirectness

**Protocol outcome 2: Exacerbation (need for OCS) at End of treatment**

- Actual outcome for Adults and young people overall: OCS use at 12 months; HR 1.07 (95%CI 0.89 to 1.29) Reported; Risk of bias: Very high; Indirectness of outcome: No indirectness
- Actual outcome for Adults and young people overall: OCS use at 12 months; RR Adjusted RR 1.11 (95%CI 0.92 to 1.34) (P=0.28 (negative binomial regression model) ); Risk of bias: Very high; Indirectness of outcome: No indirectness

**Protocol outcome 3: UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment**

- Actual outcome for Adults and young people overall: Asthma-related Hospitalisation at 12 months; HR 0.86 (95%CI 0.32 to 2.29) Reported; Risk of bias: Very high; Indirectness of outcome: No indirectness
- Actual outcome for Adults and young people overall: Asthma-related Hospitalisation at 12 months; RR Adjusted RR 0.87 (95%CI 0.33 to 2.29) (P=0.77 (negative binomial regression model) ); Risk of bias: Very high; Indirectness of outcome: No indirectness
- Actual outcome for Adults and young people overall: Asthma-related ED visit at 12 months; HR 1.22 (95%CI 0.83 to 1.78) Reported; Risk of bias: Very high; Indirectness of outcome: No indirectness
- Actual outcome for Adults and young people overall: Asthma-related ED visit at 12 months; RR Adjusted RR 1.12 (95%CI 0.74 to 1.69) (P=0.60 (negative binomial regression model) ); Risk of bias: Very high; Indirectness of outcome: No indirectness

Protocol outcomes not reported by the study

Mortality at End of Treatment; Quality of life at End of treatment; Asthma control questionnaires at End of Treatment; Rescue medication at End of Treatment; Dose of regular asthma treatment (SABA, ICS) at End of Treatment; Lung Function at End of Treatment; Symptom free days at End of Treatment; Time of school/work at End of Treatment

1 **G.20 Monitoring inhaler technique**

<b>Study</b>	<b>Al-showair 2007<sup>29</sup></b>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	(n=71)
Countries and setting	Conducted in United Kingdom; Setting: Secondary care - patients attending an outpatient clinic
Line of therapy	Mixed line
Duration of study	Intervention + follow up: 6 weeks
Method of assessment of guideline condition	Partially adequate method of assessment/diagnosis: Patients with asthma attending an outpatient clinic and receiving ICS
Stratum	Adults and young people (16 years and over)
Subgroup analysis within study	Not applicable
Inclusion criteria	Patients with asthma attending an outpatient clinic; receiving ICS from an MDI without a spacer; identified with poor inhaler technique (good coordination but inhaled too fast IFR $\geq 90$ l/min).
Exclusion criteria	Experienced an acute exacerbation of asthma within 4 weeks prior to recruitment; hearing problems and/or unable to distinguish between one and two tones produced by the 2TT tool; patients who started to inhale before actuating a dose (poor coordination).
Recruitment/selection of patients	nr
Age, gender and ethnicity	Age - Mean (SD): Verbal group 52.6 (15.7); Verbal+2TT group 58.3 (13.7). Gender (M:F): 27/44. Ethnicity:
Further population details	1. Cognitive function: Not applicable / Not stated / Unclear 2. Disability: Not applicable / Not stated / Unclear 3. Social economic disadvantage: Not applicable / Not stated / Unclear
Indirectness of population	No indirectness
Interventions	(n=36) Intervention 1: Monitoring inhaler technique + feedback - Monitoring using electronic devices + feedback. Verbal training on the most desirable inhalation technique with emphasis on breathing out slowly as far as comfortable and actuating a dose at or soon after the start of a slow inhalation. Also trained on how to use the 2Tone Trainer every morning and night to obtain the one-tone sound and to use the same inhalation procedure when using their MDI.. Duration 6 weeks. Concurrent medication/care: nr Further details: 1. Additional education training : Additional education in both groups (Counselled on compliance with the prescribed medication).

	(n=36) Intervention 2: Monitoring inhaler technique + feedback - Visual monitoring + feedback. Verbal training on the most desirable inhalation technique with emphasis on breathing out slowly as far as comfortable and actuating a dose at or soon after the start of a slow inhalation.. Duration 1 visit (6 weeks follow-up). Concurrent medication/care: nr Further details: 1. Additional education training : Additional education in both groups (Counselled on compliance with the prescribed medication).
Funding	Other (2 Tone trainers donated by Canday Medical Ltd.)
<p><b>RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: VERBAL TRAINING PLUS ELECTRONIC DEVICE TO PRACTICE versus VERBAL TRAINING</b></p> <p>Protocol outcome 1: Quality of life at End of treatment          - Actual outcome for Adults and young people (16 years and over): mini AQLQ at 6 weeks; Group 1: mean 4.6 (SD 1); n=36, Group 2: mean 4.2 (SD 1); n=35; mini AQLQ 1-7 Top=High is good outcome; Risk of bias: Very high; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 2: Lung Function at End of Treatment          - Actual outcome for Adults and young people (16 years and over): FEV1 L at 6 weeks; Group 1: mean 1.93 L (SD 0.63); n=36, Group 2: mean 2.16 L (SD 0.74); n=35; Risk of bias: Very high; Indirectness of outcome: No indirectness</p>	
Protocol outcomes not reported by the study	Mortality at End of Treatment; Exacerbation (need for OCS) at End of treatment; UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment; Asthma control questionnaires at End of Treatment; Rescue medication at End of Treatment; Dose of regular asthma treatment (SABA, ICS) at End of Treatment; Symptom free days at End of Treatment; Time of school/work at End of Treatment

Study	Ammari 2013-1 <sup>43</sup>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	(n=34)
Countries and setting	Conducted in United Kingdom; Setting: Primary care
Line of therapy	Mixed line
Duration of study	Intervention + follow up: 6 weeks
Method of assessment of guideline condition	Partially adequate method of assessment/diagnosis: Patients with asthma who collected their MDI prescriptions from community pharmacies
Stratum	Adults and young people (16 years and over):
Subgroup analysis within study	Stratified then randomised: Adults and children
Inclusion criteria	Aged 4-45 years; prescribed at least one MDI without a spacer device including a preventer; identified with poor inhaler technique (defined as poor hand-lung coordination and an IFR $\geq 90$ l/min).
Exclusion criteria	Experienced an acute exacerbation of asthma or received OCS within 4 weeks prior to recruitment; had other illnesses adversely affecting their respiratory system; hearing problems and/or unable to distinguish between one and two tones produced by the 2TT tool.
Recruitment/selection of patients	nr
Age, gender and ethnicity	Age - Mean (SD): 40.7 (9.7). Gender (M:F): 11/23. Ethnicity:
Further population details	1. Cognitive function: Not applicable / Not stated / Unclear 2. Disability: Not applicable / Not stated / Unclear 3. Social economic disadvantage: Not applicable / Not stated / Unclear
Indirectness of population	No indirectness
Interventions	(n=17) Intervention 1: Monitoring inhaler technique + feedback - Monitoring using electronic devices + feedback. All patients selected due to a fast inhalation (most common inhaler technique problem). Verbal training + the 2 tone trainer (2TT) to achieve a slow inhalation flow rate by encouraging patients to increase the length of their inhalation period. The 2TT is an MDI-like tool without a canister that is designed to give an audible feedback depending on the inhalation speed (a high pitched two tone noise if inhalation is too fast $>60$ l/min). Patients then simulate this technique when using their own MDI. . Duration 6 weeks. Concurrent medication/care: Instructed to practice using the 2TT twice daily before taking their MDI Further details: 1. Additional education training : No education in both groups

	(n=17) Intervention 2: Monitoring inhaler technique + feedback - Visual monitoring + feedback. All patients selected due to a fast inhalation (most common inhaler technique problem). Verbal training to achieve a slow inhalation flow rate by encouraging patients to increase the length of their inhalation period.. Duration 1 visit (6 week follow-up). Concurrent medication/care: nr Further details: 1. Additional education training : No education in both groups
Funding	Principal author funded by industry (Author received sponsorship to carry out studies from several pharmaceutical companies. Research sponsorship also received from EPSRC and MRC)
<p><b>RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: VERBAL TRAINING PLUS ELECTRONIC DEVICE TO PRACTICE versus VISUAL TRAINING</b></p> <p>Protocol outcome 1: Quality of life at End of treatment - Actual outcome for Adults and young people (16 years and over): mini AQLQ at 6 weeks; Group 1: mean -0.409 (SD 1.05); n=17, Group 2: mean -0.748 (SD 1.31); n=17; miniAQLQ 1-7 Top=High is good outcome; Risk of bias: Very high; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 2: Lung Function at End of Treatment - Actual outcome for Adults and young people (16 years and over): FEV1 % pred at 6 weeks; Group 1: mean 96.3 % (SD 17.6); n=17, Risk of bias: High; Indirectness of outcome: No indirectness</p>	
Protocol outcomes not reported by the study	Mortality at End of Treatment; Exacerbation (need for OCS) at End of treatment; UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment; Asthma control questionnaires at End of Treatment; Rescue medication at End of Treatment; Dose of regular asthma treatment (SABA, ICS) at End of Treatment; Symptom free days at End of Treatment; Time of school/work at End of Treatment



Study	Ammari 2013-2 <sup>43</sup>
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=12)
Countries and setting	Conducted in United Kingdom; Setting: Primary care
Line of therapy	Mixed line
Duration of study	Intervention + follow up: 6 weeks
Method of assessment of guideline condition	Partially adequate method of assessment/diagnosis: Patients with asthma who collected their MDI prescriptions from community pharmacies
Stratum	Children 5 -<16
Subgroup analysis within study	Stratified then randomised: Adults and children
Inclusion criteria	Aged 4-45 years; prescribed at least one MDI without a spacer device including a preventer; identified with poor inhaler technique (defined as poor hand-lung coordination and an IFR $\geq 90$ l/min).
Exclusion criteria	Experienced an acute exacerbation of asthma or received OCS within 4 weeks prior to recruitment; had other illnesses adversely affecting their respiratory system; hearing problems and/or unable to distinguish between one and two tones produced by the 2TT tool.
Recruitment/selection of patients	nr
Age, gender and ethnicity	Age - Mean (SD): 10.2 (3.2). Gender (M:F): 8/4. Ethnicity:
Further population details	1. Cognitive function: Not applicable / Not stated / Unclear 2. Disability: Not applicable / Not stated / Unclear 3. Social economic disadvantage: Not applicable / Not stated / Unclear
Indirectness of population	No indirectness
Interventions	(n=6) Intervention 1: Monitoring inhaler technique + feedback - Monitoring using electronic devices + feedback. All patients selected due to a fast inhalation (most common inhaler technique problem). Verbal training + the 2 tone trainer (2TT) to achieve a slow inhalation flow rate by encouraging patients to increase the length of their inhalation period. The 2TT is an MDI-like tool without a canister that is designed to give an audible feedback depending on the inhalation speed (a high pitched two tone noise if inhalation is too fast $>60$ l/min). Patients then simulate this technique when using their own MDI.. Duration 1 visit (6 week follow-up). Concurrent medication/care: Instructed to practice using the 2TT twice daily before taking their MDI Further details: 1. Additional education training : No education in both groups

	<p>(n=6) Intervention 2: Monitoring inhaler technique + feedback - Visual monitoring + feedback. All patients selected due to a fast inhalation (most common inhaler technique problem). Verbal training to achieve a slow inhalation flow rate by encouraging patients to increase the length of their inhalation period.. Duration 1 visit (6 week follow-up). Concurrent medication/care: nr</p> <p>Further details: 1. Additional education training : No education in both groups</p>
Funding	Principal author funded by industry (Author received sponsorship to carry out studies from several pharmaceutical companies. Research sponsorship also received from EPSRC and MRC)
<p><b>RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: VERBAL TRAINING PLUS ELECTRONIC DEVICE TO PRACTICE versus VERBAL TRAINING</b></p> <p>Protocol outcome 1: Quality of life at End of treatment          - Actual outcome for Children 5 -&lt;16: PAQLQ at 6 weeks; Group 1: mean -0.362 (SD 0.52); n=6, Group 2: mean -0.391 (SD 0.69); n=6; PAQLQ 1-7 Top=High is good outcome; Risk of bias: Very high; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 2: Lung Function at End of Treatment          - Actual outcome for Children 5 -&lt;16: FEV1 % pred at 6 weeks; Group 1: mean 90.9 % (SD 14.3); n=6, Risk of bias: High; Indirectness of outcome: No indirectness</p>	
Protocol outcomes not reported by the study	Mortality at End of Treatment; Exacerbation (need for OCS) at End of treatment; UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment; Asthma control questionnaires at End of Treatment; Rescue medication at End of Treatment; Dose of regular asthma treatment (SABA, ICS) at End of Treatment; Symptom free days at End of Treatment; Time of school/work at End of Treatment

Study (subsidiary papers)	Basheti 2007 <sup>123</sup> (Basheti 2008 <sup>120</sup> )
Study type	RCT (Cluster randomised; Parallel)
Number of studies (number of participants)	(n=)
Countries and setting	Conducted in Australia; Setting: Community - pharmacy education
Line of therapy	Mixed line
Duration of study	Intervention time: 6 months
Method of assessment of guideline condition	Partially adequate method of assessment/diagnosis: Doctor Dx asthma and use of ICS
Stratum	Adults and young people (16 years and over): Aged ≥14 years
Subgroup analysis within study	Not applicable
Inclusion criteria	Patients presenting with Turbuhaler or Diskus prescriptions for asthma; age ≥14 years; doctor diagnosed asthma; use of ICS with Turbuhaler or Diskus with or without LABA; no change in asthma medication or dose for 1 month.
Exclusion criteria	Did not self-administer their own medication; did not speak or understand English.
Recruitment/selection of patients	April 2003 - 2004
Age, gender and ethnicity	Age - Range: ≥14 years. Gender (M:F): nr. Ethnicity:
Further population details	1. Cognitive function: Not applicable / Not stated / Unclear 2. Disability: Not applicable / Not stated / Unclear 3. Social economic disadvantage: Not applicable / Not stated / Unclear
Indirectness of population	No indirectness
Interventions	<p>(n=56) Intervention 1: Monitoring inhaler technique + feedback - Visual monitoring + feedback. Pharmacy trained to deliver education on peak flow meter technique and inhaler technique. Assessed inhaler technique using checklists and then educated using 'show and tell' for each step on the checklist. Incorrect steps on the checklist were highlighted and attached to the patient's inhaler using a label. This was repeated at 1, 2, 3 and 6 months.. Duration 6 months. Concurrent medication/care: nr Further details: 1. Additional education training : No education in both groups</p> <p>(n=56) Intervention 2: No monitoring . Pharmacy trained to deliver education on peak flow meter technique only. Duration 1 visit (6 month follow-up). Concurrent medication/care: nr Further details: 1. Additional education training : No education in both groups</p>

Funding	Principal author funded by industry (Author grant support from GSK and AstraZenica)
<p><b>RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: VISUAL MONITORING + FEEDBACK versus NO MONITORING OF INHALER TECHNIQUE</b></p> <p>Protocol outcome 1: Quality of life at End of treatment                      - Actual outcome for Adults and young people (16 years and over): Marks AQLQ at 3 months; Group 1: mean 0.8 (SD 0.5); n=53, Group 2: mean 1.35 (SD 0.6); n=44; Marks AQLQ 0-10 Top=High is poor outcome; Risk of bias: Very high; Indirectness of outcome: No indirectness                      - Actual outcome for Adults and young people (16 years and over): Marks AQLQ at 6 months; Group 1: mean 0.8 (SD 0.6); n=53, Group 2: mean 1.3 (SD 0.6); n=44; Marks AQLQ 0-10 Top=High is poor outcome; Risk of bias: Very high; Indirectness of outcome: No indirectness</p> <p>Protocol outcome 2: Lung Function at End of Treatment                      - Actual outcome for Adults and young people (16 years and over): PEFv (Min%Max) at 3 months; Group 1: mean 83.8 % (SD 8.3); n=53, Risk of bias: Very high; Indirectness of outcome: No indirectness                      - Actual outcome for Adults and young people (16 years and over): PEFv (Min%Max) at 6 months; Group 1: mean 78.9 % (SD 9.7); n=53, Group 2: mean 74.4 % (SD 8.9); n=44; Risk of bias: Very high; Indirectness of outcome: No indirectness</p>	
Protocol outcomes not reported by the study	Mortality at End of Treatment; Exacerbation (need for OCS) at End of treatment; UHU (ED visit, hospitalisation, GP out-of-hours centre) at End of Treatment; Asthma control questionnaires at End of Treatment; Rescue medication at End of Treatment; Dose of regular asthma treatment (SABA, ICS) at End of Treatment; Symptom free days at End of Treatment; Time of school/work at End of Treatment

**1 G.21 Tele-healthcare to monitor asthma control**

**2 Table 152: Baptist 2013<sup>101</sup>**

Reference	Study type	Number of patients	Patient characteristics	Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
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Baptist, A. P., et al. (2013). A randomized controlled trial of a self-regulation intervention for older adults with asthma. <i>May. Journal of the American Geriatrics Society, 61(5), 747-753</i>	RCT  1 tertiary care centre in USA	N=70  <b>Tele:</b> N=34  <b>Control:</b> N=36		<b>Tele</b>	<b>Control</b>	3 in-person group sessions and 3 one-on-one telephone sessions. Group sessions included seven participants and a health educator who served as the leader. A health educator conducted all group and telephone sessions.	3 phone calls not related to asthma self-management. An allergist called participants randomized to the control group 1 and 2 weeks after enrolment to address any inquiries regarding information received during the asthma education session.	6 and 12 months	Hospital visits	T:0/34 C:4/36	<b>Funding:</b> American Academy of Allergy Asthma and Immunology  <b>Risk of bias:</b> • Randomised with number generator • Participants, physicians and assessors were blind • 90% included in final analysis • ACQ continuous data not reported
			Age, yrs	72.8	73.8				GP visits	T: 6/34 C: 14/36	
			% male:	32.4	13.9				FEV1 % predicted	T: 84.6 C: 76.3 P=0.17	
			% pred. FEV1	84.2	80.9						
			<b>Inclusion criteria:</b>								
<ul style="list-style-type: none"> <li>• Outpatients aged 65 and older</li> <li>• Physician diagnosis of asthma</li> <li>• Daily controller medication</li> <li>• Access to a home telephone</li> </ul>											
<b>Exclusion criteria:</b>											
<ul style="list-style-type: none"> <li>• COPD or any other primary pulmonary disorder</li> <li>• Current smokers or smoking history of &gt; 20 pack-years</li> <li>• Mental impairment</li> </ul>											

**Table 153: Barbanel 2003<sup>106</sup>**

Reference	Study type	Number of patients	Patient characteristics		Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
Barbanel, D., Eldridge, S., & Griffiths, C. (2003). Can a	RCT	N=24		<b>Tele</b>	After a 3-day training course on asthma care, patients were	The control group received no input from	6 months	North of England Asthma Scale – not	N/A	<b>Funding:</b> Not stated
	Deprive d area	<b>Tele:</b>	Age, yrs	45						

Reference	Study type	Number of patients	Patient characteristics			Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
self-management programme delivered by a community pharmacist improve asthma control? A randomised trial. <i>Thorax</i> , 58(10), 851-854.	of London	N=12  <b>Control:</b> N=12	% male:	50	41.7	allocated to a pharmacist for a 45 min educational session and weekly follow-up calls for 3 months. Education included inhaler technique and PEF meter use. Patients were also given supporting literature and a management plan.	the pharmacist.		meta-analysed		<ul style="list-style-type: none"> <li>• <b>Risk of bias:</b> Sequence generation unclear but concealed allocation</li> <li>• Blinding was not possible</li> <li>• One dropout in control was imputed</li> </ul>

**Table 154: Bender 2010<sup>151</sup>**

Reference	Study type	Number of patients	Patient characteristics	Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Source of funding	Comments
<b>Test of an interactive voice response intervention to improve adherence to controller medications in adults with asthma.</b> Journal of the American	RCT	N=50 (25 in each group) 18 to 65 years; physician-diagnosed asthma for which they were prescribed daily inhaled corticosteroid treatment. Exclusion criteria: (1) any	Mean age treatment: 39.6 (12.8) years; control 43.5 (14.3) years. % male: 40% and 32%. White 56% and 60%; Hispanic 24% and 12%; African American 20% and 20%;	2 automated interactive voice response telephone calls separated by one month, with one additional call if they reported recent symptoms of poorly controlled disease or failure to fill a prescription. Calls were completed in	Participants in the control group received no calls.	10 weeks	Mean ICS adherence (dividing the number of inhaler puffs taken by the number of puffs prescribed to be taken each day and then averaged over the 10-week interval) was	64.5 (17.2) % vs. 49.1 (16.8) %, p=0.0032	Investigator-sponsored Study Program of AstraZeneca	Randomisation and allocation concealment unclear (random table generated before study initiation); investigator blind; no attrition; no selective

Reference	Study type	Number of patients	Patient characteristics	Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Source of funding	Comments
Board of Family Medicine: 23: 159-165  Bender BG, Apter A, Bogen DK, Dickinson P, Fisher L, Wamboldt FS, and Westfall JM 2010.		significant disease or disorder that, in the opinion of the investigator, might influence the results of the study or the patient's ability to participate in the study (including other chronic health disorders, current substance abuse or dependence, mental retardation, or psychiatric disorder); and (2) current participation in any other asthma-related research or clinical trial.	Asian 0% and 8%. All not significantly different.	< 5 minutes and included content designed to inquire about asthma symptoms, deliver core educational messages, encourage refilling of inhaled corticosteroid prescriptions, and increase communication with providers			higher in the group receiving IVR intervention than in the control group  Change in Beliefs about Medications Questionnaire (scores above 0 indicate more positive beliefs and scores below 0 indicate more negative beliefs): the group receiving IVR intervention demonstrating a greater upward shift in positive medication beliefs  Change in Asthma Quality of Life Questionnaire	  0.248 (1.07) vs. -0.508 (0.913), p=0.007  -0.152 (0.92) vs. -0.381		reporting; groups comparable at baseline

Reference	Study type	Number of patients	Patient characteristics	Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Source of funding	Comments
							(higher scores indicate better quality of life)	(1.06), not significant		
							Change in Asthma Control Test (higher scores indicate better control of asthma symptoms)	-1.120 (3.90) vs. -1.840 (4.14), not significant		

**Table 155: Chan 2007<sup>297</sup>**

Reference	Study type	Number of patients	Patient characteristics			Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
Chan, D. S., et al (2007). Internet-based home monitoring and education of children with asthma is comparable to ideal office-based	RCT	N=120		<b>Tele:</b>	<b>Control:</b>	Virtual group patients received computers, internet connections, and in-home, Internet-based case	Office-based group patients received traditional in-person education and case management.	12 m	Hospital visits	T: 1/60 C: 1/60	<b>Funding:</b> US Army Medical Research Acquisition Activity
	Child clinic in Hawaii army centre	<b>Tele:</b> N=60	Age, yrs	10.2	9			ED visits	T: 4/60 C: 2/60		
		<b>Control:</b> N=60	% male	61.7	63.3			PAQLQ child	T: 6.1 (1.1) C: 5.8 (1.2)		
		<b>Inclusion criteria:</b> • Children/teens aged 6-17			PAQLQ parent			T: 6.4 (1) C: 6.2 (0.8)	<b>Risk of bias:</b>		



Reference	Study type	Number of patients	Patient characteristics	Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
care: results of a 1-year asthma in-home monitoring trial. <i>Pediatrics</i> , 119(3), 569-578.			<ul style="list-style-type: none"> <li>Persistent asthma</li> <li>Dependent of active duty or retired military personnel</li> <li>Could receive cable modem</li> <li>Willing to complete questionnaires</li> </ul> <p><b>Exclusion criteria:</b></p> <ul style="list-style-type: none"> <li>Not stated</li> </ul>	management and received education through the study website.			FEV1 % predicted	T: 97.4 (19.2) C: 92.7 (18.1)	<ul style="list-style-type: none"> <li>Random numbers table</li> <li>Un-blinded</li> <li>Dropout much higher in tele-health group (23%) than office group (8%)</li> </ul>

**Table 156: Chatkin 2006<sup>305</sup>**

Reference	Study type	Number of patients	Patient characteristics		Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments	
Chatkin, J. M., et al. (2006). Impact of a low-cost and simple intervention in enhancing treatment adherence in a Brazilian asthma sample. <i>Journal of Asthma</i> , 43(4), 263-266.	RCT  Physicians from all over Brazil were invited to include their patients	N=271		<b>Tele</b>	<b>Control</b>	Participants received 10 minute telephone calls every two weeks to provide asthma education with emphasis on treatment adherence. A specifically trained nursing student conducted the calls.	Routine care with a call at the beginning and end of the study to collect data.	Unknown follow-up	Adherence measures	None of interest	<p><b>Funding:</b> GSK Brazil</p> <p><b>Risk of bias:</b></p> <ul style="list-style-type: none"> <li>Minimal information regarding randomisation</li> <li>10 patients were not included because they did not return their</li> </ul>
		<b>Tele:</b> N=140	Age, yrs	43.3	44.4						
		<b>Control:</b> N=131	% male	25.7	29						
		<b>Inclusion criteria:</b>									
		<ul style="list-style-type: none"> <li>Adults/adolescents</li> <li>12+ years</li> <li>Mod./severe asthma according to GINA</li> </ul> <p><b>Exclusion criteria:</b></p> <ul style="list-style-type: none"> <li>Mild persistent asthma</li> </ul>									

Reference	Study type	Number of patients	Patient characteristics	Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
			<ul style="list-style-type: none"> <li>• Pregnancy or breast-feeding</li> <li>• Recent alcohol or drug abuse</li> <li>• Active medical condition</li> </ul>						drug disks and 8 for not responding to the telephone calls

**Table 157: Christakis 2012<sup>322</sup>**

Reference	Study type	Number of patients	Patient characteristics	Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Source of funding	Comments
<p><b>Improving parental adherence with asthma treatment guidelines: a randomized controlled trial of an interactive website.</b> Academic pediatrics: 12: 302-311</p> <p>Christakis DA, Garrison MM, Lozano P,</p>	RCT	N=603; 283 intervention; 320 control. Parents of children aged 2 to 10 years with asthma (at least 1 clinical encounter – clinic visit, emergency room or inpatient admission – or two prescription refills for bronchodilato	29% had mild to severe persistent asthma; 71% had mild intermittent asthma; 54% on at least one controller medication and of these, 61% took controller 5 or more days per week. Among controller users, 60% adherent in control arm and 61% in	Web-based intervention: gathers information from parents (day and night time symptoms, quick-reliever use), applies algorithm to determine asthma severity, home care practices (controller use and adherence), functional status, parental beliefs (outcomes expectation and	Control parents had similar intervention around reducing media usage among their children.	12 months	<p>Appropriate controller use: non-users converted to controller use at 6 months</p> <p>Patients who should have been on controllers at baseline (i.e. persistent asthma) but were not, who were on controllers at 6</p>	<p>15.69% control vs. 15.79% int'n, p=0.98 (denominators unclear)</p> <p>7/19 (36.84%) int'n; 5/30 (16.7%) cont; OR 2.85, 95% CI 0.63 to 14.04,</p>	National Heart, Lung and Blood Institute	Computer randomisation; 85% completed 6-month assessment and 80% at 12 months; no selective reporting; groups comparable at baseline

Reference	Study type	Number of patients	Patient characteristics	Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Source of funding	Comments
Meischke H, Zhou C, and Zimmerman FJ 2012.		rs in the last year) in an HMO and a primary care clinical practice network. Had to have convenient access to internet-enable computer, speak English at home.	intervention arm at baseline.	self-efficacy), feedback on child's asthma (recommendations regarding controller use and other aspects of asthma care), allowed parent to set goals relevant to their situation. Monthly email reminders to log on. Intervention 6 months, then opt-in for further 6 months			months	p=0.17		
							Persistent asthma on controllers at baseline but discontinued at 6 months	6/42 (14%) int'n; 3/58 (5%) cont; OR 0.33, 95% CI 0.05 to 1.67, p=0.16		
							Adherence at 6 months (5 or more days per week) to controllers for those who were prescribed them at 6 months	72% int'n vs. 62% cont, OR 1.54, 95% CI 0.90 to 2.63, p=0.10		
							Adherence at 6 months (5 or more days per week) to controllers for the persistent asthma subgroup who were	77% vs. 50%, OR 3.33, 95% CI 1.20 to 10.07, p=0.01 (denominators		

Reference	Study type	Number of patients	Patient characteristics	Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Source of funding	Comments
							prescribed them at baseline and 6 months	unclear)		
							Outcome expectations at 6 months: positive: no difference between groups; negative: lower in intervention arm.	Positive: 124/241 (51%) int'n; 122/274 (44%) cont, p=0.12. Negative: 145/241 (60%) int'n vs. 190/274 (69%) cont, p=0.03		
							Parental self-efficacy (parents somewhat or strongly agreeing that they can give their child controller medication daily) at 6	217/241 (90%) int'n vs. 218/274 (80%) cont, p=0.001		

Reference	Study type	Number of patients	Patient characteristics	Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Source of funding	Comments
							months			
							Asthma symptoms and severity at 6 and 12 months: Proportions of children with stable or improved symptoms not significantly differed between groups	Data not shown		
							Proportion of children on controllers at 12 months	50% int'n vs. 57% cont, p=0.17 (denominators unclear)		
							Of those who met severity criteria for controllers at baseline, number on them at 12 months	34/53 (64%) int'n, 50/82 (60%) cont, p=0.86		

Reference	Study type	Number of patients	Patient characteristics	Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Source of funding	Comments
							Adherence 5 or more days/week at 12 months	69/105 (66%) int'n, 88/140 (63%) cont, p=0.69		

**Table 158: Deschildre 2012<sup>427</sup>**

Reference	Study type	Number of patients	Patient characteristics		Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
Deschildre, A., et al. (2012). Home telemonitoring (forced expiratory volume in 1 s) in children with severe asthma does not reduce exacerbations. <i>European respiratory journal</i> , 39(2), 290-296.	RCT  4 paediatric clinics in France	N=50  <b>Tele:</b> N=25  <b>Control:</b> N=25		<b>Tele</b>	<b>Control</b>	Daily home spirometry transmitted to the physician via modem, and medical feedback. Depending on FEV1 results, the GP or hospital paediatrician was contacted.	12 m	Hospital visits	T: 2/21 C: 2/23	<b>Funding:</b> French Ministry of Health  <b>Risk of bias:</b> <ul style="list-style-type: none"> <li>• Unclear randomisation procedures</li> <li>• Un-blinded</li> <li>• Unbalanced attrition (higher in tele group)</li> <li>• Analysed with non-parametric tests</li> </ul>
			Age, yrs (median)	11.0	11.2			Oral steroids	T: 19/21 C: 21/23	
			% male	72	76					
			FEV1 % predicted (median)	87.4	83.3					
			<b>Inclusion criteria:</b>							
<ul style="list-style-type: none"> <li>• Children/teens aged 6-16</li> <li>• Severe allergic asthma (3<sup>rd</sup> Paediatric Asthma Consensus)</li> <li>• Frequent exacerbations</li> <li>• reversibility of &gt; 12%and/or</li> </ul>										

Reference	Study type	Number of patients	Patient characteristics	Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
			an increase of at least 200 mL • All taking LABA/ICS combo  <b>Exclusion criteria:</b> • Congenital or acquired illness other than asthma						

**Table 159: Donald 2008<sup>443</sup>**

Reference	Study type	Number of patients	Patient characteristics		Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
Donald, K. J., McBurney, H., Teichtahl, H., & Irving, L. (2008). A pilot study of telephone based asthma management. <i>Australian Family Physician</i> , 37(3), 170-173.	RCT  2 teaching hospitals in Australia	N=71		<b>Tele:</b>	6 follow-up calls from the nurse educator about current asthma symptoms, with management advice. Patients were given a PEF meter and recording instructions, a face-to-face session with an asthma nurse educator, advice on medications, triggers and management, and an Asthma Action Plan.	The control group was encouraged to continue with self-management and usual GP care	12 m	Hospital visits	T: 1/31 C: 6/29	<b>Funding:</b> Unclear  <b>Risk of bias:</b> • Unclear randomisation procedures • Researcher blinded, patients and nurses not • Low questionnaire response rate
		<b>Tele:</b> N=36	Age, years	36.2				ED visits	T: 7/36 C: 5/35	
		<b>Control:</b> N=35	% male	23.9				GP visits	T: 22/31 C: 16/29	
		<b>Inclusion criteria:</b> • Adults aged 18-55 • Previous asthma admission • Primary diagnosis of asthma  <b>Exclusion criteria:</b> • Other chronic respiratory or unstable medical condition • Cognitive disability • Psychiatric illness		Oral steroids				T: 22/31 C: 21/29		
								Absence (days)	T: 2.81 (6.26) C: 5.22 (8.38)	

**Table 160: Gruffydd-Jones 2005<sup>597</sup>**

Reference	Study type	Number of patients	Patient characteristics			Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
Gruffydd-Jones, K., et al (2005). Targeted routine asthma care in general practice using telephone triage. <i>British Journal of General Practice</i> , 55(521), 918-923.	RCT  1 general practice in England	N=194		<b>Tele:</b>	<b>Control:</b>	Contacted by telephone every 6-months by a trained asthma nurse and asked the RCPs 'three questions' plus two extra questions related to a high risk of asthma death. The nurse formulated an individualised asthma action plan with the patient.	Usual care by 6-monthly check up with an asthma nurse. Symptom scores, inhaler technique, and PEF were checked and all patients issued with an asthma action plan.	6 and 12 m	AQLQ	T: 5.93 (1.64) C: 5.79 (0.90)	<b>Funding:</b> Asthma UK  <b>Risk of bias:</b> • Random number tables • Un-blinded • Unbalanced attrition (higher in usual care)
		<b>Tele:</b> N=97	Age, years	50.8	49.6				ACQ	T: -0.18 (95% CI) (-0.38 to 0.02) C: -0.11 (-0.32 to 0.11)	
		<b>Control:</b> N=97	% male	51.5	39.2				Costs	T: 210.4(95% CI) (208.9 to 211.8) C: 332.7 (329.5 to 335.9)	
		<b>Inclusion criteria:</b> • Adults aged 17-70 • On the practice asthma list  <b>Exclusion criteria:</b> • Housebound or no phone									

**Table 161: Guendelman 2002<sup>602</sup>**

Reference	Study type	Number of patients	Patient characteristics			Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
Guendelman, S., et al (2002). Improving asthma outcomes and self-management behaviors of	RCT  1 clinic in California, USA	N=134		Tele:	Control:	Internet-based asthma self-management and education program with feedback (Health Buddy) which asked	Paper asthma diary. All children returned for 2 follow-up visits at 6 and 12 weeks when they received	3 m	Hospital visits	T: 4/62 C: 1/60	<b>Funding:</b> Unclear  <b>Risk of bias:</b> • Unclear sequence generation,
		<b>Tele:</b> N=66	Age, years	12.0	12.2				ED visits	T: 6/62 C: 11/60	
		<b>Control:</b> N=68	% male	61	54						



Reference	Study type	Number of patients	Patient characteristics	Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
inner-city children: a randomized trial of the Health Buddy interactive device and an asthma diary. <i>Archives of Pediatrics &amp; Adolescent Medicine.</i> , 156(2), 114-120.			<p><b>Inclusion criteria:</b></p> <ul style="list-style-type: none"> <li>• Children/teens aged 8-16</li> <li>• Persistent asthma</li> <li>• English speaking with a telephone in the house</li> </ul> <p><b>Exclusion criteria:</b></p> <ul style="list-style-type: none"> <li>• In another asthma study</li> <li>• Mental or physical challenges that affected the program</li> <li>• Co-morbid conditions that might affect quality of life</li> </ul>	every day about asthma status, PEF and medication. Responses were downloaded to the nurse co-ordinator overnight.	further standardised teaching from the nurse co-ordinator				<p>concealed with envelopes</p> <ul style="list-style-type: none"> <li>• Un-blinded</li> <li>• Low attrition</li> </ul>

**Table 162: Gustafson 2012<sup>610</sup>**

Reference	Study type	Number of patients	Patient characteristics			Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
Gustafson, D., et al (2012). The effects of combining web-based eHealth with telephone nurse case management for pediatric asthma control: A randomized	RCT  USA	N=301		<b>Tele:</b>	<b>Control:</b>	Automated management software with monthly calls from nurse (CHES+CM). Based on self-determination theory and designed to improve competence, social support,	Treatment as usual plus asthma information	12 m	ACQ	MD -0.31; 95% CI -0.56 to -0.06; 0=0.01	<p><b>Funding:</b> National Institute of Nursing Research</p> <p><b>Risk of bias:</b></p> <ul style="list-style-type: none"> <li>• Sequence generation fine and well concealed</li> <li>• Un-blinded</li> </ul>
		<b>Tele:</b> N=132	Age, years	7.7	8.2						
		<b>Control:</b> N=127	% male	66	57						
			Baseline ACQ	2.49	2.32						

Reference	Study type	Number of patients	Patient characteristics	Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
controlled trial. [References]. <i>Journal of medical Internet research</i> , 14(4), 41-59.			<b>Inclusion criteria:</b> <ul style="list-style-type: none"> <li>• Children aged 4-12</li> <li>• Diagnosis of asthma or wheezing</li> <li>• Controller meds and poor adherence</li> </ul> <b>Exclusion criteria:</b> <ul style="list-style-type: none"> <li>• Not described</li> </ul>	and intrinsic motivation of parents and children.					<ul style="list-style-type: none"> <li>• Balanced attrition</li> </ul>

**Table 163: Halterman 2012<sup>626</sup>**

Reference	Study type	Number of patients	Patient characteristics			Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
Halterman Jill, S. et al (2012). Working toward a sustainable system of asthma care: Development of the School-Based Preventive Asthma Care Technology (SB-PACT) trial. 49, 395-400	RCT  19 inner-city schools in New York, USA	N=100		<b>Tele:</b>	<b>Control:</b>	'SB-PACT' intervention: web-based screening, electronic communication with primary care providers, online prescription of medications, direct nurse observation of adherence in schools, assessment of symptoms online	In addition to usual care, families in both groups were provided with written educational hand-outs on asthma triggers, treatment, and local asthma resources	8 m	Hospital visits	T: 1/48 C: 1/51	<b>Funding:</b> National Heart, Lung, and Blood Institute of the National Institutes of Health  <b>Risk of bias:</b> <ul style="list-style-type: none"> <li>• Sequence generation fine and well concealed</li> <li>• Families not blind, but assessors were</li> </ul>
		<b>Tele:</b> N=48	Age, years	7.5	7.0				ED visits	T: 4/48 C: 3/51	
		<b>Control:</b> N=51	% male	52	63				GP visits	T: 6/48 C: 8/51	
			<b>Inclusion criteria:</b>							AQLQ	
			<b>Exclusion criteria:</b>				School absence				

Reference	Study type	Number of patients	Patient characteristics	Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
									• No dropout

**Table 164: Jan 2007<sup>749</sup>**

Reference	Study type	Number of patients	Patient characteristics			Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
Jan, R. L., et al. (2007). An internet-based interactive telemonitoring system for improving childhood asthma outcomes in Taiwan. <i>Telemedicine Journal and e-Health</i> , 13(3), 257-268.	RCT  1 university medical center in Taiwan	N=164		<b>Tele:</b>	<b>Control:</b>	“Blue Angel for Asthma Kids”, an Internet-based paediatric asthma monitoring program children and parents. Included symptom and PEF diaries and Asthma Action Plans based on the GINA. Data could be shared with the physician who gave feedback by phone/email.	Traditional treatment in an outpatient allergy and asthma clinic accompanied by a PEF meter and diary. Also received verbal and printed asthma education and an Action Plan as part of usual care.	3 m	PEF morning	T: 18.7 (49.4) C: 10.9 (40)	<b>Funding:</b> National Science Council and Bureau of Health Promotion  <b>Risk of bias:</b> <ul style="list-style-type: none"> <li>• Unclear sequence generation, concealed with envelopes</li> <li>• Un-blinded</li> <li>• Low attrition</li> </ul>
		<b>Tele:</b> N=88	Age, years	10.9	9.9				PEF evening	T: 23.1 (56.5) C: 11.1 (41.6)	
		<b>Control:</b> N=76	% male	39.7	36.8						
			<b>Inclusion criteria:</b> <ul style="list-style-type: none"> <li>• Children aged 6-12 years</li> <li>• Access to internet</li> <li>• Physician-diagnosed asthma</li> </ul> <b>Exclusion criteria:</b> <ul style="list-style-type: none"> <li>• Other chronic conditions such as broncho-pulmonary dysplasia</li> </ul>								

**Table 165: Khan 2004**<sup>849</sup>

Reference	Study type	Number of patients	Patient characteristics			Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
			Tele:	Control:							
Khan, M. S. R., et al (2004). Randomized controlled trial of asthma education after discharge from an emergency department. Journal of Paediatrics & Child Health, 40(12), 674-677.	RCT  1 centre in Sydney, Australia	N=310  <b>Tele:</b> N=155  <b>Control:</b> N=155		<b>Tele:</b>	<b>Control:</b>	Parents received a telephone call by an asthma nurse educator within 2 weeks of discharge to reiterate advice given at discharge. Calls lasted an average of 13 min (range 5 to 44 minutes).	All parents received written materials with facts about asthma, use of spacers, management of exercise induced asthma and when to contact a doctor.	6 m	Hospital visits	T: 0/136 C: 0/130	<b>Funding:</b> Financial Markets Foundation for Children  <b>Risk of bias:</b> • Random numbers table • Assessors blind • Possible attrition bias
			Age, years	4.9					ED visits	T: 1/136 C: 0/130	
			% male	65.5							
			<b>Inclusion criteria:</b> • Children aged 1-15 years • Recent ED discharge  <b>Exclusion criteria:</b> • Non English speaking								

**Table 166: Liu 2011**<sup>1020</sup>

Reference	Study type	Number of patients	Patient characteristics			Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
			Tele:	Control:							
Liu, W. T., et al (2011). A mobile telephone-based interactive self-care system improves asthma control.	RCT  Clinics at a teaching hospital in Taiwan	N=89  <b>Tele:</b> N=60  <b>Control:</b> N=60		<b>Tele:</b>	<b>Control:</b>	Mobile phone-based software: with electronic diary to record symptom score, reliever use, and lung function. Staff reviewed data uploaded to website and gave advice in	Written asthma diary and action plan. All subjects received asthma education, self-management plan, and	6 m	Mortality	T: 0/43 C: 0/46	<b>Funding:</b> Unclear  <b>Risk of bias:</b> • Allocation not described • Un-blinded • High attrition
			Age, years	50.4	54				Hospital visits	T: 0/43 C: 1/46	
			% male	51.2	47.8				ED visits	T: 2/43 C: 12/46	
			<b>Inclusion criteria:</b> • Adults							FEV1 % predicted	

Reference	Study type	Number of patients	Patient characteristics	Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
<i>European respiratory journal, 37(2), 310-317</i>			<ul style="list-style-type: none"> <li>Moderate/severe asthma</li> </ul>	accordance with GINA guidelines. Data were given to the doctors to adjust treatment plans.	standard treatment		PEF L/min	T: 382.7 (56) C: 343.5 (52)	

**Table 167: Ostojic 2005<sup>1278</sup>**

Reference	Study type	Number of patients	Patient characteristics			Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
Ostojic, V., et al. (2005). Improving asthma control through telemedicine: A study of short-message service. <i>Telemedicine Journal &amp; E-Health, 11(1), 28-35.</i>	RCT  1 clinic in Croatia	N=16		<b>Tele:</b>	<b>Control:</b>	Paper diary for PEF, medication use and symptoms. PEF (3 times a day), sent results to a computer in the asthma centre and received weekly text instructions from an asthma specialist about therapy or the need for extra office visits.	Both groups were treated according to GINA guidelines. Controls also kept a daily diary of PEF and symptoms, but results were only reviewed by the physician at the end of the study period.	4 m	Hospital visits  FEV1 % predicted	T: 2/8 C: 7/8	<b>Funding:</b> Unclear  <b>Risk of bias:</b> <ul style="list-style-type: none"> <li>Computer randomised</li> <li>Un-blinded</li> <li>No dropouts</li> </ul>
		Tele: N=8	Age, years	24.8	24.5					T: 81.3 (17.3) C: 78.3 (21.1)	
		Control: N=8	% male	63	50						
			% predicted FEV1	77.6	78.9						
		<b>Inclusion criteria:</b> <ul style="list-style-type: none"> <li>Adults with moderate asthma</li> <li>All using LABA/ICS</li> </ul> <b>Exclusion criteria:</b> <ul style="list-style-type: none"> <li>Adults with moderate asthma</li> <li>All using LABA/ICS</li> </ul>									

**Table 168: Pinnock 2003<sup>1348</sup>**

Reference	Study type	Number of patients	Patient characteristics	Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
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Reference	Study type	Number of patients	Patient characteristics			Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
				Tele:	Control:						
Pinnock, H., et al (2003). Accessibility, acceptability, and effectiveness in primary care of routine telephone review of asthma: pragmatic, randomised controlled trial. <i>BMJ</i> , 326(7387), 477-479.	RCT	N=278				Telephone review with the asthma nurse. The nurse tried up to 4 times to contact the patients.	Face-to-face reviews in the surgery also with the asthma nurse, one invitation was sent in the usual manner. Content of the review was as the nurse deemed appropriate.	Variable follow-up, pragmatic design	Hospital visits	T: 0/137 C: 0/141	<b>Funding:</b> Educational grant from AstraZeneca  <b>Risk of bias:</b> <ul style="list-style-type: none"> <li>Centrally randomised</li> <li>Un-blinded</li> </ul>
	4 UK GPs	Tele: N=137	Age, years	54.6	56.4				ED visits	T: 0/137 C: 0/141	
		Control: N=141	% male	41	42				Oral steroid use	T: 5/137 C: 3/141	
			Baseline AQLQ	5.17	5.16				GP visits	T: 27/137 C: 34/141	
			<b>Inclusion criteria:</b> <ul style="list-style-type: none"> <li>Adults aged 18+</li> <li>Asthma for 1 year +</li> <li>Bronchodilator prescription in previous 6 months</li> </ul> <b>Exclusion criteria:</b> <ul style="list-style-type: none"> <li>COPD</li> <li>Communication difficulties</li> </ul>						AQLQ	T: 5.15 (1.28) C: 5.52 (1.14)	

**Table 169: Pinnock 2007<sup>1347</sup>**

Reference	Study type	Number of patients	Patient characteristics			Intervention	Comparisons	Length of follow-up	Outcome measures	Effect sizes	Comments	
				Tele	Cont 1							Cont 2
Pinnock H., et al (2007). Accessibility, clinical effectiveness and practice costs of providing a telephone	RCT	N=1728				Sent 3 invitations over the study period to book either a phone or face-to-face review both at a pre-arranged	1) Usual care maintained their well-established asthma clinic but no re call was undertaken.  2) Patients were recalled to face-	12 m	AQLQ	T: 5.29 (1.2) C1: 5.27 (1.2) C2: 5.31 (1.2)	<b>Funding:</b> Scientific Foundation Board of the RCGP  <b>Risk of bias:</b> <ul style="list-style-type: none"> <li>Randomised</li> </ul>	
	1 UK GP over 3 sites	Tele: N=554	Age, yrs	43	45.4				42.3	ACQ		T: 1.20 (1) C1: 1.24 (1) C2: 1.33 (1.1)
		Control1: N=515	% male	44.2	44.7				44.9	Cost total		T: £3982 C1: £3340

Reference	Study type	Number of patients	Patient characteristics				Intervention	Comparisons	Length of follow-up	Outcome measures	Effect sizes	Comments
option for routine asthma reviews: phase IV controlled implementation study. <i>British Journal of General Practice</i> , 57(542): 714–722		<b>Control2:</b> N=659					time. Patients who did not respond to the 3 invitations were phoned and reviewed opportunistically	to-face reviews using invitations by post or with repeat prescriptions. There was no option for a phone review and no attempt to contact non-attenders.		Cost per review	C2: £4485	with coin toss • Un-blinded
			% with COPD	6.5	7.2	8.5					T: £10.03 C1: £11.85 C2: £12.74	
			<b>Inclusion criteria:</b> <ul style="list-style-type: none"> <li>Adults aged 12+ years</li> <li>Prescription in previous year</li> </ul> <b>Exclusion criteria:</b> <ul style="list-style-type: none"> <li>Diagnosis of COPD</li> </ul>									

**Table 170: Prabhakaran 2009<sup>1377</sup>**

Reference	Study type	Number of patients	Patient characteristics			Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
Prabhakaran, L., et al (2010). The use of text messaging to improve asthma control: A pilot study using the mobile phone short messaging service (SMS). <i>Journal of telemedicine and telecare</i> , 16(5), 286-290	RCT  Hospital in Singapore and location	N=120  <b>Tele:</b> N=60  <b>Control:</b> N=60		<b>Tele:</b>	<b>Control:</b>	SMS monitoring to assist with the management of their asthma control for three months.	All patients were seen by a trained asthma nurse educator who assessed their asthma control, compliance and inhaler technique prior to asthma education. The 60 patients in the control group were left to self-manage their asthma for	3 m	Mortality	T: 0/60 C: 0/60	<b>Funding:</b> Unclear  <b>Risk of bias:</b> • Randomised with slips of paper • Un-blinded • Low dropout
			Age, years	37	40				Dichot. ACT, can't use		
			% male	35	47						
			<b>Inclusion criteria:</b> <ul style="list-style-type: none"> <li>Adults aged 21+ years</li> <li>Previous asthma admission</li> <li>English speaking and able to use a mobile phone</li> </ul> <b>Exclusion criteria:</b> <ul style="list-style-type: none"> <li>Significant co-morbidity</li> </ul>								

Reference	Study type	Number of patients	Patient characteristics	Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
			<ul style="list-style-type: none"> <li>Mild asthma</li> </ul>		three months				

**Table 171: Rasmussen 2005<sup>1421</sup>**

Reference	Study type	Number of patients	Patient characteristics			Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
Rasmussen, L. et al. (2005). Internet-based monitoring of asthma: A long-term, randomized clinical study of 300 asthmatic subjects. <i>Journal of Allergy &amp; Clinical Immunology</i> , 115(6), 1137-1142.	RCT  Copenhagen Denmark	N=300		<b>Tele</b>	<b>Cont 1</b>	<b>Cont 2</b>	Electronic diary, an asthma action plan and a decision support system for the physician. Patients were given a PEF Meter and taught how to fill in a daily diary and respond to the computer's advice. Physicians gave instructions via e-mail or telephone.	12 m	Hospital visits	T: 0/85 C1: 1/88 C2: 0/80	<b>Funding:</b> Grants from H:S Corporation of University Hospital of Copenhagen, AstraZeneca, and private funds
		<b>Tele:</b> N=100	Age, yrs	28	30	30					
		<b>Control1:</b> N=100	% male	31.8	34.1	37.5					
		<b>Control2:</b> N=100	% pred FEV1	91	93	92					
			Baseline AQLQ	6.2	6.2	6.1					
			<b>Inclusion criteria:</b> <ul style="list-style-type: none"> <li>Adults aged 18-45 years</li> <li>Asthma according to ATS</li> </ul> <b>Exclusion criteria:</b> <ul style="list-style-type: none"> <li>Not described</li> </ul>								
						2) Patients were asked to contact their GP and pass on a letter describing the study and giving the test results. GPs in Copenhagen had been sent a circular about asthma and GINA guidelines.		ED visits	T: 2/85 C1: 0/88 C2: 1/80		
								GP visits	T: 3/85 C1: 2/88 C2: 1/810		
								FEV1 change (mL)	T: 187 (369) C1: 35 (281) C2: 4 (268)		<b>Risk of bias:</b> <ul style="list-style-type: none"> <li>Randomised consecutively with sealed envelopes</li> <li>Un-blinded</li> <li>Unbalanced dropout</li> <li>Some selective reporting</li> </ul>



**Table 172: Ryan 2012<sup>1478</sup>**

Reference	Study type	Number of patients	Patient characteristics			Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
				Tele:	Control:						
Ryan, D., et al (2012). Clinical and cost-effectiveness of mobile phone supported self-monitoring of asthma: multicentre randomised controlled trial. <i>BMJ (Online)</i> , 344(7854), e1756.	RCT  32 GPs in England	N=288				Twice daily recording and mobile phone based transmission of symptoms, drug use, and peak flow with immediate feedback prompting action according to an agreed plan	Paper-based monitoring with the same clinical care as the intervention group (BTS/SIGN based). Both groups also received a 30 minute education session from the practice nurse before randomisation	6 m	Hospital visits	T: 3/140 C: 1/141	<b>Funding:</b> Asthma UK  <b>Risk of bias:</b> <ul style="list-style-type: none"> <li>Centrally randomised</li> <li>Blinded outcome assessment</li> </ul>
		Tele: N=145	Age, years	46.6	51.5				ED visits	T: 3/140 C: 0/141	
		Control: N=143	% male	33.8	41.3				GP visits	T: 51/140 C: 41/141	
		Baseline ACQ	2.32	2.29	Oral steroid use				T: 28/140 C: 30/141		
		<b>Inclusion criteria:</b> <ul style="list-style-type: none"> <li>Adults aged 12+</li> <li>Poorly controlled asthma</li> </ul> <b>Exclusion criteria:</b> <ul style="list-style-type: none"> <li>Other lung disease or other clinical/social problems</li> </ul>			AQLQ				T: 5.00 (1.32) C: 4.99 (1.34)		
			ACQ	T: 1.57 (0.99) C: 1.56 (1.09)							

**Table 173: Seid 2012<sup>1541</sup>**

Reference	Study type	Number of patients	Patient characteristics			Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
				Tele:	Control:						
Seid, M., et al (2012). The In Vivo adherence intervention for at risk adolescents with asthma: Report of a randomized	RCT  1 site in Cincinnati, USA	N=26				Asthma education, in-person motivational interviewing and problem solving skills training, cell phone with	Asthma education and cell phone without tailored text messaging	1 and 3 m	None of interest	N/A	<b>Funding:</b> National Institutes of Health  <b>Risk of bias:</b> <ul style="list-style-type: none"> <li>Random number tables</li> </ul>
		Tele: N=14	% male	41.7	21.4						
Control: N=14			<b>Inclusion criteria:</b> <ul style="list-style-type: none"> <li>Adolescents aged 12-18 years</li> <li>Moderate/severe asthma</li> </ul>								

Reference	Study type	Number of patients	Patient characteristics	Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
pilot study. <i>Journal of pediatric psychology</i> , 37(4), 390-403			(NHLBI) <ul style="list-style-type: none"> <li>Symptoms in past 2 weeks</li> </ul> <p><b>Exclusion criteria:</b></p> <ul style="list-style-type: none"> <li>Co-morbid conditions</li> <li>Non English speaking</li> </ul>	tailored text messages					<ul style="list-style-type: none"> <li>Blinded outcome assessment</li> <li>Pilot study</li> </ul>

**Table 174: van der Meer 2009<sup>1803</sup>**

Reference	Study type	Number of patients	Patient characteristics			Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
Van Der Meer, V., et al (2010). Self-management for asthma on the Internet: A randomized study. <i>Nederlands tijdschrift voor geneeskunde</i> , 154(9), 403-409.	RCT  37 GPs in Holland	N=200		<b>Tele:</b>	<b>Control:</b>	Website to record FEV1 (daily), ACQ (weekly), and symptoms via internet or text. Also included asthma treatment plan and online education. Patients could contact an asthma nurse when needed. The ACQ score fed into an algorithm and patients received one of 4 treatment messages.	Control patients had access to the part of the website on which a diary of symptoms and exacerbations was kept.	12 m	AQLQ change with 95% CI	T: 0.56 (0.43 to 0.68) C: 0.18 (0.05 to 0.31)	<p><b>Funding:</b> Unclear</p> <p><b>Risk of bias:</b></p> <ul style="list-style-type: none"> <li>Computer randomisation</li> <li>Un-blinded</li> <li>Completer analysis</li> </ul>
		<b>Tele:</b> N=101	Age, years	36	37						
		<b>Control:</b> N=99	% male	32	29						
		% predicted FEV1	88	90							
		Baseline ACQ	1.12	1.11							
		% taking LABA/ICS	59	60							
		<b>Inclusion criteria:</b>									
<ul style="list-style-type: none"> <li>Adults aged 18-50 years</li> <li>ICS for &gt; 3 months in the past year</li> </ul> <p><b>Exclusion criteria:</b></p> <ul style="list-style-type: none"> <li>Currently on oral steroids</li> </ul>											

**Table 175: Vollmer 2006**<sup>1852</sup>

Reference	Study type	Number of patients	Patient characteristics			Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
				Tele:	Control:						
Vollmer, W. M., et al (2006). Use and impact of an automated telephone outreach system for asthma in a managed care setting. <i>American Journal of Managed Care</i> , 12(12), 725-733.	RCT  Large group health organisation in Oregon, USA	N=6948				Three phone calls 5 months apart with tailored advice to address recent ED care, asthma control and medication use. Optional tailored feedback. The call generated alerts for the provider as to which patients were at high risk of exacerbations.	Routine care with no telephone calls	10 m	AQLQ (in a subset of patients)	T: 5.2 (1.2) C: 5.1 (1.2)	<b>Funding:</b> Centres for Disease Control and Prevention and the Kaiser Permanente Care management Institute  <b>Risk of bias:</b> <ul style="list-style-type: none"> <li>No details about randomisation or blinding</li> <li>Some data only collected from a subset of patients</li> </ul>
		<b>Tele:</b> N=3389	Age, years	51.8	51.4					T: 132/3220 C: 121/3033	
		<b>Control:</b> N=3367	% male	35	35						
			Baseline AQLQ	5.0	5.2						
			<b>Inclusion criteria:</b> <ul style="list-style-type: none"> <li>Adults aged 18+ years</li> <li>At least 180 days of asthma medication dispensed</li> </ul> <b>Exclusion criteria:</b> <ul style="list-style-type: none"> <li>COPD</li> </ul>								

**Table 176: Willems 2007**<sup>1895</sup>

Reference	Study type	Number of patients	Patient characteristics			Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
				Tele:	Control:						
Willems, D. C., et al (2007). Process evaluation of a nurse-led telemonitoring	RCT  Single centre in the Netherl	N=109				Asthma tele-monitoring via home modem. Patients were asked to perform daily	Regular outpatient care: 3 to 6-monthly medical check-ups by	12 m	AQLQ	T: 5.73 (1.09) C: 5.48 (1.18)	<b>Funding:</b> Unclear  Baseline characteristics reported for
		<b>Tele:</b> N=55 (26 adults, 29	Age, years	27.2	28.4				ED visits	T: 0/55 C: 4/54	

Reference	Study type	Number of patients	Patient characteristics			Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
programme for patients with asthma. <i>Journal of Telemedicine &amp; Telecare</i> , 13(6), 310-317.	ands	children)  <b>Control:</b> N=54 (27 adults, 27 children)	% male	58.2	44.4	PEFR and more often in exacerbations. The nurse could increase and decrease asthma medication and involve a doctor if necessary.	their lung specialist or paediatrician				children and adults separately, but not outcome data  <b>Risk of bias:</b> <ul style="list-style-type: none"> <li>• Random number list, stratified by age</li> <li>• Un-blinded</li> <li>• Compliance for AQLQ and PEF was low</li> </ul>
			% predicted FEV1	94.9	96.0						
			<b>Inclusion criteria:</b> <ul style="list-style-type: none"> <li>• Adults and children aged 7+</li> <li>• Stage I to III GINA</li> </ul> <b>Exclusion criteria:</b> <ul style="list-style-type: none"> <li>• Severe co-morbidity</li> </ul>								

**Table 177: Xu 2011<sup>1925</sup>**

Reference	Study type	Number of patients	Patient characteristics			Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
Xu, C., et al (2010). A randomized controlled trial of an interactive voice response telephone system and specialist nurse support for childhood	RCT  Child hospitals in Australia	N=121 (82 in relevant groups)  <b>Tele:</b> N=41  <b>Control:</b> N=41		<b>Tele:</b>	<b>Control:</b>	1) Interactive Voice Response	Patients' primary care physicians were notified and continued to provide primary asthma care. All families had the same initial asthma education with	6 m	Hospital visits	T1: 4/39 T2: 4/38 C: 4/40	<b>Funding:</b> Unclear  <b>Risk of bias:</b> <ul style="list-style-type: none"> <li>• Randomisation unclear</li> <li>• Un-blinded</li> <li>• Low dropout</li> </ul>
			Age, years	T1: 7.0 T2: 6.5	7.4	2) The nurse support group received follow-up calls from one Nurse Specialist every 2 weeks. Where families			ED visits	T1: 6/39 T2: 8/39 C: 5/40	
			% male	T1: 56.4 T2: 51.2	51.2				Oral steroid use	T1: 16/39 T2: 22/41 C: 21/40	

Reference	Study type	Number of patients	Patient characteristics	Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
asthma management. <i>Journal of asthma</i> , 47(7), 768-773			<b>Inclusion criteria:</b> <ul style="list-style-type: none"> <li>Children/teens aged 3-16</li> <li>Recent exacerbation</li> </ul> <b>Exclusion criteria:</b> <ul style="list-style-type: none"> <li>Not described</li> </ul>	preferred email contact, the nurse used email to collect the same data and offer education and advice on asthma. 2)	the same Specialist Nurse.		School days lost (yes/no)	T1: 20/38 C: 22/39	
							Parent work days lost (yes/no)	T1: 13/39 C: 13/39	
							AQLQ (child), mean (SD)	T1: 1.1 (1.1) C: 0.5 (0.9)	
							AQLQ (carer), mean (SD)	T1: 1.2 (1.6) C: 1.0 (1.5)	

**Table 178: Young 2012<sup>1941</sup>**

Reference	Study type	Number of patients	Patient characteristics			Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
Young, H. N., et al (2012). Patient and pharmacist telephonic encounters (PARTE) in an underserved rural patient population with	RCT  Wisconsin, USA	N=98  <b>Tele:</b> N=49  <b>Control:</b> N=49		<b>Tele:</b>	<b>Control:</b>	Telephone consultation from pharmacists regarding their asthma self-management and medication use. Five pharmacists	Usual care, which included mail receipt of a prescription refill with written medication use instructions.	Unknown follow-up	None of interest	N/A	<b>Funding:</b> National Centre for Research Resources, National Institutes of Health  <b>Risk of bias:</b>
			Age, years	45.4	43.7						
			% male	26.5	20.4						
			<b>Inclusion criteria:</b>								
<ul style="list-style-type: none"> <li>Adults aged 19+</li> <li>Community Health Access</li> </ul>											

Reference	Study type	Number of patients	Patient characteristics	Intervention	Comparison	Length of follow-up	Outcome measures	Effect sizes	Comments
asthma: results of a pilot study. <i>Telemedicine journal and e-health</i> , 18(6), 427-433			<p>program (uninsured or underinsured people)</p> <ul style="list-style-type: none"> <li>• Diagnosis of asthma and 1+ asthma medications within 6 months</li> </ul> <p><b>Exclusion criteria:</b></p> <ul style="list-style-type: none"> <li>• Enrolment in the FHC pharmacy program</li> </ul>	incorporated the intervention into their usual practice.					<ul style="list-style-type: none"> <li>• No randomisation details</li> <li>• Blinded assessment</li> <li>• Balanced dropout</li> <li>• No relevant outcomes</li> </ul>

# Appendix H: Economic evidence tables

## H.1 Monitoring: Tele-healthcare

**Table 179: Gruffydd-Jones 2005<sup>597</sup>**

Gruffydd-Jones K, Hollinghurst S, Ward S, Taylor G. Targeted routine asthma care in general practice using telephone triage. <i>British Journal of General Practice</i> . 2005; 55:918-923.				
Study details	Population & interventions	Costs	Health outcomes	Cost-effectiveness
<p><b>Economic analysis:</b> CCA (health outcome: Mini-AQLQ scores)</p> <p><b>Study design:</b> Within-trial analysis (RCT)</p> <p><b>Approach to analysis:</b> Analysis of individual level data for asthma control and resource use with unit costs applied.</p> <p><b>Perspective:</b> UK NHS <b>Time horizon:</b> 12 months <b>Treatment effect duration:</b> 12 months <b>Discounting:</b> Not Applicable</p>	<p><b>Population:</b> Adult Asthma Patients</p> <p><b>Patient characteristics:</b> N (control): 62 N (intervention): 84</p> <p>Mean age (control): 49.6 (SD: 16.1) Mean age (intervention): 50.8 (SD: 15.4)</p> <p>Male (control): 39% Male (intervention): 51%</p> <p><b>Intervention 1:</b> Clinic Group: Patients received 'usual' care by 6 monthly check-up via dedicated asthma nurse.</p> <p><b>Intervention 2:</b></p>	<p><b>Total costs (mean per patient):</b> Intervention 1: £333.85 (SD: 410.64) Intervention 2: £209.85 (SD: 220.94) Incremental (2-1): Bootstrapped cost difference: £122.35 (p-value: 0.071)</p> <p><b>Currency &amp; cost year:</b> 2004 UK pounds</p> <p><b>Cost components incorporated:</b> Total routine care (minutes) Number of inhalers Number of tablets Non-routine consultations Length of inpatient stays</p>	<p><b>Mini-AQLQ score (median per patient at 12 months):</b> Intervention 1: 5.93 (IQR: 2.07) Intervention 2: 6.47 (IQR: 1.22) Incremental (2-1): NR, though the difference in health was not clinically significant</p>	<p><b>ICER (Intervention 2 versus Intervention 1):</b> Telephone reviews dominated clinical reviews (lower costs and higher health outcomes)</p> <p><b>Analysis of uncertainty:</b> NR</p>

	Telephone group: patients contacted by telephone at 6 monthly intervals by one or two trained asthma nurses. Patient was asked RCP Morbidity Index and if 'yes' was answered to any of the three questions a clinical asthma review was arranged. If asthma was deemed stable for 3 months telephone interviews were resumed.			
<b>Data sources</b>				
<b>Health outcomes:</b> Mini AQLQ score.				
<b>Quality-of-life weights:</b> NR				
<b>Cost sources:</b> Resource use from within RCT; resources use priced using: BNF; NHS Reference costs; PSSRU 2003				
<b>Comments</b>				
<b>Source of funding:</b> Research grant from Asthma UK. <b>Limitations:</b> Short time horizon of 12 months may not be long enough to capture adverse health impacts and therefore not give an accurate representation of long term health and cost outcomes. Health was also not measured using QALYs, only quality of life not length was considered. Lack of any sensitivity analysis reduces robustness of results.				
<b>Overall applicability<sup>(a)</sup>: Partially applicable Overall quality<sup>(b)</sup>: Potentially serious limitations</b>				

Abbreviations: CCA: cost–consequence analysis; CI: 95% confidence interval; ICER: incremental cost-effectiveness ratio; NR: not reported; QALYs: quality-adjusted life years, SD: Standard Deviation

(a) Directly applicable / Partially applicable / Not applicable

(b) Minor limitations / Potentially serious limitations / Very serious limitations

**Table 180: Ryan 2012<sup>1478</sup>**

Ryan D, Price D, Musgrave SD, Malhotra S, Lee AJ, Ayansina D et al. Clinical and cost-effectiveness of mobile phone supported self monitoring of asthma: multicentre randomised controlled trial. *BMJ*. 2012; 344:e1756.



Study details	Population & interventions	Costs	Health outcomes	Cost-effectiveness
<p><b>Economic analysis:</b> CCA (health outcome: changes in scores on asthma control questionnaire and self-efficacy )</p> <p><b>Study design:</b> One year multicentre randomised controlled trial conducted in a UK primary care setting - Within trial analysis</p> <p><b>Approach to analysis:</b> Economic evaluation based on the results of the randomised controlled trial</p> <p><b>Perspective:</b> UK NHS</p> <p><b>Time horizon:</b> 12 months</p> <p><b>Treatment effect duration:</b> 12 months</p> <p><b>Discounting:</b> NA</p>	<p><b>Population:</b> 288 adolescents and adults with poorly controlled asthma (ACQ score <math>\geq 1.5</math>)</p> <p><b>Patient characteristics:</b> N (control) =142 N (intervention) =145 Mean age (control): 51.5 (SD: 17.7) Mean age (intervention): 46.6 (SD: 18)</p> <p>Male (control): 34% Male (intervention): 41%</p> <p><b>Intervention 1:</b> Mobile phone monitoring: Twice daily recording and mobile phone based transmission of symptoms, drug use, and peak flow with immediate feedback (through t+ Asthma mobile application) prompting action to agreed plan.</p> <p><b>Intervention 2:</b> Patients asked to keep a paper diary, recording the same information gathered from intervention 1</p>	<p><b>Total costs (mean per patient):</b> Intervention 1: £315 (SD: 226) Intervention 2: £245 (SD: 201)</p> <p>Incremental (2-1): £70 (CI: £20 to £121; p = 0.006)</p> <p><b>Currency &amp; cost year:</b> 2008-2009 UK pounds</p> <p><b>Cost components incorporated:</b> Cost of delivering intervention Nursing costs Tele-monitoring service costs Cost of healthcare provision GP respiratory consultations Practice nurse respiratory consultations Secondary care costs (outpatient and admissions) Emergency services Total cost of prescriptions from respiratory drugs</p>	<p><b>QALYs (mean per patient):</b> There was no significant change in asthma control or self-efficacy between the two interventions</p>	<p><b>ICER (Intervention 2 versus Intervention 1):</b> NR</p> <p><b>Analysis of uncertainty:</b> No sensitivity analysis was conducted</p>

(symptoms, drug use, and peak flow readings twice daily).			
<b>Data sources</b>			
<b>Health outcomes:</b> Self-reported from patients who participated in the trial.			
<b>Cost sources:</b> Unit costs for all resources used by patients in the randomized controlled trial were obtained from the data sources in the UK including the NHS Reference costs (2007-2008), the Personal Social Services Research Unit (2008) and the British National Formulary (BNF 2008).			
<b>Comments</b>			
<b>Source of funding:</b> Asthma UK. <b>Limitations:</b> Short time horizon of 12 months may not be long enough to capture adverse health impacts and therefore not give an accurate representation of long term health and cost outcomes. Health was also not measured using QALYs, only quality of life not length was considered. Lack of any sensitivity analysis reduces robustness of results.			
<b>Overall applicability<sup>(a)</sup>:</b> partially applicable <b>Overall quality<sup>(b)</sup>:</b> potentially serious limitations			

Abbreviations: CCA: cost–consequence analysis; 95% CI: 95% confidence interval; ICER: incremental cost-effectiveness ratio; NR: not reported; pa: probabilistic analysis; QALYs: quality-adjusted life years

(a) Directly applicable / Partially applicable / Not applicable

(b) Minor limitations / Potentially serious limitations / Very serious limitations

**Table 181: Willems 2007<sup>1896</sup>**

Willems DC, Joore MA, Hendriks JJ, Wouters EF, Severens JL. Cost-effectiveness of a nurse-led telemonitoring intervention based on peak expiratory flow measurements in asthmatics: results of a randomised controlled trial. Cost-effectiveness and Resource Allocation. Netherlands 2007; 5:10.				
Study details	Population & interventions	Costs	Health outcomes	Cost-effectiveness
<b>Economic analysis:</b> CUA (health outcome: QALYs )  <b>Study design:</b> One year single centre randomised controlled trial – Within trial analysis  <b>Approach to analysis:</b>	<b>Population:</b> Outpatients with asthma  <b>Patient characteristics:</b> N (Control ) = 53 N (Intervention) = 56  Mean age (control over 18 years old): 45.9 (SD: 15.9) Mean age (intervention over	<b>Total costs (mean per patient):</b> Intervention 1 (over 18 years old): £1,197 (SD: £1212) Intervention 1 (between 7 and 18 years old): £409 (SD: £591)  Intervention 2 (over 18 years old): £1,550 (SD: £1,101)	<b>QALYs (mean per patient):</b>  Intervention 1 (between 7 and 18 years old): 0.0 (95% CI: 0.00 to 0.02)  Incremental (2–1) (Over 18 years old): 0.03 (95% CI: 0.00 to 0.07)	<b>ICER (Intervention 2 versus Intervention 1) (over 18 years old):</b> £10693 per QALY gained (pa) 95% CI: NR Probability Intervention 2 (adults) cost-effective (£20K/30K threshold): NR  <b>ICER (Intervention 2 versus Intervention 1) (between 7 and 18 years old):</b> £40865 per QALY gained (pa)

<p>Comparison of health outcomes and costs between tele-monitoring and usual care.</p> <p><b>Perspective:</b> Dutch societal or healthcare perspective (only healthcare perspective results shown)</p> <p><b>Time horizon:</b> 12 months</p> <p><b>Treatment effect duration:</b> 12 months</p> <p><b>Discounting:</b> NR</p>	<p>18 years old): 45.65 (SD: 11.3)</p> <p>Mean age (control between 7 and 18 years old): 10.85 (SD: 2.3)</p> <p>Mean age (intervention between 7 and 18 years old): 10.57 (SD: 2.1)</p> <p>Male (control over 18 years old): 33.3%</p> <p>Male (intervention over 18 years old): 42.3%</p> <p>Male (control between 7 and 18 years old): 55.6%</p> <p>Male (intervention between 7 and 18 years old): 72.4%</p> <p><b>Intervention 1:</b> Regular outpatient care. Three to six monthly medical check-ups by their lung specialist or paediatrician. For exacerbations patients received additional care by GP and/or outpatient care.</p> <p><b>Intervention 2:</b> Patients received an asthma monitor and had a hospital based nurse practitioner as the main caregiver. Patients were instructed to perform daily lung function tests in</p>	<p>Intervention 2 (between 7 and 18 years old): £830 (SD: £405)</p> <p>Incremental (2–1) (over 18 years old): £353 (95% CI: -£114 to £1118; p=NR)</p> <p>Incremental (2–1) (between 7 and 18 years old): £421 (95% CI: £319 to £862; p=NR)</p> <p><b>Currency &amp; cost year:</b> 2002 Euros (presented here as 2002 UK pounds<sup>(a)</sup>)</p> <p><b>Cost components incorporated:</b> General practitioner practice: (GP visit, GP telephone visit, assistant visit, assistant telephone visit, nurse practitioner visit)</p> <p>Hospital care: (day admission, emergency room visit, surgical procedures, diagnostic procedures, laboratory research, lung specialist outpatient visit, paediatric lung specialist</p>	<p>Incremental (2–1) (between 7 and 18 years old): 0.01 (95% CI: 0.00 to 0.02)</p> <p>Incremental (2–1) (Over 18 years old): 0.03 (95% CI: 0.00 to 0.07)</p>	<p>95% CI: NR</p> <p>Probability Intervention 2 (children) cost-effective (£20K/30K threshold): NR</p> <p><b>Analysis of uncertainty:</b> Using SF-36 instead of EQ-5D leads to drastically different results making the intervention dominated for adults; SF-6D was not assessed in children.</p> <p>Sensitivity analysis was conducted by excluding monitor device costs from the intervention (monitor, modem, batteries and insurance) which equated to £313. This reduced the ICER for adults to £1224 and for children to £10502. This shows that initial capital costs significantly drive the cost-effectiveness result. Therefore in the long run assuming recurrent capital costs will fall the ICER will fall over time, all other things remaining equal.</p>
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	the morning and evening and more often when they were having symptoms. Patients asked to transfer data once a month or more with symptoms. Based on data nurse was able to decrease asthma medication (after three months of stable asthma) or increase (if asthma was unstable) by one step.	outpatient visit, asthma nurse practitioner outpatient visit, other medical specialists outpatient visit) Other healthcare professional costs: (speech therapist, homoeopath, company medical officer) Prescribed medication: (medication, pharmacist fee) Professional home care Intervention costs		
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**Data sources**

**Health outcomes:** Taken from the results from the in-trial randomized controlled trial. **Quality-of-life weights:** EQ-5D, UK tariff. **Cost sources:** Volumes of hospital care were obtained from the hospital billing system of the university hospital Maastricht. All other resource costs use obtained from cost diaries. Dutch manual for cost research used for unit prices.

**Comments**

**Source of funding:** NR. **Limitations:** The costs are not from a UK perspective and therefore may not be generalizable. The time horizon is also very short at 12 months; this may not be enough time to capture rare adverse events that would have a differential probability of occurring across the two groups. The results are extremely sensitive to the choice of HRQoL measure used.

**Overall applicability<sup>(a)</sup>: Partially applicable Overall quality<sup>(b)</sup>: Potentially serious limitations**

*Abbreviations: 95% CI: 95% confidence interval; CUA: cost–utility analysis; EQ-5D: Euroqol 5 dimensions (scale: 0.0 [death] to 1.0 [full health], negative values mean worse than death); HRQoL: Health related quality of life; ICER: incremental cost-effectiveness ratio; NR: not reported; QALYs: quality-adjusted life years; SF-6D: Short form 6 dimensions (scale: 0.0 [death] to 1.0 [full health], negative values mean worse than death)*

*(a) Converted using 2002 purchasing power parities<sup>1272</sup>*

*(b) Directly applicable / Partially applicable / Not applicable*

*(c) Minor limitations / Potentially serious limitations / Very serious limitations*

# Appendix I: GRADE tables

## I.1 Monitoring: Questionnaires

**Table 182: Clinical evidence profile: Children (5-16 years) with uncontrolled asthma: Monitoring questionnaires + treatment vs UC + treatment.**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Children with uncontrolled asthma: Monitoring control + treatment	UC + treatment	Relative (95% CI)	Absolute		
<b>QOL (&lt; 6months) (follow-up 3 months; measured with: PAQLQ; range of scores: 1-7; Better indicated by higher values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	46	44	-	MD 0.4 higher (0.17 to 0.63 higher)	⊕○○○ VERY LOW	CRITICAL
<b>QOL (≥ 6months) (follow-up 12 months; measured with: PAQLQ; range of scores: 1-7; Better indicated by higher values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	46	44	-	MD 0.05 lower (0.5 lower to 0.4 higher)	⊕⊕○○ LOW	CRITICAL
<b>Exacerbations (≥ 6months) (follow-up 12 months; assessed with: Course of OCS)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>3</sup>	none	6/35 (17.1%)	15%	RR 1.14 (0.41 to 3.22)	21 more per 1000 (from 89 fewer to 333 more)	⊕○○○ VERY LOW	CRITICAL
<b>Asthma control (&lt; 6months) (follow-up 3 months; measured with: ACQ; range of scores: 0-6; Better indicated by lower values)</b>												
1	randomised trials	very	no serious inconsistency	no serious indirectness	no serious imprecision	none	46	44	-	MD 0.32 lower (0.56 to 0.08)	⊕⊕○○ LOW	CRITICAL

	trials	serious <sup>1</sup>	inconsistency	indirectness	imprecision					lower)	LOW	
<b>Asthma control (≥ 6months) (follow-up 12 months; measured with: ACQ; range of scores: 0-6; Better indicated by lower values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	46	44	-	MD 0.05 lower (0.35 lower to 0.25 higher)	⊕⊕⊕⊕ LOW	CRITICAL
<b>Lung function (&lt; 6months) (follow-up 3 months; measured with: FEV1 L; Better indicated by higher values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	46	44	-	MD 0.23 higher (0.08 to 0.38 higher)	⊕⊕⊕⊕ VERY LOW	IMPORTANT
<b>Lung function (≥ 6months) (follow-up 12 months; measured with: FEV1 L ; Better indicated by higher values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	46	44	-	MD 0.1 higher (0.11 lower to 0.31 higher)	⊕⊕⊕⊕ VERY LOW	IMPORTANT
<b>Symptom free days (&lt; 6months) (follow-up 3 months; measured with: % over 2 weeks ; range of scores: 0-100; Better indicated by higher values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>4</sup>	none	46	44	-	MD 1.5 lower (14.5 lower to 11.5 higher)	⊕⊕⊕⊕ VERY LOW	IMPORTANT
<b>Symptom free days (≥ 6months) (follow-up 12 months; measured with: % over 2 weeks; range of scores: 0-100; Better indicated by higher values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>4</sup>	none	46	44	-	MD 4 higher (9.7 lower to 17.7 higher)	⊕⊕⊕⊕ VERY LOW	IMPORTANT
<b>ICS use (&lt; 6months) (follow-up 3 months; measured with: mean daily dose ug; Better indicated by lower values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>4</sup>	none	46	44	-	MD 14 higher (79 lower to 107 higher)	⊕⊕⊕⊕ VERY LOW	IMPORTANT

ICS use (≥ 6months) (follow-up 12 months; measured with: mean daily dose ug; Better indicated by lower values)												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>4</sup>	none	46	44	-	MD 14 higher (75 lower to 103 higher)	⊕○○○ VERY LOW	IMPORTANT

- 1 The majority of the evidence was from studies at very high risk of bias
- 2 95% CI crosses one MID
- 3 95% CI for the absolute effect crosses one MID
- 4 95% CI crosses both MIDs

**Table 183: Clinical evidence profile: Adults and young people (>16 years) overall: Monitoring questionnaires + treatment vs UC + treatment.**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Adults overall: Monitoring control + treatment	UC + treatment	Relative (95% CI)	Absolute		
<b>QOL (≥ 6months) (follow-up 6-12 months; measured with: AQLQ; range of scores: 1-7; Better indicated by higher values)</b>												
2	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	171	162	-	MD 0.32 higher (0.17 to 0.47 higher)	⊕⊕⊕○ MODERATE	CRITICAL
<b>Exacerbations (≥ 6months) (follow-up 12 months; assessed with: course of OCS)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	11/91 (12.1%)	10.9%	HR 1.18 (0.51 to 2.73)	18 more per 1000 (from 52 fewer to 161 more)	⊕○○○ VERY LOW	CRITICAL
<b>Exacerbations (≥ 6months) (follow-up 6-12 months; assessed with: ER, hospitalisation or OCS )</b>												
2	randomised trials	serious <sup>1</sup>	no serious inconsistency	serious <sup>3</sup>	serious <sup>4</sup>	none	21/171 (12.3%)	11.2%	RR 1.1 (0.61 to 1.99)	11 more per 1000 (from 44 fewer to 111 more)	⊕○○○ VERY LOW	CRITICAL
<b>UHU (≥ 6months) (follow-up 6 months; assessed with: ER or hospitalisation)</b>												
1	randomised	very	no serious	no serious	serious <sup>4</sup>	none	1/80	7.1%	RR 0.17	59 fewer per 1000	⊕○○○	CRITICAL

1  
2  
3  
4  
5

	trials	serious <sup>5</sup>	inconsistency	indirectness			(1.3%)		(0.02 to 1.46)	(from 70 fewer to 33 more)	VERY LOW	
<b>Asthma control (&lt; 6 months) (follow-up 3 months; measured with: ACT; range of scores: 5-25; Better indicated by higher values)</b>												
1	randomised trials	very serious <sup>5</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	99	84	-	MD 0.3 higher (0.73 lower to 1.33 higher)	⊕⊕⊕⊕ LOW	CRITICAL
<b>Asthma control (≥ 6 months) (follow-up 12 months; measured with: ACQ ; range of scores: 0-6; Better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>6</sup>	none	91	92	-	MD 0.47 lower (0.64 to 0.3 lower)	⊕⊕⊕⊕ LOW	CRITICAL
<b>Asthma control (≥ 6 months) (follow-up 6 months; measured with: ACT; range of scores: 5-25; Better indicated by higher values)</b>												
1	randomised trials	very serious <sup>5</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	80	70	-	MD 0.5 higher (0.86 lower to 1.86 higher)	⊕⊕⊕⊕ LOW	CRITICAL
<b>Lung function (≥ 6 months) (follow-up 12 months; measured with: FEV1 L; Better indicated by higher values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>6</sup>	none	91	92	-	MD 0.25 higher (0.03 to 0.47 higher)	⊕⊕⊕⊕ LOW	IMPORTANT
<b>Symptom free days (≥ 6 months) (follow-up 12 months; measured with: % over 2 weeks; range of scores: 0-100; Better indicated by higher values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>6</sup>	none	91	92	-	MD 10.9 higher (0.05 to 21.75 higher)	⊕⊕⊕⊕ LOW	IMPORTANT
<b>ICS use (≥ 6 months) (follow-up 12 months; measured with: mean daily dose ug; Better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	91	92	-	MD 57 higher (38 lower to 152 higher)	⊕⊕⊕⊕ VERY LOW	IMPORTANT
<b>Rescue medication (&lt; 6 months) (follow-up 3 months; measured with: puffs/day; Better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>6</sup>	none	99	84	-	MD 0.62 lower (1.21 to 0.03 lower)	⊕⊕⊕⊕ LOW	IMPORTANT
<b>Rescue medication (&gt; 6 months) (follow-up 6 months; measured with: puffs/day; Better indicated by lower values)</b>												



1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	80	70	-	MD 0.23 lower (0.66 lower to 0.2 higher)	⊕⊕⊕○ MODERATE	IMPORTANT
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- 1 The majority of the evidence was from studies at high risk of bias
- 2 95% CI crosses both the MIDs
- 3 Evidence from one study with an indirect outcome (ER, hospitalisation or OCS)
- 4 95% CI for the absolute effect crosses one MID
- 5 The majority of the evidence was from studies at very high risk of bias
- 6 95% CI crosses one MID

## I.2 Monitoring: Lung function tests

**Table 184: Clinical evidence profile: Adults: Monitoring PEF versus symptom monitoring**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	PEF versus symptoms monitoring: adults	Control	Relative (95% CI)	Absolute		
<b>QOL ≥6 months (follow-up 2 years; assessed with: AQLQ increase &gt;0.5 points)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	52/134 (38.8%)	39.1%	RR 0.99 (0.73 to 1.35)	4 fewer per 1000 (from 106 fewer to 137 more)	⊕○○○ VERY LOW	CRITICAL
<b>QOL ≥6 months (follow-up 2 years; assessed with: AQLQ decrease &gt;0.5 points)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2,3</sup>	none	16/134 (11.9%)	8.6%	RR 1.39 (0.67 to 2.88)	34 more per 1000 (from 28 fewer to 162 more)	⊕○○○ VERY LOW	CRITICAL
<b>Exacerbation ≥6 months (follow-up 6-12 months; assessed with: need for OCS)</b>												
2	randomised	very	serious <sup>4</sup>	no serious	very serious <sup>3</sup>	none	17/71	16.9%	RR 1.28 (0.29 to	47 more per 1000 (from 120 fewer to	⊕○○○	CRITICAL

	trials	serious <sup>1</sup>		indirectness			(23.9%)		5.57)	772 more)	VERY LOW	
<b>Exacerbations ≥6 months (follow-up 12 months; measured with: number of OCS courses; Better indicated by lower values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	50	45	-	MD 0.20 lower (0.74 lower to 0.34 higher)	⊕⊕⊕⊕ LOW	CRITICAL
<b>UHU ≥6 months (follow-up 2 years; measured with: Total asthma-related health care utilisation; Better indicated by lower values)</b>												
1	randomised trials	serious <sup>5</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	148	146	-	MD 0.11 lower (0.59 lower to 0.37 higher)	⊕⊕⊕⊕ MODERATE	CRITICAL
<b>UHU ≥6 months (follow-up 6-12 months; assessed with: Hospitalisation)</b>												
3	randomised trials	serious <sup>5</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	4/146 (2.7%)	2.2%	RR 1.17 (0.31 to 4.43)	4 more per 1000 (from 15 fewer to 75 more)	⊕⊕⊕⊕ VERY LOW	CRITICAL
<b>UHU ≥6 months (follow-up 12 months; measured with: Number of hospital admissions; Better indicated by lower values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	50	45	-	MD 0.05 lower (0.16 lower to 0.06 higher)	⊕⊕⊕⊕ VERY LOW	CRITICAL
<b>UHU ≥6 months (follow-up 12 months; measured with: days hospitalisation; Better indicated by lower values)</b>												
1	randomised trials	serious <sup>5</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	48	40	-	MD 0.03 lower (0.21 lower to 0.15 higher)	⊕⊕⊕⊕ MODERATE	CRITICAL
<b>UHU ≥6 months (follow-up 6-12 months; assessed with: ED visits)</b>												
2	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	9/100 (9%)	2/92 (2.2%)	RR 3.78 (0.96 to 14.93)	60 more per 1000 (from 1 fewer to 303 more)	⊕⊕⊕⊕ VERY LOW	CRITICAL
<b>UHU ≥6 months (follow-up 12 months; measured with: Mean number of ED visits ; Better indicated by lower values)</b>												
2	randomised trials	serious <sup>5</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	98	85	-	MD 0.04 lower (0.2 lower to 0.12 higher)	⊕⊕⊕⊕ MODERATE	CRITICAL

<b>UHU ≥6 months (follow-up 6 months; assessed with: Unscheduled doctors visit)</b>												
2	randomised trials	serious <sup>5</sup>	very serious <sup>6</sup>	no serious indirectness	very serious <sup>3</sup>	none	22/90 (24.4%)	28.1%	RR 0.77 (0.18 to 3.34)	65 fewer per 1000 (from 230 fewer to 658 more)	⊕○○○ VERY LOW	CRITICAL
<b>Rescue medication ≥6months (follow-up 12 months; assessed with: requiring nebulised salbutamol)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	3/28 (10.7%)	5.4%	RR 1.98 (0.35 to 11.08)	53 more per 1000 (from 35 fewer to 544 more)	⊕○○○ VERY LOW	IMPORTANT
<b>FEV1 L ≥6 months (follow-up 12 months; Better indicated by higher values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	48	40	-	MD 0.26 lower (0.61 lower to 0.09 higher)	⊕○○○ VERY LOW	IMPORTANT
<b>FEV1 % ≥6 months (follow-up 6-12 months; range of scores: 0-100; Better indicated by higher values)</b>												
2	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	87	76	-	MD 0.10 higher (0.92 lower to 1.12 higher)	⊕⊕○○ LOW	IMPORTANT
<b>PEF % best ≥6 months (follow-up 6 months; range of scores: 0-100; Better indicated by higher values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	31	32	-	MD 5.31 higher (1.91 lower to 12.53 higher)	⊕○○○ VERY LOW	IMPORTANT
<b>Time off school/work ≥6 months (follow-up 6-12 months)</b>												
2	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	11/100 (11%)	8.3%	RR 1.41 (0.62 to 3.21)	34 more per 1000 (from 32 fewer to 183 more)	⊕○○○ VERY LOW	IMPORTANT
<b>Mean days off work ≥6 months (follow-up 12 months; Better indicated by lower values)</b>												
2	randomised	very	no serious	no serious	serious <sup>2</sup>	none	98	85	-	MD 2.5 higher (1.27	⊕○○○	IMPORTANT

	trials	serious <sup>1</sup>	inconsistency	indirectness							to 3.74 higher)	VERY LOW	
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<sup>1</sup> The majority of the evidence was from studies at very high risk of bias

<sup>2</sup> 95% CI crosses one MID

<sup>3</sup> 95% CI crosses two MIDs

<sup>4</sup> Heterogeneity in the point estimates, I<sup>2</sup>=52%

<sup>5</sup> The majority of the evidence was from studies at high risk of bias

<sup>6</sup> Heterogeneity in the point estimates, I<sup>2</sup>=86%

**Table 185: Clinical evidence profile: Children: Monitoring PEF versus symptom monitoring**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	PEF versus symptoms monitoring: children	Control	Relative (95% CI)	Absolute		
<b>Exacerbations &lt;6months (follow-up 3 months; assessed with: OCS)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	1/12 (8.3%)	8.3%	RR 1.00 (0.07 to 14.21)	0 fewer per 1000 (from 77 fewer to 1000 more) <sup>3</sup>	⊕○○○ VERY LOW	CRITICAL
<b>Exacerbations ≥6months (follow-up 12 months; assessed with: OCS)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	7/19 (36.8%)	0%	OR 16.34 (3.25 to 82.24)	370 more per 1000 (from 150 more to 590 more) <sup>3</sup>	⊕⊕○○ LOW	CRITICAL
<b>UHU &lt;6 months (follow-up 12 weeks; assessed with: Hospitalisation)</b>												
1	randomised trials	serious <sup>4</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	1/44 (2.3%)	0%	OR 7.56 (0.15 to 381.04)	20 more per 1000 (from 40 fewer to 80 more) <sup>3</sup>	⊕○○○ VERY LOW	CRITICAL
<b>UHU &lt;6 months (follow-up 12 weeks; assessed with: Attendance at A&amp;E)</b>												
1	randomised trials	serious <sup>4</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	1/44 (2.3%)	0%	OR 7.56 (0.15 to 381.04)	20 more per 1000 (from 40 fewer to 80 more) <sup>3</sup>	⊕○○○ VERY LOW	CRITICAL

<b>UHU(&lt;6 months) (follow-up 12 weeks; assessed with: Emergency GP visits )</b>												
1	randomised trials	serious <sup>4</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	10/44 (22.7%)	24.4%	RR 0.93 (0.44 to 1.97)	17 fewer per 1000 (from 137 fewer to 237 more)	⊖○○○ VERY LOW	CRITICAL
<b>Rescue meds ≥6 months (follow-up 12 months; assessed with: requiring nebulised salbutamol)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>5</sup>	none	2/17 (11.8%)	0%	OR 14.15 (0.79 to 252.1)	120 more per 1000 (from 50 fewer to 280 more) <sup>3</sup>	⊖○○○ VERY LOW	IMPORTANT
<b>FEV1 % best (&lt;6 months) (follow-up 12 weeks; Better indicated by higher values)</b>												
2	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	101	101	-	MD 0.39 higher (0.21 lower to 0.98 higher)	⊕⊕○○ LOW	IMPORTANT
<b>PEF % best (&lt;6 months) (follow-up 12 weeks; Better indicated by higher values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	44	45	-	MD 2.8 higher (2.15 to 3.45 higher)	⊖○○○ VERY LOW	IMPORTANT
<b>Time off school (&lt;6 months) (follow-up 12 weeks)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	15/44 (34.1%)	28.9%	RR 1.18 (0.64 to 2.18)	52 more per 1000 (from 104 fewer to 341 more)	⊖○○○ VERY LOW	IMPORTANT

<sup>1</sup> The majority of the evidence was from studies at very high risk of bias

<sup>2</sup> 95% CI crosses 2 MIDs

<sup>3</sup> Manual risk difference calculation due to no events in one group

<sup>4</sup> The majority of the evidence was from studies at high risk of bias

<sup>5</sup> 95% CI crosses one MID

## I.3 Monitoring: FeNO

**Table 186: Clinical evidence profile: FeNO versus Conventional Monitoring Adults**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	FeNO versus conventional monitoring ADULTS	Control	Relative (95% CI)	Absolute		
<b>UHU (ED visit) ≥6 months (follow-up mean 12 months)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	2/205 (0.98%)	1.4%	OR 0.68 (0.12 to 3.98)	4 fewer per 1000 (from 12 fewer to 39 more)	⊕○○○ VERY LOW	CRITICAL
<b>UHU (hospitalisation) ≥6 months (follow-up mean 12 months)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	1/205 (0.49%)	1%	OR 0.52 (0.05 to 5.07)	5 fewer per 1000 (from 9 fewer to 39 more)	⊕○○○ VERY LOW	CRITICAL
<b>Exacerbation (OCS) ≥6 months (follow-up mean 52 weeks)</b>												
3	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	33/197 (16.8%)	31.3%	RR 0.84 (0.56 to 1.26)	50 fewer per 1000 (from 138 fewer to 81 more)	⊕○○○ VERY LOW	CRITICAL
<b>Exacerbation (OCS) ≥6 months (follow-up mean 9 months)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	-	-	HR 0.91 (0.39 to 2.11)	- <sup>3</sup>	⊕○○○ VERY LOW	CRITICAL
<b>Exacerbation (OCS) ≥6 months (follow-up mean 12 months)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	-	-	OR 0.64 (0.27 to 1.56)	- <sup>3</sup>	⊕○○○ VERY LOW	CRITICAL

<b>Exacerbation (mixed) &lt;6 months (follow-up mean 4-6 months)</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	Serious indirectness <sup>6</sup>	Serious imprecision <sup>2</sup>	none	28/111 (25.2%)	41.3%	RR 0.61 (0.41 to 0.90)	161 fewer per 1000 (from 41 fewer to 244 fewer)	⊕⊕⊕⊕ LOW	CRITICAL
<b>AQLQ (≥ 6 months) (follow-up mean 6 weeks; measured with: Asthma Quality of Life Questionnaire; range of scores: 1-7; Better indicated by higher values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	115	112	-	MD 0 higher (0.22 lower to 22 higher) <sup>5</sup>	⊕⊕⊕⊕ LOW	CRITICAL
<b>ACQ ≥6 months (follow-up 9-12 months; measured with: Asthma Control Questionnaire; range of scores: 0-6; Better indicated by lower values)</b>												
2	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	320	324	-	MD 0.05 lower (0.13 lower to 0.04 higher)	⊕⊕⊕⊕ MODERATE	CRITICAL
<b>ACQ (clinically important improvement, ≥0.5) ≥6 months (follow-up mean 12 months; assessed with: Asthma Control Questionnaire)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	29/81 (35.8%)	25.7%	RR 1.39 (0.86 to 2.26)	100 more per 1000 (from 36 fewer to 324 more)	⊕⊕⊕⊕ VERY LOW	CRITICAL
<b>ACQ (mean ACQ at exacerbation) &lt;6 months (follow-up mean 4-6 months; assessed with: Asthma Control Questionnaire)</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	111	109	-	MD 0.16 lower (0.36 lower to 0.04 higher)	⊕⊕⊕⊕ HIGH	IMPORTANT
<b>ACQ (mean ACQ score at unscheduled doctor visit) &lt;6 months (follow-up mean 4-6 months; assessed with: Asthma Control Questionnaire)</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	111	109	-	MD 0.05 higher (0.18 lower to 0.28 higher)	⊕⊕⊕⊕ HIGH	IMPORTANT
<b>ACQ (mean ACQ score overall) &lt;6 months (follow-up mean 4-6months; assessed with: Asthma Control Questionnaire)</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	111	109	-	MD 0.02 lower (0.21 lower to 0.25 higher)	⊕⊕⊕⊕ HIGH	IMPORTANT
<b>FEV1 %pred (follow-up 9-12 months; range of scores: 0-100; Better indicated by higher values)</b>												

3	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	366	370	-	MD 0.45 higher (0.69 lower to 1.59 higher)	⊕○○○ VERY LOW	IMPORTANT
<b>FEV1, litres ≥6 months (follow-up mean 12 months; Better indicated by higher values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	88	78	-	MD 0.03 lower (0.11 lower to 0.06 higher)	⊕⊕○○ LOW	IMPORTANT
<b>PEF am (L/min) ≥6 months (follow-up 9-12 months; Better indicated by higher values)</b>												
2	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	161	160	-	MD 2 higher (10.39 lower to 14.39 higher)	⊕⊕○○ LOW	IMPORTANT
<b>PEF pm (L/min) ≥6 months (follow-up mean 9 months; Better indicated by higher values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	115	112	-	MD 3.8 higher (10 lower to 17.6 higher)	⊕⊕○○ LOW	IMPORTANT
<b>ICS use ≥6 months (follow-up mean 12 months; measured with: fluticasone or BDP equivalent; Better indicated by lower values)</b>												
2	randomised trials	serious <sup>1</sup>	no serious inconsistency	serious <sup>6</sup>	serious <sup>2</sup>	none	104	108	-	SMD 0.53 lower (0.8 to 0.25 lower)	⊕○○○ VERY LOW	IMPORTANT
<b>Rescue medication (puffs/day) ≥6 months (follow-up 9-12 months; Better indicated by lower values)</b>												
2	randomised trials	very serious <sup>1</sup>	no serious inconsistency	serious <sup>6</sup>	no serious imprecision	none	161	160	-	MD 0.06 lower (0.12 lower to 0 higher)	⊕○○○ VERY LOW	IMPORTANT
<b>% symptom free days ≥6 months (follow-up 12 months; range of scores: 0-100; Better indicated by higher values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	46	48	-	MD 5.6 higher (8.51 lower to 19.71 higher)	⊕○○○ VERY LOW	IMPORTANT
<b>Time of work (number of people) ≥6 months (follow-up 9 months)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	-	-	OR 2 (1.17 to 3.41)	- <sup>3</sup>	⊕○○○ VERY LOW	IMPORTANT



<sup>1</sup> Downgraded by one increment if the majority of the evidence was at high risk of bias, and downgraded by two increments if the majority of the evidence was at very high risk of bias  
<sup>2</sup> Downgraded by one increment if the confidence interval crossed one MID or by two increments if the confidence interval crossed both MIDs  
<sup>3</sup> Control group event rate not reported  
<sup>5</sup> 97.5% CI reported and extracted  
<sup>6</sup> Downgraded by one/two increments because: the majority of the evidence had indirect outcomes

**Table 187: Clinical evidence profile: FeNO versus Conventional Monitoring Children**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	FeNO versus conventional monitoring CHILD	Control	Relative (95% CI)	Absolute		
<b>UHU (unscheduled visits) ≥6 months (follow-up 46-52 weeks)</b>												
2	randomised trials	no serious risk of bias	serious <sup>1</sup>	no serious indirectness	very serious <sup>2</sup>	none	65/294 (22.1%)	29.9%	RR 0.67 (0.29 to 1.55)	99 fewer per 1000 (from 212 fewer to 164 more)	⊕○○○ VERY LOW	CRITICAL
<b>UHU (hospitalisation) ≥6 months (follow-up 46-52 weeks)</b>												
4	randomised trials	serious <sup>3</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	15/366 (4.1%)	3.4%	RR 0.97 (0.48 to 1.95)	1 fewer per 1000 (from 18 fewer to 32 more)	⊕○○○ VERY LOW	CRITICAL
<b>UHU (number of children ≥1 emergency room admin) ≥6 months (follow-up mean 52 weeks)</b>												
1	randomised trials	very serious <sup>3</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	2/45 (4.4%)	8.7%	RR 0.51 (0.1 to 2.65)	43 fewer per 1000 (from 78 fewer to 144 more)	⊕○○○ VERY LOW	CRITICAL
<b>Exacerbation (OCS) ≥6 months (follow-up mean 43 weeks)</b>												
6	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	115/462 (24.9%)	19.2%	RR 0.74 (0.61 to 0.9)	50 fewer per 1000 (from 19 fewer to 75 fewer)	⊕⊕⊕○ MODERATE	CRITICAL
<b>Asthma control (ACT score) ≥6 months (follow-up mean 46 weeks; measured with: ACT; range of scores: 5-25; Better indicated by higher values)</b>												

1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	250	244	-	MD 0.06 higher (0.27 lower to 0.39 higher)	⊕⊕⊕⊕ HIGH	CRITICAL
<b>PACQLQ (Pediatric Asthma Caregiver) ≥6 months (follow-up mean 30 weeks; measured with: Pediatric Asthma Care Quality of Life Questionnaire; range of scores: 1-7; Better indicated by higher values)</b>												
1	randomised trials	very serious <sup>3</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	75	72	-	MD 0 higher (0.24 lower to 0.24 higher)	⊕⊕○○ LOW	CRITICAL
<b>FEV1 % pred ≥6 months (follow-up 46-52 weeks; range of scores: 0-100; Better indicated by higher values)</b>												
2	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	289	290	-	MD 0.94 higher (0.31 lower to 2.19 higher)	⊕⊕⊕○ MODERATE	IMPORTANT
<b>ICS dose ≥6 months (follow-up 46 weeks; measured with: fluticasone; Better indicated by lower values)</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	serious <sup>4</sup>	no serious imprecision	none	250	244	-	MD 118.9 higher (48.5 to 189.3 higher)	⊕⊕⊕○ MODERATE	IMPORTANT
<b>% symptom free days ≥6 months (follow-up 30 weeks; range of scores: 0-100; Better indicated by higher values)</b>												
1	randomised trials	very serious <sup>3</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	75	72	-	MD 0.3 higher (10 lower to 10.6 higher)	⊕○○○ VERY LOW	IMPORTANT
<b>Number of symptom days in last 2 weeks; ≥6 months (follow-up mean 46 weeks; Better indicated by lower values)</b>												
2	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	250	244	-	MD 0.04 higher (0.21 lower to 0.29 higher)	⊕⊕⊕⊕ HIGH	IMPORTANT
<b>Number of patients not using inhaled corticosteroids or anti-leukotrienes ≥6 months (follow-up mean 12 months)</b>												
1	randomised trials	serious <sup>3</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	2/32 (6.3%)	18.8%	RR 0.33 (0.07 to 1.53)	126 fewer per 1000 (from 175 fewer to 100 more)	⊕○○○ VERY LOW	IMPORTANT
<b>Rescue medication (no. of patients needed beta-agonist due to symptoms) ≥6 months (follow-up mean 12 months)</b>												
1	randomised	very	no serious	no serious	serious <sup>2</sup>	none	16/32	81.3%	RR 0.62	309 fewer per 1000	⊕○○○	IMPORTANT

	trials	serious <sup>3</sup>	inconsistency	indirectness			(50%)		(0.42 to 0.9)	(from 81 fewer to 472 fewer)	VERY LOW	
<b>Number of school days missed in last 2 weeks; ≥6 months (follow-up mean 46 weeks; Better indicated by lower values)</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	250	244	-	MD 0.04 lower (0.12 lower to 0.04 higher)	⊕⊕⊕⊕ HIGH	IMPORTANT
<b>Time off (school/work - number of children missed school) ≥6 months (follow-up mean 12 months)</b>												
1	randomised trials	very serious <sup>3</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	10/46 (21.7%)	26.1%	RR 0.83 (0.4 to 1.73)	44 fewer per 1000 (from 157 fewer to 191 more)	⊕○○○ VERY LOW	IMPORTANT

<sup>1</sup> Downgraded by one/two increments because: heterogeneity, I<sup>2</sup>=50%, p=0.04

<sup>2</sup> Downgraded by one increment if the confidence interval crossed one MID or by two increments if the confidence interval crossed both MIDs

<sup>3</sup> Downgraded by one increment if the majority of the evidence was at high risk of bias, and downgraded by two increments if the majority of the evidence was at very high risk of bias

<sup>4</sup> Downgraded by one/two increments because: the majority of the evidence had indirect outcomes

## I.4 Monitoring: Challenge tests

**Table 188: Clinical evidence summary: ADULTS Methacholine challenge test versus no challenge test for asthma monitoring**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	ADULTS Methacholine challenge test versus no challenge test	Control	Relative (95% CI)	Absolute		
<b>Mortality (≥6 months) (follow-up 40 weeks)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	1/105 (0.95%)	0%	OR 7.53 (0.15 to 379.61)	10 more per 1000 (from 20 fewer to 40 more) <sup>3</sup>	⊕○○○ VERY LOW	CRITICAL
<b>Asthma exacerbations (≥6 months) (follow-up 40 weeks)</b>												

1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	serious <sup>4</sup>	very serious <sup>2</sup>	none	22/105 (21%)	24.3%	RR 0.86 (0.52 to 1.42)	34 fewer per 1000 (from 117 fewer to 102 more)	⊕○○○ VERY LOW	CRITICAL
<b>Rescue medications (≥6 months) (follow-up 40 weeks; measured with: Albuterol puffs/day; Better indicated by lower values)</b>												
1	randomised trials	serious <sup>5</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	105	107	-	MD 0.1 lower (0.58 lower to 0.38 higher)	⊕⊕⊕○ MODERATE	IMPORTANT
<b>ICS use &gt;6months (follow-up 40 weeks; measured with: mean daily dose (mcg; fluticasone propionate); Better indicated by higher values)</b>												
1	randomised trials	serious <sup>5</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	105	107	-	MD 131.2 higher (83.57 to 178.83 higher)	⊕⊕⊕○ MODERATE	IMPORTANT
<b>FEV1 (≥6 months) (follow-up 40-104 weeks; measured with: L; Better indicated by higher values)</b>												
2	randomised trials	serious <sup>5</sup>	serious <sup>6</sup>	no serious indirectness	no serious imprecision	none	137	142	-	MD 0.04 lower (0.09 lower to 0.16 higher)	⊕⊕○○ LOW	IMPORTANT
<b>% symptom free days (≥6 months) (follow-up 40 weeks; range of scores: 0-100; Better indicated by higher values)</b>												
1	randomised trials	serious <sup>5</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	105	107	-	MD 5.1 lower (20.06 lower to 9.86 higher)	⊕⊕⊕○ MODERATE	IMPORTANT
<b>PEF am (≥6 months) (follow-up 40 weeks; measured with: L/min; Better indicated by higher values)</b>												
1	randomised trials	serious <sup>5</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	105	107	-	MD 8.6 lower (17.20 lower to 0 higher)	⊕⊕⊕○ MODERATE	IMPORTANT
<b>PEF pm (≥6 months) (follow-up 40 weeks; measured with: L/min; Better indicated by higher values)</b>												
1	randomised trials	serious <sup>5</sup>	no serious inconsistency	no serious indirectness	serious <sup>7</sup>	none	105	107	-	MD 6 lower (29.96 lower to 17.96 higher)	⊕⊕○○ LOW	IMPORTANT

- 1 The majority of the evidence was from studies at very high risk of bias due to allocation concealment and missing data
- 2 95% CI crosses 2 MIDs
- 3 Manual calculation of absolute effect as zero events in the control group
- 4 Evidence from one study - exacerbations not defined
- 5 The majority of the evidence was from studies at high risk of bias due to allocation concealment
- 6 Point estimates show statistical heterogeneity I<sup>2</sup>=72% P<0.06. Only 2 studies so random effects model used.
- 7 95% CI crosses one MID

**Table 189: Clinical evidence summary: ADULTS Mannitol challenge test versus no challenge test for asthma monitoring**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	ADULTS Mannitol challenge test versus no challenge test	Control	Relative (95% CI)	Absolute		
<b>AQLQ (≥6 months) (follow-up 52 weeks; measured with: mini AQLQ; range of scores: 1-7; Better indicated by higher values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	serious <sup>2</sup>	no serious imprecision	none	61	58	-	MD 0.06 higher (0.3 lower to 0.42 higher)	⊕⊕⊕⊕ LOW	CRITICAL
<b>Asthma exacerbations (≥6 months) (follow-up 52 weeks)</b>												
1	randomised trials	serious <sup>3</sup>	no serious inconsistency	serious <sup>2</sup>	very serious <sup>4</sup>	none	12/61 (19.7%)	22.4%	RR 0.88 (0.44 to 1.76)	27 fewer per 1000 (from 125 fewer to 170 more)	⊕⊕⊕⊕ VERY LOW	CRITICAL
<b>Rescue medications (≥6 months) (follow-up 52 weeks; measured with: Albuterol puffs/day; Better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	serious <sup>2</sup>	serious <sup>5</sup>	none	61	58	-	MD 0.31 lower (0.73 lower to 0.11 higher)	⊕⊕⊕⊕ VERY LOW	IMPORTANT
<b>ICS use &gt;6months (follow-up 52 weeks; measured with: mean daily dose (mcg; ciclesonide); Better indicated by higher values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	serious <sup>2</sup>	no serious imprecision	none	61	58	-	MD 306 higher (241.71 to 370.29)	⊕⊕⊕⊕ LOW	IMPORTANT

										higher)		
<b>FEV1% (≥6 months) (follow-up 52 weeks; Better indicated by higher values)</b>												
1	randomised trials	serious <sup>1,6</sup>	no serious inconsistency	serious <sup>2</sup>	no serious imprecision	none	61	58	-	MD 0.3 higher (8.21 lower to 8.81 higher)	⊕⊕⊕⊕ LOW	IMPORTANT
<b>PEF% (≥6 months) (follow-up 52 weeks; range of scores: 0-100; Better indicated by higher values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	serious <sup>2</sup>	no serious imprecision	none	61	58	-	MD 2.7 lower (13.17 lower to 7.77 higher)	⊕⊕⊕⊕ LOW	IMPORTANT
<b>PEF am (≥6 months) (follow-up 52 weeks; measured with: L/min; Better indicated by higher values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	serious <sup>2</sup>	very serious <sup>4</sup>	none	61	58	-	MD 1.5 higher (34.7 lower to 37.7 higher)	⊕⊕⊕⊕ VERY LOW	IMPORTANT

<sup>1</sup> The majority of the evidence was from studies at high risk of bias due to blinding

<sup>2</sup> Patients initially underwent step-down of their existing treatment. Patients on combination inhalers were switched to an equivalent dose of the same ICS only (unclear whether LABA was continued).

<sup>3</sup> The majority of the evidence was from studies at high risk of bias due to missing data

<sup>4</sup> 95% CI crosses 2 MIDs

<sup>5</sup> 95% CI crosses one MID

<sup>6</sup> The majority of the evidence was from studies at high risk of bias due to baseline differences

**Table 190: Clinical evidence profile: CHILDREN Challenge test versus no challenge test for asthma monitoring**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	CHILDREN Challenge test versus no challenge test	Control	Relative (95% CI)	Absolute		
<b>Asthma exacerbations (≥6 months) (follow-up 2 years; assessed with: OCS course)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	serious <sup>2</sup>	very serious <sup>3</sup>	none	16/102 (15.7%)	16.4%	RR 0.96 (0.51 to	7 fewer per 1000 (from 80 fewer to 130	⊕⊕⊕⊕ VERY	CRITICAL

									1.79)	more)	LOW	
<b>ICS dose (follow-up 2 years; measured with: Mean daily dose for treatment period; Better indicated by higher values)</b>												
1	randomised trials	serious <sup>4</sup>	no serious inconsistency	serious <sup>2</sup>	serious <sup>5</sup>	none	85	90	-	MD 84 higher (10.66 to 157.34 higher)	⊕○○○ VERY LOW	IMPORTANT
<b>FEV1% (≥6 months) (follow-up 2 years; range of scores: 0-100; Better indicated by higher values)</b>												
1	randomised trials	serious <sup>4</sup>	no serious inconsistency	serious <sup>2</sup>	no serious imprecision	none	93	92	-	MD 6 higher (1.2 lower to 10.8 higher)	⊕⊕○○ LOW	IMPORTANT
<b>% symptom free days (≥6 months) (follow-up 2 years; measured with: in last 3 months of treatment; range of scores: 0-100; Better indicated by higher values)</b>												
1	randomised trials	serious <sup>4</sup>	no serious inconsistency	serious <sup>2</sup>	very serious <sup>3</sup>	none	85	90	-	MD 1.1 lower (10.1 lower to 7.9 higher)	⊕○○○ VERY LOW	IMPORTANT

<sup>1</sup> No explanation was provided

<sup>2</sup> Patients initially underwent step-down of their existing treatment.

<sup>3</sup> 95% CI crosses both MIDs

<sup>4</sup> The majority of the evidence was at high risk of bias due to allocation concealment and baseline differences

<sup>5</sup> 95% CI crosses one MID

## I.5 Monitoring adherence to treatment

**Table 191: Clinical evidence profile: Children with uncontrolled asthma: Monitoring adherence + treatment vs UC + treatment for asthma**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Children with uncontrolled asthma: Monitoring adherence + treatment	UC + treatment	Relative (95% CI)	Absolute		
<b>Adherence &lt;6months (follow-up 4 months; measured with: % of prescribed doses measured by the electronic inhaler; Better indicated by higher values)</b>												

1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	14	12	-	MD 28.9 higher (8.62 to 49.18 higher)	⊕○○○ VERY LOW	CRITICAL
<b>Adherence ≥6months (follow-up 18 months; measured with: Number of canister refills (100% adherence = 3.0); range of scores: 0-3; Better indicated by higher values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	76	81	-	MD 0.02 lower (0.29 lower to 0.25 higher)	⊕⊕○○ LOW	CRITICAL
<b>Adherence (self-reported) ≥6months (follow-up 18 months; measured with: % self-reported adherence in previous 6 months; range of scores: 0-100; Better indicated by higher values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	76	81	-	MD 1.95 higher (5.87 lower to 9.77 higher)	⊕⊕○○ LOW	CRITICAL
<b>Exacerbation &lt; 6months (follow-up 4 months; assessed with: need for OCS)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	3/14 (21.4%)	8.3%	RR 2.57 (0.31 to 21.59)	130 more per 1000 (from 57 fewer to 1000 more)	⊕○○○ VERY LOW	CRITICAL
<b>Exacerbation ≥6 months (follow-up 18 months; measured with: no. of OCS courses in 6 months; Better indicated by lower values)</b>												
1	randomised trials	serious <sup>4</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	76	81	-	MD 0.22 higher (0.19 lower to 0.63 higher)	⊕⊕⊕○ MODERATE	CRITICAL
<b>UHU ≥6 months (follow-up 18 months; measured with: Hospitalisations in previous 6 months ; Better indicated by lower values)</b>												
1	randomised trials	serious <sup>4</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	76	81	-	MD 0 higher (4.8 lower to 4.8 higher)	⊕⊕⊕○ MODERATE	CRITICAL
<b>Rescue medication &lt; 6months (follow-up 4 months; assessed with: Reliever medication 3 or more times a week)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	2/14 (14.3%)	0%	OR 6.92 (0.41 to	140 more per 1000 (from 7 more to 360	⊕○○○ VERY LOW	IMPORTANT



									118.14)	more) <sup>5</sup>		
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<sup>1</sup> The majority of the evidence was from studies at very high risk of bias  
<sup>2</sup> 95% CI crosses one MID  
<sup>3</sup> 95% CI crosses both MIDs  
<sup>4</sup> The majority of the evidence was from studies at high risk of bias  
<sup>5</sup> Manual calculation of absolute risk difference as no events in the control group

**Table 192: Clinical evidence profile: Adults overall: Monitoring adherence + treatment vs UC + treatment for asthma**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Adults overall: Monitoring adherence + treatment	UC + treatment	Relative (95% CI)	Absolute		
<b>Adherence ≥6months (follow-up 12 months; measured with: % adherence to prescription refills in previous 3 months; range of scores: 0-100; Better indicated by higher values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	0	-	-	MD 2 lower (8.61 lower to 4.61 higher)	⊕○○○ VERY LOW	CRITICAL
<b>QOL &lt;6months (follow-up 10 weeks; measured with: AQLQ; range of scores: 1-7; Better indicated by higher values)</b>												
1	randomised trials	very serious <sup>3</sup>	no serious inconsistency	serious <sup>4</sup>	serious <sup>5</sup>	none	10	9	-	MD 0.37 higher (0.08 to 0.66 higher)	⊕○○○ VERY LOW	CRITICAL
<b>Exacerbation ≥6months (follow-up 12 months; assessed with: course of OCS)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	307/1335 (23%)	22%	HR 1.07 (0.89 to 1.29)	13 more per 1000 (from 22 fewer to 54 more)	⊕⊕○○ LOW	CRITICAL
<b>UHU (hospitalisation) ≥6months (follow-up 12 months)</b>												

1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>6</sup>	none	10/1335 (0.75%)	0.81%	HR 0.86 (0.32 to 2.31)	1 fewer per 1000 (from 6 fewer to 11 more)	⊕○○○ VERY LOW	CRITICAL
<b>UHU (ED visit) ≥6months (follow-up 12 months)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>5</sup>	none	127/1335 (9.5%)	8.1%	HR 1.22 (0.83 to 1.79)	17 more per 1000 (from 13 fewer to 59 more)	⊕○○○ VERY LOW	CRITICAL
<b>Lung function &lt;6months (follow-up 10 weeks; measured with: FEV1 L; Better indicated by higher values)</b>												
1	randomised trials	very serious <sup>3</sup>	no serious inconsistency	serious <sup>4</sup>	very serious <sup>2</sup>	none	10	9	-	MD 0.12 lower (7.31 lower to 7.07 higher)	⊕○○○ VERY LOW	IMPORTANT

- 1 The majority of the evidence was from studies at very high risk of bias
- 2 95% CI crosses both MIDs
- 3 The majority of the evidence is from studies at very high risk of bias
- 4 Population indirectness: includes severe asthma
- 5 95% CI crosses one MID
- 6 95% CI crosses both the MIDs but only downgraded by one as the 95% CI for the absolute effect is small

## I.6 Monitoring inhaler technique

**Table 193: ADULTS: Monitoring inhaler technique vs no monitoring for asthma**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	ADULTS: Monitoring inhaler technique	No monitoring	Relative (95% CI)	Absolute		
<b>Lung function &lt;6 months (follow-up 3 months; measured with: PEF Min%Max (higher is less variability); range of scores: 0-100; Better indicated by higher values)</b>												
1	randomised	very	no serious	no serious	serious <sup>2</sup>	none	53	44	-	MD 6.2 higher (2.68 to 9.72)	⊕○○○ VERY	IMPORTANT

	trials	serious <sup>1</sup>	inconsistency	indirectness						higher)	LOW	
<b>Lung function ≥6 months (follow-up 6 months; measured with: PEF Min%Max (higher is less variability); range of scores: 0-100; Better indicated by higher values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	53	44	-	MD 4.5 higher (0.79 to 8.21 higher)	⊕○○○ VERY LOW	IMPORTANT
<b>QOL &lt;6 months (follow-up 3 months; measured with: Marks AQLQ; range of scores: 0-10; Better indicated by lower values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	53	44	-	MD 0.55 lower (0.77 to 0.33 lower)	⊕⊕○○ LOW	CRITICAL
<b>QOL ≥6 months (follow-up 6 months; measured with: Marks AQLQ; range of scores: 0-10; Better indicated by lower values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	53	44	-	MD 0.5 lower (0.74 to 0.26 lower)	⊕○○○ VERY LOW	CRITICAL

<sup>1</sup> The evidence was from one study at very high risk of bias for this outcome

<sup>2</sup> 95% CI crosses one MID

**Table 194: ADULTS: Monitoring (verbal and electronic) vs verbal monitoring only for asthma**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	ADULTS: Monitoring (verbal and electronic)	Verbal monitoring only	Relative (95% CI)	Absolute		
<b>QOL &lt;6 months (follow-up 6 weeks; measured with: mini AQLQ; range of scores: 1-7; Better indicated by higher values)</b>												
2	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	53	52	-	MD 0.38 higher (0.02 lower to 0.79 higher)	⊕○○○ VERY LOW	CRITICAL

Lung function <6 months (follow-up 6 weeks; measured with: FEV1 L; Better indicated by higher values)												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	36	35	-	MD 0.23 lower (0.55 lower to 0.09 higher)	⊕○○○ VERY LOW	IMPORTANT
Lung function <6 months (follow-up 6 weeks; measured with: FEV1 % pred; range of scores: 0-100; Better indicated by higher values)												
1	randomised trials	serious <sup>3</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	17	17	-	MD 9.1 higher (3.71 lower to 21.91 higher)	⊕⊕○○ LOW	IMPORTANT

<sup>1</sup> The majority of the evidence was from studies at very high risk of bias for this outcome

<sup>2</sup> 95% CI crosses one MID

<sup>3</sup> The majority of the evidence was from studies at high risk of bias for this outcome

**Table 195: CHILDREN: Monitoring (verbal and electronic) vs verbal monitoring only for asthma**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	CHILDREN: Monitoring (verbal and electronic)	Verbal monitoring only	Relative (95% CI)	Absolute		
Lung function <6 months (follow-up 6 weeks; measured with: FEV1 % pred; range of scores: 0-100; Better indicated by higher values)												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	6	6	-	MD 3.2 lower (15.27 lower to 8.87 higher)	⊕○○○ VERY LOW	IMPORTANT
QOL <6 months (follow-up 6 weeks; measured with: PAQLQ; range of scores: 1-7; Better indicated by higher values)												
1	randomised trials	very serious <sup>3</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	6	6	-	MD 0.03 higher (0.66 lower to 0.72 higher)	⊕○○○ VERY LOW	CRITICAL

<sup>1</sup> The evidence was from one study at high risk of bias for this outcome  
<sup>2</sup> 95% CI crosses both MIDs  
<sup>3</sup> No explanation was provided

## I.7 Monitoring: Tele-healthcare

**Table 196: Adult comparison 1: tele-health services vs face-to-face equivalents**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Tele-health services	face-to-face equivalents	Relative (95% CI)	Absolute		
<b>Quality of life (follow-up mean 12 months; measured with: Asthma Quality of Life Questionnaire; range of scores: 1-7; Better indicated by higher values)</b>												
3	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	491	469	-	MD 0.01 lower (0.17 lower to 0.14 higher)	⊕⊕⊕○ MODERATE	CRITICAL
<b>UHU hospitalisation (follow-up mean 6 months<sup>2</sup>)</b>												
2	randomised trials	very serious <sup>1,3</sup>	no serious inconsistency	no serious indirectness	very serious <sup>4</sup>	none	0/222 (0%)	0.6%	OR 0.14 (0 to 7.06) <sup>5</sup>	5 fewer per 1000 (from 6 fewer to 35 more)	⊕○○○ VERY LOW	CRITICAL
<b>UHU ED visit (follow-up mean 6 months<sup>2</sup>)</b>												
2	randomised trials	very serious <sup>1,3</sup>	no serious inconsistency	no serious indirectness	very serious <sup>4</sup>	none	2/222 (0.9%)	0%	OR 7.75 (0.48 to 124.9) <sup>5</sup>	-	⊕○○○ VERY LOW	CRITICAL
<b>Exacerbations requiring oral steroids</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>4</sup>	none	5/137 (3.6%)	2.1%	RR 1.72 (0.42 to 7.04)	15 more per 1000 (from 12 fewer to 127 more)	⊕○○○ VERY LOW	CRITICAL
<b>Asthma control (follow-up mean 12 months; measured with: Asthma Control Questionnaire; range of scores: 0-6; Better indicated by lower values)</b>												

2	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	354	328	-	MD 0.11 lower (0.27 lower to 0.04 higher)	⊕⊕⊕⊕ MODERATE	CRITICAL
<b>UHU GP visits (follow-up mean 6 months<sup>2</sup>)</b>												
2	randomised trials	serious <sup>1,6</sup>	no serious inconsistency	no serious indirectness	serious <sup>4</sup>	none	30/222 (13.5%)	13.2%	RR 0.86 (0.56 to 1.32)	18 fewer per 1000 (from 58 fewer to 42 more)	⊕⊕⊕⊕ LOW	CRITICAL
<b>Change in FEV1 (mL) (follow-up mean 6 months; Better indicated by higher values)</b>												
1	randomised trials	very serious <sup>1,3</sup>	no serious inconsistency	no serious indirectness	serious <sup>7</sup>	none	85	88	-	MD 152 higher (54 to 250 higher)	⊕⊕⊕⊕ VERY LOW	IMPORTANT
<b>Withdrawal (follow-up 6-12 months)</b>												
3	randomised trials	no serious risk of bias	serious <sup>8</sup>	no serious indirectness	very serious <sup>4</sup>	none	35/334 (10.5%)	12%	RR 0.78 (0.32 to 1.9)	26 fewer per 1000 (from 82 fewer to 108 more)	⊕⊕⊕⊕ VERY LOW	IMPORTANT

<sup>1</sup> Studies could not use blinding to control for performance or detection bias

<sup>2</sup> Pinnock 2003 was a pragmatic trial of variable intervention duration, but did not contribute any events to the analysis

<sup>3</sup> Evidence of sub-optimal randomisation procedures and imputation of missing values, and selective reporting

<sup>4</sup> 95% CI crosses both the MIDs

<sup>5</sup> Very rare events - Peto odds ratio used

<sup>6</sup> While there were several issues with one of the studies in the analysis, it only accounted for 6.6% of the analysis weight.

<sup>7</sup> 95% CI crossed an MID

<sup>8</sup> Heterogeneity was high (I squared = 79%)

**Table 197: Adult comparison 2: tele-monitoring vs paper-based monitoring**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Tele-monitoring	Paper-based monitoring	Relative (95% CI)	Absolute		
<b>Quality of life (follow-up 6-12 months; measured with: Asthma Quality of Life Questionnaire; range of scores: 1-7; Better indicated by higher values)</b>												

2	randomised trials	serious <sup>1</sup>	serious <sup>2</sup>	no serious indirectness	serious <sup>3</sup>	none	188	196	-	MD 0.21 higher (0.09 lower to 0.5 higher)	⊕○○○ VERY LOW	CRITICAL
<b>UHU hospitalisation (follow-up 4-6 months)</b>												
3	randomised trials	serious <sup>4</sup>	serious <sup>5</sup>	no serious indirectness	very serious <sup>6</sup>	none	5/191 (2.6%)	2.2%	RR 0.60 (0.13 to 2.86)	9 fewer per 1000 (from 19 fewer to 41 more)	⊕○○○ VERY LOW	CRITICAL
<b>UHU ED visit (follow-up mean 6 months)</b>												
2	randomised trials	serious <sup>7</sup>	serious <sup>8</sup>	no serious indirectness	very serious <sup>6</sup>	none	5/183 (2.7%)	13%	RR 0.89 (0.02 to 33.53)	14 fewer per 1000 (from 127 fewer to 1000 more)	⊕○○○ VERY LOW	CRITICAL
<b>Exacerbations requiring oral steroids (follow-up mean 6 months)</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious <sup>6</sup>	none	28/140 (20%)	21.3%	RR 0.94 (0.59 to 1.49)	13 fewer per 1000 (from 87 fewer to 104 more)	⊕⊕○○ LOW	CRITICAL
<b>Asthma control (follow-up 6-12 months; measured with: Asthma Control Questionnaire; range of scores: 0-6; Better indicated by lower values)</b>												
2	randomised trials	serious <sup>1</sup>	very serious <sup>9</sup>	no serious indirectness	serious <sup>3</sup>	none	240	238	-	MD 0.24 lower (0.72 lower to 0.24 higher)	⊕○○○ VERY LOW	CRITICAL
<b>UHU GP visits (follow-up mean 6 months)</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious <sup>3</sup>	none	51/140 (36.4%)	29.1%	RR 1.25 (0.89 to 1.76)	73 more per 1000 (from 32 fewer to 221 more)	⊕⊕⊕○ MODERATE	CRITICAL
<b>Change in FEV1 (mL) (follow-up mean 12 months; Better indicated by higher values)</b>												
1	randomised trials	serious <sup>10</sup>	no serious inconsistency	no serious indirectness	serious <sup>3</sup>	none	101	99	-	MD 250 higher (33.36 to 466.64 higher)	⊕⊕○○ LOW	IMPORTANT
<b>PEF (L/min) (follow-up mean 6 months; Better indicated by higher values)</b>												
1	randomised trials	serious <sup>7</sup>	no serious inconsistency	no serious indirectness	serious <sup>3</sup>	none	43	46	-	MD 39.2 higher (16.58 to 61.82 higher)	⊕⊕○○ LOW	IMPORTANT

Withdrawal (follow-up 4-12 months)												
4	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious <sup>6</sup>	none	58/312 (18.6%)	15.2%	RR 1.01 (0.73 to 1.39)	2 more per 1000 (from 41 fewer to 59 more)	⊕⊕○○ LOW	IMPORTANT

- <sup>1</sup> One study analysed complete cases and did not blind participants, investigators or outcome assessors, which carried the majority of the analysis weight.
- <sup>2</sup> Heterogeneity was high (I squared = 53%)
- <sup>3</sup> 95% CI crosses one of the MIDs
- <sup>4</sup> Only one study used any blinding procedures (outcome assessors), and there were uncertainties regarding allocation concealment
- <sup>5</sup> Heterogeneity was not statistically significant (I squared = 42%), but point estimates are very different
- <sup>6</sup> 95% CIs cross both MIDs
- <sup>7</sup> Study carrying the most weight did not blind outcome assessors (and could not blind participants and investigators), and dropout was high in both groups
- <sup>8</sup> Heterogeneity was high (I squared = 80%)
- <sup>9</sup> Heterogeneity was very high (I squared = 91%)
- <sup>10</sup> No blinding of outcome assessors (and unable to blind participants and investigators). Only complete cases were analysed.

**Table 198: Adult comparison 3: tele-healthcare package vs nothing (usual care)**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Tele-health packages	Nothing (usual care)	Relative (95% CI)	Absolute		
<b>Quality of life (follow-up 10-12 months; measured with: Asthma Quality of Life Questionnaire; range of scores: 1-7; Better indicated by higher values)</b>												
3	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	806	827	-	MD 0.08 higher (0.03 lower to 0.20 higher)	⊕⊕⊕○ MODERATE	CRITICAL
<b>UHU hospitalisation (follow-up 6-12 months)</b>												
4	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision <sup>2</sup>	none	1/205 (0.49%)	5.6%	OR 0.16 (0.05 to 0.56) <sup>4</sup>	47 fewer per 1000 (from 24 fewer to 53 fewer)	⊕⊕⊕○ MODERATE	CRITICAL
<b>UHU ED visit (follow-up 6-12 months)</b>												
4	randomised trials	serious <sup>1</sup>	no serious inconsistency <sup>4</sup>	no serious indirectness	very serious <sup>5</sup>	none	10/210 (4.8%)	6.5%	RR 0.82 (0.38 to 1.8)	12 fewer per 1000 (from 40 fewer to 52 more)	⊕○○○ VERY LOW	CRITICAL



										more)		
<b>Exacerbations requiring oral steroids (follow-up mean 12 months)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>5</sup>	none	21/31 (67.7%)	72.4%	RR 0.94 (0.67 to 1.3)	43 fewer per 1000 (from 239 fewer to 217 more)	⊕○○○ VERY LOW	CRITICAL
<b>Asthma control (follow-up mean 12 months; measured with: Asthma Control Questionnaire; range of scores: 0-6; Better indicated by lower values)</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	270	286	-	MD 0.04 lower (0.2 lower to 0.12 higher)	⊕⊕⊕⊕ HIGH	CRITICAL
<b>UHU GP visits (follow-up 6-12 months)</b>												
3	randomised trials	serious <sup>1</sup>	Serious <sup>6</sup>	no serious indirectness <sup>7</sup>	very serious <sup>5</sup>	none	31/150 (20.7%)	38.9%	RR 0.96 (0.39 to 2.37)	16 fewer per 1000 (from 237 fewer to 533 more)	⊕○○○ VERY LOW	CRITICAL
<b>Change in FEV1 (mL) (follow-up mean 6 months; Better indicated by higher values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>8</sup>	none	85	80	-	MD 183 higher (85 to 281 higher)	⊕⊕○○ LOW	IMPORTANT
<b>Symptom days per month (range of scores: 0-30; Better indicated by lower values)</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious <sup>8</sup>	none	311	297	-	MD 0.6 higher (0.82 lower to 2.02 higher)	⊕⊕⊕○ MODERATE	IMPORTANT
<b>Symptom nights per month (range of scores: 0-30; Better indicated by lower values)</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious <sup>8</sup>	none	311	297	-	MD 0.1 lower (1.21 lower to 1.01 higher)	⊕⊕⊕○ MODERATE	IMPORTANT
<b>Withdrawal (follow-up 6-12 months)</b>												
5	randomised trials	serious <sup>1</sup>	no serious inconsistency <sup>(4)</sup>	no serious indirectness	serious <sup>5</sup>	none	28/255 (11%)	11.1%	RR 0.81 (0.51 to 1.29)	21 fewer per 1000 (from 54 fewer to 32 more)	⊕○○○ VERY LOW	IMPORTANT

1 Issues across studies with blinding, completeness of outcome data, and allocation concealment  
2 Confidence intervals were wide but did not cross an MID  
3 Very rare events - Peto odds ratio used  
4 Point estimates were varied but statistical heterogeneity was low - random effects sensitivity did not change imprecision

<sup>5</sup> 95% CI crossed both MIDs  
<sup>6</sup> Heterogeneity was high (I squared = 66%)  
<sup>7</sup> One study was only recruited older adults (53% of analysis weight)  
<sup>8</sup> 95% CIs crossed an MID

**Table 199: Child comparison 1: tele-health services vs face-to-face equivalents**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Tele-health services	face-to-face equivalents	Relative (95% CI)	Absolute		
<b>Quality of life - child (follow-up mean 12 months; measured with: Paediatric Asthma Quality of Life Questionnaire; range of scores: 1-7; Better indicated by higher values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	60	60	-	MD 0.3 higher (0.11 lower to 0.71 higher)	⊕⊕⊕⊕ LOW	CRITICAL
<b>Quality of life - caregiver (follow-up mean 12 months; measured with: Paediatric Asthma Quality of Life Questionnaire; range of scores: 1-7; Better indicated by higher values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	60	60	-	MD 0.2 higher (0.12 lower to 0.52 higher)	⊕⊕⊕⊕ LOW	CRITICAL
<b>UHU hospitalisation (follow-up mean 12 months)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	1/60 (1.7%)	1.7%	RR 1 (0.06 to 15.62)	0 fewer per 1000 (from 16 fewer to 249 more)	⊕⊕⊕⊕ VERY LOW	CRITICAL
<b>UHU ED visit (follow-up mean 12 months)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	4/60 (6.7%)	3.3%	RR 2 (0.38 to 10.51)	33 more per 1000 (from 20 fewer to 314 more)	⊕⊕⊕⊕ VERY LOW	CRITICAL
<b>FEV1 % predicted (follow-up mean 12 months; Better indicated by higher values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	60	60	-	MD 5.2 higher (1.48 lower to 11.88 higher)	⊕⊕⊕⊕ LOW	IMPORTANT

<sup>1</sup> No blinding and unbalanced attrition  
<sup>2</sup> 95% CI crosses an MID  
<sup>3</sup> 95% CI crosses both MIDs

**Table 200: Child comparison 2: tele-monitoring vs paper-based monitoring**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Tele-monitoring	Paper-based monitoring	Relative (95% CI)	Absolute		
<b>Change in morning PEF (L/min) (follow-up mean 3 months; Better indicated by higher values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	82	71	-	MD 7.80 higher (6.37 lower to 21.97 higher)	⊕⊕⊕⊕ LOW	IMPORTANT
<b>Change in evening PEF (L/min) (follow-up mean 3 months; Better indicated by higher values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	82	71	-	MD 12 higher (3.59 lower to 27.59 higher)	⊕⊕⊕⊕ LOW	IMPORTANT
<b>Withdrawal (follow-up mean 3 months)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	6/88 (6.8%)	6.6%	RR 1.04 (0.33 to 3.26)	3 more per 1000 (from 44 fewer to 149 more)	⊕⊕⊕⊕ VERY LOW	IMPORTANT

<sup>1</sup> Participants and investigators could not be blind (outcome assessors were blinded)  
<sup>2</sup> 95% CI crosses an MID  
<sup>3</sup> 95% CI crosses both MIDs

**Table 201: Child comparison 3: tele-healthcare package vs nothing (usual care)**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Tele-health packages	Nothing (usual care)	Relative (95% CI)	Absolute		

Quality of life - child (follow-up 6-12 months; measured with: Paediatric Asthma Quality of Life Questionnaire; range of scores: 1-7; Better indicated by higher values)												
1	randomised trials	serious <sup>1</sup>	No serious inconsistency	no serious indirectness	serious <sup>3</sup>	none	41	41	-	MD 0.70 higher (0.29 to 1.11 higher)	⊕⊕○○ LOW	CRITICAL
Quality of life - caregiver (follow-up 6-12 months; measured with: Paediatric Asthma Quality of Life Questionnaire; range of scores: 1-7; Better indicated by higher values)												
2	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision <sup>2</sup>	none	89	92	-	MD 0.18 higher (0.10 lower to 0.46 higher)	⊕⊕⊕○ MODERATE	CRITICAL
UHU hospitalisation (follow-up 3-12 months)												
5	randomised trials	serious <sup>4</sup>	no serious inconsistency <sup>5</sup>	no serious indirectness	very serious <sup>6</sup>	none	11/305 (3.6%)	2%	RR 1.43 (0.59 to 3.46)	9 more per 1000 (from 8 fewer to 49 more)	⊕○○○ VERY LOW	CRITICAL
UHU ED visit (follow-up 3-12 months)												
4	randomised trials	serious <sup>4</sup>	no serious inconsistency <sup>5</sup>	no serious indirectness	very serious <sup>6</sup>	none	19/285 (6.7%)	9.2%	RR 1 (0.56 to 1.8)	0 fewer per 1000 (from 40 fewer to 74 more)	⊕○○○ VERY LOW	CRITICAL
Exacerbations requiring oral steroids (follow-up 6-12 months)												
2	randomised trials	serious <sup>4</sup>	no serious inconsistency	no serious indirectness	very serious <sup>6</sup>	none	41/62 (66.1%)	71.9%	RR 1.01 (0.8 to 1.27)	7 more per 1000 (from 144 fewer to 194 more)	⊕○○○ VERY LOW	CRITICAL
Asthma control (follow-up mean 12 months; measured with: Asthma Control Questionnaire; range of scores: 0-6; Better indicated by lower values)												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>3</sup>	none	148	153	-	MD 0.31 lower (0.56 to 0.06 lower)	⊕⊕○○ LOW	CRITICAL
UHU GP visits (follow-up mean 8 months)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious <sup>6</sup>	none	6/48 (12.5%)	15.7%	RR 0.80 (0.30 to 2.13)	31 fewer per 1000 (from 110 fewer to 177 more)	⊕⊕○○ LOW	CRITICAL
Withdrawal (follow-up 3-12 months)												
5	randomised	serious <sup>4</sup>	serious <sup>7</sup>	no serious	serious <sup>6</sup>	none	51/408	16.1%	RR 0.86	23 fewer per 1000	⊕○○○	IMPORTANT

	trials			indirectness			(12.5%)		(0.53 to 1.41)	(from 76 fewer to 66 more)	VERY LOW	
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<sup>1</sup> One or more study did not blind outcome assessors

<sup>2</sup> MID is close to, but does not cross, the 0.5 MID

<sup>3</sup> 95% CI crosses one MID

<sup>4</sup> Issues across studies with blinding, completeness of outcome data, and allocation concealment

<sup>5</sup> Point estimates were varied but statistical heterogeneity was low - random effects sensitivity did not change imprecision

<sup>6</sup> 95% CI crosses both MIDs

<sup>7</sup> Some inconsistency (I squared = 38%), random effects used

**Table 202: Adult comparison 4: Telehealthcare without healthcare professional involvement vs usual care**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interactive voice response telephone calls	no calls	Relative (95% CI)	Absolute		
<b>QOL &lt;6 months (follow-up 10 weeks; measured with: AQLQ; range of scores: 0-7; Better indicated by higher values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	25	25	-	MD 0.23 higher (0.32 lower to 0.78 higher)	⊕⊕○○ LOW	CRITICAL
<b>Asthma Control Questionnaire &lt;6 months (follow-up 10 weeks; measured with: ACT; range of scores: 5-25; Better indicated by higher values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	25	25	-	MD 0.72 higher (1.51 lower to 2.95 higher)	⊕○○○ VERY LOW	CRITICAL

<sup>1</sup> Method of randomisation and allocation concealment unclear

<sup>2</sup> Crosses one MID

<sup>3</sup> Crosses two MIDs

**Table 203: Child comparison 4: Telehealthcare without healthcare professional involvement vs usual care**

Quality assessment							No of patients	Effect	Quality	Importance
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No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Telephone calls	No calls	Relative (95% CI)	Absolute		
<b>Exacerbations ≥6 months (follow-up 6 months; assessed with: Self report OCS (assumed to be for exacerbation))</b>												
1	randomised trials	very serious <sup>1,2,3</sup>	no serious inconsistency	no serious indirectness	serious <sup>4</sup>	none	16/39 (41%)	52.5%	RR 0.78 (0.48 to 1.26)	116 fewer per 1000 (from 273 fewer to 136 more)	⊕○○○ VERY LOW	CRITICAL
<b>QOL ≥6 months (follow-up 6 months; measured with: Pediatric Asthma Quality of Life Questionnaire (carer); range of scores: 0-7; Better indicated by higher values)</b>												
1	randomised trials	very serious <sup>1,2,3</sup>	no serious inconsistency	no serious indirectness	serious <sup>4</sup>	none	39	41	-	MD 0.2 higher (0.48 lower to 0.88 higher)	⊕○○○ VERY LOW	CRITICAL
<b>QOL ≥6 months (follow-up 6 months; measured with: Pediatric Asthma Quality of Life Questionnaire (child); range of scores: 0-7; Better indicated by higher values)</b>												
1	randomised trials	very serious <sup>1,2,3</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	39	41	-	MD 0.6 higher (0.16 to 1.04 higher)	⊕⊕○○ LOW	CRITICAL
<b>UHU ED visit ≥6 months (follow-up 6 months; assessed with: ED visit self report)</b>												
1	randomised trials	very serious <sup>1,2,3</sup>	no serious inconsistency	no serious indirectness	very serious <sup>5</sup>	none	6/39 (15.4%)	12.5%	RR 1.23 (0.41 to 3.7)	29 more per 1000 (from 74 fewer to 338 more)	⊕○○○ VERY LOW	CRITICAL
<b>UHU hospitalisation ≥6 months (follow-up 6 months; assessed with: Hospital admission self report )</b>												
1	randomised trials	very serious <sup>1,2,3</sup>	no serious inconsistency	no serious indirectness	very serious <sup>5</sup>	none	4/39 (10.3%)	10%	RR 1.03 (0.28 to 3.82)	3 more per 1000 (from 72 fewer to 282 more)	⊕○○○ VERY LOW	CRITICAL
<b>School days lost ≥6 months (follow-up 6 months; assessed with: Self report (yes/no to any time off school))</b>												
1	randomised trials	very serious <sup>1,2,3</sup>	no serious inconsistency	no serious indirectness	very serious <sup>5</sup>	none	20/38 (52.6%)	56.4%	RR 0.93 (0.62 to 1.4)	39 fewer per 1000 (from 214 fewer to 226 more)	⊕○○○ VERY LOW	IMPORTANT
<b>Parents' work days lost ≥6 months (follow-up 6 months; assessed with: Self report (yes/no to any work days lost))</b>												
1	randomised trials	very serious <sup>1,2,3</sup>	no serious inconsistency	no serious indirectness	very serious <sup>5</sup>	none	13/39 (33.3%)	33.3%	RR 1 (0.53 to 1.87)	0 fewer per 1000 (from 157 fewer to 290 more)	⊕○○○ VERY LOW	IMPORTANT

<b>Controller medication use in patients who should have been on controller medications at baseline ≥6 months (follow-up 12 months; assessed with: i.e. persistent asthma )</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious <sup>4</sup>	none	7/19 (36.8%)	16.7%	RR 2.21 (0.82 to 5.97)	202 more per 1000 (from 30 fewer to 830 more)	⊕⊕⊕⊖ MODERATE	IMPORTANT
<b>Persistent asthma on controllers at baseline but discontinued at 6 months (follow-up 12 months)</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious <sup>5</sup>	none	6/42 (14.3%)	5.2%	RR 2.76 (0.73 to 10.42)	92 more per 1000 (from 14 fewer to 490 more)	⊕⊕⊖⊖ LOW	IMPORTANT
<b>Of those who met severity criteria for controllers at baseline, number on them at 12 months (follow-up 12 months)</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious <sup>4</sup>	none	34/53 (64.2%)	61%	RR 1.05 (0.81 to 1.37)	30 more per 1000 (from 116 fewer to 226 more)	⊕⊕⊕⊖ MODERATE	IMPORTANT

<sup>1</sup> Method of randomisation and allocation concealment unclear

<sup>2</sup> Groups not comparable at baseline

<sup>3</sup> Underpowered

<sup>4</sup> Crosses one MID

<sup>5</sup> Crosses two MIDs

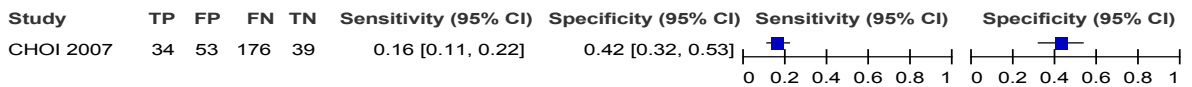
# 1 Appendix J: Forest plots

## 2 J.1 Diagnosis: Signs and symptoms

### 3 J.1.1 Coupled sensitivity / specificity forest plots and ROC curves

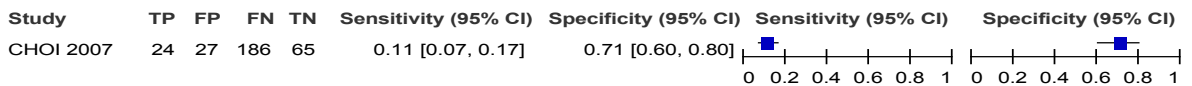
#### 4 J.1.1.1 Adults: symptoms vs. physician Dx and an objective test

5 **Figure 47: Paroxysmal coughing**



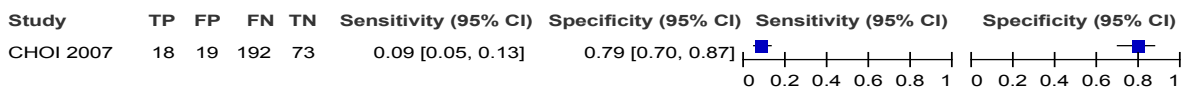
6

7 **Figure 48: Dyspnoea without wheeze**



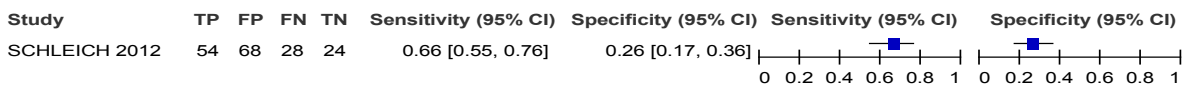
8

9 **Figure 49: Wheeze without dyspnoea**



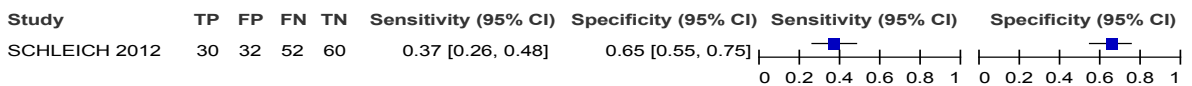
10

11 **Figure 50: Diurnal cough**



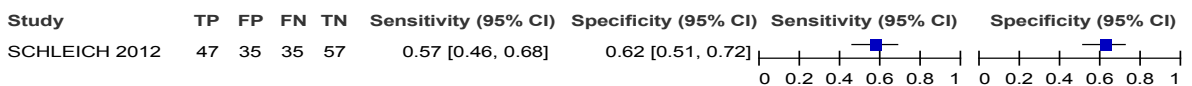
12

13 **Figure 51: Nocturnal cough**



14

15 **Figure 52: Diurnal wheeze**

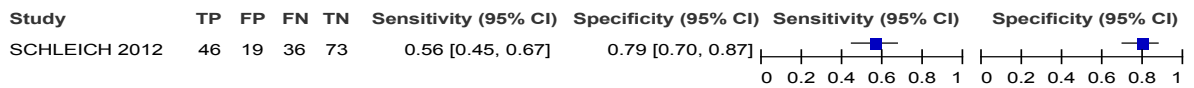


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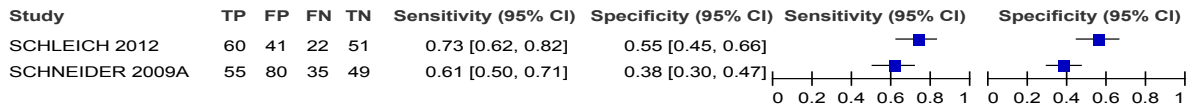


1 **Figure 53: Nocturnal wheeze**



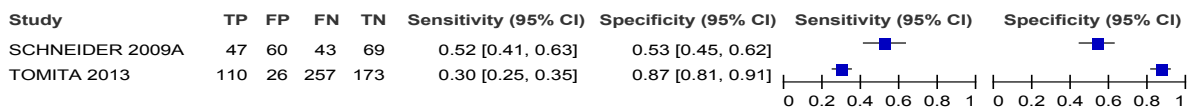
2

3 **Figure 54: Dyspnoea**



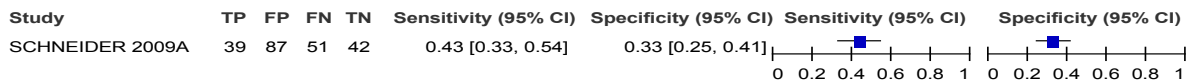
4

5 **Figure 55: Wheeze**



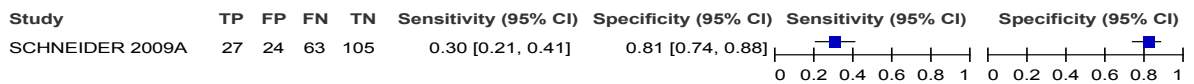
6

7 **Figure 56: Cough**



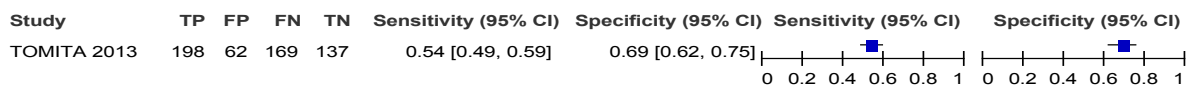
8

9 **Figure 57: Nocturnal dyspnoea**



10

11 **Figure 58: Diurnal symptoms**



12

13 **Figure 59: Total symptom score ≥5**

14 CHOI 2007: numbers for 2x2 table not reported. Sensitivity 74.3%, Specificity 47.8%

15 **Figure 60: Dyspnoea attacks**

16 SCHNEIDER 2012: numbers for 2x2 table not reported. Sensitivity 40%, Specificity 78.4%

17 **Figure 61: Dyspnoea going upstairs**

18 SCHNEIDER 2012: numbers for 2x2 table not reported. Sensitivity 47.1%, Specificity 49.6%

19 **Figure 62: Dyspnoea when walking**

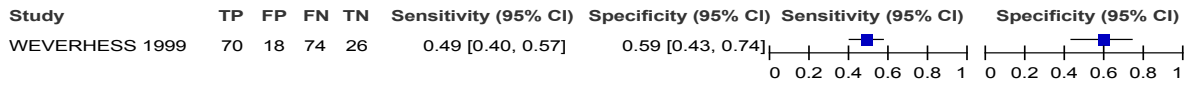
20 SCHNEIDER 2012: numbers for 2x2 table not reported. Sensitivity 4.8%, Specificity 93.2%

1 **Figure 63: Dyspnoea on minimal exercise**

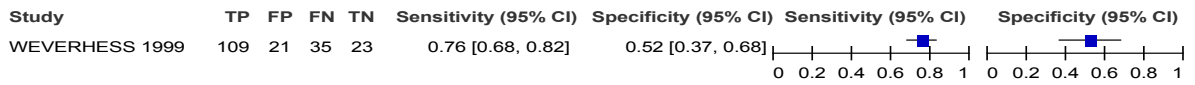
2 SCHNEIDER 2012: numbers for 2x2 table not reported. Sensitivity 2.5%, Specificity 94.1%

3 **Children <5 years: symptoms vs. physician Dx**

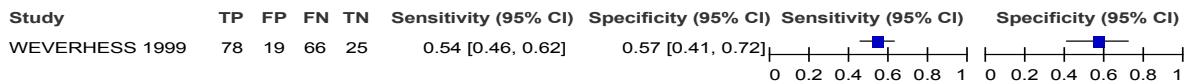
4 **Figure 64: Cough and wheeze**



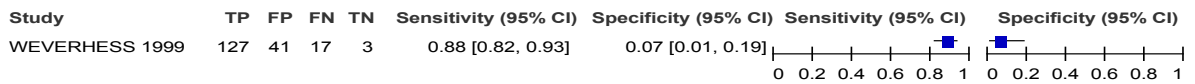
6 **Figure 65: Dyspnoea**



8 **Figure 66: Wheeze**



10 **Figure 67: Cough**

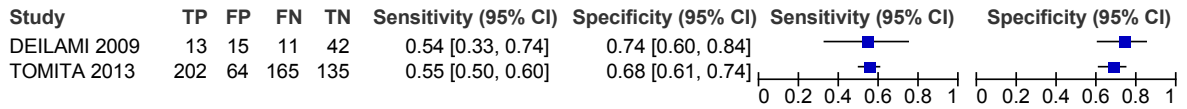


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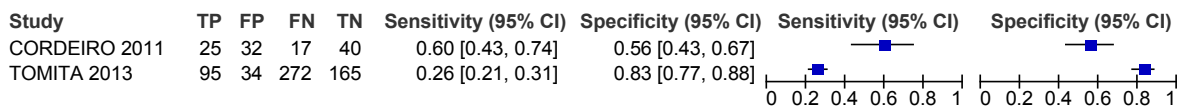
1 **J.2 Diagnosis: History of atopic disorders**

2 **J.2.1 Coupled sensitivity / specificity forest plots and ROC curves**

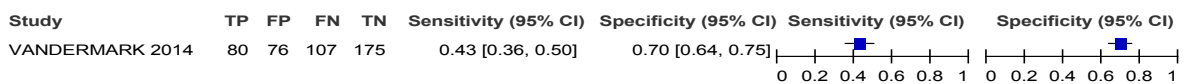
**Figure 68: Adults: Personal history of atopic disorders**



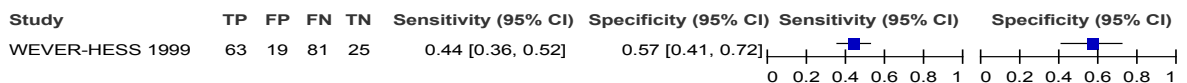
**Figure 69: Adults: Family history of atopic disorders**



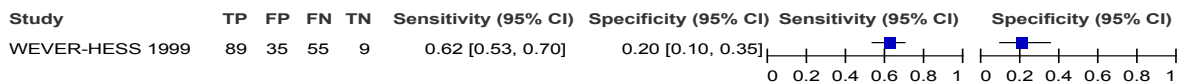
**Figure 70: Children 5-16 years: Family history of asthma**



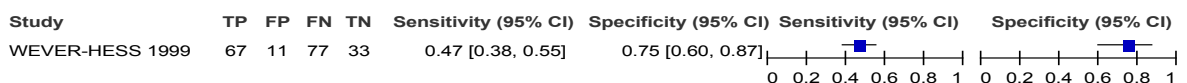
**Figure 71: Children <5 years: Family history of atopic disorders**



**Figure 72: Children <5 years: Personal history of rhinitis**



**Figure 73: Children <5 years: Personal history of eczema**

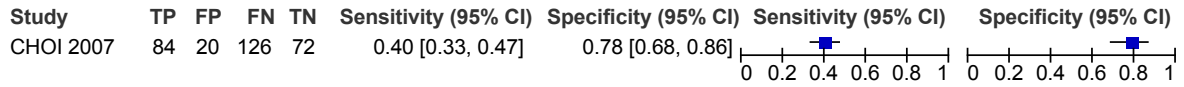


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4

1 **J.3 Diagnosis: Symptoms after exercise**

2 **J.3.1 Coupled sensitivity / specificity forest plots and ROC curves**

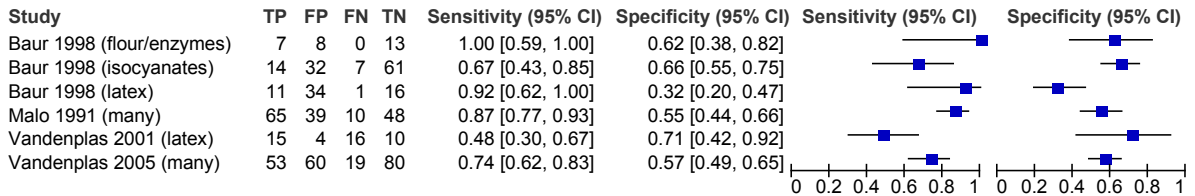
**Figure 74: Clinical history of symptoms in response to exercise vs Reference Standard (adults)**



3 **J.4 Diagnosis: Occupational asthma**

4 **J.4.1 Question whether symptoms are better away from work vs. reference standard**

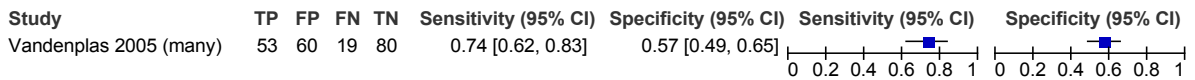
5 **Figure 75: Asking whether their symptoms are better away from work (all causative agents)**



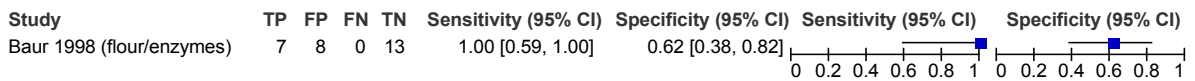
7 **Figure 76: Improvement or disappearance of symptoms at weekend.**



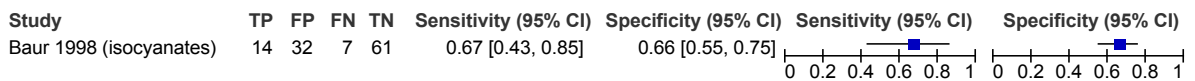
9 **Figure 77: Improvement of disappearance of symptoms during vacation.**



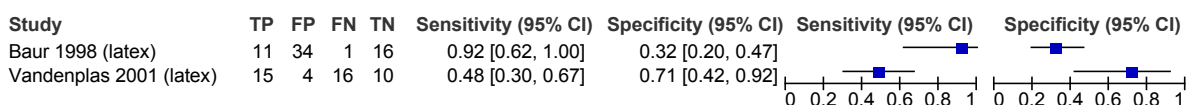
11 **Figure 78: Symptoms better away from work (flour).**



13 **Figure 79: Symptoms better away from work (isocyanate).**

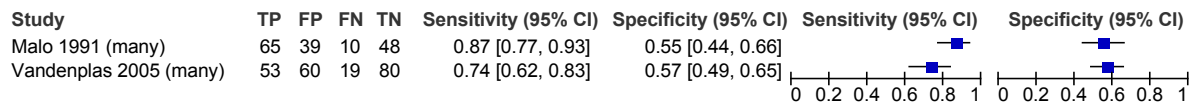


16 **Figure 80: Symptoms better away from work (latex).**



1

**Figure 81: Symptoms better away from work (many causal agents).**



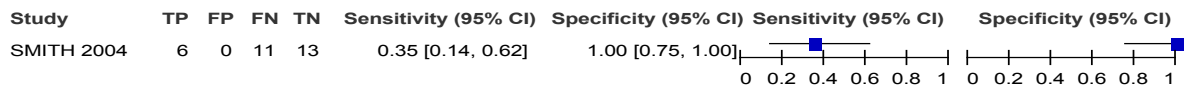
2

1 **J.5 Diagnosis: Spirometry**

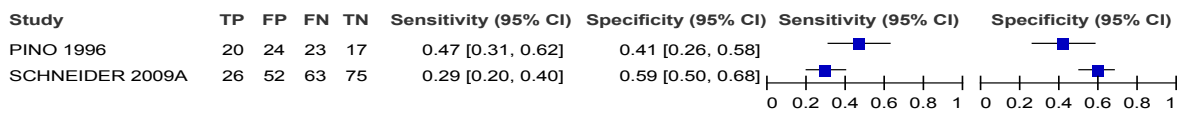
2 **J.5.1.1 Coupled sensitivity / specificity forest plots and ROC curves**

3 **Adults: FEV1/FVC ratio measures**

**Figure 82: FEV1/FVC <70%**

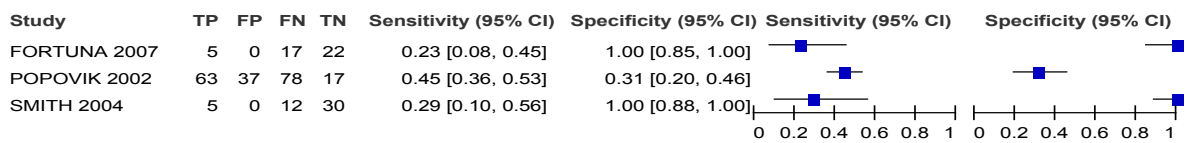


**Figure 83: FEV1/FVC <70% and/or FEV1<80%**



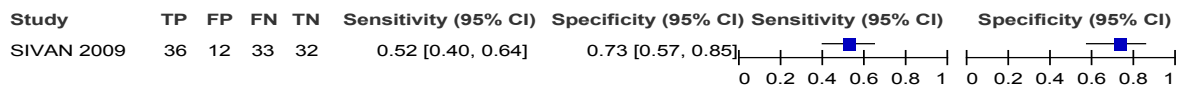
4 **Adults: FEV1 only measures**

**Figure 84: FEV1 <80%**



5 **Children: FEV1 measures**

**Figure 85: FEV1 <80%**

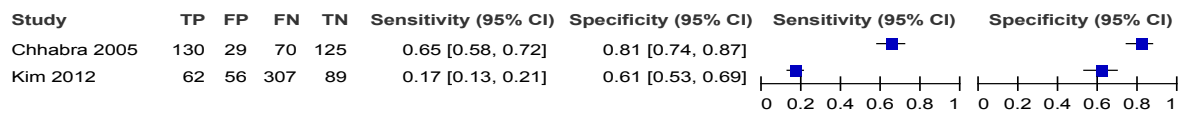


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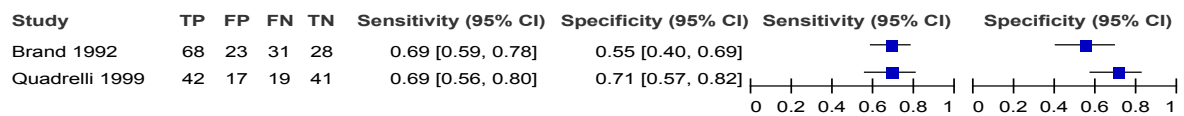
## 1 J.6 Diagnosis: Bronchodilator reversibility

### 2 J.6.1.1 Adults: Bronchodilator reversibility vs. Physician Dx

**Figure 86:  $\Delta FEV1\%init \geq 12\%$  and  $\Delta FEV1[L] \geq 0.2L$**



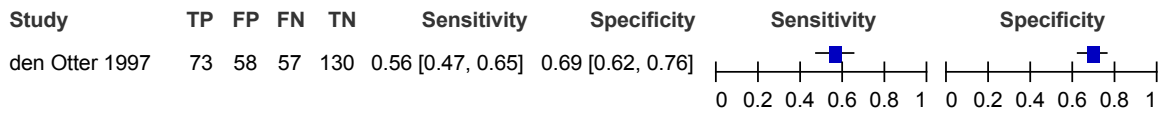
**Figure 87:  $\Delta FEV1\%init > 15\%$  and  $\Delta FEV1[L] > 0.2L$**



1 **J.7 Diagnosis: PEF variability**

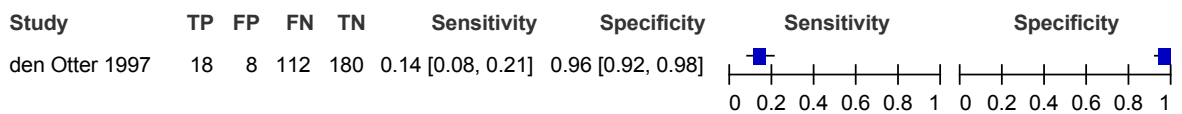
2 **J.7.1.1 Adults > 16 years**

**Figure 88: Amp%mean (mean over 3 weeks >5%)**



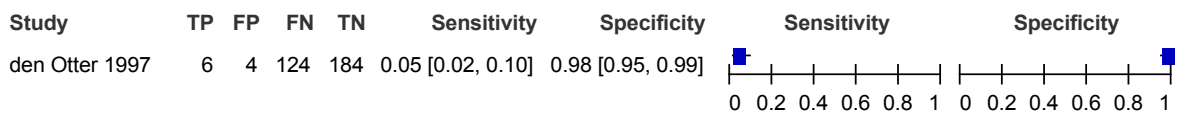
3

**Figure 89: Amp%mean (mean over 3 weeks >10%)**



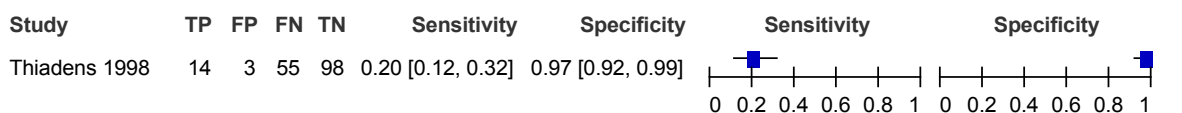
4

**Figure 90: Amp%mean (mean over 3 weeks >15%)**



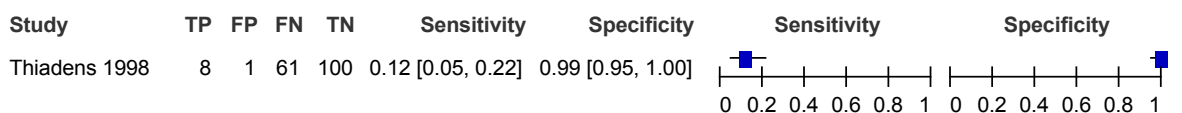
5

**Figure 91: Amp%highest (>15% on 4 days or more)**



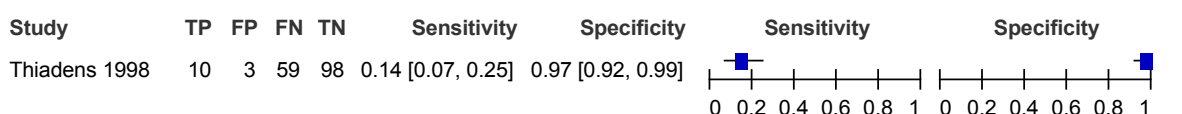
6

**Figure 92: Amp%highest (>20% on 3 days or more)**



7

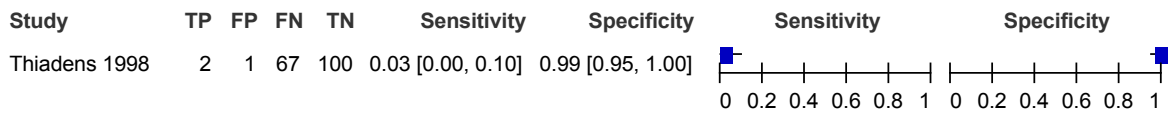
**Figure 93: Amp%highest (mean over 2 weeks >10%)**



8



**Figure 94: Amp%highest (mean over 2 weeks >10%)**

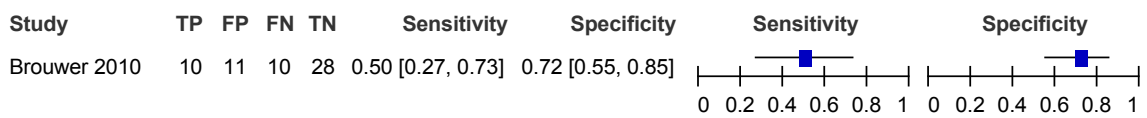


1

2 **J.7.1.2 Children 5-16 years**

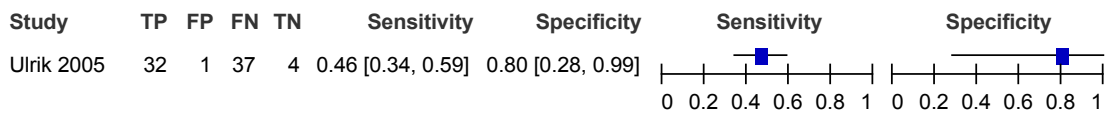
3

**Figure 95: Amp%mean >12.3%**



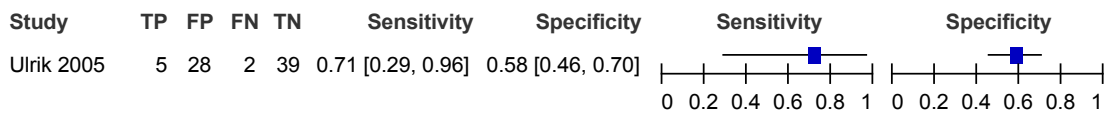
4

**Figure 96: Amp%mean >20% versus PC20 histamine >16mg/mL.**



5

**Figure 97: Amp%mean >20% versus bronchodilator reversibility change in FEV1 >10%.**



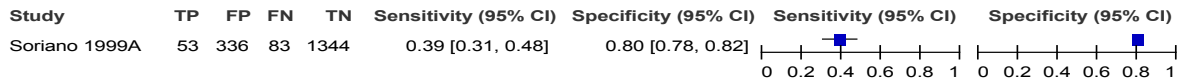
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1 **J.8 Diagnosis: Skin prick tests**

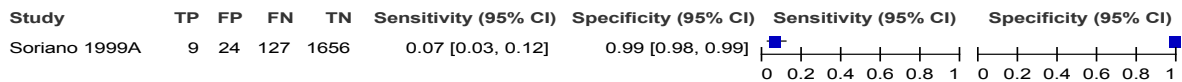
2 **J.8.1.1 Skin prick tests vs. Physician Dx with objective test: ADULTS**

**Figure 98: D. pteronyssinus (Der P) +/- D. farinae (house dust mite)**



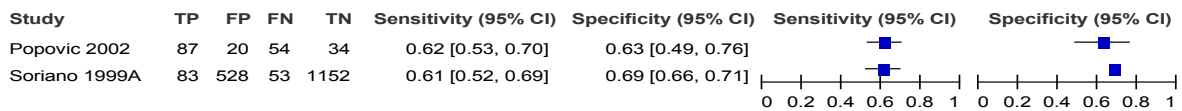
3

**Figure 99: Alternaria temius (mould)**



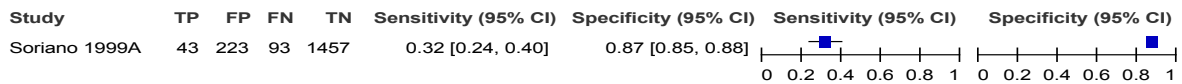
4

**Figure 100: ≥1 positive from mixed allergens (mite and grass, plus ≥1 more of weed, tree, dust, cat, dog, feathers, mould, egg, milk)**



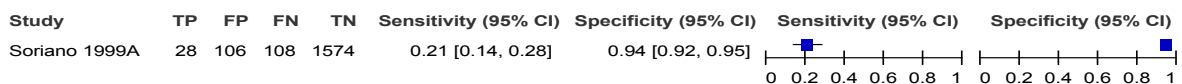
5

**Figure 101: Grasses mixed or timothy only**



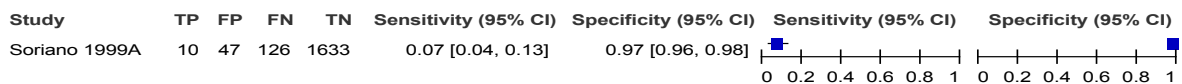
6

**Figure 102: Cat**



7

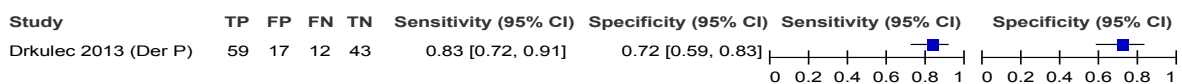
**Figure 103: Cladosporium**



8

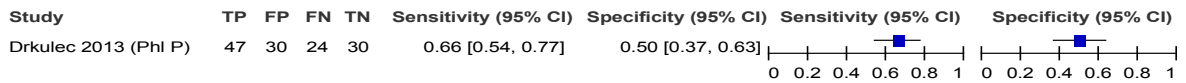
9 **J.8.1.2 Skin prick tests vs. Physician Dx with objective test: CHILDREN 5-16 years**

**Figure 104: D. pteronyssinus (Der P) +/- D. farinae (house dust mite)**



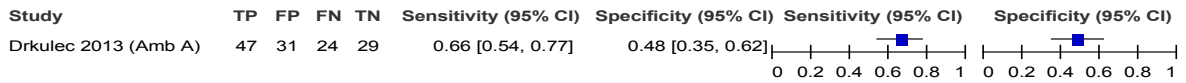
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**Figure 105: Phleum pratense (Phl P) timothy grass from Gramineae family**



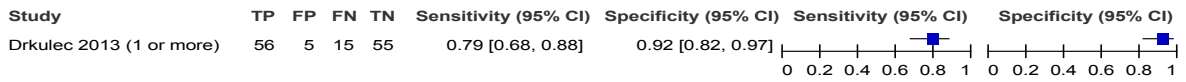
1

**Figure 106: Ambrosia artemisifoliae (Amb A) common ragweed**



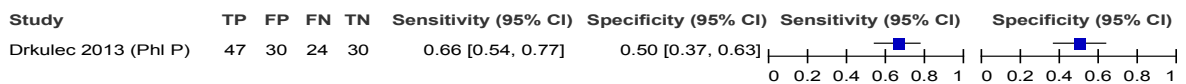
2

**Figure 107: ≥1 positive from mixed allergens (mite and grass, plus ≥1 more of weed, tree, dust, cat, dog, feathers, mould, egg, milk)**



3

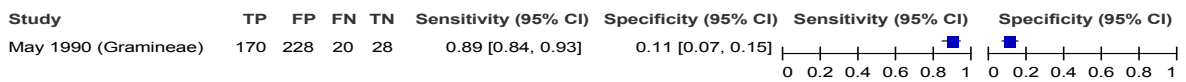
**Figure 108: Grasses mixed or timothy only**



4

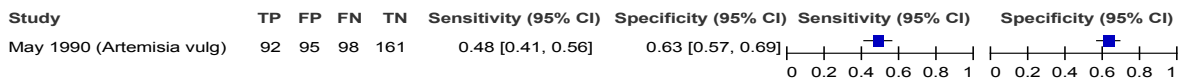
5 **J.8.1.3 Skin prick tests vs. Physician Dx *without* objective test: ADULTS**

**Figure 109: Gramineae (grasses) both wild and cultivated**



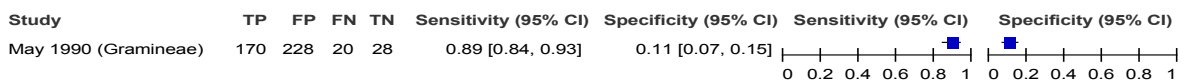
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**Figure 110: Artemisia vulgaris (mugwort)**



7

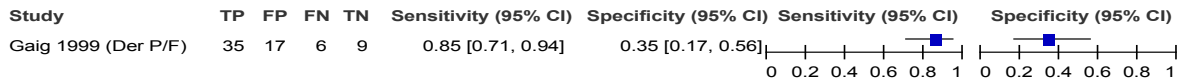
**Figure 111: Grasses mixed or timothy only .**



8

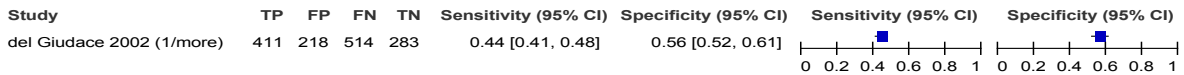
1 J.8.1.4 Skin prick tests vs. Physician Dx *without* objective test: CHILDREN 5-16 years

Figure 112: D. pteronyssinus (Der P) +/- D. farinae (house dust mite)



2

Figure 113: ≥1 positive from mixed allergens (mite and grass, plus ≥1 more of weed, tree, dust, cat, dog, feathers, mould, egg, milk ).



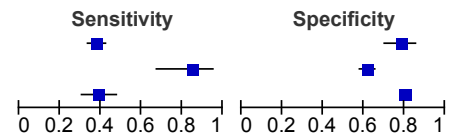
3 J.9 Diagnosis: IgE

4 J.9.1.1 Adults: IgE vs. Physician Dx

Figure 114: DUST MITE specific IgE

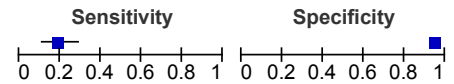
Dust mite IgE vs Physician (≥0.35 cut-off)

Study	TP	FP	FN	TN	Sensitivity	Specificity
Abraham 2007	187	27	306	97	0.38 [0.34, 0.42]	0.78 [0.70, 0.85]
Linneberg 2006	27	260	5	417	0.84 [0.67, 0.95]	0.62 [0.58, 0.65]
Soriano 1999	53	336	83	1344	0.39 [0.31, 0.48]	0.80 [0.78, 0.82]



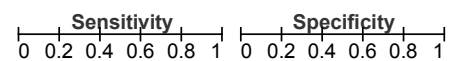
Dust mite vs. Physician Dx (≥0.70 cut-off)

Study	TP	FP	FN	TN	Sensitivity	Specificity
Plaschke 1999	16	86	68	1402	0.19 [0.11, 0.29]	0.94 [0.93, 0.95]



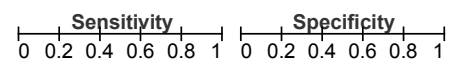
Dust mite vs. Physician Dx (≥100 cut-off)

Study	TP	FP	FN	TN	Sensitivity	Specificity
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Dust mite IgE vs. Physician Dx (unclear cut-off)

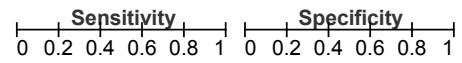
Study	TP	FP	FN	TN	Sensitivity	Specificity
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**Figure 115: BIRCH specific IgE**

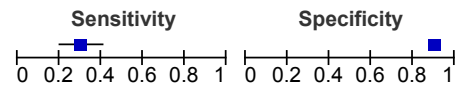
Birch IgE vs. Physician Dx ( $\geq 0.35$  cut-off)

Study TP FP FN TN Sensitivity Specificity



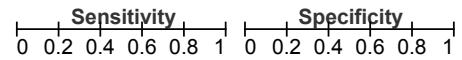
Birch IgE vs. Physician Dx ( $\geq 0.70$  cut-off)

Study	TP	FP	FN	TN	Sensitivity	Specificity
Plaschke 1999	25	155	59	1333	0.30 [0.20, 0.41]	0.90 [0.88, 0.91]



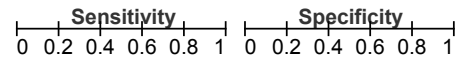
Birch IgE vs. Physician Dx ( $\geq 100$  cut-off)

Study TP FP FN TN Sensitivity Specificity



Birch IgE vs. Physician Dx (unclear cut-off)

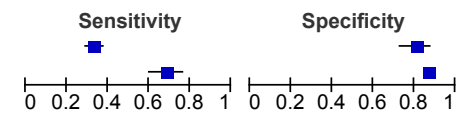
Study TP FP FN TN Sensitivity Specificity



**Figure 116: GRASSspecific IgE**

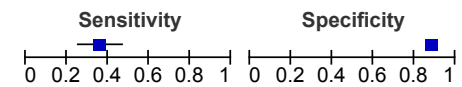
Grass IgE vs. Physician Dx ( $\geq 0.35$  cut-off)

Study	TP	FP	FN	TN	Sensitivity	Specificity
Abraham 2007	164	24	329	100	0.33 [0.29, 0.38]	0.81 [0.73, 0.87]
Soriano 1999	93	223	43	1457	0.68 [0.60, 0.76]	0.87 [0.85, 0.88]



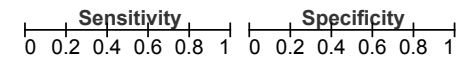
Grass IgE vs. Physician Dx ( $\geq 0.70$  cut-off)

Study	TP	FP	FN	TN	Sensitivity	Specificity
Plaschke 1999	30	187	54	1301	0.36 [0.26, 0.47]	0.87 [0.86, 0.89]



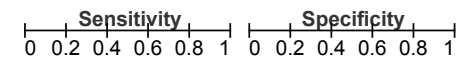
Grass IgE vs. Physician Dx ( $\geq 100$  cut-off)

Study TP FP FN TN Sensitivity Specificity



Grass IgE vs. Physician Dx (unclear cut-off)

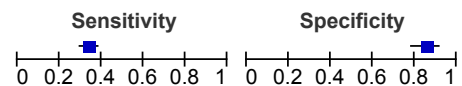
Study TP FP FN TN Sensitivity Specificity



**Figure 117: ALTERNARIAspecific IgE**

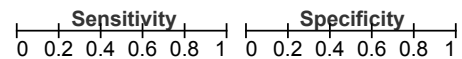
Alternaria IgE vs. Physician Dx ( $\geq 0.35$  cut-off)

Study	TP	FP	FN	TN	Sensitivity	Specificity
Abraham 2007	167	18	326	106	0.34 [0.30, 0.38]	0.85 [0.78, 0.91]



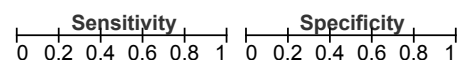
Alternaria IgE vs. Physician Dx ( $\geq 0.70$  cut-off)

Study TP FP FN TN Sensitivity Specificity



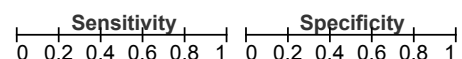
Alternaria IgE vs. Physician Dx ( $\geq 100$  cut-off)

Study TP FP FN TN Sensitivity Specificity



Alternaria IgE vs. Physician Dx (unclear cut-off)

Study TP FP FN TN Sensitivity Specificity



**Figure 118: CLADOSPORIUM specific IgE**

Cladosporium IgE vs. Physician Dx ( $\geq 0.35$  cut-off)

Study	TP	FP	FN	TN	Sensitivity	Specificity	Sensitivity	Specificity
Soriano 1999	10	47	126	1633	0.07 [0.04, 0.13]	0.97 [0.96, 0.98]		

Cladosporium IgE vs. Physician Dx ( $\geq 0.70$  cut-off)

Study	TP	FP	FN	TN	Sensitivity	Specificity	Sensitivity	Specificity
Plaschke 1999	3	15	81	1473	0.04 [0.01, 0.10]	0.99 [0.98, 0.99]		

Cladosporium IgE vs. Physician Dx ( $\geq 100$  cut-off)

Study	TP	FP	FN	TN	Sensitivity	Specificity	Sensitivity	Specificity

Cladosporium IgE vs. Physician Dx (unclear cut-off)

Study	TP	FP	FN	TN	Sensitivity	Specificity	Sensitivity	Specificity

**Figure 119: POLLEN specific IgE**

Pollen IgE vs. Physician Dx ( $\geq 0.35$  cut-off)

Study	TP	FP	FN	TN	Sensitivity	Specificity	Sensitivity	Specificity
Linneberg 2006	49	238	2	420	0.96 [0.87, 1.00]	0.64 [0.60, 0.68]		

Pollen IgE vs. Physician Dx ( $\geq 0.70$  cut-off)

Study	TP	FP	FN	TN	Sensitivity	Specificity	Sensitivity	Specificity

Pollen IgE vs. Physician Dx ( $\geq 100$  cut-off)

Study	TP	FP	FN	TN	Sensitivity	Specificity	Sensitivity	Specificity

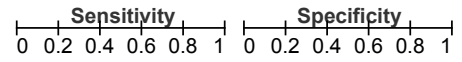
Pollen IgE vs. Physician Dx (unclear cut-off)

Study	TP	FP	FN	TN	Sensitivity	Specificity	Sensitivity	Specificity

**Figure 120: TOTAL IgE**

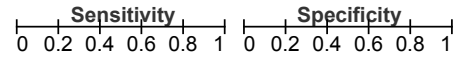
Total IgE vs. Physician Dx ( $\geq 0.35$  cut-off)

Study TP FP FN TN Sensitivity Specificity



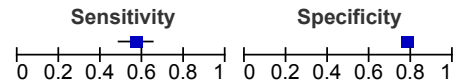
Total IgE vs. Physician Dx ( $\geq 0.70$  cut-off)

Study TP FP FN TN Sensitivity Specificity



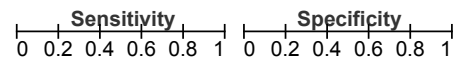
Total IgE vs. Physician Dx ( $\geq 100$  cut-off)

Study TP FP FN TN Sensitivity Specificity  
Tschoop 1998 87 1807 66 6309 0.57 [0.49, 0.65] 0.78 [0.77, 0.79]



Total IgE vs. Physician Dx (unclear cut-off)

Study TP FP FN TN Sensitivity Specificity

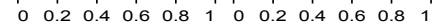


1

**Figure 121: Cat IgE**

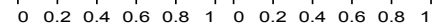
Cat IgE vs. Physiican Dx ( $\geq 0.35$  cut-off)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Abraham 2007	49	60	75	433	0.40 [0.31, 0.49]	0.88 [0.85, 0.91]		
Soriano 1999	27	106	109	1574	0.20 [0.14, 0.28]	0.94 [0.92, 0.95]		



Cat IgE vs. Physician Dx ( $\geq 0.70$  cut-off)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Plaschke 1999	34	140	50	1348	0.40 [0.30, 0.52]	0.91 [0.89, 0.92]		



2

3

**Figure 122: Dog IgE**

Dog IgE vs. Physician Dx ( $\geq 0.35$  cut-off)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Abraham 2007	42	61	82	432	0.34 [0.26, 0.43]	0.88 [0.84, 0.90]		



Dog IgE vs. Physician Dx ( $\geq 0.70$  cut-off)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)



4

5

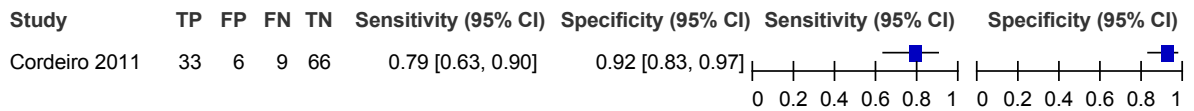
1 **J.10 Diagnosis: FeNO**

2 **J.10.1.1 Coupled sensitivity / specificity forest plots and ROC curves**

3 **Forest plots: FeNO vs. Physician Dx with objective test**

4 Adults

5 **Figure 123: FeNO >27ppb**



6

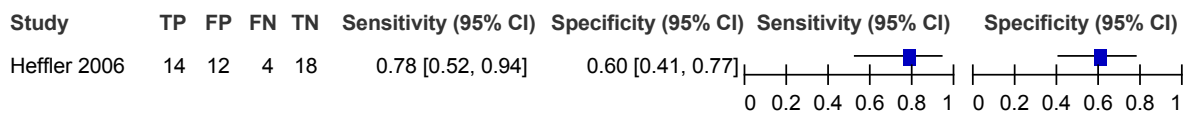
7 **ADULTS: FeNO >30ppb**

8 Voutilainen 2013. Number of TP, FP, FN and TN not provided.

9 Sensitivity: 43.0%; Specificity: 89.0%

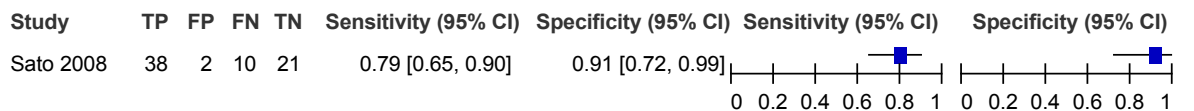
10

11 **Figure 124: FeNO >36ppb**



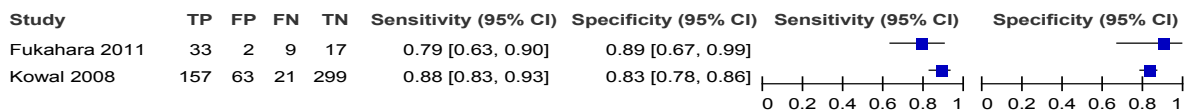
12

13 **Figure 125: FeNO >38.8ppb**



14

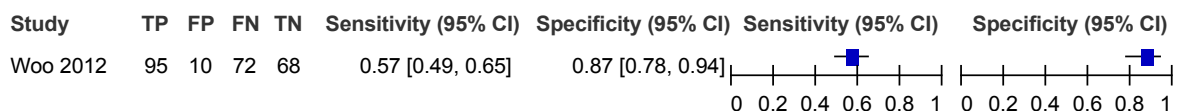
15 **Figure 126: ADULTS: FeNO >40ppb**



16

17 Children

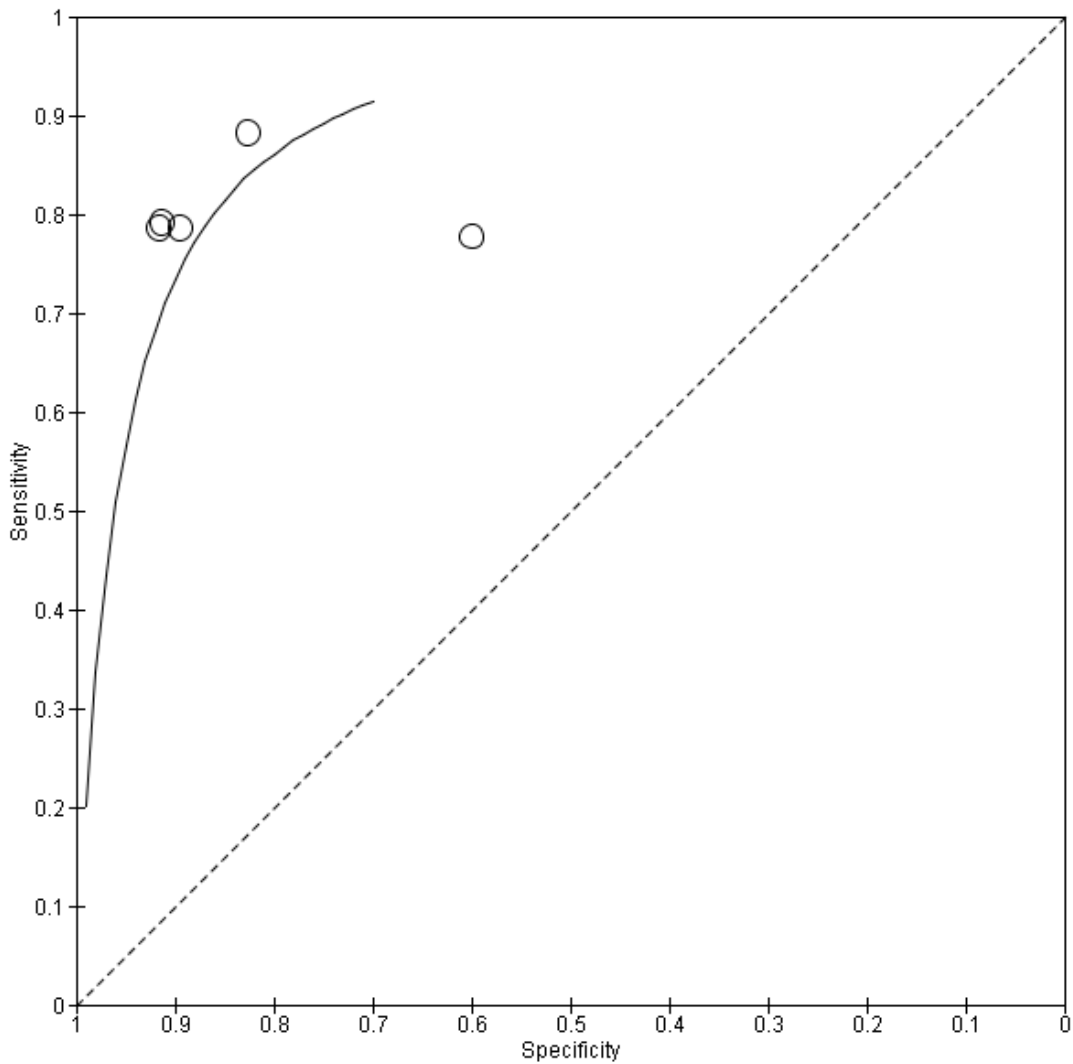
18 **Figure 127: CHILDREN: FeNO >22ppb**



19



1 **Summary ROC Curve (fitted at a variety of test thresholds, selecting one threshold per study):**  
 2 **Adults only**



3

4

5 **Forest plots: FeNO vs. other tests**

6 ADULTS:

7 **Figure 128: Adults: FeNO >30ppb versus methacholine ≤8mg/mL**

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Chatkin 1999	6	4	2	26	0.75 [0.35, 0.97]	0.87 [0.69, 0.96]		

8

## FeNO levels

**Table 204: FeNO levels – medians and means presented**

Reference	Population and mean or median FeNO levels (ppb)								
	Asthma (bronchial, allergic or non-allergic)	Chronic cough	Bronchitis	Eosinophilic bronchitis	Rhinitis	GERD	Mixed non-asthma Dx	Healthy	Cough variant asthma
BERLYNE 2000	39	-	-	65.0	-	-	-	10	-
CARDINALE 2005	22.7 (children)	-	-	-	15.3 (children)	-	-	5.9 (children)	-
CHATKIN 1999** (also c-c study)	75.0	16.7	-	-	-	-	-	28.3	-
CIPRANDI 2013^	34 (children)	-	-	-	27 children	-	-	-	-
CORDEIRO 2011**\$	44	-	-	-	21	-	17	-	-
DEYKIN 2002	57.9	-	-	-	-	-	-	26.3	-
FUKHARA 2011**	90.1	-	-	-	-	-	40.1	-	-
HEFFLER 2006**\$ (also c-c study)	59.7	-	-	-	-	-	30.4	12.2	-
KOSTIKAS 2008**£ (also c-c study)	24.0	-	-	-	17.5	-	11.0	11.0	-
KOWAL 2008** (also c-c study)	86	-	-	-	37	14.8	-	13	-
LOUHELAINEN 2008A	35.5 (children) 81.8 (adult)	- -	- -	-	-	-	-	11.9 (children) 16.6 (adult)	-
SATO 2008**	93.5	-	16.4	-	-	-	21.2	-	-
SHIMODA 2013	92.6	-	-	-	-	-	-	18.0	35.6
SHOME 2006	24.8	-	-	-	-	-	-	5.9	-
WOO 2012**	23.4 (children)	-	-	-	-	-	12.6 (children)	-	-
VOUTILAINEN 2013**\$	29.7	-	-	-	-	-	14.6	-	-
ZIETKOWSKI 2006A	64.9	-	-	-	-	-	-	12.9	-

Reference	Population and mean or median FeNO levels (ppb)								
	Asthma (bronchial, allergic or non-allergic)	Chronic cough	Bronchitis	Eosinophilic bronchitis	Rhinitis	GERD	Mixed non-asthma Dx	Healthy	Cough variant asthma
<b>MEDIAN (range) ALL</b>	50.95 (22.7-93.5)	16.7	16.4	65.0	21.0 (15.3-37.0)	14.8	17.0 (11.0-40.1)	12.6 (5.9-28.3)	35.6
<b>MEDIAN (range) Adults/mixed</b>	62.3 (24.0-93.5)	16.7	16.4	65.0	27 (17.5-37)	14.8	19.1 (11.0-40.1)	13.0 (5.9-28.3)	35.6
<b>MEDIAN (range) Children only</b>	28.7 (22.7-35.5)	-	-	-	21.2 (15.3-27)	-	12.6	8.9 (5.9-11.9)	-

- (a)** \*\* is a sens/spec study
- (b)** ^all patients have allergy (positive skin prick test)
- (c)** \$ mixed population of adults and children
- (d)** £ excluding smokers

## 1 J.11 Diagnosis: Eosinophils

### 2 J.11.1.1 ADULTS: PBE vs. Physician Dx

#### Figure 129: PBE ≥4.15%

TILEMANN 2011: 2x2 table not reported. Sensitivity 36%, specificity 83%

#### Figure 130: PBE cut-off not reported

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
POPOVIC 2002	21	33	120	21	0.15 [0.09, 0.22]	0.39 [0.26, 0.53]		

### 3 J.11.1.2 Children 5-16 years: PBE vs. Physician Dx

#### Figure 131: PBE >4%

SHIELDS 1999: 2x2 table not reported. Sensitivity 62%, specificity 67%

#### Figure 132: PBE >8%

SHIELDS 1999: 2x2 table not reported. Sensitivity 38%, specificity 93%

#### Figure 133: PBE ≥0.45 x 10<sup>9</sup>/l

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
KOTANIEMI 2002	18	8	15	41	0.55 [0.36, 0.72]	0.84 [0.70, 0.93]		

### 4 J.11.1.3 PBE counts

#### 5 Table 205: Adults: PBE counts

Study	N	Counts	Units
<b>PBE counts only</b>			
BACKER 2002	624 (N=103 asthma)	Non-asthma: <b>0.19</b> Asthma: <b>0.26</b>	x10 <sup>9</sup> /L
HALVANI 2012	98 (N=61 asthma)	Healthy: <b>0.21</b> Asthma ICS: <b>0.40</b> Asthma no ICS: <b>0.52</b>	x10 <sup>9</sup> /L
HUNTER 2002	110 (N=89 asthma)	Healthy: <b>1.9</b> Pseudoasthma: <b>2.0</b> Asthma: <b>4.3</b>	%
KHAKZAD 2009	62 (N=50 asthma)	Healthy: <b>1.2</b> All asthma: <b>1.0</b> Mild intermittent: <b>2.0</b> Mild persistent: <b>3.6</b> Moderate persistent: <b>3.2</b> Severe: <b>3.2</b>	%
KROEGEL 1998	56 (N=14 asthma)	Healthy: <b>0.10</b> Bronchiectasis: <b>0.10</b>	x10 <sup>9</sup> /L median

Study	N	Counts	Units
		COPD: <b>0.12</b> Allergic asthma: <b>0.31</b>	
METSO 2000	190 (N=160 asthma)	Healthy: <b>0.13</b> Pre-Tx 1: <b>0.11</b> Pre-Tx 2: <b>0.14</b> Pre-Tx 3: <b>0.12</b>	x10 <sup>9</sup> /L
RYTILA 2000	68 (N=25 asthma)	Healthy: <b>0.11</b> Symptomatic: <b>0.17</b> All asthma: <b>0.41</b> Atopic asthma: <b>0.51</b> Non-atopic asthma: <b>0.27</b>	x10 <sup>9</sup> /L
TOMASIAKLOZOWS KA 2012	110 (N=91 asthma)	Healthy: <b>32.0</b> A stable – no ICS: <b>29.5</b> A stable - ICS: <b>42.4</b> A unstable – ICS: <b>49.8</b>	cells/mm <sup>3</sup>
ZIETKOWSKI 2006A	140 (N=101 asthma)	Healthy: <b>119</b> A allergic: <b>247</b> A non-allergic: <b>211</b>	cells/mm <sup>3</sup>
<b>Median (range)</b>	<b>Asthma</b>	<b>0.29 (0.10 - 0.52)</b> <b>3.2 (2.0 – 4.3)</b>	<b>x10<sup>9</sup>/L</b> <b>%</b>
	<b>Non-asthma**</b>	<b>0.13 (0.10 – 0.21)</b> <b>1.9 (1.2 – 2.0)</b>	<b>x10<sup>9</sup>/L</b> <b>%</b>
<b>Median (range)</b>	<b>A – allergic</b>	<b>0.41 (0.31 – 0.51)</b>	<b>x10<sup>9</sup>/L</b>
	<b>A – non allergic</b>	<b>0.27 (0.27)</b>	<b>x10<sup>9</sup>/L</b>
<b>Other results:</b>	<ul style="list-style-type: none"> <li>• 1 study showed that &gt;50% of pts had PBE count &gt;0.45 x10<sup>9</sup>/L.</li> <li>• 2 studies showed that patients with asthma had higher PBE counts (cells/mm<sup>3</sup>) than healthy controls (although stable asthma without ICS Tx was similar to healthy controls in 1 study).</li> <li>• 1 study showed that patients with allergic asthma had higher PBE counts (cells/mm<sup>3</sup>) than patients with non-allergic asthma.</li> <li>• 1 study showed that patients with asthma treated with ICS had higher PBE counts (cells/mm<sup>3</sup>) than patients with asthma not treated with ICS (regardless of whether the asthma was stable or unstable).</li> </ul>		

1 ICS = inhaled corticosteroid; A = allergic; Tx = treatment. \*where applicable, all units have been converted into x10<sup>9</sup>/L as  
2 these are the standard units used in current UK clinical practice. \*\*this includes healthy controls

3

4 **Table 206: Children 5-16 years: PBE counts**

Study	N	Counts	Units*	
<b>PBE counts only</b>				
LABBE 2001	143 (N=88 asthma)	Healthy: <b>0.25</b> Chronic cough: <b>0.21</b> Asthma: <b>0.40</b>	x10 <sup>9</sup> /L	Children (mean 7 yrs)

Study	N	Counts	Units*	
NORDLUND 2012	39	Asthma (mild/mod): <b>0.25</b>	x10 <sup>9</sup> /L	Children (mean 14 yrs)
SILVESTRI 2001A	112	Allergic: <b>500, 7.5%</b> Non-allergic: <b>125, 2.5%</b>	Cells/mm <sup>3</sup> and %	Children (mean 11 yrs)
SILVESTRI 2003	92	All: <b>5.5%</b> Atopic: <b>6.7%</b> Non-atopic: <b>3.0%</b>	%	Children (mean 11 yrs)
TUCHINDA 1987	1000	0 – 500 = <b>40%</b> 501-1000 = <b>29%</b> 1001-1500 = <b>16%</b> 1501-2000 = <b>9%</b> >2000 = <b>7%</b>	Cells/mm <sup>3</sup>	Children <13 years (mean not reported)
VILA-INDURAIN 1999	57 (N=36 asthma)	• Healthy: <b>161</b> • Asthma (norm FEV <sub>1</sub> ): <b>509</b> • Asthma (< norm FEV <sub>1</sub> , norm with SABA): <b>397</b> • Asthma (< norm FEV <sub>1</sub> , not norm with SABA): <b>319</b>	Cells/mm <sup>3</sup>	Children (8-18 yrs, mean not reported)
<b>Mean (range)</b>	<b>Asthma</b>	<b>0.33 (0.25 – 0.40)</b>	<b>x10<sup>9</sup>/L</b>	
	<b>Non-asthma**</b>	<b>5.5 (5.5)</b>	<b>%</b>	
		<b>0.23 (0.21 – 0.25)</b>	<b>x10<sup>9</sup>/L</b>	
		<b>-</b>	<b>%</b>	
	<b>A – allergic</b>	<b>-</b>	<b>x10<sup>9</sup>/L</b>	
		<b>7.1 (6.7 – 7.5)</b>	<b>%</b>	
	<b>A - nonallergic</b>	<b>-</b>	<b>x10<sup>9</sup>/L</b>	
		<b>2.8 (2.5 – 3.0)</b>	<b>%</b>	
<b>Other results:</b>	<ul style="list-style-type: none"> <li>• 1 study showed that the % of pts decreased with increasing PBE cell counts (0-500 cells/mm<sup>3</sup> had the most pts, with &gt;2000 cells/mm<sup>3</sup> having the least).</li> <li>• 1 study showed that patients with asthma had higher PBE counts (cells/mm<sup>3</sup>) than healthy controls</li> <li>• 1 study showed that patients with allergic asthma had higher PBE counts (cells/mm<sup>3</sup>) than patients with non-allergic asthma</li> <li>• 1 study showed that patients with asthma with a normal FEV<sub>1</sub> had higher PBE counts (cells/mm<sup>3</sup>) than patients with asthma with &lt;normal FEV<sub>1</sub> (regardless of whether the FEV<sub>1</sub> normalised with SABA).</li> </ul>			

SABA = short-acting beta-agonists; \*where applicable, all units have been converted into x10<sup>9</sup>/L as these are the standard units used in current UK clinical practice. \*\*this includes healthy controls

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**Table 207: Children <5 years: PBE counts**

Study	N	Counts	Units	
<b>PBE counts only</b>				
PIIPPOSAVOLLAINE N 2007	83	Asthma: 0.1	10 <sup>9</sup> /L	Children (<2 yrs, mean not reported)

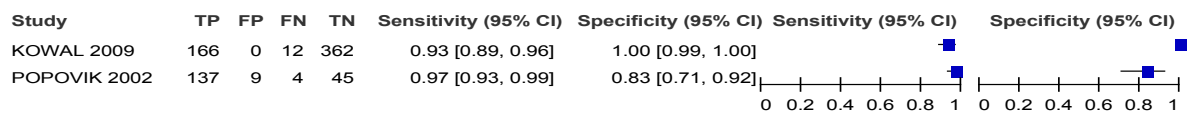
Study	N	Counts	Units
Median		Asthma 0.1	10 <sup>9</sup> /L
Range of means		Asthma 0.1	10 <sup>9</sup> /L

## 1 J.12 Diagnosis: Histamine and methacholine challenge tests

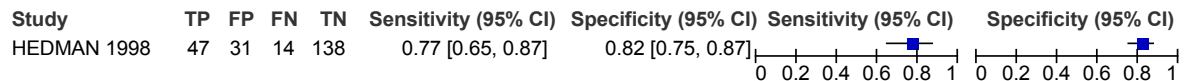
### 2 J.12.1.1 Coupled sensitivity / specificity forest plots and ROC curves

#### 3 Adults: Methacholine/Histamine Challenge Tests vs Reference Standard

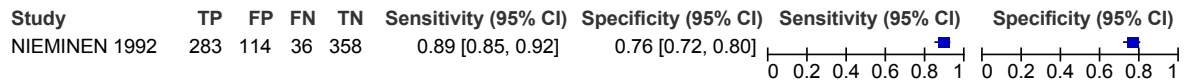
**Figure 134: PC20 ≤8mg/ml**



**Figure 135: PD20 ≤6900µg**



**Figure 136: PD20 ≤2600µg**



4

#### Children: Methacholine/Histamine Challenge Tests vs Reference Standard

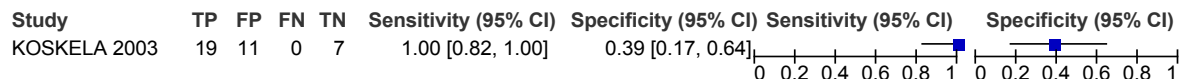
**Figure 137: Age <18 yrs- PC20 ≤16mg/ml**

Data unsuitable for RevMan:

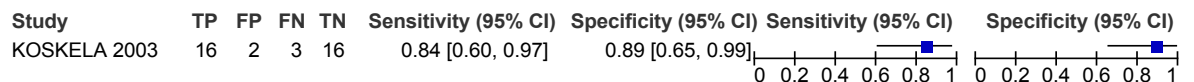
ANDERSON 2009 (n=115; MCT cut-off 16mg/ml): Sensitivity 66.2%; Specificity = 62.9%

#### Methacholine/Histamine Challenge Tests vs Other Tests

**Figure 138: Histamine Challenge Test vs Mannitol (adults)- PD15≤1mg**



**Figure 139: Histamine Challenge Test vs Mannitol (adults) - PD15≤0.4mg**



**Figure 140: Histamine Challenge Test vs Mannitol (<18 yrs)**

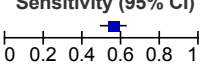
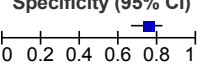
1 No data found on sensitivity or specificity

2 **J.13 Diagnosis: Mannitol challenge test**

3 **J.13.1.1 Coupled sensitivity / specificity forest plots**

4 **Mannitol Challenge Test vs Reference Standard**

**Figure 141: Mannitol Challenge Test vs Reference Standard (all age groups)  $\geq 15\%$  fall in FEV1  $\leq 635$ mg or 10% fall between consecutive doses**

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
ANDERSON 2009	134	34	106	101	0.56 [0.49, 0.62]	0.75 [0.67, 0.82]		

**Figure 142: Mannitol Challenge Test vs Reference Standard (<18 yrs)  $\geq 15\%$  fall in FEV1  $\leq 635$ mg or 10% fall between consecutive doses**

Data unsuitable for RevMan:

1. ANDERSON 2009: Sensitivity 63.2%; Specificity = 81.4%

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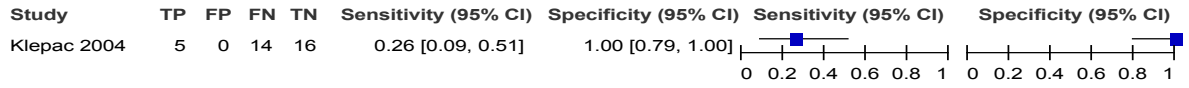


1 **J.14 Diagnosis: Exercise challenge test**

2

3 **J.14.1.1 Exercise test vs. Physician Dx: ADULTS**

**Figure 143: Exercise test  $\Delta$ FEV1  $\geq$ 10%**

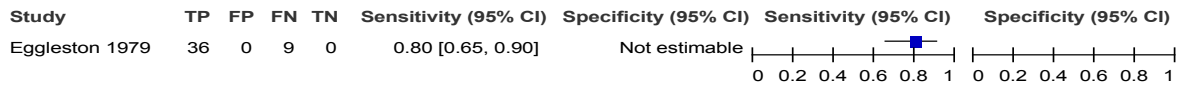


4

5 **J.14.1.2 Exercise test vs. other tests: ADULTS**

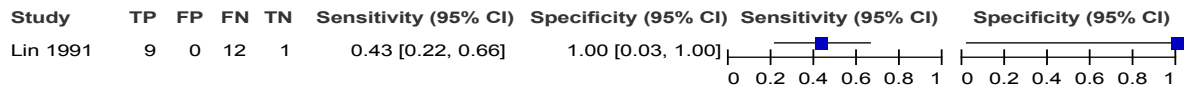
6

**Figure 144: Exercise test  $\Delta$ FEV1  $\geq$ 18% vs. methacholine**



7

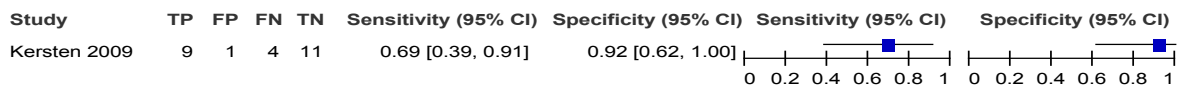
**Figure 145: Exercise test  $\Delta$ FEV1  $\geq$ 20% vs. methacholine**



8 **J.14.1.3 Exercise test vs. other tests: CHILDREN 5-16 years**

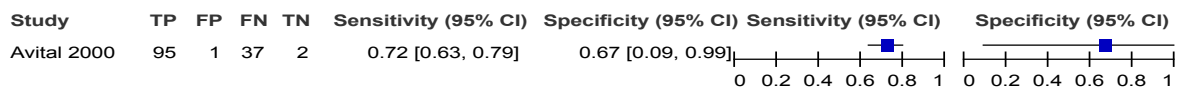
9

**Figure 146: Cold air exercise test  $\Delta$ FEV1 % init  $>$ 15% vs. mannitol  $\Delta$ FEV1 % init  $>$ 15%.**



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**Figure 147: Exercise  $\Delta$ FEV1  $\geq$ 8.2% vs. methacholine PC20  $\leq$ 8mg/mL**



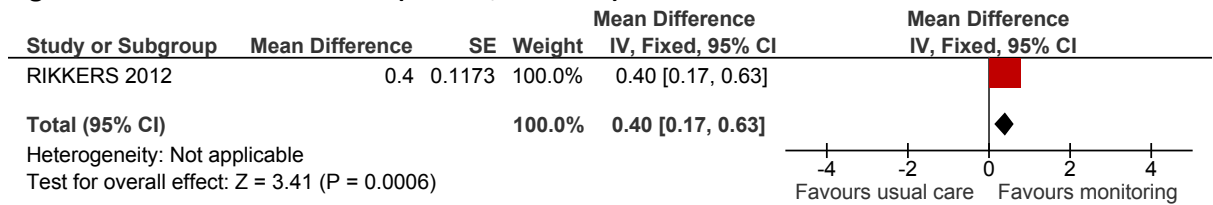
11

12

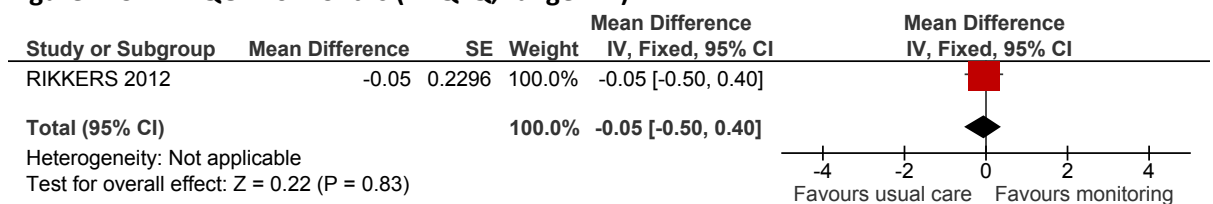
1 **J.15 Monitoring: Questionnaires**

2 **J.15.1.1 Children (5-16 years) with uncontrolled asthma: Monitoring questionnaires + treatment vs UC +**  
3 **treatment.**

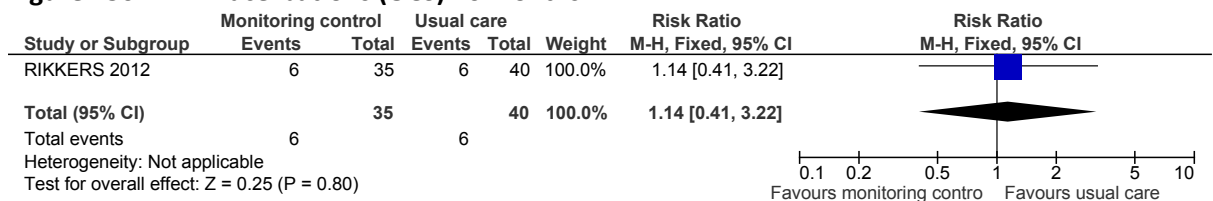
**Figure 148: QOL <6 months (PAQLQ; scale 1-7)**



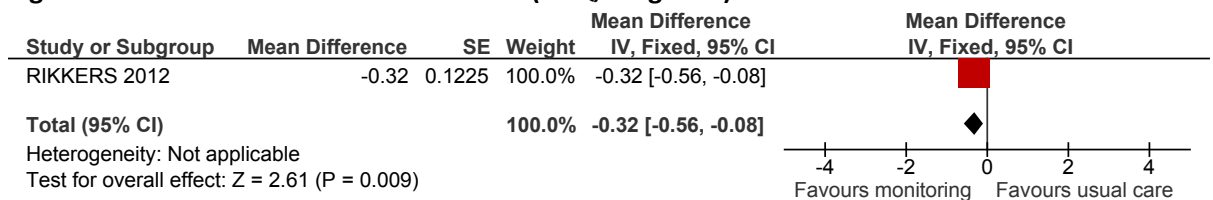
**Figure 149: QOL ≥6 months (PAQLQ; range 1-7)**



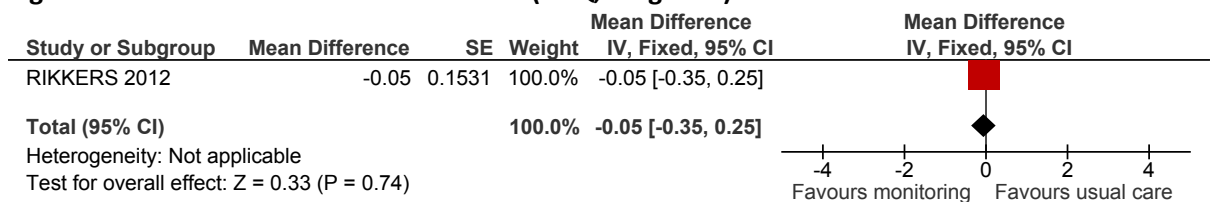
**Figure 150: Exacerbations (OCS) ≥6 months**



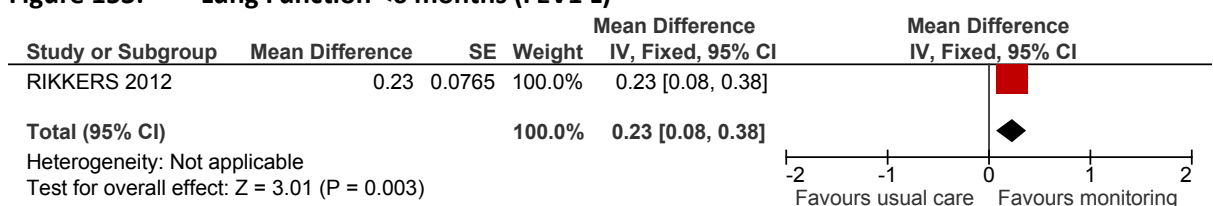
**Figure 151: Asthma control <6 months (ACQ, range 0-6)**



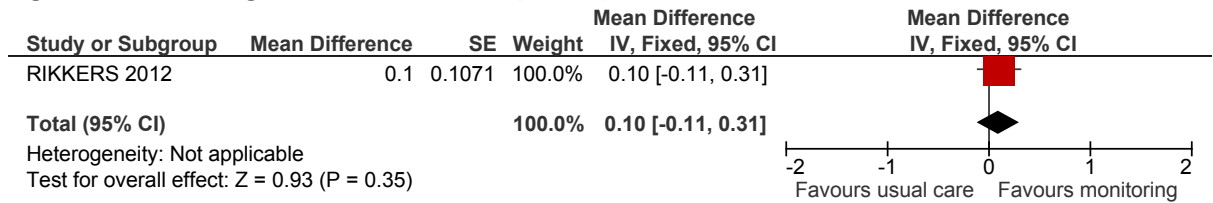
**Figure 152: Asthma control ≥6 months (ACQ, range 0-6)**



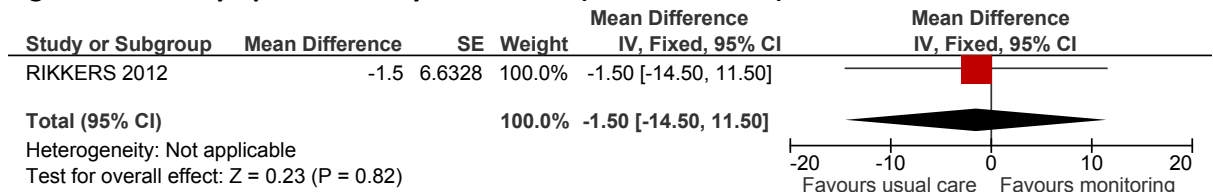
**Figure 153: Lung Function <6 months (FEV1 L)**



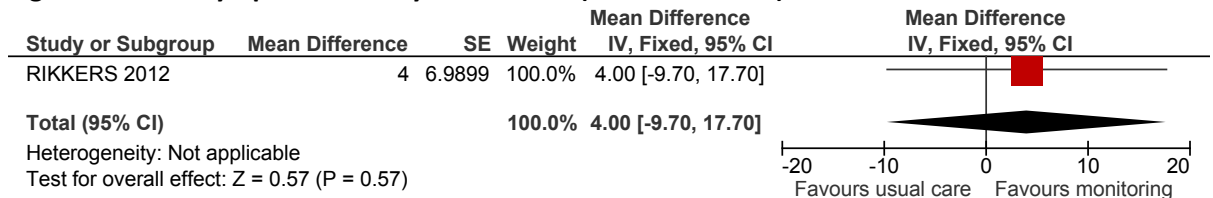
**Figure 154: Lung Function  $\geq 6$  months (FEV1 L)**



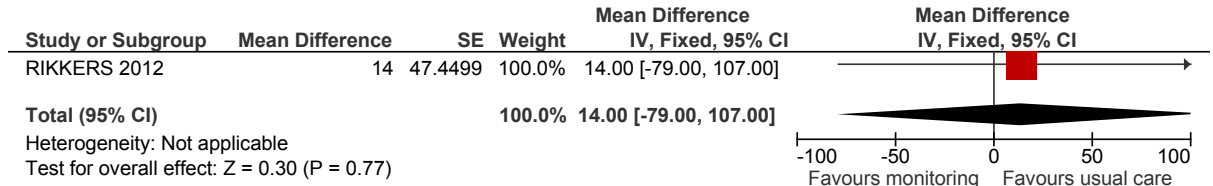
**Figure 155: Symptom free days  $< 6$  months (% over 2 weeks)**



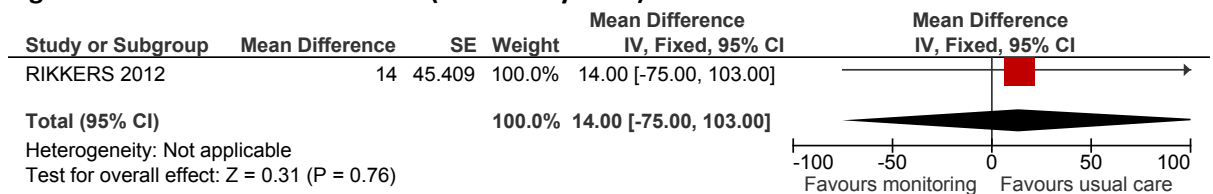
**Figure 156: Symptom free days  $\geq 6$  months (% over 2 weeks)**



**Figure 157: ICS use  $< 6$  months (mean daily dose)**



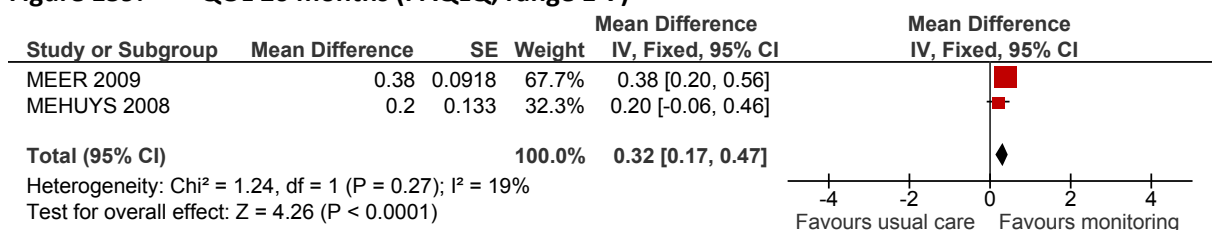
**Figure 158: ICS use  $\geq 6$  months (mean daily dose)**



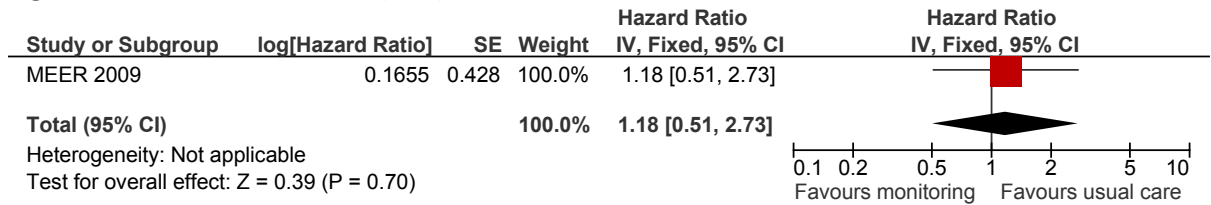
1

2 **J.15.1.2 Adults and young people ( $> 16$  years) overall: Monitoring questionnaires + treatment vs UC +**  
3 **treatment.**

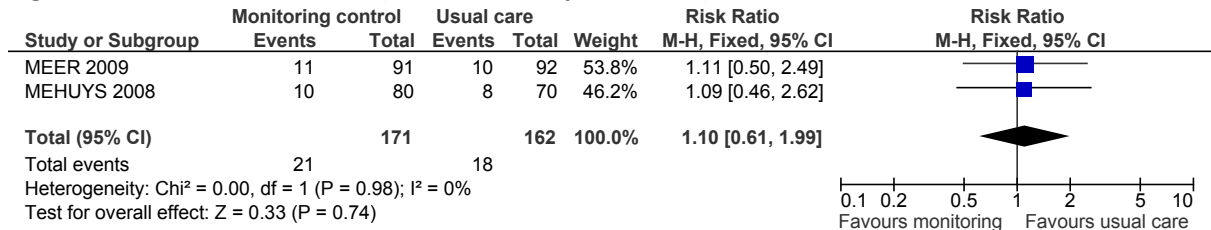
**Figure 159: QOL  $\geq 6$  months (PAQLQ; range 1-7)**



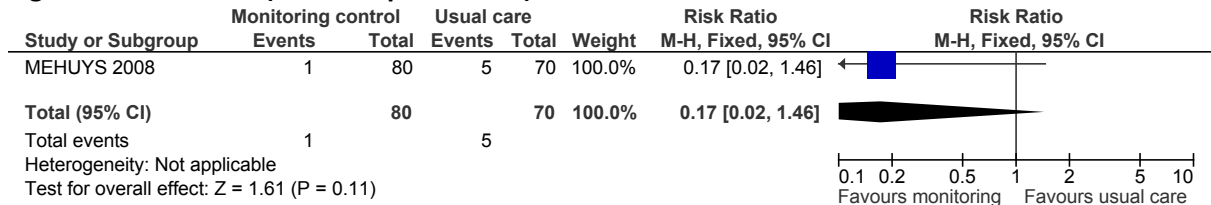
**Figure 160: Exacerbations (OCS) ≥6 months**



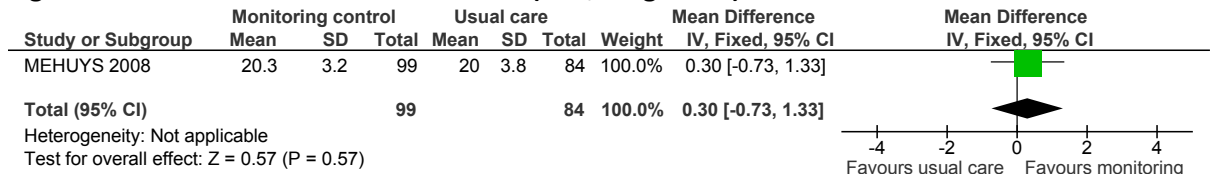
**Figure 161: Exacerbations (OCS, ER or hospitalisation) ≥6 months**



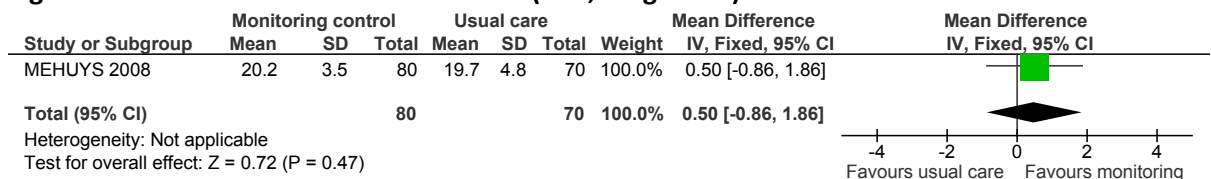
**Figure 162: UHU (ER or hospitalisation) ≥6 months**



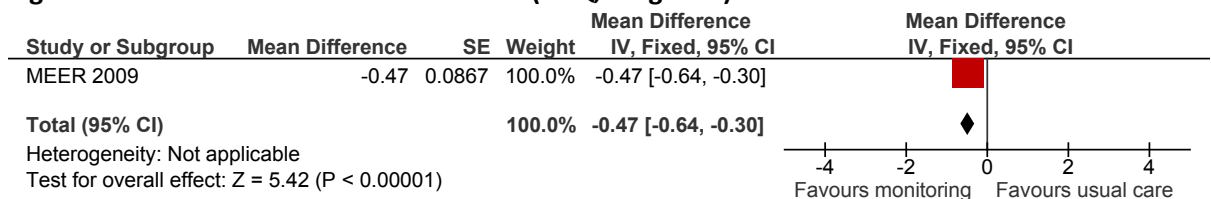
**Figure 163: Asthma control <6 months (ACT, range 5-25)**



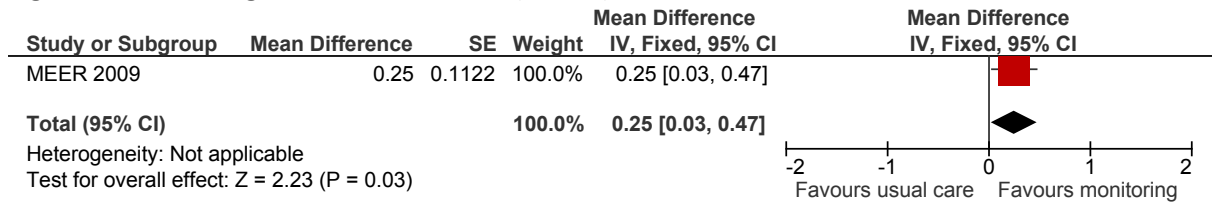
**Figure 164: Asthma control ≥6 months (ACT, range 5-25)**



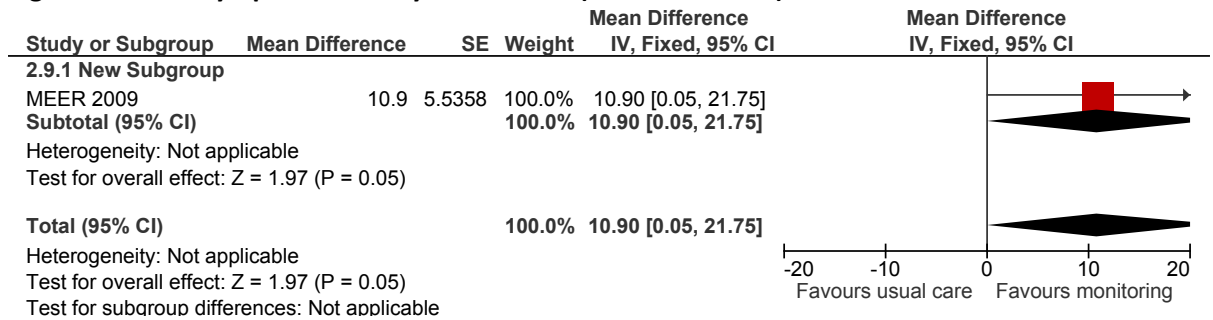
**Figure 165: Asthma control ≥6 months (ACQ, range 0-6)**



**Figure 166: Lung Function  $\geq 6$  months (FEV1 L)**

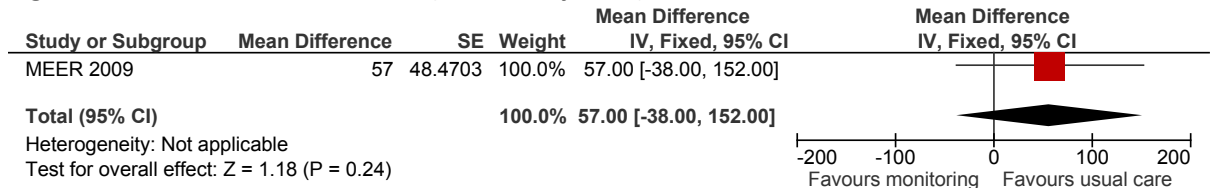


**Figure 167: Symptom free days  $\geq 6$  months (% over 2 weeks)**

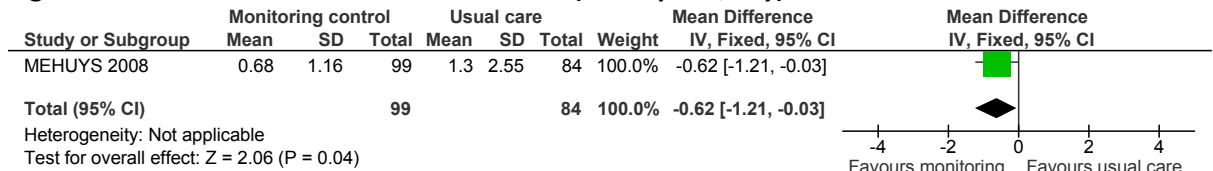


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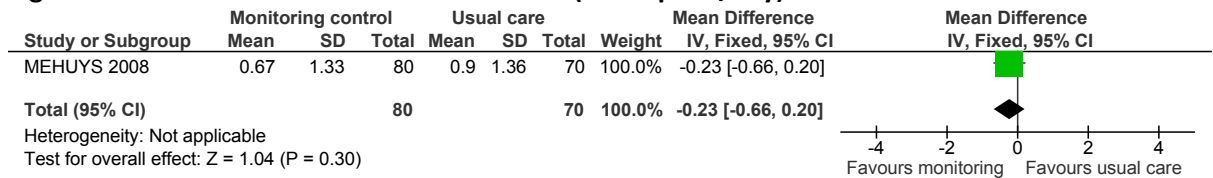
**Figure 168: ICS use  $\geq 6$  months (mean daily dose)**



**Figure 169: Rescue medication <6 months (mean puffs/day)**



**Figure 170: Rescue medication  $\geq 6$  months (mean puffs/day)**



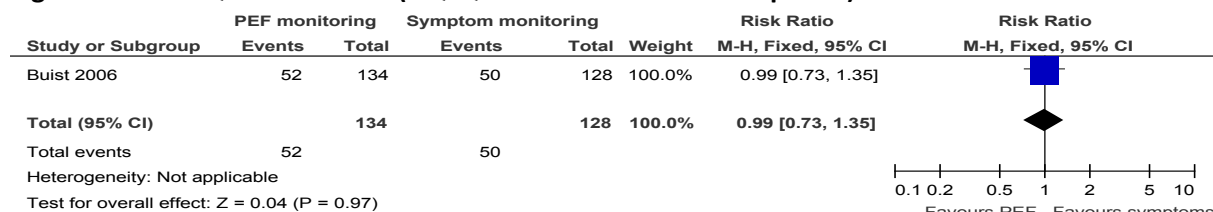
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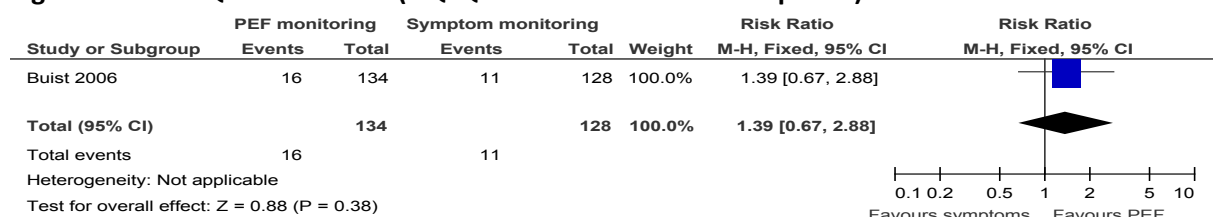
# 1 J.16 Monitoring: Lung function test

## 2 J.16.1.1 Adults: Monitoring PEF versus symptom monitoring

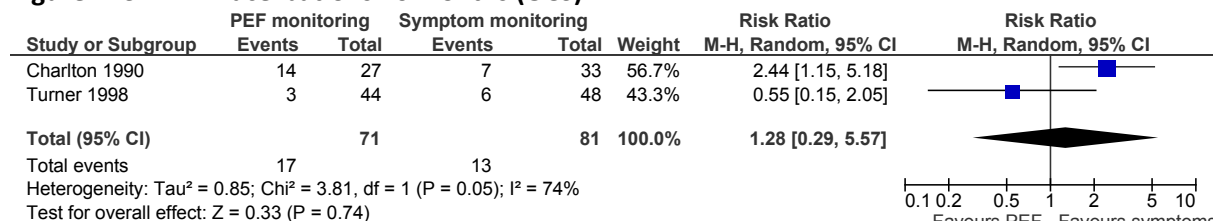
**Figure 171: QOL ≥6 months (AQLQ increase more than 0.5 points)**



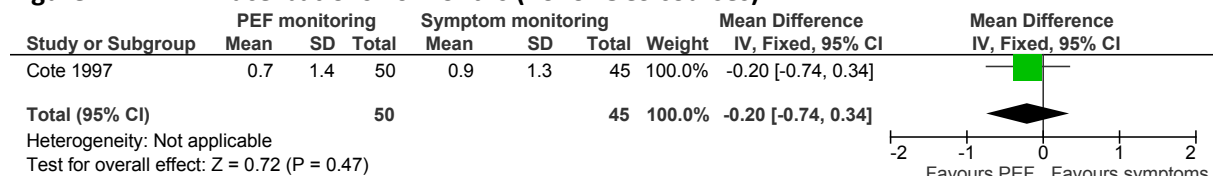
**Figure 172: QOL ≥6 months (AQLQ decrease more than 0.5 points)**



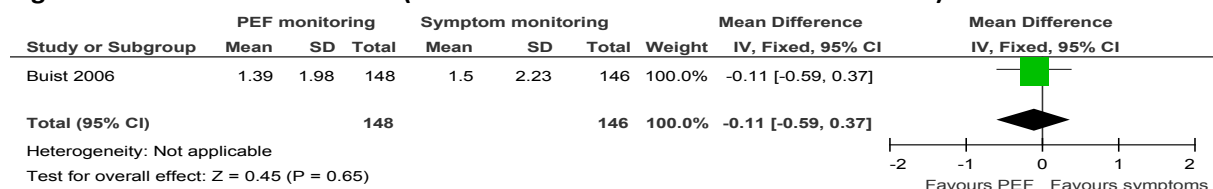
**Figure 173: Exacerbations ≥6 months (OCS)**



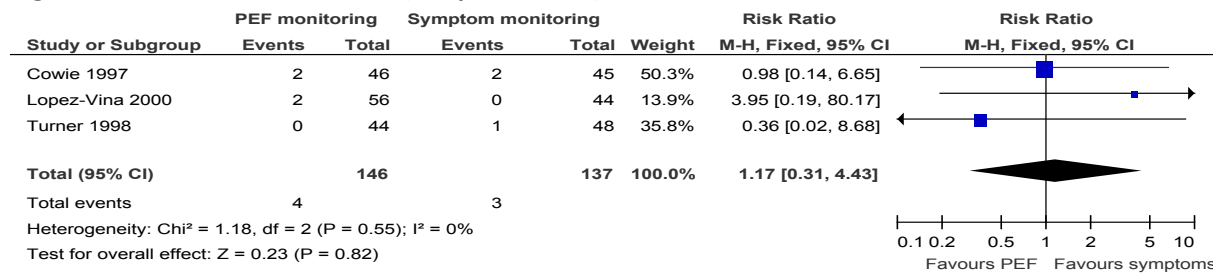
**Figure 174: Exacerbations ≥6 months (no. of OCS courses)**



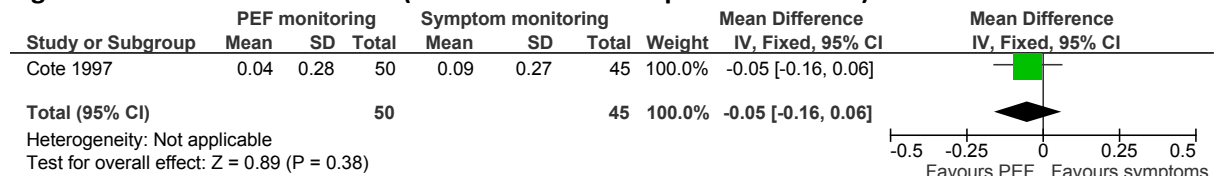
**Figure 175: UHU ≥6 months (total asthma-related health care utilisation)**



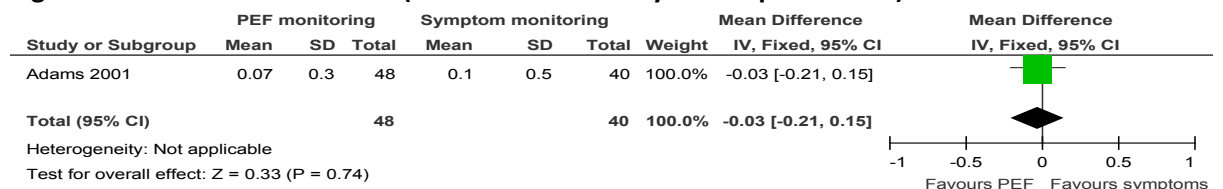
**Figure 176: UHU ≥6 months (Hospitalisation)**



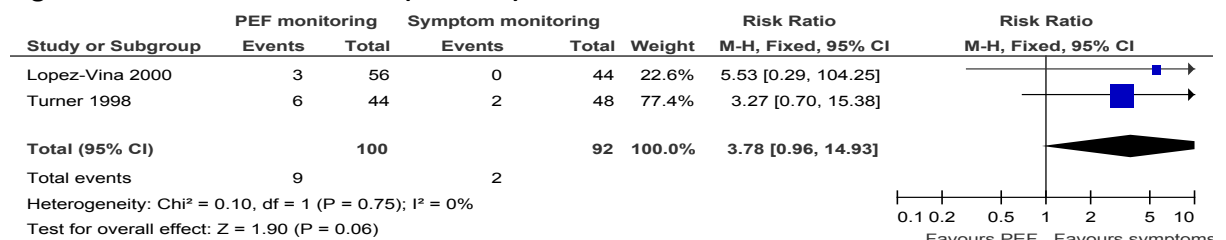
**Figure 177: UHU ≥6 months (mean number of hospital admissions)**



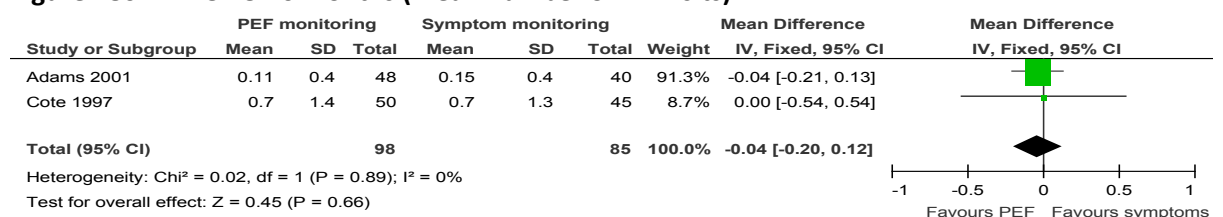
**Figure 178: UHU ≥6 months (mean number of days of hospitalisation)**



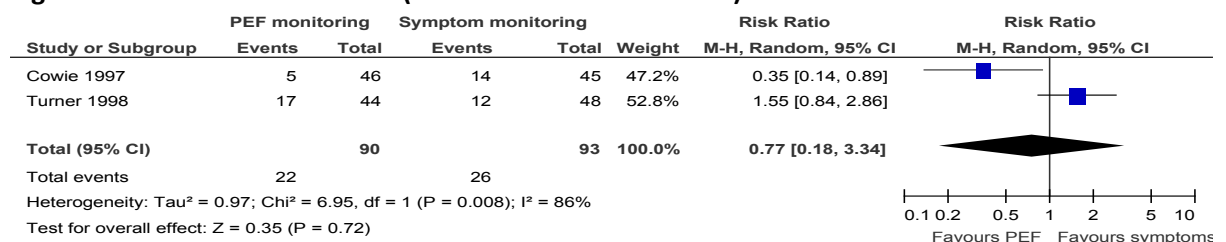
**Figure 179: UHU ≥6 months (ED visits)**



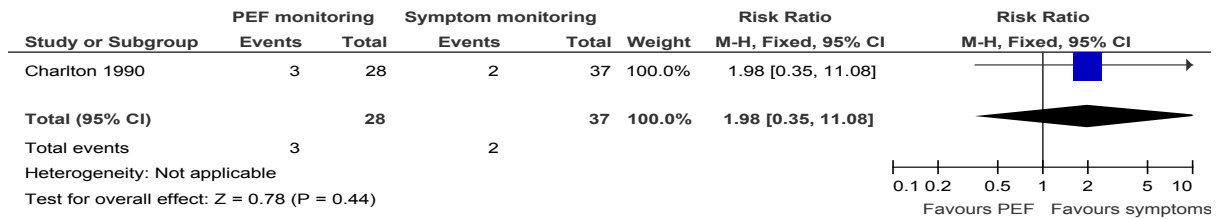
**Figure 180: UHU ≥6 months (mean number of ED visits)**



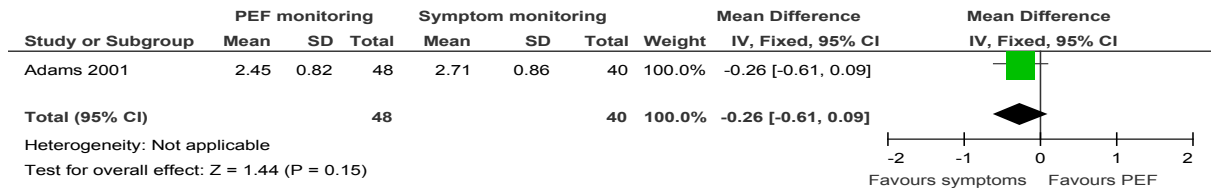
**Figure 181: UHU ≥6 months (unscheduled doctors visits)**



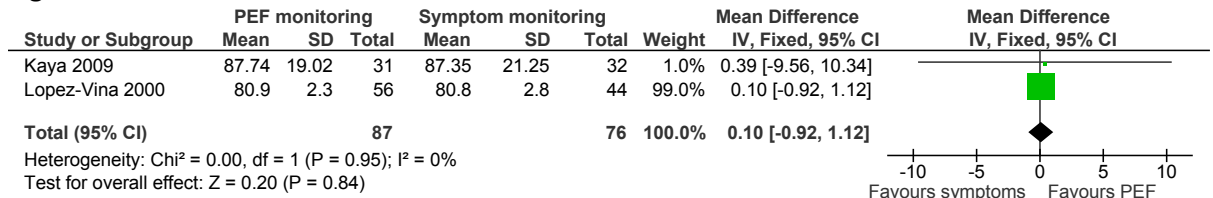
**Figure 182: Rescue medications ≥6 months (no. of patients requiring nebulised salbutamol)**



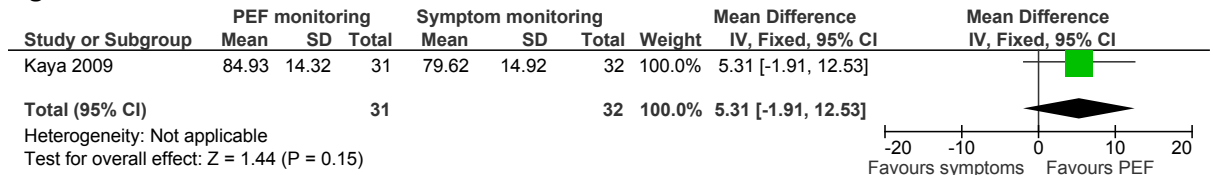
**Figure 183: FEV1 L ≥6 months**



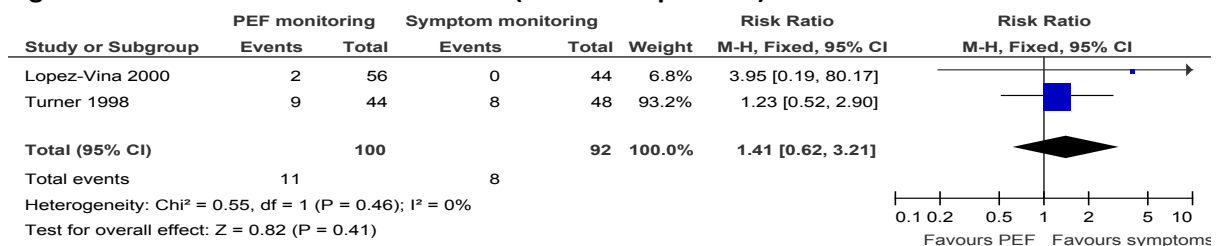
**Figure 184: FEV1 % ≥6 months**



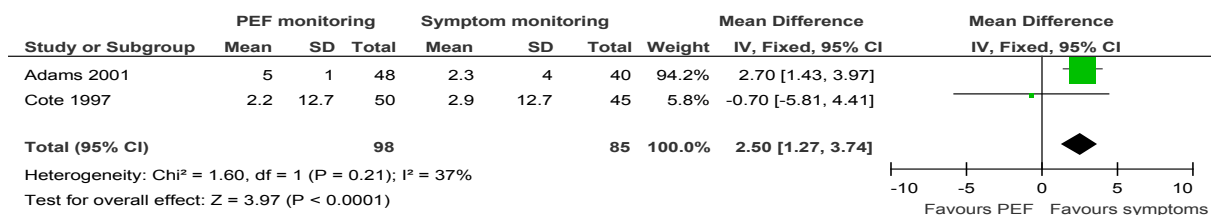
**Figure 185: PEF % ≥6 months**



**Figure 186: Time off work ≥6 months (number of patients)**



**Figure 187: Time off work ≥6 months (mean number of days)**





1 J.16.1.2 Children: Monitoring PEF versus symptom monitoring

Figure 188: Exacerbations <6 months (OCS)

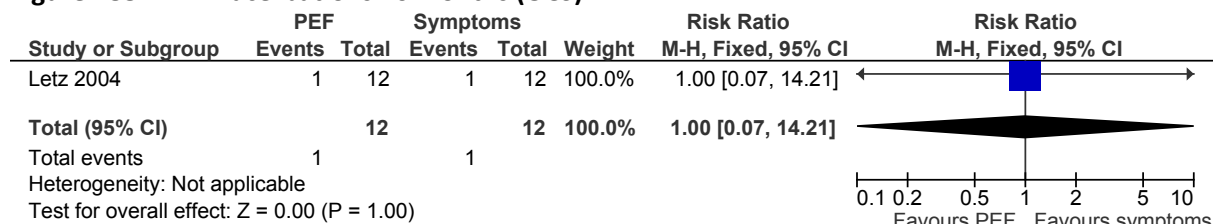


Figure 189: Exacerbations ≥6 months (OCS)

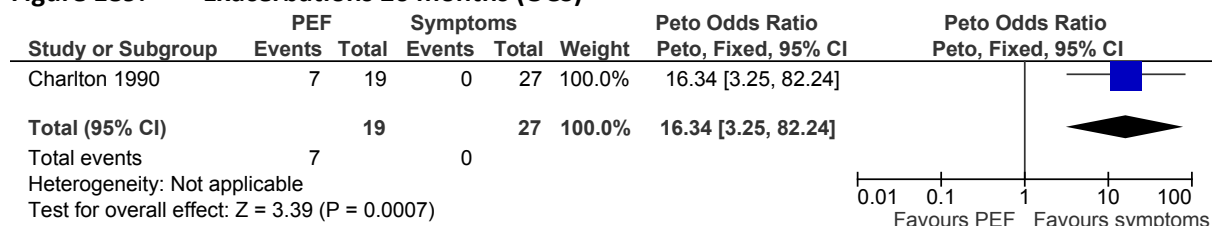


Figure 190: UHU <6 months (hospitalisation)

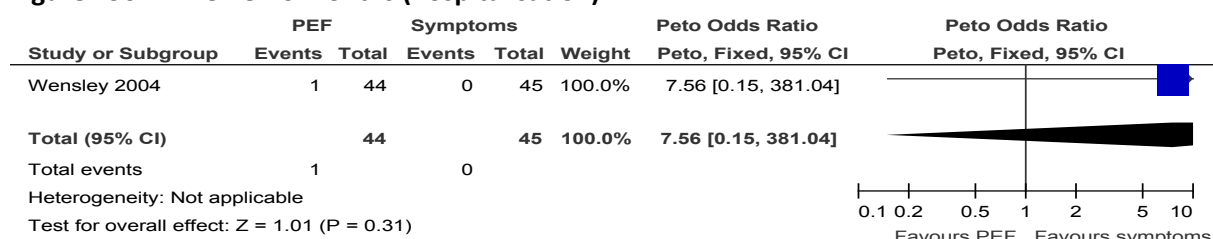


Figure 191: UHU <6 months (attendance at A&E)

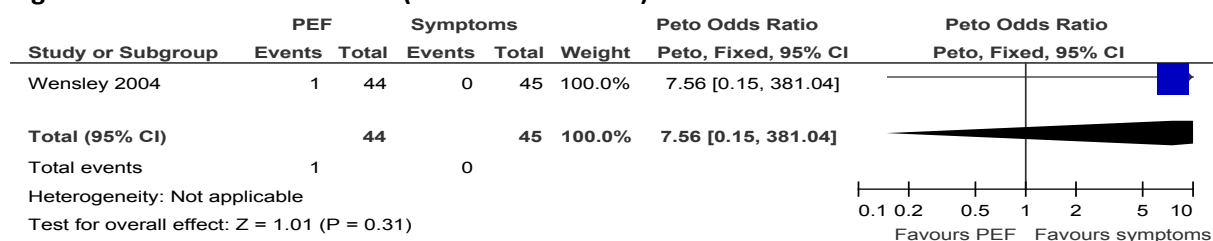
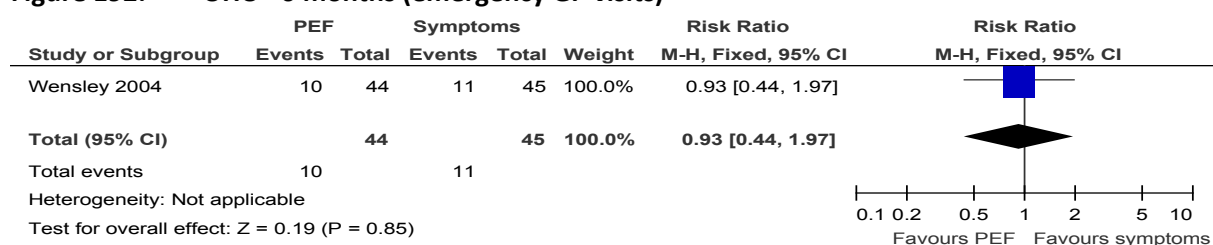
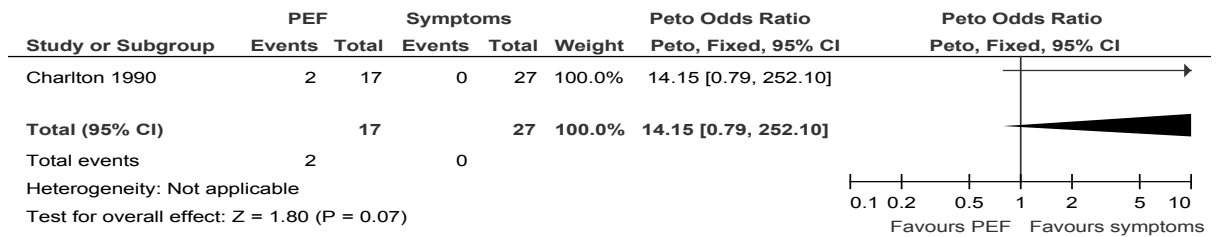


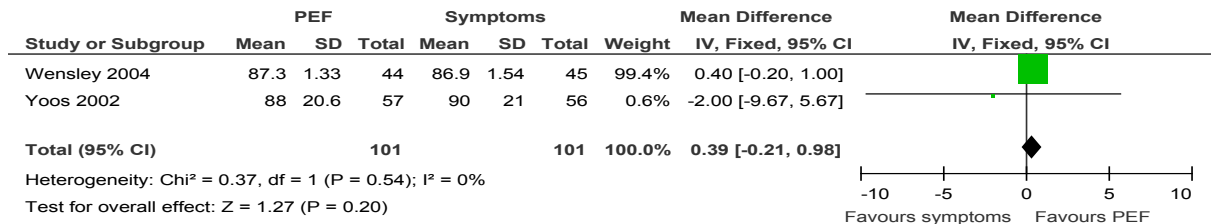
Figure 192: UHU <6 months (emergency GP visits)



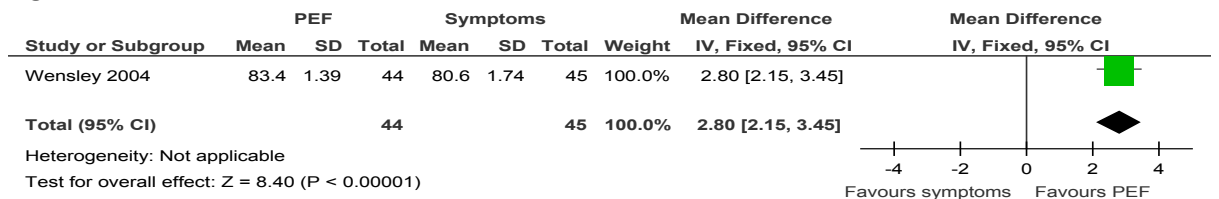
**Figure 193: Rescue medications ≥6 months (no. of patients requiring nebulised salbutamol)**



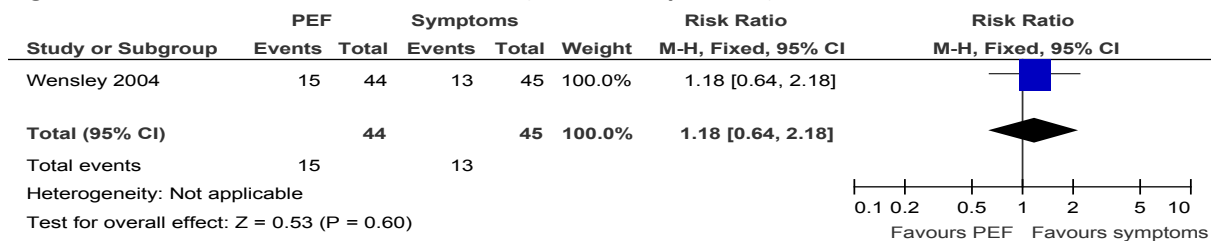
**Figure 194: FEV1 % <6 months**



**Figure 195: PEF % L/min <6 months**



**Figure 196: Time off school <6months (number of patients)**

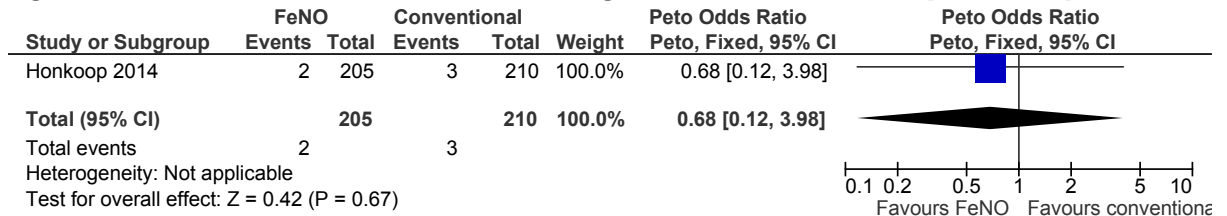


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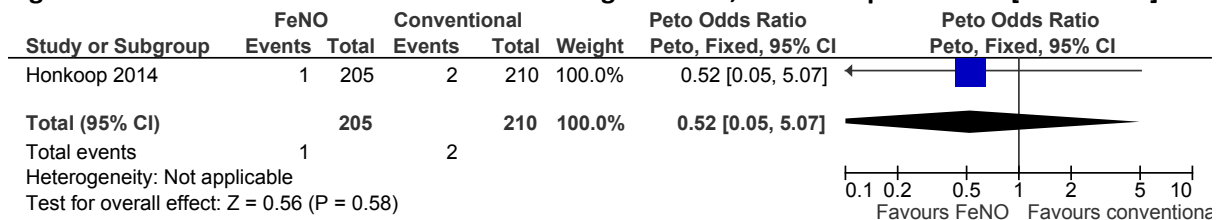
1 **J.17 Monitoring: FeNO**

2 **J.17.1.1 Adults – Unscheduled healthcare utilisation**

**Figure 197: FeNO versus Conventional Monitoring in Adults, UHU – ED visit [≥6 months]**



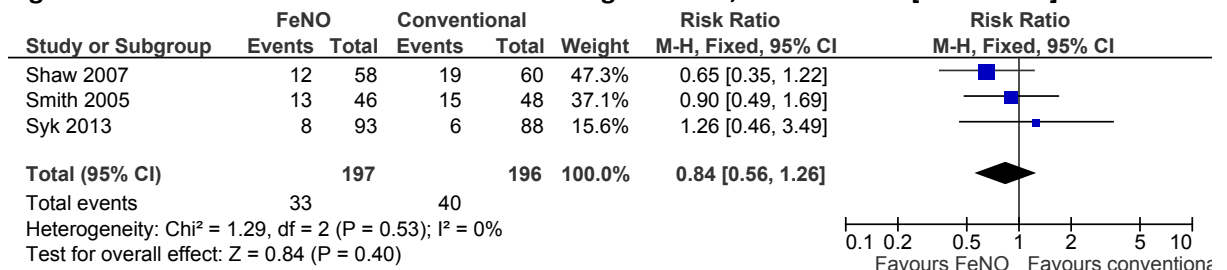
**Figure 198: FeNO versus Conventional Monitoring in Adults, UHU - hospitalisation [≥6 months]**



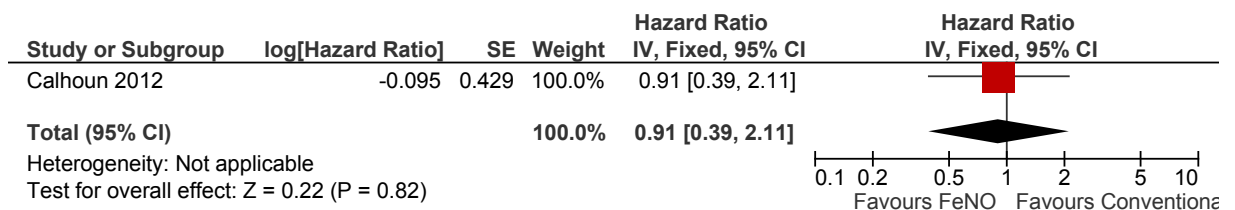
3

4 **J.17.1.2 Adults - Exacerbation**

**Figure 199: FeNO versus Conventional Monitoring in Adults, exacerbation [≥6 months]**

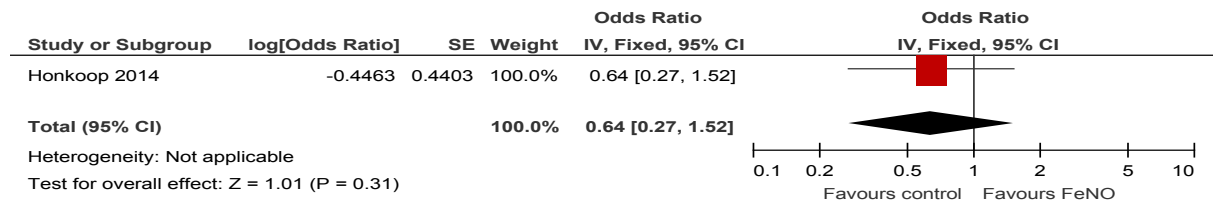


5 **Figure 200: FeNO versus Conventional Monitoring in Adults, exacerbation [≥6 months]**



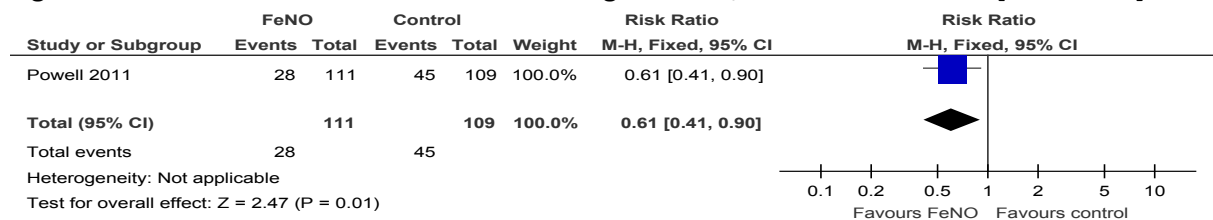
6

**Figure 201: FeNO versus Conventional Monitoring in Adults, exacerbation [≥6 months]**



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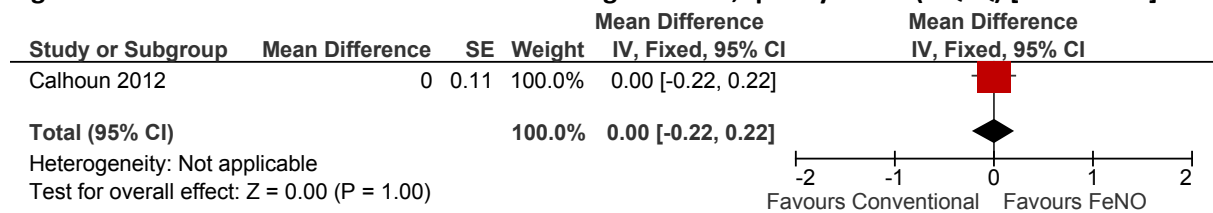
**Figure 202: FeNO versus Conventional Monitoring in Adults, exacerbation-mixed [<6 months]**



2

3 **J.17.1.3 Adults - Quality of Life**

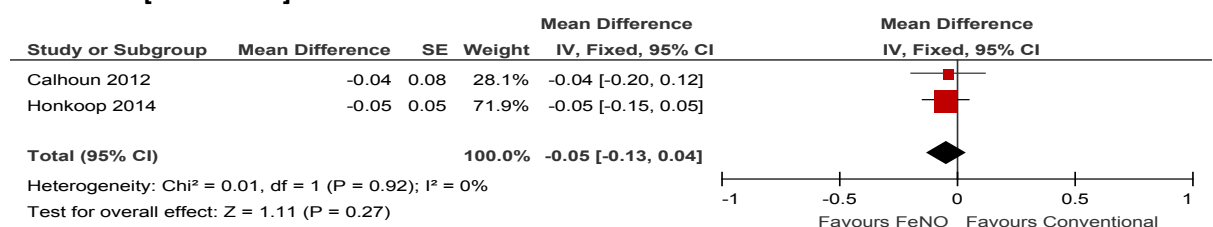
**Figure 203: FeNO versus Conventional Monitoring in Adults, quality of life (AQLQ) [≥6 months]**



4

5 **J.17.1.4 Adults - Asthma Control Questionnaire**

**Figure 204: FeNO versus Conventional Monitoring in Adults, asthma control questionnaire (ACQ) [≥6 months]**



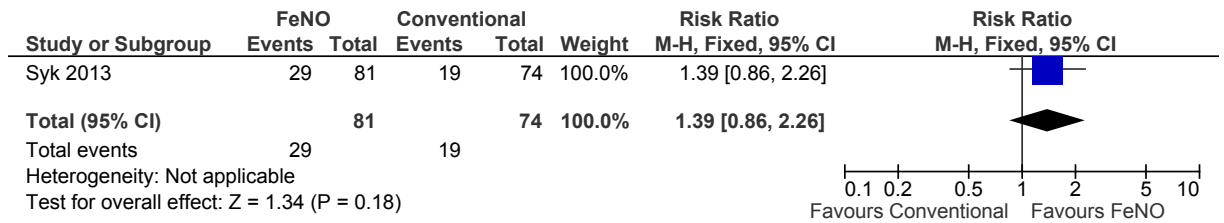
6 **Figure 205: FeNO versus Conventional Monitoring in Adults, asthma control questionnaire (ACQ, clinically important improvement, ≥0.5) [≥6 months]**

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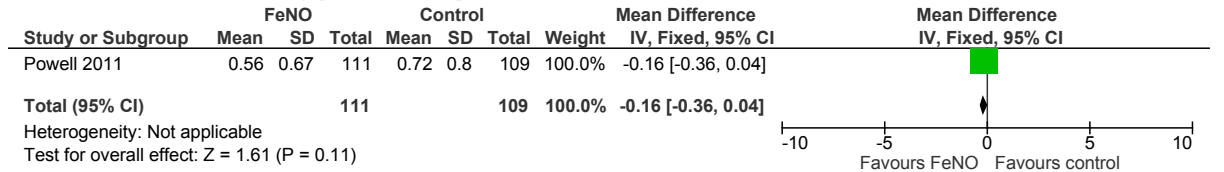
9

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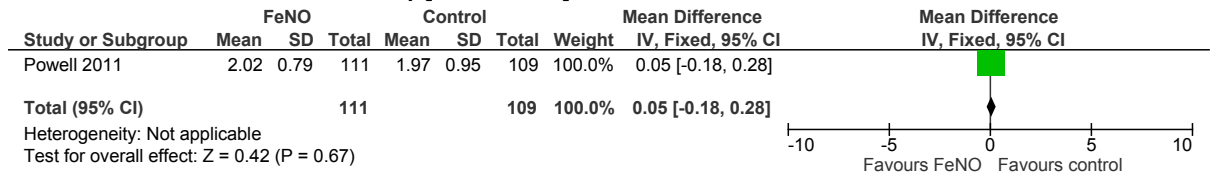
2

**Figure 206: FeNO versus Conventional Monitoring in Adults, asthma control questionnaire (ACQ, mean overall) [<6 months]**



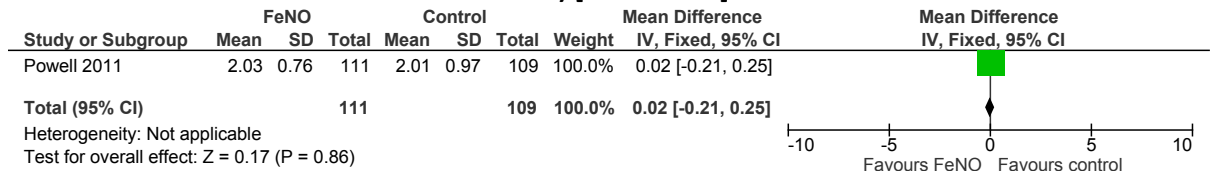
3

**Figure 207: FeNO versus Conventional Monitoring in Adults, asthma control questionnaire (ACQ, mean at exacerbation) [<6 months]**



4

**Figure 208: FeNO versus Conventional Monitoring in Adults, asthma control questionnaire (ACQ, mean at unscheduled doctor visits) [< 6 months]**

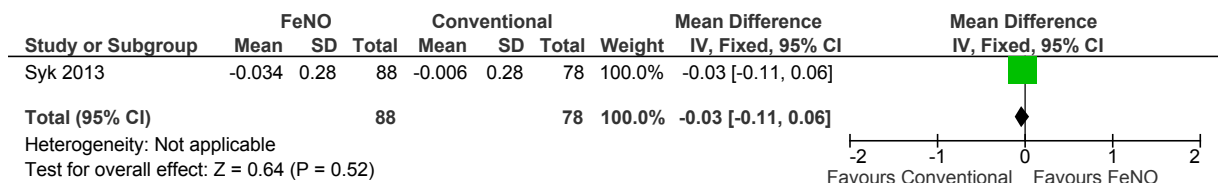


5

6 **J.17.1.5 Adults - Lung Function**

7 **Figure 209: FeNO versus Conventional Monitoring in Adults, lung function (FEV1, litres) [>=6 months]**

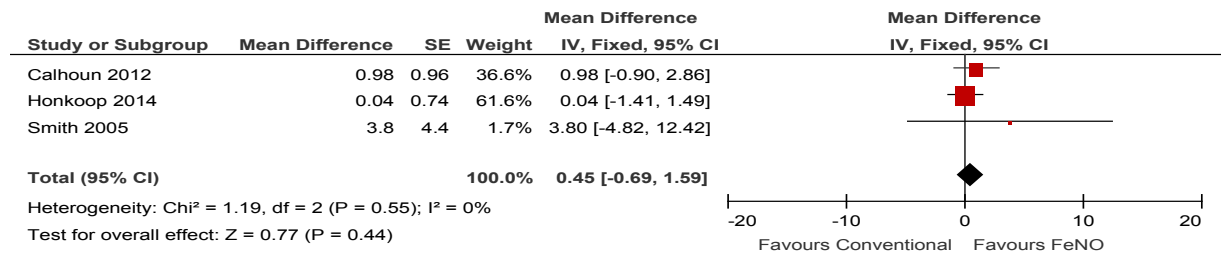
8



9

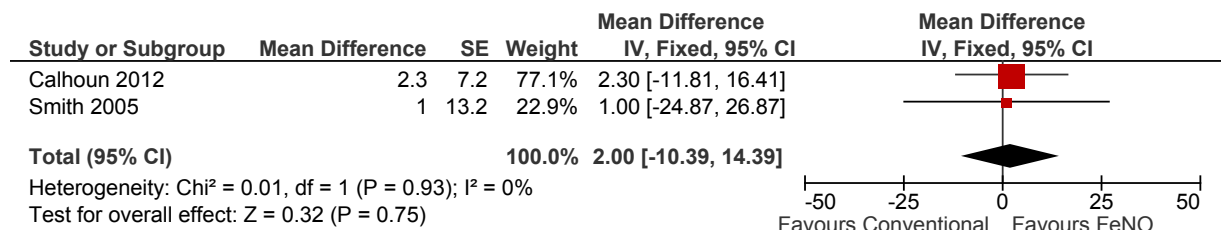
10

11 **Figure 210: FeNO versus Conventional Monitoring in Adults, lung function (FEV1, %) [>=6 months]**



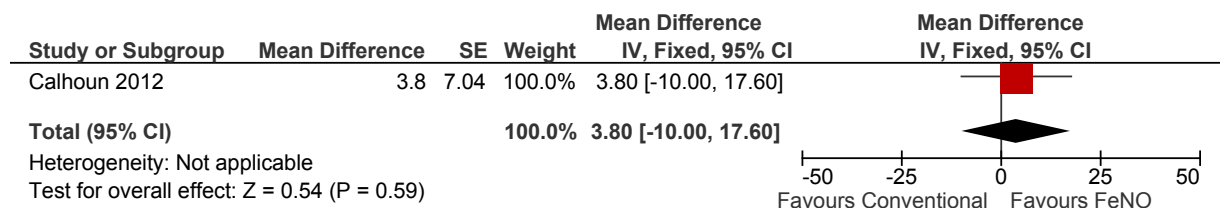
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**Figure 211: FeNO versus Conventional Monitoring in Adults, lung function (PEF am, L/min) [≥6 months]**



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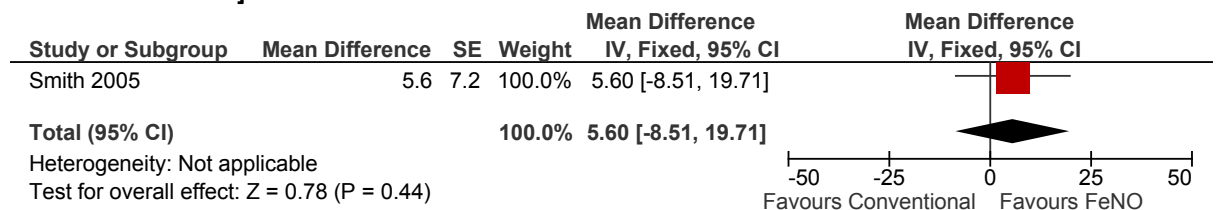
**Figure 212: FeNO versus Conventional Monitoring in Adults, lung function (PEF pm, L/min) [<6 months]**



9

10 **J.17.1.6 Adults - Symptoms**

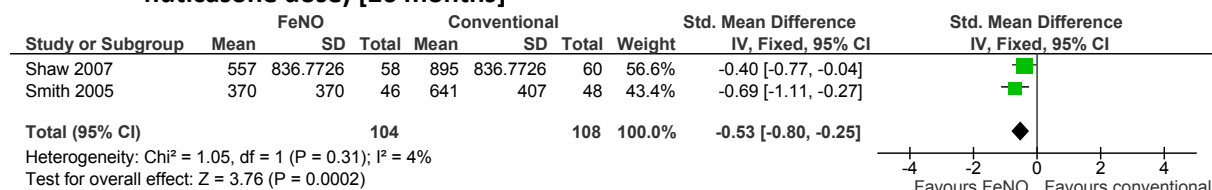
**Figure 213: FeNO versus Conventional Monitoring in Adults, % symptom free days [≥6 months]**



11

1 J.17.1.7 Adults - Dose of Regular Therapy

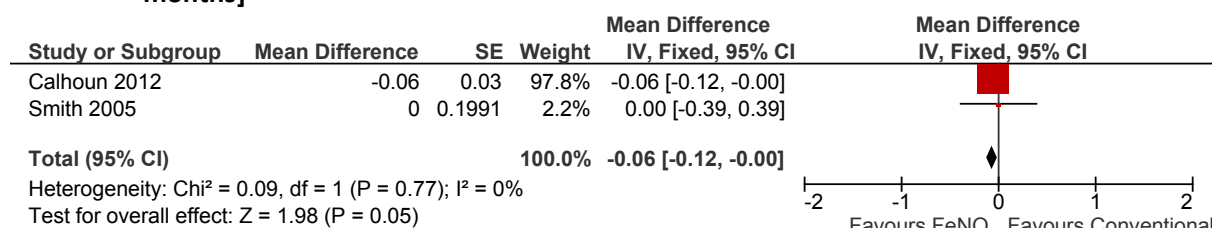
**Figure 214: FeNO versus Conventional Monitoring in Adults, dose of regular therapy (ICS use, fluticasone dose) [≥6 months]**



2

3 J.17.1.8 Adults - Rescue Medication

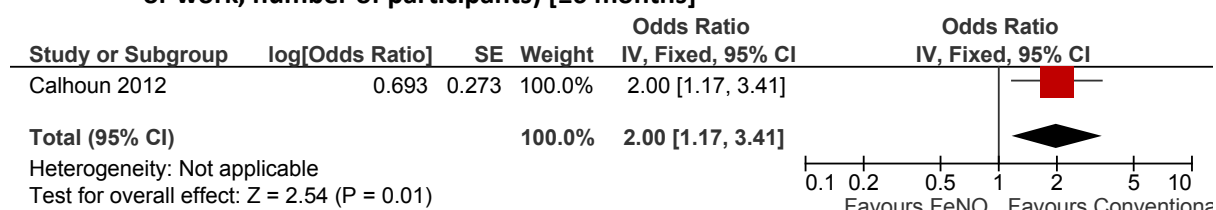
**Figure 215: FeNO versus Conventional Monitoring in Adults, rescue medication (puffs/day) [≥6 months]**



4

5 J.17.1.9 Adults - Time off school or work

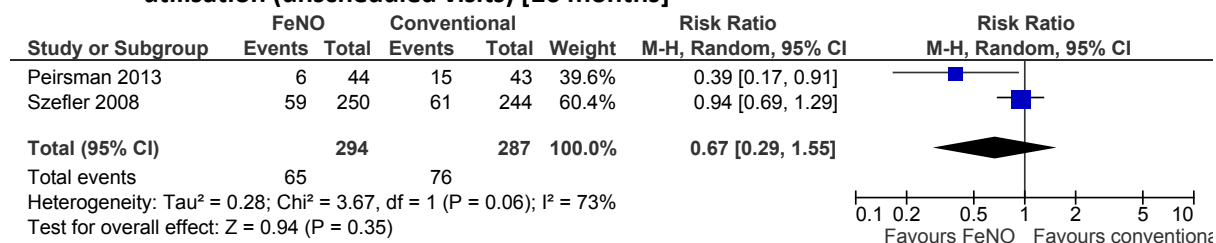
**Figure 216: FeNO versus Conventional Monitoring in Adults, time off (missing days off school or work, number of participants) [≥6 months]**



6

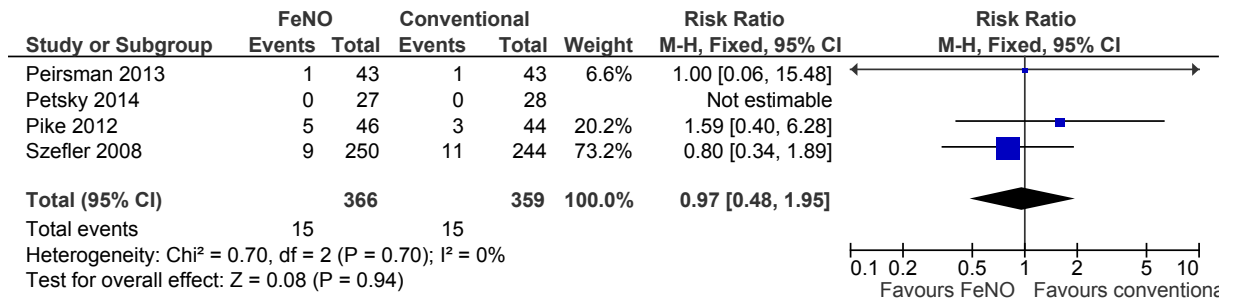
7 J.17.1.10 Children – Unscheduled Healthcare Utilisation

**Figure 217: FeNO versus Conventional Monitoring in Children, unscheduled healthcare utilisation (unscheduled visits) [≥6 months]**



8

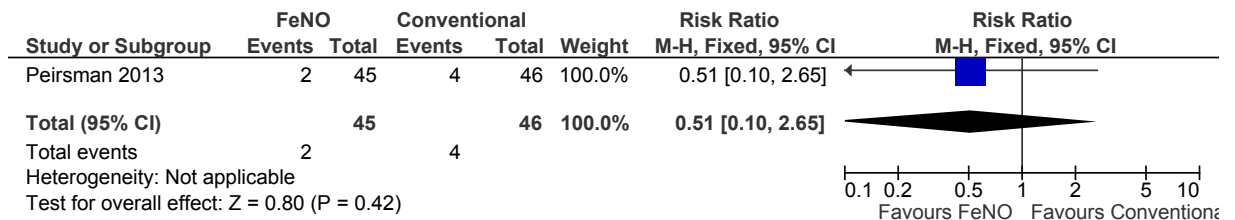
1 **Figure 218: FeNO versus Conventional Monitoring in Children, unscheduled healthcare utilisation**  
2 **(hospitalisation) [ $\geq 6$  months]**



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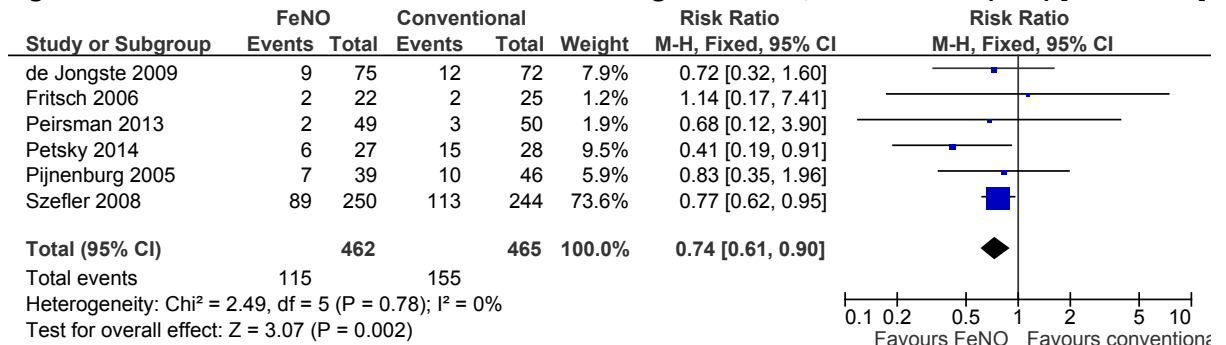
5 **Figure 219: FeNO versus Conventional Monitoring in Children, unscheduled healthcare utilisation**  
6 **(number of children  $\geq 1$  emergency room admission) [ $\geq 6$  months]**



7

8 **J.17.1.11 Children – Exacerbation**

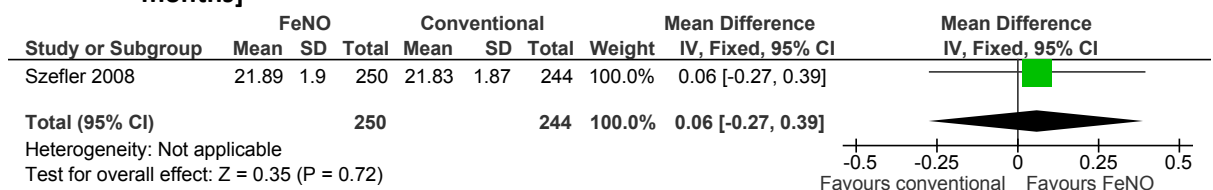
**Figure 220: FeNO versus Conventional Monitoring in Children, exacerbation (OCS) [ $\geq 6$  months]**



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10 **J.17.1.12 Children – Quality of Life**

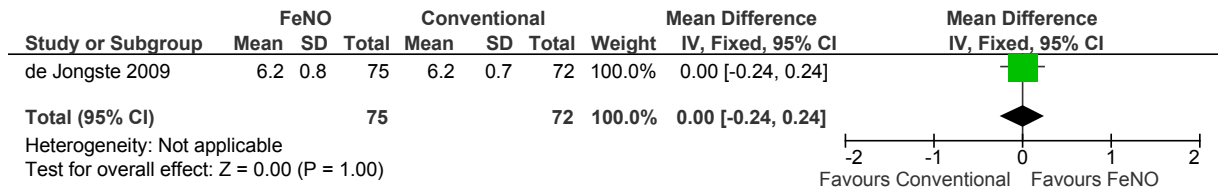
**Figure 221: FeNO versus Conventional Monitoring in Children, quality of life (ACT score) [ $\geq 6$  months]**



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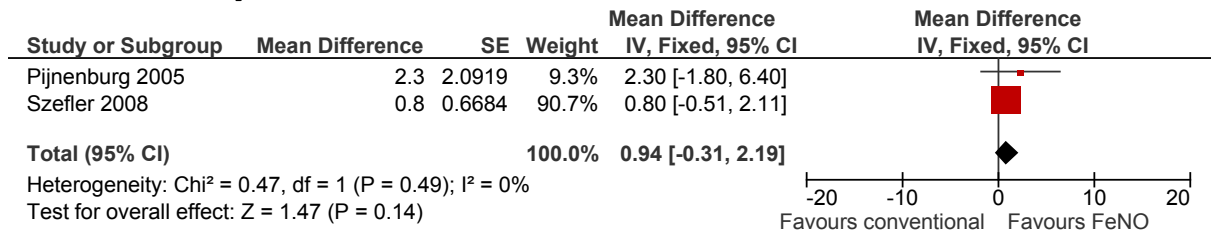


1 **Figure 222: FeNO versus Conventional Monitoring in Children, quality of life (Paediatric Asthma**  
 2 **Caregiver Quality of Life Questionnaire) [≥6 months]**



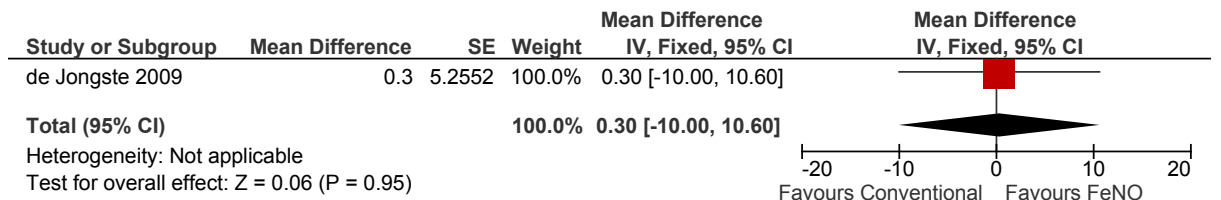
3  
 4 **J.17.1.13 Children – Lung Function**

**Figure 223: FeNO versus Conventional Monitoring in Children, lung function (FEV1 % pred) [≥6 months]**

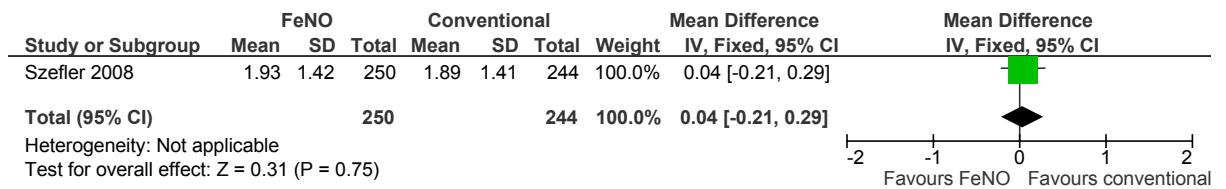


5 **J.17.1.14 Children – Symptoms**

**Figure 224: FeNO versus Conventional Monitoring in Children, symptoms (% symptom free days) [≥6 months]**



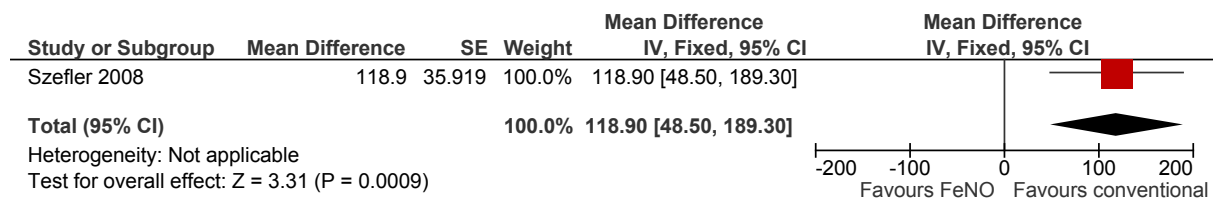
**Figure 225: FeNO versus Conventional Monitoring in Children, symptoms (number of symptom days in last 2 weeks) [≥6 months]**



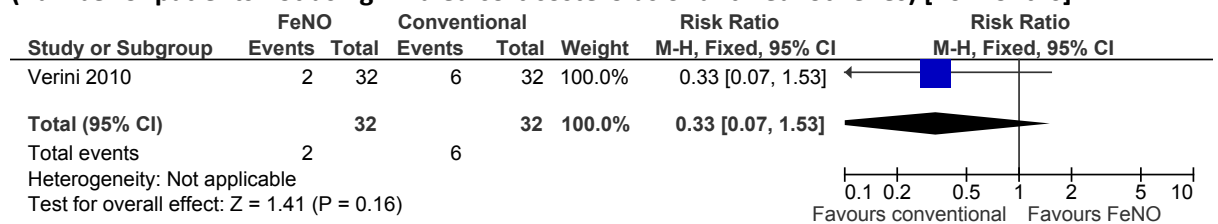
6

1 J.17.1.15 Children – Dose of Regular Therapy

**Figure 226: FeNO versus Conventional Monitoring in Children, dose of regular therapy (ICS use, daily dose) [≥6 months]**

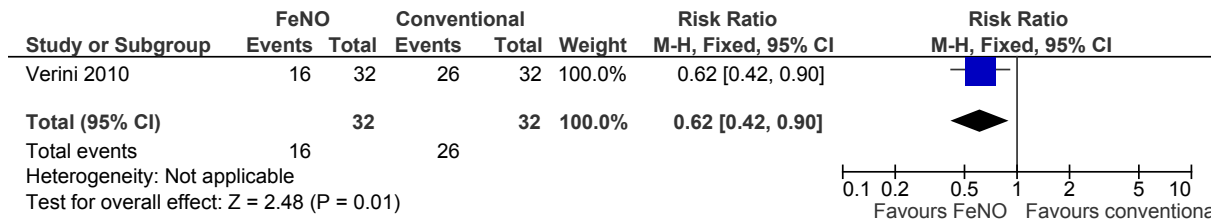


**Figure 227: FeNO versus Conventional Monitoring in Children, dose of regular therapy (number of patients not using inhaled corticosteroids or anti-leukotrienes) [≥6 months]**



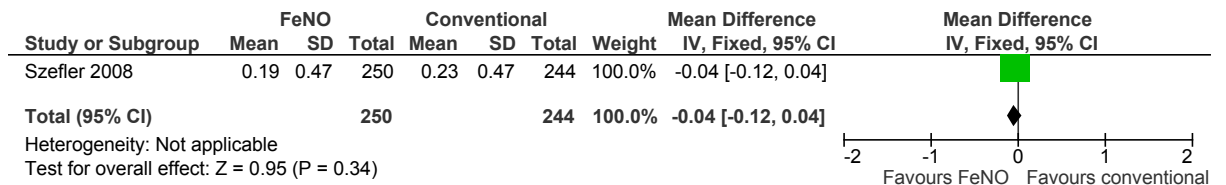
1 J.17.1.16 Children – Rescue Medication

**Figure 228: FeNO versus Conventional Monitoring in Children, rescue medication (number of patients needed beta-agonist due to symptoms) [≥6 months]**

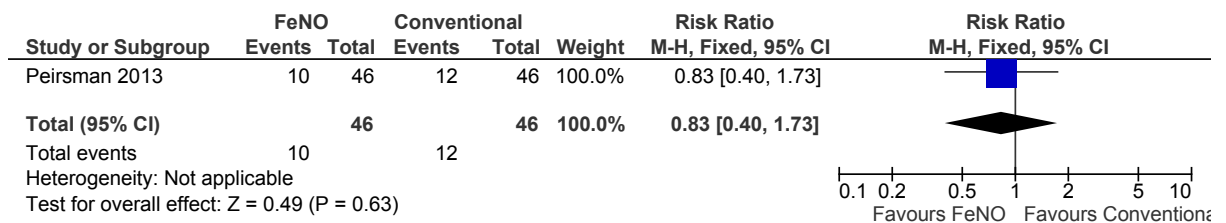


2 J.17.1.17 Children – Time Off school

**Figure 229: FeNO versus Conventional Monitoring in Children, time off (number of days missed in last 2 weeks) [≥6 months]**



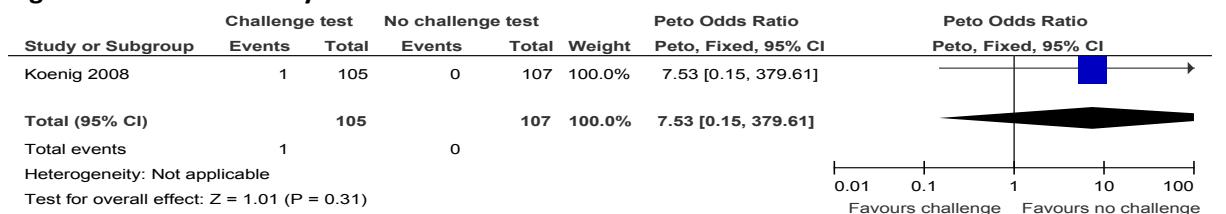
**Figure 230: FeNO versus Conventional Monitoring in Children, time off (number of children missed school) [≥6 months]**



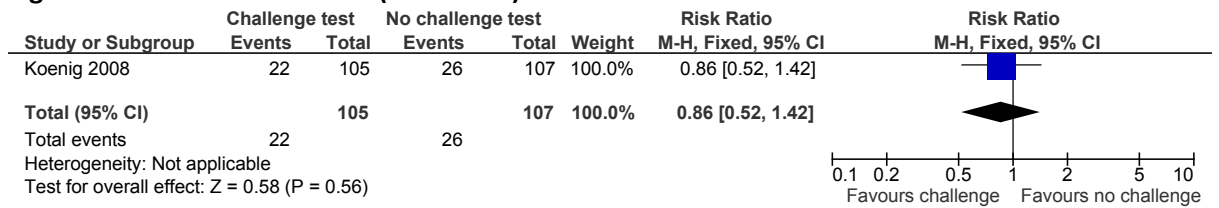
3 J.18 Monitoring: Challenge tests

4 J.18.1.1 ADULTS Methacholine challenge test versus no challenge test for asthma monitoring

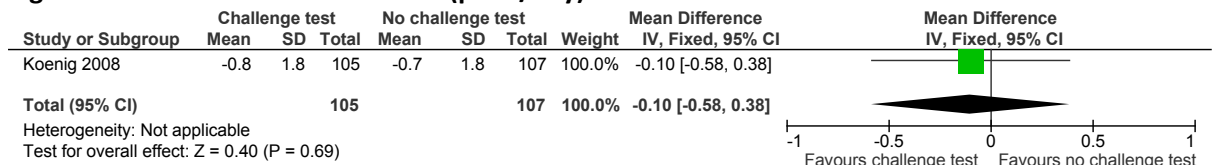
**Figure 231: Mortality ≥6 months**



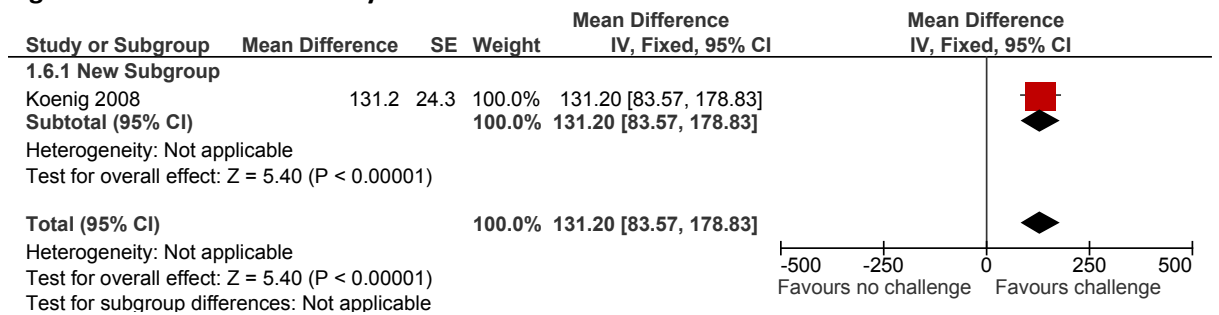
**Figure 232: Exacerbations (undefined) ≥6 months**



**Figure 233: Rescue medications (puffs/day) ≥6 months**

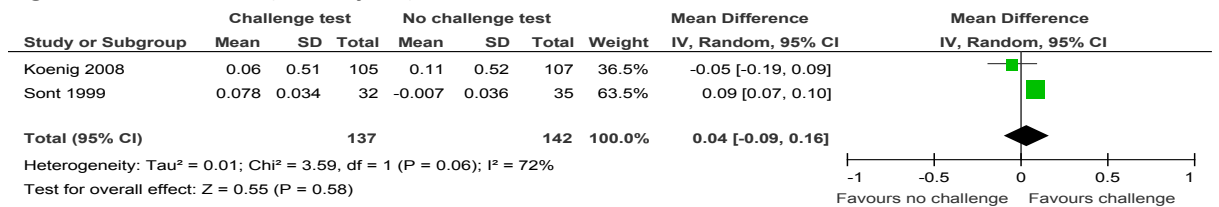


**Figure 234: ICS mean daily dose ≥6 months**

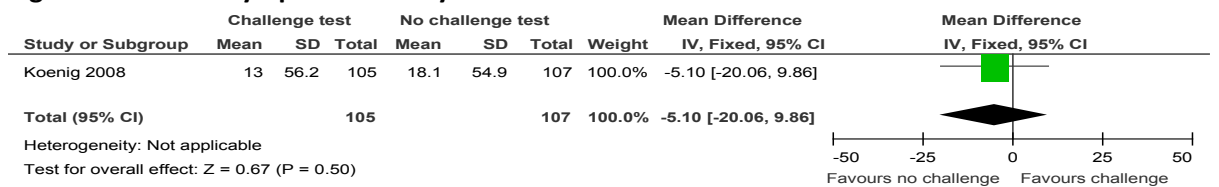


1

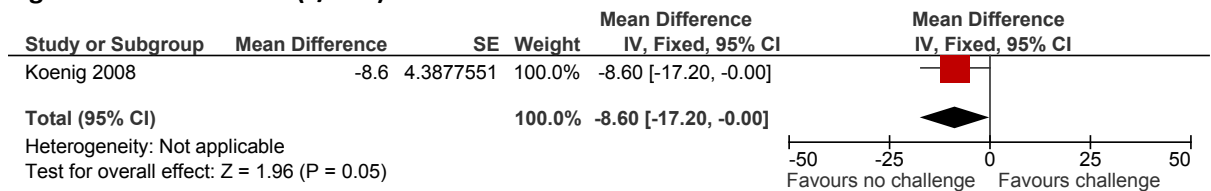
**Figure 235: FEV1 (L or L/year) ≥6 months**



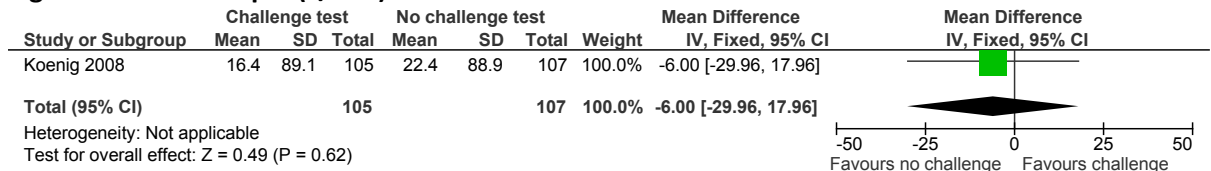
**Figure 236: % symptom free days ≥6 months**



**Figure 237: PEF am (L/min) ≥6 months**

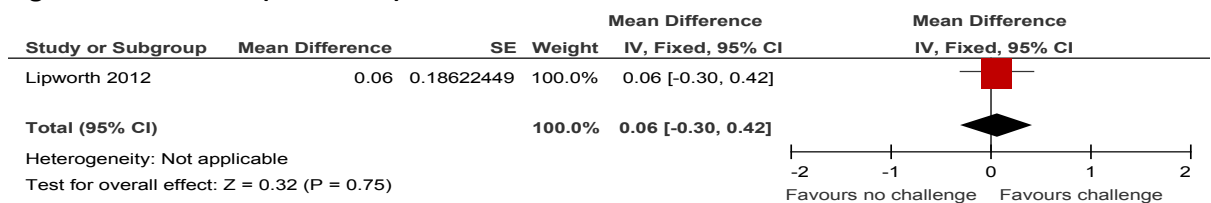


**Figure 238: PEF pm (L/min) ≥6 months**

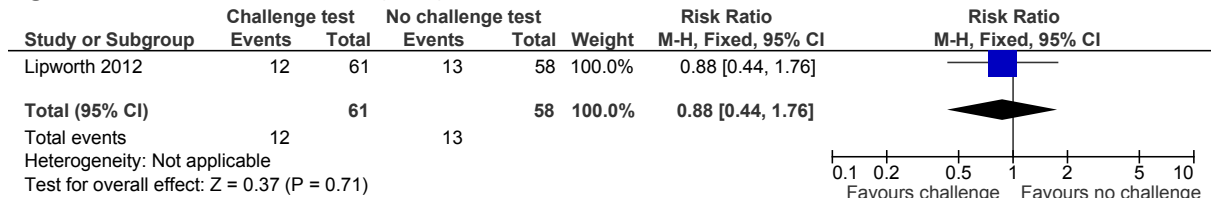


1 J.18.1.2 ADULTS Mannitol challenge test versus no challenge test for asthma monitoring

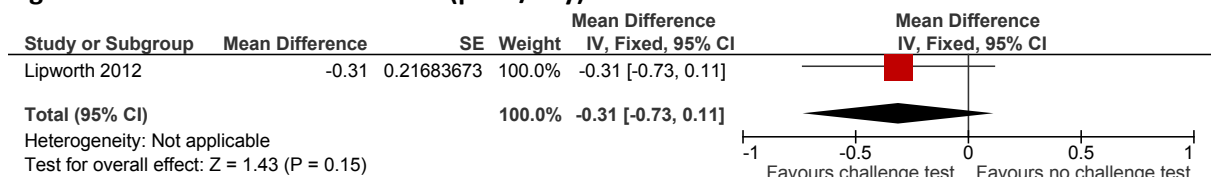
**Figure 239: QOL (miniAQLQ) ≥6 months**



**Figure 240: Exacerbations (OCS) ≥6 months**

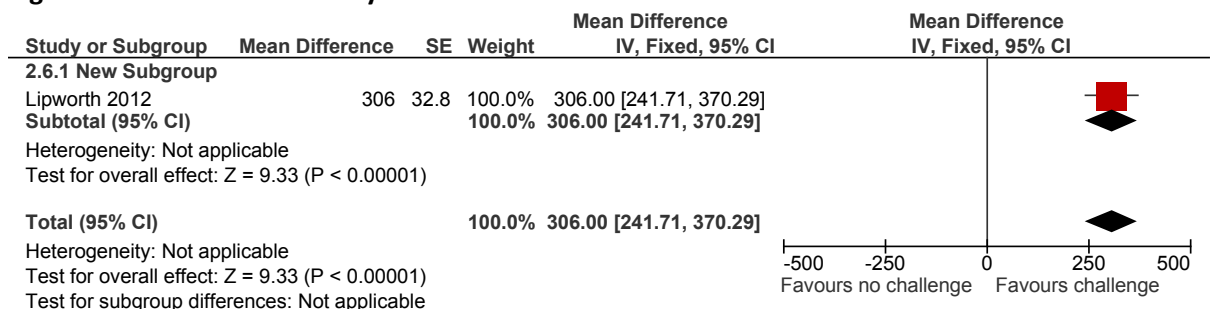


**Figure 241: Rescue medications (puffs/day) ≥6 months**

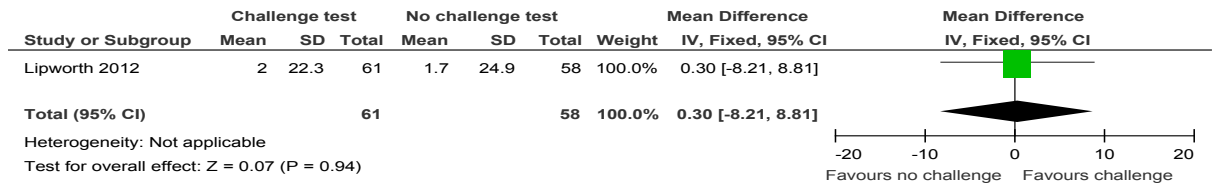


2

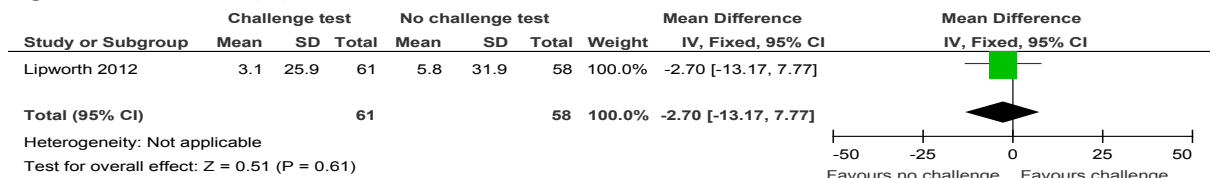
**Figure 242: ICS mean daily dose ≥6 months**



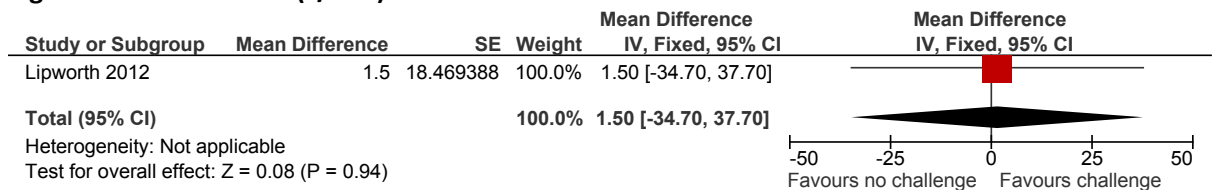
**Figure 243: FEV1 (%) ≥6 months**



**Figure 244: PEF (%) ≥6 months**

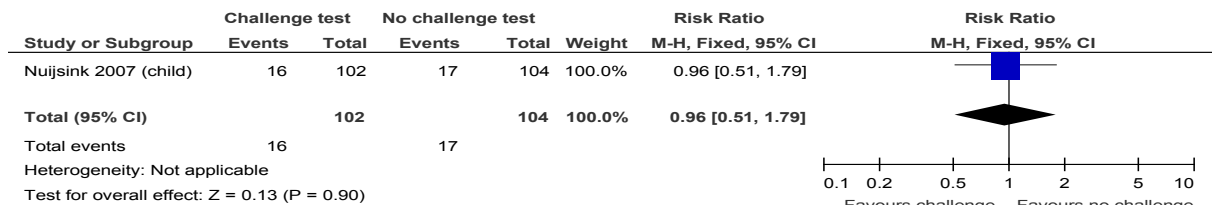


**Figure 245: PEF am (L/min) ≥6 months**

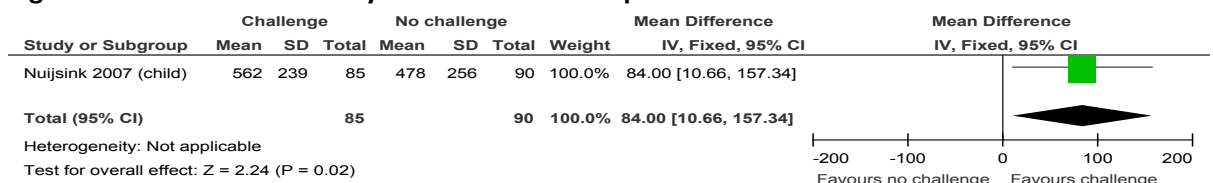


1 J.18.1.3 CHILDREN Methacholine challenge test versus no challenge test for asthma monitoring

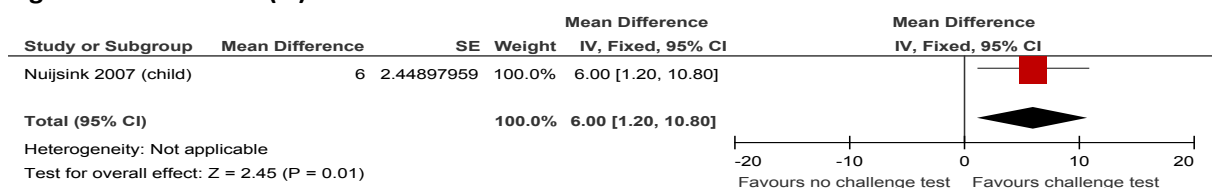
**Figure 246: Exacerbations (OCS) ≥6 months**



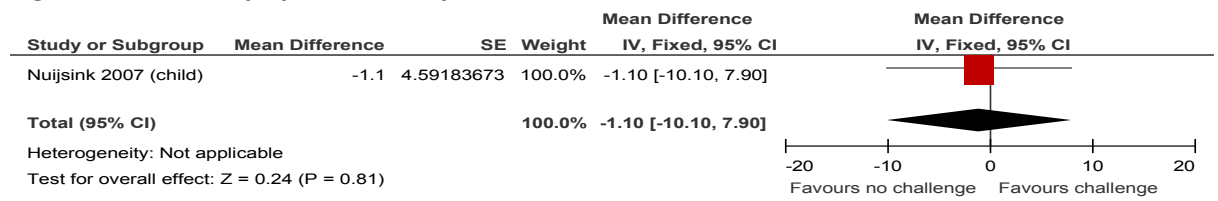
**Figure 247: ICS mean daily dose for treatment period ≥6 months**



**Figure 248: FEV1 (%) ≥6 months**



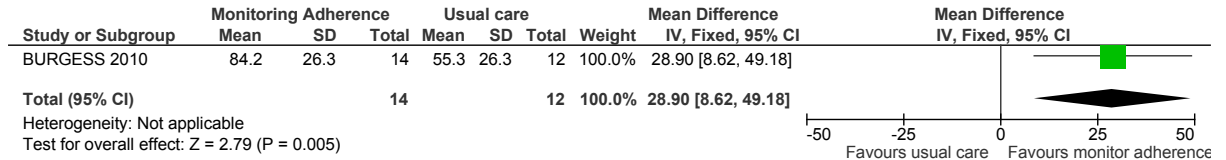
**Figure 249: % symptom free days  $\geq$  6 months**



1 **J.19 Monitoring adherence to treatment**

2 **J.19.1.1 Children (5-16 years) with uncontrolled asthma: Monitoring adherence + feedback vs no**  
3 **monitoring**

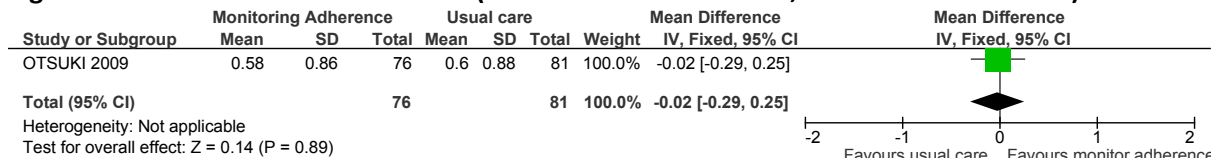
**Figure 250: Adherence <6 months (% of prescribed doses measured by the electronic inhaler)**



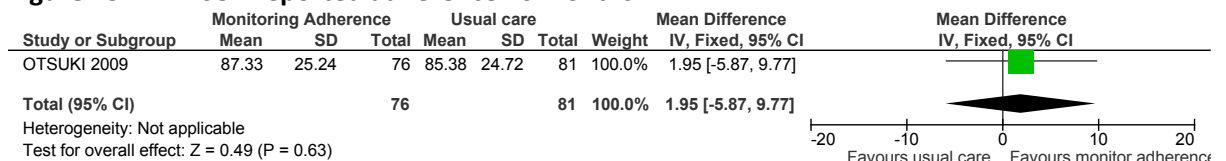
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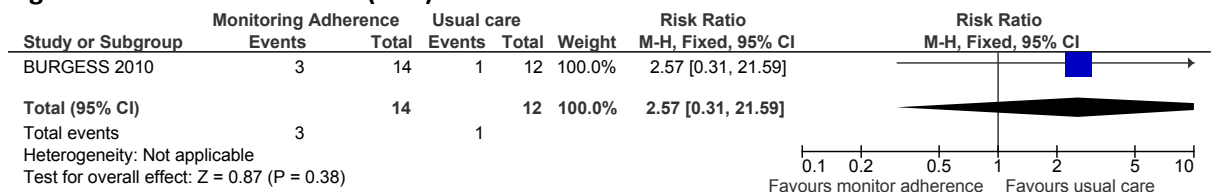
**Figure 251: Adherence ≥6 months (number of canister refills, 100% adherence = 3.0)**



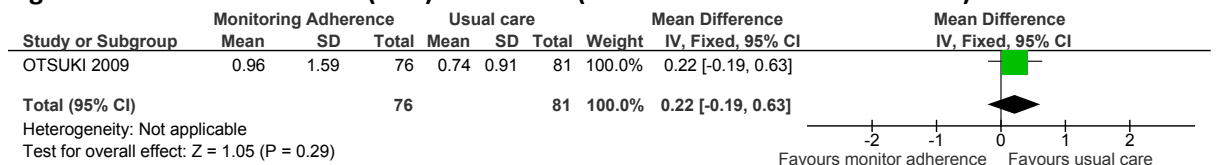
**Figure 252: Self-reported adherence ≥6 months**



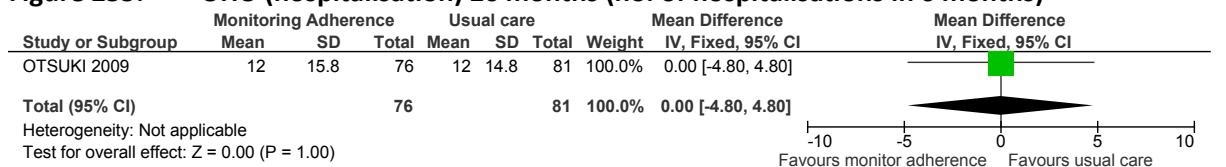
**Figure 253: Exacerbation (OCS) <6 months**



**Figure 254: Exacerbation (OCS) ≥6 months (no. of OCS courses in 6 months)**

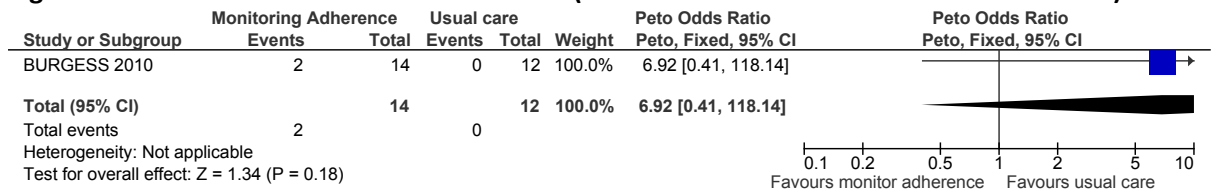


**Figure 255: UHU (hospitalisation) ≥6 months (no. of hospitalisations in 6 months)**





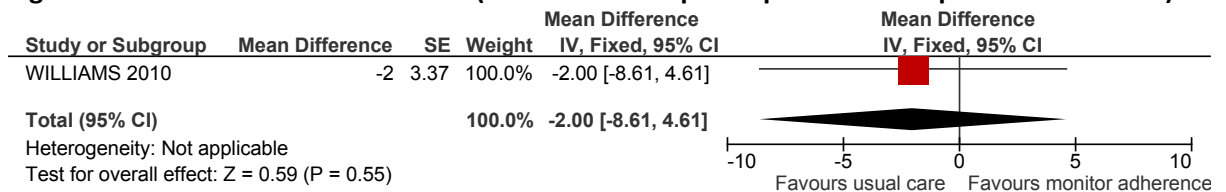
**Figure 256: Rescue medication < 6months (reliever medication 3 or more times a week)**



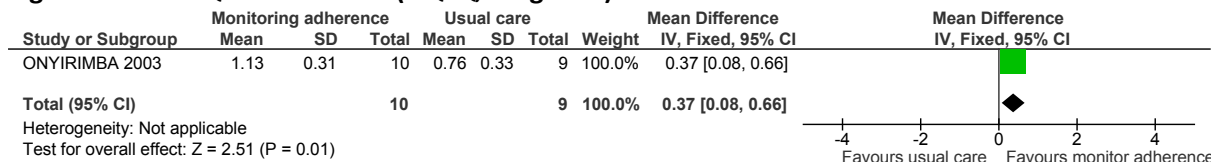
1

2 J.19.1.2 Adults (>16 years) overall: Monitoring adherence + feedback vs no monitoring

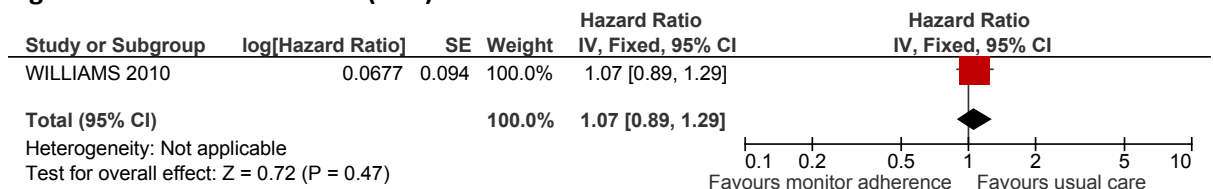
**Figure 257: Adherence ≥6 months (% adherence to prescription refills in previous 3 months)**



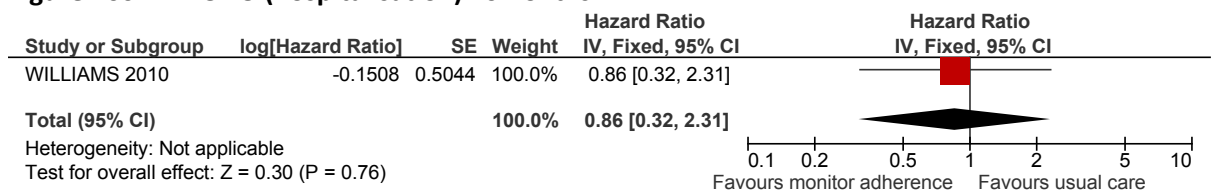
**Figure 258: QOL <6 months (AQLQ, range 1-7)**



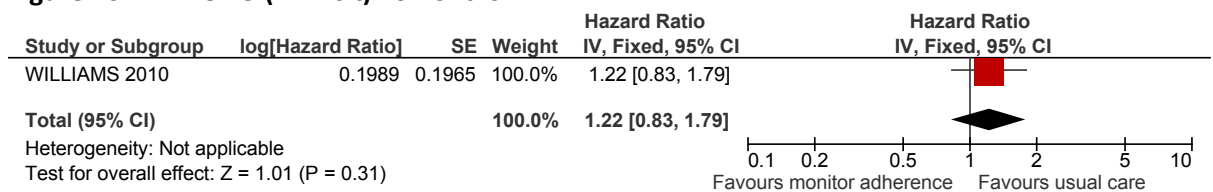
**Figure 259: Exacerbation (OCS) ≥6months**



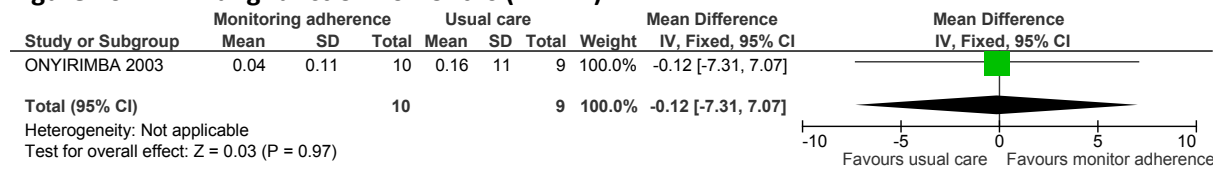
**Figure 260: UHU (hospitalisation) ≥6months**



**Figure 261: UHU (ED visit) ≥6months**



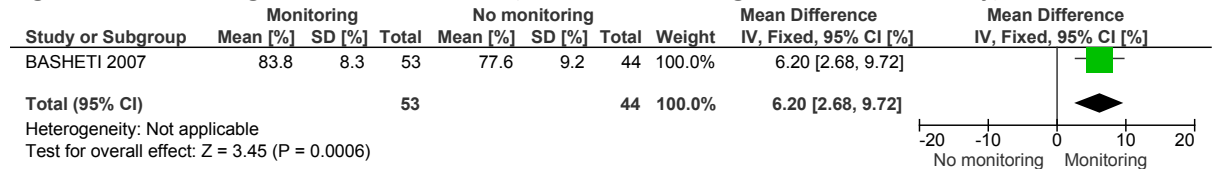
**Figure 262: Lung function <6months (FEV1 L)**



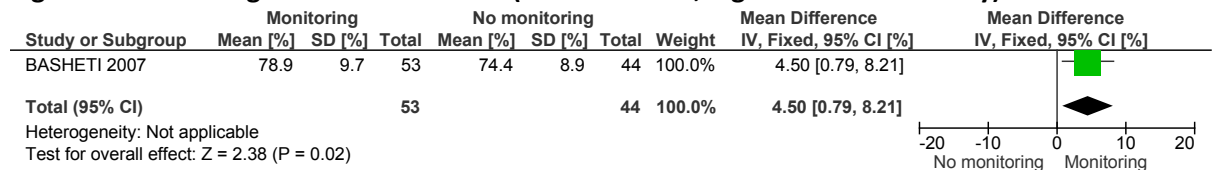
## 1 J.20 Monitoring inhaler technique

### 2 J.20.1.1 ADULTS: Monitoring inhaler technique vs no monitoring

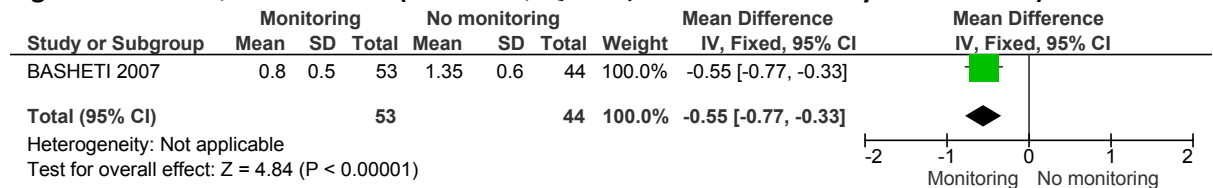
**Figure 263: Lung function <6 months (PEF Min%Max, higher is less variability)**



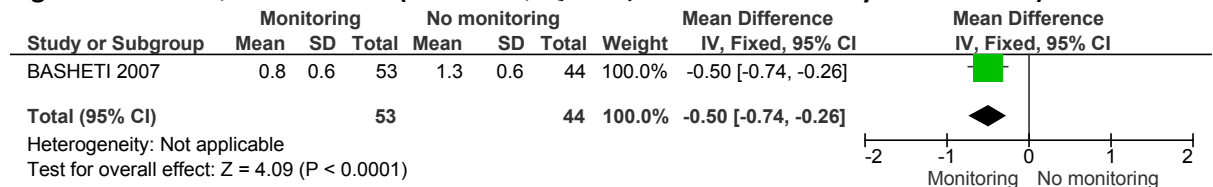
**Figure 264: Lung function ≥6 months (PEF Min%Max, higher is less variability)**



**Figure 265: QOL <6 months (Marks AQLQ, 0-10, better indicated by lower values)**

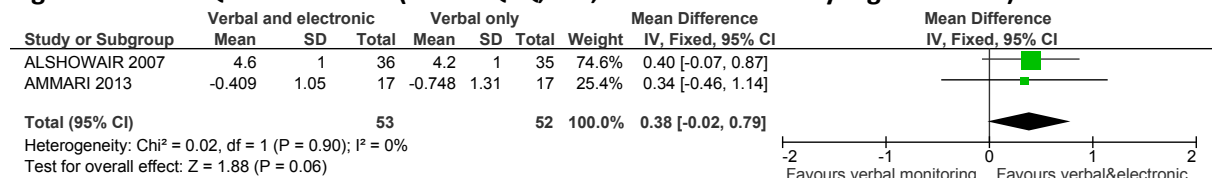


**Figure 266: QOL ≥6 months (Marks AQLQ, 0-10, better indicated by lower values)**

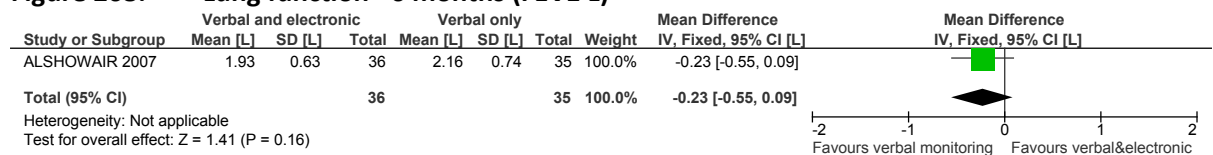


### 3 J.20.1.2 ADULTS: Monitoring (verbal and electronic) vs verbal monitoring only

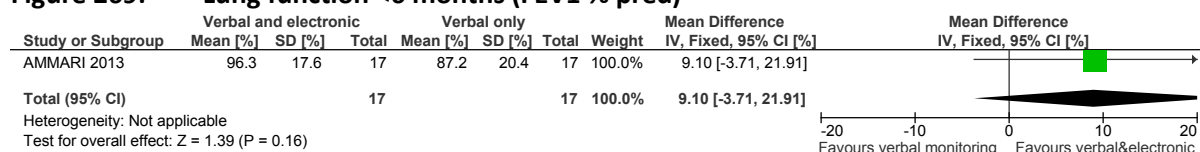
**Figure 267: QOL <6 months (mini AQLQ, 1-7, better indicated by higher values)**



**Figure 268: Lung function <6 months (FEV1 L)**



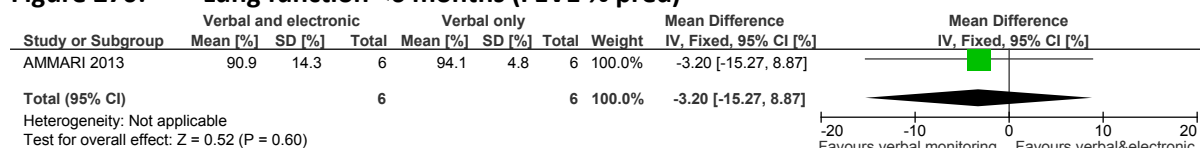
**Figure 269: Lung function <6 months (FEV1 % pred)**



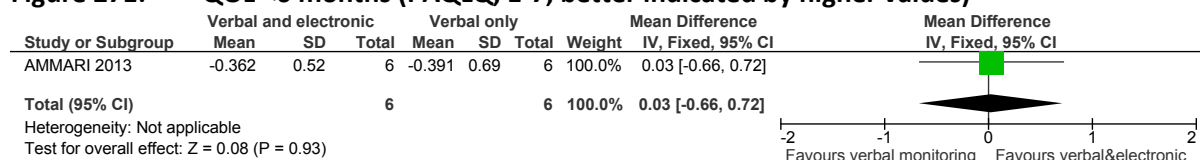
1

2 **J.20.1.3 CHILDREN: Monitoring (verbal and electronic) vs verbal monitoring only**

**Figure 270: Lung function <6 months (FEV1 % pred)**



**Figure 271: QOL <6 months (PAQLQ, 1-7, better indicated by higher values)**

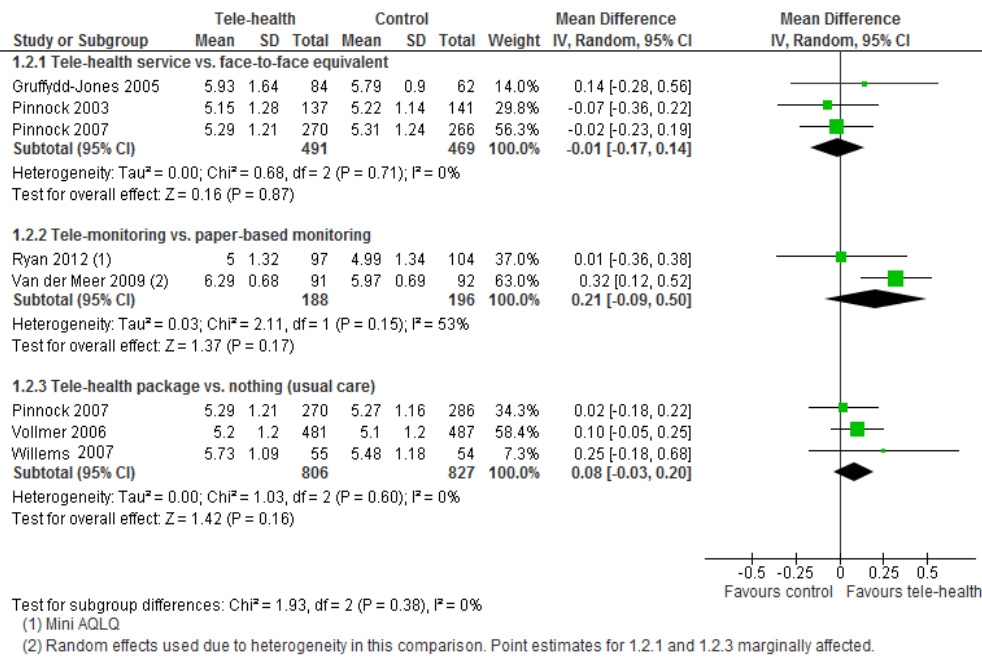


3 **J.21 Monitoring: Tele-healthcare**

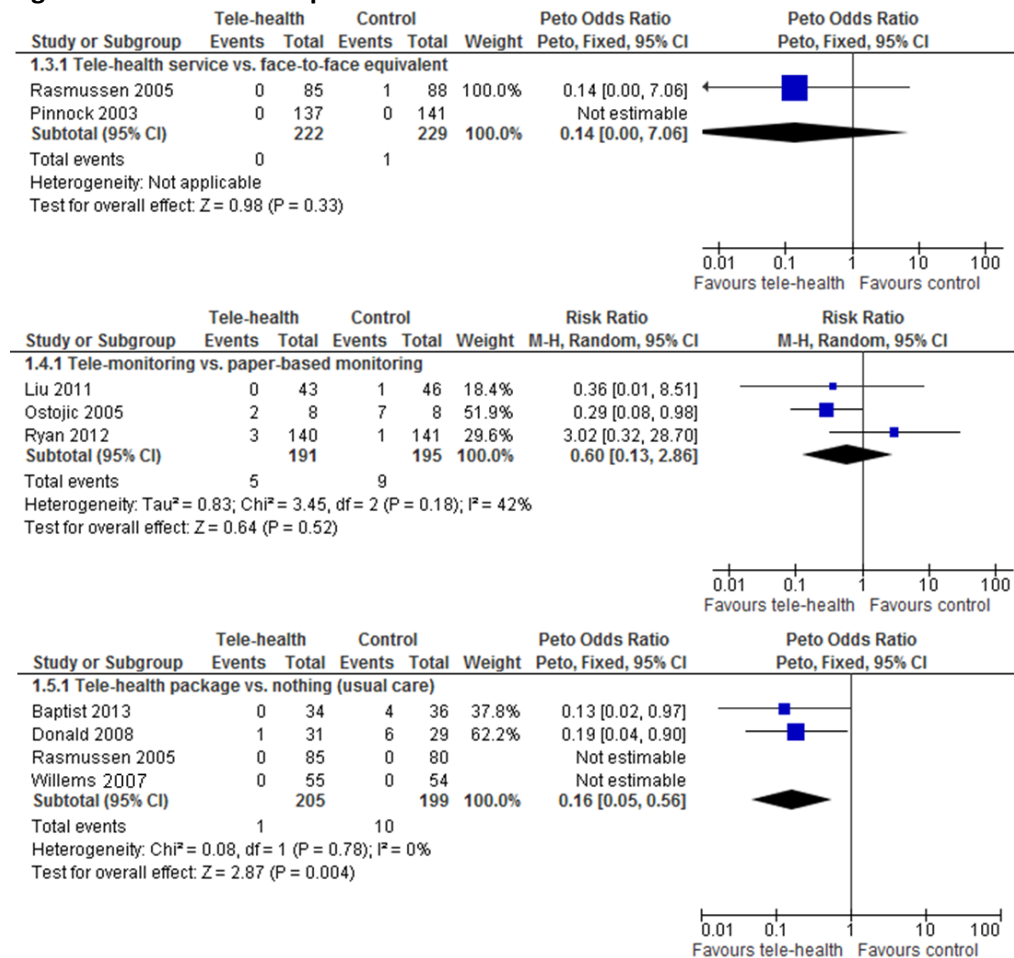
4 **J.21.1.1 Tele-healthcare for adults >17**

**Figure 272: Quality of life – Asthma Quality of Life Questionnaire (AQLQ)**

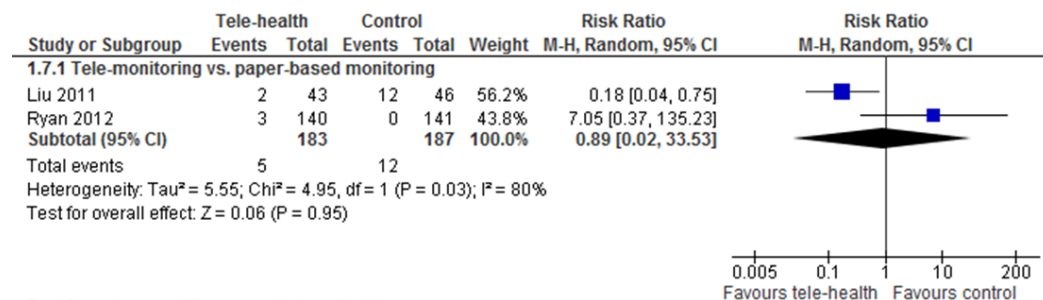
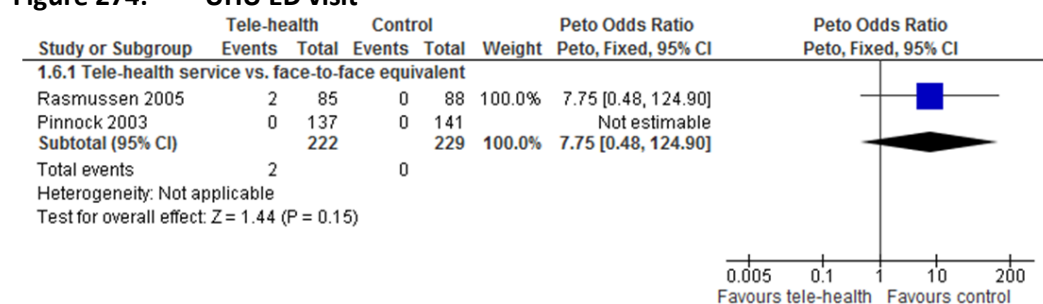
5



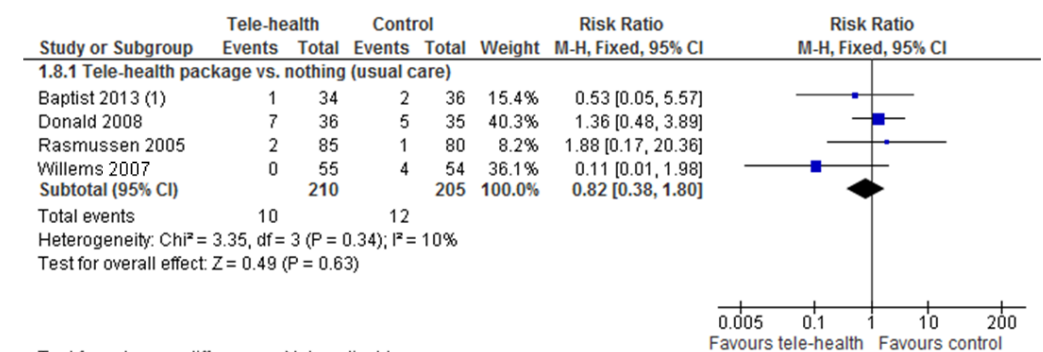
**Figure 273: UHU hospitalisation**



**Figure 274: UHU ED visit**



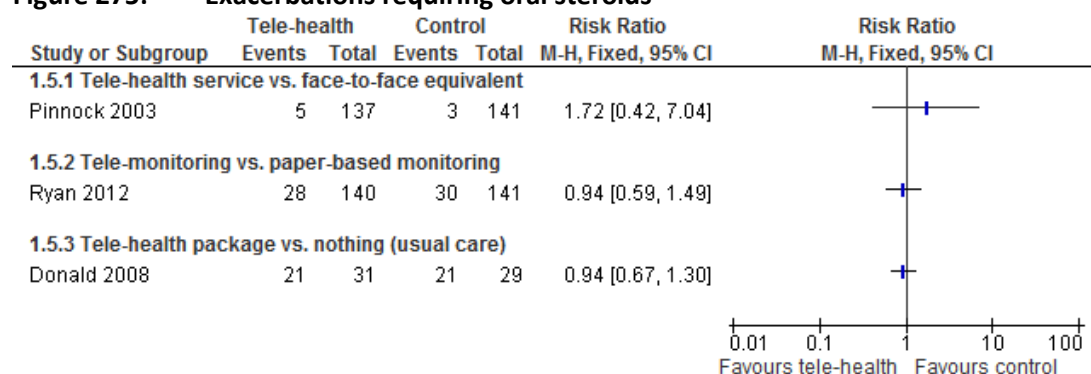
Test for subgroup differences: Not applicable



Test for subgroup differences: Not applicable  
(1) End of study data (12 months)

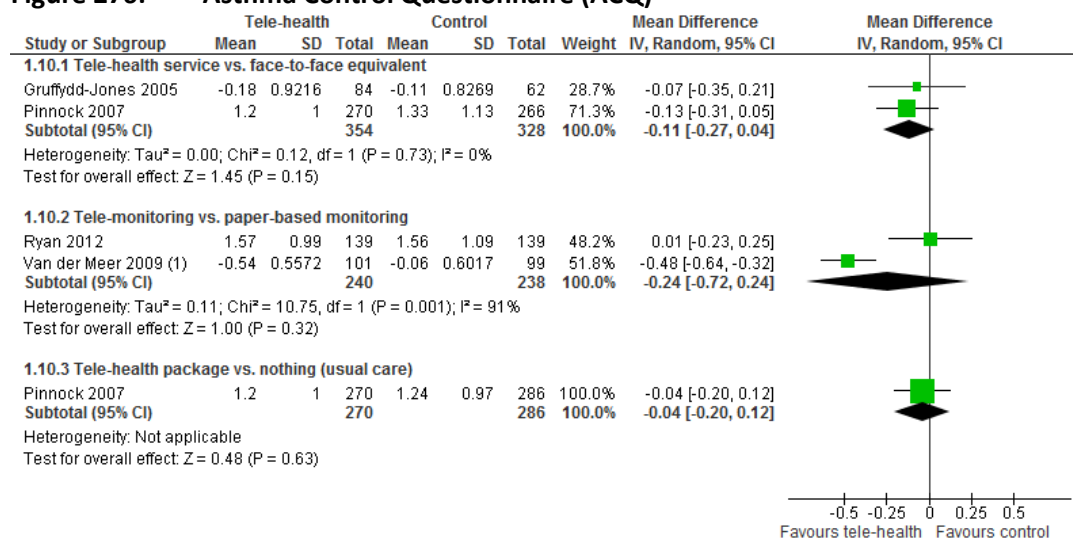
1

**Figure 275: Exacerbations requiring oral steroids**



2

**Figure 276: Asthma Control Questionnaire (ACQ)**

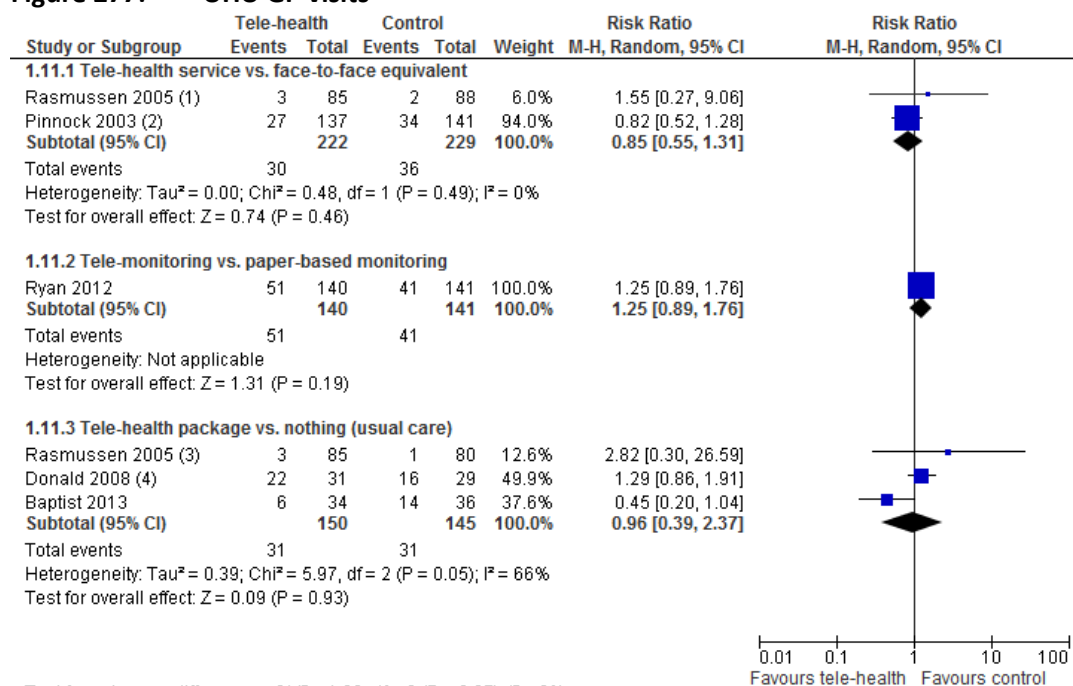


Test for subgroup differences: Chi<sup>2</sup> = 0.84, df = 2 (P = 0.66), I<sup>2</sup> = 0%

(1) Random effects used due to heterogeneity in this comparison. Did not affect results for 1.10.1 and 1.10.3.

1

**Figure 277: UHU GP visits**



Test for subgroup differences: Chi<sup>2</sup> = 1.98, df = 2 (P = 0.37), I<sup>2</sup> = 0%

(1) Described as 'unscheduled visits'

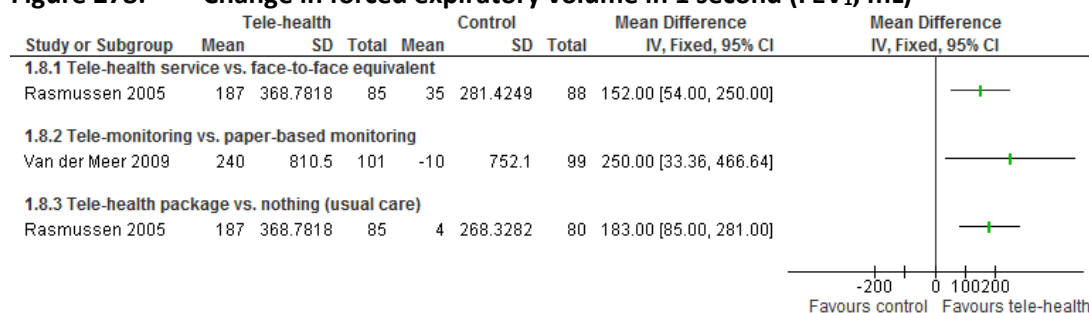
(2) Unclear if unscheduled, or total GP visits during the study period

(3) Described as 'unscheduled healthcare visits'

(4) Random effects used due to heterogeneity in this comparison. Point estimates for 1.11.1 and 1.11.2 marginally affected.

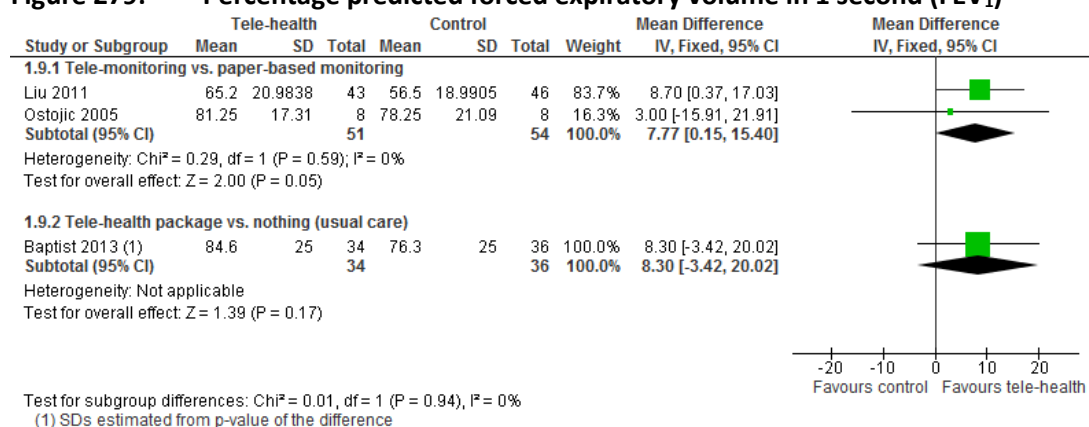
2

**Figure 278: Change in forced expiratory volume in 1 second (FEV<sub>1</sub>, mL)**



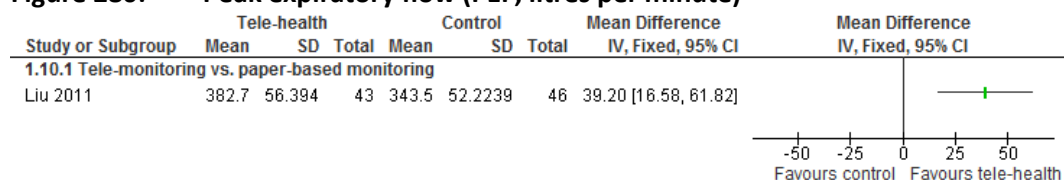
1

**Figure 279: Percentage predicted forced expiratory volume in 1 second (FEV<sub>1</sub>)**



2

**Figure 280: Peak expiratory flow (PEF, litres per minute)**

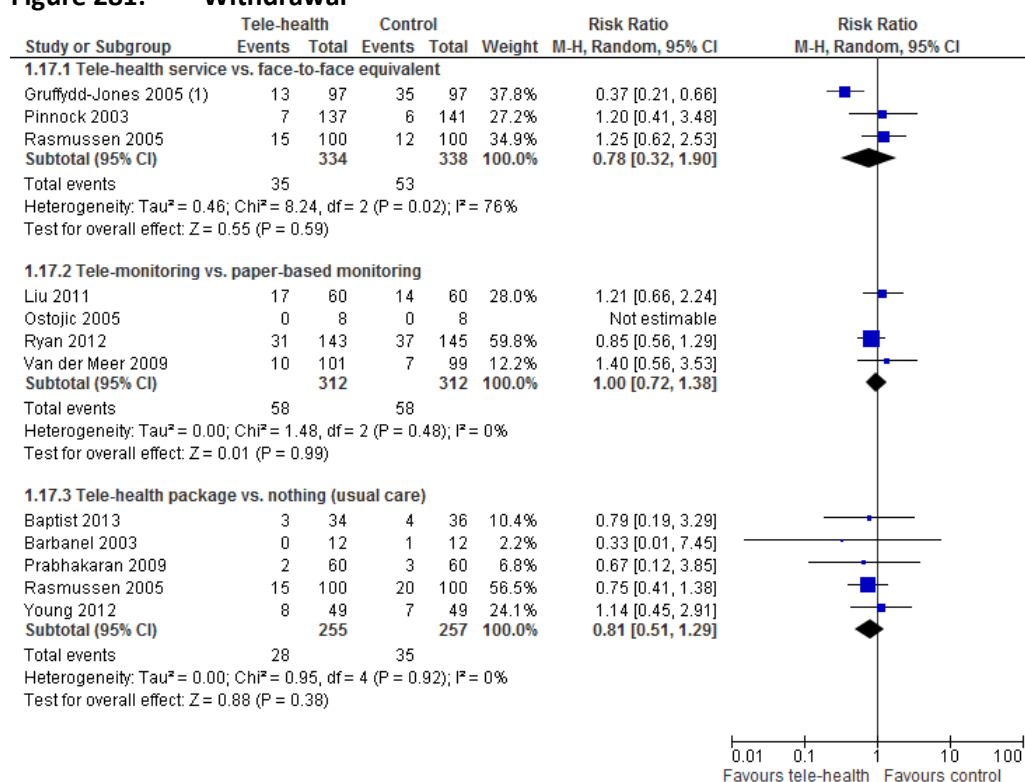


3

4



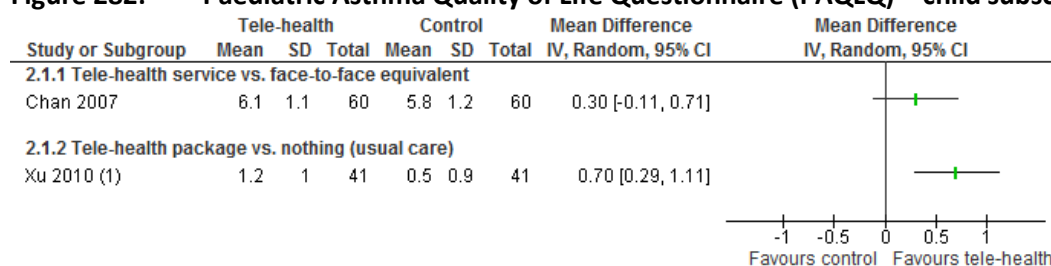
**Figure 281: Withdrawal**



1

2 J.21.1.2 Tele-healthcare for children aged 5 to 17

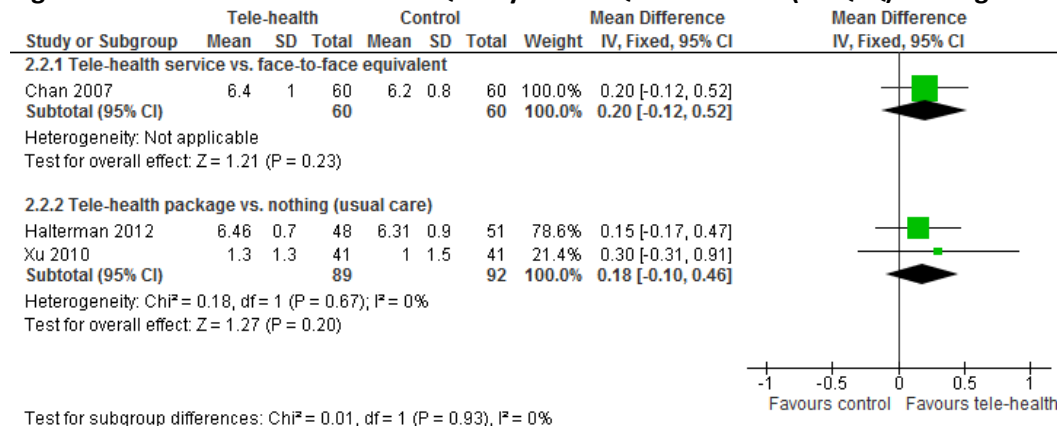
**Figure 282: Paediatric Asthma Quality of Life Questionnaire (PAQLQ) – child subscale**



(1) change scores

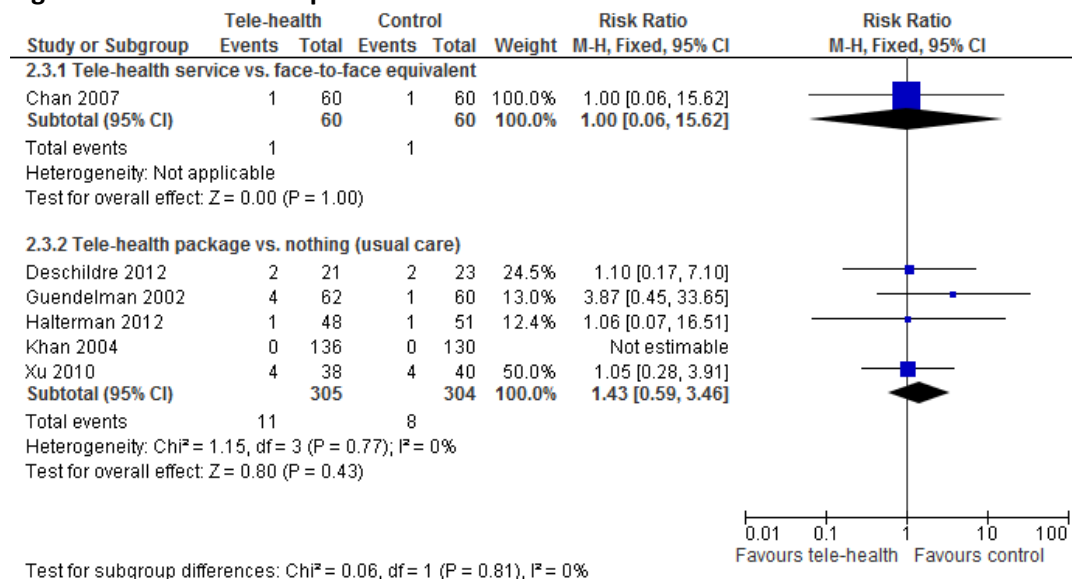
3

**Figure 283: Paediatric Asthma Quality of Life Questionnaire (PAQLQ) – caregiver subscale**



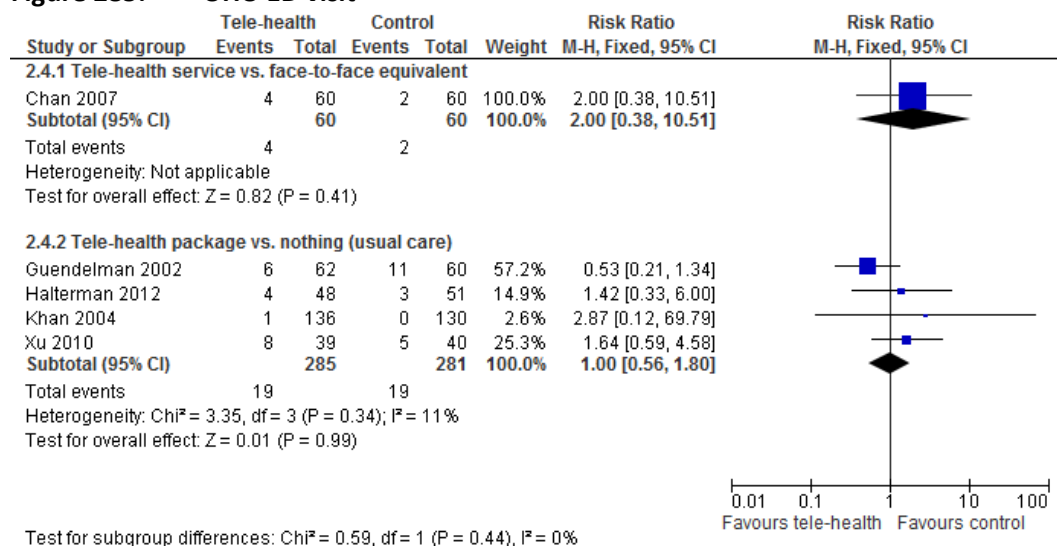
1

**Figure 284: UHU hospitalisation**



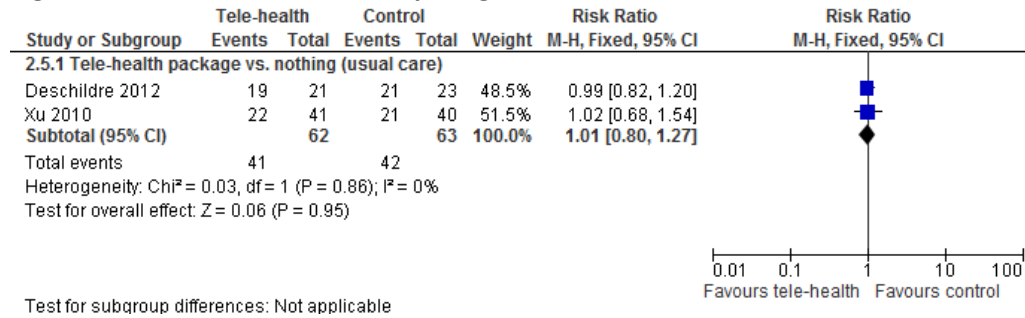
2

**Figure 285: UHU ED visit**



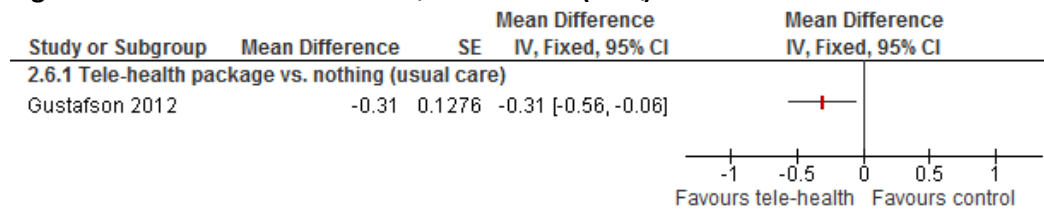
1

**Figure 286: Exacerbations requiring oral steroids**



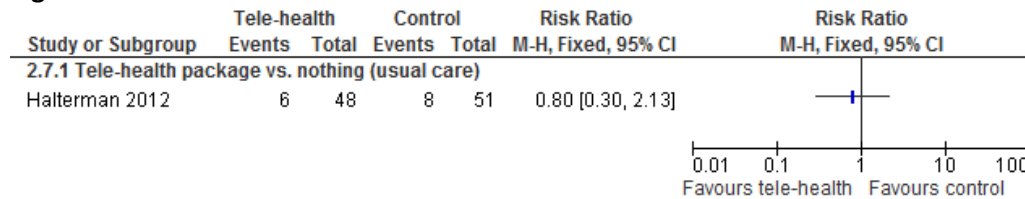
2

**Figure 287: Asthma Control Questionnaire (ACQ)**



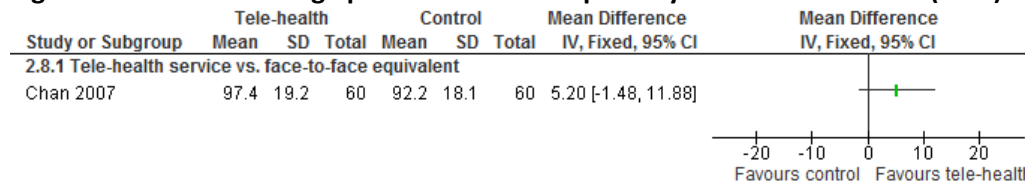
3

**Figure 288: UHU GP visits**



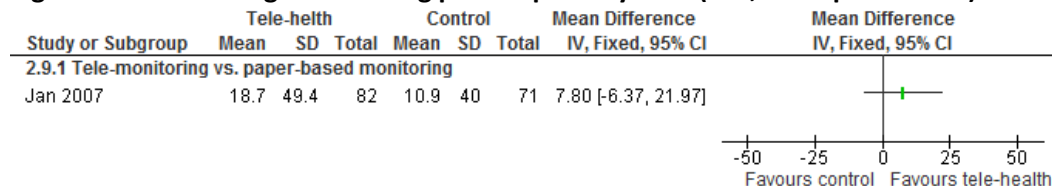
4

**Figure 289: Percentage predicted forced expiratory volume in 1 second (FEV<sub>1</sub>)**



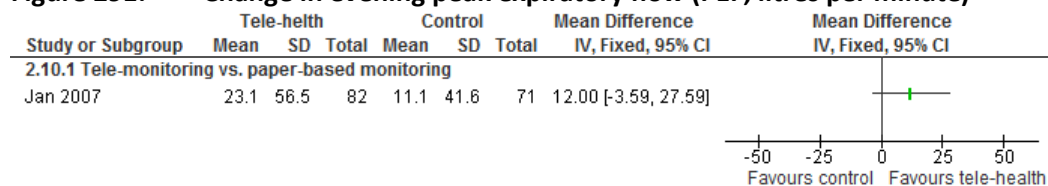
5

**Figure 290: Change in morning peak expiratory flow (PEF, litres per minute)**



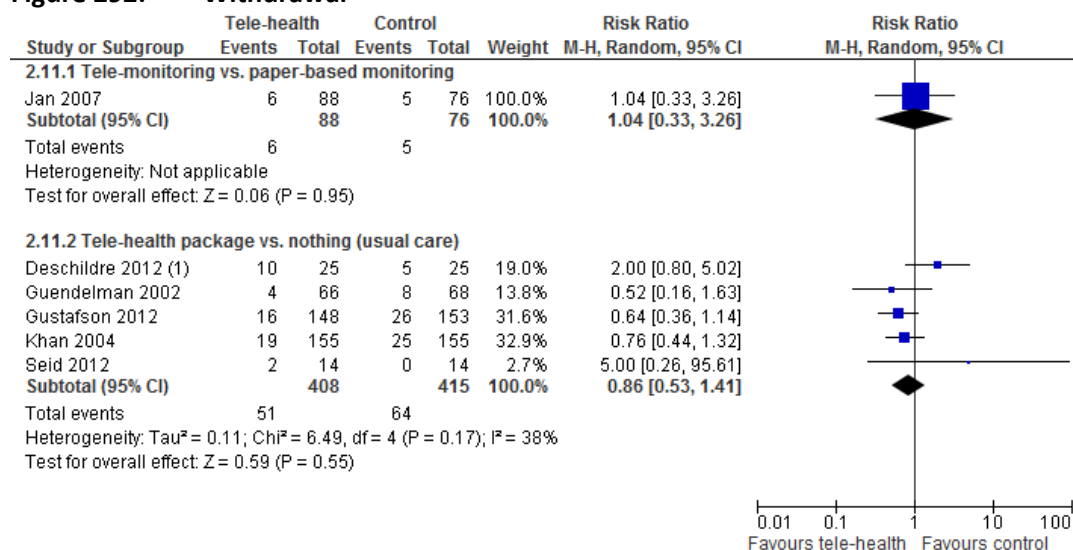
6

**Figure 291: Change in evening peak expiratory flow (PEF, litres per minute)**



1

**Figure 292: Withdrawal**

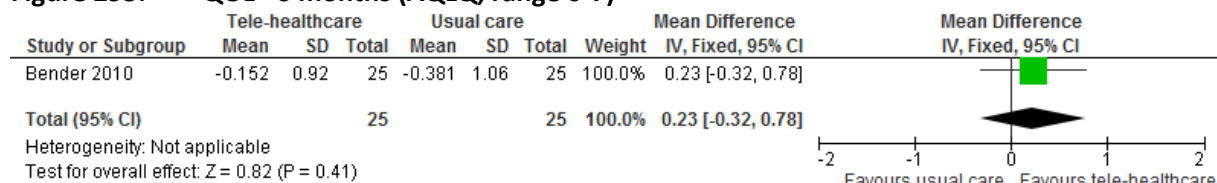


(1) Random effects used due to heterogeneity in this comparison. Point estimate for 2.11.1 not affected.

2

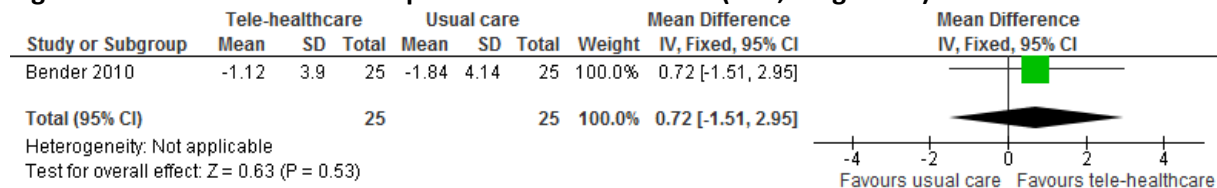
3 **J.21.1.3 Adults and young people (>16 years): Telehealthcare without healthcare professional**  
4 **involvement vs usual care**

**Figure 293: QOL <6 months (AQLQ, range 0-7)**



Heterogeneity: Not applicable  
Test for overall effect: Z = 0.82 (P = 0.41)

**Figure 294: Asthma control questionnaires <6 months (ACT, range 5-25)**



Heterogeneity: Not applicable  
Test for overall effect: Z = 0.63 (P = 0.53)

5

1 J.21.1.4 Children (5-16 years): Telehealthcare without healthcare professional involvement vs  
2 usual care

Figure 295: Exacerbations ≥6 months (OCS rescue use)



Figure 296: QOL ≥6 months (pAQLQ carer).

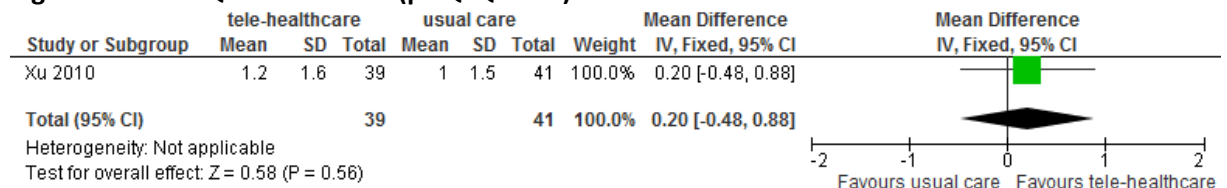


Figure 297: QOL ≥6 months (pAQLQ child).

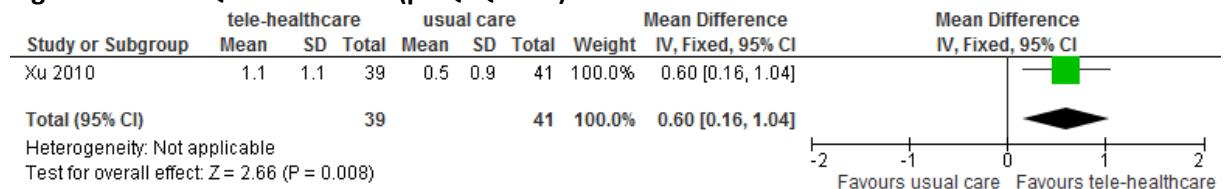


Figure 298: UHU ≥6 months (self-report ED presentation)

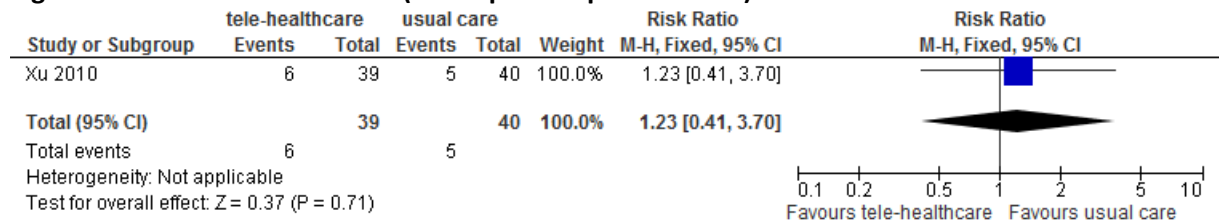
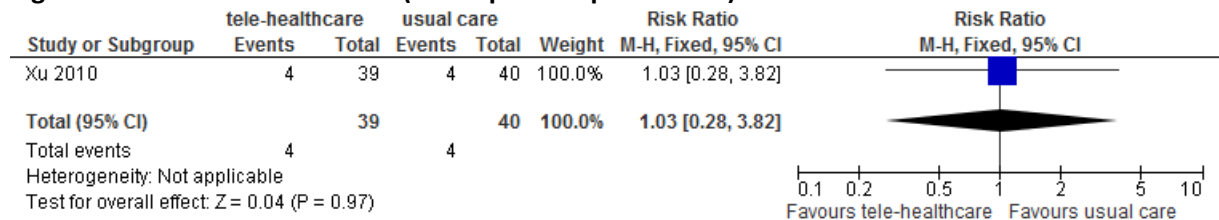
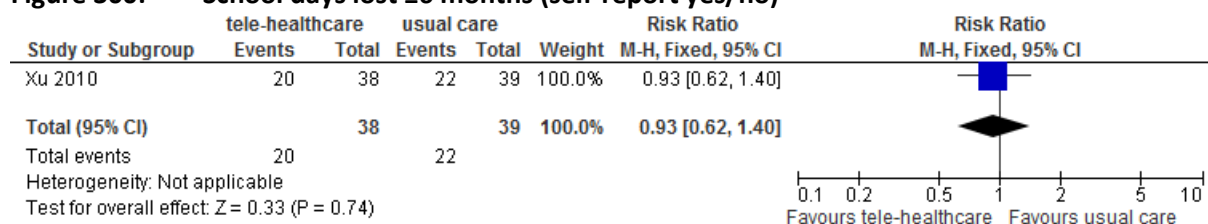


Figure 299: UHU ≥6 months (self-report hospitalisation)

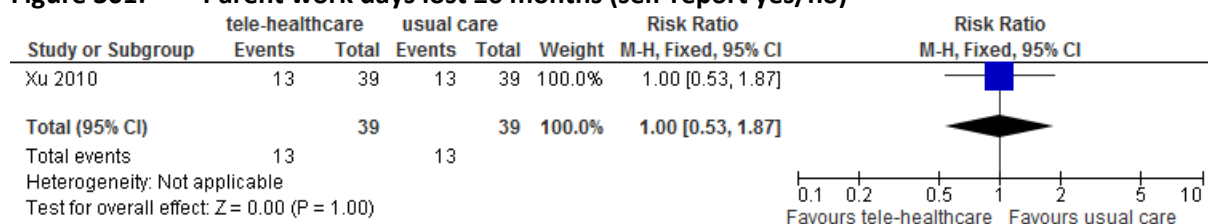


3

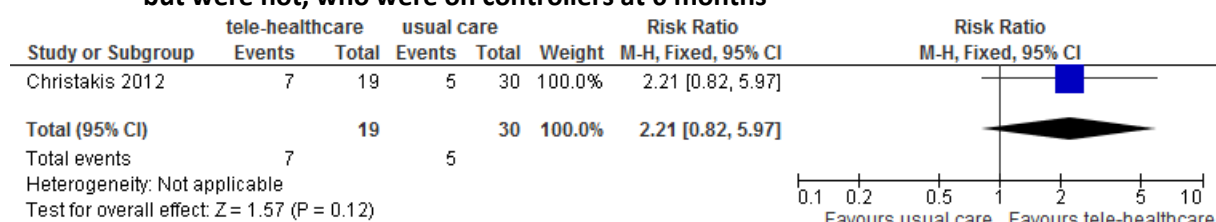
**Figure 300: School days lost  $\geq 6$  months (self-report yes/no)**



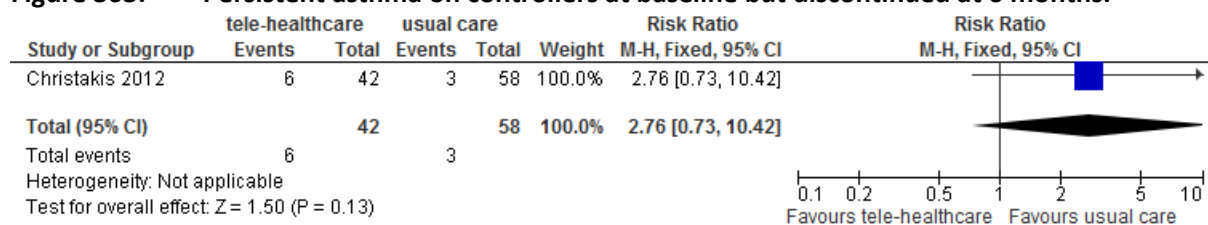
**Figure 301: Parent work days lost  $\geq 6$  months (self-report yes/no)**



**Figure 302: Patients who should have been on controllers at baseline (i.e. persistent asthma) but were not, who were on controllers at 6 months**



**Figure 303: Persistent asthma on controllers at baseline but discontinued at 6 months.**



**Figure 304: Of those who met severity criteria for controllers at baseline, number on them at 12 months**



1  
2

# Appendix K: Excluded clinical studies

## K.1 Diagnosis: Signs and symptoms

**Table 208: Studies excluded from the clinical review**

Reference	Reason for exclusion
ABRAMSON 1992 <sup>9</sup>	General population and no subgroup analysis
ABRAMSON 1996A <sup>10</sup>	General population and no subgroup analysis
ABRAMSON 2002 <sup>12</sup>	Wrong definition of Phys Dx – no objective test.
AMAT 2011 <sup>41</sup>	Wrong definition of Phys Dx – no objective test.
ANDERSON 1986 <sup>44</sup>	Wrong definition of Phys Dx – no objective test.
ANDERSON 1987 <sup>45</sup>	Wrong definition of Phys Dx – no objective test.
ANTOLINAMERIGO 2012 <sup>54</sup>	Conference abstract
ARIF 2003 <sup>67</sup>	General population and no subgroup analysis
ARIF 2004 <sup>66</sup>	Older children: wrong definition of Phys Dx – no objective test. Younger children: looks at wrong risk factors (not those specified in our protocol).
ARIF 2007 <sup>69</sup>	Wrong definition of Phys Dx – no objective test.
ARIF 2008 <sup>68</sup>	General population and no subgroup analysis; QoL only given in asthma subgroup.
ARNEDOPENA 2009 <sup>73</sup>	General population and no subgroup analysis
ARSHAD 2005 <sup>74</sup>	Wrong definition of Phys Dx – no objective test.
ASHER 2008 <sup>76</sup>	Wrong definition of Phys Dx – no objective test.
ATHERTON 1996 <sup>77</sup>	Wrong definition of Phys Dx – no objective test.
AUSTIN 1997 <sup>79</sup>	RFs for wheeze, not asthma.
BACHARIER 2012 <sup>86</sup>	Asthma (wheeze in children) and no comparison group.
BACKER 2009 <sup>89</sup>	No comparison group – asthma only.
BAI 1998 <sup>93</sup>	Wrong definition of Phys Dx – no objective test.
BALL 2000 <sup>99</sup>	Gives prevalence of asthma

Reference	Reason for exclusion
	but not symptoms.
BARRY 2012 <sup>117</sup>	General population and no subgroup analysis, and looks at the wrong risk factors (not those specified in our protocol),
BAUMAN 1992 <sup>128</sup>	Wrong definition of Phys Dx – no objective test.
BAUMANN 1986 <sup>129</sup>	Wrong comparison group: asthma vs. healthy controls.
BEACH 1995 <sup>134</sup>	Diurnal variation in methacholine results, not in symptoms.
BEEH 2003 <sup>137</sup>	Wrong population: only patients without asthma.
BELAMARICH 2000 <sup>143</sup>	Wrong definition of Phys Dx – no objective test.
BELLIA 2000 <sup>148</sup>	Wrong definition of Phys Dx – no objective test.
BENTUR 2004 <sup>154</sup>	Wrong definition of Phys Dx – no objective test.
BERG 2004 <sup>158</sup>	General population and no subgroup analysis
BERG 2011 <sup>155</sup>	Wrong definition of Phys Dx – no objective test.
BERZ 2007 <sup>166</sup>	Correct Phys Dx, but Looks at the wrong risk factors (not those specified in our protocol), and gives prevalence in people with asthma with no comparison group.
BISGAARD 2011 <sup>176</sup>	Wrong population for sens/spec: general population. Wrong population for prevalence data: asthma or general population, not asthma vs. other respiratory diseases. Predictors of asthma development are not given in useable categories.
BOLLAG 2000 <sup>184</sup>	Wrong outcomes: asthma attack rates.
BONER 2010 <sup>187</sup>	Wrong definition of Phys Dx – no objective test.
BORREGO 2009 A <sup>194</sup>	Does not give the % of people with asthma.
BORREGO 2010 <sup>195</sup>	Looks at the wrong risk factors (not those specified in



Reference	Reason for exclusion
	our protocol).
BOUDREAU 1995 <sup>201</sup>	Wrong results: presence of symptoms during histamine challenge.
BOULET 1991 <sup>203</sup>	Asthma pts only and no comparison group.
BOUSQUET 2004 <sup>205</sup>	Wrong definition of Phys Dx of asthma only group – no objective test.
BRAUNFAHRLANDER 1998 <sup>220</sup>	Wrong definition of Phys Dx – no objective test.
BRAUNFAHRLANDER 2004 <sup>221</sup>	General population and no subgroup analysis
BRENNER 2001 <sup>223</sup>	Wrong definition of Phys Dx – no objective test.
BRESCIANINI 2009 <sup>224</sup>	Wrong definition of Phys Dx – no objective test.
BROEKHUIZEN 2010 <sup>228</sup>	Cannot calculate sensitivity and specificity
BROOKE 1998 <sup>230</sup>	Wrong definition of Phys Dx – no objective test.
BRUTSCHE 2006 <sup>239</sup>	Wrong outcomes/population: prevalence of symptoms in previously asymptomatic pts.
BURNEY 1989 <sup>248</sup>	Wrong outcomes: sens/spec for wheeze, asthma attack, or bronchial irritability, not asthma Dx.
BURROWS 1991 <sup>250</sup>	Wrong definition of Phys Dx – no objective test.
BUSINCO 1979 <sup>253</sup>	Gives prevalence of people with asthma (wheezers) only, no comparison group.
CAREY 1996 <sup>272</sup>	Wrong definition of Phys Dx – no objective test.
CARTER 2006 <sup>286</sup>	Wrong definition of Phys Dx – no objective test.
CAUDRI 2007 <sup>292</sup>	Wrong definition of Phys Dx – no objective test.
CAUDRI 2009 <sup>293</sup>	Wrong definition of Phys Dx – no objective test.
CAUDRI 2010 <sup>294</sup>	Wrong outcomes: risk factors for future asthma symptoms not asthma Dx. Prevalence of symptoms in suspected asthma but not in asthma vs. other respiratory diseases.
CHANG 2013 <sup>299</sup>	Population does not match

Reference	Reason for exclusion
	protocol – family history of respiratory allergy
CHINN 2004 <sup>313</sup>	General population and no subgroup analysis
CHRISTOFF 2013 <sup>323</sup>	Conference abstract
COLEMAN 2001 <sup>355</sup>	Wrong definition of Phys Dx – no objective test.
CORDEIRO 2011 <sup>360</sup>	Population does not match protocol – general allergic symptoms not respiratory symptoms only.
CORTESALVAREZ 2007 <sup>363</sup>	Reference standard does not match protocol – history of atopic disorders in $\leq 3$ yrs with wheezing, but no Dx of asthma made
COURT 2002 <sup>367</sup>	Wrong definition of Phys Dx – no objective test.
CSONKA 2000A <sup>377</sup>	Wrong definition of Phys Dx – no objective test.
CUIJPERS 1994 <sup>378</sup>	Wrong definition of Phys Dx – no objective test.
DALES 1987 <sup>386</sup>	Wrong outcomes: sens/spec and predictors of AHR not asthma.
DALES 1988 <sup>387</sup>	Wrong outcomes: predictors of AHR not asthma.
DAS 2003 <sup>388</sup>	Levels of IgE in wheezers v. controls. Not signs and symptoms.
DEBENEDICTIS 1986 <sup>391</sup>	Not known who had asthma, but only people with chronic cough who were MCT positive.
DEMARCO 2005 <sup>399</sup>	Wrong definition of Phys Dx – no objective test.
DEMARCO 2006 <sup>400</sup>	Prognostic factors for asthma severity, rather than for developing asthma.
DEN OTTER 1998 <sup>418</sup>	Wrong outcomes; symptoms in people who consulted the GP vs. those who did not, rather than people with asthma.
DODGE 1994 <sup>440</sup>	Wrong definition of Phys Dx – no objective test.
DODGE 1996 <sup>441</sup>	Wrong definition of Phys Dx – no objective test.

Reference	Reason for exclusion
FANIRAN 1999 <sup>485</sup>	General population and no subgroup analysis
FLEMING 2000 <sup>499</sup>	Prevalence of asthma over time rather than symptoms.
FOUCARD 1984 <sup>507</sup>	Reference standard does not match protocol (children who reported asthma symptoms during the last year were regarded as having asthma)
FRANK 1996 <sup>510</sup>	Wrong definition of Phys Dx – no objective test.
FRANK 2001 <sup>511</sup>	Wrong definition of Phys Dx – no objective test.
FRANK 2008 <sup>512</sup>	Predictors of wheeze, not asthma.
FRISCHER 1993 <sup>518</sup>	Wrong definition of Phys Dx – no objective test.
FUJIMURA 2005 <sup>527</sup>	Looks at the wrong risk factors (not those specified in our protocol).
GARCINUNO 2013 <sup>544</sup>	Wrong definition of Phys Dx – no objective test.
GERALD 2009 <sup>550</sup>	Cannot calculate sensitivity and specificity
GLASGOW 2001 <sup>568</sup>	General population and no subgroup analysis; and sens/spec not in suspected asthma.
GODDEN 1994 <sup>569</sup>	Meets all inclusion criteria for prevalence study, except wrong sample size, N<200.
GOKSOR 2006 <sup>576</sup>	Wrong definition of Phys Dx – no objective test.
GOKSOR 2008 <sup>577</sup>	Wrong definition of Phys Dx – no objective test.
GUERRA 2004 <sup>605</sup>	Wrong definition of Phys Dx – no objective test.
GUILBERT 2004A <sup>607</sup>	Wrong definition of Phys Dx – no objective test.
GUILBERT 2004B <sup>606</sup>	Risk factors for wheeze in adults, not asthma.
GUILBERT 2011A <sup>608</sup>	Wrong definition of Phys Dx – no objective test.
HABBICK 1999 <sup>613</sup>	Wrong definition of Phys Dx – no objective test.
HABY 2001 <sup>614</sup>	Looks at the wrong risk

Reference	Reason for exclusion
	factors (not those specified in our protocol). Prevalence in general population.
HAFKAMP 2012 <sup>618</sup>	Looks at the wrong risk factors (not those specified in our protocol).
HAFKAMP 2013 <sup>617</sup>	Wrong definition of Phys Dx – no objective test.
HAFKAMP 2013A <sup>616</sup>	Prevalence in general population.
HAHN 1994 <sup>619</sup>	Wrong definition of Phys Dx – no objective test.
HALL 2006 <sup>621</sup>	Wrong definition of Phys Dx – no objective test.
HALLIDAY 1993 <sup>623</sup>	Wrong definition of Phys Dx – no objective test.
HALONEN 1999 <sup>624</sup>	Looks at the wrong risk factors (not those specified in our protocol). Prevalence in general population.
HALONEN 2013 <sup>625</sup>	Looks at the wrong risk factors (not those specified in our protocol). Prevalence in general population.
HANCOX 2004 <sup>628</sup>	Wrong definition of Phys Dx – no objective test.
HANCOX 2005 <sup>629</sup>	Looks at the wrong risk factors (not those specified in our protocol).
HANCOX 2006 <sup>630</sup>	Wrong definition of Phys Dx – no objective test.
HANSEL 2011 <sup>632</sup>	Cannot calculate sensitivity and specificity
HEINRICH 1998 <sup>652</sup>	Prevalence in general population.
HEINRICH 1999 <sup>651</sup>	Prevalence in general population. Looks at the wrong risk factors (not those specified in our protocol).
HEINRICH 2002 <sup>650</sup>	Wrong definition of Phys Dx – no objective test.
HENDERSON 1995 <sup>655</sup>	Predictor of wheeze, not asthma.
HENDERSON 2005 <sup>657</sup>	Prevalence in wrong population: RSV pts vs. controls, not asthma vs. other respiratory diseases.

Reference	Reason for exclusion
HENDERSON 2008 <sup>656</sup>	Wrong definition of Phys Dx – no objective test.
HENDERSON 2008A <sup>658</sup>	Wrong definition of Phys Dx – no objective test.
HENSLEY 2003 <sup>662</sup>	Prevalence in wrong population: not asthma vs. other respiratory diseases.
HERR 2012 <sup>664</sup>	Age 18 months, but assessment of symptoms made in the previous 12 months.
HERR 2012A <sup>663</sup>	Age 18 months, but assessment of symptoms made in the previous 12 months.
HICKSON 2009 <sup>668</sup>	Prevalence in general population.
HIRSCH 1999 <sup>674</sup>	Wrong definition of Phys Dx – no objective test.
HIRSCH 2004 <sup>673</sup>	Looks at a new score for Dx of asthma. However the score contains other aspects as well as symptoms, and results are not given separately for the symptoms.
HODGE 1996 <sup>675</sup>	Looks at the wrong risk factors (not those specified in our protocol).
HOEK 2012 <sup>676</sup>	Prevalence in general population.
HOLSTER 2012 <sup>682</sup>	Wrong definition of Phys Dx – no objective test. Looks at the wrong risk factors (not those specified in our protocol).
HOLT 2010 <sup>684</sup>	Prevalence in general population. Looks at the wrong risk factors (not those specified in our protocol).
HOMNICK 2007 <sup>688</sup>	Wrong definition of Phys Dx – no objective test.
HOPP 1995 <sup>694</sup>	Dx ability of questionnaire but looks at asthma a vs. controls in general population, not suspected asthma pts.
HOPPER 1995 <sup>695</sup>	Prevalence in general population.
HOPPER 2012 <sup>696</sup>	Wrong definition of Phys Dx – no objective test.

Reference	Reason for exclusion
HORAK 2003 <sup>697</sup>	Wrong definition of Phys Dx – no objective test.
HORAK 2006 <sup>699</sup>	Prevalence in general population.
HORAK 2007 <sup>698</sup>	Prevalence in general population. Looks at the wrong risk factors (not those specified in our protocol).
HORWOOD 1985 <sup>702</sup>	Meets all inclusion criteria for prognostic study in children, except wrong follow-up time: 6 years.
HU 1997 <sup>707</sup>	Prevalence in general population. Looks at the wrong risk factors (not those specified in our protocol).
HU 1997A <sup>706</sup>	Wrong definition of Phys Dx – no objective test.
HUBLET 2006 <sup>710</sup>	Prevalence in general population.
HUNGER 2010 <sup>712</sup>	Wrong definition of Phys Dx – no objective test.
ILLI 2001 <sup>725</sup>	Wrong definition of Phys Dx – no objective test.
ILLI 2001A <sup>724</sup>	Prevalence in general population.
ILLI 2004 <sup>726</sup>	Wrong definition of Phys Dx – no objective test.
ILLI 2006 <sup>727</sup>	Wrong definition of Phys Dx – no objective test.
INKLEY 1967 <sup>730</sup>	Prevalence in general population.
IRWIN 1990 <sup>731</sup>	Gives the prevalence of asthma in people with cough, not the prevalence of cough in people who do not have asthma.
ISLAM 2007 <sup>734</sup>	Wrong definition of Phys Dx – no objective test.
IVERSEN 2005 <sup>735</sup>	Wrong definition of Phys Dx – no objective test.
JACKSON 2008 <sup>739</sup>	Wrong definition of Phys Dx – no objective test.
JACOBS 2012 <sup>740</sup>	Wrong definition of Phys Dx – no objective test.
JAMES 2010 <sup>745</sup>	Wrong definition of Phys Dx – no objective test.

Reference	Reason for exclusion
JAMES 2013 <sup>746</sup>	Prevalence in general population.
JAMROZIK 2009 <sup>748</sup>	Wrong definition of Phys Dx – no objective test.
JANSON 2001 <sup>752</sup>	Wrong definition of Phys Dx – no objective test.
JANSON 2001A <sup>753</sup>	Wrong definition of Phys Dx – no objective test.
JARTTI 2008 <sup>758</sup>	Wrong definition of Phys Dx – no objective test.
JARVIS 1994 <sup>761</sup>	Prevalence in general population.
JARVIS 1996 <sup>759</sup>	Wrong definition of Phys Dx – no objective test.
JARVIS 2002 <sup>760</sup>	Wrong definition of Phys Dx – no objective test.
JEFFS 2000 <sup>763</sup>	Unclear Physy Dx – but seems like ISAAC questionnaire.
JENKINS 1994A <sup>766</sup>	Wrong definition of Phys Dx – no objective test.
JENKINS 2006 <sup>765</sup>	Wrong definition of Phys Dx – no objective test.
JOHNSON 2013 <sup>772</sup>	General population and no subgroup analysis
JOHNSTON 1998 <sup>773</sup>	Risk factors for other respiratory problems, not asthma. Prevalence of people with asthma with no comparison group.
JONES 2008 <sup>777</sup>	Results separated for different ethnic groups. Mixed ages of children (<5 and >5 years with no subgroup analysis). Wrong definition of Phys Dx – no objective test.
JOSEPH 1996 <sup>780</sup>	Wrong definition of Phys Dx – no objective test.
JOSEPH 1999 <sup>781</sup>	Reference standard does not match protocol (self-reported physician Dx of asthma – no objective test).
JOSEPH-BOWEN 2004 <sup>783</sup>	Reference standard does not match protocol; physician diagnosis + symptoms of wheeze in last 12 months + asthma meds in last 12 months (no objective test)
JUHN 2005 <sup>784</sup>	Looks at the wrong risk

Reference	Reason for exclusion
	factors (not those specified in our protocol). Unclear percentage who had objective test with the Phys Dx.
JUNG 2012 <sup>787</sup>	Looks at the wrong risk factors (not those specified in our protocol). Prevalence in general population.
JUNG 2012A <sup>786</sup>	Predictors of wheeze, not asthma.
JUST 2010 <sup>801</sup>	Predictors of wheeze, not asthma.
JUST 2013 <sup>802</sup>	Wrong outcome: predictors of different types of wheeze.
KABESCH 2004 <sup>803</sup>	Looks at the wrong risk factors (not those specified in our protocol). Prevalence in general population.
KABIR 2009 <sup>804</sup>	Wrong definition of Phys Dx – no objective test.
KABLE 2001 <sup>805</sup>	Prevalence and sens/spec in general population.
KAGEN 2014 <sup>806</sup>	Conference abstract
KAPPELLE 2012 <sup>812</sup>	Wrong definition of Phys Dx – no objective test.
KARAKOC 2002 <sup>817</sup>	Prevalence in general population, and looks at wrong risk factors (not those specified in our protocol).
KAUFFMANN 1997 <sup>822</sup>	Wrong definition of Phys Dx – no objective test.
KAUFFMANN 2011 <sup>823</sup>	Epidemiology.
KAUGARS 2008 <sup>825</sup>	Looks at wrong risk factors (not those specified in our protocol).
KEALL 2012 <sup>829</sup>	Prevalence in general population.
KEARNEY 1998 <sup>830</sup>	Wrong definition of Phys Dx – no objective test.
KEIL 1996 <sup>833</sup>	General population and no subgroup analysis
KEIL 2006 <sup>832</sup>	Review – used as a source of references
KELLY 1987 <sup>834</sup>	Unclear Phys Dx. Case-control study.
KELLY 1995 <sup>835</sup>	Wrong definition of Phys Dx –



Reference	Reason for exclusion
	no objective test.
KELLY 1996 <sup>836</sup>	Wrong definition of Phys Dx – no objective test.
KERCSMAR 2008 <sup>841</sup>	Conference summary.
KERKHOF 2009 <sup>843</sup>	Wrong definition of Phys Dx – no objective test.
KHARITONOV 1996 <sup>851</sup>	Asthma only – no comparison group. Correct Phys Dx with objective test.
KHOSHOO 2009 <sup>854</sup>	Meets all inclusion criteria for prevalence study, except sample size N<200.
KIEFTEDE 2012 <sup>855</sup>	Looks at wrong risk factors. Prevalence in general population.
KING 2004 <sup>867</sup>	Predictors of lung function, not asthma. Does not give prevalence in asthma pts.
KISS 2003 <sup>868</sup>	Symptoms as predictors of angina, not asthma! Unclear asthma Dx.
KLAASSEN 2012 <sup>874</sup>	Does not give prevalence of symptoms, or predictors, or ability to diagnose.
KLINNERT 2001 <sup>879</sup>	Wrong definition of Phys Dx – no objective test.
KLINNERT 2008 <sup>880</sup>	General population and no subgroup analysis, and looks at wrong risk factors (not those specified in out protocol).
KLIJAKOVIC 1991 <sup>881</sup>	General population and no subgroup analysis
KNEYBER 2000 <sup>882</sup>	Does not give symptoms in asthma, but bronchiolitis and control group.
KOLLER 1997 <sup>893</sup>	Age < 1 year
KOLNAAR 1995 <sup>894</sup>	Reference standard does not match protocol - comparison of histamine test to presence of asthma symptoms (not to physician Dx)
KOPONEN 2012 <sup>901</sup>	Wrong definition of Phys Dx – no objective test.
KOSHY 2010 <sup>903</sup>	General population and no subgroup analysis
KOZYRSKYJ 2003 <sup>916</sup>	Wrong definition of Phys Dx –

Reference	Reason for exclusion
	no details given or mention of objective test.
KOZYRSKYJ 2004 <sup>917</sup>	Wrong definition of Phys Dx – no objective test.
KOZYRSKYJ 2009 <sup>915</sup>	Wrong definition of Phys Dx – no objective test.
KUEHNI 2000 <sup>921</sup>	Wrong definition of Phys Dx – no objective test.
KUEHNI 2001 <sup>922</sup>	Prevalence of symptoms in people with asthma only, no comparison group.
KUEHR 1995 <sup>924</sup>	Wrong comparison group: asthma vs. non-asthma (not other respiratory symptoms).
KUHNI 1995 <sup>926</sup>	Does not mention asthma definition of Dx.
KUMAR 2008 <sup>930</sup>	General population and no subgroup analysis
KURUKULAARATCHY 2002 <sup>935</sup>	Gives prevalence data in people with asthma but no other respiratory comparison group. Prognostic data not used as wrong follow-up time: baseline (birth) to 10 years later (does not match our protocol criteria).
KURUKULAARATCHY 2003 <sup>937</sup>	Risk of wheeze not asthma (older children).
KURUKULAARATCHY 2003A <sup>939</sup>	Asthma only - no comparison group.
KURUKULAARATCHY 2004 <sup>934</sup>	Wrong population: wheeze not asthma (older children).
KURUKULAARATCHY 2004A <sup>938</sup>	General population and no subgroup analysis
KURUKULAARATCHY 2005 <sup>940</sup>	General population and no subgroup analysis; looks at wrong risk factors (not those in our protocol).
KURUKULAARATCHY 2005A <sup>936</sup>	Prevalence and risk factors for atopy, not asthma.
LABRUZZO 2007 <sup>945</sup>	Review.
LAI 2009 <sup>949</sup>	General population and no subgroup analysis
LANGE 2010 <sup>953</sup>	General population and no subgroup analysis
LAU 2000 <sup>961</sup>	General population and no subgroup analysis

Reference	Reason for exclusion
LAU 2002 <sup>963</sup>	Prevalence in wheezers (young children) but no comparison group.
LAU 2003 <sup>962</sup>	Predictors of impaired lung function not asthma.
LAU 2005 <sup>960</sup>	Wrong definition of Phys Dx – no objective test.
LAUBEREAU 2002 <sup>964</sup>	General population and no subgroup analysis
LEERMAKERS 2013 <sup>974</sup>	General population and no subgroup analysis
LEONARDI 2011 <sup>982</sup>	Wrong definition of Phys Dx – no objective test.
LEONE 2012 <sup>983</sup>	Wrong definition of Phys Dx – no objective test.
LESQUEF 1995 <sup>969</sup>	General population and no subgroup analysis
LEUNG 1994 <sup>986</sup>	Wrong definition of Phys Dx – no objective test.
LEVESQUE 2004 <sup>989</sup>	Wrong definition of Phys Dx – no objective test.
LEWIS 1995 <sup>993</sup>	Predictors of wheeze not asthma (in young people).
LEWIS 1996 <sup>992</sup>	General population and no subgroup analysis
LI 2006B <sup>998</sup>	Wrong definition of Phys Dx – no objective test.
LIEM 2007 <sup>1001</sup>	RFs for transient tachypnea and wheeze, not asthma.
LINEHAN 2007 <sup>1010</sup>	General population and no subgroup analysis.
LINEHAN 2009 <sup>1009</sup>	Prevalence in people with respiratory symptoms, not asthma.
LINEHAN 2012 <sup>1008</sup>	General population and no subgroup analysis.
LOERBROKS 2012 <sup>1024</sup>	Prevalence in general population but not in asthma subgroup.
LUYT 1993 <sup>1041</sup>	General population or asthma subgroup (no comparison group).
LUYT 1994 <sup>1040</sup>	Wrong definition of Phys Dx for children up to 5 years old: no objective test, just symptoms ascertained by

Reference	Reason for exclusion
	questionnaire.
LUYT 1995 <sup>1039</sup>	General population or asthma subgroup (no comparison group). Looks at wrong risk factors (not those specified in our protocol).
MAAS 2009 <sup>1042</sup>	Does not answer the question. Effect of allergen-reduction interventions on the prevention of asthma.
MAGDALIJNS 2011 <sup>1047</sup>	General population and no subgroup analysis
MAHER 2004 <sup>1051</sup>	Cannot calculate sensitivity and specificity
MAITRA 2004 <sup>1054</sup>	General population and no subgroup analysis
MALLOL 2010 <sup>1062</sup>	Percentage of wheezers who had asthma, rather than % of asthma who had wheeze.
MANDHANE 2005 <sup>1070</sup>	RFs for wheeze, not asthma.
MANFREDA 2001 <sup>1071</sup>	Wrong definition of Phys Dx – no objective test.
MANNING 2007 <sup>1072</sup>	Conference abstract.
MARBURY 1996 <sup>1076</sup>	General population and no subgroup analysis
MAROSSY 2007 <sup>1079</sup>	Wrong definition of Phys Dx – no objective test.
MARTINDALE 2005 <sup>1080</sup>	General population and no subgroup analysis
MARTINEZ 1995 <sup>1081</sup>	General population and no subgroup analysis
MARTINEZ 2006 <sup>1082</sup>	General population and no subgroup analysis
MATHESON 2006 <sup>1087</sup>	Looks at the wrong risk factors (not those specified in our protocol).
MATRICARDI 2008 <sup>1089</sup>	Predictors of wheeze not asthma (in young people).
MAZIAK 2002 <sup>1097</sup>	Wrong definition of Phys Dx – no objective test.
MAZIAK 2004 <sup>1098</sup>	Wrong definition of Phys Dx – no objective test.
MCCONNELL 1999 <sup>1101</sup>	Wrong definition of Phys Dx – no objective test.
MCCONNELL 2002 <sup>1102</sup>	Wrong definition of Phys Dx –

Reference	Reason for exclusion
	no objective test.
MCHEDLISHVILI 2013 <sup>1108</sup>	Conference abstract
MCKEEVER 2002 <sup>1109</sup>	Unclear age of children and follow-up time.
MICHEL 2006 <sup>1129</sup>	Dx of wheeze in older children (not asthma).
MIDODZI 2010 <sup>1131</sup>	Wrong definition of Phys Dx for children up to 5 years old: no objective test, just symptoms ascertained by questionnaire.
MIEDINGER 2007 <sup>1134</sup>	Good definition of Phys Dx, but gives sens/spec in general population (not suspected asthma), and prevalence in asthma pts only (no comparison group).
MILAM 2008 <sup>1136</sup>	No comparison group: wheeze only.
MILLSTEIN 2004 <sup>1142</sup>	Wrong definition of Phys Dx – no objective test. Wrong definition of Phys Dx – no objective test.
MITCHELL 1989 <sup>1150</sup>	General population and no subgroup analysis.
MITCHELL 1994 <sup>1148</sup>	Wrong definition of Phys Dx – no objective test.
MITCHELL 1997 <sup>1152</sup>	Methods paper – not study results.
MITCHELL 2009 <sup>1151</sup>	Predictors of wheeze, not asthma (older children)
MOHANGOO 2010 <sup>1159</sup>	Good definition of Phys Dx, but gives sensitivity/specificity in general population (not suspected asthma), and prevalence in general population (not people with asthma).
MOMAS 1998 <sup>1160</sup>	Wrong definition of Phys Dx – no objective test.
MOMMERS 2005 <sup>1161</sup>	Wrong comparison group - - prevalence in asthma vs. controls (not vs. other respiratory diseases), and looks at the wrong risk factors (not those specified in our protocol).
MORASS 2008 <sup>1166</sup>	General population and no

Reference	Reason for exclusion
	subgroup analysis; looks at the wrong risk factors (not those specified in our protocol).
MORGAN 2005 <sup>1167</sup>	Literature review.
MUSK 2011 <sup>1185</sup>	Wrong definition of Phys Dx – no objective test.
MVULA 2005 <sup>1189</sup>	General population and no subgroup analysis
NAGEL 2009A <sup>1193</sup>	Looks at the wrong risk factors (not those specified in our protocol).
NAGEL 2010 <sup>1195</sup>	Looks at the wrong risk factors (not those specified in our protocol). Prevalence of asthma in general population
NAGEL 2012 <sup>1194</sup>	Wrong definition of Phys Dx – no objective test.
NANKANI 1990 <sup>1196</sup>	Wrong definition of Phys Dx – no objective test.
NEJJARI 1994 <sup>1208</sup>	Case-control study: asthma vs. healthy controls (not other respiratory diseases).
NEUMAN 2012 <sup>1210</sup>	Wrong definition of Phys Dx – no objective test.
NEVILLE 1992 <sup>1212</sup>	Wrong definition of Phys Dx – no objective test.
NEVILLE 2001 <sup>1213</sup>	Prevalence in asthma pts only (no comparison group).
NGMANKWONG 2001 <sup>1215</sup>	General population and no subgroup analysis
NGMANKWONG 2002 <sup>1214</sup>	Wrong definition of Phys Dx – no objective test.
NICOLAI 2003 <sup>1222</sup>	General population and no subgroup analysis
NINAN 1993 <sup>1236</sup>	Prevalence data only given in the symptomatic group who are BHR+ (ie people with asthma), not in any comparison group.
NINAN 1995 <sup>1235</sup>	Reference standard does not match protocol – Dx made on the basis of symptoms
NWARU 2013 <sup>1251</sup>	General population and no subgroup analysis; wrong risk factors (not those specified in the protocol).

Reference	Reason for exclusion
OBERLE 2003 <sup>1254</sup>	Wrong definition of Phys Dx – no objective test.
ODDY 1999 <sup>1257</sup>	Wrong definition of Phys Dx – no objective test.
ODDY 2000 <sup>1255</sup>	Wrong definition of Phys Dx – no objective test.
ODDY 2002 <sup>1256</sup>	Wrong definition of Phys Dx – no objective test.
ODDY 2002A <sup>1258</sup>	General population and no subgroup analysis
ODDY 2004 <sup>1259</sup>	Wrong definition of Phys Dx – no objective test.
OSMAN 2007 <sup>1275</sup>	Wrong definition of Phys Dx – no objective test.
PALMER 2004 <sup>1286</sup>	Wrong definition of Phys Dx – no objective test.
PANICO 2007 <sup>1289</sup>	General population and no subgroup analysis
PARARAJASINGAM 1992 <sup>1295</sup>	General population and no subgroup analysis
PARK 1986 <sup>1298</sup>	Wrong definition of Phys Dx – no objective test.
PATERSON 1997 <sup>1305</sup>	General population and no subgroup analysis
PATTEMORE 1990 <sup>1307</sup>	Reference standard does not match protocol (asthma diagnosis by previous report of a diagnosis but no objective test)
PEARLMAN 2005 <sup>1309</sup>	Wrong comparison group: people with asthma on Tx vs. Tx-naïve people with asthma.
PEAT 1991A <sup>1310</sup>	Predictors of wheeze, not asthma (older children).
PEAT 1993 <sup>1312</sup>	Good Phys Dx definition, but looks at wrong risk factors for asthma (not in our protocol).
PEAT 1994 <sup>1313</sup>	Good Phys Dx definition, but only gives prevalence in General population and no subgroup analysis.
PERSKY 1998 <sup>1326</sup>	Asthma and no comparison group.
PERZANOWSKI 2008A <sup>1328</sup>	General population and no subgroup analysis
PETERS 1999 <sup>1333</sup>	Wrong definition of Phys Dx – no objective test.

Reference	Reason for exclusion
PINTO 2010 <sup>1352</sup>	General population and no subgroup analysis
PIZZICHINI 2000 <sup>1353</sup>	Wrong definition of Phys Dx – no objective test.
PLESSMULLOLI 2000 <sup>1357</sup>	General population and no subgroup analysis
PLESSMULLOLI 2001 <sup>1358</sup>	General population and no subgroup analysis
PONSONBY 2000 <sup>1362</sup>	General population - gives prevalence of symptoms in asthma vs. no asthma (not other respiratory diseases).
PONSONBY 2004 <sup>1364</sup>	General population and no subgroup analysis
PONSONBY 2008 <sup>1365</sup>	General population and no subgroup analysis
POWELL 1995 <sup>1372</sup>	Wrong definition of Phys Dx – no objective test.
POWELL 1996 <sup>1373</sup>	Wrong definition of Phys Dx – no objective test.
POWELL 1999 <sup>1371</sup>	General population and no subgroup analysis
POWER 1995 <sup>1376</sup>	Wrong definition of Phys Dx – no objective test.
PRABHU 2010 <sup>1379</sup>	Prevalence in general population and asthma, but no comparison group.
PUJADESRODRIGUEZ 2009 <sup>1398</sup>	General population and no subgroup analysis
PUJADESRODRIGUEZ 2009A <sup>1399</sup>	Wrong definition of Phys Dx – no objective test.
RADON 2002 <sup>1406</sup>	Wrong definition of Phys Dx – no objective test.
RAHERISON 2006 <sup>1409</sup>	Prevalence in asthma, but no comparison group.
RASMUSSEN 2002 <sup>1420</sup>	Wrong definition of Phys Dx – no objective test.
RAZA 2012 <sup>1423</sup>	Wrong definition of Phys Dx – no objective test.
REDLINE 2003 <sup>1427</sup>	Cannot calculate sensitivity and specificity
REGNIER 2013 <sup>1429</sup>	Looks at the wrong risk factors (not those specified in our protocol).
REMES 2001 <sup>1432</sup>	General population and no subgroup analysis; and looks



Reference	Reason for exclusion
	at the wrong risk factors (not those specified in our protocol).
RENNIE 2004 <sup>1434</sup>	Prevalence in asthma subgroup, but no comparison group.
RIETVELD 1996 <sup>1445</sup>	Wrong population for Dx accuracy – asthma vs. controls rather than suspected asthma.
RIETVELD 1998 <sup>1446</sup>	Wrong definition of Phys Dx – no objective test.
RIZWAN 2004 <sup>1450</sup>	General population and no subgroup analysis
ROBINSON 2012A <sup>1452</sup>	Correct definition of Phys Dx, but looks at the wrong risk factors (not those specified in our protocol).
RODRIGO 2013 <sup>1454</sup>	Treatment study
RODUIT 2009 <sup>1456</sup>	General population and no subgroup analysis
RONA 1995 <sup>1461</sup>	General population and no subgroup analysis
ROORDA 2001 <sup>1462</sup>	Prevalence of symptoms in suspected asthma, but not asthma vs. other respiratory diseases.
ROSIER 1994 <sup>1468</sup>	Does not answer the question. Gives data on prevalence of symptoms in patients with asthma vs. patients without asthma. Divides data into severity categories and measures of function within each category.
SALAM 2004 <sup>1486</sup>	Looks at the wrong risk factors (not those specified in our protocol).
SALOME 1987 <sup>1488</sup>	Wrong definition of Phys Dx – no objective test.
SAVENIJE 2011 <sup>1503</sup>	Wrong definition of Phys Dx – no objective test.
SCARLETT 1995 <sup>1504</sup>	General population and no subgroup analysis
SCHACHTER 2001 <sup>1507</sup>	Looks at the wrong risk factors (not those specified in our protocol).
SCHACHTER 2003 <sup>1506</sup>	General population and no

Reference	Reason for exclusion
	subgroup analysis
SCHACHTER 1984 <sup>1505</sup>	Wrong definition of Phys Dx – no objective test.
SCHAPER 2010 <sup>1508</sup>	Wrong definition of Phys Dx – no objective test.
SCHERNHAMMER 2008 <sup>1512</sup>	Wrong definition of Phys Dx – no objective test.
SCHOLTENS 2009 <sup>1523</sup>	General population and no subgroup analysis
SCHOLTENS 2009A <sup>1525</sup>	General population and no subgroup analysis
SCHOLTENS 2010 <sup>1524</sup>	General population and no subgroup analysis
SCHONBERGER 2004 <sup>1526</sup>	Meets all inclusion criteria for prognostic study, but wrong follow-up time: >5 years. Children with wheeze followed for development of asthma in adolescence.
SCHUMPERT 2006 <sup>1528</sup>	Wrong definition of Phys Dx – no objective test.
SCOTT 2010 <sup>1534</sup>	Wrong definition of Phys Dx – no objective test.
SEARS 1996 <sup>1538</sup>	Prevalence in General population and no subgroup analysis. Looks at the wrong risk factors (not those specified in our protocol).
SENNHAUSER 1995 <sup>1544</sup>	Wrong definition of Phys Dx – no objective test.
SETHILSELVAN 1993 <sup>1545</sup>	Wrong definition of Phys Dx – no objective test.
SHAHEEN 1998 <sup>1551</sup>	General population and no subgroup analysis
SHAHEEN 1999 <sup>1549</sup>	General population and no subgroup analysis
SHAHEEN 2005 <sup>1547</sup>	General population and no subgroup analysis
SHAHEEN 2000 <sup>1550</sup>	General population and no subgroup analysis
SHAHEEN 2002 <sup>1548</sup>	Prevalence of wheeze in future wheezers vs. non-wheezers (wrong comparison group).
SHANKARDASS 2009 <sup>1553</sup>	General population and no subgroup analysis
SHAVIT 2007 <sup>1557</sup>	Wrong definition of Phys Dx –

Reference	Reason for exclusion
	no objective test.
SHERRIFF 2009 <sup>1559</sup>	General population and no subgroup analysis
SHIN 2010 <sup>1564</sup>	Good definition of Phys Dx – uses objective test. BUT wrong comparison group: asthma vs. healthy controls, not other respiratory symptoms.
SHREWSBURY 2000 <sup>1571</sup>	Meta-analysis of Tx studies – shows symptoms in asthma only (no comparison group).
SIBBALD 1992 <sup>1572</sup>	General population and no subgroup analysis
SILVER 1998 <sup>1576</sup>	Wrong definition of Phys Dx – no objective test.
SILVERS 2009 <sup>1577</sup>	General population and no subgroup analysis; and looks at the wrong risk factors (not those specified in our protocol).
SILVERS 2012 <sup>1578</sup>	Looks at the wrong risk factors (not those specified in our protocol).
SIMPSON 2010 <sup>1590</sup>	Prevalence in General population and no subgroup analysis. Looks at the wrong risk factors (not those specified in our protocol).
SIN 2002 <sup>1594</sup>	Wrong definition of Phys Dx – no objective test.
SISTEK 2001A <sup>1600</sup>	Wrong definition of Phys Dx – no objective test.
SISTEK 2006 <sup>1601</sup>	Reference standard does not match protocol – asthma Dx based on questionnaire responses to doctor diagnosed asthma and attack in the last 12 months (no mention of objective test)
SMIT 2009 <sup>1609</sup>	Does not give prevalence of symptoms.
SNIJDERS 2007 <sup>1617</sup>	Looks at the wrong risk factors (not those specified in our protocol).
SOCKRIDER 2001 <sup>1619</sup>	Wrong definition of Phys Dx – no objective test.
SOLOMON 2003 <sup>1620</sup>	General population and no subgroup analysis

Reference	Reason for exclusion
SONNENSCHN 2012 <sup>1624</sup>	Looks at the wrong risk factors (not those specified in our protocol).
SONNENSCHN VAN DER VOORT 2012 <sup>1623</sup>	General population and no subgroup analysis
SORIANO 2003 <sup>1629</sup>	All asthma pts – no comparison group; does not give prevalence of symptoms.
SOTIR 2006 <sup>1630</sup>	Prevalence of asthma and wheeze in RTI pts, not symptoms in asthma.
SOTORAMIREZ 2013 <sup>1631</sup>	Wrong definition of Phys Dx – no objective test.
SPEEVANDERWEKKE 1998 <sup>1638</sup>	General population and no subgroup analysis
SPYCHER 2008 <sup>1646</sup>	General population and no subgroup analysis
SPYCHER 2009 <sup>1648</sup>	General population and no subgroup analysis
SPYCHER 2012 <sup>1647</sup>	Wrong definition of Phys Dx – no objective test.
STERN 2008 <sup>1658</sup>	Wrong definition of Phys Dx – no objective test.
STINGONE 2008 <sup>1662</sup>	Asthma and no comparison group.
STINGONE 2011 <sup>1663</sup>	Asthma and no comparison group.
STODDARD 1995 <sup>1664</sup>	General population and no subgroup analysis
STRACHAN 1985 <sup>1668</sup>	General population and no subgroup analysis
STRACHAN 1988A <sup>1669</sup>	Wrong definition of Phys Dx – no objective test.
STRACHAN 1994 <sup>1670</sup>	Wrong definition of Phys Dx – no objective test.
STRACHAN 1996 <sup>1672</sup>	Unclear definition of diagnosis – seems like self-reported.
STRACHAN 1996B <sup>1671</sup>	Wrong definition of Phys Dx – no objective test.
STRUNK 2002 <sup>1674</sup>	RFs for night-awakening due to asthma, not for asthma. Prevalence of symptoms in people with asthma but no comparison group.
SUN 2011 <sup>1681</sup>	General population and no subgroup analysis. Looks at the wrong risk factors (not

Reference	Reason for exclusion
	those specified in our protocol).
SUN 2013 <sup>1680</sup>	General population and no subgroup analysis. Looks at the wrong risk factors (not those specified in our protocol).
SUNYER 2004 <sup>1683</sup>	Wrong outcomes: fraction of asthma caused by atopy.
SUTHERLAND 2007 <sup>1685</sup>	Wrong definition of Phys Dx – no objective test.
TAGIYEVA 2010 <sup>1695</sup>	General population and no subgroup analysis
TAI 2009 <sup>1696</sup>	General population and no subgroup analysis
TAKENOUE 2012 <sup>1700</sup>	Meta-analysis of the influence of NO in the Dx of asthma.
TAN 2013 <sup>1705</sup>	Wrong population: prevalence in obstructive airways combined, not asthma separated.
TAUSSIG 2003 <sup>1715</sup>	Review of a study (TUSCON study).
TAVERAS 2006 <sup>1716</sup>	Correct definition of Phys Dx, but looks at the wrong risk factors (not those specified in our protocol).
TAYLOR 1983 <sup>1717</sup>	General population and no subgroup analysis
TAYLOR 2005 <sup>1718</sup>	Wrong definition of Phys Dx – no objective test.
THOMAS 2010 <sup>1730</sup>	Wrong definition of Phys Dx – no objective test.
THOMSON 2012 <sup>1732</sup>	General population and no subgroup analysis
THORNE 2005 <sup>1734</sup>	Looks at the wrong risk factors (not those specified in our protocol). Does not give prevalence in asthma vs. other respiratory diseases.
TIMONEN 2002 <sup>1739</sup>	Wrong definition of Phys Dx – no objective test (older children).
TO 2004 <sup>1743</sup>	Wrong definition of Phys Dx – no objective test.
TO 2009 <sup>1741</sup>	Looks at the wrong risk factors (not those specified in our protocol). Does not give

Reference	Reason for exclusion
	prevalence in asthma vs. other respiratory diseases, only in general population.
TO 2012A <sup>1742</sup>	Wrong definition of Phys Dx – no objective test.
TOLLERUD 1991 <sup>1749</sup>	Wrong definition of Phys Dx – no objective test.
TOLPPANEN 2013 <sup>1750</sup>	General population and no subgroup analysis
TOOP 1985 <sup>1754</sup>	Wrong definition of Phys Dx – no objective test.
TOREN 1993 <sup>1755</sup>	Literature review.
TORRENT 2007 <sup>1757</sup>	Wrong definition of Phys Dx – no objective test.
TROMP 2012 <sup>1767</sup>	Looks at the wrong risk factors (not those specified in our protocol).
TSE 1993 <sup>1769</sup>	Wrong definition of Phys Dx – no objective test.
TURBYVILLE 2011 <sup>1779</sup>	Wrong definition of Phys Dx – no objective test.
TURCOTTE 2003 <sup>1780</sup>	Prevalence and sens/spec in general population of athletes vs. controls (not suspected asthma, or asthma vs. other respiratory diseases).
TURNER 2008 <sup>1785</sup>	Wrong symptoms: rattles, purrs, and whistles.
TURNER 2010A <sup>1786</sup>	General population and no subgroup analysis
TURNERWARWICK 1988 <sup>1787</sup>	Prevalence in people with asthma, but no comparison group.
VALERY 2001 <sup>1794</sup>	Not UK-relevant population.
VALERY 2004 <sup>1795</sup>	Older children: looks at the wrong risk factors (not those specified in our protocol). Younger children: no comparison group (just prevalence in asthma)
VANBEVER 1999 <sup>1799</sup>	Wrong population: croup and not compared with people without asthma.
VANDERGUGTEN 2012 <sup>1801</sup>	General population and no subgroup analysis
VANDERMARK 2014 <sup>1802</sup>	Longitudinal study – symptoms

Reference	Reason for exclusion
	occurring aged 1-5 years as a predictor for asthma at 6 years
VANDERVALK 2012B <sup>1809</sup>	General population and no subgroup analysis
VANDERVALK 2013 <sup>1810</sup>	General population and no subgroup analysis
VANDEVEN 2006 <sup>1800</sup>	General population and no subgroup analysis
VANGENT 2007 <sup>1813</sup>	Wrong definition of Phys Dx – no objective test (older children).
VANGYSEL 2007 <sup>1814</sup>	General population and no subgroup analysis
VANMAANEN 2013 <sup>1815</sup>	Wrong definition of Phys Dx – no objective test.
VANNIMWEGEN 2011 <sup>1816</sup>	General population and no subgroup analysis
VANSCHAYCK 1991 <sup>1819</sup>	Meets all inclusion criteria for prevalence study except sample size is N<200.
VANSCHAYCK 2000 <sup>1818</sup>	Does not give the specific symptoms in the asthma subgroup.
VANZAANE 2007 <sup>1820</sup>	Validation of a questionnaire; but does not give prevalence of symptoms in subgroup with asthma.
VARGAS 2007 <sup>1825</sup>	Only gives data for the asthma group (no comparison group).
VEDAL 1998 <sup>1829</sup>	Wrong definition of Phys Dx – no objective test.
VELLINGA 2005 <sup>1830</sup>	Wrong definition of Phys Dx – no objective test.
VENABLES 1993 <sup>1832</sup>	Sens/spec in general population; symptoms in asthma vs. control (wrong comparison group).
VENN 2000 <sup>1833</sup>	General population and no subgroup analysis; Looks at the wrong risk factors: (not those specified in our protocol).
VENN 2001 <sup>1834</sup>	Risk factors for wheeze, not asthma (in mostly older children).
VIALDUPUY 2011 <sup>1840</sup>	Wrong definition of Phys Dx – no objective test.

Reference	Reason for exclusion
VOGELMEIER 2011 <sup>1849</sup>	Post-Tx symptoms.
VOLKMER 1995 <sup>1851</sup>	General population and no subgroup analysis
VONEHRENSTEIN 2000 <sup>1854</sup>	General population and no subgroup analysis
VONMUTIUS 1999 <sup>1855</sup>	Looks at the wrong risk factors: (not those specified in our protocol).
VUGT 2012 <sup>1860</sup>	Gives prevalence in people with obstruction, but does not subgroup into asthma or COPD etc.
WAKE 2013 <sup>1862</sup>	General population and no subgroup analysis
WANG 2008 <sup>1869</sup>	Wrong definition of Phys Dx – no objective test.
WANG 2008A <sup>1867</sup>	General population and no subgroup analysis
WANG 2010 <sup>1868</sup>	Wrong definition of Phys Dx – no objective test.
WASSALL 2005 <sup>1876</sup>	Wrong definition of Phys Dx – no objective test.
WATELET 2010 <sup>1877</sup>	Looks at the wrong risk factors: chronic cough (for the development of concomitant asthma).
WEINMAYR 2007 <sup>1882</sup>	Wrong definition of Phys Dx – no objective test.
WEINMAYR 2013 <sup>1881</sup>	Prevalence in General population and no subgroup analysis.
WHITROW 2010 <sup>1889</sup>	Wrong definition of Phys Dx – no objective test.
WICKENS 2005 <sup>1890</sup>	Wrong definition of Phys Dx – no objective test.
WICKENS 2008 <sup>1891</sup>	Prevalence in General population and no subgroup analysis.
WIJGA 2003 <sup>1894</sup>	Prevalence in general population and no subgroup analysis. Prevalence of asthma in wheezers, not prevalence of wheeze in people with asthma.
WILLERS 2007 <sup>1897</sup>	General population and no subgroup analysis; and looks



Reference	Reason for exclusion
	at the wrong risk factors: (not those specified in our protocol).
WILLERS 2008 <sup>1898</sup>	Wrong definition of Phys Dx – no objective test.
WITHERS 1998 <sup>1903</sup>	Wrong definition of Phys Dx – no objective test.
WJST 1994 <sup>1906</sup>	Wrong definition of Phys Dx – no objective test.
WJST 1998 <sup>1908</sup>	Wrong definition of Phys Dx – no objective test.
WJST 2001 <sup>1907</sup>	General population and no subgroup analysis; and looks at the wrong risk factors: (not those specified in our protocol).
WOLF 2003A <sup>1910</sup>	Wrong definition of Phys Dx – no objective test.
WOODS 2000 <sup>1917</sup>	General population and no subgroup analysis; and looks at the wrong risk factors: (not those specified in our protocol).
WOODS 2001 <sup>1918</sup>	General population and no subgroup analysis
WOODS 2001A <sup>1916</sup>	Wrong outcomes: predictors of breathlessness or food allergy intolerance in adults, not asthma.
WOODS 2002 <sup>1919</sup>	General population and food allergies, no asthma subgroup analysis
WRIGHT 2001 <sup>1921</sup>	General population and no subgroup analysis
WRIGHT 2006 <sup>1922</sup>	Wrong definition of Phys Dx – no objective test.
WUTHRICH 1995 <sup>1924</sup>	General population and no subgroup analysis
YEATTS 2000 <sup>1934</sup>	Wrong definition of Phys Dx – no objective test.
YEATTS 2000A <sup>1933</sup>	Prevalence in subgroup with asthma, but no comparison group.
YEATTS 2003 <sup>1935</sup>	General population and no subgroup analysis and looks at the wrong risk factors: (not those specified in our protocol).

Reference	Reason for exclusion
YUNGINGER 1992 <sup>1944</sup>	Dx sens/sepc data: wrong population – general population. Prevalence data: wrong comparison group – asthma vs. probable asthma or single episode wheezers.
ZHOU 2013 <sup>1955</sup>	General population and no subgroup analysis
ZOLLNER 2005 <sup>1967</sup>	General population and no subgroup analysis
ZUIDGEEST 2008 <sup>1968</sup>	Wrong definition of Phys Dx – use of asthma medication to indicate asthma.
ZUIDGEEST 2009 <sup>1969</sup>	Looks at the wrong risk factors: (not those specified in our protocol). Prevalence in asthma but no comparison group.
ZWAR 2011 <sup>1971</sup>	Correct Phys Dx but does not give prevalence of symptoms in the asthma vs. COPD groups and does not look at the correct RFs (not those specified in our protocol).

## 1 K.2 Diagnosis: History of atopic disorders

2 **Table 209: Studies excluded from the clinical review**

Reference	Reason for exclusion
ALBUQUERQUE2013 <sup>34</sup>	Conference abstract
ALVAREZPUEBLA 2002 <sup>39</sup>	Index test does not match protocol – total asthma symptoms questionnaire, not history of atopic disorders
ANDERSON 2009 <sup>48</sup>	Index test does not match protocol – history of atopic disorders not reported
BACKER 1991 <sup>88</sup>	Reference standard does not match protocol – Dx made on the basis of questionnaire
BACKER 2014 <sup>92</sup>	Index test and reference standard do not match protocol – sn/sp of FeNO to predict positive mannitol in suspected asthma (not physician diagnosis and objective test)
BEAUSOLEIL 2007 <sup>135</sup>	Review article
BEEH 2000 <sup>138</sup>	No relevant outcomes – prevalence in allergic vs non-allergic patients
BEEH 2001 <sup>139</sup>	Index test does not match protocol – atopy defined as family history or positive SPT (cannot calculate the sn/sp of family history)

Reference	Reason for exclusion
	alone)
BEEH 2004 <sup>140</sup>	Index test does not match protocol – total symptom score with no breakdown of atopy history alone
BENGASHIR 2004 <sup>149</sup>	Population does not match protocol – all patients positive for atopic dermatitis (all positive for index test)
BOCCACCINO 2007 <sup>183</sup>	Population does not match protocol - patients with respiratory symptoms picked up using a screening questionnaire
BONNER 1984 <sup>190</sup>	Review article
BREGAS 2000 <sup>222</sup>	Not in English
BURR 1975 <sup>249</sup>	No relevant outcomes and does not match review question – cannot calculate sn/sp of family history
CAFFARELLI 2005 <sup>260</sup>	Population does not match protocol – all patients positive atopic eczema (all positive for index test)
CANTANI 2003 <sup>268</sup>	Reference standard does not match protocol – no objective test
CARTER 2000 <sup>285</sup>	No relevant outcomes and does not match review question - sn/sp of patients report of allergy for positive SPT in people with confirmed asthma
CHEN 2014 <sup>307</sup>	Population does not match protocol – general population
CHRISTOFF 2013 <sup>324</sup>	Conference abstract
CIRILLO 2003 <sup>337</sup>	Population does not match protocol – general population
CORTESALVAREZ 2007 <sup>363</sup>	Reference standard does not match protocol – history of atopic disorders in ≤ 3 yrs with wheezing, but no Dx of asthma made
CVITANOVIC 2007 <sup>383</sup>	Population does not match protocol – all SPT positive.
DEBLEY 2012 <sup>404</sup>	Population does not match protocol – children aged 4-36 months with ≥3 episodes of physician Dx wheezing (all people with asthma according to protocol criteria)
DELRIO 2004 <sup>410</sup>	Case-control study – asymptomatic and symptomatic patients.
DELIU 2013 <sup>414</sup>	Conference abstract
DENG 2010 <sup>419</sup>	Population does not match protocol - patients with respiratory symptoms picked up using a screening questionnaire, not presenting to GP
DING 2012 <sup>439</sup>	Population does not match protocol - patients with respiratory symptoms picked up using a screening questionnaire

Reference	Reason for exclusion
ELIZUR 2007 <sup>470</sup>	No relevant outcomes and does not match review question – prevalence study in general population
ERIKSSON 1978 <sup>475</sup>	Population does not match protocol – all asthma and/or rhinitis
ERIKSSON 1990 <sup>476</sup>	Population does not match protocol – all asthma and/or rhinitis
EYSINK 2005 <sup>482</sup>	Case-control study – IgE positive and IgE negative
FANIRAN 1998 <sup>484</sup>	Index test does not match protocol – sn/sp of first Dx by a physician in primary healthcare
FARHOUDI 2005 <sup>487</sup>	Population does not match protocol – allergic patients with asthma and/or rhinitis
FONSECA 2004 <sup>501</sup>	Population does not match protocol – not suspected asthma only, population consisted of people with confirmed asthma
FRANK 1998 <sup>513</sup>	Population does not match protocol – general population
GALVEZ 1987 <sup>537</sup>	Reference standard objective test does not match protocol – methacholine challenge test positive defined as PC20 <25mg/ml.
GUILBERT 2004 <sup>607</sup>	Population does not match protocol – all had a personal or family history of atopic disorders
GULSVIK 1979 <sup>609</sup>	No relevant outcomes – prevalence of symptoms in the general population
GUSTAFSSON 2000 <sup>611</sup>	Population does not match protocol – children with atopic dermatitis
HAFKAMPDEGROEN 2013 <sup>615</sup>	Longitudinal prognostic study
HEDMAN 1998 <sup>647</sup>	Index test does not match protocol – history of atopic disorders not reported
JENKINS 1996 <sup>764</sup>	Index test does not match protocol – sn/sp of symptoms questionnaire. Reference standard does not match protocol – Dx based on a history of wheeze in the past 12 months
KARAKAYA 2012 <sup>816</sup>	No relevant outcomes – sn/sp of physician Dx of atopy with SPT as the gold standard
KILPELAINEN 2001B <sup>857</sup>	Index test does not match protocol – sn/sp of symptoms questionnaire
KUMAR 2010 <sup>929</sup>	No relevant outcomes – allergy Dx in patients with asthma or allergic rhinitis
KUMARI 2006 <sup>931</sup>	Case-control study – atopic and non-atopic patients
LOMBARDI 2008 <sup>1026</sup>	No relevant outcomes – prevalence of asthma and allergy in general population
LOMBARDI 2011 <sup>1025</sup>	No relevant outcomes – prevalence of asthma and allergy in general population

Reference	Reason for exclusion
MILLER 2007 <sup>1141</sup>	Population does not match protocol – general population
MONTNEMERY 2002 <sup>1162</sup>	Index test does not match protocol – sn/sp of first Dx of asthma in primary healthcare
NANTANDA 2013 <sup>1197</sup>	Population does not match protocol – includes severe asthma and >50% <12 months old.
NJA 2001 <sup>1240</sup>	Case-control study. Reference standard does not match protocol – Dx made on the basis of symptoms, no objective test
NINAN 1995 <sup>1235</sup>	Case-control study – asymptomatic and symptomatic patients. Reference standard does not match protocol – Dx made on the basis of symptoms
PEDROSA 2009 <sup>1315</sup>	No relevant outcomes – cannot calculate sn/sp of family history
RIEDLER 1994 <sup>1444</sup>	Case control study
RUGINA 2002 <sup>1475</sup>	No relevant outcomes - prevalence of symptoms in nasal polyposis
SCHLEICH 2012 <sup>1514</sup>	Index test does not match protocol – FeNO and symptoms
SMITH 2009 <sup>1615</sup>	Population does not match protocol – all currently Dx with rhinitis or asthma
SNIDER 1985 <sup>1616</sup>	Review article
STAIKUNIENE 2008 <sup>1653</sup>	Case-control study - chronic rhinosinusitis vs controls
TIMONEN 1997 <sup>1738</sup>	Population does not match protocol - patients with chronic respiratory symptoms picked up using a screening questionnaire
VALERY 2003 <sup>1796</sup>	Case-control study. Index test does not match protocol – sn/sp of symptoms questionnaire
WOO 2012 <sup>1914</sup>	Index test does not match protocol - FeNO
ZARAGOZA 2014 <sup>1949</sup>	Conference abstract

### 1 K.3 Diagnosis: Symptoms after exercise

2 **Table 210: Studies excluded from the clinical review**

Reference	Reason for exclusion
ANDERSON 2009 <sup>48</sup>	Index test does not match protocol.
ANDERSON 2010A <sup>46</sup>	Conference abstract
ANTOLINAMERIGO 2012 <sup>54</sup>	Conference abstract
BRANNAN 1998 <sup>218</sup>	No relevant outcomes and does not match

Reference	Reason for exclusion
	review question (sensitivity and specificity of mannitol challenge test to predict EIA in participants with a positive response to exercise challenge test or eucapnic hyperventilation).
BROZEK 2009 <sup>234</sup>	Conference abstract. Index test does not match protocol (exercise challenge test)
CARLSEN 2000 <sup>274</sup>	No relevant outcomes and does not match review question (comparing methods of exercise challenge test in people with confirmed asthma with exercise-induced bronchoconstriction)
CHEW 1999 <sup>309</sup>	Reference standard does not match protocol (asthma Dx made on the basis of the question 'have you (your child) ever had asthma?')
CHINELLATO 2012 <sup>312</sup>	Population does not match protocol – all people with asthma on treatment
DEMISSIE 1998 <sup>416</sup>	Population does not match protocol (general population, not suspected asthma); index test does not match protocol (general symptom questions, not symptoms after exercise); reference standard does not match protocol (Dx by questionnaire)
DRYDEN 2010 <sup>453</sup>	Review including 2 studies with exercise symptoms as the index test (population does not match protocol for both studies – general population of athletes, not suspected asthma)
FOUCARD 1984 <sup>507</sup>	Reference standard does not match protocol (children who reported asthma symptoms during the last year were regarded as having asthma)
FUENTES 2011 <sup>525</sup>	Case control study. Reference standard for Dx in the group with asthma does not match protocol (no mention of objective test) so cannot use index test vs exercise challenge test.
GREEN 1997 <sup>589</sup>	No relevant outcomes and does not match review question (cannot calculate sensitivity and specificity of 'symptoms in response to exercise' in the Dx of asthma).
HETLEVIK 2000 <sup>666</sup>	Reference standard does not match protocol (current asthma Dx if affirmative response to the question 'has your child ever had asthma?' and 'does your child still have asthma?')
HILDEBRAND 2011 <sup>671</sup>	Not in English
JONES 1994 <sup>774</sup>	Reference standard does not match protocol (not all had objective test)
JOSEPH 1999 <sup>781</sup>	Reference standard does not match

Reference	Reason for exclusion
	protocol (self-reported physician Dx of asthma – no objective test).
KERSTEN 2009 <sup>844</sup>	Index test does not match protocol – exercise challenge test not history of symptoms with exercise
KIVILLOOG 1975 <sup>871</sup>	Reference standard does not match protocol - all people with confirmed asthma and possible to calculate test vs test (sn/sp of IT in detecting positive exercise challenge) but no mention of how asthma Dx was made (no mention of objective test).
LAI 1997 <sup>948</sup>	Reference standard does not match protocol
LEX 2007 <sup>995</sup>	Index test does not match protocol – sn/sp of symptoms to detect EIB in people with asthma but includes symptoms induced by exercise and other factors such as allergy, no breakdown of those who only had symptoms to exercise
LOWHAGEN 1999 <sup>1030</sup>	Review article checked for references
LUKRAFKA 2010 <sup>1034</sup>	Reference standard does not match protocol, no objective test (asthma Dx based on affirmative answer to ‘Have you ever been told by a physician that you have asthma or bronchitis?’)
MAJAK 2013 <sup>1055</sup>	Population does not match protocol (groups with and without a history of exercise symptoms, but group without symptoms in response to exercise included patients whose asthma was in remission).
MANSOURNIA 2007 <sup>1075</sup>	Target condition does not match protocol - sn/sp of exercise symptoms to Dx EIB in the general population
NEVILLE 1992 <sup>1212</sup>	No relevant outcomes and does not match review question (prevalence of symptoms in general population)
PEDROSA 2009 <sup>1315</sup>	Index test does not match protocol – cannot calculate sn/sp of index test in Dx of asthma.
PONSONBY 1996 <sup>1363</sup>	Population does not match protocol – general population (including healthy asymptomatic children) not suspected asthma alone
RANDOLPH 1997 <sup>1416</sup>	Population does not match protocol – general population (including healthy asymptomatic children) not suspected asthma alone
RANDOLPH 2011A <sup>1417</sup>	Conference abstract
RANDOLPH 2012 <sup>1419</sup>	Conference abstract
RANDOLPH 2013 <sup>1418</sup>	Conference abstract

Reference	Reason for exclusion
REMES 2002 <sup>1433</sup>	Population does not match protocol – general population (including healthy asymptomatic children) not suspected asthma alone
SEEAR 2005 <sup>1540</sup>	No relevant outcomes and does not match review question (exercise challenge test to determine the accuracy of EIA Dx)
SIERSTED 1996 <sup>1574</sup>	Index test does not match protocol
SINCLAIR 1995 <sup>1595</sup>	Index test does not match protocol – exercise challenge test not history of symptoms with exercise
SMEETON 2006 <sup>1608</sup>	No relevant outcomes and does not match review question (prevalence of symptoms in general population)
STORMS 2000 <sup>1666</sup>	Review article
TERBLANCHE 1990 <sup>1722</sup>	Index test does not match protocol – exercise challenge test not history of symptoms with exercise
TERNESTENHASSEUS 2008 <sup>1724</sup>	No relevant outcomes and does not match review question (gives levels and changes after exercise test, cannot calculate sn/sp)
TSYBULKINA 2009 <sup>1775</sup>	Conference abstract
WEST 1996 <sup>1886</sup>	Index test and reference standard do not match protocol
ZIAEE 2009 <sup>1956</sup>	Conference abstract

## 1 K.4 Diagnosis: Symptoms after using medication

2 **Table 211: Studies excluded from the clinical review**

Reference	Reason for exclusion
AHMETAJ 2009 <sup>25</sup>	Not addressing review question (prevalence of aspirin-sensitive asthma using challenge test in people with confirmed asthma)
ALONSO 2002 <sup>38</sup>	Not addressing review question (diagnostic accuracy of challenge test vs. physician Dx of aspirin-induced asthma)
AMEISEN 1985 <sup>42</sup>	Wrong population (asthma vs. healthy controls). Wrong study type (case control)
BARLES 1988 <sup>109</sup>	Wrong population (all aspirin-sensitive asthma patients). Not Dx of asthma
BARRANCO 2009 <sup>114</sup>	Not addressing review question (aspirin challenge test to diagnose aspirin-sensitive asthma in people with confirmed asthma)
BAVBK 2010 <sup>132</sup>	Conference abstract. Not addressing review question (prevalence of aspirin-sensitive asthma in people with confirmed asthma)



Reference	Reason for exclusion
BAVBEK 2012 <sup>131</sup>	Not addressing review question (index test as a predictor of aspirin-sensitive asthma in people with confirmed asthma, not for asthma Dx)
BERGES 2002 <sup>159</sup>	Wrong population (all aspirin-sensitive asthma patients). Not Dx of asthma
BOTEY 1988 <sup>199</sup>	Wrong population (all people with asthma)
CALADO 2011 <sup>262</sup>	Conference abstract. Full paper (CALADO 2012) obtained
CALADO 2012 <sup>263</sup>	Non-English language publication (Portuguese)
CARNIMEO 1981 <sup>278</sup>	Not addressing review question (index test as a predictor of positive aspirin challenge test not for asthma Dx)
CASADEVALL 2000 <sup>288</sup>	Wrong population (asthma vs. healthy controls). Wrong study type (case control)
CASTILLO 1986 <sup>290</sup>	Wrong population (all asthma patients)
CHANG 2011 <sup>298</sup>	Not addressing review question (diagnostic accuracy of index test as a predictor of AERD in people with confirmed asthma, not for asthma Dx)
CROCE 1992 <sup>374</sup>	Wrong population (asthma vs. healthy controls). Wrong study type (case control)
DAHLEN 1990 <sup>385</sup>	Not addressing review question (aspirin challenge test to diagnose aspirin-sensitive asthma in people with confirmed asthma)
DELANEY 1976 <sup>412</sup>	Not addressing review question (index test as a predictor of positive aspirin challenge test not for asthma Dx)
GENTON 1985 <sup>549</sup>	Wrong population (asthma or urticarial)
GONZALEZ 2011 <sup>581</sup>	Wrong population (all asthma patients)
GRZELEWSKA 1981 <sup>598</sup>	Not addressing review question (index test as a predictor of aspirin-sensitive asthma)
HONG 1989 <sup>689</sup>	Wrong population (all asthma patients)
HUSSEIN 1989 <sup>717</sup>	Not addressing review question (index test as a predictor of positive aspirin challenge test not for asthma Dx)
KARAKAYA 2000 <sup>814</sup>	No comparison with reference standard
MAKOWSKA 2008 <sup>1056</sup>	Not addressing review question (aspirin challenge test to diagnose aspirin-sensitive asthma in people with confirmed asthma)
MASCIA 2005 <sup>1084</sup>	Index test vs. objective test but does not give the number of patients +ve/-ve for objective test so sensitivity and specificity of IT cannot be calculated

Reference	Reason for exclusion
MELILLO 1991 <sup>1119</sup>	Not addressing review question (index test as a predictor of positive aspirin challenge test not for asthma Dx)
MILEWSKI 1998 <sup>1138</sup>	Wrong population (asthma vs. healthy controls). Wrong study type (case control)
MILLER 2013 <sup>1140</sup>	Not addressing review question (challenge test to diagnose AERD in people with asthma)
MIRAKIAN 2012 <sup>1145</sup>	Wrong population (all aspirin-sensitive asthma patients). Not Dx of asthma
MUNOZ 2013 <sup>1180</sup>	Wrong population (patients with aspirin-sensitive asthma)
NIKLAS 1973 <sup>1221</sup>	Wrong population (all asthma patients with no history of symptoms to aspirin)
NIZANKOWSKA 2000 <sup>1239</sup>	Not addressing review question (aspirin challenge test to diagnose aspirin-sensitive asthma in people with confirmed asthma)
RACHELEFSKY 1975 <sup>1405</sup>	Not addressing review question (prevalence of aspirin-sensitive asthma using challenge test in people with confirmed asthma)
RAM 2013 <sup>1410</sup>	Wrong outcomes (not Dx of asthma)
RAMIREZ 2011 <sup>1412</sup>	Not addressing review question (reliability study of provocation test – not Dx of asthma)
STENIUS 1976 <sup>1656</sup>	Not addressing review question (prevalence of aspirin-sensitive asthma using challenge test in people with confirmed asthma)
SUETSUGU 1981 <sup>1678</sup>	Wrong population (all aspirin-sensitive asthma patients)
VAIDYANATHAN 2012 <sup>1792</sup>	Conference abstract. Not addressing review question (index test as a predictor of positive aspirin challenge test not for asthma Dx)
WEBER 1979 <sup>1878</sup>	Wrong population (all asthma patients)
WISMOL 2012 <sup>1902</sup>	Wrong population (all aspirin-sensitive asthma patients). Not Dx of asthma
ZAMBONINO 2013 <sup>1948</sup>	Conference abstract. Not addressing review question (index test not used for asthma Dx)

## 1 K.5 Diagnosis: Occupational asthma

2 **Table 212: Studies excluded from the clinical review**

Reference	Reason for exclusion
ANEE2003 <sup>51</sup>	Not asking if symptoms better away from work
ARCHAMBAULT 2001 <sup>62</sup>	Not all patients had gold standard test
BALDWIN 2002 <sup>97</sup>	Not asking if symptoms better away from work
BARBER 2007 <sup>108</sup>	Survey of diagnostic approach to single case scenario, not diagnostic value of asking if symptoms better away from work
BERNSTEIN 1993 <sup>162</sup>	Not all patients had gold standard test
BLANC 1996 <sup>180</sup>	Not asking if symptoms better away from work
CAMPBELL 2007 <sup>266</sup>	Not asking if symptoms better away from work
CARTIER 2003 <sup>287</sup>	No usable data
COTE 1990 <sup>365</sup>	Only includes people with positive history so cannot calculate specificity
COTE 1993 <sup>366</sup>	Not asking if symptoms better away from work
CRESPO 2001 <sup>373</sup>	Not asking if symptoms better away from work
CRUZ 2010 <sup>375</sup>	Not asking if symptoms better away from work
DELLABIANCA 1996 <sup>415</sup>	Not asking if symptoms better away from work
DESCATHA 2005 <sup>426</sup>	Not asking if symptoms better away from work
DOSTALER 2011 <sup>445</sup>	No gold standard for occupational asthma, only questionnaire development
DUCE 1988 <sup>456</sup>	Not asking if symptoms better away from work
ELSHABRAWI 2011 <sup>472</sup>	Not asking if symptoms better away from work
ENARSON 1988 <sup>473</sup>	Not asking if symptoms better away from work
GAUTRIN 2010 <sup>547</sup>	Not asking if symptoms better away from work
GIRARD 2004 <sup>566</sup>	Not asking if symptoms better away from work
GORDON 1997 <sup>582</sup>	Not asking if symptoms better

Reference	Reason for exclusion
	away from work
GRAMMER 1992 <sup>587</sup>	Not asking if symptoms better away from work
GRAMMER 1998 <sup>586</sup>	Not asking if symptoms better away from work
HANNU 2013 <sup>631</sup>	Not asking if symptoms better away from work
HAYATI 2008 <sup>643</sup>	Not asking if symptoms better away from work
HAYATI 2006 <sup>642</sup>	Not asking if symptoms better away from work
HUR 2008 <sup>715</sup>	Reference standard is for diagnosis of occupational asthma or occupational eosinophilic bronchitis
JARES 2012 <sup>757</sup>	No usable data
KARVALA 2010 <sup>819</sup>	Not asking if symptoms better away from work
KIM 1998 <sup>859</sup>	Not occupational asthma
KONGERUD 1992A <sup>899</sup>	All participants positive for history and bronchial challenge test
KRAW 1999 <sup>918</sup>	Not asking if symptoms better away from work
LABRECQUE 2011 <sup>944</sup>	Not asking if symptoms better away from work
LEMIERE 1999 <sup>980</sup>	Not asking if symptoms better away from work
LEMIERE 2011 <sup>978</sup>	Not asking if symptoms better away from work
LEMIERE 2011A <sup>979</sup>	Not asking if symptoms better away from work
LIPINSKA 2011 <sup>1017</sup>	Not asking if symptoms better away from work
MALO 1993 <sup>1066</sup>	Not asking if symptoms better away from work
MALO 1995 <sup>1069</sup>	Not asking if symptoms better away from work
MERGET 1991 <sup>1124</sup>	Not asking if symptoms better away from work
MIEDINGER 2013 <sup>1132</sup>	Not asking if symptoms better away from work
MIRMOHAMMADI 2010 <sup>1147</sup>	Assesses a questionnaire but asking if symptoms better away from work was not part of the definition of questionnaire-positive responses
MOORE 2009 <sup>1165</sup>	Not asking if symptoms better

Reference	Reason for exclusion
	away from work
MOORE 2010 <sup>1164</sup>	Not asking if symptoms better away from work
MOSCATO 1993 <sup>1169</sup>	Not asking if symptoms better away from work
MURPHY 2002 <sup>1182</sup>	Not asking if symptoms better away from work
NASIR 2011 <sup>1199</sup>	Not asking if symptoms better away from work
OLAGUIBEL 1989 <sup>1267</sup>	Not asking if symptoms better away from work
PERRIN 1992 <sup>1323</sup>	Not asking if symptoms better away from work
PHAKTHONGSUK 2007 <sup>1341</sup>	Not assessing asking if symptoms better away from work versus gold standard
QUIRCE 1995 <sup>1404</sup>	Not asking if symptoms better away from work
SCHLUNSEN 2011 <sup>1515</sup>	Not asking if symptoms better away from work
SCHWAIBLMAIR 1997 <sup>1529</sup>	Not asking if symptoms better away from work
SHOFER 2006 <sup>1567</sup>	Not asking if symptoms better away from work
SKOVSTED 2003 <sup>1604</sup>	Not asking if symptoms better away from work
SMITH 1987 <sup>1610</sup>	Not asking if symptoms better away from work
STENTON 1993 <sup>1657</sup>	Not asking if symptoms better away from work
SUARTHANA 2010 <sup>1676</sup>	Outcome is wheat sensitisation not asthma
SURANGE 2011 <sup>1684</sup>	Single case report not diagnostic test value
TALINI 2002 <sup>1702</sup>	Not asking if symptoms better away from work
TARLO 1991 <sup>1709</sup>	Not asking if symptoms better away from work
TARLO 2000 <sup>1710</sup>	not all participants had gold standard test
TARLO 2008 <sup>1711</sup>	Not assessing asking if symptoms better away from work versus gold standard
TARLO 2009 <sup>1712</sup>	Not assessing asking if symptoms better away from work versus gold standard

Reference	Reason for exclusion
TEE 1998 <sup>1719</sup>	Not asking if symptoms better away from work
TORRESDA 2002 <sup>1758</sup>	non-English
TURNER 2010 <sup>1784</sup>	Not asking if symptoms better away from work
VOGELMEIER 1991 <sup>1848</sup>	Not asking if symptoms better away from work
WIESLANDER 1994 <sup>1893</sup>	Not asking if symptoms better away from work
WITTCZAK 2012 <sup>1904</sup>	Not asking if symptoms better away from work
WHITE 2013 <sup>1888</sup>	General population
HATHAWAY 2014 <sup>641</sup>	General population
WALTERS 2012A <sup>1866</sup>	General population
KAYHAN 2013 <sup>828</sup>	General population

## 1 K.6 Diagnosis: Spirometry

2 **Table 213: Studies excluded from the clinical review**

Reference	Reason for exclusion
AHFMR 2002 <sup>30</sup>	Full article not available
ALBERTS 1994 <sup>32</sup>	Index test does not match protocol – sn/sp of FEF25-75%
BROUWER 2010 <sup>233</sup>	Index test does not match protocol – sn/sp of PEFv and FEV1 variation for Dx of asthma
BUFFELS 2012 <sup>242</sup>	Reference standard does not match review protocol – Dx with spirometry taken as reference.
CERVERI 2009 <sup>295</sup>	No relevant outcomes - sn/sp of FEV1/FVC in predicting airflow obstruction with lower limit of normality as gold standard in people with confirmed asthma
CIPRANDI 2010 <sup>333</sup>	Population does not match protocol – all people with asthma or rhinitis. Index test does not match protocol – FeNO
CIPRANDI 2011B <sup>332</sup>	Population does not match protocol – all Dx with allergic rhinitis and excluded if a history of asthma or referred with asthma symptoms
CIPRANDI 2011C <sup>329</sup>	Population does not match protocol – patients with allergic rhinitis; exclusion criteria was previous asthma Dx or presence of asthma symptoms.
CIPRANDI 2012 <sup>330</sup>	No relevant outcomes - sn/sp of FEV1 or FVC in predicting airways obstruction with FEF25-75% as gold standard in people with confirmed asthma

Reference	Reason for exclusion
CIRILLO 2006 <sup>335</sup>	No relevant outcomes – association between positive MCT and the ratio between FEV1 and FEF25-75%
CORDEIRO 2011 <sup>360</sup>	No relevant outcomes – cannot calculate the sn/sp of FEV1/FVC for asthma Dx. Only gives ROC AUC for FEV1/FVC
COUTO 1997 <sup>368</sup>	Index test does not match protocol - MCT
DI LORENZO 2007 <sup>432</sup>	Case control study – study gives sn/sp values for FEV1/FVC, but this includes asymptomatic healthy control group
DUNDAS 2006 <sup>459</sup>	Review article
DUPONT 2003 <sup>460</sup>	Index test does not match protocol - FeNO
DWYER 2012 <sup>462</sup>	Review article
EID 2000 <sup>466</sup>	No relevant outcomes – sn/sp of PEF to predict abnormal FEV1
FOWLER 2000 <sup>508</sup>	Index test does not match protocol – MCT and correlation of FEV1 with MCT
FRANKLIN 2003 <sup>514</sup>	Population does not match protocol – general population
FUKUHARA 2011 <sup>529</sup>	Index test does not match protocol - FeNO
GALVEZ 1987A <sup>536</sup>	No relevant outcomes – correlation between FEV1 and PC20 in people with confirmed asthma
GERALD 2004 <sup>552</sup>	Population does not match protocol – general population. Index test does not match protocol – sn/sp of procedures including symptoms questionnaire, spirometry and exercise test.
GILBERT 1985 <sup>563</sup>	Target condition does not match protocol – sn/sp of FEV1/FVC to Dx obstruction (asthma and COPD) with reference standard of clinical and body plethysmographic data
GILBERT 1986 <sup>562</sup>	Target condition and reference standard do not match protocol – Dx of obstruction based on history, physical examination, chest radiographs, biopsy and body plethysmographic data
GOEDHART 2006 <sup>572</sup>	Case control type study – confirmed asthma and COPD. Reference standard does not match protocol – without objective test.
GRZELEWSKI 2014 <sup>600</sup>	Study does not report results in such a way that it is possible to calculate sensitivity and specificity.
HARGREAVE 2009 <sup>634</sup>	Review article
HEDENSTROM 1987 <sup>646</sup>	Case control study – sn/sp of FEV1 in people with asthma vs healthy controls
HOLT 2006 <sup>683</sup>	No relevant outcomes – comparing treatment plans made by physicians using symptoms alone or with spirometry

Reference	Reason for exclusion
HUNTER 2002 <sup>713</sup>	Case control study – calculation of sn/sp in people with confirmed asthma, healthy controls and pseudoasthma, with no breakdown.
JERZYNSKA 2014 <sup>768</sup>	Study does not report results in such a way that it is possible to calculate sensitivity and specificity.
KING 1998 <sup>865</sup>	Case report
KOMAROW 2012 <sup>896</sup>	Index test does not match protocol – impulse oscillometry or BDR
LAMBERT 2013 <sup>952</sup>	Meeting abstract
LEBECQUE 1993 <sup>970</sup>	No relevant outcomes – comparing different spirometry measures in people with confirmed asthma
LEHMANN 2008 <sup>976</sup>	Population does not match protocol – general population
LIAM 2001 <sup>999</sup>	No relevant outcomes - association between FEV1 and symptoms or BDR in people with confirmed asthma
LIM 2005 <sup>1004</sup>	Review article
LINNA 1996 <sup>1012</sup>	Population does not match protocol – all people with asthma and cannot calculate sn/sp of test vs test.
LIYOU 2009 <sup>1016</sup>	Review article
LUTFI 2011 <sup>1038</sup>	Case-control study – people with confirmed asthma and healthy controls
MAGYAR 1998 <sup>1050</sup>	Review article
MELBYE 2011 <sup>1117</sup>	Population and reference standard does not match protocol – confirmed asthma, COPD and asthma+COPD. Reference standard for Dx not reported.
MELTZER 1989 <sup>1120</sup>	No relevant outcomes- comparison of PEF and FEV1 in people with confirmed asthma
MENDONCA 2011 <sup>1121</sup>	Case-control study. Asthma Dx with clinical Dx, no mention of objective test
MILLER 1990 <sup>1139</sup>	No relevant outcomes – comparing different spirometry measures in people with confirmed asthma with normal FEV1/FVC
MINAKATA 2008 <sup>1143</sup>	Population does not match protocol – presenting with diseases other than respiratory diseases
MIRAVITLLES 2012 <sup>1146</sup>	No relevant outcomes – cannot calculate the sn/sp of spirometry for asthma
MODRYKAMIEN 2009 <sup>1155</sup>	Target condition does not match protocol – sn/sp of spirometry to detect upper airway obstruction with reference standard of bronchoscopy, laryngoscopy and tomogram
NEVE 2012 <sup>1211</sup>	Population does not match protocol –



Reference	Reason for exclusion
	preschool children aged 3-5 years old with wheezing disorders
NICOLAI 1993 <sup>1223</sup>	Population does not match protocol – general populations. Index test does not match protocol – cold air challenge
NIKKHAH 2011 <sup>1233</sup>	Case control study
OTTER 1997 <sup>417</sup>	Index test does not match protocol
OZAREKHANC 2012 <sup>1280</sup>	Article not in English
PEDROSA 2009 <sup>1315</sup>	Population and index test do not match protocol – all patients normal spirometry and index test is challenge test
SATO 2008 <sup>1499</sup>	Index test does not match protocol - FeNO
SAURO 2005 <sup>1501</sup>	Populations does not match protocol – general population
SCHERMER 2000 <sup>1510</sup>	Review article
SIMON 2010 <sup>1587</sup>	All people with asthma (test vs test) – can calculate sn/sp of FEV1/FVC for detecting BDR. FEV1/FVC at 95% cut-off (best cut-off determined from ROC curve) for detecting BDR 20% increase in FEV1
SLIEKER 2003A <sup>1607</sup>	No relevant outcomes – sn/sp of PEF to predict abnormal FEV1 pre- and post-bronchodilator
STENTON 1993 <sup>1657</sup>	Population does not match protocol – screening shipyard workers and job applicants
TEETER 1999 <sup>1720</sup>	Review article
THIADENS 1999 <sup>1728</sup>	No relevant outcomes – comparison of $\Delta$ PEF and $\Delta$ FEV1 for BDR
TINKELMAN 2006 <sup>1740</sup>	Target condition does not match protocol – sn/sp of questionnaire in the Dx of COPD
TODA 2009 <sup>1744</sup>	Index test does not match protocol – FEV1/FVC used as reference standard for obstruction
WALAMIES 1998A <sup>1863</sup>	Case control study. Index test vs comparator test in people with asthma – cut-off values do not match protocol (FEV1/FVC 89% and BDR $\Delta$ FEV1pred $\geq$ 15%)
YARTSEV 2006A <sup>1930</sup>	Case- control study
YU 2004 <sup>1942</sup>	Population does not match protocol – general populations. Reference standard does not match protocol – parental report of doctor Dx asthma.
YURDAKUL 2005 <sup>1945</sup>	Case-control study. Index test does not match protocol

## 1 K.7 Diagnosis: Bronchodilator reversibility

2 **Table 214: Studies excluded from the clinical review**

Reference	Reason for exclusion
ADAMS 2003 <sup>17</sup>	No data on bronchodilator response in diagnosed asthma group
BIBI 1991 <sup>172</sup>	Wrong cut-off for FEV1: change >6%.
BIRING 2001 <sup>174</sup>	Asthma and COPD together
BONINI 2007 <sup>188</sup>	Not all participants had reference standard tests
BORREGO 2012 <sup>193</sup>	Not in English
BORREGO 2013 <sup>196</sup>	Not bronchodilator response over/under threshold versus asthma status
BOSSLEY 2009 <sup>198</sup>	Number with bronchodilator response reported but not comparison/gold standard test
BUSSAMRA 2005 <sup>254</sup>	Reference standard is the same test (bronchodilator response) with American Thoracic Society specified cut-off rather than 95 <sup>th</sup> percentile cut off
CARLSEN 1995 <sup>273</sup>	Case control study
CHOI 2007 <sup>315</sup>	Bronchodilator response is part of gold standard (index test = questionnaire)
CIPRANDI 2011 <sup>332</sup>	Allergic rhinitis patients not asthma
CIPRANDI 2011A <sup>328</sup>	Unavailable
CIPRANDI 2013 <sup>334</sup>	Bronchial reversibility as gold standard (index test = FeNO)
CORDEIRO 2011 <sup>360</sup>	Bronchial reversibility as part of gold standard (index test = FeNO)
CORSICO 2007 <sup>362</sup>	Bronchial reversibility as part of asthma diagnosis (not all participants had this test)
COTE 1990 <sup>365</sup>	Occupational asthma
DELRIO 2004 <sup>410</sup>	Not bronchial reversibility versus doctor diagnosis (all had asthma) or versus other tests for diagnosis of asthma (symptomatic versus asymptomatic on ISAAC questionnaire)
DIAS 2010 <sup>433</sup>	Not in English
DUMAS 2010 <sup>457</sup>	Bronchodilator test was gold standard as well as index test
DUNDAS 2005 <sup>458</sup>	Case control study
ELLIOTT 2013	Population does not match protocol – children less than 1 year old
FABBRI 2003 <sup>483</sup>	Variability to inhaled albuterol part of gold standard as well as index test
FISH 1978 <sup>495</sup>	Workshop not primary study
FRUCHTER 2009 <sup>524</sup>	Not all participants had bronchodilator

	reversibility test; longitudinal follow up for later diagnosis of asthma
FRUCHTER 2009 <sup>523</sup>	Correlation between PC20 and $\Delta$ FEV1 not reversibility over/under threshold versus positive/negative methacholine challenge test
GALANT 2007 <sup>535</sup>	Population does not match protocol – general population
GHARAGOZLOU 2004 <sup>555</sup>	Not all participants had bronchodilator test
GIBSON 1995 <sup>558</sup>	Not bronchodilator response
GINGO 2012 <sup>565</sup>	Not bronchodilator reversibility versus doctor diagnosis or other test for asthma
GJEVRE 2006 <sup>567</sup>	Subjects selected for meeting ATS bronchodilator response criteria
GOLDSTEIN 2001 <sup>580</sup>	Longitudinal follow up for later diagnosis of asthma
GRIFFITHS 1999 <sup>593</sup>	Bronchodilator reversibility = definition of asthma (gold standard not index test)
HELLINCKX 1998 <sup>653</sup>	Not PEF, PEFR or FEV <sub>1</sub>
HUNTER 2002 <sup>713</sup>	Case-control study. Mixed population of cases, controls and pseudoasthma in the results. Not separated out the data.
HYVARINEN 2006 <sup>719</sup>	Not PEF, PEFR or FEV <sub>1</sub>
IRWIN 1997 <sup>732</sup>	Not PEF, PEFR or FEV <sub>1</sub>
JAIN 2013 <sup>742</sup>	Not bronchodilator reversibility versus doctor diagnosis or other test for asthma
JOSEPH 2011A <sup>782</sup>	Not bronchodilator reversibility versus doctor diagnosis or eligible comparator test for asthma
KESTEN 1994 <sup>845</sup>	Lung function tests part of gold standard as well as index test
KJAER 2008A <sup>872</sup>	Case control study; bronchodilator test part of gold standard as well as index test
KONSTANTINOOU 2010 <sup>900</sup>	Longitudinal study: bronchodilator response during exacerbation compared with no exacerbation
KOWAL 2009 <sup>914</sup>	Not bronchodilator reversibility versus doctor diagnosis or other test for asthma
LEHMANN 2008 <sup>976</sup>	Bronchodilator reversibility = gold standard not index test; not shown versus doctor diagnosis of asthma or other comparator tests (only questionnaire symptoms or other measures of FEV <sub>1</sub> or FVC)
LERDLUEDEEPORN 1999 <sup>984</sup>	Not bronchodilator reversibility versus

	doctor diagnosis or other test for asthma
LINNA 1999 <sup>1012</sup>	Not bronchodilator reversibility versus doctor diagnosis or other test for asthma
LORBER 1978 <sup>1028</sup>	Wrong population – general population
MALMBERG 2003 <sup>1064</sup>	Case control study
MEHRPARVAR 2013 <sup>1115</sup>	Occupational asthma
MELE 2010 <sup>1118</sup>	Not PEF, PEFR or FEV <sub>1</sub>
MESLIER 1989 <sup>1125</sup>	Only reports change in FEV1 as % initial or absolute volume alone
MIRAVITLLES 2010 <sup>1146</sup>	Bronchodilator test part of gold standard (doctor diagnosis) as well as index test
MUNNIK 2010 <sup>1179</sup>	Bronchodilator test part of gold standard (doctor diagnosis) as well as index test
MUSK 2011 <sup>1185</sup>	Not all participants had bronchodilator test
NOWAK 1996 <sup>1247</sup>	Not all participants had bronchodilator test
OHKURA 2013 <sup>1262</sup>	Conference abstract – have enough fully published data already
OOSTVEEN 2010 <sup>1271</sup>	Age <5 years; not PEF, PEFR or FEV <sub>1</sub>
PATON 2010 <sup>1306</sup>	Not primary study
PEDROSA 2010 <sup>1316</sup>	All participants selected for negative bronchodilator test
PETANJEK 2007 <sup>1332</sup>	All participants selected for positive bronchodilator test
PINO 1996 <sup>1351</sup>	Wrong outcome measure of FEV1 (Change in FEV1% >15% - not clinically relevant)
POSTMA 1995 <sup>1370</sup>	Longitudinal study – bronchodilator test and diagnosis not at the same time
PRUITT 2012 <sup>1397</sup>	Not primary study
REED 2010 <sup>1428</sup>	Not primary study
RENWICK 1996 <sup>1436</sup>	Not all participants had bronchodilator test
RHEE 2013 <sup>1438</sup>	Bronchodilator test part of gold standard (doctor diagnosis) as well as index test
RICHTER 2008 <sup>1441</sup>	Only reports change in FEV1 as % initial or absolute volume alone
ROBINSON 2010 <sup>1451</sup>	Not bronchodilator reversibility versus doctor diagnosis or other test for asthma (same study as Robinson 2012 below)
ROBINSON 2012 <sup>1452</sup>	Not bronchodilator reversibility versus doctor diagnosis or other test for

	asthma
RUPPEL 2012 <sup>1477</sup>	Not a primary study
SALLAWAY 2011 <sup>1487</sup>	Not all participants had bronchodilator test
SALOME 1999 <sup>1489</sup>	Not all participants had bronchodilator test
SANCHEZ 2012 <sup>1490</sup>	Participants selected for negative bronchodilator test
SANCHEZ 2013 <sup>1491</sup>	Bronchodilator test part of gold standard not index test
SCHNEIDER 2013 <sup>1520</sup>	Not all participants had bronchodilator test
SCOTT 2012 <sup>1535</sup>	Not all participants had bronchodilator test
SILVESTRI 2008 <sup>1579</sup>	Bronchodilator test part of gold standard (doctor diagnosis) as well as index test (from guidelines cited references 13 and 14: asthma info page 6 of asthma guideline and COPD info on p 11 of COPD guideline; both pdfs accessed from: <a href="http://www.jornaldepneumologia.com.br/detalhe_suplemento.asp?id=40">http://www.jornaldepneumologia.com.br/detalhe_suplemento.asp?id=40</a> (in Portuguese))
SIN 2006 <sup>1592</sup>	Bronchodilator test part of gold standard (doctor diagnosis) as well as index test
SINGH 2012 <sup>1597</sup>	Not bronchodilator reversibility versus doctor diagnosis or other test for asthma
SLIEKER 2003 <sup>1607</sup>	Not all participants had bronchodilator test
SMITH 2004 <sup>1613</sup>	Bronchodilator test part of gold standard (doctor diagnosis) as well as index test
SOBOL 1985 <sup>1618</sup>	Not bronchodilator reversibility versus doctor diagnosis or other test for asthma
SPOSATO 2008 <sup>1643</sup>	Not bronchodilator reversibility versus doctor diagnosis or other test for asthma
THIADENS 1998A <sup>1726</sup>	Bronchodilator test as gold standard (doctor diagnosis) not index test
THIADENS 1999 <sup>1728</sup>	Bronchodilator test as gold standard (doctor diagnosis) as well as index test
TOMITA 2013 <sup>1753</sup>	Bronchodilator test part of gold standard (doctor diagnosis) not index test. Scoring system of signs and symptoms, algorithm based on BDR or reversibility.
TSE 2013 <sup>1770</sup>	Case control study

ULRIK 2005 <sup>1789</sup>	Wrong outcome measure of FEV1 (Change in FEV1% >10% - not clinically relevant)
VUGT 2012 <sup>1860</sup>	Bronchodilator test used as gold standard as well as index test
WALAMIES 1998 <sup>1863</sup>	Wrong cut-off value for FEV1: change ≥5%
WALRAVEN 2001 <sup>1865</sup>	Not all participants had bronchodilator test
WARDMAN 1986 <sup>1874</sup>	Not all participants had bronchodilator test
WOLFF 2012 <sup>1912</sup>	Not all participants had bronchodilator test
YANG 2011A <sup>1927</sup>	Case control study; bronchodilator test part of gold standard (doctor diagnosis) not index test
YAO 2011 <sup>1929</sup>	FeNO not bronchodilator response
YOO 2007 <sup>1937</sup>	Not doctor diagnosed asthma; not bronchodilator reversibility versus doctor diagnosis or other test for asthma
ZWAR 2011 <sup>1971</sup>	Not bronchodilator reversibility versus doctor diagnosis or other test for asthma

## 1 K.8 Diagnosis: PEF variability

2 **Table 215: Studies excluded from the clinical review**

Reference	Reason for exclusion
AGGARWAL2002 <sup>21</sup>	Case control study
AITKHALED2006 <sup>26</sup>	Not PEF over/under a certain threshold versus asthma status
ALBERTINI1989 <sup>31</sup>	Case control study
ANEES2011 <sup>50</sup>	Not PEF over/under a certain threshold versus asthma status
BARUA2005 <sup>118</sup>	Not a primary study
BASER2007 <sup>119</sup>	Not PEF versus another test for asthma (PEF included in the definition of asthma)
BECKETT2006 <sup>136</sup>	Not PEF over/under a certain threshold versus asthma status
BELLIA1985 <sup>147</sup>	Not PEF for diagnosis (prognosis of morning dip)
BERNSTEIN1993 <sup>162</sup>	Occupational asthma

Reference	Reason for exclusion
BERRY1985 <sup>165</sup>	Not PEF over/under a certain threshold versus asthma status
BOULET1994 <sup>204</sup>	Not PEF over/under a certain threshold versus asthma status
BRAND1991 <sup>212</sup>	Not PEF over/under a certain threshold versus asthma status
BRAND1997B <sup>214</sup>	Not PEF over/under a certain threshold versus asthma status
BRITTON1997 <sup>226</sup>	Not PEF over/under a certain threshold versus asthma status
BROUWER2006 <sup>232</sup>	Not PEF over/under a certain threshold versus asthma status
CHU2008 <sup>325</sup>	Not primary study; not PEF over/under a certain threshold versus asthma status
COTE1990 <sup>365</sup>	Occupational asthma
CURRIE2005 <sup>380</sup>	Not PEF over/under a certain threshold versus asthma status
DESALU2009 <sup>425</sup>	Wrong population. Reference standard – no objective test.
DICKINSON1999 <sup>436</sup>	Not PEF versus another test for asthma (PEF included in the definition of asthma)
DOW2001 <sup>447</sup>	Not PEF versus another test for asthma (PEF included in the definition of asthma)
ENRIGHT1997 <sup>474</sup>	Not PEF over/under a certain threshold versus asthma status or other test
FERDOUSI1997 <sup>489</sup>	Not PEF over/under a certain threshold versus asthma status
FERDOUSI2005 <sup>490</sup>	Not doctor-diagnosed asthma
FIELDER1999 <sup>493</sup>	Not PEF over/under a certain threshold versus asthma status
FRISCHER 1995 <sup>520</sup>	Wrong population: general population, not suspected asthma.
FRISCHER1993B <sup>519</sup>	Not PEF over/under a certain threshold versus asthma status
GIBSON1995 <sup>558</sup>	Case control study
GOLDSTEIN 2001 <sup>580</sup>	PEFv calculation includes post-BD values
HANSEN1994 <sup>633</sup>	Not PEF over/under a certain threshold versus asthma status

Reference	Reason for exclusion
HARGREAVE1982 <sup>636</sup>	Not PEF over/under a certain threshold versus asthma status
HARGREAVE1986 <sup>635</sup>	Not PEF over/under a certain threshold versus asthma status
HART2002 <sup>638</sup>	Not primary study
HEDMAN1998 <sup>647</sup>	PEF included in the definition of asthma (i.e. in reference standard not index test)
HENDERSON1989 <sup>654</sup>	Case control study
HETZEL1980 <sup>667</sup>	Not PEF over/under a certain threshold versus asthma status
HIGGINS 1992 <sup>669</sup>	Wrong reference standard: Physician Dx but no objective test.
HIGGINS1989 <sup>670</sup>	Not PEF over/under a certain threshold versus asthma status or sensitivity/specificity
HSU1997 <sup>704</sup>	Not PEF over/under a certain threshold versus asthma status or sensitivity/specificity
JAIN1998 <sup>741</sup>	No numerical data for sensitivity/specificity; not a primary study
JAMISON1993 <sup>747</sup>	Case control study
JINDAL2002 <sup>770</sup>	Not a primary study
KERCSMAR1996 <sup>840</sup>	Not a primary study
KHOO1984 <sup>853</sup>	Not PEF over/under a certain threshold versus asthma status
KOH2005 <sup>888</sup>	Not PEF over/under a certain threshold versus asthma status
KOLBE1996 <sup>892</sup>	Not PEF over/under a certain threshold versus asthma status
KUNZLI 1999 <sup>932</sup>	Wrong population: general population, not suspected asthma.
LAPRISE1997 <sup>955</sup>	Not PEF over/under a certain threshold versus asthma status
LARSSON1994 <sup>958</sup>	Not PEF over/under a certain threshold versus asthma status (PEF included in diagnosis)
LARSSON1995 <sup>957</sup>	Not PEF over/under a certain threshold versus asthma status (PEF included in diagnosis)
LAWSON2011 <sup>967</sup>	Not PEF over/under a certain threshold versus asthma status
LEBOWITZ1997 <sup>971</sup>	Not PEF over/under a certain threshold versus asthma status
LEWIS 2001 <sup>994</sup>	Wrong population: general population, not suspected asthma.



Reference	Reason for exclusion
	Wrong reference standard: Physician Dx but no objective test.
LINDENSMITH2004 <sup>1007</sup>	Not PEF over/under a certain threshold versus asthma status
LINNA1993 <sup>1014</sup>	Not PEF over/under a certain threshold versus asthma status
MAGYAR1998 <sup>1050</sup>	Not primary study
MATSUNAGA2008 <sup>1094</sup>	Not PEF over/under a certain threshold versus asthma status
MICHOUD1982 <sup>1130</sup>	Not PEF over/under a certain threshold versus asthma status
MOORE2009 <sup>1165</sup>	Function of different monitoring devices not PEF over/under a certain threshold versus asthma status or other test
MOSCATO1993 <sup>1169</sup>	Occupational asthma
MOSFELDTLAURSEN1993 <sup>1170</sup>	Not PEF over/under a certain threshold versus asthma status
MUERS1984 <sup>1175</sup>	Not PEF over/under a certain threshold versus asthma status
PAGGIARO1993 <sup>1282</sup>	Not PEF over/under a certain threshold versus asthma status or sensitivity/specificity
PARAMESWARAN1999 <sup>1293</sup>	Not PEF over/under a certain threshold versus asthma status
PINO1996 <sup>1351</sup>	Not PEF variability over/under a certain threshold versus asthma status; PEF during bronchodilator test versus FEV1 during bronchodilator test – included in bronchodilator response review
PODER1987 <sup>1359</sup>	Not PEF over/under a certain threshold versus asthma status
POGSON2009 <sup>1360</sup>	Not PEF over/under a certain threshold versus asthma status
PRIETO1998 <sup>1391</sup>	Not PEF over/under a certain threshold versus asthma status
PRIETO2000 <sup>1392</sup>	Not PEF over/under a certain threshold versus asthma status
SANO2004 <sup>1494</sup>	Not all patients had reference standard test
SEKEREL1997 <sup>1542</sup>	Not PEF over/under a certain threshold versus asthma status
SHAKERI2012 <sup>1552</sup>	Mixed population of patients with asthma and COPD
SHIRAHATA2005 <sup>1566</sup>	Not PEF over/under a certain threshold versus asthma status
SIERSTED 1994 <sup>1573</sup>	Wrong reference standard: Physician Dx but no objective test.
SIERSTED 1996 <sup>1574</sup>	Wrong reference standard: Physician Dx

Reference	Reason for exclusion
	but no objective test. Wrong population: general population, not suspected asthma.
SINGH2012 <sup>1597</sup>	Case control study
SLIEKER 2003A <sup>1607</sup>	Wrong outcome measure: PEF not PEF variability.
STEIN1997 <sup>1654</sup>	Not PEF over/under a certain threshold versus asthma status
TAJI2013 <sup>1698</sup>	Not PEF over/under a certain threshold versus asthma status
THIADENS 1999 <sup>1728</sup>	Index test is BDR
TIMONEN1997 <sup>1738</sup>	Not PEF over/under a certain threshold versus asthma status
TOKUYAMA1998 <sup>1748</sup>	Not PEF over/under a certain threshold versus asthma status
TOUNGOUSSOVA2007 <sup>1760</sup>	Not PEF over/under a certain threshold versus asthma status
VANSCHAYCK1996 <sup>1817</sup>	Not PEF over/under a certain threshold versus asthma status
VARGAS2005 <sup>1824</sup>	Not PEF over/under a certain threshold versus asthma status
VASAR1996 <sup>1826</sup>	Not PEF over/under a certain threshold versus asthma status
VENABLES1984 <sup>1831</sup>	Not PEF over/under a certain threshold versus asthma status
YOO2007 <sup>1936</sup>	Not PEF over/under a certain threshold versus asthma status
YURDAKUL2005 <sup>1945</sup>	PEF variability included as part of reference standard as well as index test
ZILMER2011 <sup>1965</sup>	Not PEF over/under a certain threshold versus asthma status
ZUREIK1995 <sup>1970</sup>	Not PEF over/under a certain threshold versus asthma status with a reference standard (comparing 2, 3 or 4 measurements of PEF versus 5)

## 1 K.9 Diagnosis: Skin prick tests

2 **Table 216: Studies excluded from the clinical review**

Reference	Reason for exclusion
ALENIZI2013 <sup>35</sup>	Conference abstract – have enough fully published data already
ALMEIDA 1999 <sup>389</sup>	Results for SPT not given thus cannot calculate sens/spec.
ANTOLIN2013 <sup>55</sup>	Conference abstract – have

Reference	Reason for exclusion
	enough fully published data already
ANTOLINAMERIGO 2012 <sup>54</sup>	Conference abstract – have enough fully published data already
ARDUSSO 2009 <sup>63</sup>	Conference abstract – have enough fully published data already
ARMENTIA2007 <sup>71</sup>	no data on SPT by/within asthma status
BARNIG 2013 <sup>113</sup>	Correlation study – cannot calculate sens/spec.
BONINI 2010 <sup>189</sup>	Conference abstract – have enough fully published data already
BRAND 1993 <sup>215</sup>	Results in mixed population of asthma/COPD (no asthma subgroup analysis).
BUSINCO1988 <sup>252</sup>	not SPT by asthma status
CAIMMI2013A <sup>261</sup>	Conference abstract – have enough fully published data already
COMERT2014 <sup>357</sup>	No reference standard
CONNOLLY1981 <sup>358</sup>	not SPT by asthma status
DEANE2005 <sup>403</sup>	not SPT by asthma status
DELACOURT1994 <sup>411</sup>	control group too young (<1 year)
DERVADERICS2002 <sup>424</sup>	no data on SPT by/within asthma status
DHARMAGE1998 <sup>430</sup>	not SPT by asthma status
DIBEK 2007 <sup>435</sup>	All asthma pts – no comparative test group thus unable to calculate sens/spec.
ESCUDERO 1993 <sup>478</sup>	Wrong reference standard: allergen challenge was part of the reference standard test.
FOUCARD1973 <sup>506</sup>	longitudinal not cross-sectional data
FUIANO2013 <sup>526</sup>	Conference abstract – have enough fully published data already
GARCIA1997 <sup>541</sup>	patients selected for previous negative SPT
GARCIAGONZALEZ1999 <sup>542</sup>	castor bean pollen not relevant to UK
GOETZ2007 <sup>574</sup>	Asian ladybug not relevant to UK, no other SPT by asthma reported

Reference	Reason for exclusion
GRADMAN2006 <sup>583</sup>	Some children had both asthma and rhinitis; table of SPT by diagnosis double counts these children so sensitivity/specificity not calculable
GRAIF 2002 <sup>584</sup>	Wrong comparison: data in this study are given for suspected asthma pts or control pts only and are for test vs. test rather than test vs physician Dx (which is the comparison we look for in suspected asthma pts)
GUDELJ 2012 <sup>601</sup>	Wrong reference standard: physician Dx includes the objective test
GUERRA1995 <sup>604</sup>	Percentages given for SPT positive and negative and number with asthma but unable to calculate raw data or sensitivity/specificity etc due to rounding
HAYES2013 <sup>645</sup>	All patients had positive SPT
HILL1994 <sup>672</sup>	not SPT by asthma status
HUERTAS2011 <sup>711</sup>	All pollen-allergic; no data on SPT by asthma status
IMBEAU1978 <sup>729</sup>	not SPT by asthma status
JULIA1995 <sup>785</sup>	Population is rhinitis and/or asthma (not suspected asthma)
KARAKAYA 2006 <sup>815</sup>	Asthma/rhinitis pts – does not split results for asthma or rhinitis groups separately, thus cannot calc sens/spec for asthma.
KAUFMAN1984 <sup>824</sup>	not SPT by asthma status
KIM 2002 <sup>863</sup>	Wrong reference standard definition: Physician Dx = patient-reported in a questionnaire.
KIM2013A <sup>858</sup>	General population
KOUTSOPIAS2013A <sup>910</sup>	Conference abstract – have enough fully published data already
KOWAL 2009 <sup>914</sup>	Unable to calculate sens/spec as the number of +ve and –ve SPTs are bnit given for SPT with asthma.
KUMAR2011A <sup>928</sup>	Conference abstract – have enough fully published data already

Reference	Reason for exclusion
KUMARI 2006 <sup>931</sup>	Wrong allergens / country for allergen: food allergies and pollen in India.
LAURENT1994 <sup>966</sup>	SPT to diagnose winter pollinosis not asthma
LEWIS1989 <sup>991</sup>	Case-control study including asthma and suspected asthma groups in the sensitivity/specificity analysis
LUISI 2012 <sup>1033</sup>	All asthma pts, but unable to calculate sens/spec of SPT vs. other tests (BDR or spirometry).
MARINOVIC2013 <sup>1077</sup>	Conference abstract – have enough fully published data already
MASULLO1996 <sup>1086</sup>	All SPT positive
MIGUERES2011 <sup>1135</sup>	selected for positive skin prick tests
MOSBECH 1987A <sup>1168</sup>	All asthma pts but wrong comparative test: bronchial, conjunctival challenge with the same allergen as the index (SPT) test.
MURRAY1985 <sup>1184</sup>	not SPT by asthma status
MUSKEN2002 <sup>1186</sup>	not SPT by asthma status
NEGRINI1992 <sup>1206</sup>	not SPT by asthma status
NIEDOSZYTKO2007 <sup>1226</sup>	not symptomatic controls
NIEMEIJER 1992A <sup>1228</sup>	All asthma pts – SPT but no comparison test, thus cannot calculate sens/spec.
NOGUEIRA1994 <sup>1242</sup>	Non-English
NOLTE 1990 <sup>1244</sup>	Suspected asthma pts recruited, but no final Physician Dx of asthma was done and the wrong comparison tests also used.
OSTERGAARD 1990 <sup>1277</sup>	All asthma pts: wrong comparison test - IgE or BPT with the allergens.
PALMACARLOS2005 <sup>1283</sup>	not SPT by asthma status
PANASZEK 2007 <sup>1287</sup>	Does not give SPT results for Dx of asthma – cannot calc sens/spec.
PANICHWATTANA2013 <sup>1288</sup>	Conference abstract – have enough fully published data already
PAPA2001 <sup>1291</sup>	selected for SPT positivity
PEARLMAN 2009 <sup>1308</sup>	Correlation study and cannot calculate sens/spec for asthma

Reference	Reason for exclusion
	pts..
QUIRALTE2005 <sup>1403</sup>	all SPT positive
RESANO1998 <sup>1437</sup>	Intradermal not skin prick test
RODRIGUEZ2013 <sup>1455</sup>	Not in English
ROTTOLI1989 <sup>1470</sup>	not SPT by asthma status
SASTRE 1996 <sup>1498</sup>	Duplicate study – already excluded
SASTRE1996 <sup>1498</sup>	not SPT by asthma status
SCHWARTZ1995 <sup>1530</sup>	not SPT by asthma status
SILVESTRI1996 <sup>1582</sup>	not SPT by asthma status
SILVESTRI1997 <sup>1581</sup>	not SPT by asthma status
SMITH2005 <sup>1612</sup>	not SPT by asthma status
SRITIPSUKHO 2004 <sup>1649</sup>	All asthma pts – no comparative test group thus unable to calculate sens/spec.
STAFANGER 1986 <sup>1650</sup>	Wrong comparison test: BPT (contains the same allergens as the index SPT)
STELMACH 2002A <sup>1655</sup>	Results for SPT allergens divided by cockroach allergen – ve and +ve pts; cannot calc sens/spec of true asthma pts.
STOKES2000 <sup>1665</sup>	not SPT by asthma status
TASKINEN 1997 <sup>1713</sup>	Wrong allergen results: results for >10 moulds all pooled together. Unable to get specific results for <i>Cladosporium</i> or <i>Alternaria</i>
TAUBER 2000 <sup>1714</sup>	Correlation study – cannot calculate sens/spec.
TOMASSEN2013 <sup>1752</sup>	General population/no objective test
TORRESRODRIGUEZ2012 <sup>1759</sup>	All skin prick positive
TROISE1992 <sup>1766</sup>	not SPT by asthma status
TSCHOPP 1998 <sup>1768</sup>	Wrong reference standard definition: Physician Dx = patient-reported in a questionnaire.
VARELA2003 <sup>1823</sup>	SPT given for asthma group but not for control group
VENTURA2007 <sup>1835</sup>	Some participants had both asthma and rhinitis so sensitivity/specificity not calculable
VERVLOET1999 <sup>1839</sup>	All skin prick positive
VIEIRA 2009 <sup>1842</sup>	Conference abstract – have enough fully published data already

Reference	Reason for exclusion
VIEIRA 2011 <sup>1843</sup>	Wrong reference standard definition: Physician Dx = patient-reported in a questionnaire. Validation study.
WEINTRAUB 2001 <sup>1883</sup>	Wrong definition of physician Dx: physician Dx was patient-reported via a questionnaire
WOODMANSEE 2009 <sup>1915</sup>	Conference abstract – have enough fully published data already
YURDAKUL 2005 <sup>1945</sup>	Case-control study including asthma and suspected asthma groups in the sensitivity/specificity analysis
ZETTERSTROM 1972 <sup>1953</sup>	Wrong country for allergen: pollen in Sweden.

## 1 K.10 Diagnosis: IgE

2 **Table 217: Studies excluded from the clinical review**

Reference	Reason for exclusion
ABDULAMIR 2009 <sup>7</sup>	Wrong outcomes: levels and correlations of IgE not no. of positive/negative.
ABUT 2007 <sup>14</sup>	Wrong outcomes: correlations of IgE not no. of positive/negative.
ADLER 1985 <sup>19</sup>	Wrong outcomes: levels of IgE not no. of positive/negative.
AGATA 1993 <sup>20</sup>	Wrong comparisons: different IgE methods compared.
AHLSTEDT 1974 <sup>22</sup>	Mixed population (asthma and/or allergic rhinitis), with no separate analysis for Dx of asthma.
AHMAD 2008 <sup>23</sup>	Incorrect study design: case-control study
AKCAKAYA 2005 <sup>27</sup>	Wrong outcomes: only gives SPT results, not IgE.
ALMQVIST 2007 <sup>37</sup>	Wrong outcomes: predictors of subsequent development of sensitisation.
BACKER 1992 <sup>91</sup>	Mixed population (asthma, rhinitis and dermatitis), with no separate analysis for Dx of asthma.
BARNES 2014 <sup>112</sup>	Conference abstract
BEEH 2000 <sup>138</sup>	Cannot calculate sens/spec as only gives numbers who were positive for each test individually.
BJORNSSON 1994 <sup>177</sup>	Wrong outcomes: correlations of IgE not no. of positive/negative.

BRANCATO 1995 <sup>210</sup>	Wrong outcomes: levels of IgE not no. of positive/negative.
BRAND 1993 <sup>215</sup>	Mixed population (asthma and COPD), with no separate analysis for Dx of asthma
BRUCE 1976 <sup>235</sup>	Wrong outcomes: levels of IgE and split by HLA antigen groups, not no. of positive/negative.
BRYANT 1975 <sup>240</sup>	Wrong reference standard: allergen-specific BPT.
BURROWS 1991 <sup>250</sup>	Wrong outcomes: predictors of subsequent development of asthma.
BUTERLEVICIUTE 2013 <sup>257</sup>	Conference abstract
CANTANI 1990 <sup>267</sup>	Mixed population (asthma and/or rhinitis with others), with no separate analysis for Dx of asthma. Wrong outcomes: Dx of atopy, not asthma.
CANTANI 2005A <sup>269</sup>	Wrong outcomes: levels of IgE not no. of positive/negative.
CANTONI 2003 <sup>268</sup>	Cannot calculate sens/spec as only gives numbers who were positive for each test individually.
CARSIN 2013 <sup>284</sup>	Wrong outcomes: predictors of subsequent development of asthma.
CASSIMOS 2008 <sup>289</sup>	Wrong outcomes: levels and correlations of IgE not no. of positive/negative.
CHAKRABARTI 1993 <sup>296</sup>	Wrong outcomes: Dx of Aspergillus lung disease not asthma.
CHAO 2001 <sup>300</sup>	Incorrect study design: case-control study.
CHEN 2014 <sup>307</sup>	General population
CHOI 2005 <sup>317</sup>	Wrong outcome (Dx): Dx of early or late airway reaction, not asthma Dx.
CHOI 2005A <sup>319</sup>	Incorrect study design: case-control study
CHOU 2002 <sup>320</sup>	Cannot calculate sens/spec as only gives numbers who were positive for asthma only.
COCKCROFT 1979 <sup>352</sup>	Wrong outcomes: correlations/relationships of IgE not no. of positive/negative.
COOKSON 1976 <sup>359</sup>	Wrong outcomes: correlations of IgE not no. of positive/negative.
CRAMERI 1998 <sup>370</sup>	Wrong outcomes: levels of IgE not no. of positive/negative.
CULLINAN 2004 <sup>379</sup>	Wrong outcomes: not Dx of asthma.
CUSTOVIC 1996 <sup>382</sup>	Does not mention IgE.
DECLERK 1986 <sup>393</sup>	Wrong comparison: methods/assay development.



DELOVIN 1994 <sup>398</sup>	Wrong comparison: sens/spec of RAST vs. mite-levels in mattress.
DOEKES 1996 <sup>442</sup>	Wrong comparison: two different methods of IgE measurement.
DUC 1988 <sup>455</sup>	Mixed population (asthma and/or rhinitis with others), with no separate analysis for Dx of asthma.
EWAN 1990 <sup>480</sup>	Mixed population (asthma and/or rhinitis with others), with no separate analysis for Dx of asthma.
EYSINK 2001 <sup>481</sup>	Wrong outcomes: predictors of subsequent development of asthma.
EYSINK 2005 <sup>482</sup>	Cannot calculate sens/spec as only gives numbers who were positive for each test individually.
FERNANDEZ 2007 <sup>492</sup>	Wrong reference standard: allergen-specific BPT.
FERNANDEZ 2011 <sup>491</sup>	Wrong reference standard: allergen-specific BPT.
FLAHERTY 1980 <sup>497</sup>	Wrong study design: case-control study. Wrong outcomes: levels of IgE not no. of positive/negative.
FREIDHOFF 1993 <sup>516</sup>	Cannot calculate sens/spec as only gives numbers who were positive or negative for each test individually.
FRITH 2011 <sup>521</sup>	Wrong comparison: SPT
GERGEN 2009 <sup>553</sup>	Cannot calculate sens/spec as only gives numbers of positives for each test individually.
GODFREY 1975 <sup>570</sup>	Wrong outcomes: levels of IgE not no. of positive/negative.
GOLDSTEIN 2005 <sup>578</sup>	Wrong population: not asthma but allergy
HAATELA 1981 <sup>612</sup>	Mixed population (wheeze or asthma), with no separate analysis for Dx of asthma.
HEIDEN 2010 <sup>649</sup>	Incorrect study design: case-control study. Wrong outcomes: levels and relationships of IgE, not no. of positive/negative.
HOFFMANN 2013 <sup>677</sup>	Wrong comparison (SPT)
HOGARTH 1973 <sup>678</sup>	Wrong comparison: SPT
IWAMOTO 1990 <sup>736</sup>	Incorrect study design: case-control study
JAAKKOLA 2006 <sup>737</sup>	Incorrect study design: case-control study
JACKOLA 2004 <sup>738</sup>	Wrong outcomes: levels and correlations of IgE not no. of positive/negative.
JANG 2007 <sup>750</sup>	Incorrect study design: case-control

	study
KALYONCU 1995 <sup>807</sup>	Incorrect study design: case-control study. Wrong outcomes: levels of IgE not no. of positive/negative.
KARADAG 2007 <sup>813</sup>	Wrong outcomes: not Dx of asthma but of atopic eczema (in general population).
KARTASAMITA 1994 <sup>818</sup>	Wrong outcomes: levels and correlations of IgE not no. of positive/negative.
KEIL 2006 <sup>832</sup>	Review – used as a source of references.
KELSO 1991 <sup>838</sup>	Mixed population (asthma and/or rhinitis), with no separate analysis for Dx of asthma.
KERKHOF 2003 <sup>842</sup>	Mixed population (asthma and/or allergy symptoms), with no separate analysis for Dx of asthma.
KHADADAH 2000A <sup>846</sup>	Wrong comparison: SPT
KING 2004 <sup>867</sup>	Wrong outcomes: levels of IgE and Odds, not no. of positive/negative.
KITANI 1993 <sup>869</sup>	Does not answer the question: compares drug-induced asthma vs. non-drug induced asthma, and only gives numbers who were positive for each test individually.
KJAER 2008 <sup>873</sup>	Wrong outcomes: results for SPT and IgE are combined.
KLINKANOVA 1995 <sup>878</sup>	Abstract not fully published paper.
KOIVIKKO 1991 <sup>889</sup>	Cannot calculate sens/spec.
KONDERAK 2013 <sup>897</sup>	Conference abstract
KOROL 2006 <sup>902</sup>	Wrong study design: case-control. Wrong outcomes: levels of IgE, not no. of positive/negative.
KOVAC 2007 <sup>911</sup>	Wrong outcomes: asthma severity.
KURIMOTO 1978 <sup>933</sup>	Wrong outcomes: agreement with IgE, not no. of positive/negative.
LAI 2002 <sup>950</sup>	Cannot calculate sens/spec as only gives numbers who were positive for each test individually.
LASKE 2003 <sup>959</sup>	Wrong outcomes: levels of IgE not no. of positive/negative.
LODRUPCARLSEN 2010A <sup>1023</sup>	Wrong outcomes: predictors of subsequent development of asthma.
MASUKO 2011 <sup>1085</sup>	Wrong population: healthy people only. Wrong outcomes: levels of IgE.
MATRICARDI 1990 <sup>1090</sup>	Mixed population (asthma and/or oculorhinitis with others), with no separate analysis for Dx of asthma.
MATRICARDI 2009 <sup>1088</sup>	Wrong outcomes: levels of IgE over time, not no. of positive/negative.

MATSUI 2010 <sup>1091</sup>	Wrong outcomes: levels of IgE not no. of positive/negative.
MOGI 1977 <sup>1156</sup>	Incorrect study design: case-control study. Wrong outcomes: levels of IgE not no. of positive/negative.
MOGI 1977A <sup>1157</sup>	Wrong outcomes: levels and correlations of IgE not no. of positive/negative.
MOUTHUY 2011 <sup>1173</sup>	Wrong outcomes: levels of IgE not no. of positive/negative.
MOVERARE 2002 <sup>1174</sup>	Mixed population (asthma and/or rhinoconjunctivitis), with no separate analysis for Dx of asthma.
MUSTONEN 2013 <sup>1188</sup>	Wrong outcomes: predictors of asthma over time linked to CRP.levels of IgE not no. of positive/negative.
MYGIND 1978 <sup>1190</sup>	Wrong outcomes: levels of IgE not no. of positive/negative.
NAVRATIL 2009 <sup>1205</sup>	Wrong outcomes: levels and relationships of IgE, not no. of positive/negative.
NIELSEN 1992 <sup>1227</sup>	Results for all allergens pooled together.
NIGGEMAN 2008 <sup>1231</sup>	Wrong outcomes: Dx of allergy made with symptoms and IgE,not Dx of asthma.
NOLLES 2001 <sup>1243</sup>	Wrong outcomes: not Dx of asthma.
NUSSLEIN 1987 <sup>1250</sup>	Wrong comparison: old RAST vs. new RAST
OKUDAIRA 1983 <sup>1265</sup>	Cannot calculate sens/spec as only gives numbers for each test individually.
ORYSZCZYN 2009 <sup>1273</sup>	Not IgE versus SPT status; cannot calculate sensitivity etc of test.
OSTERBALLE 1979 <sup>1276</sup>	Cannot calculate sens/spec as only shows data as graphs.
PANZANI 1993 <sup>1290</sup>	Not physician diagnosed asthma and no objective tests.
PARK 1997 <sup>1299</sup>	Wrong outcomes: not Dx of asthma.
PASTORELLO 1995 <sup>1304</sup>	Wrong outcomes; Dx of symptomatic and non-symptomatic allergy, not asthma.
PEAT 1996 <sup>1311</sup>	Wrong outcomes: levels of IgE not no. of positive/negative.
PECOUD 1982 <sup>1314</sup>	Wrong comparison: newer RAST test vs. older RAST test.
PEKKARINEN 2007 <sup>1318</sup>	Cannot calculate sens/spec as only gives numbers who were positive for each test individually.
PELIKAN 1982 <sup>1319</sup>	Results for all allergens pooled together.
PEPYS 1975 <sup>1320</sup>	Mixed population (asthma and/or allergic rhinitis), with no separate

	analysis for Dx of asthma.
PEREIRA 2005 <sup>1321</sup>	Mixed population (asthma and/or allergic rhinitis), with no separate analysis for Dx of asthma.
PERRIN 1983 <sup>1324</sup>	Wrong outcomes: levels of IgE not no. of positive/negative.
PERZANOWSKI 1998 <sup>1330</sup>	Report of data from several other studies.
PLASCHKE 1996 <sup>1355</sup>	Wrong outcomes: not Dx of asthma but of atopy (in general population).
PLEBANI 1995 <sup>1356</sup>	Not asthma versus no asthma (mixed population of asthma and rhinitis patients)
PRICE 1989 <sup>1388</sup>	Wrong outcomes: % agreement of SPT and RAST, not no. of positive/negative.
PRICHARD 1985 <sup>1389</sup>	Occupational asthma.
RAHERISON 2004 <sup>1408</sup>	Wrong outcomes: levels of IgE not no. of positive/negative.
REIJULA 2003 <sup>1431</sup>	Mixed population (asthma with others), with no separate analysis for Dx of asthma. Incorrect study design: case-control study.
ROGERS 2002 <sup>1457</sup>	Not asthma versus no asthma (not Dx of asthma); no reference standard or other test for allergy
ROSARIO 1997 <sup>1466</sup>	Wrong outcomes: levels and correlations of IgE not no. of positive/negative.
RUDZKI 1990 <sup>1474</sup>	Wrong population: atopic dermatitis pts.
RYDJORD 2008 <sup>1479</sup>	Wrong outcomes: not used for Dx of asthma.
SANTOSO 1998 <sup>1496</sup>	Wrong comparison: SPT
SCHOEFER 2008 <sup>1522</sup>	Wrong outcomes: levels of IgE not no. of positive/negative.
SCORDAMAGLIA 1992 <sup>1533</sup>	Mixed population (asthma, rhinitis and conjunctivitis), with no separate analysis for Dx of asthma.
SELASSIE 2000 <sup>1543</sup>	Incorrect study design: case-control study
SHARMA 2006A <sup>1556</sup>	Incorrect study design: case-control study.
SHERRILLI 1999 <sup>1560</sup>	Wrong outcomes: wheezing, not Dx of asthma.
SHIBASAKI 1997 <sup>1561</sup>	Incorrect study design: case-control study
SIMONI 2001 <sup>1588</sup>	Wrong test: PRIST test (modified RAST test) – not commonly used in current practice.
SIMPSON 2005 <sup>1589</sup>	Wrong outcomes: Dx of wheeze not asthma.

SIROUX 2003 <sup>1599</sup>	Correlation study in people with asthma
STAFANGER 1986 <sup>1650</sup>	Cannot calculate sens/spec as only gives data in graphs.
STEVENS 1983 <sup>1660</sup>	Mixed population (asthma and/or rhinitis), with no separate analysis for Dx of asthma.
STEVENS 2011 <sup>1659</sup>	Incorrect study design: case-control study
SUBIRA 1976 <sup>1677</sup>	Wrong outcomes: levels and correlations of IgE not no. of positive/negative.
SUMAN 2005 <sup>1679</sup>	Incorrect study design: case-control study. Wrong test: for indian-specific pollen.
SUNYER 1996 <sup>1682</sup>	Cannot calculate sens/spec as only gives numbers who were positive for each test individually.
SUNYER 2004 <sup>313</sup>	Not asthma versus no asthma (not Dx of asthma); no reference standard or other test for allergy
TAMURA 1991 <sup>1704</sup>	Wrong outcomes: predicted true positives and negatives, not actual numbers.
TANG 1989 <sup>1707</sup>	Wrong comparison: SPT
TANG 2010 <sup>1706</sup>	Wrong outcomes: levels of IgE not no. of positive/negative.
TERZIOGLU 1998 <sup>1725</sup>	IgE vs. SPT (measures of the same thing); no comparison with Physician Dx.
TOMASSEN 2013 <sup>1752</sup>	General population / wrong comparison (SPT).
TORRENT 2006 <sup>1756</sup>	Wrong outcomes: risk of sensitisation, not Dx of asthma.
TU 2013 <sup>1776</sup>	Conference abstract
VAGIC 2008 <sup>1791</sup>	Incorrect study design: case-control study. Wrong outcomes: levels of IgE not no. of positive/negative.
VALENCIA 1993 <sup>1793</sup>	Mixed population (asthma or rhinitis), with no separate analysis for Dx of asthma.
VANTO 1982 <sup>1822</sup>	Wrong reference standard: allergen-specific BPT.
VIANDER 1983 <sup>1841</sup>	Wrong comparison: conjunctival provocation test.
VOOREN 1983 <sup>1856</sup>	Wrong reference standard: allergen-specific BPT.
WAKAMORI 2009 <sup>1861</sup>	Wrong population: dermatitis not asthma.
WANG 1992 <sup>1871</sup>	Wrong test: MAST test – not commonly used in current practice. RAST test also used in study but results not reported.

WANG 2009 <sup>1870</sup>	Wrong outcomes: levels of IgE and predictors of mortality.
WEDNER 1987 <sup>1879</sup>	Wrong allergen: rare plant
WEINMAYR 2007 <sup>1882</sup>	Wrong outcomes: not used for Dx of asthma.
WICKMAN 2005 <sup>1892</sup>	Mixed population (asthma and/or allergic rhinitis), with no separate analysis for Dx of asthma.
WITTEMAN 1996 <sup>1905</sup>	Wrong outcomes: levels of IgE not no. of positive/negative.
WOODMANSEE 2009 <sup>1915</sup>	Abstract only (conference abstract, not a full paper)
YANG 2010 <sup>1928</sup>	Abstract only (conference abstract, not a full paper)
YAZICIOGLU 1994 <sup>1932</sup>	Incorrect study design: case-control study. Results for all allergens pooled together.
ZIMMERMAN 1988A <sup>1966</sup>	Mixed population (asthma and/or rhinitis and others), with no separate analysis for Dx of asthma.

## 1 K.11 Diagnosis: FeNO

2 **Table 218: Studies excluded from the clinical review**

Reference	Reason for exclusion
<i>ANSARIN2001</i> <sup>52</sup>	Not treatment naïve (>50% on CS treatment)
<i>ANTUS2010</i> <sup>56</sup>	Not treatment naïve (>50% on CS treatment)
<i>ARTLICH1996</i> <sup>75</sup>	N<50 for case-control study
<i>AVITAL2001</i> <sup>84</sup>	Reference standard objective test not widely used
<i>BACKER 2014</i> <sup>92</sup>	Reference standard does not match protocol – sn/sp of FeNO to predict positive mannitol in suspected asthma (not physician diagnosis and objective test)
<i>BAKKEHEIM2011</i> <sup>95</sup>	Not treatment naïve (>50% on CS treatment)
<i>BALINOTTI2013</i> <sup>98</sup>	No objective test for asthma, only Asthma Predictive Index
<i>BARALDI2003</i> <sup>105</sup>	Case-control study for FeNO levels but <50 people
<i>BARALDI2003A</i> <sup>102</sup>	Not treatment naïve (>50% on CS treatment)
<i>BARALDI2005</i> <sup>104</sup>	N<50 for case-control study
<i>BARALDI2006</i> <sup>103</sup>	Case-control study for FeNO levels but <50 people
<i>BARRETO2001</i> <sup>115</sup>	Not treatment naïve (unclear % of

Reference	Reason for exclusion
	patients on CS treatment)
<i>BARRETO2006</i> <sup>116</sup>	N<50 for case-control study
<i>BEG2009</i> <sup>141</sup>	Index test does not match protocol – flow rate of 200ml/s
<i>BEIGELMAN2008</i> <sup>142</sup>	Not treatment naïve and no objective test
<i>BERKMAN2005</i> <sup>160</sup>	Index test does not match protocol – flow rate of 250ml/s
<i>BERNSTEIN2009</i> <sup>163</sup>	Not treatment naïve (no restrictions on treatment)
<i>BERRY2005A</i> <sup>164</sup>	Not treatment naïve (>50% on CS treatment)
<i>BEVER2003</i> <sup>167</sup>	Non-English
<i>BOBOLEA2012</i> <sup>182</sup>	Not full paper (letter)
<i>BOMMARITO2008</i> <sup>185</sup>	Not treatment naïve; no objective test
<i>BRINDICCI2007</i> <sup>225</sup>	N<50 for case-control study
<i>BRODLIE2010</i> <sup>227</sup>	Review not primary study
<i>BRUSSEE2005</i> <sup>237</sup>	Population does not match protocol – general population.
<i>BYRNES1997</i> <sup>259</sup>	Not treatment naïve (>50% on CS treatment)
<i>CARRARO2005</i> <sup>280</sup>	N<50 for case-control study
<i>CARRARO2007A</i> <sup>282</sup>	Not treatment naïve (>50% on CS treatment)
<i>CARRARO2010</i> <sup>281</sup>	N<50 for case-control study
<i>CASTRORODRIGUEZ2013</i> <sup>291</sup>	All people with asthma for FeNO levels but <50 people
<i>CHEROTKORNOBIS2011</i> <sup>308</sup>	Case-control study for FeNO levels but <50 people
<i>CHO2013</i> <sup>314</sup>	Index test does not match protocol – incorrect flow rate
<i>CHOW2009</i> <sup>321</sup>	Results split into obese vs. non-obese pts; if use the non-obese people with asthma it means N<50 for case-control study. Otherwise meets all inclusion criteria.
<i>CIPRANDI2010</i> <sup>333</sup>	Reference standard does not match protocol – unclear if objective test used
<i>COLONSEMIDEY2000</i> <sup>356</sup>	All people with asthma for FeNO levels but <50 people
<i>CORRADI2001</i> <sup>361</sup>	N<50 for case-control study (if exclude the subgroup on CS Tx)
<i>CRANE2012</i> <sup>371</sup>	Not treatment naïve; no objective test
<i>DEBLEY2010</i> <sup>405</sup>	Asthma only pts, but N<50.
<i>DEBOT2013</i> <sup>392</sup>	No objective test
<i>DECIMO2011</i> <sup>406</sup>	Meets all inclusion criteria, but does not report the FeNO levels.

Reference	Reason for exclusion
<i>DEDIEGO2005</i> <sup>394</sup>	FeNO levels but <50 people; not sensitivity/ specificity vs. other test
<i>DEGOUW2001</i> <sup>395</sup>	N<50 for case-control study
<i>DEGROOT2012</i> <sup>396</sup>	Not treatment naïve (all on CS treatment)
<i>DELEN2000</i> <sup>413</sup>	Not treatment naïve (unclear % of patients on CS treatment)
<i>DELGIUDICE2004</i> <sup>409</sup>	All people with asthma for FeNO levels but <50 people
<i>DEMEER2005</i> <sup>401</sup>	No relevant outcomes – cannot calculate sn/sp of FeNO for Dx of asthma
<i>DOTSCH1996</i> <sup>446</sup>	Unclear physician Dx.
<i>DRESSEL2008</i> <sup>448</sup>	Method of asthma Dx not reported.
<i>DRESSEL2010</i> <sup>449</sup>	Unclear physician Dx.
<i>EKROOS2009</i> <sup>467</sup>	Index test does not match protocol – flow rate of 80-150ml/s
<i>ELHALAWANI2003</i> <sup>468</sup>	Suspected EIB and exercise challenge test.
<i>ELLIOTT 2013</i> <sup>471</sup>	Population does not match protocol – children less than 1 year old
<i>FABBRI2003</i> <sup>483</sup>	Case-control study for FeNO levels but <50 people
<i>FITZPATRICK2006</i> <sup>496</sup>	Severe asthma and moderate asthma. If exclude the severe asthma subgroup then N<50 for case-control study.
<i>FORMANEK2002</i> <sup>504</sup>	Index test does not match protocol – nitrite levels not FeNO
<i>FORTUNA2007</i> <sup>505</sup>	Reference standard objective test does not match protocol – methacholine challenge test cut-off at 16mg/ml
<i>FOWLER2009</i> <sup>509</sup>	Not treatment naïve (>50% on CS treatment)
<i>FRANK1998</i> <sup>513</sup>	Not treatment naïve (unclear % of patients on CS treatment)
<i>FRANKLIN2003</i> <sup>514</sup>	Population does not match protocol – general population, asymptomatic children
<i>FRANKLIN2004</i> <sup>515</sup>	Population does not match protocol – general population
<i>FUJIMURA2008</i> <sup>528</sup>	FeNO levels but <50 patients
<i>GABRIELE2005</i> <sup>530</sup>	All people with asthma for FeNO levels but <50 people
<i>GADE2009</i> <sup>531</sup>	Asthma only pts but N<50.
<i>GAGLIARDO2009</i> <sup>532</sup>	Not treatment naïve (>50% on CS treatment)
<i>GEVORGYAN2013</i> <sup>554</sup>	Review not primary study
<i>GRONKE2002</i> <sup>594</sup>	Population does not match protocol – all



Reference	Reason for exclusion
	atopic and comparing FeNO levels in groups with different durations of asthma
<i>GRZELEWSKI 2014</i> <sup>600</sup>	Study does not report results in such a way that it is possible to calculate sensitivity and specificity.
HAHN 2007	Sn/sp of FeNO for predicting response to ICS treatment, not asthma
<i>HENRIKSEN2001</i> <sup>659</sup>	Not treatment naïve (unclear % of patients on CS treatment)
<i>HENRIKSEN2002</i> <sup>661</sup>	No relevant outcomes – cannot calculate sn/sp of FeNO for Dx of asthma
<i>HENRIKSEN2003</i> <sup>660</sup>	Not treatment naïve (unclear % of patients on CS treatment)
<i>HERVAS2008</i> <sup>665</sup>	Not treatment naïve (unclear % of patients on CS treatment)
HOGMAN2001 <sup>680</sup>	Not treatment naïve (>50% on CS treatment)
<i>HOGMAN2002</i> <sup>679</sup>	Not treatment naïve (>50% on CS treatment)
HOLGUIN2011 <sup>681</sup>	Not treatment naïve (>50% on CS treatment)
<i>HORVATH2004</i> <sup>701</sup>	Physician Dx with no objective tests (just does SPT).
HOVI2010 <sup>703</sup>	Non-English
HSU2013 <sup>705</sup>	Sn/sp of FeNO for predicting response to ICS treatment, not asthma
HUSZAR2002 <sup>718</sup>	Index test does not match protocol – flow rate of 5-6L/min
ISHIZUKA2011 <sup>733</sup>	No objective test
JATAKANON1998A <sup>762</sup>	All asthma pts but N<50
JENTZSCH2006 <sup>767</sup>	Not treatment naïve (>50% on CS treatment)
<i>JERZYNSKA 2014</i> <sup>768</sup>	Study does not report results in such a way that it is possible to calculate sensitivity and specificity.
KANAZAWA2004 <sup>809</sup>	Case-control study. Phys Dx with objective test but wrong cut-off for objective test (BDR >20% - should be 12%)
KATSOULIS2013 <sup>820</sup>	Reference standard does not match protocol – sn/sp of FeNO to predict positive methacholine challenge test not physician diagnosis of asthma with objective test.
KEEN2011 <sup>831</sup>	Not treatment naïve (>50% on CS treatment)
<i>KHARITONOV2003</i> <sup>850</sup>	Unclear physician Dx.

Reference	Reason for exclusion
<i>KIELBASA2008</i> <sup>856</sup>	Not treatment naïve (>50% on CS treatment)
<i>KIM2013</i> <sup>864</sup>	Wrong-cut off for the MCT objective test as part of Phys Dx. MCT <16mg/ml or FEV1 12% (doesn't give the % Dx by MCT or FEV1).
<i>KLEIS2007</i> <sup>876</sup>	Wrong-cut off for the MCT objective test as part of Phys Dx. MCT <16mg/ml – should be 8mg/ml.
<i>KO2009</i> <sup>884</sup>	Not treatment naïve (>50% on CS treatment)
<i>KOMAKULA2007</i> <sup>895</sup>	Not treatment naïve (>50% on CS treatment)
<i>KONDO2003</i> <sup>898</sup>	FeNO levels but <50 people
<i>KOSKELA2008</i> <sup>904</sup>	Not treatment naïve (>50% on CS treatment)
<i>KOVESI2008</i> <sup>913</sup>	Not treatment naïve (unclear % on CS treatment)
<i>KOVESI2009</i> <sup>912</sup>	No objective test
<i>LAGRUTTA2003</i> <sup>942</sup>	Not treatment naïve (>50% on CS treatment)
<i>LANGLEY2003</i> <sup>954</sup>	Not treatment naïve (>50% on CS treatment)
<i>LARA2008</i> <sup>956</sup>	Not treatment naïve (>50% on CS treatment)
<i>LEHTIMAKI2002</i> <sup>977</sup>	FeNO levels measured but not reported in paper (only alveolar NO concentration and bronchial NO flux)
<i>LEONDELABARRA2011</i> <sup>981</sup>	Cannot calculate sn/sp
<i>LEUPPI2002</i> <sup>988</sup>	Population does not match protocol – FeNO levels in patients with atopy, not asthma
<i>LI2006</i> <sup>996</sup>	All people with asthma for FeNO levels but <50 people
<i>LI2006A</i> <sup>997</sup>	Not treatment naïve (>50% on CS treatment)
<i>LIM2000A</i> <sup>1005</sup>	Not treatment naïve (>50% on CS treatment)
<i>LINN2009B</i> <sup>1011</sup>	Population does not match protocol – general population
<i>LUDVIKSDOTTIR2012</i> <sup>1032</sup>	Review not primary study
<i>MACLEOD2009</i> <sup>1043</sup>	Not treatment naïve (>50% on CS treatment)
<i>MALBYSCHOOS2012</i> <sup>1057</sup>	All on CS Tx.
<i>MALINOVSKI2009</i> <sup>1060</sup>	No objective test
<i>MALINOVSKI2012</i> <sup>1059</sup>	Reference standard does not match protocol – not all patients had objective test (response to treatment only)

Reference	Reason for exclusion
<i>MALMBERG2003</i> <sup>1064</sup>	Sens/spec is calculated for the wrong population: suspected asthma vs. healthy controls.
<i>MALMBERG2009</i> <sup>1065</sup>	Comparator test does not match protocol – outdoor running test with non-standard cut-off
<i>MANSO2011</i> <sup>1074</sup>	Only reports FeNO levels but is not a case-control study or case-series. Pts are suspected asthma.
<i>MARTINS2008</i> <sup>1083</sup>	Population does not match protocol – FeNO levels in symptomatic patients, not asthma
<i>MATSUNAGA2011</i> <sup>1093</sup>	Unclear cut-off for objective test part of the Phys Dx.
<i>MCELDOWNEY2008</i> <sup>1104</sup>	FeNO levels but <50 people
<i>MENZIES2007A</i> <sup>1122</sup>	Not treatment naïve (>50% on CS treatment)
<i>MITSUFUJI2001</i> <sup>1153</sup>	FeNO levels after bronchoprovocation
<i>MONTUSCHI2010</i> <sup>1163</sup>	Unclear cut-offs for objective tests as part of the Phys Dx.
<i>MUSK2011</i> <sup>1185</sup>	Not asthma vs. no asthma
<i>NADIF2010</i> <sup>1192</sup>	Reference standard does not match protocol – no objective test
<i>NARANG2002</i> <sup>1198</sup>	Not treatment naïve (>50% on CS treatment)
<i>NELSON1997</i> <sup>1209</sup>	Not treatment naïve (>50% on CS treatment)
<i>NICKELS2014</i> <sup>1219</sup>	Conference abstract
<i>NICKELS2014A</i> <sup>1220</sup>	Conference abstract
<i>NICOLAOU2006</i> <sup>1224</sup>	Population does not match protocol – FeNO levels in general population and patients with wheeze
<i>NOGAMI2003</i> <sup>1241</sup>	No relevant outcomes – correlation of FeNO and FEV1
<i>NORDVALL2005</i> <sup>1246</sup>	Population does not match protocol – general population
<i>OH2008</i> <sup>1261</sup>	Population does not match protocol – only chronic cough and unclear treatment
<i>OHKURA2009</i> <sup>1263</sup>	Not treatment naïve (>50% on CS treatment)
<i>OHKURA2013</i> <sup>1262</sup>	Conference abstract
<i>OJOO2005</i> <sup>1264</sup>	Case-control study for FeNO levels but <50 people
<i>OLIN2006</i> <sup>1268</sup>	Population does not match protocol – general population
<i>ONUR2011</i> <sup>1269</sup>	FeNO levels but <50 people
<i>OZAREKHANC2012</i> <sup>1280</sup>	Non-English

Reference	Reason for exclusion
<i>PARAMESWARAN2001</i> <sup>1292</sup>	Case-control study for FeNO levels but <50 people
<i>PAREDI2002</i> <sup>1296</sup>	Case-control study for FeNO levels but <50 people
<i>PAREDI2005</i> <sup>1297</sup>	People with asthma only for FeNO levels but <50 people
<i>PEDROSA2010</i> <sup>1316</sup>	Reference standard objective test does not match protocol – methacholine challenge test cut-off at 16mg/ml
<i>PEIRSMAN 2013</i> <sup>1317</sup>	Study included in FeNO monitoring review
<i>PERZANOWSKI2010</i> <sup>1331</sup>	No objective test (only questionnaire report of wheeze)
<i>PERZANOWSKI2010A</i> <sup>1329</sup>	Population does not match protocol – general population
<i>PETSKY 2010</i> <sup>1336</sup>	Abstract
<i>PETSKY 2014</i> <sup>1340</sup>	Study included in FeNO monitoring review
<i>PIACENTINI1999</i> <sup>1343</sup>	People with asthma only for FeNO levels but <50 people
<i>PIACENTINI2000</i> <sup>1342</sup>	Not treatment naïve (>50% on CS treatment)
<i>PRADO2011</i> <sup>1380</sup>	Non-English
<i>PRASAD2006</i> <sup>1381</sup>	Population does not match protocol – general population
<i>PRIETO2009</i> <sup>1393</sup>	Not treatment naïve (>50% on CS treatment). Reference standard does not match protocol - ICS responsiveness.
<i>PROFITA2010</i> <sup>1394</sup>	Not treatment naïve (>50% on CS treatment)
<i>RADULOVIC2010</i> <sup>1407</sup>	FeNO levels but <50 people
<i>RAMIREZ2010</i> <sup>1411</sup>	FeNO versus C-reactive protein (not in protocol)
<i>RAMSER2008</i> <sup>1413</sup>	Sn/sp of FeNO to predict BHR or positive exercise challenge test.
<i>RATNAWATI2006</i> <sup>1422</sup>	Not treatment naïve (>50% on CS treatment)
<i>REID2003</i> <sup>1430</sup>	N<50 pts who are ICS naïve, for a study which can only calculate FeNO levels.
<i>RICCIONI2012</i> <sup>1440</sup>	Not treatment naïve (unclear % on CS treatment)
<i>ROBINSON2012A</i> <sup>1452</sup>	Population does not match protocol – general population
<i>ROBROEKS2007</i> <sup>1453</sup>	Not treatment naïve (>50% on CS treatment)
<i>ROLLA2007</i> <sup>1458</sup>	Not asthma vs. non-asthma
<i>ROSA2011</i> <sup>1465</sup>	No objective test (only questionnaire report of wheeze)

Reference	Reason for exclusion
<i>ROSIAS2004</i> <sup>1467</sup>	Not treatment naïve (>50% on CS treatment)
<i>ROUHOS2008</i> <sup>1472</sup>	Not asthma
<i>SACHSOLSEN2010</i> <sup>1482</sup>	Population does not match protocol – general population
<i>SAITO2004</i> <sup>1484</sup>	Population does not match protocol – FeNO levels in patients with and without wheeze, no Dx of asthma
<i>SAKAI2010</i> <sup>1485</sup>	Reference standard does not match protocol – no objective test
<i>SALOME1999</i> <sup>1489</sup>	Population does not match protocol – general population
<i>SANDRINI2010</i> <sup>1492</sup>	Review not primary study
<i>SARAIVA2009</i> <sup>1497</sup>	FeNO levels but <50 people; not treatment naïve
<i>SATOUCHI1996</i> <sup>1500</sup>	Case-control study for FeNO levels but <50 people
<i>SCHLEICH2012</i> <sup>1514</sup>	Reference standard objective test does not match protocol - methacholine challenge test cut-off at 16mg/ml
<i>SCHNEIDER2009</i> <sup>1521</sup>	Wrong reference standard: Physician Dx with objective test, but objective test uses the wrong cut-off: methacholine at 16ug/ml (should be 8ug/ml).
<i>SCHNEIDER2013</i> <sup>1520</sup>	Wrong reference standard: Physician Dx with objective test, but objective test uses the wrong cut-off: methacholine at 16ug/ml (should be 8ug/ml).
<i>SCHNEIDER2014</i> <sup>1518</sup>	Wrong reference standard: no objective test
<i>SCHULZE2013</i> <sup>1527</sup>	Reference standard does not match protocol – no objective test
<i>SCOLLO2000</i> <sup>1532</sup>	All people with asthma for FeNO levels but <50 people
<i>SCOTT2010</i> <sup>1534</sup>	Population does not match protocol – general population
<i>SEE2013</i> <sup>1539</sup>	Population does not match protocol – general population
<i>SETHI2010</i> <sup>1546</sup>	All people with asthma for FeNO levels but <50 people
<i>SHIN2006</i> <sup>1565</sup>	Case-control study for FeNO levels but <50 people
<i>SHORT2011</i> <sup>1570</sup>	Not treatment naïve (>50% on CS treatment)
<i>SILKOFF2000</i> <sup>1575</sup>	FeNO levels but < 50 people
<i>SILVESTRI2000</i> <sup>1584</sup>	Index test does not match protocol – incorrect flow rate
<i>SILVESTRI2001</i> <sup>1585</sup>	Index test does not match protocol –

Reference	Reason for exclusion
	incorrect flow rate
<i>SILVESTRI2003</i> <sup>1586</sup>	Population does not match protocol – FeNO levels in people with atopic and non-atopic asthma
<i>SILVESTRI2006</i> <sup>1580</sup>	Case-control study for FeNO levels but <50 people
SIMON2010 <sup>1587</sup>	No relevant outcomes – correlation analysis
<i>SIMPSON2008</i> <sup>1591</sup>	Review not primary study
SINGH2007 <sup>1596</sup>	Treatment study; not FeNO for diagnosis or levels in asthma/non-asthma
SIPPEL2000 <sup>1598</sup>	No relevant outcomes – correlation analysis
SIVAN2009 <sup>1602</sup>	Index test does not match protocol – no flow rate reported
SMITH2004 <sup>1613</sup>	Reference standard objective test does not match protocol - hypertonic saline challenge test
SMITH2005 <sup>1612</sup>	Reference standard objective test does not match protocol - ICS response only used for Dx in a proportion of patients.
SONNAPPA2010 <sup>1622</sup>	Not treatment naïve (>50% on CS treatment)
SONNAPPA2011 <sup>1621</sup>	Population does not match protocol – FeNO levels in general population and patients with wheeze
<i>SORDILLO2011</i> <sup>1626</sup>	Population does not match protocol – general population
SPALLAROSSA2003 <sup>1636</sup>	Wrong phys Dx – does not mention objective test.
SPITALE2012 <sup>1642</sup>	Review not primary study
STRUNK2003 <sup>1675</sup>	No relevant outcomes – correlation analysis
SUTHERLAND2007 <sup>1685</sup>	Not treatment naïve; no objective test
SVERRILD2009 <sup>1689</sup>	Population does not match protocol – general population
SVERRILD2010 <sup>1688</sup>	Population does not match protocol – general population
TAMASI2009 <sup>1703</sup>	Population does not match protocol – pregnancy
TERADA2001 <sup>1721</sup>	All people with asthma for FeNO levels but <50 people
THOMAS2005 <sup>1731</sup>	Population does not match protocol – general population
TILEMANN2011 <sup>1737</sup>	Wrong reference standard: Physician Dx with objective test, but objective test uses the wrong cut-off: methacholine at 16ug/ml (should be 8ug/ml).

Reference	Reason for exclusion
TOMASIAKLOZOWSKA2012 <sup>1751</sup>	Case-control study for FeNO levels but <50 people (excluding those on CS treatment)
TRAVERS2007 <sup>1764</sup>	Population does not match protocol – general population
TSUJINO2000 <sup>1771</sup>	Unclear / insufficient Dx criteria. National heart and lung institute criteria.
TUFVESSON2007 <sup>1778</sup>	Case-control (rhinitis vs healthy controls: 26 of the rhinitis patients also had asthma but with the n=12 healthy controls this only makes n=38
TURKTAS2003 <sup>1782</sup>	All people with asthma for FeNO levels but <50 people
UASUF1999 <sup>1788</sup>	Reference standard does not match protocol – no objective test
VANAMSTERDAM2003 <sup>1797</sup>	Population does not match protocol – general population
VANASCH2008 <sup>1798</sup>	Population does not match protocol – general population
VANDERVALK2012 <sup>1808</sup>	Population does not match protocol – general population
VANDERVALK2012A <sup>1807</sup>	No relevant outcomes – FeNO for monitoring
VERLEDEN1999 <sup>1837</sup>	Population does not match protocol – smokers and non-smokers
VIEIRA2011 <sup>1843</sup>	Population does not match protocol – general population
VISSER2000 <sup>1847</sup>	Case-control study for FeNO levels but <50 people (excluding those on CS treatment)
VOORENDVAN2013 <sup>1857</sup>	Conference abstract
WANG2012 <sup>1872</sup>	Reference standard does not match protocol – not all patients had objective test
WARKE2002 <sup>1875</sup>	No relevant outcomes – sn/sp is not for Dx of asthma
WELSH2007 <sup>1884</sup>	Population does not match protocol – general population
WILLIAMSON2010 <sup>1900</sup>	Not treatment naïve (>50% of asthma patients on CS treatment)
XU2011 <sup>1925</sup>	No objective test
YAO2011 <sup>1929</sup>	Population does not match protocol – general population
YAVUZ2012 <sup>1931</sup>	No relevant outcomes – FeNO for monitoring
YOON2012 <sup>1938</sup>	Not treatment naïve; not FeNO levels in asthma vs. non-asthma or diagnostic accuracy

Reference	Reason for exclusion
ZETTERQUIST2008 <sup>1952</sup>	Case-control study for FeNO levels but <50 people
ZHAO2013 <sup>1954</sup>	No objective test
ZIETKOWSKI2007 <sup>1963</sup>	Case-control study for FeNO levels but <50 people
ZIETKOWSKI2008 <sup>1959</sup>	Case-control study for FeNO levels but <50 people
ZIETKOWSKI2008A <sup>1958</sup>	Case-control study for FeNO levels but <50 people
ZIETKOWSKI2008B <sup>1961</sup>	Case-control study for FeNO levels but <50 people
ZIETKOWSKI2009 <sup>1964</sup>	Case-control study for FeNO levels but <50 people
ZIETKOWSKI2010 <sup>1960</sup>	Case-control study for FeNO levels but <50 people
ZIETKOWSKI2010B <sup>1962</sup>	Exclude: correlations not sensitivity/specificity for FeNO; <50 treatment naïve patients + healthy controls

## 1 K.12 Diagnosis: Eosinophils

2 **Table 219: Studies excluded from the clinical review**

Reference	Reason for exclusion
ADJAMI 2011 <sup>18</sup>	Conference abstract. Wrong outcomes: levels and correlations of eosinophils, not no. of positive/negative
ALVAREZPUEBLA 2003 <sup>40</sup>	Wrong outcomes: levels and correlations of eosinophils, not no. of positive/negative
ATTAPATTU 1991 <sup>78</sup>	General population. Wrong comparative test: blood eosinophils vs. SPT.
BARNES 1999 <sup>111</sup>	Combinations of tests. Does not report eosinophil counts.
BJORNSSON 1994 <sup>177</sup>	Incorrect population
BOUZIGON 2012 <sup>206</sup>	Wrong outcomes: levels and correlations of eosinophils, not no. of positive/negative
BRAND 1993 <sup>215</sup>	Not addressing specified population: mixed population (no asthma subgroup analysis)
BURNETT 2011 <sup>247</sup>	Conference abstract. Wrong outcomes: levels and correlations of eosinophils, not no. of positive/negative.



Reference	Reason for exclusion
BURROWS 1991 <sup>250</sup>	Not addressing specified outcomes: predictors of future disease of asthma
CRATER 1999 <sup>372</sup>	NOT addressing specified outcomes
DIFRANCO 2003 <sup>431</sup>	Not addressing review question: sputum eosinophil not blood; eosinophil blood levels given at baseline but N<50.
DILORENZO 2007 <sup>432</sup>	Incorrect study design
FRANKLIN 2003 <sup>514</sup>	Wrong outcomes: levels and correlations of eosinophils, not no. of positive/negative.
FRETTE 1991 <sup>517</sup>	Wrong outcomes: levels and correlations of eosinophils, not no. of positive/negative
FUJIMURA 2005 <sup>527</sup>	Predictors of future asthma development and eosinophil levels, but N<50.
HALLDEN 1999 <sup>622</sup>	Case-control study which reports levels of eosinophils, but N<50.
HASTIE 2013 <sup>640</sup>	Incorrect population
HYVARINEN 2010 <sup>720</sup>	Predictors of future asthma development
IMAI 1999 <sup>728</sup>	Case-control study which reports levels of eosinophils, but N<50.
JANG 2003 <sup>751</sup>	Case control: but N<50 and does not report eosinophil counts at baseline, only correlations.
JUNG 2011 <sup>788</sup>	NOT addressing review question: excluded asthma patients
KARTASAMITA 1994 <sup>818</sup>	Not addressing specified outcomes
KOWAL 2009 <sup>914</sup>	Not addressing specified outcomes/population
KUEHR 1994 <sup>923</sup>	Mixed population of asthma and non-asthma but data not separated.
LECKIE 2000 <sup>972</sup>	Wrong study: looks at effects of treatment
LIANG 2012 <sup>1000</sup>	Not addressing review question
LIM 2010 <sup>1003</sup>	Conference abstract. Wrong outcomes: levels and

Reference	Reason for exclusion
	correlations of eosinophils, not no. of positive/negative.
MAGNAN 1998 <sup>1049</sup>	Not addressing review question. Wrong outcomes: levels and correlations of eosinophils, not no. of positive/negative.
MAHMOUD 2011 <sup>1053</sup>	Incorrect study design
MAHMOUD 2013 <sup>1052</sup>	Meeting abstract
MALINOVSKI 2013 <sup>1061</sup>	Incorrect population & reference standard
MATSUNAGA 2011 <sup>1093</sup>	Incorrect study design. Not addressing specified outcomes
MATSUNAGA 2012 <sup>1092</sup>	NOT addressing specified outcomes
MEYER 2014 <sup>1128</sup>	Incorrect population
MOHAMMADIEN 2009 <sup>1158</sup>	Wrong study/Incorrect study design: case-control study and relationships + levels
NOGAMI 2003 <sup>1241</sup>	Not addressing specified outcomes: values not given
PALMER 2001 <sup>1285</sup>	Not addressing clinical/review question
PARK 2013 <sup>1301</sup>	Conference abstract
POHUNEK 2005 <sup>1361</sup>	Wrong outcomes: predictors of subsequent development of asthma.
POSTMA 1995 <sup>1370</sup>	Incorrect population
PRONK 2001 <sup>1395</sup>	Case control study, but does not report levels of blood eosinophils.
RAZI 2010 <sup>1424</sup>	Wrong outcomes: eosinophil count as predictor of response to treatment
ROQUET 1996 <sup>1464</sup>	Levels: hyperactive versus hyperactive patients; N,50.
SOUMA 2011 <sup>1633</sup>	Conference abstract. Wrong outcomes: associations of eosinophil levels.
SPALLAROSSA 1995 <sup>1635</sup>	Case-control study which reports levels of eosinophils, but N<50.
SPECTOR 2012 <sup>1637</sup>	Case-control study which reports levels of eosinophils, but N<50.
TSYBULKINA 2012 <sup>1773</sup>	Conference abstract. Wrong

Reference	Reason for exclusion
	outcomes: levels and correlations of eosinophils, not no. of positive/negative.
ULRIK 2005 <sup>1789</sup>	General population. Does not give +ve and -ve for eosinophils or eosinophil levels.
VOLBEDA 2013 <sup>1850</sup>	Not disease but markers of control (i.e. monitoring)
YURDAKUL 2005 <sup>1945</sup>	Incorrect study design
ZEDAN 2010 <sup>1950</sup>	Incorrect study design

## 1 K.13 Diagnosis: Histamine and methacholine challenge tests

2 **Table 220: Studies excluded from the clinical review**

Reference	Reason for exclusion
ALBERTS 1994 <sup>32</sup>	Index test and reference standard do not match protocol – sn/sp of FEF25-75% in predicting positive methacholine test
ALBORNOZ 1995 <sup>33</sup>	All people with confirmed asthma and no comparator test
ALVAREZPUEBLA 2003 <sup>40</sup>	Reference standard does not match protocol (Dx based on symptoms without objective test)
ANDERSON 2010A <sup>46</sup>	Conference abstract
ANDERSON 2011 <sup>47</sup>	Review article
ANDREGNETTE 2011 <sup>49</sup>	Conference abstract
ANTOLINAMERIGO 2012 <sup>54</sup>	Conference abstract
ANTOLINAMERIGO 2013 <sup>55</sup>	Conference abstract
AVITAL 1995 <sup>82</sup>	Population does not match protocol – mean age < 5years
AVITAL 1995A <sup>83</sup>	Comparator tests do not match protocol (methacholine vs AMP and exercise) and sn/sp of methacholine not compared to reference standard of physician Dx with objective test (American Thoracic Soc diagnostic criteria for asthma)
BACKER 1991 <sup>88</sup>	Reference standard does not match protocol – questionnaire based on symptoms and physician Dx without report of objective test
BACKER 1992 <sup>91</sup>	No relevant outcomes and does not match review question - relationship between bronchial responsiveness and IgE
BACKER 1992B <sup>90</sup>	Index test does not match protocol (sn and sp of physician Dx and symptoms in relation to exercise challenge)

Reference	Reason for exclusion
BACKER 1995 <sup>87</sup>	Population does not match protocol - prevalence of positive HCT in general population and correlation with asthma and atopy
BACKER 2014 <sup>92</sup>	Index test and reference standard do not match protocol – sn/sp of FeNO to predict positive mannitol in suspected asthma (not physician diagnosis and objective test)
BAILLY 2011 <sup>94</sup>	No relevant outcomes and does not match review question (different methods of measuring methacholine response, Pc20 used as part of reference standard for Dx)
BALLWEG 2012 <sup>100</sup>	Review article
BARBEN 2011 <sup>107</sup>	Index test does not match protocol – mannitol and exercise challenge test
BASIR 1995 <sup>124</sup>	Index test does not match protocol – methacholine challenge test. No reference standard of physician diagnosis with objective test
BENNETT 1987 <sup>153</sup>	No relevant outcomes and does not match review question (different methods of measuring methacholine and histamine response; all people with confirmed asthma and comparator does not match protocol)
BERKMAN 2005 <sup>160</sup>	Reference standard does not match protocol – physician Dx without objective test in a proportion of patients and no data on the percentage of patients who were Dx with an objective test.
BEYDON 2008 <sup>168</sup>	No relevant outcomes and does not match review question – correlation between BDR and methacholine response
BIBI 1991 <sup>172</sup>	Reference standard does not match protocol – physician Dx without objective test. Cannot compare index test vs comparator test as people with suspected asthma and no suitable reference standard
BIRNBAUM 2007 <sup>175</sup>	Review article
BONAVIA 1996 <sup>186</sup>	Comparator tests and reference standard do not match protocol (asthma group defined by symptom score not physician Dx)
BOONSAWAT 1992 <sup>191</sup>	Reference standard does not match protocol (physician Dx without objective test)
BOUAZIZ 1996 <sup>200</sup>	Comparing different methods of measuring methacholine test (all patients with asthma and no comparator test)
BRAND 1993 <sup>215</sup>	Index test does not match protocol – no challenge test performed
BRUSCHI 1989 <sup>236</sup>	Population does not match protocol -

Reference	Reason for exclusion
	general population not suspected asthma
BUSSE 2005 <sup>255</sup>	Review / report from workshop
CARLSEN 1998 <sup>275</sup>	case-control study
CARLSTEN 2011 <sup>277</sup>	Reference standard does not match protocol – Dx was clinical decision made by the paediatric allergist based on symptoms of wheeze and cough, use of medications and physical findings
CHATHAM 1982 <sup>303</sup>	Sn/sp of histamine and methacholine vs exercise in people with asthma and controls (does not match this protocol comparator). No reference standard of physician Dx with objective test.
CHOI 2003 <sup>316</sup>	Index test does not match protocol (incorrect cut-off for positive test)
CHOI 2007A <sup>318</sup>	Population does not match protocol (all patients had positive methacholine challenge test)
CHUNG 2010 <sup>326</sup>	Conference abstract – sn/sp of mannitol and methacholine but reference standard not mentioned
CIPRANDI 2010 <sup>333</sup>	No relevant outcomes and does not match review question – correlation between FeNO and methacholine PC20 and sn/sp of FeNO to predict positive methacholine test
CIPRANDI 2011 <sup>331</sup>	Population does not match protocol – all Dx with allergic rhinitis and excluded if a history of asthma or referred with asthma symptoms
CIRILLO 2009 <sup>336</sup>	Population does not match protocol – all Dx with allergic rhinitis and excluded if a history of asthma or referred with asthma symptoms
COCKCROFT 1979 <sup>352</sup>	No relevant outcomes and does not match review question (correlation between allergen PC20 and histamine PC20 in people with confirmed asthma)
COCKCROFT 1992 <sup>351</sup>	Reference standard does not match protocol – Dx based on questionnaire (previous doctor diagnosis or wheeze symptoms)
COCKCROFT 2005 <sup>350</sup>	No relevant outcomes and does not match review question (correlation between allergen, histamine and methacholine PC20 in people with confirmed asthma)
COCKCROFT 2009 <sup>353</sup>	Review article
COCKCROFT 2010 <sup>354</sup>	Review article
CORDEIRO 2011 <sup>360</sup>	Index test and reference standard do not match protocol – histamine test used as part of reference standard to Dx (index test

Reference	Reason for exclusion
	= FeNO)
DEHAUT 1983 <sup>407</sup>	No relevant outcomes and does not match review question (different methods of measuring histamine response)
DELGIUDICE 2004 <sup>409</sup>	No relevant outcomes and does not match review question – correlation between FeNO and PC20 (all patients with asthma but Dx made by physician with no objective test)
DEN OTTER 1997 <sup>417</sup>	Reference standard for asthma diagnosis included methacholine/histamine challenge test
DI LORENZO 2007 <sup>432</sup>	Case control type study with 3 groups (asthma Dx by symptoms and objective test; gastro-oesophageal reflux group with asthma symptoms; healthy controls) – study gives sn/sp values for MCT but this is based on 52% of patients having asthma (includes asymptomatic healthy control group)
DREWEK 2009 <sup>450</sup>	Index test does not match protocol (sn and sp of FEF25-75 to measure methacholine response; diagnosis of asthma based on symptoms during challenge test)
DURAND 2011 <sup>454</sup>	Conference abstract – reference standard not mentioned
DURZO 2012 <sup>384</sup>	Conference abstract
FORASTIERE 1991 <sup>502</sup>	Reference standard does not match protocol (asthma defined as affirmative answer to ‘has a doctor ever said this child has asthma’ or 3 out of 4 wheezing symptoms on questionnaire)
FORTUNA 2007 <sup>505</sup>	Methacholine used as reference standard - sn/sp of FeNO, eos, spirometry and BDR with positive methacholine test used to diagnose asthma
FRANKLIN 2003 <sup>514</sup>	Population does not match protocol (all asymptomatic at time of the study)
FRUCHTER 2009 <sup>524</sup>	Reference standard does not match protocol - not physician diagnosis and objective test
GADE 2009 <sup>531</sup>	Does not match review question (influence of mannitol and methacholine tests on each other)
GARCIA-RIO 2004 <sup>543</sup>	Population does not match protocol – all had positive histamine challenge
GHODRATI 2011 <sup>556</sup>	Not in English
GILBERT 1990 <sup>564</sup>	No relevant outcomes and does not match review question (healthy controls and people with confirmed asthma with no

Reference	Reason for exclusion
	comparator test)
GODFREY 1999 <sup>571</sup>	No relevant outcomes and does not match review question (healthy controls and people with confirmed asthma with no comparator test)
GOLDSTEIN 1994 <sup>579</sup>	Reference standard does not match protocol – based on symptoms and response to therapy (no objective test)
GOLDSTEIN 2001 <sup>580</sup>	Does not match review question – longitudinal follow-up to asthma diagnosis and methacholine test used as part of reference standard to Dx asthma
GRAIF 2002 <sup>584</sup>	Sn/sp of SPT with positive methacholine test used to diagnose asthma (no reference standard of physician Dx to calculate sn/sp of methacholine test)
GREENSPON 1992 <sup>592</sup>	Reference standard does not match protocol – Dx asthma group gave a history typical of asthma and had histories of acute exacerbation that were relieved by bronchodilator therapy
GRUCHALLA 2003 <sup>595</sup>	Reference standard does not match protocol – methacholine used as part of Dx of asthma for calculation of sn/sp of symptoms questionnaire in the Dx of asthma
HIGGINS 1992 <sup>669</sup>	Reference standard does not match protocol – Dx based on symptoms questionnaire or ‘ever had asthma attack’ (no mention of objective test)
HOPP 1984 <sup>693</sup>	No relevant outcomes and does not match review question (healthy controls and people with confirmed asthma with no comparator test).
HUNTER 2002 <sup>713</sup>	Methacholine challenge tests used as one of the objective tests to Dx asthma in the group with asthma
HUR 2009 <sup>716</sup>	Conference abstract
HUR 2010 <sup>714</sup>	Conference abstract – duplicate of Hur 2010
IRWIN 1997 <sup>732</sup>	Population does not match protocol – all symptomatic and methacholine challenge positive
JAMES 1992 <sup>743</sup>	Reference standard does not match protocol (physician Dx without objective test and/or wheeze in the last 12 months)
JAMES 1997 <sup>744</sup>	Review article – summarises studies sn/sp of challenge tests but ref standard does not match protocol (use symptom questionnaire and diagnosis based on wheeze in last 12 months or asthma Dx by doctor)

Reference	Reason for exclusion
JOHNSON 1987 <sup>771</sup>	Reference standard does not match protocol – association of methacholine response with symptoms not physician Dx
JOSEPH 2004 <sup>783</sup>	Reference standard does not match protocol; physician diagnosis + symptoms of wheeze in last 12 months + asthma meds in last 12 months (no objective test)
KANG 2005 <sup>810</sup>	No relevant outcomes and does not match review question (people with confirmed asthma with no comparator test)
KHALID 2009 <sup>848</sup>	Sn/sp of different measure for methacholine challenge (with PC20 positive/negative used for asthma Dx)
KIM 2002 <sup>863</sup>	Reference standard does not match protocol (correlation of BHR with risk factors and symptoms from questionnaire – no physician Dx)
KIM 2014A <sup>862</sup>	Conference abstract
KIM 2014B <sup>860</sup>	Case control study
KING 1989 <sup>866</sup>	Index test and reference standard do not match protocol – sn/sp of wheezing on max forced exhalation as predictor of positive methacholine test
KIVASTIK 2007 <sup>870</sup>	Population does not match protocol (age range 3-6 years)
KNOX 1989 <sup>883</sup>	No relevant outcomes and does not match review question (different methods of measuring methacholine response)
KOLNAAR 1995 <sup>894</sup>	Reference standard does not match protocol - comparison of histamine test to presence of asthma symptoms (not to physician Dx)
LAU 2002 <sup>963</sup>	Population does not match protocol – general population
LEE 2011 <sup>973</sup>	Conference abstract
LEVIN 2011 <sup>990</sup>	Reference standard does not match protocol - self-reported symptoms of asthma in the last 12 months
LEWIS 2001 <sup>994</sup>	Reference standard does not match protocol - self reported doctor-Dx asthma and no mention of objective test
LIEM 2008 <sup>1002</sup>	No relevant outcomes and does not match review question (healthy controls and people with confirmed asthma with no comparator test)
LINNA 1998 <sup>1013</sup>	All patients with asthma and no comparator test (comparing different methods of measuring methacholine challenge)
LUMELLI 2010 <sup>1035</sup>	Conference abstract



Reference	Reason for exclusion
MADSEN 1985 <sup>1045</sup>	Reference standard does not match protocol – some patients were Dx without objective test on basis of answer to 2 questions on attacks of shortness of breath
MADSEN 1986 <sup>1044</sup>	Reference standard does not match protocol – some patients were Dx without objective test on basis of answer to 2 questions on attacks of shortness of breath
MALMBERG 2001 <sup>1063</sup>	No relevant outcomes and does not match review question (people with confirmed asthma with no comparator test)
MANNINO 1996 <sup>1073</sup>	Methacholine challenge test but no comparator or reference standard test
MANSO 2011 <sup>1074</sup>	Reference standard does not match protocol – methacholine test used as reference standard to Dx asthma in some patients
MCCLEAN 2010 <sup>1099</sup>	No relevant outcomes and does not match review question (healthy controls and people with confirmed asthma with no comparator test). Physician diagnosis without objective test
MCGARVEY 1998 <sup>1106</sup>	No relevant outcomes and does not match review question - histamine challenge in comparison to treatment response for various respiratory diseases
METSO 1996 <sup>1126</sup>	Reference standard does not match protocol
MIEDINGER 2010 <sup>1133</sup>	Reference standard does not match protocol – not all patients Dx with asthma had an objective test (some physician Dx only)
MULLER 1993 <sup>1176</sup>	Case control study
NADASKIC 2010 <sup>1191</sup>	Conference abstract
NICKELS 2014 <sup>1219</sup>	Conference abstract
NIGGEMANN 2001 <sup>1230</sup>	Reference standard does not match protocol - sn/sp if histamine challenge to predict asthma symptoms (not diagnosis of asthma)
NISH 1992 <sup>1237</sup>	Reference standard does not match protocol – physician Dx with objective test not reported and histamine challenge used as part of reference standard to Dx
OCONNOR 1994 <sup>1252</sup>	Reference standard does not match protocol - affirmative response to ‘have you ever had asthma?’
OHKURA 2013 <sup>1262</sup>	Conference abstract
OKUPA 2012 <sup>1266</sup>	Conference abstract
PALMEIRO 1992 <sup>1284</sup>	Reference standard does not match protocol – asthma Dx based on

Reference	Reason for exclusion
	questionnaire responses
PARAMESWARAN 1999 <sup>1293</sup>	Reference standard does not match protocol - physician Dx without objective test
PARK 2009 <sup>1300</sup>	Conference abstract
PARKER 2004 <sup>1302</sup>	Population does not match protocol (all patients had positive methacholine challenge test and looking at factors which influence the PC20)
PARKERSON 2011 <sup>1303</sup>	Review article
PATTEMORE 1990 <sup>1307</sup>	Reference standard does not match protocol (asthma diagnosis by previous report of a diagnosis but no objective test)
PEDROSA 2009 <sup>1315</sup>	Index test and reference standard do not match protocol – methacholine test used as reference standard to Dx asthma and assess sn/sp of AMP challenge
PEDROSA 2010 <sup>1316</sup>	Index test and reference standard do not match protocol – methacholine test used as reference standard to Dx asthma and assess sn/sp of FeNO
PERPINA 1993 <sup>1322</sup>	Case control type study with 4 groups (asthma; rhinitis; chronic bronchitis; healthy controls) – study gives sn/sp values for MCT but this is based all patients (includes asymptomatic healthy control group)
POPA 1988 <sup>1366</sup>	No relevant outcomes and does not match review question (healthy controls and people with confirmed asthma with no comparator test).
PORSBJERG 2007 <sup>1368</sup>	Population does not match protocol – relationship between the response to methacholine and mannitol in asymptomatic subjects who do not have asthma
PORSBJERG 2009 <sup>1369</sup>	Review article
PRATTER 1983 <sup>1383</sup>	Index test and reference standard do not match protocol – sn/sp of wheeze symptoms vs reference standard of physician Dx with methacholine test
PRIETO 1998 <sup>1391</sup>	Index test and reference standard do not match protocol – methacholine test used as reference standard to Dx asthma and assess sn/sp of PEFV
PRIETO 1998A <sup>1390</sup>	No relevant outcomes and does not match review question (differences in dose-response curve to methacholine in asthma, rhinitis and controls)
PUOLIJOKI 1992 <sup>1400</sup>	Population does not match protocol – all methacholine challenge test negative patients

Reference	Reason for exclusion
PUROKIVI 2007 <sup>1401</sup>	Index test does not match protocol – hypertonic histamine challenge
REMES 2002 <sup>1433</sup>	Methacholine challenge tests used as one of the objective tests to Dx asthma
RENWICK 1996 <sup>1436</sup>	Chronic airway obstruction prevalence and BDR
RIJCKEN 1989 <sup>1447</sup>	Reference standard does not match protocol (sensitivity and specificity of histamine challenge test to detect self-reported symptoms (symptomatic or asymptomatic))
ROQUET 1996 <sup>1464</sup>	No relevant outcomes and does not match review question –sn/sp of Eos to predict positive challenge test
SACHOLSEN 2010 <sup>1482</sup>	Population does not match protocol - general population not all people with asthma or suspected asthma
SCHLEICH 2012 <sup>1514</sup>	Methacholine challenge test used as part of the reference standard to Dx asthma in suspected asthma patients without airway obstruction or BDR
SCHMIDT 1992 <sup>1516</sup>	All patients with asthma and no comparator test (comparing different methods of histamine challenge). Physician Dx only, no objective test
SCHNEIDER 2009A <sup>1519</sup>	Methacholine challenge test used as part of the reference standard to Dx asthma and assess the sn/sp of spirometry in GP
SCHULZE 2013 <sup>1527</sup>	No relevant outcomes and does not match review question – sn/sp of methacholine challenge to detect a positive allergen response
SHAPIRO 1982 <sup>1555</sup>	Reference standard does not match protocol – methacholine test used as reference standard to Dx asthma
SIERSTED 1994 <sup>1573</sup>	Reference standard does not match protocol – asthma Dx based on questionnaire responses to doctor diagnosed asthma and symptoms (no mention of objective test)
SIERSTED 1994 <sup>1573</sup>	Duplicate – ordered twice, already excluded for this review
SIERSTED 1996 <sup>1574</sup>	Reference standard does not match protocol – methacholine test used as part of reference standard to Dx asthma
SISTEK 2006 <sup>1601</sup>	Reference standard does not match protocol – asthma Dx based on questionnaire responses to doctor diagnosed asthma and attack in the last 12 months (no mention of objective test)

Reference	Reason for exclusion
SORIANO 1999 <sup>1627</sup>	Reference standard does not match protocol - positive methacholine test used to Dx asthma
SOVIJARVI 1986 <sup>1634</sup>	No relevant outcomes and does not match review question – different methods of measuring methacholine test
SPIROPOULOS 1986 <sup>1641</sup>	No relevant outcomes and does not match review question – sn/sp of methacholine test in predicting hyper-reactive airway symptoms not physician Dx of asthma
SPOSATO 2014 <sup>1644</sup>	Index test and reference standard do not match protocol
SPRINGER 2000 <sup>1645</sup>	Population does not match protocol (aged 2-8 years). All people with confirmed asthma and no comparator test
STAHL 2009 <sup>1651</sup>	Conference abstract
SUN 2007 <sup>318</sup>	Duplicate of CHOI 2007A – already excluded in this review
SVERRILD 2009 <sup>1689</sup>	Same data used for Sverrild 2010 paper already excluded from this review.
SVERRILD 2010 <sup>1688</sup>	Reference standard does not match protocol - physician Dx without objective test (physician Dx made on the basis of symptoms in the last 12 months in combination with either a eNO level of greater than 30 ppb, a history of allergic rhinoconjunctivitis, dermatitis, a positive skin prick test response, a familial predisposition to atopic disease, nonallergic rhinoconjunctivitis, or an FEV1/forced vital capacity ratio of less than 75%).
SVERRILD 2012 <sup>1687</sup>	Review article
SVERRILD 2013 <sup>1686</sup>	Sn/sp of FeNO in predicting positive mannitol response. Reference standard does not match protocol - physician Dx with no mention of objective test
TAKAMI 2013 <sup>1699</sup>	No relevant outcomes and does not match review question (correlation study)
TERNESTEN 2002 <sup>1723</sup>	Methacholine challenge test used as part of the reference standard to Dx asthma
TIE 2012 <sup>1736</sup>	Reference standard does not match protocol
TODD 2004 <sup>1745</sup>	Not relevant outcomes and does not answer review question - all people with asthma with positive methacholine challenge (comparing methods of performing methacholine test)
TOELLE 1992 <sup>1746</sup>	Methacholine challenge test used as part of the reference standard to Dx asthma
TOWNLEY 1975 <sup>1762</sup>	Reference standard does not match

Reference	Reason for exclusion
	protocol – no objective test
TOWNLEY 1990 <sup>1761</sup>	Can only calculate sensitivity (methacholine challenge in suspected asthma and asymptomatic controls – all suspected group were Dx based on reference standard and no Dx of control group reported)
VILOZNI 2009 <sup>1846</sup>	Population does not match protocol (aged 3-6 years)
WONGTIM 1997 <sup>1913</sup>	Methacholine challenge test used as part of the reference standard to Dx asthma
WOO 2012 <sup>1914</sup>	Methacholine challenge test used as part of the reference standard to Dx asthma – Dx based on symptoms and BDR and/or positive methacholine challenge
WOOLCOCK 1984 <sup>1920</sup>	Histamine challenge test but no comparator or reference standard test (looking at dose-response curve to histamine in people with asthma and controls)
WU 2011 <sup>1923</sup>	Conference abstract
XU 2001 <sup>1926</sup>	Reference standard does not match protocol - asthma was defined as a history of physician-diagnosed asthma at any time in the past (no mention of objective test)
YURDAKUL 2005 <sup>1945</sup>	Reference standard does not match protocol – methacholine test used as part of reference standard to Dx asthma
ZAGHLOUL 2009 <sup>1947</sup>	Conference abstract

## 1 K.14 Diagnosis: Mannitol challenge test

2 **Table 221: Studies excluded from the clinical review**

Reference	Reason for exclusion
ALBERTS 1994 <sup>32</sup>	Index test and reference standard do not match protocol – sn/sp of FEF25-75% in predicting positive methacholine test
ALBORNOZ 1995 <sup>33</sup>	All people with confirmed asthma and no comparator test
ALVAREZPUEBLA 2003 <sup>40</sup>	Reference standard does not match protocol (Dx based on symptoms without objective test)
ANDERSON 2010A <sup>46</sup>	Conference abstract
ANDERSON 2011 <sup>47</sup>	Review article
ANDREGNETTE 2011 <sup>49</sup>	Conference abstract
ANTOLINAMERIGO 2012 <sup>54</sup>	Conference abstract
ANTOLINAMERIGO 2013 <sup>55</sup>	Conference abstract
AVITAL 1995 <sup>82</sup>	Population does not match protocol – mean age < 5years

Reference	Reason for exclusion
AVITAL 1995A <sup>83</sup>	Comparator tests do not match protocol (methacholine vs AMP and exercise) and sn/sp of methacholine not compared to reference standard of physician Dx with objective test (American Thoracic Soc diagnostic criteria for asthma)
BACKER 1991 <sup>88</sup>	Reference standard does not match protocol – questionnaire based on symptoms and physician Dx without report of objective test
BACKER 1992 <sup>91</sup>	No relevant outcomes and does not match review question - relationship between bronchial responsiveness and IgE
BACKER 1992B <sup>90</sup>	Index test does not match protocol (sn and sp of physician Dx and symptoms in relation to exercise challenge)
BACKER 1995 <sup>87</sup>	Population does not match protocol - prevalence of positive HCT in general population and correlation with asthma and atopy
BACKER 2014 <sup>92</sup>	Index test and reference standard do not match protocol – sn/sp of FeNO to predict positive mannitol in suspected asthma (not physician diagnosis and objective test)
BAILLY 2011 <sup>94</sup>	No relevant outcomes and does not match review question (different methods of measuring methacholine response, Pc20 used as part of reference standard for Dx)
BALLWEG 2012 <sup>100</sup>	Review article
BARBEN 2011 <sup>107</sup>	Reference standard does not match protocol – sn/sp for Mannitol test only calculated taking into account index test result. Can calculated sn/sp of mannitol vs exercise test in children but this is only in suspected asthma (cannot do calculation for those children Dx according to the RS)
BASIR 1995 <sup>124</sup>	No reference standard of physician diagnosis with objective test
BENNETT 1987 <sup>153</sup>	No relevant outcomes and does not match review question (different methods of measuring methacholine and histamine response; all people with confirmed asthma and comparator does not match protocol)
BERKMAN 2005 <sup>160</sup>	Reference standard does not match protocol – physician Dx without objective test in a proportion of patients and no data on the percentage of patients who were Dx with an objective test.
BEYDON 2008 <sup>168</sup>	No relevant outcomes and does not match review question – correlation between BDR and methacholine response

Reference	Reason for exclusion
BIBI 1991 <sup>172</sup>	Index test does not match protocol – methacholine challenge test
BIRNBAUM 2007 <sup>175</sup>	Review article
BONAVIA 1996 <sup>186</sup>	Comparator tests and reference standard do not match protocol (asthma group defined by symptom score not physician Dx)
BOONSAWAT 1992 <sup>191</sup>	Reference standard does not match protocol (physician Dx without objective test)
BOUAZIZ 1996 <sup>200</sup>	Comparing different methods of measuring methacholine test (all patients with asthma and no comparator test)
BRAND 1993 <sup>215</sup>	Index test does not match protocol – no challenge test performed
BRUSCHI 1989 <sup>236</sup>	Population does not match protocol - general population not suspected asthma
BUSSE 2005 <sup>255</sup>	Review / report from workshop
CARLSEN 1998 <sup>275</sup>	case-control study
CARLSTEN 2011 <sup>277</sup>	Reference standard does not match protocol – Dx was clinical decision made by the paediatric allergist based on symptoms of wheeze and cough, use of medications and physical findings
CHATHAM 1982 <sup>303</sup>	Sn/sp of histamine and methacholine vs exercise in people with asthma and controls (does not match this protocol comparator). No reference standard of physician Dx with objective test.
CHOI 2003 <sup>316</sup>	Index test does not match protocol – methacholine challenge test
CHOI 2007A <sup>318</sup>	Population does not match protocol (all patients had positive methacholine challenge test)
CHUNG 2010 <sup>326</sup>	Conference abstract – sn/sp of mannitol and methacholine but reference standard not mentioned
CIPRANDI 2010 <sup>333</sup>	No relevant outcomes and does not match review question – correlation between FeNO and methacholine PC20 and sn/sp of FeNO to predict positive methacholine test
CIPRANDI 2011 <sup>331</sup>	Population does not match protocol – all Dx with allergic rhinitis and excluded if a history of asthma or referred with asthma symptoms
CIRILLO 2009 <sup>336</sup>	Population does not match protocol – all Dx with allergic rhinitis and excluded if a history of asthma or referred with asthma symptoms
COCKCROFT 1979 <sup>352</sup>	No relevant outcomes and does not match review question (correlation between

Reference	Reason for exclusion
	allergen PC20 and histamine PC20 in people with confirmed asthma)
COCKCROFT 1992 <sup>351</sup>	Reference standard does not match protocol – Dx based on questionnaire (previous doctor diagnosis or wheeze symptoms)
COCKCROFT 2005 <sup>350</sup>	No relevant outcomes and does not match review question (correlation between allergen, histamine and methacholine PC20 in people with confirmed asthma)
COCKCROFT 2009 <sup>353</sup>	Review article
COCKCROFT 2010 <sup>354</sup>	Review article check for refs
CORDEIRO 2011 <sup>360</sup>	Index test and reference standard do not match protocol – histamine test used as part of reference standard to Dx (index test = FeNO)
DEHAUT 1983 <sup>407</sup>	No relevant outcomes and does not match review question (different methods of measuring histamine response)
DELGIUDICE 2004 <sup>409</sup>	No relevant outcomes and does not match review question – correlation between FeNO and PC20 (all patients with asthma but Dx made by physician with no objective test)
DI LORENZO 2007 <sup>432</sup>	Case control type study with 3 groups (asthma Dx by symptoms and objective test; gastro-oesophageal reflux group with asthma symptoms; healthy controls) – study gives sn/sp values for MCT but this is based on 52% of patients having asthma (includes asymptomatic healthy control group)
DREWEK 2009 <sup>450</sup>	Index test does not match protocol (sn and sp of FEF25-75 to measure methacholine response; diagnosis of asthma based on symptoms during challenge test)
DURAND 2011 <sup>454</sup>	Conference abstract – reference standard not mentioned
DURZO 2012 <sup>384</sup>	Conference abstract
FORASTIERE 1991 <sup>502</sup>	Reference standard does not match protocol (asthma defined as affirmative answer to ‘has a doctor ever said this child has asthma’ or 3 out of 4 wheezing symptoms on questionnaire)
FORTUNA 2007 <sup>505</sup>	Methacholine used as reference standard - sn/sp of FeNO, eos, spirometry and BDR with positive methacholine test used to diagnose asthma
FRANKLIN 2003 <sup>514</sup>	Population does not match protocol (all asymptomatic at time of the study)
FRUCHTER 2009 <sup>524</sup>	Index test and reference standard do not match protocol – sn/sp of BDR to predict



Reference	Reason for exclusion
	positive methacholine in suspected asthma (not physician diagnosis and objective test)
GADE 2009 <sup>531</sup>	Does not match review question (influence of mannitol and methacholine tests on each other)
GARCIA-RIO 2004 <sup>543</sup>	Population does not match protocol – all had positive histamine challenge
GHODRATI 2011 <sup>556</sup>	Not in English
GILBERT 1990 <sup>564</sup>	No relevant outcomes and does not match review question (healthy controls and people with confirmed asthma with no comparator test)
GODFREY 1999 <sup>571</sup>	No relevant outcomes and does not match review question (healthy controls and people with confirmed asthma with no comparator test)
GOLDSTEIN 1994 <sup>579</sup>	Index test does not match protocol – methacholine challenge test
GOLDSTEIN 2001 <sup>580</sup>	Does not match review question – longitudinal follow-up to asthma diagnosis and methacholine test used as part of reference standard to Dx asthma
GRAIF 2002 <sup>584</sup>	Sn/sp of SPT with positive methacholine test used to diagnose asthma (no reference standard of physician Dx to calculate sn/sp of methacholine test)
GREENSPON 1992 <sup>592</sup>	Reference standard does not match protocol – Dx asthma group gave a history typical of asthma and had histories of acute exacerbation that were relieved by bronchodilator therapy
GRUCHALLA 2003 <sup>595</sup>	Reference standard does not match protocol – methacholine used as part of Dx of asthma for calculation of sn/sp of symptoms questionnaire in the Dx of asthma
HEDMAN 1998 <sup>647</sup>	Index test does not match protocol – methacholine challenge test
HIGGINS 1992 <sup>669</sup>	Reference standard does not match protocol – Dx based on symptoms questionnaire or ‘ever had asthma attack’ (no mention of objective test)
HOPP 1984 <sup>693</sup>	No relevant outcomes and does not match review question (healthy controls and people with confirmed asthma with no comparator test).
HUNTER 2002 <sup>713</sup>	Methacholine challenge tests used as one of the objective tests to Dx asthma in the group with asthma
HUR 2009 <sup>716</sup>	Conference abstract

Reference	Reason for exclusion
HUR 2010 <sup>714</sup>	Conference abstract – duplicate of Hur 2010
IRWIN 1997 <sup>732</sup>	Population does not match protocol – all symptomatic and methacholine challenge positive
JAMES 1992 <sup>743</sup>	Reference standard does not match protocol (physician Dx without objective test and/or wheeze in the last 12 months)
JAMES 1997 <sup>744</sup>	Review article – summarises studies sn/sp of challenge tests but ref standard does not match protocol (use symptom questionnaire and diagnosis based on wheeze in last 12 months or asthma Dx by doctor)
JOHNSON 1987 <sup>771</sup>	Reference standard does not match protocol – association of methacholine response with symptoms not physician Dx
JOSEPH 2004 <sup>783</sup>	Reference standard does not match protocol; physician diagnosis + symptoms of wheeze in last 12 months + asthma meds in last 12 months (no objective test)
KANG 2005 <sup>810</sup>	No relevant outcomes and does not match review question (people with confirmed asthma with no comparator test)
KHALID 2009 <sup>848</sup>	Sn/sp of different measure for methacholine challenge (with PC20 positive/negative used for asthma Dx)
KIM 2002 <sup>863</sup>	Reference standard does not match protocol (correlation of BHR with risk factors and symptoms from questionnaire – no physician Dx)
KIM 2014 <sup>860</sup>	Case control study
KIM 2014A <sup>862</sup>	Conference abstract
KING 1989 <sup>866</sup>	Index test and reference standard do not match protocol – sn/sp of wheezing on max forced exhalation as predictor of positive methacholine test
KIVASTIK 2007 <sup>870</sup>	Population does not match protocol (age range 3-6 years)
KNOX 1989 <sup>883</sup>	No relevant outcomes and does not match review question (different methods of measuring methacholine response)
KOLNAAR 1995 <sup>894</sup>	Reference standard does not match protocol - comparison of histamine test to presence of asthma symptoms (not to physician Dx)
KOSKELA 2003 <sup>905</sup>	All patients with asthma and comparator test does not match protocol (comparators histamine and cold air challenge tests)
KOWAL 2009 <sup>914</sup>	Index test does not match protocol – histamine challenge test

Reference	Reason for exclusion
LEE 2011 <sup>973</sup>	Conference abstract
LEVIN 2011 <sup>990</sup>	Reference standard does not match protocol - self-reported symptoms of asthma in the last 12 months
LEWIS 2001 <sup>994</sup>	Reference standard does not match protocol - self reported doctor-Dx asthma and no mention of objective test
LIEM 2008 <sup>1002</sup>	No relevant outcomes and does not match review question (healthy controls and people with confirmed asthma with no comparator test)
LINNA 1998 <sup>1013</sup>	All patients with asthma and no comparator test (comparing different methods of measuring methacholine challenge)
LUMELLI 2010 <sup>1035</sup>	Conference abstract
MADSEN 1985 <sup>1045</sup>	Reference standard does not match protocol – some patients were Dx without objective test on basis of answer to 2 questions on attacks of shortness of breath
MADSEN 1986 <sup>1044</sup>	Reference standard does not match protocol – some patients were Dx without objective test on basis of answer to 2 questions on attacks of shortness of breath
MALMBERG 2001 <sup>1063</sup>	No relevant outcomes and does not match review question (people with confirmed asthma with no comparator test)
MANNINO 1996 <sup>1073</sup>	Methacholine challenge test but no comparator or reference standard test
MANSO 2011 <sup>1074</sup>	Reference standard does not match protocol – methacholine test used as reference standard to Dx asthma in some patients
MCCLEAN 2010 <sup>1099</sup>	No relevant outcomes and does not match review question (healthy controls and people with confirmed asthma with no comparator test). Physician diagnosis without objective test
MCGARVEY 1998 <sup>1106</sup>	No relevant outcomes and does not match review question - histamine challenge in comparison to treatment response for various respiratory diseases
METSO 1996 <sup>1126</sup>	Reference standard does not match protocol
MIEDINGER 2010 <sup>1133</sup>	Reference standard does not match protocol – not all patients Dx with asthma had an objective test (some physician Dx only)
MULLER 1993 <sup>1176</sup>	Case control study
NADASKIC 2010 <sup>1191</sup>	Conference abstract
NICKELS 2014 <sup>1219</sup>	Conference abstract

Reference	Reason for exclusion
NIEMINEN 1992 <sup>1229</sup>	Index test does not match protocol – methacholine challenge test
NIGGEMANN 2001 <sup>1230</sup>	Reference standard does not match protocol - sn/sp if histamine challenge to predict asthma symptoms (not diagnosis of asthma)
NISH 1992 <sup>1237</sup>	Reference standard does not match protocol – physician Dx with objective test not reported and histamine challenge used as part of reference standard to Dx
OCONNOR 1994 <sup>1252</sup>	Reference standard does not match protocol - affirmative response to ‘have you ever had asthma?’
OHKURA 2013 <sup>1262</sup>	Conference abstract
OKUPA 2012 <sup>1266</sup>	Conference abstract
OTTER 1997 <sup>417</sup>	Index test does not match protocol – histamine challenge test
PALMEIRO 1992 <sup>1284</sup>	Reference standard does not match protocol – asthma Dx based on questionnaire responses
PARAMESWARAN 1999 <sup>1293</sup>	Reference standard does not match protocol - physician Dx without objective test
PARK 2009 <sup>1300</sup>	Conference abstract
PARKER 2004 <sup>1302</sup>	Population does not match protocol (all patients had positive methacholine challenge test and looking at factors which influence the PC20)
PARKERSON 2011 <sup>1303</sup>	Review article
PATTEMORE 1990 <sup>1307</sup>	Reference standard does not match protocol (asthma diagnosis by previous report of a diagnosis but no objective test)
PEDROSA 2009 <sup>1315</sup>	Index test and reference standard do not match protocol – methacholine test used as reference standard to Dx asthma and assess sn/sp of AMP challenge
PEDROSA 2010 <sup>1316</sup>	Index test and reference standard do not match protocol – methacholine test used as reference standard to Dx asthma and assess sn/sp of FeNO
PERPINA 1993 <sup>1322</sup>	Case control type study with 4 groups (asthma; rhinitis; chronic bronchitis; healthy controls) – study gives sn/sp values for MCT but this is based on all patients (includes asymptomatic healthy control group)
POPA 1988 <sup>1366</sup>	No relevant outcomes and does not match review question (healthy controls and people with confirmed asthma with no comparator test).
PORSBJERG 2007 <sup>1368</sup>	Population does not match protocol – relationship between the response to

Reference	Reason for exclusion
	methacholine and mannitol in asymptomatic subjects who do not have asthma
PORSBJERG 2009 <sup>1369</sup>	Review article
PRATTER 1983 <sup>1383</sup>	Index test and reference standard do not match protocol – sn/sp of wheeze symptoms vs reference standard of physician Dx with methacholine test
PRIETO 1998 <sup>1391</sup>	Index test and reference standard do not match protocol – methacholine test used as reference standard to Dx asthma and assess sn/sp of PEFV
PRIETO 1998A <sup>1390</sup>	No relevant outcomes and does not match review question (differences in dose-response curve to methacholine in asthma, rhinitis and controls)
PUOLIJOKI 1992 <sup>1400</sup>	Population does not match protocol – all methacholine challenge test negative patients
PUROKIVI 2007 <sup>1401</sup>	Index test does not match protocol – histamine challenge test
REMES 2002 <sup>1433</sup>	Methacholine challenge tests used as one of the objective tests to Dx asthma
RENWICK 1996 <sup>1436</sup>	Chronic airway obstruction prevalence and BDR
RIJCKEN 1989 <sup>1447</sup>	Reference standard does not match protocol (sensitivity and specificity of histamine challenge test to detect self-reported symptoms (symptomatic or asymptomatic))
ROQUET 1996 <sup>1464</sup>	No relevant outcomes and does not match review question –sn/sp of Eos to predict positive challenge test
SACHOLSEN 2010 <sup>1482</sup>	Population does not match protocol - general population not all with asthma or suspected asthma
SCHLEICH 2012 <sup>1514</sup>	Methacholine challenge test used as part of the reference standard to Dx asthma in suspected asthma patients without airway obstruction or BDR
SCHMIDT 1992 <sup>1516</sup>	All patients with asthma and no comparator test (comparing different methods of histamine challenge). Physician Dx only, no objective test
SCHNEIDER 2009A <sup>1519</sup>	Methacholine challenge test used as part of the reference standard to Dx asthma and assess the sn/sp of spirometry in GP
SCHULZE 2013 <sup>1527</sup>	No relevant outcomes and does not match review question – sn/sp of methacholine challenge to detect a positive allergen response

Reference	Reason for exclusion
SHAPIRO 1982 <sup>1555</sup>	Reference standard does not match protocol – methacholine test used as reference standard to Dx asthma
SIERSTED 1994 <sup>1573</sup>	Reference standard does not match protocol – asthma Dx based on questionnaire responses to doctor diagnosed asthma and symptoms (no mention of objective test)
SIERSTED 1994 <sup>1573</sup>	Duplicate – ordered twice, already excluded for this review
SIERSTED 1996 <sup>1574</sup>	Reference standard does not match protocol – methacholine test used as part of reference standard to Dx asthma
SISTEK 2006 <sup>1601</sup>	Reference standard does not match protocol – asthma Dx based on questionnaire responses to doctor diagnosed asthma and attack in the last 12 months (no mention of objective test)
SORIANO 1999 <sup>1627</sup>	Reference standard does not match protocol - positive methacholine test used to Dx asthma
SOVIJARVI 1986 <sup>1634</sup>	No relevant outcomes and does not match review question – different methods of measuring methacholine test
SPIROPOULOS 1986 <sup>1641</sup>	No relevant outcomes and does not match review question – sn/sp of methacholine test in predicting hyper-reactive airway symptoms not physician Dx of asthma
SPOSATO 2014 <sup>1644</sup>	Index test and reference standard do not match protocol
SPRINGER 2000 <sup>1645</sup>	Population does not match protocol (aged 2-8 years). All people with confirmed asthma and no comparator test
STAHL 2009 <sup>1651</sup>	Conference abstract
SUN 2007 <sup>318</sup>	Duplicate of CHOI 2007A – already excluded in this review
SVERRILD 2009 <sup>1689</sup>	Same data used for Sverrild 2010 paper already excluded from this review.
SVERRILD 2010 <sup>1688</sup>	Reference standard does not match protocol - physician Dx without objective test (physician Dx made on the basis of symptoms in the last 12 months in combination with either a eNO level of greater than 30 ppb, a history of allergic rhinoconjunctivitis, dermatitis, a positive skin prick test response, a familial predisposition to atopic disease, nonallergic rhinoconjunctivitis, or an FEV1/forced vital capacity ratio of less than 75%).
SVERRILD 2012 <sup>1687</sup>	Review article

Reference	Reason for exclusion
SVERRILD 2013 <sup>1686</sup>	sn/sp of FeNO in predicting positive mannitol response. Reference standard does not match protocol - physician Dx with no mention of objective test
TAKAMI 2013 <sup>1699</sup>	No relevant outcomes and does not match review question (correlation study)
TERNESTEN 2002 <sup>1723</sup>	Methacholine challenge test used as part of the reference standard to Dx asthma
TIE 2012 <sup>1736</sup>	Reference standard does not match protocol
TODD 2004 <sup>1745</sup>	Not relevant outcomes and does not answer review question - all people with asthma with positive methacholine challenge (comparing methods of performing methacholine test)
TOELLE 1992 <sup>1746</sup>	Methacholine challenge test used as part of the reference standard to Dx asthma
TOWNLEY 1975 <sup>1762</sup>	Reference standard does not match protocol – no objective test
TOWNLEY 1990 <sup>1761</sup>	Can only calculate sensitivity (methacholine challenge in suspected asthma and asymptomatic controls – all suspected group were Dx based on reference standard and no Dx of control group reported)
VILOZNI 2009 <sup>1846</sup>	Population does not match protocol (aged 3-6 years)
WONGTIM 1997 <sup>1913</sup>	Methacholine challenge test used as part of the reference standard to Dx asthma
WOO 2012 <sup>1914</sup>	Methacholine challenge test used as part of the reference standard to Dx asthma – Dx based on symptoms and BDR and/or positive methacholine challenge
WOOLCOCK 1984 <sup>1920</sup>	Histamine challenge test but no comparator or reference standard test (looking at dose-response curve to histamine in people with asthma and controls)
WU 2011 <sup>1923</sup>	Conference abstract
XU 2001 <sup>1926</sup>	Reference standard does not match protocol - asthma was defined as a history of physician-diagnosed asthma at any time in the past (no mention of objective test)
YURDAKUL 2005 <sup>1945</sup>	Reference standard does not match protocol – methacholine test used as part of reference standard to Dx asthma
ZAGHLOUL 2009 <sup>1947</sup>	Conference abstract

## 1 K.15 Diagnosis: Exercise challenge test

2 **Table 222: Studies excluded from the clinical review**

Reference	Reason for exclusion
ALBERTS1994 <sup>32</sup>	Not exercise test
ANDERSON2009 <sup>48</sup>	Exercise test as gold standard not index test
ANDERSON2010A <sup>46</sup>	Exercise test as gold standard not index test
ANDERSON2011 <sup>47</sup>	Not primary study
ANSLEY2012 <sup>53</sup>	Not exercise test
ARIASIRIGOYEN1999 <sup>65</sup>	Case control study
AVITAL 1995A <sup>83</sup>	Wrong cut-off value: Change in FEV1 of 5% is very low.
AVITAL1995 <sup>82</sup>	Mean age <5 years
BACKER 1992 <sup>90</sup>	Wrong population: general population, not suspected asthma.
BACKER1991 <sup>88</sup>	Not exercise test +/- versus histamine challenge +/- or diagnosis of asthma
BAILLY2011 <sup>94</sup>	Not exercise
BARBEN2011 <sup>107</sup>	Exercise test as gold standard not index test
BELCHER1987 <sup>144</sup>	Not exercise test to diagnose asthma (refractoriness to second test)
BENARB 2011 <sup>150</sup>	Wrong reference standard: ISAAC questionnaire but no objective test.
BENNETT1987 <sup>153</sup>	Not exercise
BERKMAN 2005 <sup>160</sup>	Wrong reference standard: physician Dx but no objective test.
BEYDON2008 <sup>168</sup>	Not exercise
BHAGAT1984 <sup>169</sup>	Not exercise test over/under threshold versus comparator
BLACKIE1990 <sup>179</sup>	Review not primary study
BOCCACCINO2007 <sup>183</sup>	No comparator test of diagnosis of asthma/no asthma
BORGES2011 <sup>192</sup>	Review not primary study
BOUGAULT2010 <sup>202</sup>	Not exercise test
BRANNAN2012 <sup>219</sup>	Review not primary study
BROZEK2009 <sup>234</sup>	Case control study
BUCHVALD2005 <sup>241</sup>	Exercise test as gold standard not index test
CALVERT2005 <sup>265</sup>	Case control study
CAREY2010 <sup>271</sup>	Not diagnosis of asthma (healthy subjects)
CARLSEN 1998 <sup>275</sup>	Wrong reference standard: physician Dx but no objective test.



Reference	Reason for exclusion
CARLSEN2002 <sup>276</sup>	Not primary study
CARLSTEN2011 <sup>277</sup>	Not exercise test
CHATHAM1982 <sup>303</sup>	Unclear cut-offs. Case-control study
CHEN2014 <sup>307</sup>	Population does not match protocol – general population
CHOI2005 <sup>317</sup>	EIB as outcome not index test
CLEARIE2010 <sup>339</sup>	Elite athletes
COCKCROFT1992 <sup>351</sup>	Not exercise test
COCKCROFT2009 <sup>353</sup>	SR not primary study - no data presented
COCKCROFT2009A <sup>349</sup>	Review not primary study
COCKCROFT2010 <sup>354</sup>	Not a primary study – no data presented
DEMISSIE 1998 <sup>416</sup>	Wrong reference standard: physician Dx but no objective test.
DICKINSON2006 <sup>438</sup>	Elite athletes
DICKINSON2006A <sup>437</sup>	Elite athletes
DOR1999 <sup>444</sup>	Non-English
DRYDEN2010 <sup>453</sup>	Exercise test as gold standard not index test
ELHALAWANI2003 <sup>468</sup>	Exercise test as gold standard not index test
ELIASSON1992 <sup>469</sup>	Case control study
FEITOSA2012 <sup>488</sup>	Exercise test as gold standard not index test
FUENTES2011 <sup>525</sup>	Case control study
GARCIADLARUBIA1998 <sup>540</sup>	Case control study
GARCIARIO2004 <sup>543</sup>	Not exercise test
GERALD2002 <sup>551</sup>	Information on subjects with positive exercise test only, not those with negative test
GIFT1994 <sup>561</sup>	Commentary not primary study
GODFREY1999 <sup>571</sup>	Compares outcome of exercise test in subjects with asthma against previously published studies in normal populations; data for test results comparing exercise with methacholine challenge within asthma group not shown
GRUCHALLA2003 <sup>595</sup>	Case control study and not all participants had exercise test
GRUCHALLA2009 <sup>596</sup>	Not exercise test
GRZELEWSKI2012 <sup>599</sup>	Exercise test as gold standard not index test
HOLZER2002 <sup>687</sup>	Not exercise test as index test
HOLZER2003 <sup>686</sup>	Not exercise test as index test
HOPP1984 <sup>693</sup>	Not exercise test
HORIE1983 <sup>700</sup>	Not exercise positive/negative versus

Reference	Reason for exclusion
	asthma diagnosis or other test positive/negative
JOHNSON1987 <sup>771</sup>	Not exercise test
JONES1994 <sup>774</sup>	Case control study with longitudinal follow up
JONES1994A <sup>775</sup>	Case control study
JOOS2003 <sup>778</sup>	Review not primary study
KANAZAWA2002 <sup>808</sup>	Not exercise test +/- versus asthma diagnosis or other test
KANNISTO2000 <sup>811</sup>	No data on exercise +/- versus comparator
KING1989 <sup>866</sup>	Not exercise test
KIVILOOG 1975 <sup>871</sup>	Wrong outcome measure: not a standard measure (change in PEFR $\geq 15\%$ )
KNOX1989 <sup>883</sup>	Not exercise test
KOH1996 <sup>887</sup>	Not exercise +/- versus comparator +/-`
KOH1998 <sup>886</sup>	Not exercise +/- versus comparator +/-`
KOTANIEMISYRJANEN2002 <sup>907</sup>	Exercise test part of gold standard not index test
LAZOVELASQUEZ2005 <sup>968</sup>	Case control study
LEX2007 <sup>995</sup>	Exercise test as gold standard not index test
LIEM2008 <sup>1002</sup>	Not exercise test
LUNTSOV2012 <sup>1036</sup>	Not exercise +/- versus comparator +/-`
MADSEN1985 <sup>1045</sup>	Not exercise test
MADSEN1986 <sup>1044</sup>	Not exercise test
MALMBERG2009 <sup>1065</sup>	Exercise test as gold standard not index test
MANSO2011 <sup>1074</sup>	Not exercise test
MIEDINGER2010 <sup>1133</sup>	Case control study
MODL 1995 <sup>1154</sup>	Wrong population: symptom-free and medication-free people with asthma
MULLER 1993 <sup>1176</sup>	Not exercise test
MUSSAFFI1986 <sup>1187</sup>	Not exercise +/- versus comparator +/-`
NEIJENS1983 <sup>1207</sup>	Review not primary study
NISH1992 <sup>1237</sup>	Exercise test as part of gold standard not index test
NISHIO2007 <sup>1238</sup>	Exercise test as gold standard not index test
OBATA1994 <sup>1253</sup>	Case control study
PEDROSA2009 <sup>1315</sup>	Not exercise test
PONSONBY 1996 <sup>1363</sup>	Wrong reference standard: ISAAC questionnaire but no objective test.
PORSBJERG2009 <sup>1369</sup>	Not primary study

Reference	Reason for exclusion
PRATTER1989 <sup>1382</sup>	Not all patients had exercise test and exercise test part of gold standard not index
PUOLIJOKI1992 <sup>1400</sup>	Not exercise test
RAMSER2008 <sup>1413</sup>	Exercise test as gold standard not index test
RANDOLPH2011 <sup>1415</sup>	Review not primary study
RANDOLPH2011A <sup>1417</sup>	Unclear what is the gold standard
REMES 2002 <sup>1433</sup>	Wrong reference standard: physician Dx but no objective test.
RIEDLER1992A <sup>1443</sup>	Non-English
RIEDLER1994 <sup>1444</sup>	Case control study
RIEDLER1997 <sup>1442</sup>	Review, not primary study.
ROMBERG2011 <sup>1459</sup>	Elite athletes
ROMBERG2012 <sup>1460</sup>	Elite athletes
ROUHOS2010 <sup>1471</sup>	Exercise test mentioned but results not reported
RUNDELL2004 <sup>1476</sup>	Exercise = index test but also part of gold standard
SACHSOLSEN2010 <sup>1482</sup>	Exercise test as part of gold standard not index test
SACHSOLSEN2013 <sup>1483</sup>	Case control study
SCOLLO2000 <sup>1532</sup>	Exercise test as gold standard not index test
SHAPIRO1982 <sup>1555</sup>	Not exercise test
SIERSTED 1996 <sup>1574</sup>	Wrong population: general population, not suspected asthma.
SIN2009 <sup>1593</sup>	Data versus methacholine test was not all in asthma patients; data versus diagnosis not calculable
SINCLAIR1995 <sup>1595</sup>	Exercise test as both index and comparison test
SMITH1990 <sup>1614</sup>	Exercise test as gold standard not index test
SOTORAMOS2013 <sup>1632</sup>	Comparator test is FeNO – not on list in protocol
SOVIJARVI1986 <sup>1634</sup>	Not exercise test
SPIERING2004 <sup>1640</sup>	Exercise test as gold standard not index test
SPIROPOULOS1986 <sup>1641</sup>	Not exercise test
STICKLAND2011 <sup>1661</sup>	Review, not primary study. Exercise test as gold standard not index test
TAL1984 <sup>1701</sup>	Cold air and exercise tests are both index tests – no comparator from protocol list
TERBLANCHE 1990 <sup>1722</sup>	Wrong population: general population, not suspected asthma.

Reference	Reason for exclusion
TOWNLEY1975 <sup>1762</sup>	Not exercise test
TSYBULKINA2008 <sup>1774</sup>	No comparator
TSYBULKINA2011 <sup>1772</sup>	Not exercise +/- versus comparator +/-`
VILOZNI2007 <sup>1845</sup>	Children aged 3 to 6 years (mean <5 years); not exercise test positive/negative versus diagnosis or other test
VILOZNI2009 <sup>1846</sup>	Not exercise test
WEST1996 <sup>1886</sup>	Case control study
WOJNAROWSKI1996 <sup>1909</sup>	Not exercise test

## 1 K.16 Monitoring: Questionnaires

2 **Table 223: Studies excluded from the clinical review**

Reference	Reason for exclusion
ADAMS 2000 <sup>16</sup>	Validation of AQLQ-M.
APFELBACHER 2011 <sup>57</sup>	Review article
APFELBACHER 2012 <sup>58</sup>	Validation study of mini AQLQ-J and AQLQ-S and correlation with symptoms, control and patient characteristics.
ALMOAMARY 2012 <sup>28</sup>	Intervention does not match protocol – asthma control questionnaire score to guide initial therapy not ongoing management.
BARLEY 1999 <sup>110</sup>	Correlation of diary cards with questionnaires and lung function.
BATEMAN 2001 <sup>126</sup>	Review article
BATEMAN 2006 <sup>127</sup>	Intervention does not match protocol – step down of treatment according to monitoring using GINA guidelines.
BAYLISS 2000 <sup>133</sup>	Validation of ITG-ASF QOL questionnaire.
BHOOGAL 2006 <sup>171</sup>	Systematic review - intervention and comparison do not match protocol – monitoring symptoms vs PEF
BIME 2012 <sup>173</sup>	Validation study of ASUI
BRAIDO 2012 <sup>208</sup>	Validation of RhinAsthma Patient Perspective QOL questionnaire.
BUIST 2006 <sup>243</sup>	Intervention does not match protocol – monitoring using a peak flow monitor.
CARRANZARROSENZWEIG 2007 <sup>279</sup>	Conference abstract
CARROLL 2013 <sup>283</sup>	Review article
DESOUZA 2011 <sup>402</sup>	Not in English
EHRIS 2006 <sup>465</sup>	Validation of mini AQLQ
ERKOCOGLU 2012 <sup>477</sup>	Comparison of control determined by C-ACT or GINA
EVERHART 2009 <sup>479</sup>	Validation of a pictorial version of the AQLQ
GALANT 1999 <sup>534</sup>	Conference abstract

Reference	Reason for exclusion
GARRATT 2000 <sup>546</sup>	Validation of AQLQ
GRAINGER-ROUSSEAU 1996 <sup>585</sup>	Article not available
GREEN 2007 <sup>588</sup>	No relevant outcomes - results of phase 2 (ACT completed for physician visits) not reported in this paper.
GREEN 2013 <sup>590</sup>	Comparison of level of control between measures (FeNO, spirometry, cACT and clinical assessment).
GUENDELMAN 2002 <sup>602</sup>	Intervention does not match protocol – interactive self-management and education programme, includes questions about symptoms, PEF, use of medications and health services and functional status (not symptoms alone)
GUENDELMAN 2004 <sup>603</sup>	Intervention does not match protocol – interactive self-management and education programme, includes questions about symptoms, PEF, use of medications and health services and functional status (not symptoms alone)
HALBERT 2009 <sup>620</sup>	Systematic review of validation studies.
HOLT 2010A <sup>685</sup>	Review of ACT
JAN 2007 <sup>749</sup>	Intervention does not match protocol – monitoring of symptoms and PEF (comparison of diaries and electronic diaries)
JIA 2013 <sup>769</sup>	Systematic review of validation studies of ACT and ACQ
JUNIPER 1993 <sup>794</sup>	Validation of AQLQ.
JUNIPER 1996 <sup>792</sup>	Validation of PAQLQ
JUNIPER 1997 <sup>793</sup>	Validation of the PAQLQ
JUNIPER 1999 <sup>791</sup>	Validation of the mini AQLQ
JUNIPER 1999A <sup>789</sup>	Validation of the AQLQ-S
JUNIPER 1999C <sup>797</sup>	Validation of the ACQ
JUNIPER 2000 <sup>796</sup>	No relevant outcomes. Comparison of daily control diary and clinician assessment of control.
JUNIPER 2001 <sup>795</sup>	Validation of 4 QOL instruments
JUNIPER 2001A <sup>798</sup>	Validation of the ACQ
JUNIPER 2005 <sup>800</sup>	Validation of the AQLQ 12+
JUNIPER 2005A <sup>799</sup>	Validation of 3 shortened versions of the ACQ
JUNIPER 2010 <sup>790</sup>	Validation of ACQ in children.
KATZ 1999 <sup>821</sup>	Validation of AQLQ-M
KAVUT 2010 <sup>826</sup>	Intervention does not match protocol – asthma awareness session, ACT is an outcome.

Reference	Reason for exclusion
KHEIR 2008 <sup>852</sup>	Intervention does not match protocol – pharmaceutical care service including assessment of adherence and PEF monitoring to guide care plan.
KWON 2008A <sup>941</sup>	Conference abstract
LEUNG 2013 <sup>987</sup>	Review article
LIU 2007 <sup>1019</sup>	Development and validation of cACT
LOBO 2007 <sup>1022</sup>	Conference abstract. Validation of PAQLQ in severe asthma.
MAGNAN 2004 <sup>1048</sup>	Review article
MARKS 1993 <sup>1078</sup>	Validation study of AQLQ-M and correlation with symptoms, lung function and BHR.
MCDONALD 2009 <sup>1103</sup>	Conference abstract. Validation of ACQ in children.
NATHAN 2004 <sup>1200</sup>	Validation of the ACT
NGUYEN 2014 <sup>1216</sup>	Validation of ACQ in children.
PINNOCK 2012 <sup>1350</sup>	Validation of the RCP-3
PRABHAKARAN 2010A <sup>1378</sup>	Intervention does not match protocol - monitoring using SMS service based on symptoms and medication use.
THOMAS 2009 <sup>1729</sup>	Validation of the RCP-3 and cross-sectional correlation analysis with control, QOL, BD use, lung function and FeNO.
TURNER 1998 <sup>1783</sup>	Intervention does not match protocol – PEF monitoring vs symptom monitoring (symptoms monitoring does not focus on symptom scores or diaries to monitor control)
VANGAALLEN 2013 <sup>1812</sup>	Same study as MEER 2009 (included in this review). Long term follow-up at 30 months but monitoring intervention ended at 12 months. Already using outcomes at 12 months (use of 30 months would be double counting for >6months).
WING 2012 <sup>1901</sup>	Validation of PAQLQ and mini PAQLQ.
YOOS 2002 <sup>1940</sup>	Intervention and comparison do not match protocol – monitoring symptoms vs symptoms + PEF
ZEMEK 2008 <sup>1951</sup>	Systematic review - intervention and comparison do not match protocol – monitoring symptoms vs PEF

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## 1 K.17 Monitoring: Lung function tests

2 **Table 224: Studies excluded from the clinical review**

Study	Exclusion reason
Abramson 2010 <sup>13</sup>	Not guideline condition. Asthma or COPD patients are included and the results are not shown separately
Abramson 2012 <sup>11</sup>	Incorrect interventions. Spirometry intervention versus usual care (abstract only)
Anon 2004 <sup>4</sup>	Commentary not primary study
Armour 2007 <sup>72</sup>	Incorrect interventions. Intervention is not monitoring with spirometry or PEF
Ayres 1996 <sup>85</sup>	Both groups monitored PEF
Berg 1997 <sup>156</sup>	Incorrect interventions. No self-management in control group
Bheekie 2001 <sup>170</sup>	Alternate allocation (not randomized). Inadequate allocation concealment. No relevant outcomes.
Boath 1998 <sup>181</sup>	Conference abstract not freely available
Bramson 1996 <sup>209</sup>	Not full paper. Commentary on a study already excluded from this review (LAHDESUO 1996)
Brouwer 2008 <sup>231</sup>	Not SR or RCT
Charlton 1994 <sup>301</sup>	Incorrect interventions. Both groups monitored PEF
De asis 2004 <sup>390</sup>	No clinical outcomes. Cost-effectiveness paper based on clinical data from a paper already included in this review (COWIE 1997)
Deschildre 2012 <sup>427</sup>	Severe asthma. Severe allergic asthma according to the Third Paediatric Asthma Consensus (i. e. frequent acute episodes requiring oral corticosteroid therapy, associated with moderate episodes (exercise-induced asthma, chronic cough, sleep disturbances, treatment with short-acting beta 2-agonists >3 times per week) and airflow limitation). Incorrect intervention. Incorrect interventions
Drummond 1994 <sup>452</sup>	Incorrect interventions. No self-management in control group
Gibson 2002 <sup>560</sup>	SR: self-management (PEF or symptoms) versus usual care
Gibson 2004 <sup>559</sup>	SR: all RCTs checked
Huang 2009 <sup>709</sup>	Not self-management in the control group
Ignacio 1993 <sup>721</sup>	Not in English
Ignacio-garcia 1995 <sup>722</sup>	Incorrect interventions. Intervention group received education and self-management plan. Control group were monitored by their physician according to symptoms but did not receive education or a self-mangement plan.
Jan 2007 <sup>749</sup>	Incorrect interventions. Both groups used PEF monitoring
Janson 2010 <sup>755</sup>	Not self-monitoring peak flow. Not self-monitoring peak flow . Not self-monitoring peak flow versus not (intervention = monthly trend PEF data given to GPs; control allowed to use PEF)
Janson-bjerklie 1988 <sup>756</sup>	Not self-management
Jones 1995 <sup>776</sup>	Incorrect interventions. Control group did not have self-management
Kelso 2005 <sup>837</sup>	Commentary not primary study

Kemple 2003 <sup>839</sup>	Action plans but not PEF monitoring versus not (not all intervention group had a peak flow monitor)
Klein 2001 <sup>875</sup>	Control group also given peak flow meter. Incorrect interventions
Kotses 1996 <sup>908</sup>	2 groups both self-managed with PEF, the third group did not self-manage. Incorrect interventions
Kotses 2007 <sup>909</sup>	Conference abstract not freely available
Lahdensuo 1996 <sup>947</sup>	Incorrect interventions. No self-management in control group
Lahdensuo 1998 <sup>946</sup>	Incorrect interventions. Control group did not have self-management
Lefevre 2002 <sup>975</sup>	SR: RCTs checked, all already in separately
Löwhagen 2002 <sup>1031</sup>	Incorrect interventions. Wrong comparator (ECP)
Magar 2005 <sup>1046</sup>	No self-management in control group
Malo 1993 <sup>1068</sup>	Crossover study
Mcgrath 2001 <sup>1107</sup>	SR: RCTs checked
Mcmullen 2002 <sup>1112</sup>	Not our outcomes (qualitative data from Yoos 2002 trial)
Milenkovic 2007 <sup>1137</sup>	Incorrect interventions. No self-management in control group
Nhlbi 2005 <sup>1217</sup>	Protocol only, no results
Osman 2002 <sup>1274</sup>	Incorrect interventions. No self-monitoring in control group
Persaud 1996 <sup>1325</sup>	No self-management in control group
Powell 2002 <sup>1375</sup>	SR: RCTs checked
Reddel 2006 <sup>1426</sup>	Review article
Ross 2012 <sup>1469</sup>	No self-management in control group (abstract only)
Sangha 2004 <sup>1493</sup>	Not review population. Not persistent asthma (seasonal symptoms)
Schermer 2002 <sup>1511</sup>	Incorrect interventions. Control group did not self-manage
Slader 2006 <sup>1605</sup>	Incorrect interventions. Not randomised comparison of PEF monitoring versus other self-monitoring
Slader 2007 <sup>1606</sup>	Incorrect interventions. Not randomised comparison of PEF versus symptoms monitoring
Stahlman 2006 <sup>1652</sup>	Crossover study. Crossover
Tagaya 2005 <sup>1694</sup>	Incorrect interventions. No self management in control group
Tapp 2007 <sup>1708</sup>	Incorrect interventions. Education (could be self-management with PEF or symptoms or both) versus no education, not self-management with PEF versus no PEF
Thoonen 2003 <sup>1733</sup>	Incorrect interventions. No self management in control group
Thurber 2006 <sup>1735</sup>	Conference abstract not freely available
Toelle 2011 <sup>1747</sup>	Withdrawn by Cochrane Library
Van der palen 1998 <sup>1805</sup>	SR: RCTs checked
Van der palen 2001 <sup>1806</sup>	Control group did not self-treat exacerbations
Vazquez 1993 <sup>1828</sup>	Not PEF self-management versus other self-management. Incorrect interventions
Walders 2006 <sup>1864</sup>	Incorrect interventions. All participants had self-management based on PEF and symptoms



Weinberger 2002 <sup>1880</sup>	Incorrect interventions. No self-monitoring in control group
Yoon 1993 <sup>1939</sup>	Incorrect interventions. All participants had peak flow meter; randomised comparison was of an education session
Zemek 2008 <sup>1951</sup>	SR: all included studies already on our list individually

## 1 K.18 Monitoring: FeNO

2 **Table 225: Studies excluded from the clinical review**

Reference	Reason for exclusion
<sup>92</sup> BACKER 2014	Population does not match protocol. Not monitoring FeNO.
HASHIMOTO 2011 <sup>639</sup>	Population does not match protocol – severe asthma
HONKOOP 2011 <sup>692</sup>	Published trial protocol
HONKOOP 2013 <sup>690</sup>	Conference abstract
KATSOULIS 2013 <sup>820</sup>	Population does not match protocol. Not monitoring FeNO
LURA 2010 <sup>1037</sup>	Conference abstract
MALERBA 2008 <sup>1058</sup>	Intervention does not match protocol – monitoring FeNO and sputum eosinophils combined.
NICKELS 2014 <sup>1219</sup>	Conference abstract
NICKELS 2014A <sup>1220</sup>	Conference abstract
OHKURA 2013 <sup>1262</sup>	Conference abstract
PETSKY 2010 <sup>1337</sup>	Conference abstract
PETSKY 2010 <sup>1336</sup>	Conference abstract (duplicate)
PETSKY 2010 <sup>1336</sup>	Conference abstract (duplicate)
SCHNEIDER 2014 <sup>1518</sup>	Population does not match protocol. Not FeNO monitoring.
SYK 2012 <sup>1690</sup>	Conference abstract
SYK 2012A <sup>1691</sup>	Conference abstract
VOORENDVAN 2013 <sup>1857</sup>	Conference abstract
VOUTILAINEN 2013 <sup>1858</sup>	Population does not match protocol. Not FeNO monitoring.
WANICH 2009 <sup>1873</sup>	Commentary

## 3 K.19 Monitoring: Peripheral blood eosinophils

4 **Table 226: Studies excluded from the clinical review**

Reference	Reason for exclusion
ALMOSAWI 2008 <sup>36</sup>	Study design does not match protocol – observational case control study comparing eosinophil levels.
BASYIGIT 2004A <sup>125</sup>	Intervention does not match protocol – not monitoring blood eosinophils.
BELDA 2001 <sup>145</sup>	Study design does not match protocol –

Reference	Reason for exclusion
	observational prognostic study of eosinophil levels as a risk factor for exacerbation.
BRUSSELLE 2013 <sup>238</sup>	Review article
BUSH 2005 <sup>251</sup>	Clinical trial protocol only. Population does not match protocol – severe asthma. Intervention does not match protocol – monitoring using sputum not blood eosinophils.
BUSSE 2013 <sup>256</sup>	Intervention does not match protocol – not monitoring.
DEYKIN 2005 <sup>428</sup>	Intervention does not match protocol – not monitoring.
GREEN 2002A <sup>591</sup>	Intervention does not match protocol (monitoring sputum eosinophils).
LOWHAGEN 2002 <sup>1031</sup>	Intervention and comparison do not match protocol – monitoring serum eosinophil cationic protein vs monitoring PEF (as % best, not PEFv).
MALERBA 2008 <sup>1058</sup>	Study design does not match protocol – observational case series (all patients monitored, no control group). Intervention does not match protocol (monitoring sputum eosinophils).
NIIMI 1999 <sup>1232</sup>	Review article
PARAMESWARAN2000A <sup>1294</sup>	Conference abstract
PETSKY 2007 <sup>1339</sup>	Systematic review - intervention does not match protocol (monitoring sputum eosinophils).
PETSKY 2012 <sup>1338</sup>	Systematic review - intervention does not match protocol (monitoring sputum eosinophils).
PREHN 2000 <sup>1384</sup>	Pilot study. Study design does not match protocol – observational case series (all patients monitored using serum eosinophil protein levels, no control group).
ZACHARASIEWICZ 2006 <sup>1946</sup>	Review article

## 1 K.20 Monitoring: Challenge tests

2 **Table 227: Studies excluded from the clinical review**

Reference	Reason for exclusion
ARKINS 1968 <sup>70</sup>	Not relevant to review question
BELDA 2006 <sup>146</sup>	Intervention does not match protocol – Step-down treatment strategy, BHR as an outcome.
BRAND 1992A <sup>211</sup>	Population and intervention do not match protocol
FORESI 2005 <sup>503</sup>	Intervention does not match protocol – RCT of 2 step-down treatment strategies,

Reference	Reason for exclusion
	BHR as an outcome.
HAYES 2012 <sup>644</sup>	Intervention does not match protocol - Health Technology assessment of Mannitol challenge test for diagnosis not monitoring.
JOOS 2003A <sup>779</sup>	Review article
MCKINLAY 2011 <sup>1110</sup>	Conference abstract. Relevant for mannitol
NUIJSINK 2013 <sup>1249</sup>	Same study as NUIJSINK 2007 – long term follow up after intervention had finished.
PADOVANO 2000 <sup>1281</sup>	Conference abstract
PROSPERINI 2002 <sup>1396</sup>	Intervention does not match protocol – Step-down treatment strategy, BHR as an outcome.
RENSEN 1998 <sup>1435</sup>	Conference abstract
SCHERR 2012 <sup>1513</sup>	Conference abstract – intervention does not match protocol
SHORT 2011A <sup>1569</sup>	Conference abstract. Relevant for mannitol
THOONEN 2003 <sup>1733</sup>	Intervention does not match protocol

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## 1 K.21 Monitoring: Adherence to treatment

2 **Table 228: Studies excluded from the clinical review**

Reference	Reason for exclusion
APTER 2005 <sup>60</sup>	Not full paper (clinical trial protocol only). Intervention does not match protocol.
ARMOUR 2007 <sup>72</sup>	Intervention does not match protocol – asthma management plan including counselling/education, review of inhaler technique, review of adherence and referral to GP.
BALDWIN 1991 <sup>96</sup>	Intervention and comparison do not match protocol – new portable system vs conventional system for monitoring theophylline levels.
BENDER 2014 <sup>152</sup>	Conference abstract
BLACK 2008 <sup>178</sup>	Not full paper (conference abstract only).
BOZEK 2010 <sup>207</sup>	No relevant outcomes and does not match review question. Correlation between cognitive status and compliance in elderly people with asthma.
BRANDT 1994 <sup>217</sup>	Intervention does not match protocol - intervention included monitoring of inhaler technique, monitoring theophylline levels and counselling. Population does not match protocol – moderate to severe asthma.
BROERS 2002 <sup>229</sup>	Not full paper (conference abstract only).
BURGESS 2009 <sup>245</sup>	Not full paper (conference abstract only) – full text assessed BURGESS 2010
CHIA 2008 <sup>311</sup>	Intervention does not match protocol – education on asthma and inhaler technique.
GIBSON 2009 <sup>557</sup>	Intervention and comparison does not match protocol – systematic review of FeNO vs symptom monitoring.
JANSON 2005 <sup>754</sup>	Not full paper (clinical trial protocol only). Intervention does not match protocol.
KRISHNAN 2012 <sup>919</sup>	No relevant outcomes and does not match review question – comparison between subjective and objective measures of adherence.
LAUFENBERGHORSTMANN 2006 <sup>965</sup>	Intervention does not match protocol - community pharmacist initiated intervention included monitoring of inhaler technique and adherence.
MATUI 2014 <sup>1095</sup>	Systematic review. Intervention does not match protocol.
MCCLURE 2008 <sup>1100</sup>	Intervention does not match protocol - supervision of medication administration in children to improve adherence (not based on feedback as a result of monitoring

Reference	Reason for exclusion
	adherence).
MEHUYS 2008 <sup>1116</sup>	No relevant outcomes and does not match review question. Monitoring level of asthma control to guide therapy
MITCHELL 2005 <sup>1149</sup>	Intervention does not match protocol – asthma clinical pathway.
MOULLEC 2012 <sup>1172</sup>	Intervention does not match protocol – systematic review of interventions to improve adherence (eg self-management and decision support).
MUNDY 2007 <sup>1178</sup>	Review article
NIDES 1993 <sup>1225</sup>	Population does not match protocol – not people with asthma.
PERTSEVA 2004 <sup>1327</sup>	Not full paper (conference abstract only).
PETITTO 2012 <sup>1334</sup>	Not full paper – full text assessed KRISHNAN 2012. No relevant outcomes and does not match review question – comparison between subjective and objective measures of adherence.
RAND 1994 <sup>1414</sup>	Review article
SANTOS 2010 <sup>1495</sup>	Intervention does not match protocol – counselling intervention to improve adherence.
STRANDBYGAARD 2010 <sup>1673</sup>	Intervention does not match protocol – daily SMS reminder to take medication (adherence is an outcome, intervention is not monitoring adherence).
TRAN 2014 <sup>1763</sup>	Systematic review. Intervention does not match protocol.
VASBINDER 2013 <sup>1827</sup>	Intervention does not match protocol – text reminder 15 minutes following missed dose to improve adherence (not based on monitoring the individual patient's adherence)
VRIES 2010 <sup>1859</sup>	Not in English.
VOLLMER 2011 <sup>1853</sup>	Intervention does not match protocol – refill reminder call to improve adherence both before and after missed prescription fill (not based on monitoring the individual patient's adherence)

## 1 K.22 Monitoring: Inhaler technique

2 **Table 229: Studies excluded from the clinical review**

Reference	Reason for exclusion
BASHETI 2005 <sup>122</sup>	No relevant outcomes – primary outcome is inhaler

Reference	Reason for exclusion
	technique score.
BASHETI 2006 <sup>121</sup>	Conference abstract
BOSNIC 2010 <sup>197</sup>	No relevant outcomes – primary outcome is inhaler technique score.
BRAND 2005 <sup>216</sup>	Review article.
BYNUM 2001 <sup>258</sup>	No relevant outcomes – primary outcome is inhaler technique score.
CICUTTO 2013 <sup>327</sup>	Intervention does not match protocol – asthma education.
FARBER 2009 <sup>486</sup>	Review article
GOEMAN 2013 <sup>573</sup>	Intervention does not match protocol – asthma education.
KUETHE 2013 <sup>925</sup>	Systematic review. Intervention does not match protocol – nurse led care vs physician led care.
KUMAR 2009 <sup>927</sup>	Intervention does not match protocol – asthma education.
LAUFENBERGHORSTMANN 2006 <sup>965</sup>	Study design does not match protocol – observational study.
MCELNAY 1989 <sup>1105</sup>	Study design does not match protocol – observational study.
MULLOY 1996 <sup>1177</sup>	Intervention does not match protocol – asthma education.
NIDES 1993 <sup>1225</sup>	Population does not match protocol – not people with asthma.
NIMMO 1993 <sup>1234</sup>	Population does not match protocol – asthma and COPD. Crossover study of 2 types of inhaler.
PRESS 2012 <sup>1385</sup>	Population does not match protocol – mixed asthma and COPD (33% asthma)
ROOTMENSEN 2008 <sup>1463</sup>	Intervention does not match protocol – asthma education.
RYDMAN 1999 <sup>1480</sup>	No relevant outcomes – primary outcome is inhaler technique score.
SAVAGE 2003 <sup>1502</sup>	No relevant outcomes – inhaler technique score.

Reference	Reason for exclusion
	Immediately before and after intervention, not long-term follow-up of patient outcomes.
SKAER 1996 <sup>1603</sup>	Study design does not match protocol – observational study.
TURGEON 1996 <sup>1781</sup>	No relevant outcomes – inhaler technique score. UHU and missed school days assessed but not reported.
VAN DER PALAN 1997 <sup>1804</sup>	Population does not match protocol – COPD.
VERVER 1996 <sup>1838</sup>	No relevant outcomes – inhaler technique score and self-reported symptoms.

## 1 K.23 Monitoring: Tele-healthcare

2 **Table 230: Studies excluded from the clinical review**

Reference	Reason for exclusion
ACTRN12606000400561 <sup>80</sup>	Abstract only (protocol or conference abstract, not a full paper)
Ahmed 2011 <sup>24</sup>	Study protocol
Apter 2000 <sup>59</sup>	Intervention does not match the protocol (not tele-healthcare)
Araujo 2012 <sup>61</sup>	Study design does not match protocol (crossover design)
Arguel 2013 <sup>64</sup>	Ongoing study
Bendeer NCT00958932 <sup>152</sup>	Abstract only (protocol or conference abstract, not a full paper)
Burbank 2012 <sup>244</sup>	Abstract only (protocol or conference abstract, not a full paper)
Bynum 2001 <sup>258</sup>	Intervention does not match the protocol (not monitoring)
Chen 2013 <sup>306</sup>	Intervention does not match the protocol (not tele-healthcare)
Clark 2007 <sup>338</sup>	Intervention does not match the protocol (not monitoring)
Clover N0702196597 <sup>5</sup>	Abstract only (protocol or conference abstract, not a full paper)
Cruz-Correia 2007 <sup>376</sup>	Study design does not match protocol (crossover design)

Reference	Reason for exclusion
De Jongste 2009 <sup>397</sup>	Intervention does not match the protocol (FeNO monitoring)
DRKS00000584 <sup>461</sup>	Population does not match protocol (mixed diagnoses)
Eakin 2012 <sup>463</sup>	Intervention does not match the protocol (not tele-healthcare)
eMATIC NTR2583 <sup>1827</sup>	Ongoing study
Finkelstein CRISP <sup>494</sup>	Abstract only (protocol or conference abstract, not a full paper)
Fonseca 2006 <sup>500</sup>	Not outcome of RCT.
Friedman CRISP <sup>2</sup>	Abstract only (protocol or conference abstract, not a full paper)
Garbutt 2010 <sup>538</sup>	Intervention does not match the protocol (not monitoring)
Garbutt 2012 <sup>539</sup>	Ongoing study
Gustafson NCT00993590 <sup>347</sup>	Study terminated
Hashimoto 2011 <sup>639</sup>	Population (severe asthma and monitoring to taper OCS dose)
Huang 2013 <sup>708</sup>	Abstract only (protocol or conference abstract, not a full paper)
Ilo 2014 <sup>723</sup>	Non-English language publication (Japanese). Education not monitoring.
Kokubu 1999 <sup>891</sup>	Non-English language publication (Japanese)
Kokubu 2000 <sup>890</sup>	Non-English language publication (Japanese)
Lam 2011 <sup>951</sup>	Abstract only (protocol or conference abstract, not a full paper)
Mayers NCT00562081 <sup>343</sup>	Abstract only (protocol or conference abstract, not a full paper)
Merchant 2013 <sup>1123</sup>	Abstract only (protocol or conference abstract, not a full paper)
Moldrup NCT00917410 <sup>345</sup>	Study design does not match protocol (no control group)
Murphy 2001 <sup>1183</sup>	Abstract only (protocol or conference abstract, not a full paper)
NCT00149474 <sup>340</sup>	Abstract only (protocol or conference abstract, not a full paper)



Reference	Reason for exclusion
NCT00964301 <sup>346</sup>	Ongoing study
NCT01117805 <sup>348</sup>	Ongoing study
Osman N0411013273 <sup>1</sup>	Abstract only (protocol or conference abstract, not a full paper)
Partridge N0016132017 <sup>3</sup>	Abstract only (protocol or conference abstract, not a full paper)
Petrie 2012 <sup>1335</sup>	No relevant outcomes (primary outcome – adherence).
Razi 2012 <sup>1425</sup>	No relevant outcomes
Ricci 2001 <sup>1439</sup>	Unclear methodology (could not locate any information)
Rikkers 2012 <sup>1449</sup>	Included in monitoring questionnaires review: self-management based on monitoring online ACQ scores (no monitoring of ACQ scores in the control group)
Rikkers-Mutsaert 2010 <sup>1448</sup>	Abstract only (protocol or conference abstract, not a full paper)
Schatz 2010 <sup>1509</sup>	Study design does not match protocol (letter)
Sciamanna 2013 <sup>1531</sup>	Abstract only (protocol or conference abstract, not a full paper)
Searing 2012 <sup>1537</sup>	Abstract only (protocol or conference abstract, not a full paper)
Shanovich 2009 <sup>1554</sup>	Abstract only (protocol or conference abstract, not a full paper)
Sparrow NCT00232557 <sup>341</sup>	Abstract only (protocol or conference abstract, not a full paper)
Stout 2012 <sup>1667</sup>	Study design does not match protocol (cluster randomised feasibility trial)
Strandbygeerd 2010 <sup>1673</sup>	No uploading of patient information.
Strunk NCT00910585 <sup>344</sup>	Abstract only (protocol or conference abstract, not a full paper)
Taitel 2014 <sup>1697</sup>	Not monitoring (only one telephone call)
Uysal 2013 <sup>1790</sup>	Experimental study looking at the feasibility of using the ACT via text
van Gaalen 2012 <sup>1811</sup>	Abstract only (protocol or

Reference	Reason for exclusion
	conference abstract, not a full paper).
VANGAALLEN 2013 <sup>1812</sup>	Included in monitoring questionnaires review: self-management based on monitoring online ACQ scores (no monitoring of ACQ scores in the control group).
Vollmer 2011 <sup>1853</sup>	No relevant outcomes (primary outcome – adherence).
VOOREND-VAN 2013 <sup>1857</sup>	Abstract only (protocol or conference abstract, not a full paper)
Wouters NCT00411346 <sup>342</sup>	Abstract only (protocol or conference abstract, not a full paper)
Yun 2013 <sup>1943</sup>	No relevant outcomes (QOL reported incompletely, cannot combine in meta-analysis).

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## Appendix L: Excluded economic studies

### L.1 Diagnosis: FeNO

**Table 231: Studies excluded from the economic review**

Reference	Reason for exclusion
BERG2008 <sup>157</sup>	Price 2009 <sup>1387</sup> is an update of this analysis
Harnan 2013 <sup>637</sup>	This study only assessed diagnostic tests in isolation rather than as part of a diagnostic pathway.
PRICE2009 <sup>1387</sup>	This study only assessed diagnostic tests in isolation rather than as part of a diagnostic pathway.

### L.2 Monitoring: Lung function tests

**Table 232: Studies excluded from the economic review**

Reference	Reason for exclusion
De Asis <sup>390</sup>	This study was assessed as partially applicable with very serious limitations.

### L.3 Monitoring: FeNO

**Table 233: Studies excluded from the economic review**

Reference	Reason for exclusion
Price 2009 <sup>1387</sup>	This study was assessed as partially applicable with very serious limitations. Harnan et al. 2013 <sup>637</sup> is more recent and more applicable.
Berg 2008 <sup>157</sup>	This study was assessed as partially applicable with very serious limitations. Price et al. 2009 <sup>1387</sup> updated this analysis using a UK NHS perspective and is hence more applicable.

### L.4 Monitoring: Tele-healthcare

**Table 234: Studies excluded from the economic review**

Reference	Reason for exclusion
Pinnock 2007 <sup>1347</sup>	Only includes cost to the service rather than cost to the NHS. Including these additional costs could change the results of the study as cost differences are very small.
Pinnock 2005 <sup>1349</sup>	Only uses proportion of patients reviewed as an outcome. Excluding quality of life from the analysis could change the results as face to face reviews may improve health outcomes.

# Appendix M: Cost-effectiveness analysis: Diagnosis of asthma in adults and young people aged over 16

## M.1 Introduction

There are a variety of tests that can be used to diagnose asthma, and no clear gold standard. Available tests have different costs and different levels of accuracy, therefore it is important to identify which combination of tests represents a cost-effective use of NHS resources. Currently it is believed that asthma is over-diagnosed with a large portion of individuals with asthma currently being in-correctly diagnosed. This concern has been confirmed in a recent study by Aaron et al<sup>6</sup> which found that nearly a third of individuals with an asthma diagnosis did not have asthma. Misdiagnosis of asthma represents a large waste of NHS resources as a significant portion of patients will be receiving treatment that does not improve their condition. For these reasons the GDG prioritised original economic analysis to be conducted to compare different combinations of diagnostic tests for the diagnosis of asthma. This analysis will weigh up the cost of providing additional tests against the cost savings from reducing unnecessary asthma treatment and improved health outcomes from providing the correct treatment.

The economic review found no studies that assessed the cost-effectiveness of diagnostic pathways. However two studies were found which assessed the cost-effectiveness of asthma diagnostic tests as standalone tests. Although the results from these studies give little indication of how cost-effective a test will be as part of a pathway they do give insight into the methods used to build an economic model for asthma diagnosis. These methods are compared to the following analysis in M.4.4.

## M.2 Methods

### M.2.1 Model overview

#### M.2.1.1 Comparators

Six diagnostic strategies were created using combinations of the following tests:

- spirometry
- bronchodilator reversibility
- FeNO
- peak expiratory flow variability
- challenge tests.

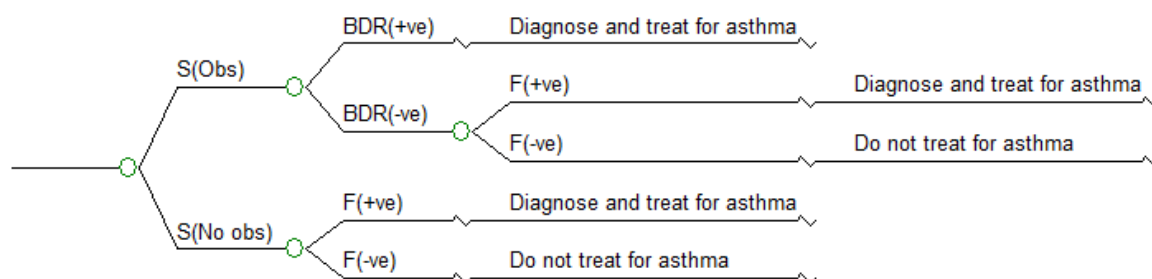
When comprising the diagnostic algorithms the GDG considered the diagnostic accuracy of the test alongside the practicality of performing the test. The GDG agreed that spirometry should be conducted first as the results can be reported straight away, unlike PEFv whereby monitoring takes place over two weeks, and the test is fairly common and well used in practice. The results can also help rule-out other conditions such as COPD and can be followed up immediately with a bronchodilator reversibility (BDR) test. After a BDR test the GDG agreed that FeNO would be the next most sensible test to conduct as combined with

previous results from the spirometry and BDR test the clinician would have a very good indication as to whether the individual had asthma. After FeNO, where appropriate, PEFv would be the next logical test to conduct as the diagnosis can be kept in primary care. If the diagnosis remains uncertain after the results from these tests then the GDG agreed the individual should be referred for a challenge test, which is performed outside of primary care. The GDG agreed that only one challenge test would ever be conducted per patient meaning that challenge testing would only appear once in a diagnostic strategy. Therefore once the diagnostic strategies were developed it was proposed to duplicate each strategy which used challenge testing using the diagnostic accuracies and costs of histamine/methacholine, mannitol or exercise challenge test. However once the costs of an exercise challenge test and a methacholine challenge test had been established it was apparent that the exercise challenge test was the more expensive test (see M.2.3.7). The clinical review also found that exercise challenge tests had a lower sensitivity and specificity when compared to a methacholine challenge test. Therefore exercise challenge tests were not modelled as they would always be dominated (more costly and provide lower health outcomes) when compared to methacholine challenge tests. Mannitol was also not modelled as the clinical review found it had a low sensitivity and specificity. Adding mannitol to the diagnostic pathway would in fact decrease the overall diagnostic accuracy of the pathway making it dominated by strategies that did not use challenge tests.

### Strategy 1

Strategy 1 involves the fewest number of tests. The exact point that each test appears in the diagnostic pathway and at which point patients are diagnosed with asthma is shown in Figure 305. For example in Figure 305 spirometry (S) is used as the initial test, followed by bronchodilator reversibility (BDR) if S detects obstruction (Obs) or FeNO (F) if S does not detect obstruction (No obs). BDR is not performed after a non-obstructive spirometry as there is no obstructive airway to reverse. If BDR is negative this is followed by F. A diagnosis of asthma is made with either a positive BDR or F, while asthma is excluded only with a negative F.

Figure 305: Strategy 1



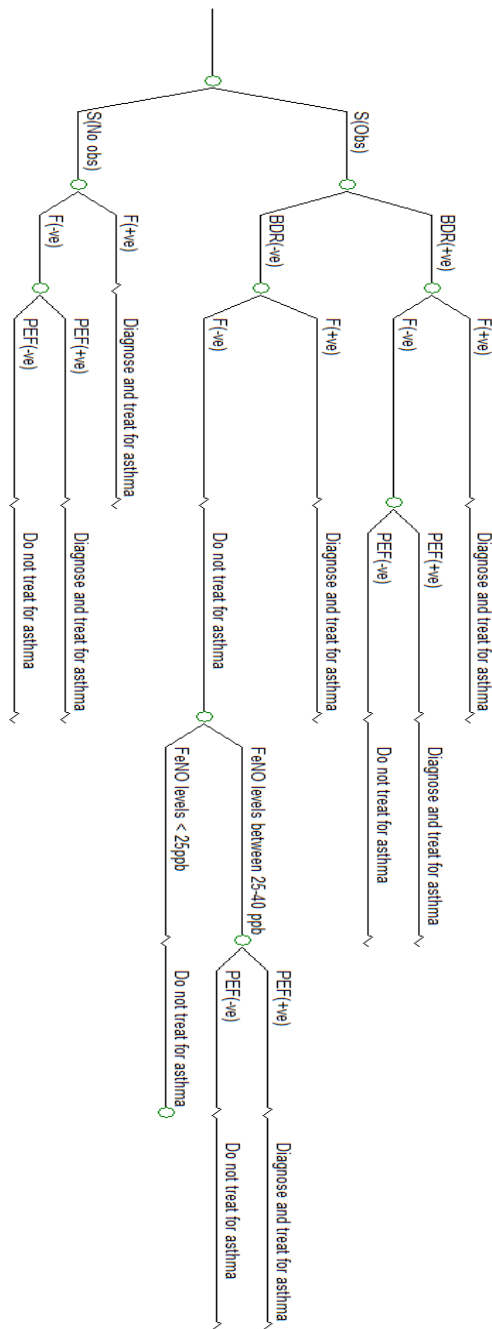
(-ve): negative; (+ve): positive; BDR: bronchodilator reversibility test; F: FeNO; S: spirometry; (Obs): obstruction

### Strategy 2

The second strategy involves spirometry, bronchodilator reversibility, FeNO and PEF variability (PEF). The diagnostic pathway is shown in Figure 306. As more tests can be conducted after a FeNO test, if a patient receives a negative FeNO test, the FeNO level that

1 was measured in the patient is also taken into account when deciding what to do next. This  
 2 test is considered negative when the FeNO level is below 40 parts per billion (ppb), however  
 3 the confidence in excluding a diagnosis of asthma depends on how close to this cut off the  
 4 result is. If the FeNO level is below 25 parts per billion (ppb), along with an obstructive  
 5 spirometry and a negative BDR, asthma is ruled out. If the FeNO level is between 25 – 40ppb  
 6 then the diagnosis of asthma still cannot be ruled out and further tests are conducted. In  
 7 strategy 2 below the patient goes on to have a PEFv test.

8 **Figure 306: Strategy 2**



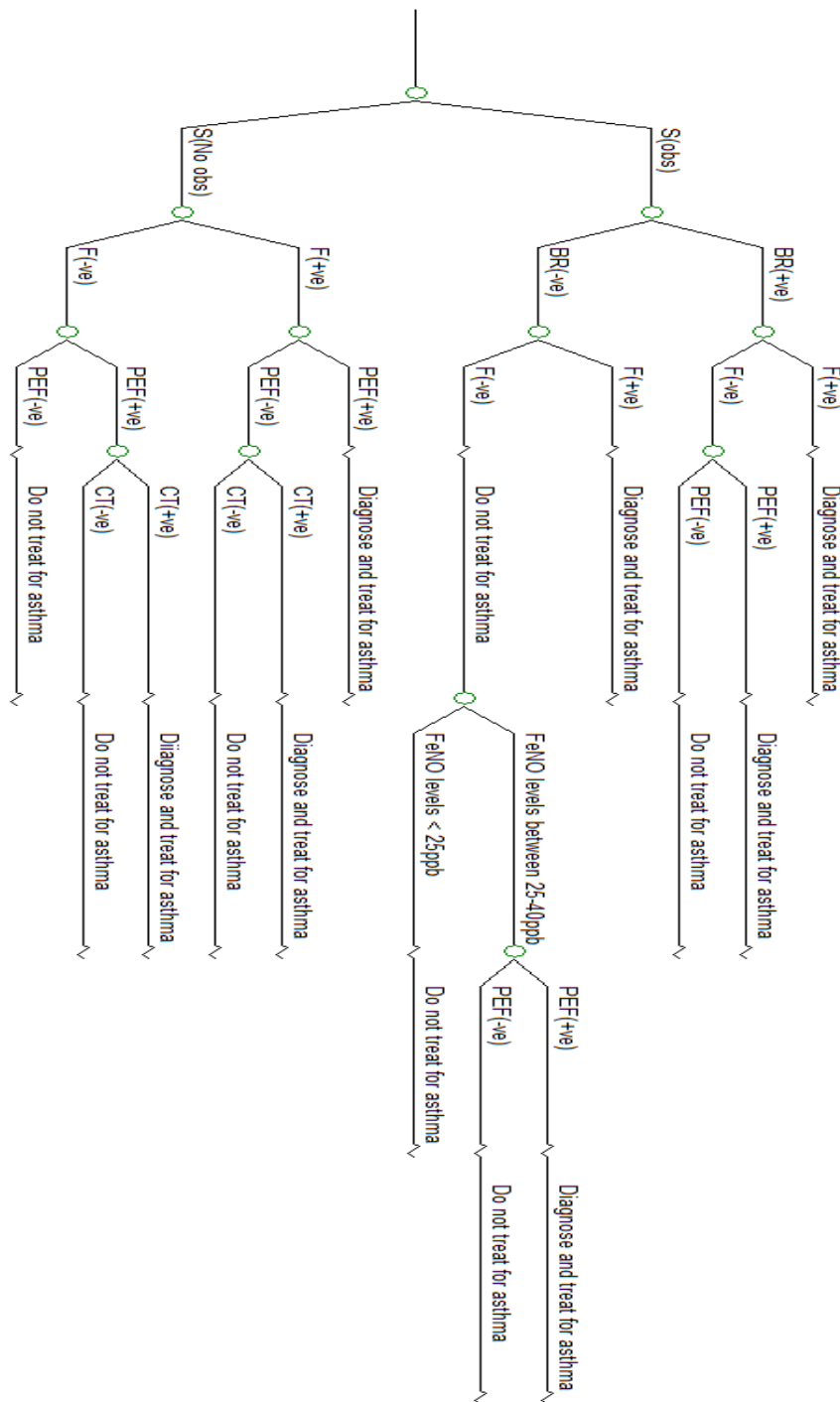
9  
 10 (-ve): negative; (+ve): positive; BDR: bronchodilator reversibility test; F: FeNO; S: spirometry; (Obs):  
 11 obstruction; PEF: peak expiratory flow variability

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**Strategy 3**

The third strategy uses spirometry, bronchodilator reversibility, FeNO, PEF variability and a methacholine challenge test (CT). The diagnostic pathway is shown in Figure 307. Note in this pathway challenge tests are only used on patients who have a non-obstructive spirometry.

**Figure 307: Strategy 3**



7  
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(-ve): negative; (+ve): positive; BDR: bronchodilator reversibility test; CT: challenge test; F: FeNO; S: spirometry; (Obs): obstruction; PEF: peak expiratory flow variability

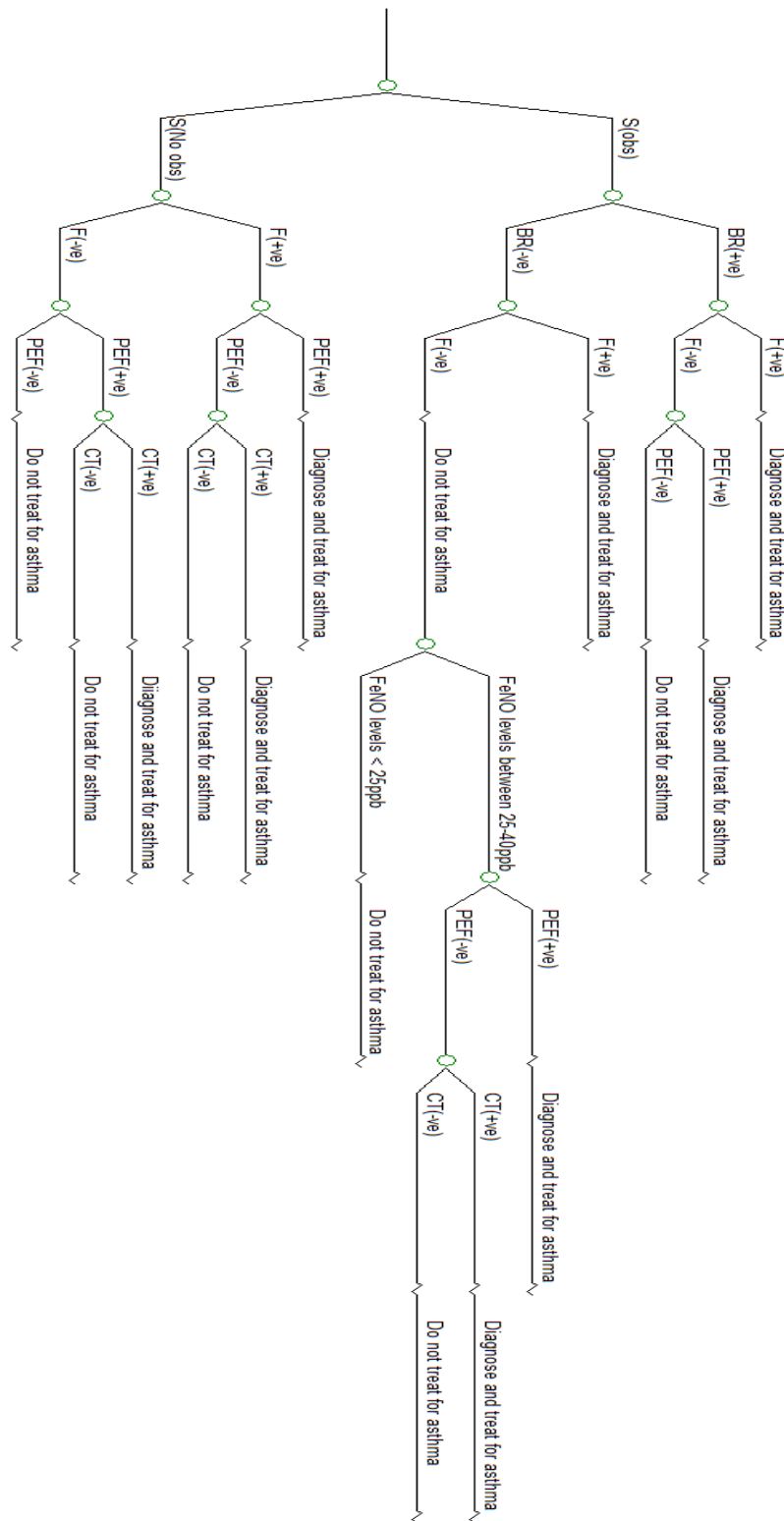
1        **Strategy 4**

2        The fourth strategy shown in Figure 308 expands the use of challenge tests as seen in strategy  
3        3. Now a CT is also conducted on patients with a positive BDR, negative FeNO and a negative  
4        PEFv result. The use of FeNO levels is also taken into account, whereby a CT is only  
5        conducted in this arm when FeNO levels are between 25-40ppb.



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**Figure 308: Strategy 4**



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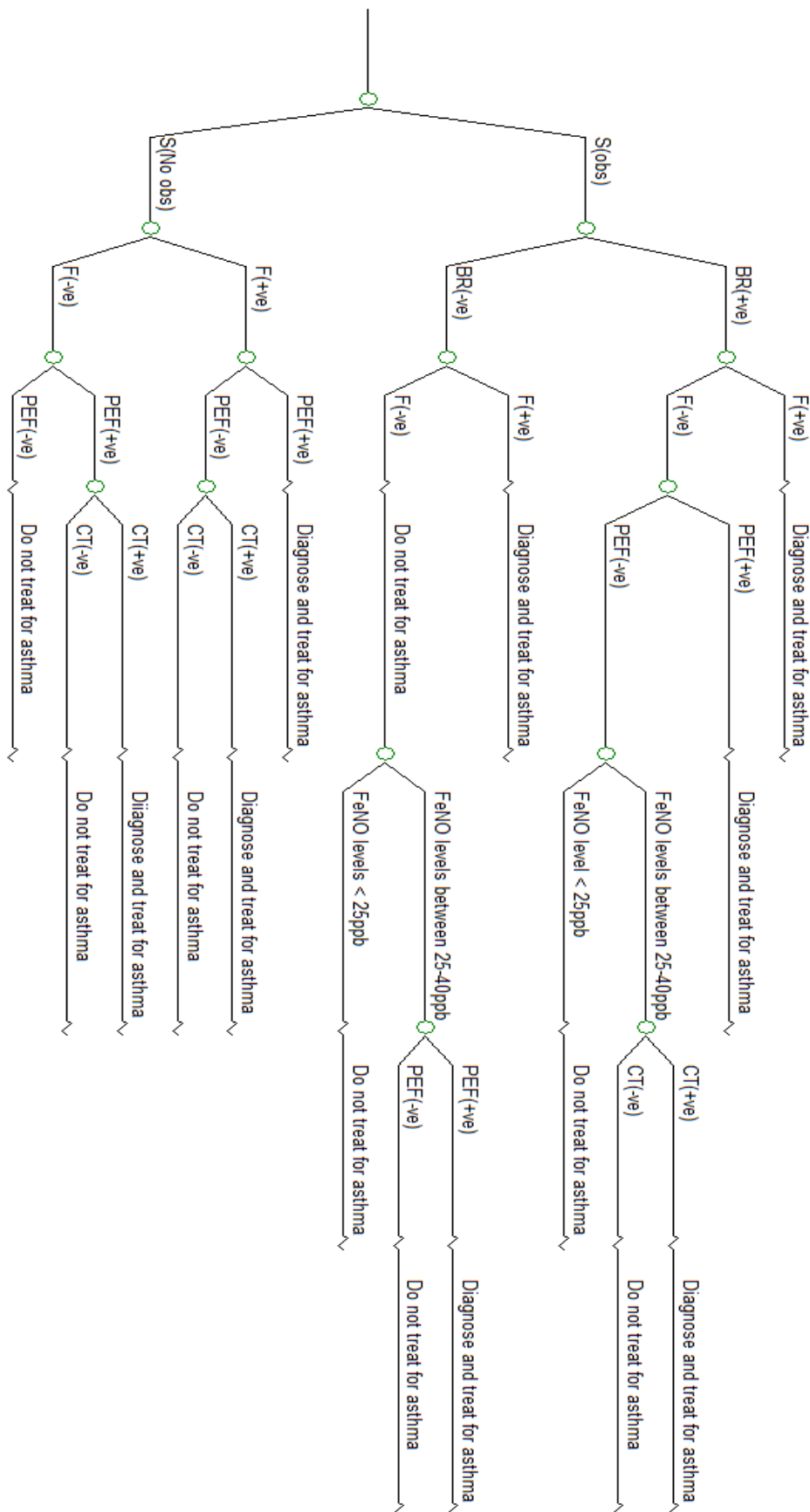
*(-ve): negative; (+ve): positive; BDR: bronchodilator reversibility test; CT: challenge test; F: FeNO; S: spirometry; (Obs): obstruction; PEF: peak expiratory flow variability*

**1 Strategy 5**

2 The fifth strategy, shown below in Figure **309**, also expands the use of challenge tests, as  
3 seen in strategy 3, however places the additional CT at a different point in the pathway. Now  
4 a CT is also conducted on patients with a negative BDR, negative FeNO (between 25-40ppb)  
5 and a negative PEFv test result.

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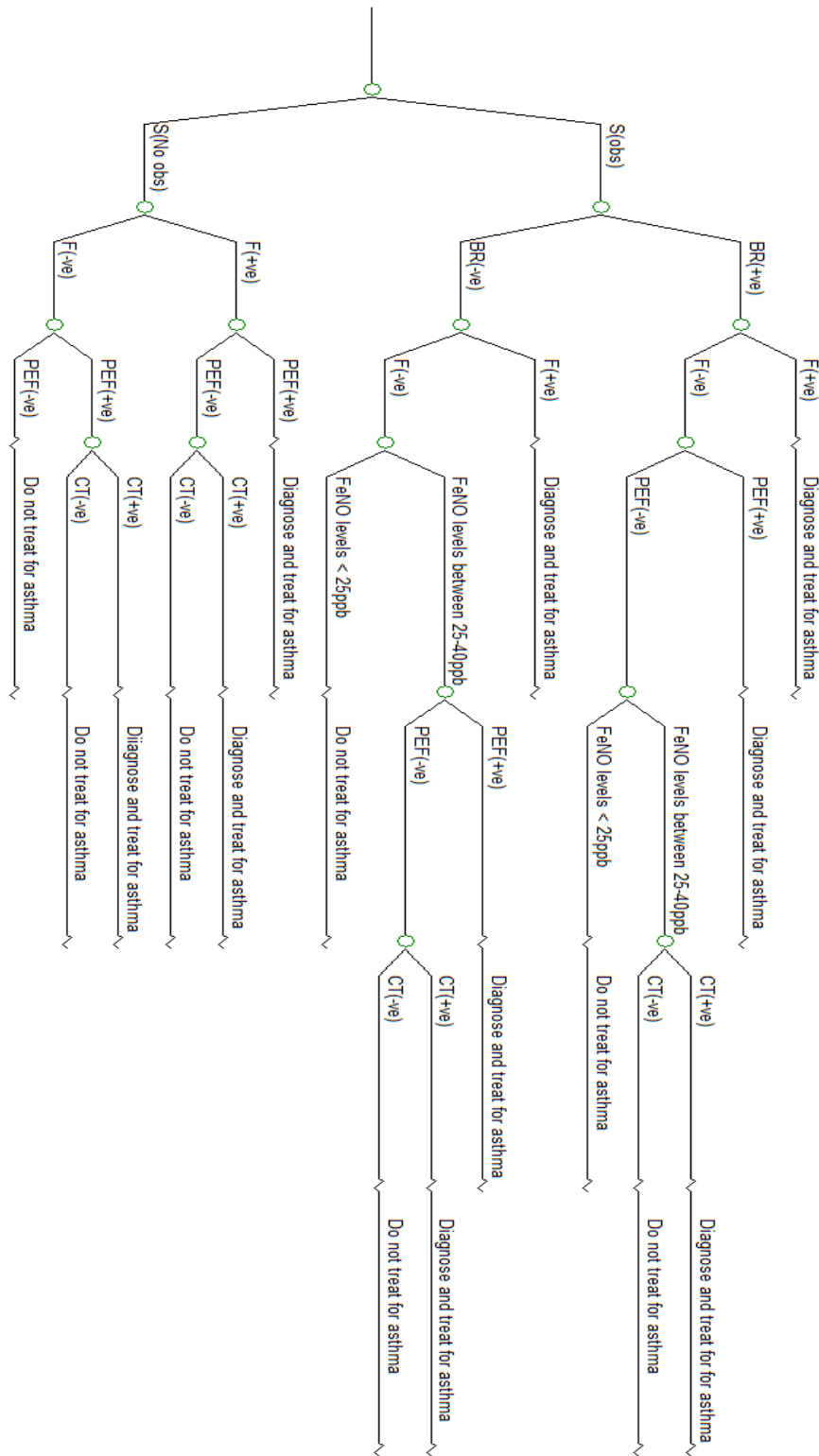
**Figure 309: Strategy 5**



2

- 1 **Strategy 6**
- 2 The sixth strategy, shown below in Figure 310, is the most comprehensive and uses the
- 3 maximum number of challenge tests.

4 **Figure 310: Strategy 6**



5

## 1 Strategy 7

2 A final strategy considered involves not giving the patient any tests and diagnosing without  
 3 the use of objective tests. To make this strategy more reflective of current practice it is  
 4 assumed that some of the non-asthmatics will be correctly diagnosed as not having asthma.  
 5 One prevailing thought is that one third of people currently diagnosed with asthma are  
 6 misdiagnosed, ie they do not have asthma (False positive) according to a study by Aaron et  
 7 al<sup>6</sup>. Therefore the proportion of false positives calculated in this strategy will be a third of the  
 8 total number of positive diagnoses made:

$$9 \frac{\textit{False positives}}{\textit{False positives} + \textit{True positives}} = \frac{1}{3}$$

10 As no tests are conducted the only costs that are incurred in this strategy are those that  
 11 occur after the diagnosis is made (e.g. the cost of asthma treatment). An assumption was  
 12 made that all people with asthma are correctly diagnosed giving this strategy a sensitivity of  
 13 100%.

### 14 M.2.1.2 Population

15 The model considers patients over 16 years of age who present symptoms of asthma to their  
 16 GP. Patients who present symptoms in a secondary care setting are not considered.

17 A separate analysis was considered for children between 5 – 16 years of age. However there  
 18 were no included studies in the clinical review which identified the diagnostic accuracy of  
 19 bronchodilator reversibility in this age group. As this test would appear in all diagnostic  
 20 pathways its diagnostic accuracy would highly influence which pathway is cost-effective. On  
 21 top of this, the evidence found for the diagnostic accuracies of other tests on children was  
 22 weak.

### 23 M.2.1.3 Time horizon, perspective, discount rates used

24 The analysis follows the standard assumptions of the reference case including discounting at  
 25 3.5% for costs and health effects, and incremental analysis is conducted. A sensitivity  
 26 analysis using a discount rate of 1.5% for costs and 1.5% for health benefits is conducted. A  
 27 lifetime horizon has been chosen to fully capture the long-term adverse outcome derived  
 28 from incorrect diagnosis.

## 29 M.2.2 Approach to modelling

30 The model is based on two parts:

- 31 • **Decision tree** - Using the sensitivity and specificity, combined with data on the  
 32 prevalence of asthma in the defined population, the model identifies the proportion of  
 33 patients that receive a true positive (TP), true negative (TN), false positive (FP) or false  
 34 negative (FN) diagnosis.
- 35 • **Markov model** - Once the diagnosis is made the patient moves on to the second part of  
 36 the model which involves a Markov model to fully evaluate the patients' health and cost  
 37 outcomes.

38 Further information and technical details are provided below.

### 1 M.2.2.1 Model structure

#### 2 Diagnostic pathways (decision tree)

3 First of all patients go through a decision tree to calculate the proportion that will receive  
 4 either a FN, FP, TN or TP diagnosis. The way this is calculated is shown below in Figure 308.  
 5 Here strategy 1 is used as an example (detailed in **Figure 305** above).

6 In Figure 308 below the circles represent chance nodes. This means that the outcome is  
 7 determined by a probability, rather than a decision. When the patient enters the model,  
 8 they have a probability of having asthma or not, depending on the asthma prevalence in the  
 9 defined population. If the patient has asthma then the probability of a test result being  
 10 positive is determined by the sensitivity of that test. If the patient does not have asthma  
 11 then the probability of the test result being negative is determined by the specificity of that  
 12 test. Using these probabilities the decision tree can calculate the proportion of patients that  
 13 will end up at each arm. For example the probability of an asthmatic patient having an  
 14 obstructive spirometry and a positive result from a bronchodilator reversibility test is:

$$\begin{aligned}
 15 \quad & \text{Probability}(\text{Asthma} \cap S(\text{Obs}) \cap \text{BDR}(+ve)) \\
 16 \quad & = (\text{Probability of having asthma}) * (\text{Sensitivity of spirometry}) \\
 17 \quad & * (\text{Sensitivity of bronchodilator reversibility})
 \end{aligned}$$

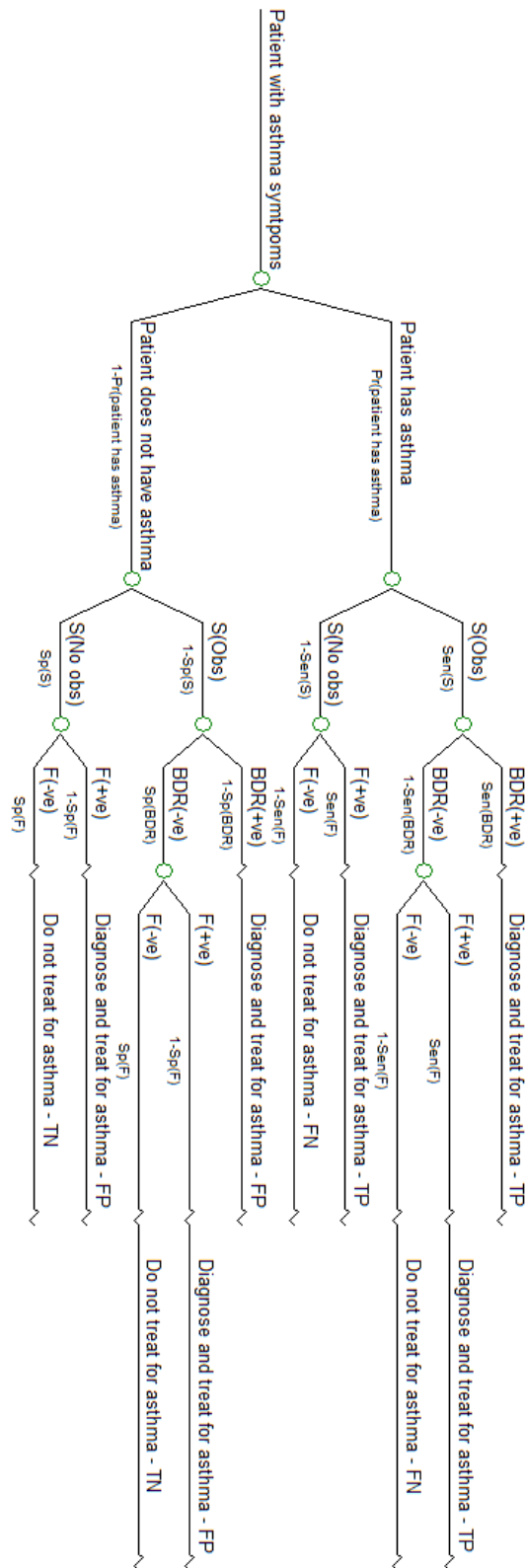
18 In this case the patient will receive a true positive diagnosis. Likewise the probability of a  
 19 non-asthmatic having an obstructive spirometry and a positive BDR result is:

$$\begin{aligned}
 20 \quad & \text{Probability}(\text{No Asthma} \cap S(\text{Obs}) \cap \text{BDR}(+ve)) \\
 21 \quad & = (\text{Probability of not having asthma}) \\
 22 \quad & * (1 - \text{Specificity of spirometry}) * (1 \\
 23 \quad & - \text{specificity of bronchodilator reversibility})
 \end{aligned}$$

24 In this case the patient will receive a false positive diagnosis.

25 Once the proportion of patients that will receive either a TP, TN, FP or FN diagnosis is  
 26 calculated, final health and cost outcomes are determined by a Markov model which is  
 27 discussed below.

1 **Figure 311: Calculating patient movement through the model**



2  
 3 (-ve): negative; (+ve): positive; BDR: bronchodilator reversibility test;; F: FeNO; S: spirometry; (Obs):  
 4 obstruction; Sen: sensitivity; Sp: specificity; TP: True positive; FP: false positive; FN: False negative; TN:  
 5 True negative.

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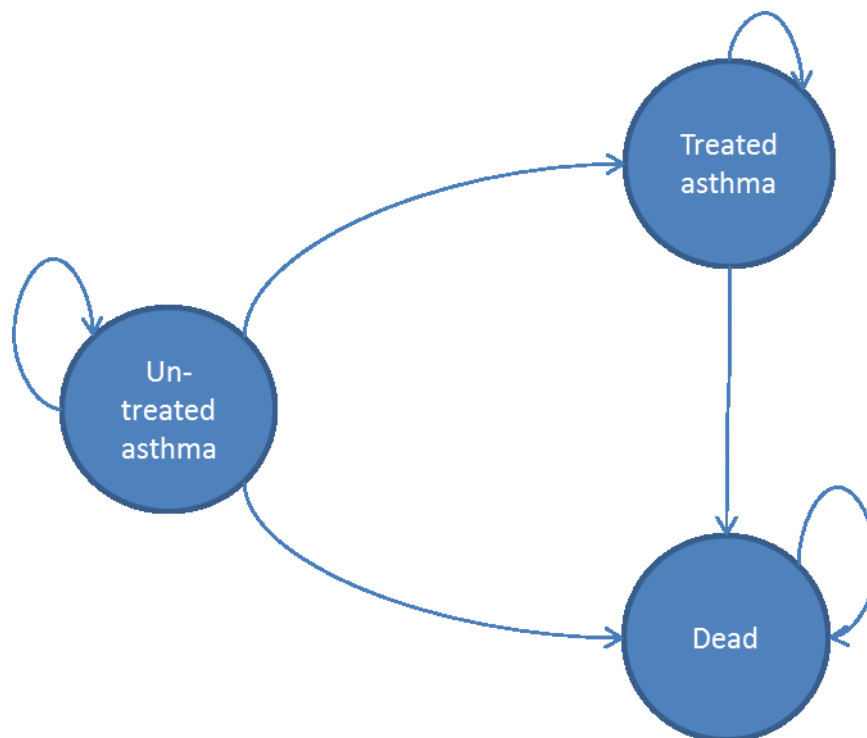
### Calculating health and cost outcomes after diagnosis for patients who have asthma (Markov model)

The decision tree will determine the proportion of people with asthma that receive a correct diagnosis (true positive) and that receive an incorrect diagnosis (false negative).

#### *False negatives*

After a false negative diagnosis is made the patient enters the Markov model depicted in Figure 312.

**Figure 312: Markov model for false negative diagnoses**



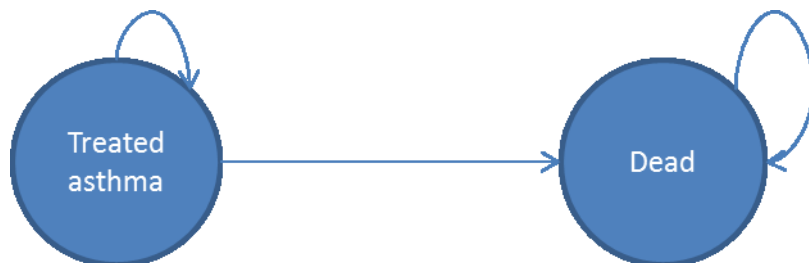
The patient starts in the state 'un-treated asthma'. After a cycle length of six months there is a probability that the false negative diagnosis will be rectified and the patient will be treated for asthma. This probability is determined by whether or not the patient has an exacerbation. It is assumed that after an exacerbation the patient will be correctly re-diagnosed as having asthma. In this case the patient is treated and moves from 'un-treated asthma' to 'treated asthma'. After one year has passed the patient will move to treated asthma, regardless of whether they have had an exacerbation, and a re-diagnosis cost is added. This is to reflect that a patient with un-treated asthma will have persisting symptoms and an assumption was imposed that a methacholine challenge test along with a respiratory outpatient visit and persisting asthmatic symptoms would guarantee a correct diagnosis at this point. The probability of the patient entering the dead state is contingent on an all-cause mortality rate plus an added mortality risk associated with an exacerbation. As the patient is more likely to exacerbate if they are untreated, the mortality risk is slightly higher for un-treated asthmatics.

The costs associated with each state are discussed in section M.2.3.7. The quality of life (QoL) associated with each state is discussed in section M.2.3.6.



1 *True positives*

2 After a true positive diagnosis is made the patient enters the Markov model depicted in  
3 Figure 313.

4 **Figure 313: Markov model for true positive**

5

6

7 The patient starts in the 'treated asthma' state and remains there until they die. The QoL,  
8 exacerbations, and costs associated with this state are the same as those in the 'treated  
9 asthma' state in Figure 312.

10

11 **Calculating health and cost outcomes after diagnosis for patients that do not have asthma**  
12 **(Markov model)**

13 The decision tree will determine the proportion of non-asthmatic patients that receive a  
14 correct diagnosis (true negative) and the proportion that receive an incorrect diagnosis (false  
15 positive).

16 An important aspect of the model was to consider the condition the individual is likely to  
17 have if they present asthma symptoms but don't have asthma. The true underlying condition  
18 the patient has will determine the length and severity of misdiagnosis. The GDG identified  
19 four sub-groups of patients that would have asthmatic symptoms but not have asthma:

20 The first two subgroups of patients would have an illness that would go un-treated if an  
21 asthma diagnosis were made, as the physician would believe the patient was being correctly  
22 treated. As these patients would forego correct treatment then during this period of  
23 incorrect diagnosis they would receive a lower quality of life, relative to what they could  
24 achieve with optimal treatment. The NHS would also incur unnecessary asthma treatment  
25 costs. The GDG considered that the two main groups this would affect are patients with  
26 COPD or chronic heart failure. As these patients will remain symptomatic after asthma  
27 treatment the probability of re-diagnosis will be high and increase over time as it becomes  
28 clearer that asthma treatment is not helping the patients. It is worth noting that once these  
29 patients are being correctly treated the NHS will now incur the cost of the respective  
30 treatment meaning that re-diagnosis is not necessarily cost-saving.

31 The third and fourth subgroups of patients would not forego any treatment because they  
32 are labelled as having asthma. Therefore for these patients there is no disutility from being  
33 labelled as asthmatic; instead the only disadvantage of incorrect diagnosis is that the NHS  
34 has to incur unnecessary asthma treatment costs. The GDG considered that the two main  
35 groups this would affect are patients with physical de-conditioning or short-lived acute  
36 symptoms. Patients with short-lived acute symptoms, such as those recovering from an  
37 infection, would not be on asthma medication long as they would quickly become  
38 asymptomatic, naturally rather than due to medication, and stop taking asthma medication.

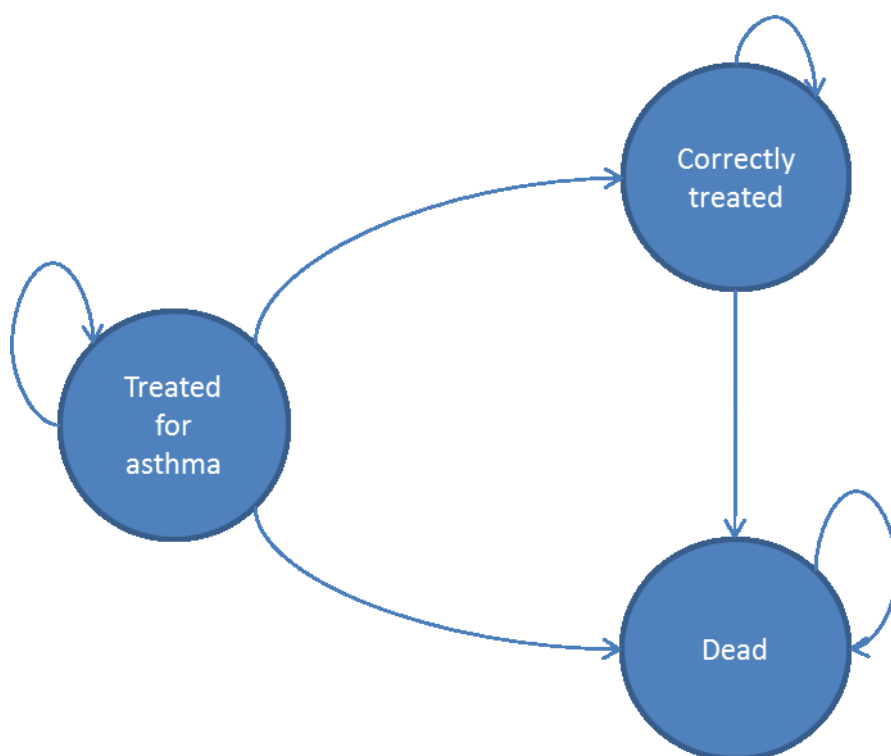
1 Individuals with physical de-conditioning however could remain on asthma medication for a  
2 long time as they remain symptomatic but symptoms would rise and fall over time.

3 The GDG recognised that there would be other conditions that the patient could have  
4 however the four outlined above would cover the majority and those not covered would  
5 produce similar outcomes to those outlined above. As there is no data in the literature on  
6 the distribution of diseases amongst the misdiagnosed asthmatics an assumption was made  
7 that the probability of a patient having one of the above conditions was equal. This  
8 assumption, along with all data inputs used for these patients, are extensively tested in the  
9 sensitivity analysis, detailed in section M.2.5.

## 10 False positives

11 After a false positive diagnosis is made the patient enters the Markov model depicted below  
12 in Figure 314.

13 **Figure 314: Markov model for false positives**



14  
15 The individual starts in the state 'treated for asthma', as the individual does not have asthma  
16 this can be classed as 'incorrect treatment'. After a cycle length of six months there is a  
17 probability that the individual will be correctly diagnosed as not having asthma. This  
18 probability is contingent on the under-lying condition the individual has. After each cycle the  
19 probability of correct diagnosis increases, the extent to which also depends on the patient's  
20 underlying condition. This is to reflect the fact that the longer un-treated symptoms reside  
21 the more likely the physician is to make a re-diagnosis. If the individual is correctly re-  
22 diagnosed then they move to the state 'correctly treated', which means they are receiving  
23 the treatment for the condition they actually have (if a treatment is required), where they  
24 remain until they die. The model assumes that once asthma is excluded, the real condition is  
25 diagnosed correctly. To enter the state 'correctly treated' it is assumed that a patient has a  
26 respiratory outpatient visit and under-goes a methacholine challenge test to rule-out the  
27 diagnosis of asthma, as this test was identified as having the highest sensitivity and

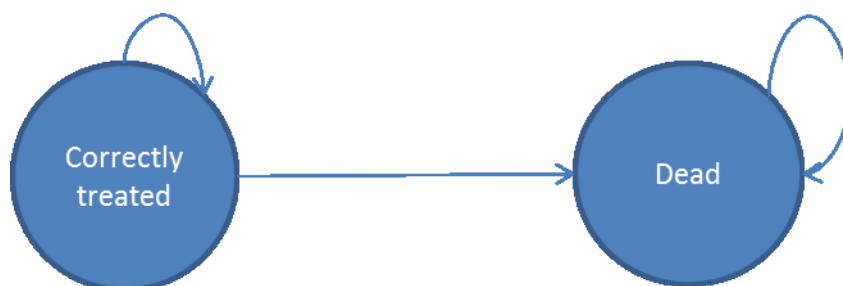
1 specificity in the clinical review. A sensitivity analysis was conducted around re-diagnosis  
2 costs as detailed in section M.2.5.

3 The costs associated with each state are discussed in section M.2.3.7. The quality of life  
4 (QoL) associated with each state is discussed in section M.2.3.6.

### 5 **True negatives**

6 After a true negative diagnosis is made the patient enters the Markov model in Figure 315.

7 **Figure 315: Markov model for true negative**



8

9

10 It is assumed that by ruling out asthma as a potential cause of symptoms the individual will  
11 start in the state 'correctly treated', which means they are receiving the treatment for the  
12 condition they actually have (if a treatment is required) and remain there until they die. The  
13 QoL and costs associated with this state are the same as those in Figure 314.

### 14 **M.2.2.2 Key assumptions**

15 The key assumptions of the model are summarised in **Table 235** below:

16 **Table 235: Summary of key assumptions**

Assumption	Comment
A patient with a false negative diagnosis will always be correctly re-diagnosed after an exacerbation.	
A patient with a false negative diagnosis will remain misdiagnosed for a maximum of one year, even if an exacerbation does not occur.	
Adults correctly identified as not having asthma will either have, with equal probability: acute symptoms, physical de-conditioning, chronic heart failure or COPD.	This assumption was built into the model to address the concern that those identified as not having asthma are likely to have something else. This ensures the model gives a better reflection of the true costs and health losses incurred through misdiagnosis.
After a true negative diagnosis patients are assumed to be correctly treated for their true underlying condition.	This assumption is built on the fact that ruling out asthma as a potential cause of symptoms will help rule in the true diagnosis after further tests. The costs of these tests (such as an echocardiogram) have been excluded from the model as they will be incurred for both true negatives and false positives and therefore there will be no incremental cost.
Uncontrolled asthma was used as a proxy for	

Assumption	Comment
untreated asthma when calculating QoL	
FeNO is conditionally independent with other tests	As FeNO is the only test in the model that measures inflammation of the airways a patient's FeNO count is unlikely to be dependent on the results of other tests. Likewise other lung function test results are unlikely to be dependent on a patient's FeNO count. Therefore this test was considered to be conditionally independent with all other tests. Further details regarding conditional independence are provided in section M.2.2.3 below.

### 1 M.2.2.3 Conditional dependence

2 In the clinical review, the sensitivity and specificity of each test was calculated across the  
 3 whole population of interest. However, if a test is only conducted after a certain test result  
 4 (for example if test 2 is only conducted following a positive result from test 1 then ideally we  
 5 would use accuracy data for the second test on this sub-group of the original population.  
 6 The sensitivity and specificity of a test will be different in this sub-group if the two tests (T1  
 7 and T2 in example below) are conditionally dependent. **Table 236** below shows how  
 8 conditional dependence affects the probability of obtaining two test results.

9 **Table 236: Probability of obtaining two test results**

Event	Probability
<b>Patients who have the disease</b>	
T1(+ve) AND T2(-ve)	$Se(T1) \times (1 - Se(T2)) - \gamma_{se}$
T1(+ve) AND T2(+ve)	$Se(T1) \times Se(T2) + \gamma_{se}$
T1(-ve) AND T2(+ve)	$(1 - Se(T1)) \times Se(T2) - \gamma_{se}$
T1(-ve) AND T2(-ve)	$(1 - Se(T1)) \times (1 - Se(T2)) + \gamma_{se}$
<b>Patients who do not have the disease</b>	
T1(+ve) AND T2(-ve)	$(1 - Sp(T1)) \times Sp(T2) - \gamma_{sp}$
T1(+ve) AND T2(+ve)	$(1 - Sp(T1)) \times (1 - Sp(T2)) + \gamma_{sp}$
T1(-ve) AND T2(+ve)	$Sp(T1) \times (1 - Sp(T2)) - \gamma_{sp}$
T1(-ve) AND T2(-ve)	$Sp(T1) \times Sp(T2) + \gamma_{sp}$

10 Abbreviations: *Se* = sensitivity; *Sp* = specificity; *T1* = test 1; *T2* = test 2;  $\gamma_{se}$  = sensitivity covariance;  $\gamma_{sp}$  = specificity  
 11 covariance

12 From **Table 236** shows that the probability of obtaining any one result is dependent on the  
 13 covariance between the two sensitivities  $\gamma_{se}$  or specificities  $\gamma_{sp}$ . Assuming that tests 1 and 2  
 14 are positively correlated, the upper-limit of these co-variances can be calculated as follows:

$$15 \quad \gamma_{se} = \text{MIN}(Se_1(1 - Se_2); Se_2(1 - Se_1))$$

$$16 \quad \gamma_{sp} = \text{MIN}(Sp_1(1 - Sp_2); Sp_2(1 - Sp_1))$$

17 where MIN is a function which selects the minimum value between those listed.

18 This limit ensures the probability of obtaining two test results is bounded between zero and  
 19 one. Therefore the covariance must fall between zero and this upper limit. If a test result is  
 20 highly dependent on a previous test result then the covariance is likely to fall closer to the  
 21 upper limit. If the result of the second test is fairly independent from the result of the first

1 test then the covariance will be closer to zero. This method is outlined in full in Gardener et  
2 al<sup>545</sup>.

3 For the model the GDG were asked to give their opinion on how strongly they believed the  
4 conditional dependence between two tests were. Tests that were weakly dependent were  
5 given a covariance value closer to zero; tests that were moderately dependent were given a  
6 value midway between zero and the upper limit. The results are shown in **Table 237**. Some  
7 points to note:

- 8 • FeNO does not appear as it was assumed to be conditionally independent with the other  
9 tests.
- 10 • The diagnostic review on bronchodilator reversibility was assessed in patients that had an  
11 obstructive spirometry therefore conditional dependence will have already been taken  
12 into account between those two tests.
- 13 • The conditional dependence between spirometry and other tests has not been  
14 considered as the GDG agreed that other test results are unlikely to be dependent on the  
15 results from a single spirometry.
- 16 • Finally it is assumed that the dependence between tests will be the same for individuals  
17 with and without asthma. Therefore the strength of dependence applies equally to  
18 specificities and sensitivities.

19 **Table 237: Strength of dependence between tests**

Test 1	Test 2	Strength of dependence (value given between 0 and 1)	Source
Bronchodilator reversibility	PEFv	Weak (0.1)	GDG opinion
PEFv	Histamine/Methacholine	Moderate (0.5)	GDG opinion
Bronchodilator reversibility	Histamine/Methacholine	Moderate (0.5)	GDG opinion

20 *Abbreviations: PEFv= Peak expiratory flow variability*

21 Using this information and the formulas in **Table 236** the sensitivity and specificity of tests  
22 which occur further down the pathway can be re-calculated to account for conditional  
23 dependence. For example the specificity of test 2 for patients without asthma who test  
24 positive for test 1 is:

$$25 \quad Sp_2 = \frac{\text{Probability}(T1_{+ve} \cap T2_{-ve})}{Sp_1}$$

26 Using the formula for  $\text{Probability}(T1_{+ve} \cap T2_{-ve})$  from **Table 236** and results from **Table**  
27 **237** we know:

$$28 \quad \text{Probability}(T1_{+ve} \cap T2_{-ve}) = (1 - Sp_1)(Sp_2) - \{(\gamma_{sp}) * (\text{Strength of dependence})\}$$

29 Here 'strength of dependence' lies between zero and one.

30 Although conditional dependence has been incorporated into the model not every  
31 dependency has been accounted for. As challenge tests are incorporated last in the  
32 diagnostic pathway they will have the most dependencies between tests. In the model  
33 conditional dependence has not been fully incorporated for challenge test results that are  
34 dependent on more than one test result. In some circumstances a challenge test will be  
35 dependent on the results from a PEFv test and a BDR test. An assumption was made that if a

challenge test proceeds a BDR and PEFv test then the conditional dependence will only be taken into account between the BDR test and the challenge test. Rather than formally model three way dependencies, this issue has been examined in a sensitivity analysis detailed in section M.2.5.

#### M.2.2.4 Uncertainty

The model was built probabilistically to take account of the uncertainty around input parameter point estimates. A probability distribution was defined for each model input parameter. When the model was run, a value for each input was randomly selected simultaneously from its respective probability distribution; mean costs and mean QALYs were calculated using these values. The model was run 5,000 times for the base case.

**Table 238: Description of the type and properties of distributions used in the probabilistic sensitivity analysis**

Parameter	Type of distribution	Properties of distribution
Specificity	Beta	Bounded between 0 and 1. As the sample size and the number of events were specified $r$ and $n$ values were calculated as follows: $r = (\text{True negatives})$ $n = (\text{Number of patients}) - (\text{True negatives})$
Diagnostic Odds ratio (DOR) <sup>a</sup>	Normal	Derived from: Mean = $\ln(\text{DOR})$ Standard error = $\text{Se}(\ln(\text{DOR}))$
Exacerbation rate	Log-normal	Derived from the mean and standard deviation
Utility, asthma prevalence, transition probabilities, covariance strength	Beta	Bounded between 0 and 1. Derived from mean of a domain and its standard error, using the method of moments. Alpha and beta values were calculated as follows: $\text{Alpha} = \text{mean}^2 * [(1 - \text{mean}) / \text{SE}^2] - \text{mean}$ $\text{Beta} = \text{Alpha} * [(1 - \text{mean}) / \text{mean}]$
NHS Reference Costs, test costs	Gamma	Bounded at 0, positively skewed. Derived from mean and its standard error. Alpha and lambda values were calculated as follows: $\text{Alpha} = (\text{mean} / \text{SE})^2$ $\text{Lambda} = \text{SE}^2 / \text{Mean}$

Note: When the standard error (SE) is not given an assumption was imposed that the SE is 20% of the mean.

a) The use of the diagnostic odds ratio is discussed in section M.2.3.3

In addition, various deterministic sensitivity analyses were undertaken to test the robustness of model assumptions. In these, one or more inputs were changed and the analysis rerun to evaluate the impact on results and whether conclusions on which intervention should be recommended would change.

As sensitivities were estimated as functions of other variables, no distributions were attached to these parameters.

## 1 M.2.3 Model inputs

### 2 M.2.3.1 Summary table of model inputs

3 Model inputs were based on clinical evidence identified in the systematic review undertaken  
4 for the guideline, supplemented by additional data sources as required. Model inputs were  
5 validated with clinical members of the GDG. A summary of the model inputs used in the  
6 base-case (primary) analysis is provided in Table 239 below. More details about sources,  
7 calculations and rationale for selection can be found in the sections following this summary  
8 table.

9 **Table 239: Summary of base-case model inputs**

Input	Input	Source
Probability patient is male (adult)	0.40	Weighted average from the diagnostic studies identified in the clinical review
Patient age at diagnosis (adult)	43	Weighted average from the diagnostic studies identified in the clinical review
Time horizon	Lifetime	
Discount rate	Costs = 3.5%; effects = 3.5%	

10 **Table 240: Overview of parameters and parameter distributions used in the model**

Parameter description	Point estimate	Probability distribution	Distribution parameters	Source
<b>Decision tree probabilities</b>				
Prevalence of asthma	0.406	Beta	$\alpha = 606, \beta = 887$	Taken from a meta-analysis of the diagnostic studies identified in the clinical review, see section (A.2.3.2)
Sensitivity of spirometry	0.465	-	-	Pino 1996 <sup>1351</sup>
Specificity of spirometry	0.415	Beta	$r = 17, n = 41$	Pino 1996 <sup>1351</sup>
Ln(Diagnostic odds ratio for spirometry)	-0.485	Normal	$\mu = -0.485, \sigma = 0.44$	Derived from sensitivity and specificity, see section M.2.3.3
Sensitivity of BDR used in model	0.409	Distributions were fitted directly on the parameters derived from each of the two studies and in each iteration the pooled average was calculated from the individual parameters.	-	Pooled average from Kim 2012 <sup>861</sup> and Chhabra 2005 <sup>310</sup> below
Specificity of BDR used in model	0.713		-	Pooled average from Kim 2012 <sup>861</sup> and Chhabra 2005 <sup>310</sup> below - see below

Parameter description	Point estimate	Probability distribution	Distribution parameters	Source
Sensitivity of BDR (Chhabra 2012)	0.65	-	-	Chhabra 2005 <sup>310</sup>
Specificity of BDR (Chhabra 2012)	0.811	Beta	$r = 125, n = 154$	Chhabra 2005 <sup>310</sup>
Ln(Diagnostic odds ratio for BDR) (Chhabra 2012)	2.08	Normal	$\mu = 2.08, \sigma = 0.25$	Derived from sensitivity and specificity, section M.2.3.3
Sensitivity of BDR (Kim 2012)	0.168	-	-	Kim 2012 <sup>861</sup>
Specificity of BDR (Kim 2012)	0.614	Beta	$r = 89, n = 145$	Kim 2012 <sup>861</sup>
Ln(Diagnostic odds ratio for BDR) (Kim 2012)	-1.14	Normal	$\mu = -1.14, \sigma = 0.22$	Derived from sensitivity and specificity, section M.2.3.3
Sensitivity of FeNO	0.88	-	-	Kowal 2009 <sup>914</sup>
Specificity of FeNO	0.83	Beta	$R = 299, n = 362$	Kowal 2009 <sup>914</sup>
Ln(Diagnostic odds ratio for FeNO)	3.57	Normal	$\mu = 3.57, \sigma = 0.27$	Derived from sensitivity and specificity, section M.2.3.3
Sensitivity of PEFv	0.116	-	-	Thiadens 1998 <sup>1727</sup>
Specificity of PEFv	0.99	Beta	$R = 100, n = 101$	Thiadens 1998 <sup>1727</sup>
Ln(Diagnostic odds ratio for PEFv)	2.57	Normal	$\mu = 2.57, \sigma = 1.07$	Derived from sensitivity and specificity, section M.2.3.3
Sensitivity of histamine challenge test	0.933	-	-	Kowal 2009 <sup>914</sup>
Specificity of histamine challenge test	0.99 <sup>(a)</sup>	Beta <sup>(a)</sup>	$R = 358, n = 362$	Kowal 2009 <sup>914</sup>
Ln(Diagnostic odds ratio for histamine challenge test)	8.52	Normal	$\mu = 8.52, \sigma = 1.05$	Derived from sensitivity and specificity, section M.2.3.3
Mean FeNO level for an asthmatic	96	Lognormal	$\mu = 4.32, \sigma = 0.52$	See section M.2.3.3 for derivation
Probability that FeNO level < 25ppb for a patient with asthma and a FeNO below 40ppb	0.142	-	-	Derived from the distribution around the mean FeNO level for patients with asthma
Mean FeNO level for a non-asthmatic	25	Lognormal	$\mu = 2.77, \sigma = 0.94$	See section M.2.3.3 for derivation
Probability that FeNO level < 25ppb for a patient without asthma and a FeNO level below 40ppb	0.823	-	-	Derived from the distribution around the mean FeNO level for patients without asthma
Strength of dependence between BDR and PEFv	0.1	Beta	$\alpha = 6.11, \beta = 54.96$	GDG opinion
Strength of dependence between PEFv and histamine/methacholine	0.5	Beta	$\alpha = 85.7, \beta = 85.7$	GDG opinion
Strength of dependence between BDR and	0.5	Beta	$\alpha = 85.7, \beta = 85.7$	GDG opinion



Parameter description	Point estimate	Probability distribution	Distribution parameters	Source
histamine/methacholine				
Proportion of non-asthmatic patients that have acute symptoms	0.25	Beta <sup>(c)</sup>	$\alpha = 78.16, \beta = 233.8$	GDG opinion
Proportion of non-asthmatic patients that have physical de-conditioning	0.25	Beta <sup>(c)</sup>	$\alpha = 78.16, \beta = 233.8$	GDG opinion
Proportion of non-asthmatic patients that have heart failure	0.25	Beta <sup>(c)</sup>	$\alpha = 78.16, \beta = 233.8$	GDG opinion
Proportion of non-asthmatic patients that have COPD	0.25	Beta <sup>(c)</sup>	$\alpha = 78.16, \beta = 233.8$	GDG opinion
<b>Utility weights</b>				
QoL increase from asthma treatment	0.0443	Beta	$\alpha = 23.86, \beta = 518.33$	McTaggart et al <sup>1113</sup>
Disutility from severe exacerbation	0.56	Beta	$\alpha = 0.91, \beta = 71$	Lloyd et al <sup>1021</sup>
Duration of severe exacerbation (in years)	0.08	Gamma	$\alpha = 19.26, \lambda = 246.34$	Harnan 2014 <sup>637</sup>
Disutility from non-severe exacerbation	0.32	Beta	$\alpha = 0.537, \beta = 1.14$	Lloyd et al <sup>1021</sup>
Duration of non-severe exacerbation (years)	0.01	Gamma	$\alpha = 82.9, \lambda = 8259$	Harnan 2014 <sup>637</sup>
QoL increase for a mild severity COPD patient being correctly treated for COPD as opposed to asthma.	0.045	Beta	$\alpha = 23.83, \beta = 505.73$	Spencer et al <sup>1639</sup>
QoL increase for a moderate severity COPD patient being correctly treated for COPD as opposed to asthma.	0.025	Beta	$\alpha = 24.35, \beta = 949.65$	Spencer et al <sup>1639</sup>
QoL increase for a heart failure patient being correctly treated for heart failure as opposed to asthma.	0.098	Beta	$\alpha = 22.45, \beta = 206.65$	Gohler et al <sup>575</sup>
<b>Cost (£)<sup>(b)</sup></b>				
Cost of hospitalised exacerbation	£873.75	Gamma	$\alpha = 25, \lambda = 0.028$	NHS reference costs <sup>420</sup> (weighted average of HRG codes DZ15H, DZ15J, DZ15K, DZ15L)
Cost of non-hospitalised exacerbation	£38.33	Gamma	$\alpha = 25, \lambda = 0.65$	PSSRU <sup>381</sup> , NHS drug tariff <sup>1218</sup>
Cost of spirometry	£16.86	Gamma	$\alpha = 100, \lambda = 5.93$	GDG opinion, PSSRU <sup>381</sup> , NHS supply catalogue <sup>422</sup>
Cost of BDR	£26.16	Gamma	$\alpha = 100, \lambda = 3.82$	GDG opinion, PSSRU <sup>381</sup> , NHS supply catalogue <sup>422</sup>
Cost of FeNO	£13.66	Gamma	$\alpha = 100, \lambda = 4.23$	GDG opinion, PSSRU <sup>381</sup> , NHS supply catalogue <sup>422</sup>

Parameter description	Point estimate	Probability distribution	Distribution parameters	Source
Cost of PEF	£21.08	Gamma	$\alpha = 100, \lambda = 4.74$	GDG opinion, PSSRU <sup>381</sup> , NHS supply catalogue <sup>422</sup>
Cost of Bronchial Challenge Studies, HRG code: DZ36Z	£102	Lognormal	$\alpha = 25, \lambda = 0.2451$	NHS reference costs <sup>421</sup>
Cost of respiratory outpatient visit	£150.22	Gamma	$\alpha = 100, \lambda = 0.6657$	NHS reference costs <sup>420</sup>
Cost of GP appointment	£37	-	-	PSSRU <sup>381</sup>
Cost of annual asthma management	£290.00	Gamma	See <b>Table 254</b>	Price et al <sup>1386</sup>
Cost of annual asthma management for patients without asthma but who have acute symptoms	£180.00	Gamma	See <b>Table 254</b>	Price et al <sup>1386</sup>
Cost of annual asthma management for patients without asthma but who have chronic symptoms	£248.91	Gamma	See <b>Table 254</b>	Price et al <sup>1386</sup>
Annual cost of COPD management for moderate severity	£307.74	Gamma	$\alpha = 25, \lambda = 0.08$	NICE 2010 COPD guideline <sup>1201</sup>
Annual cost of COPD management for mild severity	£149.68	Gamma	$\alpha = 25, \lambda = 0.17$	NICE 2010 COPD guideline (CG101) <sup>1201</sup>
Cost of heart failure treatment	£135	Gamma	$\alpha = 25, \lambda = 0.19$	NICE 2014 Acute heart failure guideline (CG187) <sup>1202</sup>
<b>Transition probabilities for Markov model and mortality adjustments</b>				
Annual exacerbation rate for un-treated asthmatics	1.02	Lognormal	$\mu = 0.02, \sigma = 0.1$	Harnan 2014 <sup>637</sup>
Annual exacerbation rate for treated asthmatics	0.42	Lognormal	$\mu = -0.87, \sigma = 0.2$	Shaw et al <sup>1558</sup>
Probability of exacerbation for un-treated asthmatic per cycle	40%	-	-	<i>Derived from the exacerbation rate for un-treated asthmatics. See section (M.2.4)</i>
Probability of exacerbation for un-treated asthmatic per cycle	19%	-	-	<i>Derived from the exacerbation rate for un-treated asthmatics. See section (M.2.4)</i>
Proportion of exacerbations that are hospitalised	2.7%	Beta	R = 40,243, n = 1474698	See section (M.2.3.6) for derivation and source input
Probability of death after hospitalisation	0.41%	Beta	R = 165, n = 40,243	National review of asthma deaths 2014 <sup>1473</sup>
Probability of correct re-diagnosis for patients with acute symptoms in 6 months	20%	Beta	$\alpha = 21.87, \beta = 87.47$	GDG opinion, see section M.2.3.5 for further details.
Probability of correct re-diagnosis for patients with	1%	Beta	$\alpha = 0.06, \beta =$	GDG opinion, see section M.2.3.5 for

Parameter description	Point estimate	Probability distribution	Distribution parameters	Source
physical de-conditioning in 6 months			5.77	further details.
Probability of correct re-diagnosis for patients with moderate COPD in 6 months	20%	Beta	$\alpha = 21.87, \beta = 87.47$	GDG opinion, see section M.2.3.5 for further details.
Probability of correct re-diagnosis for patients with mild COPD in 6 months	10%	Beta	$\alpha = 6.11, \beta = 55$	GDG opinion, see section M.2.3.5 for further details.
Probability of correct re-diagnosis for patients with heart failure in 6 months	30%	Beta	$\alpha = 21.87, \beta = 87.47$	GDG opinion, see section M.2.3.5 for further details.
Absolute probability increase of correct re-diagnosis after each 6-month cycle for patients with acute symptoms	20%	Beta	$\alpha = 21.87, \beta = 87.47$	GDG opinion, see section M.2.3.5 for further details.
Absolute probability increase of correct re-diagnosis after each 6-month cycle for patients with physical de-conditioning	0.5%	Beta	$\alpha = 0.01, \beta = 2.42$	GDG opinion, see section M.2.3.5 for further details.
Absolute probability increase of correct re-diagnosis after each 6-month cycle for patients with moderate COPD	20%	Beta	$\alpha = 21.87, \beta = 87.47$	GDG opinion, see section M.2.3.5 for further details.
Absolute probability increase of correct re-diagnosis after each 6-month cycle for patients with mild COPD	5%	Beta	$\alpha = 1.59, \beta = 30.17$	GDG opinion, see section M.2.3.5 for further details.
Absolute probability increase of correct re-diagnosis after each 6-month cycle for patients with heart failure	20%	Beta	$\alpha = 21.87, \beta = 87.47$	GDG opinion, see section M.2.3.5 for further details.
Hazard ratio of mortality for COPD patient	1.28	Lognormal	$\mu = 0.247, \sigma = 0.064$	Diaz-Guzman et al <sup>434</sup>
Hazard ratio of mortality for patient with physical de-conditioning	1.18	Lognormal	$\mu = 0.166, \sigma = 0.028$	Flegal 2013 <sup>498</sup>
Hazard ratio of mortality for patient with chronic heart failure	2.1	Lognormal	$\mu = 0.742, \sigma = 0.103$	Mosterd 2001 <sup>1171</sup>

Abbreviations: BDR: bronchodilator reversibility; FeNO: fractional exhaled nitric oxide; PEF: peak expiratory flow variability

(a) This study found that the specificity of histamine and methacholine challenge tests were 100%. However the GDG agreed that there is no perfect test so this value was reduced to 99% to reflect the high specificity but allowing some scope for error. This assumption was also incorporated into the beta distribution by changing the number of true negatives to achieve a specificity of 99%.

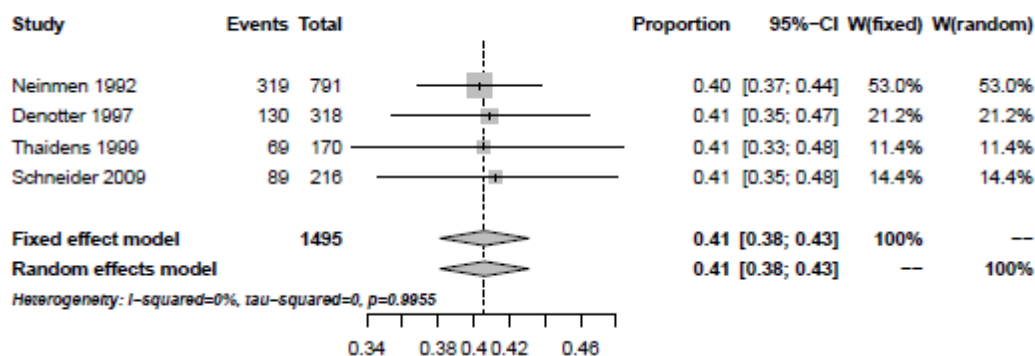
(b) These are costs of the tests as they appear in the pathway rather than the cost of conducting the test independently

(c) To ensure these values sum to one once a value has been chosen from each distribution the probability of having a particular disease becomes:  $Prob(disease A) = Prob(disease A) / \sum Prob(disease_n)$  where each probability is taken from its respective beta distribution.

### M.2.3.2 Initial cohort settings

The initial cohort settings were derived from information given in the studies included in our clinical review of diagnostic accuracy studies. The prevalence of asthma was obtained from a meta-analysis of all the included diagnostic studies which looked at the model's defined population. Ideally prevalence would be based only on UK studies, however no UK studies were included in the clinical reviews. To obtain a prevalence estimate applicable to the population in the model a few exclusion criteria were imposed. Firstly studies were excluded which only looked at children or looked at both adults and children and did not separate out the results. The prevalence of asthma is likely to deviate significantly between adults and children and therefore including child studies could bias the prevalence, most likely upwards. Secondly studies were included only if the inclusion criteria for patient entry into the study were patients presenting symptoms of asthma. For example if only patients with a normal spirometry were allowed to enter the study then the prevalence of asthma would fall as a significant portion of asthmatics have an obstructive spirometry. Finally as no study was conducted in the UK the GDG agreed that studies which were conducted in Northern Europe, North America, Australia and New Zealand would give a better indication of asthma prevalence in the UK. Therefore studies outside of these areas were excluded when calculating asthma prevalence. The resulting meta-analysis is shown below in Figure 316 was based on four studies<sup>417,1519,1728</sup>.

**Figure 316: Meta-analysis for asthma prevalence**



The majority of excluded studies had a lower prevalence rate ranging from 20% to 37%. Three studies had a prevalence of approximately 70% however they were all in Asian countries (Japan and S. Korea). It is worth noting a paper by Morice et al found asthma prevalence to be on average 25% across 13 studies in patients with chronic cough. This paper was not used in the base case as it is not clear what the exact recruitment methods were for patients into the studies, secondly patients entering the model are likely to exhibit other asthma symptoms rather than just a chronic cough. However this study suggests that the 41% estimate produced above is unlikely to be an underestimate of asthma prevalence in the defined population.

This value was also tested in the sensitivity analysis detailed in section M.2.5.

### 1 M.2.3.3 Diagnostic accuracies

#### 2 *Using diagnostic odds ratios to conduct probabilistic sensitivity analysis*

3 The clinical review did not identify enough diagnostic studies to conduct meaningful  
 4 diagnostic meta-analyses. Therefore, for each test included in the model the most relevant  
 5 study used for the base case was identified as that which had: the correct cut-off, most  
 6 relevant population and best reference standard. As there is no universally agreed reference  
 7 standard for the diagnosis of asthma, the GDG agreed that an appropriate reference  
 8 standard would be an objective test alongside a physician diagnosis. The bronchodilator  
 9 reversibility test was the only exception where an average was taken from the two studies  
 10 identified in the clinical review. The reason was that the GDG could not identify one study  
 11 being more appropriate than the other, therefore an average was used in the base case and  
 12 each separate set of diagnostic accuracies was used in a sensitivity analysis.

13 To account for uncertainty around diagnostic accuracies and correlation between sensitivity  
 14 and specificity a joint distribution was used when making diagnostic accuracies probabilistic.  
 15 The following method is outlined in Genders et al.<sup>548</sup> First of all the diagnostic odds ratio  
 16 (DOR) was calculated for the diagnostic test:

$$17 \quad DOR = \frac{sensitivity}{1 - sensitivity} * \frac{specificity}{1 - specificity}$$

18 The standard error of the log DOR was calculated using the absolute values for the number  
 19 of TP, TN, FP and FN:

$$20 \quad SE(\ln(DOR)) = \sqrt{\frac{1}{TP} + \frac{1}{FN} + \frac{1}{TN} + \frac{1}{FP}}$$

21 Using these equations a normal distribution was fitted using the log of the DOR and the  
 22 standard error of ln(DOR). Once the DOR is calculated, the sensitivity can become a function  
 23 of the DOR and the specificity:

$$24 \quad sensitivity = 1 - \frac{specificity}{specificity + (1 - specificity) * DOR}$$

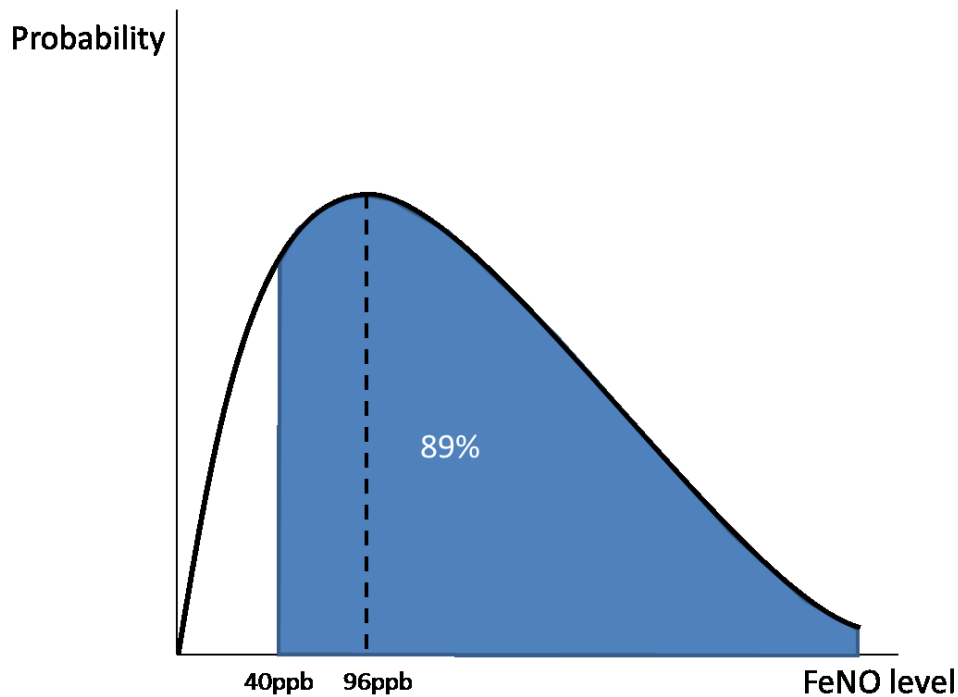
25 Finally a beta distribution was fitted around the specificity of the test, therefore when  
 26 probabilistic sensitivity analysis is conducted the specificity will change in accordance to the  
 27 overall diagnostic uncertainty and its relationship with the test sensitivity.

#### 28 *Using additional cut-offs for negative FeNO results*

29 In some diagnostic strategies we had to take into account the probability of a FeNO level  
 30 below 25ppb together with the probability of receiving a negative FeNO result (FeNO level <  
 31 40 ppb). The GDG recognised that the lower an individual's FeNO level was the lower the  
 32 probability the individual has asthma. Current guidelines<sup>1536</sup> recommend that an individual  
 33 with a FeNO level below 25ppb is highly unlikely to have asthma. None of the studies  
 34 identified in the clinical review gave a sensitivity and specificity at 25ppb cut-off. Therefore  
 35 to calculate the probability of a patient with asthma producing a FeNO level below 25ppb  
 36 two pieces of information were used:

- 37 • The mean FeNO level for an asthmatic.
- 38 • The sensitivity of FeNO at a 40ppb cut-off.

1 **Figure 317: Probability distribution of FeNO levels in individuals with asthma**

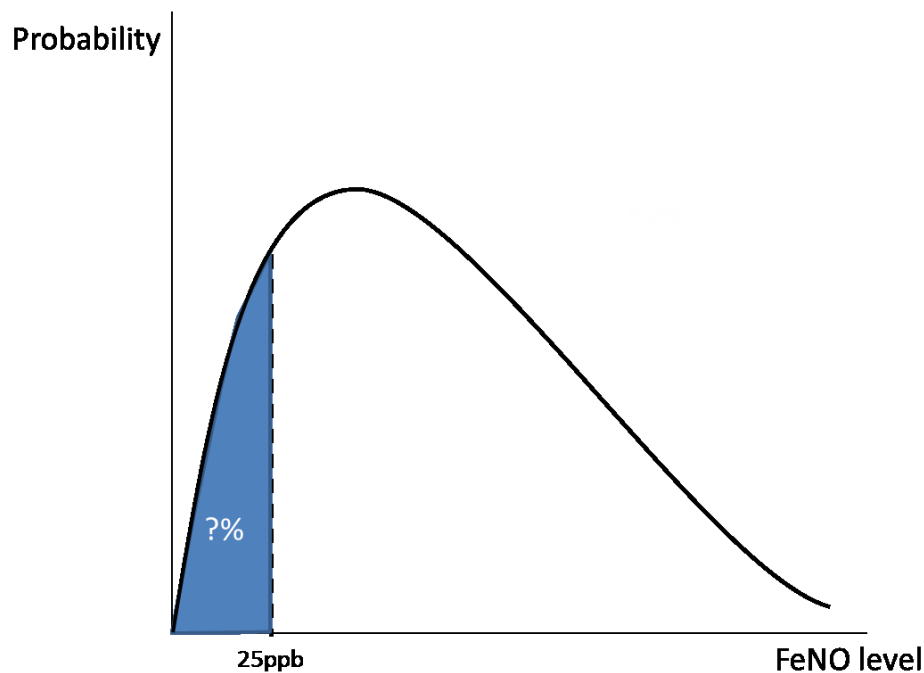


2

3 As shown in Figure 317 above, using these two pieces of information a distribution was  
 4 fitted around what FeNO level would be achieved by asthmatics. At 40ppb the sensitivity  
 5 used for FeNO in the model was 89%. This means that the area under the curve highlighted  
 6 in blue should equate to 89%. The mean FeNO level calculated for asthmatics in that study  
 7 was 96ppb. As FeNO levels cannot go below zero a gamma and lognormal distribution were  
 8 fitted to see which was more appropriate. A lognormal distribution was chosen as the  
 9 gamma distribution gave a much higher probability to values close to zero whereas the  
 10 lognormal gave a more even distribution amongst lower values. After this distribution was  
 11 fitted, the final step was to calculate the proportion of patients with asthma that would  
 12 produce a FeNO level below 25ppb.

13 **Figure 318: Probability distribution of FeNO levels in individuals with asthma**

14



1

2 As shown in Figure 318 above this was done by calculating the area under the distribution  
3 that fell to the left of 25ppb.

4 The same process was then completed for patients without asthma except this time the  
5 mean FeNO level for non-asthmatics and the specificity at a 40ppb cut-off (instead of the  
6 sensitivity) were used.

#### 7 **M.2.3.4 Mortality**

8 For all patients at any point in the model the probability of death is determined by an age  
9 specific all-cause mortality rate. For patients with asthma the probability of death is also  
10 dependent on the probability of having a hospitalised exacerbation and the probability of  
11 death after hospitalisation. As exacerbation rates are higher in un-treated asthmatics, the  
12 overall probability of death calculated by the model is slightly higher for un-treated  
13 asthmatics compared to treated asthmatics. For non-asthmatics correct or incorrect  
14 treatment has no differential impact on mortality. Age-specific all-cause mortality, weighted  
15 for the gender split of the cohort population, was based on the most recent available life  
16 tables for England and Wales (2012-2013)<sup>1260</sup>. For non-asthmatic conditions hazard ratios  
17 were identified in the literature for patients with: COPD, chronic heart failure and de-  
18 conditioning. In the model the hazard ratio in people with obesity is used as a proxy for  
19 physical de-conditioning.

#### 20 **M.2.3.5 Re-diagnosis and exacerbation rates**

21 The transition probability of re-diagnosis was determined through GDG opinion. The  
22 transition probability for correct re-diagnosis for false negatives was calculated using an  
23 assumption whereby the probability of re-diagnosis is contingent on whether the patient has  
24 an exacerbation.

25 Exacerbation rates were taken from the clinical review conducted on monitoring asthma  
26 control. For individuals with asthma who remain untreated, due to a false negative  
27 diagnosis, the exacerbation rate was taken from Harnan et al.<sup>637</sup> As the exacerbation rate for  
28 untreated asthma was derived mostly from assumption, due to the lack of clinical data, this

value was extensively tested in a sensitivity analysis. A study by Shaw et al<sup>1558</sup> was chosen to reflect the exacerbation rates of a treated asthma patient as it was the most current study conducted in a UK setting. Once the exacerbation rates had been derived these were converted into transition probabilities for the respective cycle length (6 months) before inputting into the Markov model. The above conversion was done using the following formulae:

$\text{Selected rate } (r) = \frac{-\ln(1 - P)}{t}$	Where $P$ =probability of event over time $t$ $t$ =time over which probability occurs (1 year)
$\text{Transition Probability } (P) = 1 - e^{-rt}$	Where $r$ =selected rate $t$ =cycle length (6 months)

For false positives there was no clinical evidence to derive the length of time an individual would retain the incorrect asthma diagnosis for. The GDG agreed this value would vary considerably, with some individuals being re-diagnosed within the year whereas others would retain the diagnosis for the rest of their life. The GDG concurred that the probability of re-diagnosis would be contingent on the underlying condition causing the asthma symptoms to occur. As outlined in section M.2.2.1 four conditions were used in this model:

#### *Heart failure*

The GDG considered that most individuals with heart failure would be re-diagnosed within a year and a few individuals may retain an asthma diagnosis beyond two years. To achieve this, an assumption was imposed that 30% of individuals would be re-diagnosed in the first 6 months and every 6 months the probability of re-diagnosis would increase by 20 percentage points. Therefore after two and a half years no individuals with heart failure would retain an asthma diagnosis in the model.

#### *COPD*

Individuals with mild COPD could remain misdiagnosed with asthma for a considerable length of time and the GDG therefore gave a low probability of re-diagnosis every 6 months of 10%. Every 6 months the probability of re-diagnosis would increase by 5 percentage points as the GDG considered that eventually a re-diagnosis would occur. Individuals with moderate COPD however would be re-diagnosed much sooner as their symptoms would appear far less well managed. Therefore the probability of re-diagnosis was set to 20% each 6 months and this increased by 10 percentage points for every 6 months after that.

#### *Physical deconditioning*

Individuals with physical deconditioning were the one group the GDG agreed that re-diagnosis may never occur. Therefore the probability of re-diagnosis was set to a low 1% each 6 months and this only increased by 0.5 percentage points for every occurring 6 months.

#### *Acute symptoms*

Finally the GDG agreed that individuals with acute symptoms would receive a re-diagnosis very quickly as symptoms would completely subside over a short period of time. Therefore the probability of re-diagnosis was set to 20% each 6 months and this increased by 20 percentage points for every occurring 6 months.

These values were extensively tested in a sensitivity analysis detailed in section M.2.5.



### 1 M.2.3.6 Utilities

#### 2 *Utility in people with asthma*

3 The QoL for patients with asthma was derived from a systematic search of the literature.  
 4 Only one study<sup>1113</sup> measured asthma utility in a UK population using EQ-5D with UK weights,  
 5 as per the NICE reference case. The study details asthma utility for four levels of self-  
 6 reported asthma control: uncontrolled, moderately controlled, well controlled and fully  
 7 controlled as shown in **Table 241**.

8 **Table 241: Quality of life and level of asthma control**

Self-reported asthma control	Utility measured using EQ-5D
Very well controlled	0.9
Well controlled	0.84
Adequately controlled	0.81
Not controlled	0.8

9 *Source: McTaggart et al (2008)<sup>1113</sup>*

10 It was assumed that un-treated individuals with asthma will receive a QoL equal to a person  
 11 with 'not controlled' asthma. Individuals that are treated for asthma will achieve a higher  
 12 level of control. A study by Price et al details the proportion of patients being treated for  
 13 asthma in the UK that are experiencing either: full control, partial control or uncontrolled  
 14 asthma as shown in **Table 242**:

15 **Table 242: Levels of asthma control for treated patients with asthma**

Asthma control	Proportion
Controlled	18.2%
Partially controlled	60%
Uncontrolled	21.8%

16 *Source: Price et al<sup>1386</sup>*

17 The study shows that while some patients achieve full control the majority achieve either  
 18 partial control or remain uncontrolled. It was assumed that well controlled, detailed in **Table**  
 19 **241**, represents the QoL for partial control, and adequate control represents the QoL for  
 20 uncontrolled, treated asthma. Therefore the health related quality of life (HRQoL) for  
 21 treated asthmatics is:

$$\begin{aligned}
 22 \quad HRQoL_{Treated} &= Proportion(uncontrolled) * HRQoL(adequately controlled) \\
 23 \quad &+ Proportion(partial control) * HRQoL(well controlled) \\
 24 \quad &+ Proportion(controlled) * HRQoL(very well controlled)
 \end{aligned}$$

25 Using the information detailed above the average HRQoL for treated asthma is 0.8443.  
 26 Therefore the HRQoL increase for treating asthma is:

$$27 \quad HRQoL_{Treated} - HRQoL(not\ controlled) = 0.8443 - 0.8 = 0.0443$$

#### 29 *Utility of exacerbation*

30 One limitation with the EQ-5D questionnaire is that the individual is asked how their health  
 31 is on that specific day when the questionnaire is administered. Therefore the EQ5D score

1 does not take into account the HRQoL impact from exacerbations (if the patient had no  
 2 exacerbation on that day). A study by Lloyd et al<sup>1021</sup> derives an EQ-5D measure for  
 3 exacerbations. Therefore in the model a patient receives a disutility if they experience an  
 4 exacerbation. The size of this disutility is determined by whether the exacerbation is severe  
 5 and therefore requiring hospitalisation and is weighted by the duration. The disutility is  
 6 shown in **Table 243**.

7 **Table 243: Disutility a patient experiences with an exacerbation**

Severity of exacerbation	Quality of life decrease during exacerbation	Duration of exacerbation (years)	Disutility (QALYs)
Severe	0.56	0.08	0.0448
Non-severe	0.32	0.01	0.0032

8 *Source: Lloyd et al<sup>1021</sup>*

9 To calculate the proportion of adults that would have a hospitalised (severe) exacerbation,  
 10 the proportion of hospitalised exacerbations was divided by the total number of  
 11 exacerbations. The total number of exacerbations that occur each year was calculated by  
 12 taking the annual probability of having an exacerbation and multiplying this by the number  
 13 of adults with asthma in the UK (4.1 million taken from asthma UK). The annual probability  
 14 of having an exacerbation was extracted from Shaw et al.<sup>1558</sup> The total number of annual  
 15 hospitalisations in adults (40,243) was taken from the National review of Asthma deaths.<sup>1473</sup>

16 *Utility of correctly treating non-asthmatics with asthma symptoms*

17 For patients with COPD it is assumed that they will have either moderate or mild severity of  
 18 COPD. In the model if the spirometry shows an obstruction an assumption was made that  
 19 the patient would have moderate COPD whereas a spirometry showing no obstruction  
 20 would indicate mild COPD. The quality of life associated with COPD severity is shown in  
 21 Table 244.

22 **Table 244: Quality of life for COPD patients by severity**

COPD severity	Quality of life (SE)	Quality of life if treated for asthma
Mild	0.81 (0.02)	0.765
Moderate	0.72 (0.03)	0.695
Severe	0.67 (0.05)	NA

23 *Source: Spencer et al<sup>1639</sup>*

24 In the model if the patient has COPD but is treated for asthma then they will receive a QoL  
 25 between two severity levels, depending on how severe their COPD is. Therefore if a patient  
 26 has mild COPD and is being treated for asthma they will receive a quality of life of 0.765,  
 27 which is a quality of life half way between mild and moderate COPD. The GDG decided to  
 28 use the value half way between these points as asthma medication will slightly help treat  
 29 COPD. Once the patient has been correctly re-diagnosed as having COPD their QoL will  
 30 increase to the mean QoL for their severity level.

31 For patients with heart failure it was assumed that the majority would be classified under  
 32 the New York Heart Association (NYHA) as class 2. Patients classified under NYHA class 1 are  
 33 less likely to present any asthma related symptoms whereas patients with NYHA class 3 and  
 34 4 are likely to present non-asthma related symptoms that will indicate heart failure. The  
 35 GDG made an assumption that 80% of patients would be class II, 10% would be class I and  
 36 10% would be class III. The quality of life for each class is shown in Table 245.

1 **Table 245: Quality of life by NYHA class**

NYHA class	Quality of life (95% CI)	Quality of life if treated for asthma
I	0.855 (0.845 – 0.864)	0.771
II	0.771 (0.761 – 0.781)	0.673
III	0.673 (0.665 – 0.690)	0.532
IV	0.532 (0.480 – 0.584)	NA

2 *Source: Gholer et al<sup>575</sup>*

3 As the NYHA class the patient falls into is determined by the severity of their symptoms an  
 4 assumption was used that patients who would fall under NYHA class II would have the  
 5 quality of life of a patient with class III. Therefore a patient with class II heart failure being  
 6 treated for asthma will have a QoL of 0.673. This QoL will increase to 0.770 once the patient  
 7 has been correctly re-diagnosed and is treated accordingly.

8 These quality of life increases are extensively tested in the sensitivity analyses detailed in  
 9 M.2.5.

10 Individuals with either acute symptoms or physical de-conditioning will receive no quality of  
 11 life benefit from being correctly re-diagnosed as not having asthma. This is because any  
 12 other management would not be mutually exclusive with asthma medication and therefore  
 13 these costs and HRQoL benefits would occur in both true negatives and false positives  
 14 leading to no incremental benefit. Individuals with ‘acute symptoms’ will therefore receive a  
 15 quality of life equal to the general population 0.96. Individuals with physical deconditioning  
 16 will receive a quality of life equal to the general population minus a disutility of 0.05. Both  
 17 these values were taken from Harnan et al.<sup>637</sup> This disutility takes into account their  
 18 symptoms and is thus equal to the disutility of having asthma. These values will not  
 19 influence the cost-effectiveness of any strategy as they are not influenced by whether the  
 20 individual is falsely diagnosed.

21 **M.2.3.7 Resource use and costs**22 **Diagnostic tests – primary care**

23 For diagnostic tests conducted in primary care, resource use was elicited from the GDG. This  
 24 included information on: the health care professional who conducts the test, the time taken  
 25 to administer the test, and the equipment used. Costs were then applied using data from the  
 26 NHS supply chain catalogue<sup>422</sup> and the PSSRU<sup>381</sup>. Costs of individual tests conducted in  
 27 primary care are reported below (Table 246 to Table 249). Training costs have not been  
 28 included as a marginal cost, under the assumption that over time training costs marginalise  
 29 to zero per patient.

30 **Table 246: Cost of spirometry**

Item	Quantity	Unit cost	Total Cost (quantity*unit cost)	Source
Time of GP practice nurse to conduct the test	20 minutes	£0.73 per minute	£14.66	GDG opinion, PSSRU <sup>381</sup>
Micro-lab spirometer <sup>(a)</sup>	1/1500	£1498.90 per spirometer	£1.00	GDG opinion, NHS supply catalogue <sup>422</sup>

Item	Quantity	Unit cost	Total Cost (quantity*unit cost)	Source
Bacterial filter, 3-litre syringe for calibration <sup>(a)</sup>	1/1500	£295.77 per syringe	£0.20	GDG opinion, NHS supply catalogue <sup>422</sup>
Bacterial filter	1	£0.99 per filter	£0.99	NHS supply catalogue <sup>422</sup>
<b>Total</b>			<b>£16.86</b>	

(a) To calculate the marginal cost it was assumed that the equipment lasts for 5 years and is used on average 1500 times in this period.

**Table 247: Cost of bronchodilator reversibility**

Item	Quantity	Unit cost	Total Cost (quantity*unit cost)	Source
Time taken to administer bronchodilator and check for reversibility	20 minutes	£0.73 per minute	£14.66	GDG opinion, PSSRU <sup>381</sup>
Volumatic spacer	1	£3.81 per spacer	£3.81	NHS supply catalogue <sup>422</sup>
MDI	1	£5.50 per MDI	£5.50	NHS supply catalogue <sup>422</sup>
Spirometry equipment to check for reversibility <sup>(a)</sup>	1	£2.19 (see <b>Table 246</b> above)	£2.19	NHS supply catalogue <sup>422</sup>
<b>Total</b>			<b>£26.16</b>	

(a) When a bronchodilator reversibility test is being performed in the model the first spirometry reading will have already been taken.

**Table 248: Cost of FeNO**

Item	Quantity	Unit cost	Total Cost (quantity*unit cost)	Source
Time taken to conduct test with GP practice nurse	10 minutes	£0.73 per minute	£7.30	GDG opinion, PSSRU <sup>381</sup>
Marginal cost of using equipment (NIOX VERO <sup>(a)</sup> )	1	£6.36 per use	£6.36	Harnan et al <sup>637</sup>
<b>Total</b>			<b>£13.66</b>	

(a) It was assumed that NIOX VERO is the most commonly used FeNO test

**Table 249: Cost of peak expiratory flow variability**

Item	Quantity	Unit cost	Total Cost (quantity*unit cost)	Source
Time taken to	10 minutes	£0.73 per minute	£7.30	GDG opinion,

Item	Quantity	Unit cost	Total Cost (quantity*unit cost)	Source
instruct patient how to use test with GP practice nurse				PSSRU <sup>381</sup>
Time taken to interpret results by GP practice nurse	10 minutes	£0.73 per minute	£7.30	GDG opinion, PSSRU <sup>381</sup>
Mini wright peak flow meter	1	£6.48 per meter	£6.48	NHS supply catalogue <sup>422</sup>
<b>Total</b>			<b>£21.08</b>	

### 1 Diagnostic tests – secondary care

2 The following tests are conducted in a secondary care setting. The costs of exercise and  
 3 histamine/methacholine challenge tests are detailed in **Table 250** and **Table 251**  
 4 respectively. It is assumed that a GP will refer a patient to have a challenge test and the  
 5 patient will complete the test in a secondary care setting. The results of the test will be  
 6 interpreted by a respiratory physician and sent back to the GP for analysis.

### 7 Table 250: Cost of exercise challenge test

Item	Quantity	Unit cost	Total cost	Source
Cost of interpreting result – 15 minutes of associate specialist time	1	£23.50	£23.50	GDG opinion, PSSRU <sup>381</sup>
Investigation costs	1	£167	£167	NHS reference costs <sup>420</sup> - (Complex lung function exercise testing <sup>(a)</sup> HRG code: DZ31Z)
Cost of GP referral	1	£37	£37	GDG opinion, PSSRU <sup>381</sup>
<b>Total</b>			<b>£227.50</b>	

8 (a) The HRG cost was weighted assuming that the test would only be conducted in outpatient and direct access

### 9 Table 251: Cost of histamine/methacholine

Item	Quantity	Unit cost	Total cost	Source
Cost of interpreting result – 15 minutes of associate specialist time	1	£23.50	£23.50	GDG opinion, PSSRU <sup>381</sup>
Investigation costs	1	£102.00	£102.00	NHS reference costs <sup>421</sup> - (Bronchial challenge studies <sup>(a)</sup> HRG code: DZ36Z)
Cost of GP referral	1	£37	£37	GDG opinion, PSSRU <sup>381</sup>
<b>Total</b>			<b>£162.50</b>	

(a) The HRG cost was chosen assuming that the test would only be conducted in directly accessed diagnostic services

To parameterise the reference costs probabilistically, the distribution of best fit was found by fitting a gamma and lognormal distribution. To fit each distribution, the standard deviation of the trust cost was estimated matching the reported interquartile range to that calculated using the reported mean, and where appropriate the distribution's alpha and beta values. The distribution of best fit was that which provided the interquartile range of closest value to that reported by the NHS reference cost.

### Cost of asthma treatment

The annual cost of asthma management was taken from a study by Price et al<sup>1386</sup>. A large driver of the cost of asthma management is the level of asthma control the individual achieves. Individuals achieving poor asthma control will have higher drug costs as they will be on a higher step of asthma medication receiving more expensive treatments. Likewise, individuals achieving good asthma control will have lower drug costs as they will be on a much less intensive form of treatment. The study by Price et al differentiates annual asthma costs by level of control and number of exacerbations. This annual cost incorporates: drug costs, GP consultations and hospitalisations and is shown in **Table 252**. N (%) represents the number and percentage of patients that fall in a particular cohort, mean (SD) represents the mean cost and its associated standard deviation.

**Table 252: Annual asthma costs**

Level of GINA control		Number of exacerbations			
		0	1	2-3	4+
Controlled	N (%)	2583 (16.2%)	196 (1.2%)	38 (0.24%)	13 (0.08%)
	Mean annual cost (SD)	£180 (£225)	£284 (£287)	£471 (£408)	£573 (£481)
Partially controlled	N (%)	7079 (44.5%)	814 (5.1%)	307 (1.9%)	67 (0.42%)
	Mean annual cost (SD)	£238 (£279)	£397 (£358)	£557 (£427)	£645 (£549)
Uncontrolled	N (%)	3642 (22.8%)	745 (4.7%)	399 (2.1%)	102 (0.64%)
	Mean annual cost (SD)	£319 (£366)	£491 (£416)	£672 (£493)	£928 (£755)
Annual weighted asthma cost	£290				

Source: Price et al<sup>1386</sup>

Using this information the annual cost of asthma management can be calculated for the average asthma patient by taking a weighted average. This is done by weighting the cost of asthma management by the proportion of patients experiencing a certain number of exacerbations at a certain level of control. This average cost is equal to £290.

It was noted that since this cost was estimated the NICE asthma management guideline has recommended a cheaper treatment option that could effect approximately 30% of individuals with asthma. The recommendation suggest adding lutektrine receptor agonists (LTRAs) instead of long-acting beta-agonists (LABAs) for those whose asthma remains uncontrolled on inhaled corticosteroids (ICS) alone. ICS+LTRA is approximatey 60% cheaper

1 than ICS+LABA. Therefore at most this recommendation will reduce the overall medication  
2 spend on asthma by 18% (60% cost reduction for 30% of people with asthma).

3 The impact to total asthma costs as measured above will be smaller as medication costs only  
4 represent a portion of the total asthma spend. The impact this development may have on  
5 the model results is explored in sensitivity analysis 8 by reducing overall asthma costs by  
6 25%.

#### 7 *Annual cost of asthma treatment for non-asthmatics*

8 Individuals who do not have asthma but are prescribed asthma medication (false positive)  
9 are likely to have a different annual cost compared to individuals with asthma. This has been  
10 incorporated into the model by extrapolating from the data presented in **Table 252**.

11 For individuals with acute symptoms they are likely to appear to be achieving full asthma  
12 control as their symptoms will pass with time. As they don't have asthma they will not  
13 experience any exacerbations. Therefore the cost given to these individuals in the model is  
14 the cost associated with controlled asthma and zero exacerbations which in **Table 252** is  
15 £180.

16 For individuals with either heart failure or physical de-conditioning their symptoms will be  
17 worse and it will appear that their asthma may be uncontrolled, however they won't  
18 experience any exacerbations. Therefore for these individuals a weighted cost of asthma  
19 management was calculated based on the number of individuals experiencing zero  
20 exacerbations but achieving differing levels of asthma control. As there is no data on the  
21 perceived level of asthma control achieved by non-asthmatics an assumption was made that  
22 the proportions achieving a certain level for control will be the same as asthmatics. This  
23 information is displayed in **Table 253** and has been extrapolated from the data presented in  
24 Table 252. The GDG also noted that once the individual has been diagnosed with heart  
25 failure some individuals will retain their incorrect asthma diagnosis and remain on asthma  
26 treatment for the rest of their life. Therefore in the model 25% of the cost of asthma  
27 management will be retained after the individual has been diagnosed as having heart failure.  
28 This value was removed in a sensitivity analysis detailed in section M.2.5.

29 **Table 253: Annual asthma costs for people with an incorrect diagnosis of asthma who have**  
30 **either heart failure or physical deconditioning**

		Number of exacerbations
<b>Level of GINA control</b>		<b>0</b>
<b>Controlled</b>	(%)	(19.4%)
	Mean (SD)	£180 (£225)
<b>Partially controlled</b>	(%)	(53.2%)
	Mean (SD)	£238 (279)
<b>Uncontrolled</b>	(%)	(27.4%)
	Mean (SD)	£319 (£366)
<b>Annual average asthma cost</b>	£248.91	

31  
32 Finally for COPD patients it was assumed that if they were treated for asthma then they  
33 would incur the same costs as an asthma patient. This is likely to be an underestimate as  
34 COPD patients exacerbate more than asthma patients especially if they are being treated for

1 asthma as opposed to COPD. This will make the results more conservative for strategies with  
2 higher specificities.

3 These costs are tested in the sensitivity analysis in section M.2.5.

#### 4 *Adding uncertainty around asthma costs*

5 As shown by the large standard deviations in **Table 252**, there is a great deal of uncertainty  
6 around the annual cost of asthma. This uncertainty was captured by attaching gamma  
7 distributions to each combination of control and exacerbation. The distribution parameters  
8 attached are shown in **Table 254**. Alpha and lambda parameters were calculated using the  
9 mean and standard deviation detailed in **Table 252**.

10 **Table 254: Gamma distribution parameters for annual asthma costs<sup>(a)</sup>**

Level of control/no. of exacerbations	Point estimate	Alpha	Lambda
Controlled / 0	£180	0.64	0.004
Partially controlled / 0	£238	0.72	0.003
Uncontrolled / 0	£319	0.76	0.002
Controlled / 1	£284	0.98	0.003
Partially controlled / 1	£397	1.23	0.003
Uncontrolled / 1	£491	1.39	0.003
Controlled / 2-3	£472	1.34	0.003
Partially controlled / 2-3	£557	1.7	0.003
Uncontrolled / 2-3	£672	1.86	0.003
Controlled / 4+	£573	1.4	0.002
Partially controlled / 4+	£645	1.38	0.002
Uncontrolled / 4+	£928	1.51	0.002

11 (a) Numbers are rounded to 2 decimal places or nearest integer  
12

#### 13 *Annual cost of non-asthmatic treatment*

14 For patients with COPD and heart failure once they are correctly re-diagnosed the NHS will  
15 incur the costs of their respective treatment rather than asthma medication.

16 The costs for COPD management were taken from the NICE COPD guideline.<sup>1201</sup> In the  
17 guideline the annual incremental costs of a patient with mild COPD, relative to the general  
18 population, were £149.68. For patients with moderate COPD this incremental cost increases  
19 to £307.74. Therefore in the model once a patient with COPD is correctly re-diagnosed and  
20 treated for COPD, the NHS will incur these costs rather than asthma management costs.

21 For heart failure patients the NHS will incur the cost of heart failure medication once the  
22 patient is correctly re-diagnosed. This cost was estimated to be £135 per year in the recent  
23 acute heart failure guideline<sup>1202</sup>.

#### 24 *Cost of exacerbations*

25 In the model exacerbation costs are calculated for patients who have an exacerbation whilst  
26 they are not being treated for asthma. This cost is dependent on whether the exacerbation is  
27 severe. If the exacerbation is not severe then the cost includes one GP appointment (£37  
28 from PSSRU<sup>381</sup>) and a course of oral steroids with Prednisolone (cost=£1.33 from NHS drug



1 tariff<sup>1218</sup>). If the exacerbation is severe then the patient will be hospitalised and the cost of  
 2 asthma hospitalisation will be added (cost = £873.74 from NHS reference cost<sup>420</sup>).

3 Therefore the average cost of an exacerbation is:

$$\begin{aligned}
 & \text{Average cost of exacerbation} \\
 & = \text{Prob}(\text{hospitalisation}) * \text{cost}(\text{hospitalisation}) \\
 & - (1 - \text{Prob}(\text{Hospitalisation})) * \text{cost}(\text{non - severe exacerbation})
 \end{aligned}$$

7 Once the patient is being treated for asthma the exacerbation costs have already been taken  
 8 into account as reported in Table 252 and therefore these costs as calculated above are  
 9 excluded in these patients to avoid double counting.

## 10 M.2.4 Computations

11 The model was constructed in TreeAge Pro 2009<sup>1765</sup> and was evaluated by cohort simulation.  
 12 Time dependency was built in by cross referencing the cohorts age as a respective risk factor  
 13 for mortality.

14 QALYs for the cohort were computed each cycle. To calculate QALYs for each cycle, Q(t), the  
 15 time spent in the alive state of the model was weighted by a utility value that is dependent  
 16 on the time spent in the model and the health state. QALYs were then discounted to reflect  
 17 time preference (discount rate = 3.5%) using the following formula:

18

$$\text{Discounted total} = \frac{\text{Total}}{(1+r)^n}$$

Where:

$r$ =discount rate per annum

$n$ =time (years)

19 QALYs during the first cycle were not discounted. The total discounted QALYs were the sum  
 20 of the discounted QALYs per cycle. The total discounted QALYs were the sum of the  
 21 discounted QALYs per cycle.

22 Costs per cycle, C(t), were calculated in the same way as QALYs. Costs were discounted to  
 23 reflect time preference (discount rate = 3.5%) in the same way as QALYs using the formula  
 24 above.

### 25 *Estimating cost-effectiveness*

26 The widely used cost-effectiveness metric is the incremental cost-effectiveness ratio (ICER).  
 27 This is calculated by dividing the difference in costs associated with two alternatives by the  
 28 difference in QALYs. The decision rule then applied is that if the ICER falls below a given cost  
 29 per QALY threshold the result is considered to be cost-effective. If both costs are lower and  
 30 QALYs are higher the option is said to dominate and an ICER is not calculated.

$$\text{ICER} = \frac{\text{Costs}(B) - \text{Costs}(A)}{\text{QALYs}(B) - \text{QALYs}(A)}$$

Where: Costs(A) = total costs for option A; QALYs(A) = total QALYs for option A

Cost-effective if:

- ICER < Threshold

31 When there are more than two comparators, as in this analysis, options must be ranked in  
 32 order of increasing cost then options ruled out by dominance or extended dominance before  
 33 calculating ICERs excluding these options. An option is said to be dominated, and ruled out,

1 if another intervention is less costly and more effective. An option is said to be extendedly  
2 dominated if a combination of two other options would prove to be less costly and more  
3 effective.

4 It is also possible, for a particular cost-effectiveness threshold, to re-express cost-  
5 effectiveness results in term of net monetary benefit (NMB). This is calculated by multiplying  
6 the total QALYs for a comparator by the threshold cost per QALY value (for example,  
7 £20,000) and then subtracting the total costs (formula below). The decision rule then  
8 applied is that the comparator with the highest NMB is the most cost-effective option at the  
9 specified threshold. That is the option that provides the highest number of QALYs at an  
10 acceptable cost.

$$Net\ Monetary\ Benefit\ (X) = (QALYs(X) \times \lambda) - Costs(X)$$

Where:  $\lambda$  = threshold (£20,000 per QALY gained)

Cost-effective if:

- Highest net benefit

11 Both methods of determining cost-effectiveness will identify exactly the same optimal  
12 strategy. For ease of computation NMB is used in this analysis to identify the optimal  
13 strategy.

14 Results are also presented graphically where total costs and total QALYs for each diagnostic  
15 strategy are shown. Comparisons not ruled out by dominance or extended dominance are  
16 joined by a line on the graph where the slope represents the incremental cost-effectiveness  
17 ratio.

## 18 M.2.5 Sensitivity analyses

19 The sensitivity analyses conducted below were undertaken to test some of the key  
20 assumptions employed in the model.

21 **Table 255: Sensitivity analyses conducted**

Analysis	Parameter	Description	Values	Comment
S1	Probability of COPD, physical deconditioning, heart failure or acute symptoms being cause of asthmatic symptoms	As the exact distribution of these underlying conditions is unknown this sensitivity analysis addresses different distributions between the four conditions. The model was run eight times with each condition being given a higher proportion (35%) once and a lower proportion (15%) once. The distribution between the remaining three conditions was set to be equal.	a) Probability of COPD being cause of symptoms: 15%, 35%  b) Probability of obesity being cause of symptoms: 15%, 35%  c) Probability of heart failure being cause of symptoms: 15%, 35%  d) Probability of symptoms being	As there is no indication of what this distribution might be extreme values were run to cover a large range.

Analysis	Parameter	Description	Values	Comment
			acute: 15%, 35%	
S2	Sensitivity and specificity of bronchodilator reversibility	In the clinical review two papers were identified for bronchodilator reversibility that used the correct cut-off and had the right population. In the base case an average was taken of the two studies. This sensitivity analysis re-runs the model using both sources separately.	a) Sensitivity: 61% Specificity: 80%  b) Sensitivity: 17% Specificity: 61%	Diagnostic accuracy taken from Chhabra et al <sup>310</sup> and Kim et al <sup>861</sup>
S3	Sensitivity and specificity of FeNO	In the clinical review one other paper was identified for FeNO that used the 40ppb cut-off and had the right population. The model was re-run using these values.	Sensitivity: 79% Specificity: 89%	Diagnostic accuracy taken from Fukuhara 2012 <sup>529</sup>
S4	Sensitivity and specificity of MCT	In the clinical review one other study was identified for MCT that used the correct cut-off and had the right population. The model was re-run using these values.	Sensitivity: 97% Specificity: 83%	Diagnostic accuracy taken from Niemen 1992 <sup>1229</sup>
S5	Sensitivity and specificity of spirometry	In the clinical review one other study was identified for spirometry that used the correct cut-off and had the right population. The model was re-run using these values.	Sensitivity: 29% Specificity: 59%	Diagnostic accuracy taken from Schneider 2009 <sup>1519</sup>
S6	Probability of re-diagnosis for false positives.	This parameter was derived from clinical judgement as no data exists on what the real value is likely to be. Two scenarios were considered, one where re-diagnosis occurs much faster (probability of re-diagnosis is higher) and one where re-diagnosis occurs much slower (probability of re-	Probability of re-diagnosis is twice as likely, all relevant probabilities doubled.  Probability of re-diagnosis is more unlikely, all relevant probabilities halved.	As there is no indication of what this value might be extreme values were run to cover a wide range.

Analysis	Parameter	Description	Values	Comment
		diagnosis is lower).		
S7	Probability of re-diagnosis for false negatives	This parameter was derived from clinical judgement as no data exists on what the real value is likely to be. An assumption was made that a patient with asthma would always be diagnosed within a year. This assumption was tested by running the model twice, once where this value is halved and once where this value is doubled.	Maximum length of time for an asthmatic to remain undiagnosed:  6 months, 2 years	As there is no indication of what this value might be extreme values were run to cover a wide range.
S8	Cost of asthma medication for false positives	This parameter was derived by extrapolating from robust data on annual asthma costs. Two scenarios were considered: one where asthma treatment costs were 25% higher and one where asthma treatment costs were 25% lower.	Asthma treatment costs for patients with COPD: £218, £363  Asthma treatment costs for patients with acute symptoms: £135, £225  Asthma treatment costs for patients with obesity: £186, £311  Asthma treatment costs for patients with heart failure: £186, £311	As there is no indication of what this value might be extreme values were run to cover a wide range.
S9	Strength of dependence between PEFv and BDR	This parameter was derived from clinical judgement as no data could be found on its exact value. This value was increased to reflect the possibility of PEFv results being more conditionally dependent on the result from BDR.	Strength of dependence between BDR and PEFv: 0.5	As there is no indication of what this value might be extreme values were run to cover a wide range.
S10	Strength of dependence between challenge tests and BDR	This parameter was derived from clinical judgement as no data could be found on its exact value. This value was increased to reflect	Strength of dependence between histamine challenge test and BDR: 0.75	As there is no indication of what this value might be extreme values were run to cover a wide range.

Analysis	Parameter	Description	Values	Comment
		the possibility of challenge test results being more conditionally dependent on the result from a BDR test.		
S11	Strength of dependence between challenge tests and PEFv	This parameter was derived from clinical judgement as no data could be found on its exact value. This value was increased to reflect the possibility of challenge test results being more conditionally dependent on the result from PEFv.	Strength of dependence between histamine challenge test and PEFv: 0.75	As there is no indication of what this value might be extreme values were run to cover a wide range.
S12	Quality of life improvement for COPD patients being correctly treated for COPD as opposed to asthma.	This parameter was extrapolated from the literature using GDG opinion. Two sensitivities were run, one where QoL improvements for COPD patients are 50% higher and one where they are 50% lower.	QoL increase for a mild severity COPD patient being correctly treated: 0.01 – 0.06 QoL increase for a moderate COPD patient being correctly treated: 0.02 – 0.09	As there is no indication of what this value might be extreme values were run to cover a wide range.
S13	Quality of life improvement for heart failure patients being correctly treated for heart failure as opposed to asthma.	This parameter was extrapolated from the literature using GDG opinion. Two sensitivities were run, one where QoL improvements for heart failure patients are 50% higher and one where they are 50% lower.	QoL increase for a heart failure patient being correctly treated: 0.04 – 0.15	As there is no indication of what this value might be extreme values were run to cover a wide range.
S14	Re-diagnosis costs	This parameter was extrapolated using GDG opinion. Sensitivity was run where re-diagnosis costs only included one GP appointment. This can be seen as the minimum cost it could be.	Cost of re-diagnosis: £37	As there is no indication of what this value might be the lowest plausible estimate was used as an extreme value.
S15	Asthma prevalence	This parameter was derived from a meta-analysis. The model was re-run using the lower and upper limits of the 95% confidence	Asthma prevalence: 0.37, 0.43	

Analysis	Parameter	Description	Values	Comment
		interval.		
S16	Cost of methacholine challenge tests	A threshold analysis was run around the cost of methacholine challenge tests to see when treatment decisions would change.	Threshold analysis: Value run from £50 - £600	
S17	Conducting all primary care tests in one appointment	In the base case it was assumed that all primary care tests would be performed in one sitting. This sensitivity analysis adds the cost of one GP appointment to each primary care test	Cost of BDR, FeNO and PEFv increased by one GP appointment (£37)	
S18	Exacerbation rate for a untreated asthmatic	In the base case this value was based on weak data. For ethical reasons the exacerbation rate of an untreated asthmatic is unlikely to be known. The exacerbation rate for an untreated asthmatic will have an ambiguous effect on the model results as a high exacerbation rate is associated with disutility and a slightly higher mortality rate; however a high exacerbation rate means patients are re-diagnosed quicker which means a higher quality of life.	Threshold analysis: Exacerbation rate of untreated asthmatic run from 0.5 – 1.5.	As there is no indication of what this value might be extreme values were run to cover a wide range.
S19	Discount rate	Discount rate was changed from 3% for costs and QALYs to 1.5%. This is to reflect uncertainty around the true discount rate.	Discount rate: 1.5%	
S20	Probability that a heart failure patient retains an incorrect asthma diagnosis permanently	The GDG noted that even after the true cause of symptoms has been identified, some heart failure patients will incorrectly retain a diagnosis of asthma as the two diseases are not necessarily	Probability of heart failure patient retaining asthma diagnosis: 0%	

Analysis	Parameter	Description	Values	Comment
		mutually exclusive. In the base case this value was set as 25%. This assumption was removed in this sensitivity analysis.		
S21	Sensitivity and specificity of MCT	A two way sensitivity analysis was conducted on these two values running the diagnostic sensitivity from 90 – 98% and the specificity from 80 – 99%. This range covers the uncertainty surrounding what the diagnostic accuracy is of these tests in light of the clinical evidence and conditional dependence.	Sensitivity of MCT: 90-98%  Specificity of MCT: 80-99%	
S22	Cost of FeNO	The cost of FeNO was based on the assumption that the test would be used 300 times per year. The marginal cost of FeNO was varied under the assumption that the number of uses per machine could be much lower.	Threshold analysis: Value run from £10 - £100	

1

## 2 M.2.6 Interpreting Results

3 NICE's report 'Social value judgements: principles for the development of NICE guidance'<sup>1203</sup>  
 4 sets out the principles that GDGs should consider when judging whether an intervention  
 5 offers good value for money. In general, an intervention was considered to be cost-effective  
 6 if either of the following criteria applied (given that the estimate was considered plausible):

- 7 • The intervention dominated other relevant strategies (that is, it was both less costly in  
 8 terms of resource use and more clinically effective compared with all the other relevant  
 9 alternative strategies), or
- 10 • The intervention costs less than £20,000 per quality-adjusted life-year (QALY) gained  
 11 compared with the next best strategy.

12

13 As we have several interventions, we use the NMB to rank the strategies on the basis of their  
 14 relative cost-effectiveness. The highest NMB identifies the optimal strategy at a willingness  
 15 to pay of £20,000 per QALY gained.

## 1 M.2.7 Model validation

2 The model was developed in consultation with the GDG; model structure, inputs and results  
3 were presented to and discussed with the GDG for clinical validation and interpretation.

4 The model was systematically checked by the health economist undertaking the analysis;  
5 this included inputting null and extreme values and checking that results were plausible  
6 given inputs. The model was peer reviewed by a second experienced health economist from  
7 the NCGC; this included systematic checking all of the model calculations.

## 8 M.3 Results

### 9 M.3.1 Base case

10 The results below in **Table 256** show that diagnostic strategy 3 has the highest net monetary  
11 benefit and is therefore the most cost-effective way of diagnosing asthma. Strategy 6  
12 produces the highest number of QALYs however is not deemed cost-effective at a £20,000  
13 per QALY threshold. Strategy 1 produces the least QALYs and the highest cost.

14 **Table 256: Base case results (probabilistic)**

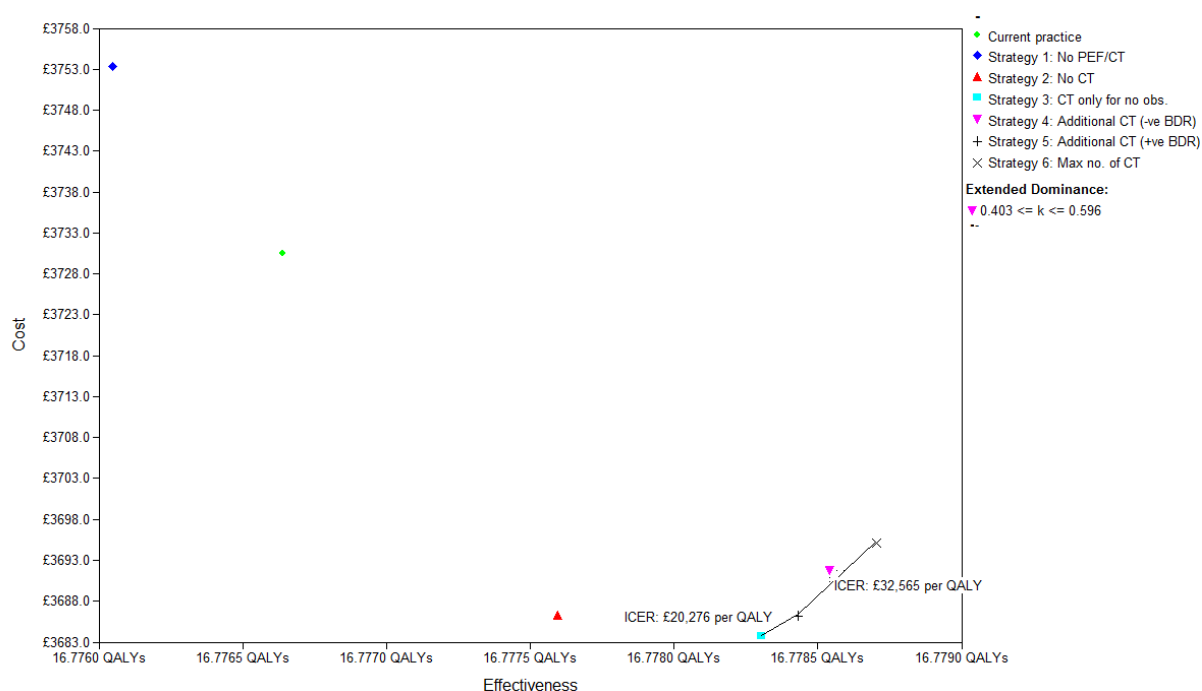
Strategy	Mean per patient		NMB at £20,000 threshold	Rank at £20,000 threshold	Probability of being CE at £20,000 threshold
	QALYs	Cost			
Current practice	16.7766	£3,730	£331,802	6	6%
Strategy 1	16.7760	£3,753	£331,768	7	0%
Strategy 2	16.7776	£3,686	£331,866	5	19%
Strategy 3	16.7783	£3,683	£331,882	1	44%
Strategy 4	16.7785	£3,691	£331,878	4	0%
Strategy 5	16.7784	£3,686	£331,881	2	23%
Strategy 6	16.7787	£3,695	£331,879	3	8%

15 (a) Full details on each strategy is covered in section M.2.1.1

16 **Figure 319** below shows the results from **Table 256** above on a cost-effectiveness plane. As  
17 you can see current practice and strategy 1 are dominated options, producing lower health  
18 gains at a higher cost relative to other strategies. Strategies 4 and 5 are extendedly  
19 dominated.



1 **Figure 319: Cost-effectiveness plane showing incremental costs and QALYs of each**  
 2 **individual strategy**



3  
 4 **Table 257** below shows the overall sensitivity and specificity of each diagnostic pathway,  
 5 that is the percentage of patients with asthma that receive a true positive diagnosis and the  
 6 percentage of patients without asthma that receive a true negative diagnosis.

7 **Table 257: Diagnostic accuracies of each strategy**

	Current practice	Strategy 1	Strategy 2	Strategy 3	Strategy 4	Strategy 5	Strategy 6
Sensitivity	100%	90.3%	89.3%	86.3%	88.7%	87.7%	90.3%
Specificity	65.8%	69.1%	82.4%	89.5%	89.4%	89.4%	89.4%

8 *Note: Accuracies rounded to one decimal place*

9 **Table 257** shows that no strategy has a single highest value for sensitivity and specificity  
 10 though strategy 6 has the highest diagnostic odds ratio. Finally Table 258 details the cost of  
 11 diagnostic tests associated with each strategy.

12 **Table 258: Cost of testing in each strategy**

	Current practice	Strategy 1	Strategy 2	Strategy 3	Strategy 4	Strategy 5	Strategy 6
Cost associated with diagnostic tests	£0	£42	£52	£92	£100	£95	£103

13 Table 258 shows that although the strategies that include challenge tests cost more the  
 14 increase in cost is far less than the cost of a single challenge tests as the majority of  
 15 individuals will not go on to receive one.

### M.3.2 Sensitivity analyses

The following sensitivity analyses were run deterministically. Of the 22 sensitivity analyses conducted, as detailed in section M.2.5, the following resulted in a change in conclusions of the model. All other sensitivity analyses led to no change in the cost-effectiveness rankings of the strategies and therefore the model is robust to changes in those parameters.

*S2a: Changing the sensitivity and specificity of BDR to 61% and 80% respectively.*

Table 259 below shows the results of just the non-dominated strategies. As you can see strategy 5 is now the most cost-effective strategy at a £20,000 per QALY threshold. This is because a higher sensitivity of BDR means that more patients with asthma will receive a positive BDR result. As the pathway continues after a positive BDR it becomes more cost-effective to continue testing after negative test results to ensure false negatives are kept to a minimum. Likewise now the specificity is higher, more non-asthmatics receive a negative BDR result; therefore it becomes less cost-effective to continue testing after negative BDR results as the number of false negatives is already quite low.

**Table 259: Results of sensitivity analysis S2a**

Strategy	Mean per patient		ICER (per QALY gained)
	QALYs	Cost	
Strategy 3 (CT only after no obs)	16.8355	£3,550	-
Strategy 5 (additional CT after -ve BDR)	16.8357	£3,552	£10,667
Strategy 6 (largest amount of CT)	16.8358	£3,561	£56,755

*S2b: Changing the sensitivity and specificity of BDR to 17% and 61% respectively.*

Table 260 below shows the results of just the non-dominated strategies. Now strategy 5 is extendedly dominated. As the sensitivity of BDR is much lower very few asthmatics receive a positive BDR result. Likewise the low specificity means that lots of non-asthmatics will receive a positive BDR result. After a positive BDR test the individual will receive a FeNO test. If the FeNO comes out negative then, with these BDR diagnostic accuracies, it is highly likely that the individual does not have asthma thus making challenge testing beyond this point less cost-effective. Likewise as the majority of asthmatics will receive a negative BDR result it will be more cost-effective to keep testing beyond this point to ensure these false negatives are rectified.

**Table 260: Results of sensitivity analysis S2b**

Strategy	Mean per patient		ICER (per QALY gained)
	QALYs	Cost	
Strategy 3 (CT only after no obs)	16.7838	£3,692	-
Strategy 4 (additional CT after -ve BDR)	16.7841	£3,699	£24,281
Strategy 6 (largest amount of CT)	16.7842	£3,703	£60,422

*S3: Changing the sensitivity and specificity of FeNO to 79% and 89% respectively.*

The results in Table 261 show that the only non-dominated strategies are strategy 2, 5 and 6. As the FeNO specificity is much higher it becomes less cost-effective to continue testing after a positive result. Therefore if the individual has a non-obstructive spirometry and a positive FeNO then it becomes less cost-effective to continue testing after that point. Likewise a lower sensitivity means it is more cost-effective to keep testing after a negative FeNO result to ensure false negative results are reversed. Taking these two points into account strategy 3 becomes less cost-effective and strategies 5 and 6 become more cost-effective causing strategy 3 to become extendedly dominated.

**Table 261: Results of sensitivity analysis S3**

Strategy	Mean per patient		ICER (per QALY gained)
	QALYs	Cost	
Strategy 2 (No CT)	16.7832	£3,659	-
Strategy 5 (additional CT after +ve BDR)	16.7838	£3,670	£19,307
Strategy 6 (largest amount of CT)	16.7843	£3,684	£28,691

*S4: Changing the sensitivity and specificity of MCT to 97% and 83% respectively*

The results in Table 262 show that the results from the base case are sensitive to changes in the diagnostic accuracy of a methacholine challenge test. In this sensitivity analysis the specificity is drastically decreased to 83%, from 99%. The sensitivity is increased however from 93% to 97%. As challenge tests are leading to fewer true negatives strategy 3 no longer dominates. It is worth noting that additional challenge tests after a bronchodilator reversibility test are no longer cost-effective. This is because although these additional challenge tests increase the sensitivity of the diagnostic pathway they now significantly reduce the specificity.

**Table 262: Results of sensitivity analysis S4**

Strategy	Mean per patient		ICER (per QALY gained)
	QALYs	Cost	
Strategy 2 (No CT)	16.7832	£3,692	-
Strategy 3 (CT only after no obs)	16.7838	£3,698	£8,530
Strategy 5 (additional CT after +ve BDR)	16.7840	£3,708	£62,477
Strategy 6 (largest amount of CT)	16.7840	£3,717	£170,957

*S15: Threshold analysis on the cost of methacholine challenge test.*

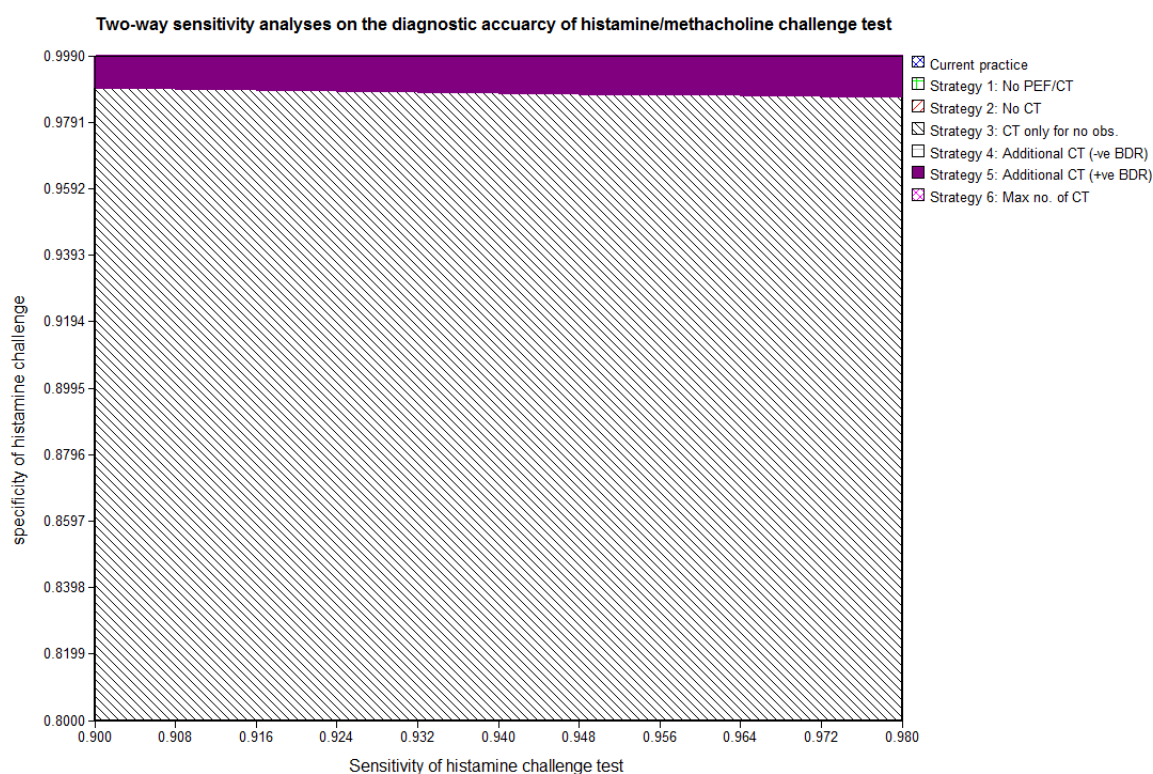
The sensitivity analysis showed that if the cost of a methacholine challenge test was £88 lower at £75 then strategy 6 (maximum number of challenge tests) becomes the new most cost-effective strategy. Likewise if the cost of the test was £87 higher at £240 then strategy 2 (no challenge tests) becomes the most cost-effective option. In reality as the methacholine challenge test is an infrequently used test; if this test was to be used more frequently then the costs could fall due to economies of scale. Therefore the likelihood of the test cost exceeding £240 is unlikely.

*S20: Two way sensitivity analysis on the sensitivity and specificity of MCT*

Figure 320 below shows the most cost-effective strategy for a range of different values used for the sensitivity and specificity of a MCT. The shaded colour indicates which strategy is

1 most cost-effective at particular co-ordinates on the graph, with sensitivity being on the x-  
 2 axis and specificity being on the y-axis. The graph shows that challenge tests stil cost-  
 3 effective if the sensitivity and specificity are far lower than the values used in the base case  
 4 (93% sensitivity and 99% specificity). There is no clinical evidence to suggest the values are  
 5 this low and conditional depondence would not cause the overall sensitivity AND specificity to  
 6 decrease.

7 **Figure 320: Two way sensitivity analysis on sensitivity and specificity of a MCT**



8  
 9 **S22: Changing the cost of FeNO**

10 The marginal cost of FeNO was taken from the recent NICE DAP as detailed in Table 248. This  
 11 marginal cost equated to £13.66 of which £6.36 was dedicated to the marginal cost per  
 12 patient for the equipment use. When the cost of FeNO increased above £93 none of the  
 13 diagnostic strategies were cost-effective at a £20,000 per QALY threshold and therefore  
 14 current practice became the most cost-effective strategy. If the cost of FeNO was £93 then  
 15 the cost-effective ranking of strategies remained unchanged. For the marginal cost of FeNO  
 16 to rise to £93 the machine would only be used approximately 28 times in a 5 year time span.  
 17 The GDG noted that even for small GP practices under the most conservative assumptions of  
 18 the number of new diagnoses made each year, this level of use would still be attainable.

19

## 1 M.4 Discussion

### 2 M.4.1 Summary of results

3 This analysis showed that providing challenge tests as part of a diagnostic pathway for  
4 individuals who present with asthma symptoms, have a non-obstructive spirometry and  
5 conflicting PEFv and FeNO results (strategy 3) is the most cost-effective strategy at a £20,000  
6 per QALY threshold. Further challenge testing on patients with an obstructive spirometry  
7 provided higher health outcomes however was not cost-effective at a £20,000 per QALY  
8 threshold. All other strategies were either dominated or extendedly dominated.

9 The sensitivity analyses show that there is an element of uncertainty regarding the use of  
10 challenge tests for individuals who have an obstructive spirometry. The value of these  
11 additional challenge tests (those detailed in strategies 4, 5 and 6) is contingent on the  
12 diagnostic accuracy of bronchodilator reversibility tests, FeNO and methacholine challenge  
13 tests. This level of uncertainty has been captured in the recommendations whereby these  
14 tests are considered but not routinely offered.

15 In all sensitivity analysis a diagnostic pathway that incorporated challenge testing was always  
16 a cost-effective strategy. This is despite the fact there are many aspects of the model  
17 that reduce the cost-effectiveness of challenge testing. For example it is assumed there is no  
18 mortality impact from falsely diagnosing individuals who have COPD and heart failure with  
19 asthma. Secondly the model does not cover all illnesses that could receive a false diagnosis  
20 of asthma. Conditions such as lung cancer and tuberculosis could have profound health  
21 consequences if misdiagnosed as asthma.

22 With regards to the routine use of challenge tests in asthma diagnosis for individuals with  
23 unobstructive spirometry (strategy 3) the model results are highly robust to changes in all  
24 key assumptions made within the model. Therefore although there is uncertainty regarding  
25 conditional dependence and the health and cost consequences of false diagnoses, solving  
26 this uncertainty will not change the conclusions of the model.

### 27 M.4.2 Limitations and interpretation

28 The main limitation with the model is the lack of clinical data available to inform some of the  
29 key parameters; mainly those surrounding misdiagnosis for non-asthmatics. To compensate  
30 for this, all the assumptions made have been conservative towards strategies that produce  
31 higher specificities. Firstly the model assumes that 50% of patients without asthma forego  
32 no quality of life from being diagnosed with asthma. In reality this number is likely to be an  
33 overestimate and there are likely to be some adverse effects of asthma medication as well  
34 that have not been captured. Secondly severe illnesses such as lung cancer have not been  
35 captured in this model which would have drastic quality of life impact if misdiagnosed as  
36 asthma. Finally no mortality effects have been captured for heart failure patients from  
37 foregoing correct treatment. All of this means that challenge testing for patients with non-  
38 obstructive spirometry is likely to be more cost-effective than is depicted in the model. It is  
39 worth noting that these limitations were extensively tested in the sensitivity analyses and  
40 challenge testing remained cost-effective at a £20,000 per QALY threshold in all of them.

41 Another limitation is that the evidence collected for the diagnostic accuracy of each test was  
42 not conducted in the appropriate subgroup of patients. For example in the diagnostic  
43 pathway ideally we would want to know the diagnostic accuracy of PEFv in a subgroup of  
44 patients who present symptoms of asthma and have no obstruction and a negative FeNO.

1 Instead the diagnostic accuracy was taken from a review on all patients who present asthma  
2 symptoms. This issue was tackled for the majority of tests, as detailed in section M.2.2.3,  
3 however conditional dependence was not fully incorporated for challenge tests in the  
4 model. A sensitivity analysis showed that both the sensitivity and specificity of a  
5 methacholine challenge test would have to decrease significantly to make them no longer  
6 cost-effective at a £20,000 per QALY threshold therefore indicating that conditional  
7 dependence is unlikely to have an impact of the model results.

### 9 **M.4.3 Generalisability to other populations or settings**

10 The results produced in this analysis are specific to a UK setting. To generalise the results to  
11 other countries the costs used and asthma prevalence parameter would need to be re-  
12 evaluated as these are likely to be country specific. Consideration also needs to be made as  
13 to how challenge tests are conducted. In this analysis it is assumed the GP refers the patient  
14 for the challenge test where it is performed and analysed in a secondary care setting. The  
15 results are then referred back to the GP where they discuss treatment options with the  
16 patient. Other methods of conducting the challenge test will have different cost implications  
17 and therefore make the results less generalizable to other settings.

18 It is worth noting that these results are not generalisable for children aged 16 or younger.  
19 The main reason for this is that the asthma prevalence in this population is very different. In  
20 a child population asthma is likely to be a much more common cause of a chronic cough. As  
21 asthma prevalence is higher this will increase the cost-effectiveness of more sensitive  
22 diagnostic strategies. Secondly children will not have other common conditions such COPD  
23 or heart failure for example. This will affect the final cost and health outcomes of each  
24 diagnostic strategy.

### 25 **M.4.4 Comparisons with published studies**

26 This is the first economic evaluation that addresses the cost-effectiveness of diagnostic  
27 pathways for diagnosing asthma. However other studies have attempted to assess the cost-  
28 effectiveness of asthma diagnostic tests on their own rather than as part of a pathway. To do  
29 this these studies have to make similar assumptions outlined in the methods above. Only  
30 one study attempts to do this and that is a study by Harnan et al.<sup>637</sup> The approach taken by  
31 Harnan et al was to assume that non-asthmatics had a disutility that remained until the  
32 correct diagnosis was made. This disutility was equal to the difference in quality of life  
33 between an asthmatic and a non-asthmatic. This approach attaches a much higher quality of  
34 life loss to incorrect diagnosis than the methods used in our model as it assumes all non-  
35 asthmatics will forego treatment that will cure them of their asthmatic symptoms. The  
36 approach by Harnan also overestimates the cost-savings to the NHS. If an individual is being  
37 treated for asthma then they forego correct medication, therefore the unnecessary asthma  
38 medication is a cost but there are savings being made by not prescribing the correct  
39 medication. The overall cost to the NHS from incorrectly prescribing asthma medication is  
40 therefore lower as money is not spent on the correct medication. Therefore relative to other  
41 methods the results produced in this analysis are much more conservative for strategies  
42 with higher specificities. As the results from Harnan et al are for singular diagnostic tests,  
43 their results are not comparable to the analysis presented above.

#### 1 **M.4.5 Conclusions**

2 The main conclusion to be drawn from this model is that there is a place for routine  
3 challenge testing in a diagnostic pathway, despite its initial high cost. This is because its  
4 initial high costs are then offset by reduced unnecessary asthma management and a gain in  
5 QALYs. This conclusion was robust to a wide range of sensitivity analyses. A second  
6 important conclusion is that there is scope for further challenge tests, conducted on patients  
7 further down the pathway after an obstructive spirometry, to be cost-effective at a £20,000  
8 per QALY threshold. In the base case the ICER for providing these extra challenge tests was  
9 £32,565 per QALY. However the sensitivity analyses showed there were some scenarios  
10 where it was cost-effective to do extra challenge tests, particularly for individuals who  
11 receive a positive bronchodilator result. The GDG believed further challenge tests would be  
12 cost-effective in some situations. For example if another diagnosis, such as COPD, is  
13 considered likely then further challenge testing should not be considered. Therefore these  
14 additional challenge tests should not be routinely carried out, unlike those placed in strategy  
15 3.

#### 16 **M.4.6 Implications for future research**

17 Areas in the model that were most uncertain are difficult to resolve with further research  
18 due to ethical implications. For example the difference in quality of life between treated and  
19 untreated patients with asthma, or the quality of life lost by treating a heart failure patient  
20 with asthma medication. Although there was considerable uncertainty surrounding some  
21 diagnostic accuracies and conditional dependence the model results were robust to large  
22 changes in these parameters. Therefore additional research in these areas will not lead to  
23 any changes in management. One key area of uncertainty revolved around the diagnostic  
24 accuracy of mannitol. There was limited evidence on the diagnostic accuracy of mannitol and  
25 it is a cheaper test to perform relative to other challenge tests. There is also scope for  
26 mannitol to be conducted in primary care. If mannitol was proven to have a higher  
27 sensitivity and specificity then it could be a more cost-effective replacement for  
28 methacholine in the diagnostic pathway.  
29

# Appendix N: Research recommendations

## N.1 High-priority research recommendations

**N.1.1.1 Research question 1:** What is the acceptability and diagnostic accuracy of objective tests that could be used to comprise a diagnostic pathway for asthma in children and young people aged 5 to 16 (for example, exercise challenge, direct bronchial challenge with histamine or methacholine, indirect bronchial challenge with mannitol and peripheral blood eosinophil count)?

**Why this is important:** Asthma is a common condition, diagnosed in nearly 1 in 10 children. There are no validated and reliable objective criteria for diagnosing asthma, so the vast majority of asthma diagnoses are currently based on symptoms and signs. However, symptoms and signs consistent with a diagnosis of asthma are not specific to the condition and can be present in other illnesses. This diagnostic uncertainty results in many children being incorrectly diagnosed with asthma, and many children with asthma in whom the diagnosis is delayed or missed. A single objective measure, or set of objective measures, that can be performed easily in non-specialist clinical settings (although it is noted that challenge tests need to be performed in specialist settings) will help improve diagnostic certainty and reduce the proportion of children treated inappropriately for asthma. This would ensure that children with the condition are identified and treated early.

### Criteria for selecting high-priority research recommendations:

PICO question	<p><b>Population:</b> Children aged 5-16 years with respiratory symptoms.</p> <p><b>Index test:</b> Exercise challenge, direct bronchial challenge with histamine or methacholine, indirect bronchial challenge with mannitol and peripheral blood eosinophil count.</p> <p><b>Reference standard:</b> Physician diagnosis of asthma with an objective test (e.g. spirometry +/- BDR and FeNO test).</p> <p><b>Outcome:</b> Diagnostic accuracy (sensitivity and specificity); serious adverse events; adverse events.</p>
Importance to patients or the population	Correct and timely diagnosis of asthma in children will lead to appropriate treatment and improve patient outcomes.
Relevance to NICE guidance	Data from this research question will improve the sensitivity and specificity of the diagnostic algorithm in a future update of the NICE guideline.
Relevance to the NHS	Appropriate identification of children with asthma will reduce over-diagnosis and result in a reduction of inappropriate treatment. This will result in cost savings to the NHS.
National priorities	This is appropriate for the priority areas of improved management of long term conditions and reduction in respiratory morbidity and mortality.
Current evidence base	There is very little high quality data available on objective tests for the diagnosis of asthma in children aged 5-16 years. The current data available are inconsistent and are of limited utility in setting clear objective measurements in this age group.
Equality	n/a
Study design	This requires primary research in children who have clinical respiratory illnesses. Cross-sectional studies would be used for the assessment of the diagnostic accuracy of one (or a combination) of objective tests in the diagnosis of asthma or non-asthma, as determined by the reference standard. Randomised controlled trials could also be used to compare the downstream effects of test



	accuracy on patient outcomes.
Feasibility	Most secondary and tertiary clinical facilities will be able to participate in a multicentre study which would allow the rapid recruitment of the required number of children to give clear answers to the research question.
Other comments	Asthma is one of the most common clinical diagnoses made in children and leads to the prescription and consumption of preventive drugs that have known side-effects. Reduction in incorrect diagnosis of asthma could be viewed as a public health measure and the studies suggested would reduce the drug-load and cost-burden of unnecessary drugs.
Importance	<ul style="list-style-type: none"> <li>High: the research is essential to inform future updates of key recommendations in the guideline.</li> </ul>

1 **N.1.1.2 Research question 2:** What is the clinical and cost effectiveness of using an indirect  
2 bronchial challenge test with mannitol to diagnose asthma in adults (aged 17 and over)?

3 **Why this is important:** Chronic airway inflammation is associated with bronchial hyper-  
4 responsiveness, which is integral to defining asthma. Bronchial challenge testing can help  
5 diagnose asthma and assess response to inhaled corticosteroid therapy. It can also be used  
6 to monitor asthma control, alongside assessing symptoms and lung function. It is  
7 increasingly used in asthma management, although currently most tests are performed only  
8 in specialised centres or research settings.

9 Indirect challenge tests with inhaled mannitol act via active inflammatory cells and  
10 mediators, whereas direct challenge tests with inhaled histamine or methacholine act  
11 directly on bronchial smooth muscle. Indirect challenge testing is more specific but less  
12 sensitive than direct challenges.

13 Direct challenge testing may not identify a person who will respond to inhaled steroids. A  
14 positive result to an indirect challenge may reflect active airway inflammation that is likely to  
15 respond to inhaled corticosteroid therapy. Because a response to mannitol indicates active  
16 airway inflammation, identifying non-responsiveness in treated patients may help  
17 demonstrate good asthma control with inhaled corticosteroid therapy and identify people  
18 less likely to deteriorate after a dose reduction.

19 Mannitol bronchial challenge testing is quicker and simpler than current direct tests (which  
20 are generally confined to specialist respiratory centres), and uses a standardised inhaler  
21 device, so is potentially more useful in primary care.

22 **Criteria for selecting high-priority research recommendations:**

PICO question	<p><b>Population:</b> Adults and young people aged over 16 years with respiratory symptoms.</p> <p><b>Index test:</b> Indirect BCT with mannitol.</p> <p><b>Comparison:</b> Direct BCT with histamine or methacholine.</p> <p><b>Reference standard:</b> Physician diagnosis of asthma with an objective test.</p> <p><b>Outcome:</b> Diagnostic accuracy (sensitivity and specificity); adverse events.</p>
Importance to patients or the population	<p>Asthma is a treatable, but as yet incurable, chronic inflammatory condition of the lungs. A number of recent studies and reports highlight significant variations in the standard of care across the country with evidence that poor quality care is associated with worse outcomes, poorer quality of life and increased healthcare utilisation.</p> <p>Asthma is one of the most prevalent long-term conditions in the UK. It affects 5.4 million people, is a leading cause of avoidable hospital admissions, and is responsible for more than £1 billion of NHS spending every year. Premature</p>

	mortality rates from asthma are over 1.5 times higher in the UK than in the rest of Europe, but there is no reason why the standard of care in the UK should be any lower than that of other European countries. <sup>423,1911</sup>
Relevance to NICE guidance	Clarification of the role of mannitol BCT both in terms of diagnostic accuracy compared to direct BCTs and as a potential tool in the monitoring of asthma would allow the NICE guideline on the diagnosis and monitoring of asthma to make firm recommendations regarding its use in clinical practice.
Relevance to the NHS	Asthma continues to result in a significant number of avoidable deaths, admissions and quality of life impairment, all with associated costs. Better diagnosis and monitoring of asthma will reduce healthcare utilisation, reduce the economic burden to the NHS and improve quality of life to people with asthma.
National priorities	The NHS Atlas of Variation in Healthcare demonstrates that there is significant variation in health outcomes for asthma across the NHS in England. The National Review of Asthma Deaths (NRAD) <sup>1473</sup> identified a number of quality and safety concerns related to the provision of asthma care in the UK. It raised particular concern around standards in primary care concluding that there was an urgent need to tackle 'complacency' about asthma.
Current evidence base	Indirect BCTs (such as mannitol) are more specific, though less sensitive, than direct BCT (such as methacholine, histamine) for identifying patients with active asthma. The potential for monitoring asthma with airway hyper-responsiveness is of particular interest to clinicians. Sont el al. demonstrated that management of asthma therapy based on reducing BHR in conjunction with symptoms and lung function leads to more effective control of asthma than management based on symptom control alone. The current evidence base suggests bronchial challenge testing is useful in the diagnosis of asthma. Mannitol BCT has high specificity for the diagnosis of asthma, although the sensitivity is only moderate when compared to direct BCTs (e.g. methacholine, histamine). The clinical efficacy and cost-effectiveness of mannitol BCT within a diagnostic algorithm for suspected asthma requires more research particularly in patients not receiving inhaled corticosteroids (ICS). The potential use of the mannitol challenge to assist monitoring of asthma in clinical practice is also of particular interest with respect to facilitating down titration of ICS and worthy of further research. The mannitol BCT provides a standardised, reproducible, rapid and simple test that does not require specialised equipment and may have some practical advantages, particularly for use in primary care.
Equality	Asthma affects all ages and ethnic groups, and the design of the research needs to encompass this.
Study design	Appropriately designed and powered real world randomised controlled trials: a) comparing mannitol BCT to direct BCT in the diagnosis of asthma in adults. b) comparing mannitol BCT to current recommended guideline based approach in the monitoring of asthma in adults. Particularly important outcome measures will include healthcare utilisation, exacerbation frequency, cumulative steroid burden (oral and inhaled) and cost-effectiveness.
Feasibility	Asthma is very common and uncontrolled in over half of all patients. Mannitol BCT was developed to solve some of the practical issues associated with other BCTs and to make BCTs more widely available to clinicians. It is feasible and practical to recommend future research in this area.
Other comments	None.
Importance	<ul style="list-style-type: none"> <li>High: the research is essential to inform future updates of key</li> </ul>

recommendations in the guideline.

1 **N.1.1.3 Research question 3:** What is the clinical and cost effectiveness of using electronic alert  
2 systems designed to monitor and improve adherence with regular inhaled maintenance  
3 therapy in people with asthma?

4 **Why this is important:** Adherence with regular maintenance inhaled corticosteroids, on  
5 their own or in combination with long-acting beta agonists, is of paramount importance to  
6 achieve control of asthma and prevent asthma attacks. Published evidence in patients with  
7 severe asthma suggests that at least 30% of patients are partially or non-adherent with their  
8 prescribed medications<sup>1181</sup>, and the Royal College of Physicians' National Review of Asthma  
9 Deaths(NRAD)<sup>1473</sup> demonstrated that poor adherence was associated with 38% of asthma  
10 deaths.

11 **Criteria for selecting high-priority research recommendations:**

PICO question	<p><b>Population:</b> Adults, children and young people with mild to moderate asthma.</p> <p><b>Intervention:</b> Monitoring adherence using different technologies/devices (eg prescription and refill monitoring systems; electronic monitoring inhalers).</p> <p><b>Comparison:</b> Usual care; different frequencies of monitoring adherence using different technologies/devices.</p> <p><b>Outcomes:</b> Mortality; QoL; exacerbations; unscheduled healthcare utilisation; adherence; asthma control.</p>
Importance to patients or the population	<p>Adherence with regular inhaled asthma therapies is suboptimal in a significant proportion of patients with asthma. Targetted intervention studies, that have improved adherence, have demonstrated a significant improvement in asthma control and reduced healthcare utilisation.</p> <p>Asthma outcomes have not improved in the last 15 years and the personal and economic costs of poor control are high. The efficient use of systems to monitor adherence and improve patient adherence and outcomes via feedback mechanisms, and the integration of these new technologies into healthcare are important for patients and for healthcare systems in terms of convenience, costs and outcomes.</p>
Relevance to NICE guidance	<p>Identification of clinically and cost-effective methods of monitoring adherence will allow the NICE guideline on Asthma: Diagnosis and Monitoring to make recommendations on the appropriate use of adherence monitoring strategies in NHS care.</p>
Relevance to the NHS	<p>Asthma continues to lead to avoidable deaths and considerable unscheduled health care utilization. Improved adherence with prescribed therapies will have a significant impact on health care utilization and improve asthma related quality of life.</p>
National priorities	<p>Reducing mortality considered amenable to healthcare is the overarching indicator of Domain 1 of the NHS Outcomes Framework, and poor adherence has been identified in the national review of Asthma deaths as a potentially avoidable factor in asthma deaths. Improving outcomes in asthma are highlighted in the National Strategy in COPD and Asthma as a national priority.</p>
Current evidence base	<p>There is a very limited current evidence base on the best monitoring method to monitor and feedback on a person's adherence to asthma maintenance therapy, in order to improve patient outcomes of QOL, morbidity and mortality. The majority of published studies have been conducted in patients with severe asthma, which comprise less than 5% of the asthma population.</p> <p>Further research is required to determine the optimal method of monitoring adherence for improving adherence and patient outcomes, particularly in people with mild to moderate asthma.</p>

Equality	Asthma affects all ages and ethnic groups, and the design of the research needs to encompass this. In particular, the study of adherence monitoring interventions needs to ensure that the programmes are accessible to those with learning and physical disabilities, non-English speakers, different age groups and those with health literacy problems.
Study design	Cluster randomised controlled trials comparing monitoring adherence using different technologies/devices. Implicit in the investigation of the best monitoring method or device, is that poor adherers will be detected and feedback will improve adherence to controller medication and therefore improve patient outcomes and asthma control. A range of studies may be needed, including 'efficacy' trials and more pragmatic 'real-world' effectiveness and implementation trials. Studies will need to compare the different devices/strategies that are currently available to monitor adherence and feedback this information to patients with the aim of improving adherence and patient outcomes. Studies need to include health economic evaluation and be of sufficient duration to confirm persistence of benefit (minimum of 12 months). Studies should be adequately powered to detect sub-groups who are likely to respond or not respond to this strategy.
Feasibility	Asthma is common and uncontrolled in over half of all patients. Multiple different technologies to monitor adherence are already available.
Other comments	There are commercial implications to technologies designed to monitor adherence and commercial partnership is possible. Intellectual property rights issues will need to be considered.
Importance	<ul style="list-style-type: none"> <li>High: the research is essential to inform future updates of key recommendations in the guideline.</li> </ul>

1 **N.1.1.4 Research question 4:** What is the current frequency and the current method being used to  
 2 check the inhaler technique of people with asthma? What is the optimal frequency and the  
 3 best method of checking inhaler technique to improve clinical outcomes for people with  
 4 asthma?

5 **Why this is important:** Knowing and understanding how to use an inhaler properly is the  
 6 cornerstone of asthma management and symptom control. There has been an increase in  
 7 the types of inhaler devices and the types of delivery system available. The various types of  
 8 drugs for asthma control are also available in different inhaler devices on their own and in a  
 9 combination of 2 drugs. It is therefore vital for patients to learn the proper inhaler technique  
 10 for their device to ensure optimum drug delivery to the lungs for asthma control.

11 **Criteria for selecting high-priority research recommendations:**

PICO question	<p><b>Population:</b> Adults, children and young people aged 5-16 years with a confirmed diagnosis of asthma; children 0-5 years with recurrent wheeze.</p> <p><b>Intervention:</b> Electronic devices to monitor inhaler technique; visual assessment by doctor, nurse or pharmacist.</p> <p><b>Comparison:</b> Different frequencies of monitoring inhaler technique; monitoring using electronic devices vs. monitoring by visual assessment.</p> <p><b>Outcomes:</b> Mortality; QoL; exacerbations; unscheduled healthcare utilisation; adherence; asthma control.</p>
Importance to patients or the population	Proper inhaler technique for optimum drug delivery to the lungs of people with asthma is vital for asthma control. Asthma exacerbations can occur frequently if not properly controlled. This has a significant impact on the quality of life and constitutes a considerable healthcare burden with pressures on secondary care emergency departments. There is a lack of objective evidence that regular review of inhaler technique improves asthma control and reduces exacerbations.

	<p>This is important because checking inhaler technique is a simple intervention that if effective could result in lower doses of inhaled steroids to control the asthma and in a reduction of acute exacerbations.</p>
Relevance to NICE guidance	<p>The answer to this question will allow NICE to make a definitive statement on the optimal frequency and the best method of checking inhaler technique to improve clinical outcome for people with asthma.</p>
Relevance to the NHS	<p>Acute asthma attacks are one of the commonest reasons for visits to hospital emergency departments. The most expensive expenditure for the NHS is on prescribing the inhaled drugs used for respiratory conditions. It is estimated that the top three most expensive drugs in the NHS are inhalers. It is important to teach patients with asthma the correct technique for using their inhalers. It is equally important to review their inhaler technique regularly. Current guidance is to check the patient's inhaler technique annually. The inhalers should only be prescribed after patient has received training in the use of the device and have demonstrated satisfactory technique.</p> <p>Satisfactory understanding of individual inhaler techniques and regular checking by the clinicians and pharmacists is vital to improving clinical outcomes for control of asthma.</p>
National priorities	<p>The intervention is simple and could result in better asthma control without increasing medication use. The 'prescribing and medicine uses' recommendation from NRAD (National Review of Asthma Deaths)<sup>1473</sup> is to assess inhaler technique routinely and formally document at every annual review. It should also be checked by the pharmacist when a new device is dispensed.</p>
Current evidence base	<p>There is a lack of good quality data available. Different studies used non-standardised scores making comparisons difficult. Teaching inhaler technique has been shown to improve correct usage but it is less clear if that leads to improved asthma control.</p> <p>For 'monitoring inhaler technique vs no monitoring' evidence was only available in adults from one small RCT and evidence was of low and very low quality for all outcomes.</p> <p>For 'Monitoring using an electronic training device and physician feedback compared to physician feedback only', evidence in adults was available from 2 studies, and in children from 1 study. Evidence for all outcomes was of low and very low quality.</p> <p>Based on the NRAD report, people with asthma who are unable to use their inhaler correctly are at risk of poor asthma control, potentially resulting in an asthma attack. It is recorded in the report that only 96 out of 135 (71%) patients had an assessment of inhaler technique.</p>
Equality	<p>Asthma affects all ages and ethnic groups, and the design of the research needs to encompass this. In particular, the study needs to ensure that the programmes are accessible to those with learning and physical disabilities, non-English speakers, different age groups and those with health literacy problems.</p>
Study design	<p>A systematic review is needed first to elucidate the current frequency and the current method being used to check inhaler technique. This will inform randomised control trials to investigate the optimal frequency and best method of checking inhaler technique.</p>
Feasibility	<p>Due to the multiple different types of inhaler currently available it will be difficult to develop a single study to answer this critical research question. However, it will be possible to look at dry powder and metered dose inhalers separately to address the issues of how best to teach inhaler technique and the optimal frequency for monitoring it.</p> <p>All primary and secondary care facilities will be able to participate in a multicentre study which would allow the rapid recruitment of the required number of participants to give a clear answer to the research question.</p>

Other comments	It is important to study simple techniques that improve control without increases in steroid medication. Trials to check inhaler technique for monitoring asthma control will attract commercial sponsors. However given the size of the problem, the potential impact to the patients and the NHS and the favourable policy context, a high quality study addressing this question would be an appropriate target for NIHR funding.
Importance	<ul style="list-style-type: none"> <li>High: the research is essential to inform future updates of key recommendations in the guideline.</li> </ul>

1 **N.1.1.5 Research question 5:** What is the long-term (more than 12 months) clinical and cost  
 2 effectiveness of using tele-healthcare as a means to monitor asthma control in adults, young  
 3 people and children? Methods of tele-healthcare can include telephone interview (with  
 4 healthcare professional involvement) and internet or smartphone-based monitoring support  
 5 (no healthcare professional involvement).

6 **Why this is important:** Asthma outcomes have not improved in the past 15 years, and the  
 7 personal and economic costs of poor control are high. Computers and smartphones play an  
 8 ever-greater role in modern life, with a growing proportion of people using them regularly  
 9 for work, leisure, communication and information. The efficient use of distance monitoring  
 10 systems and the integration of new technologies into healthcare are important for patients  
 11 and for healthcare systems in terms of convenience, costs and outcomes.

12 **Criteria for selecting high-priority research recommendations:**

PICO question	<p><b>Population:</b> Adults, children and young people with a confirmed diagnosis of asthma.</p> <p><b>Intervention:</b> Monitoring asthma control using telephone interview with a healthcare professional and internet/smartphone-based monitoring support.</p> <p><b>Comparison:</b> Usual care; monitoring asthma control with healthcare professional involvement e.g. telephone interview vs. monitoring asthma control with no healthcare professional involvement e.g. internet/smartphone-based monitoring support.</p> <p><b>Outcome:</b> Mortality; QoL; exacerbations; unscheduled healthcare utilisation; adherence; asthma control.</p>
Importance to patients or the population	Asthma is a long-term and incurable condition, and outcomes remain sub-optimal. Regular monitoring and self-management are recommended in guidelines to improve outcomes, but can be difficult to achieve in practice. New technologies can be used to improve communication between patient and clinician and to provide individualised education and self-management support.
Relevance to NICE guidance	Clarification of the role of tele-healthcare in asthma will allow the NICE guidelines relating to the diagnosis and monitoring of asthma to make recommendations on the appropriate use of tele-healthcare strategies in NHS care.
Relevance to the NHS	Asthma continues to result in avoidable deaths, admissions and quality of life impairment, all with associated costs. More efficient monitoring can allow proactive care to prevent adverse outcomes and so potentially reduces health resource use and costs by more efficient care.
National priorities	Reducing mortality considered amenable to healthcare is the overarching indicator of Domain 1 of the NHS Outcomes Framework, and inadequate monitoring has been identified in the national review of Asthma deaths as a potentially avoidable factor in asthma deaths. Improving outcomes in asthma are highlighted in the National Strategy in COPD and Asthma as a national priority.

Current evidence base	The current evidence base of tele-healthcare in asthma is inadequate and contradictory; some studies have indicated potential benefits, but some have not. Further research is required to identify the modality of tele-healthcare that is most effective (e.g. telephone support, internet/smartphone based monitoring and self-management support), qualifying the acceptability, benefits, risks and costs associated with different programmes in different patient groups.
Equality	Asthma affects all ages and ethnic groups, and the design of the research needs to encompass this. In particular, the study of digital technology interventions needs to ensure that the programmes are accessible to those with learning and physical disabilities, non-English speakers, different age groups and those with health literacy problems.
Study design	Appropriately designed and powered randomised controlled trials comparing tele-healthcare interventions with usual care and with other monitoring strategies. A range of studies may be needed, including 'efficacy' trials and more pragmatic 'real-world' effectiveness and implementation trials. Cluster randomisation is likely to be needed to prevent 'contamination' of control groups. Studies need to include health economic evaluation and be of sufficient length to confirm persistence of benefit (minimum of 12 months). Studies should be adequately powered to detect sub-groups who are likely to respond or not respond to this strategy.
Feasibility	Asthma is very common and uncontrolled in over half of all patients. With technological advances, access to tele-healthcare and digital technologies is common and relatively inexpensive.
Other comments	There are potential commercial implications to tele-healthcare monitoring systems, and commercial partnership is possible. IPR issues will need to be carefully considered.
Importance	<ul style="list-style-type: none"> <li>• High: the research is essential to inform future updates of key recommendations in the guideline.</li> </ul>

## N.2 Other research recommendations

6. What is the clinical and cost effectiveness of using validated quality of life questionnaires and the RCP 3 Questions as tools to monitor asthma control in adults and young people aged over 16 years?
7. What is the clinical and cost effectiveness of using validated paediatric questionnaires to monitor asthma control in children aged 5-16 years old with asthma?
8. What is the clinical and cost effectiveness of using blood eosinophils as a tool to monitor asthma control?
9. Which patient groups are likely to benefit from FeNO monitoring to guide asthma management, for example, individuals with atopy, frequent asthma attacks, poor adherence?
10. What is the clinical and cost effectiveness of FeNO-guided monitoring of asthma in real-world settings?

# Appendix O: Contributors to the guideline

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- Sarah Willett – Guideline Lead
- Martin Allaby – Clinical Adviser
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- Judith Thornton – Technical Lead
- Ross Maconachie – Health Economist
- Gareth Haman – Editor

## Stakeholders

- Aerocrine
- Alder Hey Children’s Hospital, Liverpool
- Association for Respiratory Technology & Physiology (incorporating the views of the Global Lung Initiative Group)
- Association of Respiratory Nurse Specialists
- Asthma UK
- Astrazeneca
- Boehringer Ingelheim Ltd
- British Medical Association
- British Paediatric Respiratory Society
- British Society for Allergy & Clinical Immunology
- British Thoracic Society
- Cochrane Airways Group
- Department of Health
- Department of Health, Social Services and Public Safety - Northern Ireland
- DGH
- Digital Assessment Service, NHS Choices
- Durham Dales, Easington and Sedgfield
- Education for Health
- Faculty of Pharmaceutical Medicine
- Faculty of Sport and Exercise Medicine
- Group of Occupational Respiratory Disease Specialists
- HQT Diagnostics
- Leeds Teaching Hospitals NHS Trust
- London Respiratory Network
- Manchester University
- Mid Yorkshire NHS Trust
- Napp Pharmaceuticals
- National Inhaler Group



- 1 • National Paediatric Respiratory and Allergy Nurses Group (NPRANG)
- 2 • Neonatal and Paediatric Pharmacists Group (NPPG)
- 3 • News reporter for GP Magazine David Millett
- 4 • NHS England
- 5 • NHS Stockport CCG
- 6 • NORTH EAST LONDON FOUNDATION TRUST
- 7 • North West Severe Asthma Network
- 8 • Novartis Pharmaceuticals UK Ltd
- 9 • Orion Pharma UK Ltd
- 10 • Oxford Centre for Respiratory Medicine
- 11 • Primary Care Respiratory Society UK
- 12 • RCP NRAD 2014 Clinical Lead
- 13 • Royal College of General Practitioners
- 14 • Royal College of Nursing
- 15 • Royal College of Paediatrics and Child Health
- 16 • Royal College of Pathologists
- 17 • Royal College of Physicians
- 18 • Scottish Intercollegiate Guidelines Network (SIGN)
- 19 • South eastern Hampshire CCG
- 20 • The Anaphylaxis Campaign
- 21 • The National Allergy Strategy Group
- 22 • Thermo Fisher Scientific
- 23 • UHL
- 24 • United Kingdom Clinical Pharmacy Association Respiratory Group

## Appendix P: References

- 1 N0411013273 - A randomised controlled trial of benefits of specialist review or telephone follow up after an Accident and Emergency attendance for asthma. [Clinical trial]. 1997
- 2 Impact of a telecommunication system in childhood asthma. [Clinical trial]. 1999. Available from: [http://projectreporter.nih.gov/project\\_info\\_details.cfm?aid=6185659&icde=0](http://projectreporter.nih.gov/project_info_details.cfm?aid=6185659&icde=0) [Last accessed: 10 November 2014]
- 3 N0016132017 - Proposal to study whether we can reduce hospital attendance by those with respiratory conditions without compromising care by the use of telephone consultation. [Clinical trial]. 2003
- 4 Peak expiratory flow rate does not predict asthma exacerbations. *Journal of Family Practice*. 2004; 53(8):608
- 5 N0702196597 - Self-management of chronic conditions using telemedicine. [Clinical trial]. 2006
- 6 Aaron SD, Vandemheen KL, Boulet LP, McIvor RA, Fitzgerald JM, Hernandez P et al. Overdiagnosis of asthma in obese and nonobese adults. *Canadian Medical Association Journal*. 2008; 179(11):1121-1131
- 7 Abdulmir AS, Hafidh RR, Abubakar F. Different inflammatory mechanisms in lungs of severe and mild asthma: Crosstalk of NF-kappa-B, TGFbeta1, Bax, Bcl-2, IL-4 and IgE. *Scandinavian Journal of Clinical and Laboratory Investigation*. 2009; 69(4):487-495
- 8 Abraham CM, Ownby DR, Peterson EL, Wegienka G, Zoratti EM, Williams LK et al. The relationship between seroatopy and symptoms of either allergic rhinitis or asthma. *Journal of Allergy and Clinical Immunology*. 2007; 119(5):1099-1104
- 9 Abramson M, Kutin J, Bowes G. The prevalence of asthma in Victorian adults. *Australian and New Zealand Journal of Medicine*. 1992; 22(4):358-363
- 10 Abramson M, Kutin J, Czarny D, Walters EH. The prevalence of asthma and respiratory symptoms among young adults: is it increasing in Australia? *Journal of Asthma*. 1996; 33(3):189-196
- 11 Abramson MJ, Schattner RL, Holton C, Simpson P, Briggs N, Beilby J et al. Spirometry and regular follow-up do not improve outcomes in children or adolescents with asthma. *Respirology*. 2012; 17:50
- 12 Abramson M, Matheson M, Wharton C, Sim M, Walters EH. Prevalence of respiratory symptoms related to chronic obstructive pulmonary disease and asthma among middle aged and older adults. *Respirology*. 2002; 7(4):325-331
- 13 Abramson MJ, Schattner RL, Sulaiman ND, Birch KE, Simpson PP, Del Colle EA et al. Do spirometry and regular follow-up improve health outcomes in general practice patients with asthma or COPD? A cluster randomised controlled trial. *Medical Journal of Australia*. 2010; 193(2):104-109

- 1 14 Abut L, Ozerol I, Apan T. Total and specific IgE in the sera of patients with asthma,  
2 urticaria, or allergic rhinitis from the Southeast Anatolia region of Turkey. *Laboratory*  
3 *Medicine*. 2007; 38(10):621-623
- 4 15 Adams RJ, Boath K, Homan S, Campbell DA, Ruffin RE. A randomized trial of peak-flow  
5 and symptom-based action plans in adults with moderate-to-severe asthma.  
6 *Respirology*. 2001; 6(4):297-304
- 7 16 Adams RJ, Ruffin RE, Smith BJ. Validity of a modified version of the Marks Asthma  
8 Quality of Life Questionnaire. *Journal of Asthma*. 2000; 37(2):131-143
- 9 17 Adams RJ, Wilson DH, Appleton S, Taylor A, Dal Grande E, Chittleborough CR et al.  
10 Underdiagnosed asthma in South Australia. *Thorax*. 2003; 58(10):846-850
- 11 18 Adjami M, Hooshiar B, Rafiee A, Ghafari J, Ajami A. Serum level of IL-6 and IL-8 in  
12 severe and mild asthma. *Allergy*. 2011; 66:518
- 13 19 Adler TR, Beall GN, Heiner DC. Immunologic and clinical correlates of bronchial  
14 challenge responses to Bermuda grass pollen extracts. *Journal of Allergy and Clinical*  
15 *Immunology*. 1985; 75(1 Pt.1):31-36
- 16 20 Agata H, Yomo A, Hanashiro Y, Muraki T, Kondo N, Orii T. Comparison of the MAST  
17 chemiluminescent assay system with RAST and skin tests in allergic children. *Annals of*  
18 *Allergy*. 1993; 70(2):153-157
- 19 21 Aggarwal AN, Gupta D, Kumar V, Jindal SK. Assessment of diurnal variability of peak  
20 expiratory flow in stable asthmatics. *Journal of Asthma*. 2002; 39(6):487-491
- 21 22 Ahlstedt S, Eriksson N, Lindgren S, Roth A. Specific IgE determination by RAST  
22 compared with skin and provocation tests in allergy diagnosis with birch pollen,  
23 timothy pollen and dog epithelium allergens. *Clinical Allergy*. 1974; 4(2):131-140
- 24 23 Ahmad Al Obaidi AH, Mohamed Al Samarai AG, Yahya Al Samarai AK, Al Janabi JM. The  
25 predictive value of IgE as biomarker in asthma. *Journal of Asthma*. 2008; 45(8):654-663
- 26 24 Ahmed S, Bartlett SJ, Ernst P, Pare G, Kanter M, Perreault R. Effect of a web-based  
27 chronic disease management system on asthma control and health-related quality of  
28 life: Study protocol for a randomized controlled trial. *Trials*. 2011; 12(1):260
- 29 25 Ahmetaj LN, Kokollari F, Lokaj V. Prevalence of aspirin-induced asthma in certain group  
30 of kosovo population and its presentation. *Macedonian Journal of Medical Sciences*.  
31 2009; 2(1):42-48
- 32 26 Ait-Khaled N, Enarson DA. How to diagnose asthma and determine the degree of  
33 severity of the disease. *International Journal of Tuberculosis and Lung Disease*. 2006;  
34 10(3):252-255
- 35 27 Akcakaya N, Cokugras H, Camcioglu Y, Ozdemir M. Skin test hypersensitivity for  
36 childhood asthma in Istanbul during a period of 16 years. *Allergologia Et*  
37 *Immunopathologia*. 2005; 33(1):15-19

- 1 28 Al Moamary MS, Al-Kordi AG, Al Ghobain MO, Tamim HM. Utilization and  
2 responsiveness of the asthma control test (ACT) at the initiation of therapy for patients  
3 with asthma: a randomized controlled trial. *BMC Pulmonary Medicine*. 2012; 12:14
- 4 29 Al-Showair RAM, Pearson SB, Chrystyn H. The potential of a 2Tone Trainer to help  
5 patients use their metered-dose inhalers. *Chest*. 2007; 131(6):1776-1782
- 6 30 Alberta Heritage Foundation for Medical Research. Efficacy and/or effectiveness of  
7 spirometry and forced oscillation technique in the diagnosis of childhood asthma.  
8 Alberta Heritage Foundation for Medical Research (AHFMR), 2002
- 9 31 Albertini M, Politano S, Berard E, Boutte P, Mariani R. Variation in peak expiratory flow  
10 of normal and asymptomatic asthmatic children. *Pediatric Pulmonology*. 1989;  
11 7(3):140-144
- 12 32 Alberts WM, Ferris MC, Brooks SM, Goldman AL. The FEF25-75% and the clinical  
13 diagnosis of asthma. *Annals of Allergy*. 1994; 73(3):221-225
- 14 33 Albornoz C, Calvo M, Marin F. Correlation between the clinical classification of  
15 bronchial asthma severity and the methacholine test in children. *Journal of*  
16 *Investigational Allergology and Clinical Immunology*. 1995; 5(6):322-324
- 17 34 Albuquerque LA, Silva JM, Camara A, Arruda LK, Ferriani VP. Wheezing in young  
18 children and development of asthma in school age: Use of the Asthma Predictive Index  
19 in a subtropical environment. *Allergy: European Journal of Allergy and Clinical*  
20 *Immunology*. 2013; 68:277-278
- 21 35 Alenizi AA, Arifhodzic N, Alenezi AA, Alanezi AT. The high prevalence of sensitisation to  
22 pollen allergens in adult patients with respiratory allergy in Kuwait. *Allergy*. 2013;  
23 68:457-458
- 24 36 Almosawi TA, Al-Zubaidy TS, Howorth PH. Sputum eosinophil markers in monitoring  
25 asthmatic patients in United Arab Emirates. *Saudi Medical Journal*. 2008; 29(7):1061-  
26 1064
- 27 37 Almqvist C, Li Q, Britton WJ, Kemp AS, Xuan W, Tovey ER et al. Early predictors for  
28 developing allergic disease and asthma: examining separate steps in the 'allergic  
29 march'. *Clinical and Experimental Allergy*. 2007; 37(9):1296-1302
- 30 38 Alonso-Llamazares A, Martinez-Cocera C, Dominguez-Ortega J, Robledo-Echarren T,  
31 Cimarra-Alvarez M, Mesa del Castillo M. Nasal provocation test (NPT) with aspirin: a  
32 sensitive and safe method to diagnose aspirin-induced asthma (AIA). *Allergy*. 2002;  
33 57(7):632-635
- 34 39 Alvarez Puebla MJ, Castillo R, Rey A, Ortega N, Blanco C, Carrillo T. Sputum  
35 eosinophilia and maximal airway narrowing in *Dermatophagoides pteronyssinus*  
36 allergic rhinitis patients: only rhinitis or rhinitis plus mild asthma? *Chest*. 2002;  
37 122(5):1560-1565
- 38 40 Alvarez-Puebla MJ, Garcia-Figueroa BE, Tabar-Purroy AI, Olaguibel-Rivera JM.  
39 Discriminant analysis in allergic rhinitis and asthma: methacholine dose-response  
40 slope allows a good differentiation between mild asthma and rhinitis. *Respiratory*  
41 *Medicine*. 2003; 97(1):30-36

- 1 41 Amat F, Vial A, Pereira B, Petit I, Labbe A, Just J. Predicting the long-term course of  
2 asthma in wheezing infants is still a challenge. *ISRN Allergy*. 2011; 2011:493624
- 3 42 Ameisen JC, Capron A, Joseph M, Maclouf J, Vorng H, Pancre V et al. Aspirin-sensitive  
4 asthma: abnormal platelet response to drugs inducing asthmatic attacks. Diagnostic  
5 and physiopathological implications. *International Archives of Allergy and Applied  
6 Immunology*. 1985; 78(4):438-448
- 7 43 Ammari WG, Chrystyn H. Optimizing the inhalation flow and technique through  
8 metered dose inhalers of asthmatic adults and children attending a community  
9 pharmacy. *Journal of Asthma*. 2013; 50(5):505-513
- 10 44 Anderson HR, Bland JM, Patel S, Peckham C. The natural history of asthma in  
11 childhood. *Journal of Epidemiology and Community Health*. 1986; 40(2):121-129
- 12 45 Anderson HR, Bland JM, Peckham CS. Risk factors for asthma up to 16 years of age.  
13 Evidence from a national cohort study. *Chest*. 1987; 91(6 Suppl):127S-130S
- 14 46 Anderson SD, Pearlman DS, Weiler JM, Perry CP, Charlton B. Mannitol and  
15 methacholine tests to identify EIB and asthma in children with symptoms but no  
16 definite diagnosis: A phase 3 study. *Journal of Allergy and Clinical Immunology*. 2010;  
17 125(2 Suppl.1):AB3
- 18 47 Anderson SD, Brannan JD. Bronchial provocation testing: the future. *Current Opinion  
19 in Allergy and Clinical Immunology*. 2011; 11(1):46-52
- 20 48 Anderson SD, Charlton B, Weiler JM, Nichols S, Spector SL, Pearlman DS et al.  
21 Comparison of mannitol and methacholine to predict exercise-induced  
22 bronchoconstriction and a clinical diagnosis of asthma. *Respiratory Research*. 2009;  
23 10:4
- 24 49 Andregnette M, Fernandez-Nieto M, Sanchez S, Garcia M, Aguado E, Ibanez M et al.  
25 Comparison of bronchial hyperresponsiveness to methacholine and mannitol in  
26 asthmatic children. *Journal of Allergy and Clinical Immunology*. 2011; 127(2  
27 Suppl.1):AB134
- 28 50 Anees W, Blainey D, Moore VC, Robertson K, Burge PS. Differentiating occupational  
29 asthmatics from non-occupational asthmatics and irritant-exposed workers.  
30 *Occupational Medicine*. 2011; 61(3):190-195
- 31 51 Anees W. Use of pulmonary function tests in the diagnosis of occupational asthma.  
32 *Annals of Allergy, Asthma and Immunology*. 2003; 90(5 Suppl.2):47-51
- 33 52 Ansarin K, Chatkin JM, Ferreira IM, Gutierrez CA, Zamel N, Chapman KR. Exhaled nitric  
34 oxide in chronic obstructive pulmonary disease: Relationship to pulmonary function.  
35 *European Respiratory Journal*. 2001; 17(5):934-938
- 36 53 Ansley L, Kippelen P, Dickinson J, Hull JHK. Misdiagnosis of exercise-induced  
37 bronchoconstriction in professional soccer players. *Allergy*. 2012; 67(3):390-395
- 38 54 Antolin-Amerigo D, Rodriguez-Rodriguez M, Barbarroja EJ, Sanchez-Gonzalez M,  
39 Alvarez-Mon SM. The utility of mannitol challenge in the assessment of asthma.  
40 *Allergy*. 2012; 67:460

- 1 55 Antolin-Amerigo D, Sanchez-Gonzalez MJ, Rodriguez-Rodriguez M, Barbarroja-  
2 Escudero J, Alvarez-Mon M. Asthma diagnosis and treatment-1004. The utility of  
3 mannitol challenge in the assessment of asthma. *World Allergy Organization Journal*.  
4 2013; 6
- 5 56 Antus B, Barta I, Kullmann T, Lazar Z, Valyon M, Horvath I et al. Assessment of exhaled  
6 breath condensate pH in exacerbations of asthma and chronic obstructive pulmonary  
7 disease: A longitudinal study. *American Journal of Respiratory and Critical Care  
8 Medicine*. 2010; 182(12):1492-1497
- 9 57 Apfelbacher CJ, Hankins M, Stenner P, Frew AJ, Smith HE. Measuring asthma-specific  
10 quality of life: structured review. *Allergy*. 2011; 66(4):439-457
- 11 58 Apfelbacher CJ, Jones C, Hankins M, Smith H. Validity of two common asthma-specific  
12 quality of life questionnaires: Juniper mini asthma quality of life questionnaire and  
13 Sydney asthma quality of life questionnaire. *Health and Quality of Life Outcomes*.  
14 2012; 10:97
- 15 59 Apter A. Inhaled steroid adherence in moderate or severe asthma. [Clinical trial], 2000
- 16 60 Apter A. Comparison of two medication adherence strategies to improve asthma  
17 treatment adherence. *ClinicalTrials Gov*. 2005;
- 18 61 Araujo L, Jacinto T, Moreira A, Castel-Branco MG, Delgado L, Costa-Pereira A et al.  
19 Clinical efficacy of web-based versus standard asthma self-management. *Journal of  
20 Investigational Allergology and Clinical Immunology*. 2012; 22(1):28-34
- 21 62 Archambault S, Malo J-L, Infante-Rivard C, Ghezzo H, Gautrin D. Incidence of  
22 sensitization, symptoms, and probable occupational rhinoconjunctivitis and asthma in  
23 apprentices starting exposure to latex. *Journal of Allergy and Clinical Immunology*.  
24 2001; 107(5 Suppl.):921-923
- 25 63 Arduzzo LRF, Molinas J, Crisci CD, Jares EJ, Molinas S. Prevalence of sensitization to  
26 soybean hull in patients with asthma and/or allergic rhinitis in Argentina. *Journal of  
27 Allergy and Clinical Immunology*. 2009; 123(2 Suppl.1):S231
- 28 64 Arguel A, Lau AY, Dennis S, Liaw ST, Coiera E. An internet intervention to improve  
29 asthma management: rationale and protocol of a randomized controlled trial. *JMIR  
30 Research Protocols*. 2013; 2(2):e28
- 31 65 Arias Irigoyen J. Mild to moderate asthmatics and free running. *Journal of  
32 Investigational Allergology and Clinical Immunology*. 1999; 9(1):50-54
- 33 66 Arif AA, Borders TF, Patterson PJ, Rohrer JE, Xu KT. Prevalence and correlates of  
34 paediatric asthma and wheezing in a largely rural USA population. *Journal of  
35 Paediatrics and Child Health*. 2004; 40(4):189-194
- 36 67 Arif AA, Delclos GL, Lee ES, Tortolero SR, Whitehead LW. Prevalence and risk factors of  
37 asthma and wheezing among US adults: an analysis of the NHANES III data. *European  
38 Respiratory Journal*. 2003; 21(5):827-833

- 1 68 Arif AA. Presence of asthma with night-time asthma symptoms is associated with  
2 impaired health-related quality of life in children. *Journal of Asthma*. 2008; 45(10):908-  
3 910
- 4 69 Arif AA, Delclos GL, Colmer-Hamood J. Association between asthma, asthma  
5 symptoms and C-reactive protein in US adults: data from the National Health and  
6 Nutrition Examination Survey, 1999-2002. *Respirology*. 2007; 12(5):675-682
- 7 70 Arkins JA, Schleuter DP, Fink JN. The effect of corticosteroids on methacholine  
8 inhalation in symptomatic bronchial asthma. *Journal of Allergy*. 1968; 41(4):209-216
- 9 71 Armentia A, Bartolome B, Puyo M, Paredes C, Calderon S, Asensio T et al. Tobacco as  
10 an allergen in bronchial disease. *Annals of Allergy, Asthma and Immunology*. 2007;  
11 98(4):329-336
- 12 72 Armour C, Bosnic-Anticevich S, Brillant M, Burton D, Emmerton L, Krass I et al.  
13 Pharmacy Asthma Care Program (PACP) improves outcomes for patients in the  
14 community. *Thorax*. 2007; 62(6):496-502
- 15 73 Arnedo-Pena A, Puig-Barbera J, Bellido-Blasco JB, Pac-Sa MR, Campos-Cruanes JB,  
16 Artero-Sivera A et al. Risk factors and prevalence of asthma in schoolchildren in  
17 Castellon (Spain): a cross-sectional study. *Allergologia Et Immunopathologia*. 2009;  
18 37(3):135-142
- 19 74 Arshad SH, Kurukulaaratchy RJ, Fenn M, Matthews S. Early life risk factors for current  
20 wheeze, asthma, and bronchial hyperresponsiveness at 10 years of age. *Chest*. 2005;  
21 127(2):502-508
- 22 75 Artlich A, Hagenah JU, Jonas S, Ahrens P, Gortner L. Exhaled nitric oxide in childhood  
23 asthma. *European Journal of Pediatrics*. 1996; 155(8):698-701
- 24 76 Asher MI, Stewart AW, Clayton T, Crane J, Ellwood PI, Mackay R et al. Has the  
25 prevalence and severity of symptoms of asthma changed among children in New  
26 Zealand? ISAAC Phase Three. *New Zealand Medical Journal*. 2008; 121(1284):52-63
- 27 77 Atherton HA, White PT, Hewett G, Howells K. Relationship of daytime asthma  
28 symptom frequency to morning peak expiratory flow. *European Respiratory Journal*.  
29 1996; 9(2):232-236
- 30 78 Attapattu MC. Allergic bronchopulmonary aspergillosis among asthmatics. *Ceylon*  
31 *Medical Journal*. 1991; 36(2):45-51
- 32 79 Austin JB, Russell G. Wheeze, cough, atopy, and indoor environment in the Scottish  
33 Highlands. *Archives of Disease in Childhood*. 1997; 76(1):22-26
- 34 80 Australian New Zealand Clinical Trials Registry. ACTRN12606000400561 - Improving  
35 childhood asthma management through a telemedicine monitoring network. 2006.  
36 Available from:  
37 [https://www.anzctr.org.au/Trial/Registration/TrialReview.aspx?ACTRN=12606000400](https://www.anzctr.org.au/Trial/Registration/TrialReview.aspx?ACTRN=12606000400561)  
38 561 [Last accessed: 10 November 2014]

- 1 81 Avital A, Godfrey S, Springer C. Exercise, methacholine, and adenosine 5'-  
2 monophosphate challenges in children with asthma: relation to severity of the disease.  
3 *Pediatric Pulmonology*. 2000; 30(3):207-214
- 4 82 Avital A, Picard E, Uwyied K, Springer C. Comparison of adenosine 5'-monophosphate  
5 and methacholine for the differentiation of asthma from chronic airway diseases with  
6 the use of the auscultative method in very young children. *Journal of Pediatrics*. 1995;  
7 127(3):438-440
- 8 83 Avital A, Springer C, Bar-Yishay E, Godfrey S. Adenosine, methacholine, and exercise  
9 challenges in children with asthma or paediatric chronic obstructive pulmonary  
10 disease. *Thorax*. 1995; 50(5):511-516
- 11 84 Avital A, Uwyied K, Berkman N, Godfrey S, Bar-Yishay E, Springer C. Exhaled nitric  
12 oxide and asthma in young children. *Pediatric Pulmonology*. 2001; 32(4):308-313
- 13 85 Ayres JG, Campbell LM. A controlled assessment of an asthma self-management plan  
14 involving a budesonide dose regimen. OPTIONS Research Group. *European Respiratory*  
15 *Journal*. 1996; 9(5):886-892
- 16 86 Bacharier LB, Guilbert TW. Diagnosis and management of early asthma in preschool-  
17 aged children. *Journal of Allergy and Clinical Immunology*. 2012; 130(2):287-296
- 18 87 Backer V. Bronchial hyperresponsiveness in children and adolescents. *Danish Medical*  
19 *Bulletin*. 1995; 42(5):397-409
- 20 88 Backer V, Groth S, Dirksen A, Bach-Mortensen N, Hansen KK, Laursen EM et al.  
21 Sensitivity and specificity of the histamine challenge test for the diagnosis of asthma in  
22 an unselected sample of children and adolescents. *European Respiratory Journal*.  
23 1991; 4(9):1093-1100
- 24 89 Backer V, Rasmussen LM. Exercise-Induced Asthma Symptoms and Nighttime Asthma:  
25 Are They Similar to AHR? *Journal of Allergy*. 2009; 2009:378245
- 26 90 Backer V, Ulrik CS. Bronchial responsiveness to exercise in a random sample of 494  
27 children and adolescents from Copenhagen. *Clinical and Experimental Allergy*. 1992;  
28 22(8):741-747
- 29 91 Backer V, Ulrik CS, Wendelboe D, Bach-Mortensen D, Hansen KK, Laursen EM et al.  
30 Distribution of serum IgE in children and adolescents aged 7 to 16 years in  
31 Copenhagen, in relation to factors of importance. *Allergy*. 1992; 47(5):484-489
- 32 92 Backer V, Sverrild A, Porsbjerg C. FENO and AHR mannitol in patients referred to an  
33 out-of-hospital asthma clinic: a real-life study. *Journal of Asthma*. 2014; 51(4):411-416
- 34 93 Bai J, Peat JK, Berry G, Marks GB, Woolcock AJ. Questionnaire items that predict  
35 asthma and other respiratory conditions in adults. *Chest*. 1998; 114(5):1343-1348
- 36 94 Bailly C, Crenesse D, Albertini M. Evaluation of impulse oscillometry during bronchial  
37 challenge testing in children. *Pediatric Pulmonology*. 2011; 46(12):1209-1214



- 1 95 Bakkeheim E, Mowinckel P, Carlsen KH, Burney P, Carlsen KCL. Altered oxidative state  
2 in schoolchildren with asthma and allergic rhinitis. *Pediatric Allergy and Immunology*.  
3 2011; 22(2):178-185
- 4 96 Baldwin DR, Berg JD, Buckley BM, Mackay AD. Theophylline analysis at the chest clinic-  
5 -comparison of a portable versus conventional system. *Respiratory Medicine*. 1991;  
6 85(1):21-25
- 7 97 Baldwin DR, Gannon P, Bright P, Newton DT, Robertson A, Venables K et al.  
8 Interpretation of occupational peak flow records: level of agreement between expert  
9 clinicians and Oasys-2. *Thorax*. 2002; 57(10):860-864
- 10 98 Balinotti JE, Colom A, Kofman C, Teper A. Association between the asthma predictive  
11 index and levels of exhaled nitric oxide in infants and toddlers with recurrent  
12 wheezing. *Archivos Argentinos De Pediatría*. 2013; 111(3):191-195
- 13 99 Ball TM, Castro-Rodriguez JA, Griffith KA, Holberg CJ, Martinez FD, Wright AL. Siblings,  
14 day-care attendance, and the risk of asthma and wheezing during childhood. *New  
15 England Journal of Medicine*. 2000; 343(8):538-543
- 16 100 Ballweg T. Mannitol Bronchial Challenge Test. *Journal of Asthma and Allergy  
17 Educators*. 2012; 3(2):82
- 18 101 Baptist AP, Ross JA, Yang Y, Song PX, Clark NM. A randomized controlled trial of a self-  
19 regulation intervention for older adults with asthma. *Journal of the American  
20 Geriatrics Society*. 2013; 61(5):747-753
- 21 102 Baraldi E, Ghiro L, Piovan V, Carraro S, Zacchello F, Zanconato S. Safety and success of  
22 exhaled breath condensate collection in asthma. *Archives of Disease in Childhood*.  
23 2003; 88(4):358-360
- 24 103 Baraldi E, Giordano G, Pasquale MF, Carraro S, Mardegan A, Bonetto G et al. 3-  
25 Nitrotyrosine, a marker of nitrosative stress, is increased in breath condensate of  
26 allergic asthmatic children. *Allergy*. 2006; 61(1):90-96
- 27 104 Baraldi E, Bonetto G, Zacchello F, Filippone M. Low exhaled nitric oxide in school-age  
28 children with bronchopulmonary dysplasia and airflow limitation. *American Journal of  
29 Respiratory and Critical Care Medicine*. 2005; 171(1):68-72
- 30 105 Baraldi E, Ghiro L, Piovan V, Carraro S, Ciabattini G, Barnes PJ et al. Increased exhaled  
31 8-isoprostane in childhood asthma. *Chest*. 2003; 124(1):25-31
- 32 106 Barbanel D, Eldridge S, Griffiths C. Can a self-management programme delivered by a  
33 community pharmacist improve asthma control? A randomised trial. *Thorax*. 2003;  
34 58(10):851-854
- 35 107 Barben J, Kuehni CE, Strippoli MP, Schiller B, Hammer J, Trachsel D et al. Mannitol dry  
36 powder challenge in comparison with exercise testing in children. *Pediatric  
37 Pulmonology*. 2011; 46(9):842-848
- 38 108 Barber CM, Naylor S, Bradshaw LM, Francis M, Harris-Roberts J, Rawbone R et al.  
39 Approaches to the diagnosis and management of occupational asthma amongst UK  
40 respiratory physicians. *Respiratory Medicine*. 2007; 101(9):1903-1908

- 1 109 Barles PG, Duce Garcia F, Portillo Olmo JR, Perez Aznar J, Escuer Alarma JL. Adverse  
2 reaction of acetaminophen as an alternative analgesic in A.A.S. Triad. *Allergologia Et*  
3 *Immunopathologia*. 1988; 16(5):321-325
- 4 110 Barley EA, Jones PW. A comparison of global questions versus health status  
5 questionnaires as measures of the severity and impact of asthma. *European*  
6 *Respiratory Journal*. 1999; 14(3):591-596
- 7 111 Barnes KC, Freidhoff LR, Horowitz EM, Mathias RA, Mulkern DM, Bonacum JT et al.  
8 Physician-derived asthma diagnoses made on the basis of questionnaire data are in  
9 good agreement with interview-based diagnoses and are not affected by objective  
10 tests. *Journal of Allergy and Clinical Immunology*. 1999; 104(4 Pt 1):791-796
- 11 112 Barnes-Mercado S, Velazquez V, Pietri-Ramirez A. Are total serum IgE levels good  
12 predictors of allergies in children? *Journal of Allergy and Clinical Immunology*. 2014;  
13 133(2 Suppl.1):AB125
- 14 113 Barnig C, Purohit A, Casset A, Sohy C, Lieutier-Colas F, Sauleau E et al. Nonallergic  
15 airway hyperresponsiveness and allergen-specific IgE levels are the main determinants  
16 of the early and late asthmatic response to allergen. *Journal of Investigational*  
17 *Allergology and Clinical Immunology*. 2013; 23(4):267-274
- 18 114 Barranco P, Bobolea I, Larco JI, Prior N, Lopez-Serrano MC, Quirce S. Diagnosis of  
19 aspirin-induced asthma combining the bronchial and the oral challenge tests: a pilot  
20 study. *Journal of Investigational Allergology and Clinical Immunology*. 2009; 19(6):446-  
21 452
- 22 115 Barreto M, Villa MP, Martella S, Falasca C, Guglielmi F, Pagani J et al. Off-line exhaled  
23 nitric oxide measurements in children. *Pediatric Pulmonology*. 2001; 32(2):159-167
- 24 116 Barreto M, Villa MP, Montesano M, Rennerova Z, Monti F, Darder MT et al. Reduced  
25 exhaled nitric oxide in children after testing of maximal expiratory pressures. *Pediatric*  
26 *Pulmonology*. 2006; 41(2):141-145
- 27 117 Barry RJ, Pickett W, Rennie DC, Senthilselvan A, Cockcroft DW, Lawson JA. Factors  
28 contributing to risks for pediatric asthma in rural Saskatchewan. *Annals of Allergy,*  
29 *Asthma and Immunology*. 2012; 109(4):255-259
- 30 118 Barua P, O'Mahony MS. Overcoming gaps in the management of asthma in older  
31 patients: new insights. *Drugs and Aging*. 2005; 22(12):1029-1059
- 32 119 Baser S, Ozkurt S, Topuz B, Kiter G, Karabulut H, Akdag B et al. Peak expiratory flow  
33 monitoring to screen for asthma in patients with allergic rhinitis. *Journal of*  
34 *Investigational Allergology and Clinical Immunology*. 2007; 17(4):211-215
- 35 120 Basheti IA, Armour CL, Bosnic-Anticevich SZ, Reddel HK. Evaluation of a novel  
36 educational strategy, including inhaler-based reminder labels, to improve asthma  
37 inhaler technique 1503. *Patient Education and Counseling*. 2008; 72(1):26-33
- 38 121 Basheti IA, Reddel HK, Armour CL, Bosnic-Anticevich SZ. Impact of inhaler technique:  
39 improved asthma outcomes with a simple intervention by community pharmacists.  
40 *Respirology*. 2006; 11(Suppl 2):Abstract

- 1 122 Basheti IA, Reddel HK, Armour CL, Bosnic-Anticevich SZ. Counseling about turbuhaler  
2 technique: needs assessment and effective strategies for community pharmacists.  
3 *Respiratory Care*. 2005; 50(5):617-623
- 4 123 Basheti IA, Reddel HK, Armour CL, Bosnic-Anticevich SZ. Improved asthma outcomes  
5 with a simple inhaler technique intervention by community pharmacists. *Journal of*  
6 *Allergy and Clinical Immunology*. 2007; 119(6):1537-1538
- 7 124 Basir R, Lehrman SG, De Lorenzo LJ, Kalenderian R, Maguire GP. Lack of significant  
8 bronchial reactivity to inhaled normal saline in subjects with a positive methacholine  
9 challenge test. *Journal of Asthma*. 1995; 32(1):63-67
- 10 125 Basyigit I, Yildiz F, Ozkara SK, Boyaci H, Ilgazli A, Ozkarakas O. Effects of different anti-  
11 asthmatic agents on induced sputum and eosinophil cationic protein in mild  
12 asthmatics. *Respirology*. 2004; 9(4):514-520
- 13 126 Bateman ED. Measuring asthma control. *Current Opinion in Allergy and Clinical*  
14 *Immunology*. 2001; 1(3):211-216
- 15 127 Bateman ED, Jacques L, Goldfrad C, Atienza T, Mihaescu T, Duggan M. Asthma control  
16 can be maintained when fluticasone propionate/salmeterol in a single inhaler is  
17 stepped down. *Journal of Allergy and Clinical Immunology*. 2006; 117(3):563-570
- 18 128 Bauman A, Mitchell CA, Henry RL, Robertson CF, Abramson MJ, Comino EJ et al.  
19 Asthma morbidity in Australia: an epidemiological study. *Medical Journal of Australia*.  
20 1992; 156(12):827-831
- 21 129 Baumann UA, Haerdi E, Keller R. Relations between clinical signs and lung function in  
22 bronchial asthma: how is acute bronchial obstruction reflected in dyspnoea and  
23 wheezing? *Respiration*. 1986; 50(4):294-300
- 24 130 Baur X, Huber H, Degens PO, Allmers H, Ammon J. Relation between occupational  
25 asthma case history, bronchial methacholine challenge, and specific challenge test in  
26 patients with suspected occupational asthma. *American Journal of Industrial Medicine*.  
27 1998; 33(2):114-122
- 28 131 Bavbek S, Yilmaz I, Celik G, Aydin O, Erkekol FO, Orman A et al. Prevalence of aspirin-  
29 exacerbated respiratory disease in patients with asthma in Turkey: a cross-sectional  
30 survey. *Allergologia Et Immunopathologia*. 2012; 40(4):225-230
- 31 132 Bavbek S, Yilmaz I, Celik G, Aydin O, Erkekol FO, Aktas A et al. Prevalence of aspirin  
32 intolerance in patients with asthma in Turkey: A cross-sectional survey. *European*  
33 *Annals of Allergy and Clinical Immunology*. 2010; 42(2):42
- 34 133 Bayliss MS, Espindle DM, Buchner D, Blaiss MS, Ware JE. A new tool for monitoring  
35 asthma outcomes: the ITG Asthma Short Form. *Quality of Life Research*. 2000;  
36 9(4):451-466
- 37 134 Beach JR, Stenton SC, Connolly MJ, Walters EH, Hendrick DJ. Effects of diurnal variation  
38 and prolonged refractoriness on repeated measurements of airways responsiveness to  
39 methacholine. *Thorax*. 1995; 50(3):235-239

- 1 135 Beausoleil JL, Fiedler J, Spergel JM. Food Intolerance and childhood asthma: what is  
2 the link? *Paediatric Drugs*. 2007; 9(3):157-163
- 3 136 Beckett WS, Gent JF, Naeher LP, Belanger K, Triche EW, Bracken MB et al. Peak  
4 expiratory flow rate variability is not affected by home combustion sources in a group  
5 of nonsmoking women. *Archives of Environmental and Occupational Health*. 2006;  
6 61(4):176-182
- 7 137 Beeh KM, Beier J, Kornmann O, Meier C, Taeumer T, Buhl R. A single nasal allergen  
8 challenge increases induced sputum inflammatory markers in non-asthmatic subjects  
9 with seasonal allergic rhinitis: correlation with plasma interleukin-5. *Clinical and  
10 Experimental Allergy*. 2003; 33(4):475-482
- 11 138 Beeh KM, Ksoll M, Buhl R. Elevation of total serum immunoglobulin E is associated  
12 with asthma in nonallergic individuals. *European Respiratory Journal*. 2000; 16(4):609-  
13 614
- 14 139 Beeh KM, Micke P, Ksoll M, Buhl R. Cigarette smoking, but not sensitization to  
15 *Alternaria*, is associated with severe asthma in urban patients. *Journal of Asthma*.  
16 2001; 38(1):41-49
- 17 140 Beeh KM, Kornmann O, Beier J, Ksoll M, Buhl R. Clinical application of a simple  
18 questionnaire for the differentiation of asthma and chronic obstructive pulmonary  
19 disease. *Respiratory Medicine*. 2004; 98(7):591-597
- 20 141 Beg MFS, Alzoghaibi MA, Abba AA, Habib SS. Exhaled nitric oxide in stable chronic  
21 obstructive pulmonary disease. *Annals of Thoracic Medicine*. 2009; 4(2):65-70
- 22 142 Beigelman A, Mauger D, Mao J, Bacharier LB. Association between fractional  
23 concentration of exhaled nitric oxide (FeNO) levels and risk of respiratory tract illness  
24 in preschool children with moderate to severe intermittent wheezing. *Journal of  
25 Allergy and Clinical Immunology*. 2008; 21(2 Suppl.1):S76
- 26 143 Belamarich PF, Luder E, Kattan M, Mitchell H, Islam S, Lynn H et al. Do obese inner-city  
27 children with asthma have more symptoms than nonobese children with asthma?  
28 *Pediatrics*. 2000; 106(6):1436-1441
- 29 144 Belcher NG, Rees PJ, Clark TJ, Lee TH. A comparison of the refractory periods induced  
30 by hypertonic airway challenge and exercise in bronchial asthma. *American Review of  
31 Respiratory Disease*. 1987; 135(4):822-825
- 32 145 Belda J, Giner J, Casan P, Sanchis J. Mild exacerbations and eosinophilic inflammation  
33 in patients with stable, well-controlled asthma after 1 year of follow-up. *Chest*. 2001;  
34 119(4):1011-1017
- 35 146 Belda J, Parameswaran K, Lemiere C, Kamada D, O'Byrne PM, Hargreave FE. Predictors  
36 of loss of asthma control induced by corticosteroid withdrawal. *Canadian Respiratory  
37 Journal*. 2006; 13(3):129-133
- 38 147 Bellia V, Cibella F, Migliara G. Characteristics and prognostic value of morning dipping  
39 of peak expiratory flow rate in stable asthmatic subjects. *Chest*. 1985; 88(1):89-93

- 1 148 Bellia V, Pistelli R, Filippazzo G, Cibella F, Scichilone N, Catalano F et al. Prevalence of  
2 nocturnal asthma in a general population sample: determinants and effect of aging.  
3 *Journal of Asthma*. 2000; 37(7):595-602
- 4 149 Ben-Gashir MA, Seed PT, Hay RJ. Predictors of atopic dermatitis severity over time.  
5 *Journal of the American Academy of Dermatology*. 2004; 50(3):349-356
- 6 150 Benarab-Boucherit Y, Mehdioui H, Nedjar F, Delpierre S, Bouchair N, Aberkane A.  
7 Prevalence rate of exercise-induced bronchoconstriction in Annaba (Algeria)  
8 schoolchildren. *Journal of Asthma*. 2011; 48(5):511-516
- 9 151 Bender BG, Apter A, Bogen DK, Dickinson P, Fisher L, Wamboldt FS et al. Test of an  
10 interactive voice response intervention to improve adherence to controller  
11 medications in adults with asthma. *Journal of the American Board of Family Medicine*.  
12 2010; 23(2):159-165
- 13 152 Bender BG, Cvietusa P, Goodrich G, Lowe CR, Nuanes H, Shetterly S et al. A 24-month  
14 randomized, controlled trial of an automated speech recognition program to improve  
15 adherence in pediatric asthma. *Journal of Allergy and Clinical Immunology*. 2014;  
16 133(2 Suppl.1):AB166
- 17 153 Bennett JB, Davies RJ. A comparison of histamine and methacholine bronchial  
18 challenges using the DeVilbiss 646 nebulizer and the Rosenthal-French dosimeter.  
19 *British Journal of Diseases of the Chest*. 1987; 81(3):252-259
- 20 154 Bentur L, Beck R, Irving CS, Godfrey S. Nocturnal wheeze measurement in young  
21 asthmatics. *Pediatric Asthma, Allergy and Immunology*. 2004; 17(3):191-197
- 22 155 Berg CM, Thelle DS, Rosengren A, Lissner L, Toren K, Olin AC. Decreased fraction of  
23 exhaled nitric oxide in obese subjects with asthma symptoms: data from the  
24 population study INTERGENE/ADONIX. *Chest*. 2011; 139(5):1109-1116
- 25 156 Berg J, Dunbar-Jacob J, Sereika SM. An evaluation of a self-management program for  
26 adults with asthma. *Clinical Nursing Research*. 1997; 6(3):225-238
- 27 157 Berg J, Lindgren P. Economic evaluation of FE(NO) measurement in diagnosis and 1-  
28 year management of asthma in Germany. *Respiratory Medicine*. 2008; 102(2):219-231
- 29 158 Berg J, Rachelefsky G, Jones CA, Tichacek MJ, Morpew T. Identification of preschool  
30 children with asthma from low-income families in Los Angeles, CA. *Annals of Allergy,  
31 Asthma and Immunology*. 2004; 93(5):465-471
- 32 159 Berges-Gimeno MP, Simon RA, Stevenson DD. The natural history and clinical  
33 characteristics of aspirin-exacerbated respiratory disease. *Annals of Allergy, Asthma  
34 and Immunology*. 2002; 89(5):474-478
- 35 160 Berkman N, Avital A, Breuer R, Bardach E, Springer C, Godfrey S. Exhaled nitric oxide in  
36 the diagnosis of asthma: comparison with bronchial provocation tests. *Thorax*. 2005;  
37 60(5):383-388
- 38 161 Berlyne GS, Parameswaran K, Kamada D, Efthimiadis A, Hargreave FE. A comparison of  
39 exhaled nitric oxide and induced sputum as markers of airway inflammation. *Journal of  
40 Allergy and Clinical Immunology*. 2000; 106(4):638-644

- 1 162 Bernstein DI, Korbee L, Stauder T, Bernstein JA, Scinto J, Herd ZL et al. The low  
2 prevalence of occupational asthma and antibody-dependent sensitization to  
3 diphenylmethane diisocyanate in a plant engineered for minimal exposure to  
4 diisocyanates. *Journal of Allergy and Clinical Immunology*. 1993; 92(3):387-396
- 5 163 Bernstein JA, Davis B, Alvarez-Puebla MJ, Nguyen D, Levin L, Olaguibel JM. Is exhaled  
6 nitric oxide a useful adjunctive test for assessing asthma? *Journal of Asthma*. 2009;  
7 46(9):955-960
- 8 164 Berry MA, Shaw DE, Green RH, Brightling CE, Wardlaw AJ, Pavord ID. The use of  
9 exhaled nitric oxide concentration to identify eosinophilic airway inflammation: an  
10 observational study in adults with asthma. *Clinical and Experimental Allergy*. 2005;  
11 35(9):1175-1179
- 12 165 Berry RB, Fairshter RD. Partial and maximal expiratory flow-volume curves in normal  
13 and asthmatic subjects before and after inhalation of metaproterenol. *Chest*. 1985;  
14 88(5):697-702
- 15 166 Berz JB, Carter AS, Wagmiller RL, Horwitz SM, Murdock KK, Briggs-Gowan M.  
16 Prevalence and correlates of early onset asthma and wheezing in a healthy birth  
17 cohort of 2- to 3-year olds. *Journal of Pediatric Psychology*. 2007; 32(2):154-166
- 18 167 Bever HP, Chng SY, Dahlia S, Goh DYT. The influence of spirometry on the level of  
19 exhaled nitric oxide in asthmatic children. *European Respiratory Journal*. 2003;  
20 22(Suppl 45):569s
- 21 168 Beydon N, M'Buila C, Peiffer C, Bernard A, Zaccaria I, Denjean A. Can bronchodilator  
22 response predict bronchial response to methacholine in preschool coughers? *Pediatric  
23 Pulmonology*. 2008; 43(8):815-821
- 24 169 Bhagat RG, Grunstein MM. Comparison of responsiveness to methacholine, histamine,  
25 and exercise in subgroups of asthmatic children. *American Review of Respiratory  
26 Disease*. 1984; 129(2):221-224
- 27 170 Bheekie A, Syce JA, Weinberg EG. Peak expiratory flow rate and symptom self-  
28 monitoring of asthma initiated from community pharmacies. *Journal of Clinical  
29 Pharmacy and Therapeutics*. 2001; 26(4):287-296
- 30 171 Bhogal SK, Zemek RL, Ducharme F. Written action plans for asthma in children.  
31 *Cochrane Database of Systematic Reviews*. 2006; Issue 3:CD005306.  
32 DOI:10.1002/14651858.CD005306.pub2
- 33 172 Bibi H, Montgomery M, Pasterkamp H, Chernick V. Relationship between response to  
34 inhaled salbutamol and methacholine bronchial provocation in children with  
35 suspected asthma. *Pediatric Pulmonology*. 1991; 10(4):244-248
- 36 173 Bime C, Wei CY, Holbrook JT, Sockrider MM, Revicki DA, Wise RA. Asthma symptom  
37 utility index: reliability, validity, responsiveness, and the minimal important difference  
38 in adult asthmatic patients. *Journal of Allergy and Clinical Immunology*. 2012;  
39 130(5):1078-1084

- 1 174 Biring MS, Madison S, Mohsenifar Z. Use of forced inspiratory vital capacity to identify  
2 bronchodilator reversibility in obstructive lung disease. *Journal of Asthma*. 2001;  
3 38(6):495-500
- 4 175 Birnbaum S, Barreiro TJ. Methacholine challenge testing: identifying its diagnostic role,  
5 testing, coding, and reimbursement. *Chest*. 2007; 131(6):1932-1935
- 6 176 Bisgaard H, Pipper CB, Bonnelykke K. Endotyping early childhood asthma by  
7 quantitative symptom assessment. *Journal of Allergy and Clinical Immunology*. 2011;  
8 127(5):1155-1164
- 9 177 Bjornsson E, Janson C, Hakansson L, Enander I, Venge P, Boman G. Serum eosinophil  
10 cationic protein in relation to bronchial asthma in a young Swedish population. *Allergy*.  
11 1994; 49(9):730-736
- 12 178 Black PN, Garratt E, Arandjus C, Salmon BT, Sutherland G. An inhaler with ring tones  
13 improves compliance with inhaled steroids in childhood asthma. *American Thoracic  
14 Society International Conference, May 16-21, 2008, Toronto*. 2008;Poster
- 15 179 Blackie SP, Pardy RL. Exercise testing in the assessment of pulmonary disease. *Clinical  
16 Reviews in Allergy*. 1990; 8(2-3):215-227
- 17 180 Blanc PD, Cisternas M, Smith S, Yelin E. Occupational asthma in a community-based  
18 survey of adult asthma. *Chest*. 1996; 109(3 Suppl.):56S-57S
- 19 181 Boath K, Homan S, Adams R, Campbell D. Written action plans for asthma; symptoms  
20 or peak flow based? *Australian and New Zealand Journal of Medicine*. 1998; 28:256
- 21 182 Bobolea ID, Barranco P, Lopez-Carrasco V, Calderon O, Guillen D, Quirce S. Is  
22 methacholine challenge sufficient to rule out bronchial hyperresponsiveness in  
23 patients with suspected asthma? *Journal of Allergy and Clinical Immunology*. 2012;  
24 129(2 SUPPL. 1):AB3
- 25 183 Boccaccino A, Peroni DG, Pietrobelli A, Piacentini GL, Aversano MP, Spinosa E et al.  
26 Forced oscillometry is applicable to epidemiological settings to detect asthmatic  
27 children. *Allergy and Asthma Proceedings*. 2007; 28(2):170-173
- 28 184 Bollag U, Paget WJ, Oberreich J, Cloetta J. Asthma in the community: Observations by  
29 the Swiss Sentinel Surveillance Network over a ten year period (1988-1997). *European  
30 Journal of General Practice*. 2000; 6(4):122-129
- 31 185 Bommarito L, Migliore E, Bugiani M, Heffler E, Guida G, Bucca C et al. Exhaled nitric  
32 oxide in a population sample of adults. *Respiration*. 2008; 75(4):386-392
- 33 186 Bonavia M, Crimi E, Quaglia A, Brusasco V. Comparison of early and late asthmatic  
34 responses between patients with allergic rhinitis and mild asthma. *European  
35 Respiratory Journal*. 1996; 9(5):905-909
- 36 187 Boner AL, Piacentini GL, Peroni DG, Irving CS, Goldstein D, Gavriely N et al. Children  
37 with nocturnal asthma wheeze intermittently during sleep. *Journal of Asthma*. 2010;  
38 47(3):290-294

- 1 188 Bonini M, Lapucci G, Petrelli G, Todaro A, Pamich T, Rasi G et al. Predictive value of  
2 allergy and pulmonary function tests for the diagnosis of asthma in elite athletes.  
3 *Allergy*. 2007; 62(10):1166-1170
- 4 189 Bonini S, Bonifazi F, Maggi E, Mascialino B, Melioli G, Mus-sap M et al. Allergen  
5 component resolved diagnostics in multi-sensitized patients with respiratory  
6 symptoms. *Journal of Allergy and Clinical Immunology*. 2010; 125(2 Suppl.1):AB136
- 7 190 Bonner JR. The epidemiology and natural history of asthma. *Clinics in Chest Medicine*.  
8 1984; 5(4):557-565
- 9 191 Boonsawat W, Salome CM, Woolcock AJ. Effect of allergen inhalation on the maximal  
10 response plateau of the dose-response curve to methacholine. *American Review of  
11 Respiratory Disease*. 1992; 146(3):565-569
- 12 192 Borges MC, Ferraz E, Vianna EO. Bronchial provocation tests in clinical practice. *Sao  
13 Paulo Medical Journal*. 2011; 129(4):243-249
- 14 193 Borrego LM, Couto M, Almeida I, Morais-Almeida M. Pre-school spirometry in clinical  
15 practice. *Revista Portuguesa De Imunoalergologia*. 2012; 20(1):23-31
- 16 194 Borrego LM, Stocks J, Leiria-Pinto P, Peralta I, Romeira AM, Neuparth N et al. Lung  
17 function and clinical risk factors for asthma in infants and young children with  
18 recurrent wheeze. *Thorax*. 2009; 64(3):203-209
- 19 195 Borrego LM, Stocks J, Leiria-Pinto P, Peralta I, Romeira AM, Rosado-Pinto J et al. Lung  
20 function and clinical risk factors for asthma in infants and young children with  
21 recurrent wheeze. *Revista Portuguesa De Imunoalergologia*. 2010; 18(2):117-135
- 22 196 Borrego LM, Stocks J, Almeida I, Stanojevic S, Antunes J, Leiria-Pinto P et al.  
23 Bronchodilator responsiveness using spirometry in healthy and asthmatic preschool  
24 children. *Archives of Disease in Childhood*. 2013; 98(2):112-117
- 25 197 Bosnic-Anticevich SZ, Sinha H, So S, Reddel HK. Metered-dose inhaler technique: The  
26 effect of two educational interventions delivered in community pharmacy over time.  
27 *Journal of Asthma*. 2010; 47(3):251-256
- 28 198 Bossley CJ, Saglani S, Kavanagh C, Payne DNR, Wilson N, Tsartsali L et al. Corticosteroid  
29 responsiveness and clinical characteristics in childhood difficult asthma. *European  
30 Respiratory Journal*. 2009; 34(5):1052-1059
- 31 199 Botey J, Navarro C, Marin A, Eseverri JL. Aspirin-induced asthma in children.  
32 *Allergologia Et Immunopathologia*. 1988; 16(3):145-149
- 33 200 Bouaziz N, Beyaert C, Gauthier R, Monin P, Peslin R, Marchal F. Respiratory system  
34 reactance as an indicator of the intrathoracic airway response to methacholine in  
35 children. *Pediatric Pulmonology*. 1996; 22(1):7-13
- 36 201 Boudreau D, Styhler A, Gray-Donald K, Martin JG. A comparison of breathlessness  
37 during spontaneous asthma and histamine-induced bronchoconstriction. *Clinical and  
38 Investigative Medicine*. 1995; 18(1):25-32



- 1 202 Bougault V, Turmel J, Boulet LP. Bronchial challenges and respiratory symptoms in  
2 elite swimmers and winter sport athletes: Airway hyperresponsiveness in asthma: its  
3 measurement and clinical significance. *Chest*. 2010; 138(2 Suppl.):31S-37S
- 4 203 Boulet LP, Milot J, Turcotte H. Relationship between changes in diurnal variation of  
5 expiratory flows, lung volumes and respiratory symptoms after acute asthma.  
6 *Respiratory Medicine*. 1991; 85(6):487-493
- 7 204 Boulet LP, Turcotte H, Brochu A. Persistence of airway obstruction and  
8 hyperresponsiveness in subjects with asthma remission. *Chest*. 1994; 105(4):1024-  
9 1031
- 10 205 Bousquet J, Boushey HA, Busse WW, Canonica GW, Durham SR, Irvin CG et al.  
11 Characteristics of patients with seasonal allergic rhinitis and concomitant asthma.  
12 *Clinical and Experimental Allergy*. 2004; 34(6):897-903
- 13 206 Bouzigon E, Monier F, Boussaha M, Le Moual N, Huyvaert H, Matran R et al.  
14 Associations between nitric oxide synthase genes and exhaled NO-related phenotypes  
15 according to asthma status. *PloS One*. 2012; 7(5):e36672
- 16 207 Bozek A, Jarzab J. Adherence to asthma therapy in elderly patients. *Journal of Asthma*.  
17 2010; 47(2):162-165
- 18 208 Braido F, Baiardini I, Stagi E, Scichilone N, Rossi O, Lombardi C et al. RhinAsthma  
19 patient perspective: a short daily asthma and rhinitis QoL assessment. *Allergy*. 2012;  
20 67(11):1443-1450
- 21 209 Bramson R. Self-management of asthma. *Journal of Family Practice*. 1996; 43(1):21-22
- 22 210 Brancato I, Signoriello G, de Angelis CP, Verde R, Cioffi D, Maselli R. Asthma and  
23 bronchial reactivity: a contribution from multivariate analysis. *Monaldi Archives for  
24 Chest Disease*. 1995; 50(2):81-85
- 25 211 Brand PL, Kerstjens HA, Postma DS, Sterk PJ, Quanjer PH, Sluiter HJ et al. Long-term  
26 multicentre trial in chronic nonspecific lung disease: methodology and baseline  
27 assessment in adult patients. Dutch CNSLD Study Group. *European Respiratory  
28 Journal*. 1992; 5(1):21-31
- 29 212 Brand PL, Postma DS, Kerstjens HA, Koeter GH. Relationship of airway  
30 hyperresponsiveness to respiratory symptoms and diurnal peak flow variation in  
31 patients with obstructive lung disease. *American Review of Respiratory Disease*. 1991;  
32 143(5 Pt.1):916-921
- 33 213 Brand PL, Quanjer PH, Postma DS, Kerstjens HA, Koeter GH, Dekhuijzen PN et al.  
34 Interpretation of bronchodilator response in patients with obstructive airways disease.  
35 The Dutch Chronic Non-Specific Lung Disease (CNSLD) Study Group. *Thorax*. 1992;  
36 47(6):429-436
- 37 214 Brand PLP, De Gooijer A, Postma DS. Changes in peak expiratory flow in healthy  
38 subjects and in patients with obstructive lung disease. *European Respiratory Journal,  
39 Supplement*. 1997; 10(24):69S-71S

- 1 215 Brand PLP, Kerstjens HAM, Jansen HM, Kauffman HF, De Monchy JGR, Kerrebijn KF et  
2 al. Interpretation of skin tests to house dust mite and relationship to other allergy  
3 parameters in patients with asthma and chronic obstructive pulmonary disease.  
4 *Journal of Allergy and Clinical Immunology*. 1993; 91(2):560-570
- 5 216 Brand PLP. Key issues in inhalation therapy in children. *Current Medical Research and  
6 Opinion*. 2005; 21(Suppl.4):S27-S32
- 7 217 Brandt HD, Muntingh GL. Decreasing asthma morbidity. *South African Medical Journal*.  
8 1994; 84(12):842-844
- 9 218 Brannan JD, Koskela H, Anderson SD, Chew N. Responsiveness to mannitol in  
10 asthmatic subjects with exercise- and hyperventilation-induced asthma. *American  
11 Journal of Respiratory and Critical Care Medicine*. 1998; 158(4):1120-1126
- 12 219 Brannan JD, Loughheed MD. Airway hyperresponsiveness in asthma: mechanisms,  
13 clinical significance, and treatment. *Frontiers in Physiology*. 2012; 3:460
- 14 220 Braun-Fahrlander C, Gassner M, Grize L, Minder CE, Varonier HS, Vuille JC et al.  
15 Comparison of responses to an asthma symptom questionnaire (ISAAC core questions)  
16 completed by adolescents and their parents. SCARPOL-Team. Swiss Study on  
17 Childhood Allergy and Respiratory Symptoms with respect to Air Pollution. *Pediatric  
18 Pulmonology*. 1998; 25(3):159-166
- 19 221 Braun-Fahrlander C, Gassner M, Grize L, Takken-Sahli K, Neu U, Stricker T et al. No  
20 further increase in asthma, hay fever and atopic sensitisation in adolescents living in  
21 Switzerland. *European Respiratory Journal*. 2004; 23(3):407-413
- 22 222 Bregas M, Diego DA, Perpi TM. Usefulness of the IUATLD respiratory symptoms  
23 questionnaire for the differential diagnosis of bronchial asthma and chronic bronchitis.  
24 *Archivos De Bronconeumologia*. 2000; 36(8):441-449
- 25 223 Brenner BE, Chavda KK, Karakurum MB, Karras DJ, Camargo CAJ, Investigators MARC.  
26 Circadian differences among 4,096 emergency department patients with acute  
27 asthma. *Critical Care Medicine*. 2001; 29(6):1124-1129
- 28 224 Brescianini S, Brunetto B, Iacovacci P, D'Ippolito C, Alberti G, Schirru MA et al.  
29 Prevalence of self-perceived allergic diseases and risk factors in Italian adolescents.  
30 *Pediatric Allergy and Immunology*. 2009; 20(6):578-584
- 31 225 Brindicci C, Ito K, Barnes PJ, Kharitonov SA. Effect of an inducible nitric oxide synthase  
32 inhibitor on differential flow-exhaled nitric oxide in asthmatic patients and healthy  
33 volunteers. *Chest*. 2007; 132(2):581-588
- 34 226 Britton J. Measurement of peak flow variability in community populations:  
35 methodology. *European Respiratory Journal, Supplement*. 1997; 24:42S-44S
- 36 227 Brodlić M, McKean MC. Exhaled nitric oxide in the diagnosis of childhood asthma.  
37 *BMJ*. 2010; 340(7738):113-114
- 38 228 Broekhuizen BDL, Sachs APE, Hoes AW, Moons KGM, van den Berg JWK, Dalinghaus  
39 WH et al. Undetected chronic obstructive pulmonary disease and asthma in people

- 1 over 50 years with persistent cough. *British Journal of General Practice*. 2010;  
2 60(576):489-494
- 3 229 Broers S, Smets EM, Bindels PJ, Haes JC. Design of the IMPACT intervention study:  
4 patient-GP communication and adherence to asthma medication. *International*  
5 *Primary Care Respiratory Group Congress: Amsterdam, June 2002*. 2002;36
- 6 230 Brooke AM, Lambert PC, Burton PR, Clarke C, Luyt DK, Simpson H. Recurrent cough:  
7 natural history and significance in infancy and early childhood. *Pediatric Pulmonology*.  
8 1998; 26(4):256-261
- 9 231 Brouwer AFJ, Brand PLP. Asthma education and monitoring: what has been shown to  
10 work. *Paediatric Respiratory Reviews*. 2008; 9(3):193-200
- 11 232 Brouwer AFJ, Roorda RJ, Brand PLP. Home spirometry and asthma severity in children.  
12 *European Respiratory Journal*. 2006; 28(6):1131-1137
- 13 233 Brouwer AFJ, Visser CAN, Duiverman EJ, Roorda RJ, Brand PLP. Is home spirometry  
14 useful in diagnosing asthma in children with nonspecific respiratory symptoms?  
15 *Pediatric Pulmonology*. 2010; 45(4):326-332
- 16 234 Brozek G, Zejda J, Farnik M. Practical usefulness of submaximal exercise challenge test  
17 in a population asthma screening test in children. *Allergy*. 2009; 64:562-563
- 18 235 Bruce CA, Bias WB, Norman PS, Lightenstein LM, Marsh DG. Studies of HLA antigen  
19 frequencies, IgE levels, and specific allergic sensitivities in patients having ragweed  
20 hayfever, with and without asthma. *Clinical and Experimental Immunology*. 1976;  
21 25(1):67-72
- 22 236 Bruschi C, Cerveri I, Zoia MC, Maccarini L, Grassi M, Rampulla C. Bronchial  
23 responsiveness to inhaled methacholine in epidemiological studies: comparison of  
24 different indices. *European Respiratory Journal*. 1989; 2(7):630-636
- 25 237 Brussee JE, Smit HA, Kerkhof M, Koopman LP, Wijga AH, Postma DS et al. Exhaled nitric  
26 oxide in 4-year-old children: relationship with asthma and atopy. *European*  
27 *Respiratory Journal*. 2005; 25(3):455-461
- 28 238 Brusselle GG, Maes T, Bracke KR. Eosinophils in the spotlight: Eosinophilic airway  
29 inflammation in nonallergic asthma. *Nature Medicine*. 2013; 19(8):977-979
- 30 239 Brutsche MH, Downs SH, Schindler C, Gerbase MW, Schwartz J, Frey M et al. Bronchial  
31 hyperresponsiveness and the development of asthma and COPD in asymptomatic  
32 individuals: SAPALDIA cohort study. *Thorax*. 2006; 61(8):671-677
- 33 240 Bryant DH, Burns MW, Lazarus L. The correlation between skin tests, bronchial  
34 provocation tests and the serum level of IgE specific for common allergens in patients  
35 with asthma. *Clinical Allergy*. 1975; 5(2):145-157
- 36 241 Buchvald F, Hermansen MN, Nielsen KG, Bisgaard H. Exhaled nitric oxide predicts  
37 exercise-induced bronchoconstriction in asthmatic school children. *Chest*. 2005;  
38 128(4):1964-1967

- 1 242 Buffels J, Degryse J, Liistro G, Decramer M. Differential diagnosis in a primary care  
2 population with presumed airway obstruction: A real-life study. *Respiration*. 2012;  
3 84(1):44-54
- 4 243 Buist AS, Vollmer WM, Wilson SR, Frazier EA, Hayward AD. A randomized clinical trial  
5 of peak flow versus symptom monitoring in older adults with asthma. *American  
6 Journal of Respiratory and Critical Care Medicine*. 2006; 174(10):1077-1087
- 7 244 Burbank A, Rettiganti M, Brown RH, Jones S, Perry TT. Asthma education via  
8 telemedicine: Effects on asthma knowledge and self-efficacy. *Journal of Investigative  
9 Medicine*. 2012; 2012(60):1-401
- 10 245 Burgess S, Sly P, Devadason S. Monitoring and providing feedback on adherence  
11 improves adherence with preventive medication in childhood asthma [Abstract].  
12 *Respirology*. 2009; 14(Suppl.1):A76
- 13 246 Burgess SW, Sly PD, Devadason SG. Providing feedback on adherence increases use of  
14 preventive medication by asthmatic children. *Journal of Asthma*. 2010; 47(2):198-201
- 15 247 Burnett M, Wegienka G, Havstad S, Ownby D, Cole JC, Zoratti E. The relationship of  
16 fractional exhaled nitric oxide levels to allergy and asthma biomarkers in young adults.  
17 *Journal of Allergy and Clinical Immunology*. 2011; 127(2 Suppl.1):AB58
- 18 248 Burney PG, Chinn S, Britton JR, Tattersfield AE, Papacosta AO. What symptoms predict  
19 the bronchial response to histamine? Evaluation in a community survey of the  
20 bronchial symptoms questionnaire (1984) of the International Union Against  
21 Tuberculosis and Lung Disease. *International Journal of Epidemiology*. 1989; 18(1):165-  
22 173
- 23 249 Burr ML, St Leger AS, Bevan C, Merrett TG. A community survey of asthmatic  
24 characteristics. *Thorax*. 1975; 30(6):663-668
- 25 250 Burrows B, Lebowitz MD, Barbee RA, Cline MG. Findings before diagnoses of asthma  
26 among the elderly in a longitudinal study of a general population sample. *Journal of  
27 Allergy and Clinical Immunology*. 1991; 88(6):870-877
- 28 251 Bush A. The use of inflammatory markers to guide therapy in children with severe  
29 asthma. 2005. Available from: <http://www.clinicaltrials.gov/ct/show/NCT00262340>  
30 [Last accessed: 11 July 2013]
- 31 252 Businco L, Cantani A, Farinella F, Businco E. Month of birth and grass pollen or mite  
32 sensitization in children with respiratory allergy: A significant relationship. *Clinical  
33 Allergy*. 1988; 18(3):269-274
- 34 253 Businco L, Frediani T, Lucarelli S, Finocchi M, Puddu M, Businco E. A prospective study  
35 of wheezing infants: clinical and immunological results. *Annals of Allergy*. 1979;  
36 43(2):120-122
- 37 254 Bussamra MH, Cukier A, Stelmach R, Rodrigues JC. Evaluation of the magnitude of the  
38 bronchodilator response in children and adolescents with asthma. *Chest*. 2005;  
39 127(2):530-535

- 1 255 Busse WW, Wanner A, Adams K, Reynolds HY, Castro M, Chowdhury B et al.  
2 Investigative bronchoprovocation and bronchoscopy in airway diseases. *American*  
3 *Journal of Respiratory and Critical Care Medicine*. 2005; 172(7):807-816
- 4 256 Busse W, Spector S, Rosen K, Wang Y, Alpan O. High eosinophil count: a potential  
5 biomarker for assessing successful omalizumab treatment effects. *Journal of Allergy*  
6 *and Clinical Immunology*. 2013; 132(2):485-486
- 7 257 Buterleviciute N, Paltarackiene V, Rudzeviciene O. Frequency of normal serum total IgE  
8 in allergic diseases in children. *Allergy*. 2013; 68:280-281
- 9 258 Bynum A, Hopkins D, Thomas A, Copeland N, Irwin C. The effect of telepharmacy  
10 counseling on metered-dose inhaler technique among adolescents with asthma in  
11 rural Arkansas. *Telemedicine Journal and E-Health*. 2001; 7(3):207-217
- 12 259 Byrnes CA, Dinarevic S, Shinebourne EA, Barnes PJ, Bush A. Exhaled nitric oxide  
13 measurements in normal and asthmatic children. *Pediatric Pulmonology*. 1997;  
14 24(5):312-318
- 15 260 Caffarelli C, Bacchini PL, Gruppi L, Bernasconi S. Exercise-induced bronchoconstriction  
16 in children with atopic eczema. *Pediatric Allergy and Immunology*. 2005; 16(8):655-661
- 17 261 Caimmi S, De Amici M, Trovamala V, Caimmi D, Testa G, Marseglia A et al. Usefulness  
18 of molecular diagnosis. *Allergy*. 2013; 68:311-312
- 19 262 Calado G, Gaspar MJ, Chambel M, Martins P, Leiria PP. Nonsteroidal antiinflammatory  
20 drugs hypersensitivity in pediatric patients with asthma. *Allergy*. 2011; 66:162
- 21 263 Calado G, Gaspar MJ, Chambel M, Martins P, Leiria PP. Nonsteroidal anti-inflammatory  
22 drugs hypersensitivity in pediatric patients with asthma. *Revista Portuguesa De*  
23 *Imunoalergologia*. 2012; 20(4):273-280
- 24 264 Calhoun WJ, Ameredes BT, King TS, Icitovic N, Bleecker ER, Castro M et al. Comparison  
25 of physician-, biomarker-, and symptom-based strategies for adjustment of inhaled  
26 corticosteroid therapy in adults with asthma: the BASALT randomized controlled trial.  
27 *JAMA*. 2012; 308(10):987-997
- 28 265 Calvert J, Burney P. Effect of body mass on exercise-induced bronchospasm and atopy  
29 in African children. *Journal of Allergy and Clinical Immunology*. 2005; 116(4):773-779
- 30 266 Campbell CP, Jackson AS, Johnson AR, Thomas PS, Yates DH. Occupational sensitization  
31 to lupin in the workplace: occupational asthma, rhinitis, and work-aggravated asthma.  
32 *Journal of Allergy and Clinical Immunology*. 2007; 119(5):1133-1139
- 33 267 Cantani A, Ferrara M, Barbieri C, Monteleone A, Businco L. Evaluation of new test  
34 (Phadiatop(TM)) for the screening of respiratory allergic disorders in children. *Annals*  
35 *of Allergy*. 1990; 64(2 I):158-161
- 36 268 Cantani A, Micera M. Epidemiology of atopy in 220 children: Diagnostic reliability of  
37 skin prick tests and total and specific IgE levels. *Minerva Pediatrica*. 2003; 55(2):129-  
38 142

- 1 269 Cantani A, Micera M. A prospective study of asthma desensitization in 1182 children,  
2 592 asthmatic children and 590 nonatopic controls. *European Review for Medical and*  
3 *Pharmacological Sciences*. 2005; 9(6):325-329
- 4 270 Cardinale F, De Benedictis FM, Muggeo V, Giordano P, Loffredo MS, Iacoviello G et al.  
5 Exhaled nitric oxide, total serum IgE and allergic sensitization in childhood asthma and  
6 allergic rhinitis. *Pediatric Allergy and Immunology*. 2005; 16(3):236-242
- 7 271 Carey DG, Aase KA, Pliego GJ. The acute effect of cold air exercise in determination of  
8 exercise-induced bronchospasm in apparently healthy athletes. *Journal of Strength*  
9 *and Conditioning Research*. 2010; 24(8):2172-2178
- 10 272 Carey VJ, Weiss ST, Tager IB, Leeder SR, Speizer FE. Airways responsiveness, wheeze  
11 onset, and recurrent asthma episodes in young adolescents. The East Boston  
12 Childhood Respiratory Disease Cohort. *American Journal of Respiratory and Critical*  
13 *Care Medicine*. 1996; 153(1):356-361
- 14 273 Carlsen KH, Carlson KC, Halvorsen R. Tidal flow volume loops and inflammatory  
15 indicators in small children. *International Archives of Allergy and Immunology*. 1995;  
16 107(1-3):163-165
- 17 274 Carlsen KH, Engh G, Mork M. Exercise-induced bronchoconstriction depends on  
18 exercise load. *Respiratory Medicine*. 2000; 94(8):750-755
- 19 275 Carlsen KH, Engh G, Mork M, Schroder E. Cold air inhalation and exercise-induced  
20 bronchoconstriction in relationship to metacholine bronchial responsiveness: different  
21 patterns in asthmatic children and children with other chronic lung diseases.  
22 *Respiratory Medicine*. 1998; 92(2):308-315
- 23 276 Carlsen KH, Carlsen KCL. Exercise-induced asthma. *Paediatric Respiratory Reviews*.  
24 2002; 3(2):154-160
- 25 277 Carlsten C, Dimich-Ward H, Ferguson A, Becker A, DyBuncio A, Chan-Yeung M. Airway  
26 hyperresponsiveness to methacholine in 7-year-old children: sensitivity and specificity  
27 for pediatric allergist-diagnosed asthma. *Pediatric Pulmonology*. 2011; 46(2):175-178
- 28 278 Carnimeo N, Resta O, Foschino-Barbaro MP. Functional assessment of airways  
29 bronchoconstriction with nebulized acetyl salicylic acid. *Allergologia Et*  
30 *Immunopathologia*. 1981; 9(1):1-8
- 31 279 Carranza Rosenzweig JR, Jhingran PM, Dalal AA. Impact and use of asthma control test  
32 (ACT) on healthcare resource use (HCRU) in a managed care (MC) setting [Abstract].  
33 *Journal of Allergy and Clinical Immunology*. 2007; 119(1 Suppl):S72
- 34 280 Carraro S, Folesani G, Corradi M, Zanconato S, Gaston B, Baraldi E. Acid-base  
35 equilibrium in exhaled breath condensate of allergic asthmatic children. *Allergy*. 2005;  
36 60(4):476-481
- 37 281 Carraro S, Piacentini G, Lusiani M, Uyan ZS, Filippone M, Schiavon M et al. Exhaled air  
38 temperature in children with bronchopulmonary dysplasia. *Pediatric Pulmonology*.  
39 2010; 45(12):1240-1245

- 1 282 Carraro S, Rezzi S, Reniero F, Heberger K, Giordano G, Zanconato S et al. Metabolomics  
2 applied to exhaled breath condensate in childhood asthma. *American Journal of*  
3 *Respiratory and Critical Care Medicine*. 2007; 175(10):986-990
- 4 283 Carroll W. Limitations of asthma control questionnaires in the management and follow  
5 up of childhood asthma. *Paediatric Respiratory Reviews*. 2013; 14(4):229-231
- 6 284 Carsin AE, Zock JP, Jarvis D, Basagana X, Heinrich J, Toren K et al. Serum total  
7 immunoglobulin E is a surrogate of atopy in adult-onset asthma: a longitudinal study.  
8 *International Archives of Allergy and Immunology*. 2013; 160(4):387-392
- 9 285 Carter ER, Pulos E, Delaney J, Matheson EJ, Moffitt DR. Allergy history does not predict  
10 skin test reactivity in asthmatic children. *Journal of Asthma*. 2000; 37(8):685-690
- 11 286 Carter ER, Debley JS, Redding GR. Chronic productive cough in school children:  
12 prevalence and associations with asthma and environmental tobacco smoke exposure.  
13 *Cough*. 2006; 2:11
- 14 287 Cartier A. Diagnosing occupational asthma. *Allergy and Clinical Immunology*  
15 *International*. 2003; 15(5):197-202
- 16 288 Casadevall J, Ventura PJ, Mullol J, Picado C. Intranasal challenge with aspirin in the  
17 diagnosis of aspirin intolerant asthma: evaluation of nasal response by acoustic  
18 rhinometry. *Thorax*. 2000; 55(11):921-924
- 19 289 Cassimos DC, Tsalkidis A, Tripsianis GA, Stogiannidou A, Anthracopoulos M, Ktenidou-  
20 Kartali S et al. Asthma, lung function and sensitization in school children with a history  
21 of bronchiolitis. *Pediatrics International*. 2008; 50(1):51-56
- 22 290 Castillo JA, Picado C. Prevalence of aspirin intolerance in asthmatics treated in a  
23 hospital. *Respiration*. 1986; 50(3):153-157
- 24 291 Castro-Rodriguez JA, Sardon O, Perez-Yarza EG, Korta J, Aldasoro A, Corcuera P et al.  
25 Young infants with recurrent wheezing and positive asthma predictive index have  
26 higher levels of exhaled nitric oxide. *Journal of Asthma*. 2013; 50(2):162-165
- 27 292 Caudri D, Wijga A, Gehring U, Smit HA, Brunekreef B, Kerkhof M et al. Respiratory  
28 symptoms in the first 7 years of life and birth weight at term: the PIAMA Birth Cohort.  
29 *American Journal of Respiratory and Critical Care Medicine*. 2007; 175(10):1078-1085
- 30 293 Caudri D, Wijga A, Schipper A, Hoekstra M, Postma DS, Koppelman GH et al. Predicting  
31 the long-term prognosis of children with symptoms suggestive of asthma at preschool  
32 age. *Journal of Allergy and Clinical Immunology*. 2009; 124(5):903-907
- 33 294 Caudri D, Wijga AH, Hoekstra MO, Kerkhof M, Koppelman GH, Brunekreef B et al.  
34 Prediction of asthma in symptomatic preschool children using exhaled nitric oxide,  
35 Rint and specific IgE. *Thorax*. 2010; 65(9):801-807
- 36 295 Cerveri I, Corsico AG, Accordini S, Cervio G, Ansaldo E, Grosso A et al. What defines  
37 airflow obstruction in asthma? *European Respiratory Journal*. 2009; 34(3):568-573

- 1 296 Chakrabarti A, Roy P, Jindal SK. Evaluation of serological methods for determination of  
2 specific IgE in diagnosis of aspergillus lung disease. *Indian Journal of Medical Research.*  
3 1993; 97:118-121
- 4 297 Chan DS, Callahan CW, Hatch-Pigott VB, Lawless A, Proffitt HL, Manning NE et al.  
5 Internet-based home monitoring and education of children with asthma is comparable  
6 to ideal office-based care: results of a 1-year asthma in-home monitoring trial.  
7 *Pediatrics.* 2007; 119(3):569-578
- 8 298 Chang HS, Park JS, Jang AS, Park SW, Uh St, Kim YH et al. Diagnostic value of clinical  
9 parameters in the prediction of aspirin-exacerbated respiratory disease in asthma.  
10 *Allergy, Asthma and Immunology Research.* 2011; 3(4):256-264
- 11 299 Chang TS, Lemanske RFJ, Guilbert TW, Gern JE, Coen MH, Evans MD et al. Evaluation of  
12 the modified asthma predictive index in high-risk preschool children. *Journal of Allergy  
13 and Clinical Immunology In Practice.* 2013; 68(2):152-156
- 14 300 Chao PL, Peng HJ, Tang RB, Hung MW, Tsai LC. Serum specific IgE reactivity to  
15 recombinant Der f 11 in asthmatic children. *Journal of Asthma.* 2001; 38(5):391-398
- 16 301 Charlton I, Antoniou AG, Atkinson J, Campbell MJ, Chapman E, Mackintosh T et al.  
17 Asthma at the interface: bridging the gap between general practice and a district  
18 general hospital. *Archives of Disease in Childhood.* 1994; 70(4):313-318
- 19 302 Charlton I, Charlton G, Broomfield J, Mullee MA. Evaluation of peak flow and  
20 symptoms only self management plans for control of asthma in general practice. *BMJ.*  
21 1990; 301(6765):1355-1359
- 22 303 Chatham M, Bleecker ER, Smith PL. A comparison of histamine, methacholine, and  
23 exercise airway reactivity in normal and asthmatic subjects. *American Review of  
24 Respiratory Disease.* 1982; 126(2):235-240
- 25 304 Chatkin JM, Ansarin K, Silkoff PE, McClean P, Gutierrez C, Zamel N et al. Exhaled nitric  
26 oxide as a noninvasive assessment of chronic cough. *American Journal of Respiratory  
27 and Critical Care Medicine.* 1999; 159(6):1810-1813
- 28 305 Chatkin JM, Blanco DC, Scaglia N, Wagner MB, Fritscher CC. Impact of a low-cost and  
29 simple intervention in enhancing treatment adherence in a Brazilian asthma sample.  
30 *Journal of Asthma.* 2006; 43(4):263-266
- 31 306 Chen SH, Huang JL, Yeh KW, Tsai YF. Interactive support interventions for caregivers of  
32 asthmatic children. *Journal of Asthma : Official Journal of the Association for the Care  
33 of Asthma.* 2013; 50(6):649-657
- 34 307 Chen X, Li Y, Zeng M. Diagnostic values of combination of free running asthma  
35 screening test and total serum allergen IgE level in children with asthma. *Chinese  
36 Medical Journal.* 2014; 127(5):873-877
- 37 308 Cherot-Kornobis N, Hulo S, Edme JL, de Broucker V, Matran R, Sobaszek A. Analysis of  
38 nitrogen oxides (NOx) in the exhaled breath condensate (EBC) of subjects with asthma  
39 as a complement to exhaled nitric oxide (FeNO) measurements: a cross-sectional  
40 study. *BMC Research Notes.* 2011; 4:202



- 1 309 Chew FT, Goh DYT, Lee BW. Under-recognition of childhood asthma in Singapore:  
2 Evidence from a questionnaire survey. *Annals of Tropical Paediatrics*. 1999; 19(1):83-  
3 91
- 4 310 Chhabra SK. Acute bronchodilator response has limited value in differentiating  
5 bronchial asthma from COPD. *Journal of Asthma*. 2005; 42(5):367-372
- 6 311 Chia YC, Vinothini A, Liew SM. Impact of nurse educators on medication adherence in  
7 patients with asthma; a randomised controlled trial [Abstract]. *Primary Care  
8 Respiratory Journal*. 2008; 17(2):130
- 9 312 Chinellato I, Piazza M, Sandri M, Cardinale F, Peroni DG, Boner AL et al. Evaluation of  
10 association between exercise-induced bronchoconstriction and childhood asthma  
11 control test questionnaire scores in children. *Pediatric Pulmonology*. 2012; 47(3):226-  
12 232
- 13 313 Chinn S, Jarvis D, Burney P, Luczynska C, Ackermann-Liebrich U, Anto JM et al. Increase  
14 in diagnosed asthma but not in symptoms in the European Community Respiratory  
15 Health Survey. *Thorax*. 2004; 59(8):646-651
- 16 314 Cho YJ, Lim HJ, Park JS, Lee JH, Lee CT, Yoon HI. Measurement of fractional exhaled  
17 nitric oxide in stable bronchiectasis. *Tuberculosis and Respiratory Diseases*. 2013;  
18 74(1):7-14
- 19 315 Choi BW, Yoo KH, Jeong JW, Yoon HJ, Kim SH, Park YM et al. Easy diagnosis of asthma:  
20 computer-assisted, symptom-based diagnosis. *Journal of Korean Medical Science*.  
21 2007; 22(5):832-838
- 22 316 Choi IS, Hong SN, Lee YK, Koh YI, Jang AS, Lee HC. Asthmatic airway inflammation is  
23 more closely related to airway hyperresponsiveness to hypertonic saline than to  
24 methacholine. *Korean Journal of Internal Medicine*. 2003; 18(2):83-88
- 25 317 Choi IS, Koh YI, Koh JS, Lee MG. Sensitivity of the skin prick test and specificity of the  
26 serum-specific IgE test for airway responsiveness to house dust mites in asthma.  
27 *Journal of Asthma*. 2005; 42(3):197-202
- 28 318 Choi SH, Kim DK, Yoo Y, Yu J, Koh YY. Comparison of deltaFVC between patients with  
29 allergic rhinitis with airway hypersensitivity and patients with mild asthma. *Annals of  
30 Allergy, Asthma and Immunology*. 2007; 98(2):128-133
- 31 319 Choi SY, Sohn MH, Yum HY, Kwon BC, Kim KE. Correlation between inhalant allergen-  
32 specific IgE and pulmonary function in children with asthma. *Pediatric Pulmonology*.  
33 2005; 39(2):150-155
- 34 320 Chou T-Y, Wu K-Y, Shieh C-C, Wang J-Y. The clinical efficacy of in vitro allergen-specific  
35 IgE antibody test in the diagnosis of allergic children with asthma. *Acta Paediatrica  
36 Taiwanica*. 2002; 43(1):35-39
- 37 321 Chow JSW, Leung ASM, Li WWS, Tse TPK, Sy HY, Leung TF. Airway inflammatory and  
38 spirometric measurements in obese children. *Hong Kong Medical Journal*. 2009;  
39 15(5):346-352

- 1 322 Christakis DA, Garrison MM, Lozano P, Meischke H, Zhou C, Zimmerman FJ. Improving  
2 parental adherence with asthma treatment guidelines: a randomized controlled trial of  
3 an interactive website. *Academic Pediatrics*. United States 2012; 12(4):302-311
- 4 323 Christoff GC, Karova EG. Clinical relevance of inhalant and food allergens sensitisation  
5 in a cross-sectional epidemiological study of atopic diseases. *Allergy: European Journal  
6 of Allergy and Clinical Immunology*. 2013; 68:540
- 7 324 Christoff GC, Karova EG, Stoeva IL. Association between asthma and rhinitis  
8 prevalence, use of health resources, quality of life, and number of atopic  
9 sensitisations. *Allergy: European Journal of Allergy and Clinical Immunology*. 2013;  
10 68:243-244
- 11 325 Chu MW, Han JK. Introduction to pulmonary function. *Otolaryngologic Clinics of North  
12 America*. 2008; 41(2):387-viii
- 13 326 Chung C, Choi Y, Kim S, Park S, Min K, Moon H et al. Feasibility of mannitol provocation  
14 test to identify bronchial asthma in Korean population: Comparative analysis with  
15 methacholine challenge test. *Allergy*. 2010; 65:554
- 16 327 Cicutto L, To T, Murphy S. A randomized controlled trial of a public health nurse-  
17 delivered asthma program to elementary schools. *Journal of School Health*. 2013;  
18 83(12):876-884
- 19 328 Ciprandi G, Brambilla I, Tosca MA, Arrigo T, Salpietro A, Leonardi S et al. Body mass  
20 index is related with bronchial function and reversibility in children with allergic  
21 rhinitis and asthma. *International Journal of Immunopathology and Pharmacology*.  
22 2011; 24(4 Suppl):21-24
- 23 329 Ciprandi G, Capasso M, Tosca MA. Early bronchial involvement in children with allergic  
24 rhinitis. *American Journal of Rhinology and Allergy*. 2011; 25(1):e30-e33
- 25 330 Ciprandi G, Capasso M, Tosca M, Salpietro C, Salpietro A, Marseglia G et al. A forced  
26 expiratory flow at 25-75% value <65% of predicted should be considered abnormal: a  
27 real-world, cross-sectional study. *Allergy and Asthma Proceedings*. 2012; 33(1):e5-e8
- 28 331 Ciprandi G, Cirillo I, Signori A. Impact of allergic rhinitis on bronchi: an 8-year follow-up  
29 study. *American Journal of Rhinology and Allergy*. 2011; 25(2):e72-e76
- 30 332 Ciprandi G, Signori A, Cirillo I. Relationship between bronchial hyperreactivity and  
31 bronchodilation in patients with allergic rhinitis. *Annals of Allergy, Asthma and  
32 Immunology*. 2011; 106(6):460-466
- 33 333 Ciprandi G, Tosca MA, Capasso M. Exhaled nitric oxide in children with allergic rhinitis  
34 and/or asthma: a relationship with bronchial hyperreactivity. *Journal of Asthma*. 2010;  
35 47(10):1142-1147
- 36 334 Ciprandi G, Tosca MA, Capasso M. High exhaled nitric oxide levels may predict  
37 bronchial reversibility in allergic children with asthma or rhinitis. *Journal of Asthma*.  
38 2013; 50(1):33-38

- 1 335 Cirillo I, Klersy C, Marseglia GL, Vizzaccaro A, Pallestrini E, Tosca M et al. Role of  
2 FEF25%-75% as a predictor of bronchial hyperreactivity in allergic patients. *Annals of*  
3 *Allergy, Asthma and Immunology*. 2006; 96(5):692-700
- 4 336 Cirillo I, Pistorio A, Tosca M, Ciprandi G. Impact of allergic rhinitis on asthma: effects  
5 on bronchial hyperreactivity. *Allergy*. 2009; 64(3):439-444
- 6 337 Cirillo I, Vizzaccaro A, Tosca MA, Milanese M, Ciprandi G. Prevalence and treatment of  
7 allergic rhinitis in Italian conscripts. *European Annals of Allergy and Clinical*  
8 *Immunology*. 2003; 35(6):204-207
- 9 338 Clark NM, Gong ZM, Si JW, Lin X, Bria WF, Johnson TR. A randomized trial of a self-  
10 regulation intervention for women with asthma. *Chest*. 2007; 132(1):88-97
- 11 339 Clearie KL, Williamson PA, Vaidyanathan S, Short P, Goudie A, Burns P et al. Disconnect  
12 between standardized field-based testing and mannitol challenge in Scottish elite  
13 swimmers. *Clinical and Experimental Allergy*. 2010; 40(5):731-737
- 14 340 ClinicalTrials.gov. NCT00149474 - Peak Flow Monitoring in Older Adults With Asthma.  
15 2005. Available from: <http://clinicaltrials.gov/ct2/show/NCT00149474> [Last accessed:  
16 10 November 2014]
- 17 341 ClinicalTrials.gov. NCT00232557 - Telecommunications System in Asthma. 2005.  
18 Available from: <http://clinicaltrials.gov/ct2/show/NCT00232557> [Last accessed: 10  
19 November 2014]
- 20 342 ClinicalTrials.gov. NCT00411346 - Patient Research In Self-Management of Asthma  
21 (PRISMA). 2006. Available from: <http://clinicaltrials.gov/ct2/show/NCT00411346> [Last  
22 accessed: 10 November 2014]
- 23 343 ClinicalTrials.gov. NCT00562081 - The Virtual Asthma Clinic (VAC). 2007. Available  
24 from: <http://clinicaltrials.gov/ct2/show/NCT00562081> [Last accessed: 10 November  
25 2014]
- 26 344 ClinicalTrials.gov. NCT00910585 - Coaching in Childhood Asthma. 2009. Available from:  
27 <http://clinicaltrials.gov/ct2/show/NCT00910585> [Last accessed: 10 November 2014]
- 28 345 ClinicalTrials.gov. NCT00917410 - Mobile Phone Text for Optimizing Asthma  
29 Treatment. 2009. Available from: <http://clinicaltrials.gov/ct2/show/NCT00917410>  
30 [Last accessed: 10 November 2014]
- 31 346 ClinicalTrials.gov. NCT00964301 - Telemedicine Education for Rural Children With  
32 Asthma. 2009. [Last accessed: 10 November 2014]
- 33 347 ClinicalTrials.gov. NCT00993590 - Mobile CHES Research on Emergency Medical  
34 Services for Children. 2009. Available from:  
35 <http://clinicaltrials.gov/show/NCT00993590> [Last accessed: 10 November 2014]
- 36 348 ClinicalTrials.gov. NCT01117805 - Women of Color and Asthma Control. 2010.  
37 Available from: <http://clinicaltrials.gov/ct2/show/NCT01117805> [Last accessed: 10  
38 November 2014]

- 1 349 Cockcroft DW, Davis BE. Diagnostic and therapeutic value of airway challenges in  
2 asthma. *Current Allergy and Asthma Reports*. 2009; 9(3):247-253
- 3 350 Cockcroft DW, Davis BE, Boulet LP, Deschesnes F, Gauvreau GM, O'Byrne PM et al. The  
4 links between allergen skin test sensitivity, airway responsiveness and airway response  
5 to allergen. *Allergy*. 2005; 60(1):56-59
- 6 351 Cockcroft DW, Murdock KY, Berscheid BA, Gore BP. Sensitivity and specificity of  
7 histamine PC20 determination in a random selection of young college students.  
8 *Journal of Allergy and Clinical Immunology*. 1992; 89(1 Pt 1):23-30
- 9 352 Cockcroft DW, Ruffin RE, Frith PA. Determinants of allergen-induced asthma: Dose of  
10 allergen, circulating IgE antibody concentration, and bronchial responsiveness to  
11 inhaled histamine. *American Review of Respiratory Disease*. 1979; 120(5):1053-1058
- 12 353 Cockcroft D, Davis B. Direct and indirect challenges in the clinical assessment of  
13 asthma. *Annals of Allergy, Asthma and Immunology*. 2009; 103(5):363-400
- 14 354 Cockcroft DW. Direct challenge tests: Airway hyperresponsiveness in asthma: its  
15 measurement and clinical significance. *Chest*. 2010; 138(2 Suppl):18S-24S
- 16 355 Coleman H, McCann DC, McWhirter J, Calvert M, Warner JO. Asthma, wheeze and  
17 cough in 7- to 9-year-old British schoolchildren. *Ambulatory Child Health*. 2001; 7(3-  
18 4):313-321
- 19 356 Colon-Semidey AJ, Marshik P, Crowley M, Katz R, Kelly HW. Correlation between  
20 reversibility of airway obstruction and exhaled nitric oxide levels in children with  
21 stable bronchial asthma. *Pediatric Pulmonology*. 2000; 30(5):385-392
- 22 357 Comert S, Demir AU, Karakaya G, Kalyoncu AF. Minimum prick test panel for adult  
23 patients with asthma and rhinitis in Ankara, Turkey. *Journal of Asthma*. 2014;  
24 51(4):417-422
- 25 358 Connolly CK. House dust mite hypersensitivity: Morning dipping and severity of  
26 wheeze. *Respiration*. 1981; 42(4):258-262
- 27 359 Cookson JB, Merrett J, Merrett TG. Identification of allergen-specific IgE antibodies in  
28 the sera of African asthmatics. *Clinical Allergy*. 1976; 6(4):395-398
- 29 360 Cordeiro D, Rudolphus A, Snoey E, Braunstahl GJ. Utility of nitric oxide for the  
30 diagnosis of asthma in an allergy clinic population. *Allergy and Asthma Proceedings*.  
31 2011; 32(2):119-126
- 32 361 Corradi M, Montuschi P, Donnelly LE, Pesci A, Kharitonov SA, Barnes PJ. Increased  
33 nitrosothiols in exhaled breath condensate in inflammatory airway diseases. *American  
34 Journal of Respiratory and Critical Care Medicine*. 2001; 163(4):854-858
- 35 362 Corsico AG, Villani S, Zoia MC, Niniano R, Ansaldo E, Cervio G et al. Chronic productive  
36 cough in young adults is very often due to chronic rhino-sinusitis. *Monaldi Archives for  
37 Chest Disease*. 2007; 67(2):90-94
- 38 363 Cortes Alvarez N, Martin Mateos MA, Plaza Martin AM, Giner Munoz MT, Piquer M,  
39 Sierra Martinez JI. Risk factors of developing asthma in children with recurrent

- 1 wheezing in the first three years of life. *Allergologia Et Immunopathologia*. 2007;  
2 35(6):228-231
- 3 364 Cote J, Cartier A, Robichaud P, Boutin H, Malo JL, Rouleau M et al. Influence on asthma  
4 morbidity of asthma education programs based on self-management plans following  
5 treatment optimization. *American Journal of Respiratory and Critical Care Medicine*.  
6 1997; 155(5):1509-1514
- 7 365 Cote J, Kennedy S, Chan-Yeung M. Sensitivity and specificity of PC20 and peak  
8 expiratory flow rate in cedar asthma. *Journal of Allergy and Clinical Immunology*. 1990;  
9 85(3):592-598
- 10 366 Cote J, Kennedy S, Chan-Yeung M. Quantitative versus qualitative analysis of peak  
11 expiratory flow in occupational asthma. *Thorax*. 1993; 48(1):48-51
- 12 367 Court CS, Cook DG, Strachan DP. Comparative epidemiology of atopic and non-atopic  
13 wheeze and diagnosed asthma in a national sample of English adults. *Thorax*. 2002;  
14 57(11):951-957
- 15 368 Couto A, Goncalves L, Reis Ferreira JM. Diagnostic value of FEV1 in inhalatory  
16 challenge test. *Atemwegs- Und Lungenkrankheiten*. 1997; 23(7):421-422
- 17 369 Cowie RL, Revitt SG, Underwood MF, Field SK. The effect of a peak flow-based action  
18 plan in the prevention of exacerbations of asthma. *Chest*. 1997; 112(6):1534-1538
- 19 370 Cramer R, Hemmann S, Ismail C, Menz G, Blaser K. Disease-specific recombinant  
20 allergens for the diagnosis of allergic bronchopulmonary aspergillosis. *International  
21 Immunology*. 1998; 10(8):1211-1216
- 22 371 Crane J, Lampshire P, Wickens K, Epton M, Siebers R, Ingham T et al. Asthma, atopy  
23 and exhaled nitric oxide in a cohort of 6-yr-old New Zealand children. *Pediatric Allergy  
24 and Immunology*. 2012; 23(1):59-64
- 25 372 Crater SE, Peters EJ, Martin ML, Murphy AW, Platts-Mills TA. Expired nitric oxide and  
26 airway obstruction in asthma patients with an acute exacerbation. *American Journal of  
27 Respiratory and Critical Care Medicine*. 1999; 159(3):806-811
- 28 373 Crespo JF, Rodriguez J, Vives R, James JM, Reano M, Daroca P et al. Occupational IgE-  
29 mediated allergy after exposure to lupine seed flour. *Journal of Allergy and Clinical  
30 Immunology*. 2001; 108(2):295-297
- 31 374 Croce M, Costa Manso E, Croce J, Gato JJ, Vargas F. Bronchial challenge with aspirin  
32 lysine in the diagnosis of asthmatics with sensitization to aspirin and its inhibition by  
33 aerosolized furosemide. *Journal of Investigational Allergology and Clinical  
34 Immunology*. 1992; 2(4):196-204
- 35 375 Cruz M, Velasco M, Roca O, Culebras M, Morell F, Munoz X. Addition of exhaled breath  
36 condensate Ph to pef monitoring to improve the diagnosis of occupational asthma.  
37 *American Journal of Respiratory and Critical Care Medicine*. 2010; 181(1  
38 MeetingAbstracts)
- 39 376 Cruz-Correia R, Fonseca J, Lima L, Araujo L, Delgado L, Castel-Branco MG et al. Web-  
40 based or paper-based self-management tools for asthma--patients' opinions and

- 1 quality of data in a randomized crossover study. *Studies in Health Technology and*  
2 *Informatics*. 2007; 127:178-189
- 3 377 Csonka P, Kaila M, Laippala P, Kuusela AL, Ashorn P. Wheezing in early life and asthma  
4 at school age: predictors of symptom persistence. *Pediatric Allergy and Immunology*.  
5 2000; 11(4):225-229
- 6 378 Cuijpers CE, Wesseling GJ, Swaen GM, Sturmans F, Wouters EF. Asthma-related  
7 symptoms and lung function in primary school children. *Journal of Asthma*. 1994;  
8 31(4):301-312
- 9 379 Cullinan P, MacNeill SJ, Harris JM, Moffat S, White C, Mills P et al. Early allergen  
10 exposure, skin prick responses, and atopic wheeze at age 5 in English children: A  
11 cohort study. *Thorax*. 2004; 59(10):855-861
- 12 380 Currie GP, Fardon TC, Lee DK. The role of measuring airway hyperresponsiveness and  
13 inflammatory biomarkers in asthma. *Therapeutics and Clinical Risk Management*.  
14 2005; 1(2):83-92
- 15 381 Curtis L. Unit costs of health and social care 2013. Canterbury: Personal Social Services  
16 Research Unit, University of Kent; 2013. Available from:  
17 <http://www.pssru.ac.uk/project-pages/unit-costs/2013/index.php>
- 18 382 Custovic A, Taggart SCO, Francis HC, Chapman MD, Woodcock A. Exposure to house  
19 dust mite allergens and the clinical activity of asthma. *Journal of Allergy and Clinical*  
20 *Immunology*. 1996; 98(1):64-72
- 21 383 Cvitanovic S, Znaor L, Kanceljak-Macan B, Macan J, Gudelj I, Grbic D. Allergic rhinitis  
22 and asthma in southern Croatia: impact of sensitization to *Ambrosia elatior*. *Croatian*  
23 *Medical Journal*. 2007; 48(1):68-75
- 24 384 D'urzo A. Simple spirometry as a first line test for asthma diagnosis in primary care.  
25 *Canadian Respiratory Journal*. 2012; 19(3):e36
- 26 385 Dahlen B, Zetterstrom O. Comparison of bronchial and per oral provocation with  
27 aspirin in aspirin-sensitive asthmatics. *European Respiratory Journal*. 1990; 3(5):527-  
28 534
- 29 386 Dales RE, Ernst P, Hanley JA, Battista RN, Becklake MR. Prediction of airway reactivity  
30 from responses to a standardized respiratory symptom questionnaire. *American*  
31 *Review of Respiratory Disease*. 1987; 135(4):817-821
- 32 387 Dales RE, Nunes F, Partyka D, Ernst P. Clinical prediction of airways  
33 hyperresponsiveness. *Chest*. 1988; 93(5):984-986
- 34 388 Das BK, Kumar S, Panda BK, Mishra OP. Serum immunoglobulin E in early childhood  
35 wheezing. *Indian Journal of Pediatrics*. 2003; 70(3):213-215
- 36 389 de Almeida MM, Pinto JR. Bronchial asthma in children: clinical and epidemiologic  
37 approach in different Portuguese speaking countries. *Pediatric Pulmonology*  
38 *Supplement*. 1999; 27(S18):49-53

- 1 390 de Asis ML, Greene R. A cost-effectiveness analysis of a peak flow-based asthma  
2 education and self-management plan in a high-cost population. *Journal of Asthma.*  
3 *United States* 2004; 41(5):559-565
- 4 391 De Benedictis FM, Canny GJ, Levison H. Methacholine inhalational challenge in the  
5 evaluation of chronic cough in children. *Journal of Asthma.* 1986; 23(6):303-308
- 6 392 de Bot CMA, Moed H, Bindels PJE, van Wijk RG, Berger MY, de Groot H et al. Exhaled  
7 nitric oxide measures allergy not symptoms in children with allergic rhinitis in primary  
8 care: a prospective cross-sectional and longitudinal cohort study. *Primary Care*  
9 *Respiratory Journal.* 2013; 22(1):44-50
- 10 393 De Clerck LS, Verhelst JA, Bleys W, Blockx P, Stevens WJ. Comparative evaluation of  
11 the multiple RAST and discrete RAST for inhalant allergy. *Allergy.* 1986; 41(5):327-330
- 12 394 De Diego A, Martinez E, Perpina M, Nieto L, Compte L, Macian V et al. Airway  
13 inflammation and cough sensitivity in cough-variant asthma. *Allergy.* 2005;  
14 60(11):1407-1411
- 15 395 De Gouw HW, Marshall-Partridge SJ, Van Der Veen H, Van Den Aardweg JG, Hiemstra  
16 PS, Sterk PJ. Role of nitric oxide in the airway response to exercise in healthy and  
17 asthmatic subjects. *Journal of Applied Physiology.* 2001; 90(2):586-592
- 18 396 de Groot EP, Nijkamp A, Duiverman EJ, Brand PLP. Allergic rhinitis is associated with  
19 poor asthma control in children with asthma. *Thorax.* 2012; 67(7):582-587
- 20 397 de Jongste JC, Carraro S, Hop WC, CHARISM Study Group, Baraldi E. Daily  
21 telemonitoring of exhaled nitric oxide and symptoms in the treatment of childhood  
22 asthma. *American Journal of Respiratory and Critical Care Medicine.* 2009; 179(2):93-  
23 97
- 24 398 De Lovinfosse S, Charpin D, Dornelas A, Birnbaum J, Vervloet D. Can mite-specific IgE  
25 be used as a surrogate for mite exposure? *Allergy.* 1994; 49(1):64-66
- 26 399 de Marco R, Locatelli F, Cazzoletti L, Bugianio M, Carosso A, Marinoni A. Incidence of  
27 asthma and mortality in a cohort of young adults: a 7-year prospective study.  
28 *Respiratory Research.* 2005; 6:95
- 29 400 de Marco R, Marcon A, Jarvis D, Accordini S, Almar E, Bugiani M et al. Prognostic  
30 factors of asthma severity: a 9-year international prospective cohort study. *Journal of*  
31 *Allergy and Clinical Immunology.* 2006; 117(6):1249-1256
- 32 401 de Meer G, van Amsterdam JGC, Janssen NAH, Meijer E, Steerenberg PA, Brunekreef B.  
33 Exhaled nitric oxide predicts airway hyper-responsiveness to hypertonic saline in  
34 children that wheeze. *Allergy.* 2005; 60(12):1499-1504
- 35 402 de Souza PG, Sant'Anna CC, March MFBP. Quality of life in asthmatic children: A  
36 literature review. *Revista Paulista De Pediatria.* 2011; 29(4):640-644
- 37 403 Deane PMG. Conifer pollen sensitivity in western New York: cedar pollens. *Allergy and*  
38 *Asthma Proceedings.* 2005; 26(5):352-355

- 1 404 Debley J, Stanojevic S, Filbrun AG, Subbarao P. Bronchodilator responsiveness in  
2 wheezy infants and toddlers is not associated with asthma risk factors. *Pediatric*  
3 *Pulmonology*. 2012; 47(5):421-428
- 4 405 Debley JS, Stamey DC, Cochrane ES, Gama KL, Redding GJ. Exhaled nitric oxide, lung  
5 function, and exacerbations in wheezy infants and toddlers. *Journal of Allergy and*  
6 *Clinical Immunology*. 2010; 125(6):1228-1234
- 7 406 Decimo F, Capristo C, Amelio R, Maiello N, Capristo AF, Miraglia Del Giudice M.  
8 Evaluation of bronchial hyperreactivity with mannitol dry powder challenge test in a  
9 paediatric population with intermittent allergic asthma or allergic rhinitis.  
10 *International Journal of Immunopathology and Pharmacology*. 2011; 24(4):1069-1074
- 11 407 Dehaut P, Rachiele A, Martin RR, Malo JL. Histamine dose-response curves in asthma:  
12 reproducibility and sensitivity of different indices to assess response. *Thorax*. 1983;  
13 38(7):516-522
- 14 408 Deilami GD, Khandashpour M, Paknejad O, Pazooki M. Evaluation of methacholine  
15 challenge test results in chronic cough patients referring to clinic of pulmonary  
16 disease. *Acta Medica Iranica*. 2009; 47(3):175-179
- 17 409 del Giudice MM, Brunese FP, Piacentini GL, Pedulla M, Capristo C, Decimo F et al.  
18 Fractional exhaled nitric oxide (FENO), lung function and airway hyperresponsiveness  
19 in naive atopic asthmatic children. *Journal of Asthma*. 2004; 41(7):759-765
- 20 410 Del Rio-Navarro BE, Hernandez-Roman MP, Espinola Reyna G, Berber A, Escalante-  
21 Dominguez AJ, Gonzalez-Reyes M et al. A comparative study of bronchodilator  
22 reversibility with albuterol, between asthma symptomatic and asymptomatic children  
23 according to ISAAC questionnaire in Mexico City. *Allergologia Et Immunopathologia*.  
24 2004; 32(6):334-339
- 25 411 Delacourt C, Labbe D, Vassault A, Brunet-Langot D, de Blic J, Scheinmann P.  
26 Sensitization to inhalant allergens in wheezing infants is predictive of the development  
27 of infantile asthma. *Allergy*. 1994; 49(10):843-847
- 28 412 Delaney JC. The diagnosis of aspirin idiosyncrasy by analgesic challenge. *Clinical*  
29 *Allergy*. 1976; 6(2):177-181
- 30 413 Delen FM, Sippel JM, Osborne ML, Law S, Thukkani N, Holden WE. Increased exhaled  
31 nitric oxide in chronic bronchitis: comparison with asthma and COPD. *Chest*. 2000;  
32 117(3):695-701
- 33 414 Deliu M, Belgrave D, Semic-Jusufagic A, Lowe L, Simpson A, Custovic A. Longitudinal  
34 analysis of the impact of rhinitis on asthma severity during childhood: A population-  
35 based birth cohort study. *Allergy: European Journal of Allergy and Clinical*  
36 *Immunology*. 2013; 68:108-109
- 37 415 Dellabianca A, Omodeo P, Colli MC, Bianchi P, Scibilia J, Moscato G. Bronchial  
38 responsiveness to ultrasonic "fog" in occupational asthma due to low molecular  
39 weight chemicals. *Annals of Allergy, Asthma and Immunology*. 1996; 77(5):378-384



- 1 416 Demissie K, White N, Joseph L, Ernst P. Bayesian estimation of asthma prevalence, and  
2 comparison of exercise and questionnaire diagnostics in the absence of a gold  
3 standard. *Annals of Epidemiology*. 1998; 8(3):201-208
- 4 417 den Otter JJ, Reijnen GM, van den Bosch WJ, van Schayck CP, Molema J, Van Weel C.  
5 Testing bronchial hyper-responsiveness: provocation or peak expiratory flow  
6 variability? *British Journal of General Practice*. 1997; 47(421):487-492
- 7 418 den Otter JJ, van Dijk B, van Schayck CP, Molema J, Van Weel C. How to avoid  
8 underdiagnosed asthma/chronic obstructive pulmonary disease? *Journal of Asthma*.  
9 1998; 35(4):381-387
- 10 419 Deng X, Gebretsadik T, Jin M, Gao YT, Bai C, Christman JW et al. Development of a  
11 nomogram for identification of asthma among adults in epidemiologic studies. *Annals  
12 of Allergy, Asthma and Immunology*. 2010; 105(3):203-210
- 13 420 Department of Health. NHS reference costs 2012-13. 2012. Available from:  
14 [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/261  
15 154/nhs\\_reference\\_costs\\_2012-13\\_acc.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/261154/nhs_reference_costs_2012-13_acc.pdf) [Last accessed: 17 March 2014]
- 16 421 Department of Health. NHS reference costs 2013-14. 2014. Available from:  
17 [https://www.gov.uk/government/publications/nhs-reference-costs-2013-to-2014  
18](https://www.gov.uk/government/publications/nhs-reference-costs-2013-to-2014) [Last accessed: 14 January 2015]
- 19 422 Department of Health. NHS Supply Chain Catalogue. 2014. Available from:  
20 <http://www.supplychain.nhs.uk/> [Last accessed: 21 November 2014]
- 21 423 Department of Health Medical Directorate Respiratory Team. An outcomes strategy for  
22 chronic obstructive pulmonary disease (COPD) and asthma. London. Department of  
23 Health, 2011. Available from:  
24 [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/216  
25 139/dh\\_128428.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216139/dh_128428.pdf)
- 26 424 Dervaderics M, Fust G, Otos M, Barok J, Pataky G. Differences in the sensitisation to  
27 ragweed pollen and occurrence of late summer allergic symptoms between native and  
28 immigrant workers of the nuclear power plant of Hungary. *Immunological  
29 Investigations*. 2002; 31(1):29-40
- 30 425 Desalu OO, Oluboyo PO, Salami AK. The prevalence of bronchial asthma among adults  
31 in Ilorin, Nigeria. *African Journal of Medicine and Medical Sciences*. 2009; 38(2):149-  
32 154
- 33 426 Descatha A, Fromageot C, Ameille J, Lejaille M, Falaize L, Louis A et al. Is forced  
34 oscillation technique useful in the diagnosis of occupational asthma? *Journal of  
35 Occupational and Environmental Medicine*. 2005; 47(8):847-853
- 36 427 Deschildre A, Beghin L, Salleron J, Iliescu C, Thumerelle C, Santos C et al. Home  
37 telemonitoring (forced expiratory volume in 1 s) in children with severe asthma does  
38 not reduce exacerbations. *European Respiratory Journal*. 2012; 39(2):290-296
- 39 428 Deykin A, Lazarus SC, Fahy JV, Wechsler ME, Boushey HA, Chinchilli VM et al. Sputum  
40 eosinophil counts predict asthma control after discontinuation of inhaled  
41 corticosteroids. *Journal of Allergy and Clinical Immunology*. 2005; 115(4):720-727

- 1 429 Deykin A, Massaro AF, Drazen JM, Israel E. Exhaled nitric oxide as a diagnostic test for  
2 asthma: online versus offline techniques and effect of flow rate. *American Journal of*  
3 *Respiratory and Critical Care Medicine*. 2002; 165(12):1597-1601
- 4 430 Dharmage SC, Abramson M, Raven J, Thien FC, Walters EH. Why do only some of the  
5 young adults with bronchial hyperreactivity wheeze? *Journal of Asthma*. 1998;  
6 35(5):391-399
- 7 431 Di Franco A, Bartoli ML, Carnevali S, Cianchetti S, Bacci E, Dente FL et al. Analysis of  
8 sputum cell counts during spontaneous moderate exacerbations of asthma in  
9 comparison to the stable phase. *Journal of Asthma*. 2003; 40(2):155-162
- 10 432 Di Lorenzo G, Mansueto P, Esposito-Pellitteri M, Ditta V, Castello F, Lo Bianco C et al.  
11 The characteristics of different diagnostic tests in adult mild asthmatic patients:  
12 comparison with patients with asthma-like symptoms by gastro-oesophageal reflux.  
13 *Respiratory Medicine*. 2007; 101(7):1455-1461
- 14 433 Dias RM, Chacur FH, Carvalho SRdS, Neves DD. Which functional parameters can help  
15 differentiate severe asthma from COPD? *Revista Portuguesa De Pneumologia*. 2010;  
16 16(2):253-272
- 17 434 Diaz-Guzman E, Khosravi M, Mannino DM. Asthma, chronic obstructive pulmonary  
18 disease, and mortality in the U.S. population. *COPD*. 2011; 8(6):400-407
- 19 435 Dibek ME, Reha CM. Skin prick test results of child patients diagnosed as bronchial  
20 asthma. *Allergologia Et Immunopathologia*. 2007; 35(1):21-24
- 21 436 Dickinson JA, Meaker M, Searle M, Ratcliffe G. Screening older patients for obstructive  
22 airways disease in a semi-rural practice. *Thorax*. 1999; 54(6):501-505
- 23 437 Dickinson JW, Whyte GP, McConnell AK, Harries MG. Screening elite winter athletes  
24 for exercise induced asthma: a comparison of three challenge methods. *British Journal*  
25 *of Sports Medicine*. 2006; 40(2):179-182
- 26 438 Dickinson JW, Whyte GP, McConnell AK, Nevill AM, Harries MG. Mid-expiratory flow  
27 versus FEV1 measurements in the diagnosis of exercise induced asthma in elite  
28 athletes. *Thorax*. 2006; 61(2):111-114
- 29 439 Ding YP, Yao HX, Tang XL, He HW, Shi HF, Lin L et al. An epidemiology study of  
30 bronchial asthma in the Li ethnic group in China. *Asian Pacific Journal of Tropical*  
31 *Medicine*. 2012; 5(2):157-161
- 32 440 Dodge R, Cline MG, Lebowitz MD, Burrows B. Findings before the diagnosis of asthma  
33 in young adults. *Journal of Allergy and Clinical Immunology*. 1994; 94(5):831-835
- 34 441 Dodge R, Martinez FD, Cline MG, Lebowitz MD, Burrows B. Early childhood respiratory  
35 symptoms and the subsequent diagnosis of asthma. *Journal of Allergy and Clinical*  
36 *Immunology*. 1996; 98(1):48-54
- 37 442 Doekes G. Enzyme immunoassays for total and allergen specific IgE in population  
38 studies. *Occupational and Environmental Medicine*. 1996; 53(1):63-70

- 1 443 Donald KJ, McBurney H, Teichtahl H, Irving L. A pilot study of telephone based asthma  
2 management. *Australian Family Physician*. 2008; 37(3):170-173
- 3 444 Dor A, Liebhart J, Malolepszy J. Comparison of exercise and histamine provocation  
4 tests in patients with bronchial asthma. *Pneumonologia i Alergologia Polska*. 1999;  
5 67(1-2):22-27
- 6 445 Dostaler M, Olajos-Clow J, Turcotte SE, Minard JP, Holness D, Haines T et al.  
7 Development and validation of a work-related asthma screening questionnaire.  
8 *American Journal of Respiratory and Critical Care Medicine*. 2011; 183(1  
9 MeetingAbstracts)
- 10 446 Dotsch J, Demirakca S, Terbrack HG, Huls G, Rascher W, Kuhl PG. Airway nitric oxide in  
11 asthmatic children and patients with cystic fibrosis. *European Respiratory Journal*.  
12 1996; 9(12):2537-2540
- 13 447 Dow L, Fowler L, Phelps L, Waters K, Coggon D, Kinmonth AL et al. Prevalence of  
14 untreated asthma in a population sample of 6000 older adults in Bristol, UK. *Thorax*.  
15 2001; 56(6):472-476
- 16 448 Dressel H, de la Motte D, Reichert J, Ochmann U, Petru R, Angerer P et al. Exhaled  
17 nitric oxide: independent effects of atopy, smoking, respiratory tract infection, gender  
18 and height. *Respiratory Medicine*. 2008; 102(7):962-969
- 19 449 Dressel H, Muller F, Fischer R, Rommelt H, Hohlfeld JM, Behr J et al. Independent  
20 information of nonspecific biomarkers in exhaled breath condensate. *Respiration*.  
21 2010; 80(5):401-409
- 22 450 Drewek R, Garber E, Stanclik S, Simpson P, Nugent M, Gershan W. The FEF25-75 and its  
23 decline as a predictor of methacholine responsiveness in children. *Journal of Asthma*.  
24 2009; 46(4):375-381
- 25 451 Drkulec V, Nogalo B, Perica M, Plavec D, Pezer M, Turkalj M. Sensitization profile in  
26 differential diagnosis: allergic asthma vs. chronic (nonspecific) cough syndrome.  
27 *Medical Science Monitor*. 2013; 19:409-415
- 28 452 Drummond N, Abdalla M, Beattie JAG, Buckingham JK, Lindsay T, Osman LM et al.  
29 Effectiveness of routine self monitoring of peak flow in patients with asthma. *BMJ*.  
30 1994; 308(6928):564-567
- 31 453 Dryden DM, Spooner CH, Stickland MK, Vandermeer B, Tjosvold L, Bialy L et al.  
32 Exercise-induced bronchoconstriction and asthma. Rockville, MD. Agency for  
33 Healthcare Research and Quality, 2010. Available from:  
34 [http://www.ahrq.gov/research/findings/evidence-based-reports/eibeia-evidence-](http://www.ahrq.gov/research/findings/evidence-based-reports/eibeia-evidence-report.pdf)  
35 [report.pdf](http://www.ahrq.gov/research/findings/evidence-based-reports/eibeia-evidence-report.pdf)
- 36 454 Du Rand IA, O'Reilly L, Wilson D. Impact study of 243 indirect bronchial provocation  
37 tests with mannitol in the diagnosis and management of asthma. *Thorax*. 2011;  
38 66:A149
- 39 455 Duc J, Peitrequin R, Pecoud A. Value of a new screening test for respiratory allergy.  
40 *Allergy*. 1988; 43(5):332-337

- 1 456 Duce F, de Gregorio MA, Perez J, Portillo JR, Pascual G, Alfonso ER. A prospective and  
2 immunologic study of factory workers exposed to TDI (toluene diisocyanate).  
3 *Allergologia Et Immunopathologia*. 1988; 16(3):139-144
- 4 457 Dumas ME, Praud JP, Joseph MC, Geoffroy M, Vlachos-Mayer H. Assessment of the  
5 bronchodilator response in preschool asthmatics. *Paediatric Respiratory Reviews*.  
6 2010; 11:S79
- 7 458 Dundas I, Chan EY, Bridge PD, McKenzie SA. Diagnostic accuracy of bronchodilator  
8 responsiveness in wheezy children. *Thorax*. 2005; 60(1):13-16
- 9 459 Dundas I, Mckenzie S. Spirometry in the diagnosis of asthma in children. *Current*  
10 *Opinion in Pulmonary Medicine*. 2006; 12(1):28-33
- 11 460 Dupont LJ, Demedts MG, Verleden GM. Prospective evaluation of the validity of  
12 exhaled nitric oxide for the diagnosis of asthma. *Chest*. 2003; 123(3):751-756
- 13 461 Dwinger S, Dirmaier J, Herbarth L, Konig HH, Eckardt M, Kriston L et al. Telephone-  
14 based health coaching for chronically ill patients: study protocol for a randomized  
15 controlled trial. *Trials*. 2013; 14:337
- 16 462 Dwyer TM, Abraham GE. Spirometry: How should we order this bedrock of diagnosis  
17 and management for asthma and COPD? *Respiratory Care*. 2012; 57(10):1692-1695
- 18 463 Eakin MN, Rand CS, Bilderback A, Bollinger ME, Butz A, Kandasamy V et al. Asthma in  
19 Head Start children: effects of the Breathmobile program and family communication  
20 on asthma outcomes. *Journal of Allergy and Clinical Immunology*. 2012; 129(3):664-  
21 670
- 22 464 Eggleston PA. A comparison of the asthmatic response to methacholine and exercise.  
23 *Journal of Allergy and Clinical Immunology*. 1979; 63(2):104-110
- 24 465 Ehrs PO, Nokela M, Stallberg B, Hjemdahl P, Wikstrom Jonsson E. Brief questionnaires  
25 for patient-reported outcomes in asthma: validation and usefulness in a primary care  
26 setting. *Chest*. 2006; 129(4):925-932
- 27 466 Eid N, Yandell B, Howell L, Eddy M, Sheikh S. Can peak expiratory flow predict airflow  
28 obstruction in children with asthma? *Pediatrics*. 2000; 105(2):354-358
- 29 467 Ekroos H, Rouhos A, Pallasaho P, Karjalainen J, Sarna S, Sovijarvi ARA. Equally elevated  
30 concentrations of exhaled nitric oxide in nonatopic and low-sensitized atopic  
31 asthmatics. *Respiratory Medicine*. 2009; 103(1):152-158
- 32 468 ElHalawani SM, Ly NT, Mahon RT, Amundson DE. Exhaled nitric oxide as a predictor of  
33 exercise-induced bronchoconstriction. *Chest*. 2003; 124(2):639-643
- 34 469 Eliasson AH, Phillips YY, Rajagopal KR, Howard RS. Sensitivity and specificity of  
35 bronchial provocation testing. An evaluation of four techniques in exercise-induced  
36 bronchospasm. *Chest*. 1992; 102(2):347-355
- 37 470 Elizur A, Pollack N, Boslaugh SE, Kannai Y, Katz Y. Maternal positive skin prick test  
38 results and asthma prediction after early childhood wheezing. *Annals of Allergy,*  
39 *Asthma and Immunology*. 2007; 98(6):540-545

- 1 471 Elliott M, Heltshe SL, Stamey DC, Cochrane ES, Redding GJ, Debley JS. Exhaled nitric  
2 oxide predicts persistence of wheezing, exacerbations, and decline in lung function in  
3 wheezy infants and toddlers. *Clinical and Experimental Allergy*. 2013; 43(12):1351-  
4 1361
- 5 472 Elshabrawi IA, Abu NA, Sedky M, Elnawawy A, Montaser M. Work related asthma in  
6 the Damietta governorate. *Allergy*. 2011; 66:590
- 7 473 Enarson DA, Vedal S, Chan-Yeung M. Fate of grainhandlers with bronchial  
8 hyperreactivity. *Clinical and Investigative Medicine*. 1988; 11(3):193-197
- 9 474 Enright PL, Burchette RJ, Peters JA, Lebowitz MD, McDonnell WF, Abbey DE. Peak flow  
10 lability: Association with asthma and spirometry in an older cohort. *Chest*. 1997;  
11 112(4):895-901
- 12 475 Eriksson NE. Food sensitivity reported by patients with asthma and hay fever. A  
13 relationship between food sensitivity and birch pollen-allergy and between food  
14 sensitivity and acetylsalicylic acid intolerance. *Allergy*. 1978; 33(4):189-196
- 15 476 Eriksson NE. Allergy screening with Phadiatop and CAP Phadiatop in combination with  
16 a questionnaire in adults with asthma and rhinitis. *Allergy*. 1990; 45(4):285-292
- 17 477 Erkocoglu M, Akan A, Civelek E, Kan R, Azkur D, Kocabas CN. Consistency of GINA  
18 criteria and childhood asthma control test on the determination of asthma control.  
19 *Pediatric Allergy and Immunology*. 2012; 23(1):34-39
- 20 478 Escudero AI, Sanchez-Guerrero IM, Mora AM, Soriano V, Lopez JD, Garcia FJ et al. Cost-  
21 effectiveness of various methods of diagnosing hypersensitivity to *Alternaria*.  
22 *Allergologia Et Immunopathologia*. 1993; 21(4):153-157
- 23 479 Everhart RS, Fiese BH. Development and initial validation of a pictorial quality of life  
24 measure for young children with asthma. *Journal of Pediatric Psychology*. 2009;  
25 34(9):966-976
- 26 480 Ewan PW, Coote D. Evaluation of a capsulated hydrophilic carrier polymer (the  
27 ImmunoCAP) for measurement of specific IgE antibodies. *Allergy*. 1990; 45(1):22-29
- 28 481 Eysink P, Bindels P, Huisman J, Bottema B, Aalberse R, Schade B. Development of  
29 specific immunoglobulin E in coughing toddlers: a medical records review of symptoms  
30 in general practice. *Pediatric Allergy and Immunology*. 2001; 12(3):133-141
- 31 482 Eysink PED, Ter Riet G, Aalberse RC, van Aalderen WMC, Roos CM, van der Zee JS et al.  
32 Accuracy of specific IgE in the prediction of asthma: development of a scoring formula  
33 for general practice. *British Journal of General Practice*. 2005; 55(511):125-131
- 34 483 Fabbri LM, Romagnoli M, Corbetta L, Casoni G, Busljetic K, Turato G et al. Differences  
35 in airway inflammation in patients with fixed airflow obstruction due to asthma or  
36 chronic obstructive pulmonary disease. *American Journal of Respiratory and Critical  
37 Care Medicine*. 2003; 167(3):418-424
- 38 484 Faniran AO, Peat JK, Woolcock AJ. Persistent cough: is it asthma? *Archives of Disease  
39 in Childhood*. 1998; 79(5):411-414

- 1 485 Faniran AO, Peat JK, Woolcock AJ. Prevalence of atopy, asthma symptoms and  
2 diagnosis, and the management of asthma: comparison of an affluent and a non-  
3 affluent country. *Thorax*. 1999; 54(7):606-610
- 4 486 Farber HJ. Care management for childhood asthma: What works? *Pediatric Asthma,*  
5 *Allergy and Immunology*. 2009; 22(3):105-110
- 6 487 Farhoudi A, Razavi A, Chavoshzadeh Z, Heidarzadeh M, Bemanian MH, Nabavi M.  
7 Descriptive study of 226 patients with allergic rhinitis and asthma in karaj city. *Iranian*  
8 *Journal of Allergy, Asthma, and Immunology*. 2005; 4(2):99-101
- 9 488 Feitosa LAS, Dornelas de Andrade A, Reinaux CMA, Britto MCA. Diagnostic accuracy of  
10 exhaled nitric oxide in exercise-induced bronchospasm: Systematic review. *Revista*  
11 *Portuguesa De Pneumologia*. 2012; 18(4):198-204
- 12 489 Ferdousi HA, Dreborg S. Asthma, bronchial hyperreactivity and mediator release in  
13 children with birch pollinosis. ECP and EPX levels are not related to bronchial  
14 hyperreactivity. *Clinical and Experimental Allergy*. 1997; 27(5):530-539
- 15 490 Ferdousi HA, Zetterstrom O, Dreborg S. Bronchial hyper-responsiveness predicts the  
16 development of mild clinical asthma within 2 yr in school children with hay-fever.  
17 *Pediatric Allergy and Immunology*. 2005; 16(6):478-486
- 18 491 Fernandez C, Bevilacqua E, Fernandez N, Gajate P, de la Camara AG, Garcimartin M et  
19 al. Asthma related to *Alternaria* sensitization: an analysis of skin-test and serum-  
20 specific IgE efficiency based on the bronchial provocation test. *Clinical and*  
21 *Experimental Allergy*. 2011; 41(5):649-656
- 22 492 Fernandez C, Cardenas R, Martin D, Garcimartin M, Romero S, de la Camara AG et al.  
23 Analysis of skin testing and serum-specific immunoglobulin E to predict airway  
24 reactivity to cat allergens. *Clinical and Experimental Allergy*. 2007; 37(3):391-399
- 25 493 Fielder HM, Lyons RA, Heaven M, Morgan H, Govier P, Hooper M. Effect of  
26 environmental tobacco smoke on peak flow variability. *Archives of Disease in*  
27 *Childhood*. 1999; 80(3):253-256
- 28 494 Finkelstein MM, Chapman KR, McIvor RA, Sears MR. Mortality among subjects with  
29 chronic obstructive pulmonary disease or asthma at two respiratory disease clinics in  
30 Ontario. *Canadian Respiratory Journal*. 2011; 18(6):327-332
- 31 495 Fish JE, Permutt S. Which test best measures a bronchodilator response? *Chest*. 1978;  
32 73(6 Suppl):986-987
- 33 496 Fitzpatrick AM, Gaston BM, Erzurum SC, Teague WG, National Institutes of  
34 Health/National Heart LaBISARP. Features of severe asthma in school-age children:  
35 Atopy and increased exhaled nitric oxide. *Journal of Allergy and Clinical Immunology*.  
36 2006; 118(6):1218-1225
- 37 497 Flaherty DK, Geller M, Surfus JE. HLA antigen frequencies and natural history in  
38 *Alternaria*-sensitive and perennial nonallergic asthmatics. *Journal of Allergy and*  
39 *Clinical Immunology*. 1980; 66(5):408-416

- 1 498 Flegal KM, Kit BK, Orpana H, Graubard BI. Association of all-cause mortality with  
2 overweight and obesity using standard body mass index categories: a systematic  
3 review and meta-analysis. *JAMA*. 2013; 309(1):71-82
- 4 499 Fleming DM, Cross KW, Sunderland R, Ross AM. Comparison of the seasonal patterns  
5 of asthma identified in general practitioner episodes, hospital admissions, and deaths.  
6 *Thorax*. 2000; 55(8):662-665
- 7 500 Fonseca JA, Costa-Pereira A, Delgado L, Fernandes L, Castel-Branco MG. Asthma  
8 patients are willing to use mobile and web technologies to support self-management.  
9 *Allergy*. 2006; 61(3):389-390
- 10 501 Fonseca JA, Delgado L, Costa-Pereira A, Tavares C, Moreira A, Morete A et al.  
11 Evaluation of the Asthma Life Quality test for the screening and severity assessment of  
12 asthma. *Allergy*. 2004; 59(11):1198-1204
- 13 502 Forastiere F, Pistelli R, Michelozzi P, Corbo GM, Agabiti N, Bertollini R et al. Indices of  
14 nonspecific bronchial responsiveness in a pediatric population. *Chest*. 1991;  
15 100(4):927-934
- 16 503 Foresi A, Mastropasqua B, Chetta A, D'Ippolito R, Testi R, Olivieri D et al. Step-down  
17 compared to fixed-dose treatment with inhaled fluticasone propionate in asthma.  
18 *Chest*. 2005; 127(1):117-124
- 19 504 Formanek W, Inci D, Lauener RP, Wildhaber JH, Frey U, Hall GL. Elevated nitrite in  
20 breath condensates of children with respiratory disease. *European Respiratory  
21 Journal*. 2002; 19(3):487-491
- 22 505 Fortuna AM, Feixas T, Gonzalez M, Casan P. Diagnostic utility of inflammatory  
23 biomarkers in asthma: exhaled nitric oxide and induced sputum eosinophil count.  
24 *Respiratory Medicine*. 2007; 101(11):2416-2421
- 25 506 Foucard T. A follow-up study of children with asthmatoïd bronchitis. I. Skin test  
26 reactions and IgE antibodies to common allergens. *Acta Paediatrica Scandinavica*.  
27 1973; 62(6):633-644
- 28 507 Foucard T, Sjoberg O. A prospective 12-year follow-up study of children with wheezy  
29 bronchitis. *Acta Paediatrica Scandinavica*. 1984; 73(5):577-583
- 30 508 Fowler SJ, Dempsey OJ, Sims EJ, Lipworth BJ. Screening for bronchial  
31 hyperresponsiveness using methacholine and adenosine monophosphate.  
32 Relationship to asthma severity and beta(2)-receptor genotype. *American Journal of  
33 Respiratory and Critical Care Medicine*. 2000; 162(4 Pt 1):1318-1322
- 34 509 Fowler SJ, Langley SJ, Truman NJ, Woodcock A, Simpson A, Custovic A. Long-term  
35 effects of allergen sensitization and exposure in adult asthma: a prospective study.  
36 *World Allergy Organization Journal*. 2009; 2(5):83-90
- 37 510 Frank P, Ferry S, Moorhead T, Hannaford P. Use of a postal questionnaire to estimate  
38 the likely under-diagnosis of asthma-like illness in adults. *British Journal of General  
39 Practice*. 1996; 46(406):295-297

- 1 511 Frank PI, Frank TL, Cropper J, Hirsch S, Niven RM, Hannaford P et al. The use of a  
2 screening questionnaire to identify children with likely asthma. *British Journal of*  
3 *General Practice*. 2001; 51(463):117-120
- 4 512 Frank PI, Morris JA, Hazell ML, Linehan MF, Frank TL. Long term prognosis in preschool  
5 children with wheeze: longitudinal postal questionnaire study 1993-2004. *BMJ*. 2008;  
6 336(7658):1423-1426
- 7 513 Frank TL, Adisesh A, Pickering AC, Morrison JF, Wright T, Francis H et al. Relationship  
8 between exhaled nitric oxide and childhood asthma. *American Journal of Respiratory*  
9 *and Critical Care Medicine*. 1998; 158(4):1032-1036
- 10 514 Franklin PJ, Turner SW, Le Souef PN, Stick SM. Exhaled nitric oxide and asthma:  
11 complex interactions between atopy, airway responsiveness, and symptoms in a  
12 community population of children. *Thorax*. 2003; 58(12):1048-1052
- 13 515 Franklin PJ, Stick SM, Le Souef PN, Ayres JG, Turner SW. Measuring exhaled nitric oxide  
14 levels in adults: the importance of atopy and airway responsiveness. *Chest*. 2004;  
15 126(5):1540-1545
- 16 516 Freidhoff LR, Marsh DG. Relationship among asthma, serum IgE levels and skin test  
17 sensitivity to inhaled allergens. *International Archives of Allergy and Immunology*.  
18 1993; 100(4):355-361
- 19 517 Frette C, Annesi I, Korobaeff M, Neukirch F, Dore MF, Kauffmann F. Blood eosinophilia  
20 and FEV1. Cross-sectional and longitudinal analyses. *American Review of Respiratory*  
21 *Disease*. 1991; 143(5 Pt 1):987-992
- 22 518 Frischer T, Kuehr J, Meinert R, Karmaus W, Urbanek R. Risk factors for childhood  
23 asthma and recurrent wheezy bronchitis. *European Journal of Pediatrics*. 1993;  
24 152(9):771-775
- 25 519 Frischer T, Kuehr J, Meinert R, Karmaus W, Urbanek R. Influence of maternal smoking  
26 on variability of peak expiratory flow rate in school children. *Chest*. 1993; 104(4):1133-  
27 1137
- 28 520 Frischer T, Meinert R, Urbanek R, Kuehr J. Variability of peak expiratory flow rate in  
29 children: short and long term reproducibility. *Thorax*. 1995; 50(1):35-39
- 30 521 Frith J, Fleming L, Bossley C, Ullmann N, Bush A. The complexities of defining atopy in  
31 severe childhood asthma. *Clinical and Experimental Allergy*. 2011; 41(7):948-953
- 32 522 Fritsch M, Uxa S, Horak F, Putschoegl B, Dehlink E, Szepfalusi Z et al. Exhaled nitric  
33 oxide in the management of childhood asthma: A prospective 6-months study.  
34 *Pediatric Pulmonology*. 2006; 41(9):855-862
- 35 523 Fruchter O, Hardak E, Yigla M. The response to bronchodilators in adults is not  
36 predictive of bronchial-hyperreactivity. *Journal of Asthma*. 2009; 46(5):455-459
- 37 524 Fruchter O, Yigla M. Bronchodilator response after negative methacholine challenge  
38 test predicts future diagnosis of asthma. *Journal of Asthma*. 2009; 46(7):722-725



- 1 525 Fuentes C, Contreras S, Padilla O, Castro-Rodriguez JA, Moya A, Caussade S. Exercise  
2 challenge test: is a 15% fall in FEV(1) sufficient for diagnosis? *Journal of Asthma*. 2011;  
3 48(7):729-735
- 4 526 Fuiano N, Incorvaia C, Diddi G. Diagnostic performance of the atopy patch test with  
5 inhalant allergens. *Allergy*. 2013; 68:419
- 6 527 Fujimura M, Nishizawa Y, Nishitsuji M, Nomura S, Abo M, Ogawa H. Predictors for  
7 typical asthma onset from cough variant asthma. *Journal of Asthma*. 2005; 42(2):107-  
8 111
- 9 528 Fujimura M, Ohkura N, Abo M, Furusho S, Waseda Y, Ichikawa Y et al. Exhaled nitric  
10 oxide levels in patients with atopic cough and cough variant asthma. *Respirology*.  
11 2008; 13(3):359-364
- 12 529 Fukuhara A, Saito J, Sato S, Sato Y, Nikaido T, Saito K et al. Validation study of asthma  
13 screening criteria based on subjective symptoms and fractional exhaled nitric oxide.  
14 *Annals of Allergy, Asthma and Immunology*. 2011; 107(6):480-486
- 15 530 Gabriele C, Pijnenburg MWH, Monti F, Hop W, Bakker ME, De Jongste JC. The effect of  
16 spirometry and exercise on exhaled nitric oxide in asthmatic children. *Pediatric Allergy  
17 and Immunology*. 2005; 16(3):243-247
- 18 531 Gade E, Thomsen SF, Porsbjerg C, Backer V. The bronchial response to mannitol is  
19 attenuated by a previous methacholine test: but not vice versa. *Clinical and  
20 Experimental Allergy*. 2009; 39(7):966-971
- 21 532 Gagliardo R, La Grutta S, Chanez P, Profita M, Paterno A, Cibella F et al. Non-invasive  
22 markers of airway inflammation and remodeling in childhood asthma. *Pediatric Allergy  
23 and Immunology*. 2009; 20(8):780-790
- 24 533 Gaig P, Enrique E, Garcia-Ortega P, Olona M, del Mar San Miguel M, Richart C. Asthma,  
25 mite sensitization, and sleeping in bunks. *Annals of Allergy, Asthma and Immunology*.  
26 1999; 82(6):531-533
- 27 534 Galant DM. Effect of feedback to physicians on asthma patients' health-related quality  
28 of life. *Dissertation Abstracts International: Section B: the Sciences & Engineering*.  
29 1999; 60(2B)
- 30 535 Galant SP, Morpew T, Amaro S, Liao O. Value of the bronchodilator response in  
31 assessing controller naive asthmatic children. *Journal of Pediatrics*. 2007; 151(5):457-  
32 462
- 33 536 Galvez RA, McLaughlin FJ, Levison H. The relationship between airway obstruction and  
34 bronchial hyperreactivity in childhood asthma. *Annals of Allergy*. 1987; 58(1):45-47
- 35 537 Galvez RA, McLaughlin FJ, Levison H. The role of the methacholine challenge in  
36 children with chronic cough. *Journal of Allergy and Clinical Immunology*. 1987;  
37 79(2):331-335
- 38 538 Garbutt JM, Banister C, Highstein G, Sterkel R, Epstein J, Bruns J et al. Telephone  
39 coaching for parents of children with asthma: impact and lessons learned. *Archives of  
40 Pediatrics and Adolescent Medicine*. 2010; 164(7):625-630

- 1 539 Garbutt JM, Highstein G, Yan Y, Strunk RC. Partner randomized controlled trial: study  
2 protocol and coaching intervention. *BMC Pediatrics*. 2012; 12:42
- 3 540 Garcia de la Rubia S, Pajaron-Fernandez MJ, Sanchez-Solis M, Martinez-Gonzalez Moro  
4 I, Perez-Flores D, Pajaron-Ahumada M. Exercise-induced asthma in children: a  
5 comparative study of free and treadmill running. *Annals of Allergy, Asthma and  
6 Immunology*. 1998; 80(3):232-236
- 7 541 Garcia JJ, Trigo MM, Cabezudo B, Recio M, Vega JM, Barber D et al. Pollinosis due to  
8 Australian pine (*Casuarina*): An aerobiologic and clinical study in southern Spain.  
9 *Allergy*. 1997; 52(1):11-17
- 10 542 Garcia-Gonzalez JJ, Bartolome-Zavala B, Del Mar Trigo-Perez M, Barcelo-Munoz JM,  
11 Fernandez-Melendez S, Negro-Carrasco MA et al. Pollinosis to *Ricinus communis*  
12 (castor bean): an aerobiological, clinical and immunochemical study. *Clinical and  
13 Experimental Allergy*. 1999; 29(9):1265-1275
- 14 543 Garcia-Rio F, Mediano O, Ramirez M, Vinas A, Alonso A, Alvarez-Sala R et al. Usefulness  
15 of bronchial reactivity analysis in the diagnosis of bronchial asthma in patients with  
16 bronchial hyperresponsiveness. *Respiratory Medicine*. 2004; 98(3):199-204
- 17 544 Garcinuno AC, Gandarillas IM, Cobo RA, Perez CI, Diaz EE, Yanez MB et al. Early  
18 patterns of wheezing in asthmatic and nonasthmatic children. *European Respiratory  
19 Journal*. 2013; 42(4):1020-1028
- 20 545 Gardner IA, Stryhn H, Lind P, Collins MT. Conditional dependence between tests  
21 affects the diagnosis and surveillance of animal diseases. *Preventive Veterinary  
22 Medicine*. 2000; 45(1-2):107-122
- 23 546 Garratt AM, Hutchinson A, Russell I. Patient-assessed measures of health outcome in  
24 asthma: a comparison of four approaches. *Respiratory Medicine*. 2000; 94(6):597-606
- 25 547 Gautrin D, Malo JL. Risk factors, predictors, and markers for work-related asthma and  
26 rhinitis. *Current Allergy and Asthma Reports*. 2010; 10(5):365-372
- 27 548 Genders T, Hunink M. Modeling the Joint Distribution of Sensitivity and Specificity.  
28 *Society for Medical Decision Making*. 2009; 31
- 29 549 Genton C, Frei PC, Pecoud A. Value of oral provocation tests to aspirin and food  
30 additives in the routine investigation of asthma and chronic urticaria. *Journal of Allergy  
31 and Clinical Immunology*. 1985; 76(1):40-45
- 32 550 Gerald JK, Sun Y, Grad R, Gerald LB. Asthma morbidity among children evaluated by  
33 asthma case detection. *Pediatrics*. 2009; 124(5):e927-e933
- 34 551 Gerald LB, Redden D, Turner-Henson A, Feinstein R, Hemstreet MP, Hains C et al. A  
35 multi-stage asthma screening procedure for elementary school children. *Journal of  
36 Asthma*. 2002; 39(1):29-36
- 37 552 Gerald LB, Grad R, Turner-Henson A, Hains C, Tang S, Feinstein R et al. Validation of a  
38 multistage asthma case-detection procedure for elementary school children.  
39 *Pediatrics*. 2004; 114(4):e459-e468

- 1 553 Gergen PJ, Arbes SJJ, Calatroni A, Mitchell HE, Zeldin DC. Total IgE levels and asthma  
2 prevalence in the US population: results from the National Health and Nutrition  
3 Examination Survey 2005-2006. *Journal of Allergy and Clinical Immunology*. 2009;  
4 124(3):447-453
- 5 554 Gevorgyan A, Fokkens WJ. Fractional exhaled nitric oxide (FeNO) measurement in  
6 asthma and rhinitis. *Primary Care Respiratory Journal*. 2013; 22(1):10-11
- 7 555 Gharagozlou M, Kompani F, Movahedi M. Comparison between peak expiratory flow  
8 rate and forced expiratory volume in one second in the evaluation of children  
9 suspected to have asthma. *Iranian Journal of Allergy, Asthma and Immunology*. 2004;  
10 3(1):21-24
- 11 556 Ghodrati S, Hormati A, Mousavi NN, Afifian M. Comparison of FEV1 and PEF values in  
12 cough variant asthma during methacholine challenge test. *Journal of Zanjan University  
13 of Medical Sciences and Health Services*. 2011; 19(77):3
- 14 557 Gibson PG. Using fractional exhaled nitric oxide to guide asthma therapy: design and  
15 methodological issues for ASThma Treatment ALgorithm studies. *Clinical and  
16 Experimental Allergy*. 2009; 39(4):478-490
- 17 558 Gibson PG, Mattoli S, Sears MR, Dolovich J, Hargreave FE. Increased peak flow  
18 variability in children with asymptomatic hyperresponsiveness. *European Respiratory  
19 Journal*. 1995; 8(10):1731-1735
- 20 559 Gibson PG, Powell H. Written action plans for asthma: an evidence-based review of  
21 the key components. *Thorax*. 2004; 59(2):94-99
- 22 560 Gibson PG, Powell H, Wilson A, Abramson MJ, Haywood P, Bauman A et al. Self-  
23 management education and regular practitioner review for adults with asthma.  
24 *Cochrane Database of Systematic Reviews*. 2002; Issue 3:CD001117.  
25 DOI:10.1002/14651858.CD001117
- 26 561 Gift AG. The effect of cold air on asthmatic patients. *Perspectives in Respiratory  
27 Nursing*. 1994; 5(4):6
- 28 562 Gilbert R, Auchincloss JH. What is a 'restrictive' defect? *Archives of Internal Medicine*.  
29 1986; 146(9):1779-1781
- 30 563 Gilbert R, Auchincloss JHJ. The interpretation of the spirogram. How accurate is it for  
31 'obstruction'? *Archives of Internal Medicine*. 1985; 145(9):1635-1639
- 32 564 Gilbert R, Auchincloss JHJ. Post-test probability of asthma following methacholine  
33 challenge. *Chest*. 1990; 97(3):562-565
- 34 565 Gingo MR, Wenzel SE, Steele C, Kessinger CJ, Lucht L, Lawther T et al. Asthma diagnosis  
35 and airway bronchodilator response in HIV-infected patients. *Journal of Allergy and  
36 Clinical Immunology*. 2012; 129(3):708-714
- 37 566 Girard F, Chaboillez S, Cartier A, Cote J, Hargreave FE, Labrecque M et al. An effective  
38 strategy for diagnosing occupational asthma: use of induced sputum. *American Journal  
39 of Respiratory and Critical Care Medicine*. 2004; 170(8):845-850

- 1 567 Gjevre JA, Hurst TS, Taylor-Gjevre RM, Cockcroft DW. The American Thoracic Society's  
2 spirometric criteria alone is inadequate in asthma diagnosis. *Canadian Respiratory*  
3 *Journal*. 2006; 13(8):433-437
- 4 568 Glasgow NJ, Ponsonby AL, Yates RE, McDonald T, Attewell R. Asthma screening as part  
5 of a routine school health assessment in the Australian Capital Territory. *Medical*  
6 *Journal of Australia*. 2001; 174(8):384-388
- 7 569 Godden DJ, Ross S, Abdalla M, McMurray D, Douglas A, Oldman D et al. Outcome of  
8 wheeze in childhood. Symptoms and pulmonary function 25 years later. *American*  
9 *Journal of Respiratory and Critical Care Medicine*. 1994; 149(1):106-112
- 10 570 Godfrey RC. Asthma and IgE levels in rural and urban communities of The Gambia.  
11 *Clinical Allergy*. 1975; 5(2):201-207
- 12 571 Godfrey S, Springer C, Bar-Yishay E, Avital A. Cut-off points defining normal and  
13 asthmatic bronchial reactivity to exercise and inhalation challenges in children and  
14 young adults. *European Respiratory Journal*. 1999; 14(3):659-668
- 15 572 Goedhart DM, Zanen P, Lammers JW. Relevant and redundant lung function  
16 parameters in discriminating asthma from COPD. *COPD*. 2006; 3(1):33-39
- 17 573 Goeman D, Jenkins C, Crane M, Paul E, Douglass J. Educational intervention for older  
18 people with asthma: a randomised controlled trial. *Patient Education and Counseling*.  
19 2013; 93(3):586-595
- 20 574 Goetz DW. *Harmonia axyridis* ladybug hypersensitivity in clinical allergy practice.  
21 *Allergy and Asthma Proceedings*. 2007; 28(1):50-57
- 22 575 Gohler A, Geisler BP, Manne JM, Kosiborod M, Zhang Z, Weintraub WS et al. Utility  
23 estimates for decision-analytic modeling in chronic heart failure--health states based  
24 on New York Heart Association classes and number of rehospitalizations. *Value in*  
25 *Health*. 2009; 12(1):185-187
- 26 576 Goksor E, Amark M, Alm B, Gustafsson PM, Wennergren G. Asthma symptoms in early  
27 childhood--what happens then? *Acta Paediatrica*. 2006; 95(4):471-478
- 28 577 Goksor E, Gustafsson PM, Alm B, Amark M, Wennergren G. Reduced airway function in  
29 early adulthood among subjects with wheezing disorder before two years of age.  
30 *Pediatric Pulmonology*. 2008; 43(4):396-403
- 31 578 Goldstein IF, Perzanowski MS, Lendor C, Garfinkel RS, Hoepner LA, Chew GL et al.  
32 Prevalence of allergy symptoms and total IgE in a New York City cohort and their  
33 association with birth order. *International Archives of Allergy and Immunology*. 2005;  
34 137(3):249-257
- 35 579 Goldstein MF, Pacana SM, Dvorin DJ, Dunskey EH. Retrospective analyses of  
36 methacholine inhalation challenges. *Chest*. 1994; 105(4):1082-1088
- 37 580 Goldstein MF, Veza BA, Dunskey EH, Dvorin DJ, Belecanech GA, Haralabatos IC.  
38 Comparisons of peak diurnal expiratory flow variation, postbronchodilator FEV(1)  
39 responses, and methacholine inhalation challenges in the evaluation of suspected  
40 asthma. *Chest*. 2001; 119(4):1001-1010

- 1 581 Gonzalez-Perez R, Poza-Guedes P, Vives-Conesa R. The nose as a target organ in the  
2 diagnosis of severe aspirin-exacerbated respiratory disease. *American Journal of*  
3 *Rhinology and Allergy*. 2011; 25(3):166-169
- 4 582 Gordon SB, Curran AD, Murphy J, Sillitoe C, Lee G, Wiley K et al. Screening  
5 questionnaires for bakers' asthma--are they worth the effort? *Occupational Medicine*.  
6 1997; 47(6):361-366
- 7 583 Gradman J, Wolthers OD. Allergic conjunctivitis in children with asthma, rhinitis and  
8 eczema in a secondary outpatient clinic. *Pediatric Allergy and Immunology*. 2006;  
9 17(7):524-526
- 10 584 Graif Y, Yigla M, Tov N, Kramer MR. Value of a negative aeroallergen skin-prick test  
11 result in the diagnosis of asthma in young adults: correlative study with methacholine  
12 challenge testing. *Chest*. 2002; 122(3):821-825
- 13 585 Grainger-Rousseau T-J, McElnay JC. A model for community pharmacist involvement  
14 with general practitioners in the management of asthma patients. *Journal of Applied*  
15 *Therapeutics*. 1996; 1(2):145-161
- 16 586 Grammer L, Shaughnessy M, Kenamore B. Utility of antibody in identifying individuals  
17 who have or will develop anhydride-induced respiratory disease. *Chest*. 1998;  
18 114(4):1199-1202
- 19 587 Grammer LC, Harris KE, Sonenthal KR, Ley C, Roach DE. A cross-sectional survey of 46  
20 employees exposed to trimellitic anhydride. *Allergy Proceedings*. 1992; 13(3):139-142
- 21 588 Green AW, Foels TJ. Improving asthma management: one health plan's experience.  
22 *American Journal of Managed Care*. 2007; 13(8):482-485
- 23 589 Green R, Luyt D. Clinical characteristics of childhood asthmatics in Johannesburg.  
24 *South African Medical Journal*. 1997; 87(7):878-882
- 25 590 Green RJ, Klein M, Becker P, Halkas A, Lewis H, Kitchin O et al. Disagreement among  
26 common measures of asthma control in children. *Chest*. 2013; 143(1):117-122
- 27 591 Green RH, Brightling CE, McKenna S, Hargadon B, Parker D, Bradding P et al. Asthma  
28 exacerbations and sputum eosinophil counts: a randomised controlled trial. *Lancet*.  
29 2002; 360(9347):1715-1721
- 30 592 Greenspon LW, Gracely E. A discriminant analysis applied to methacholine  
31 bronchoprovocation testing improves classification of patients as normal, asthma, or  
32 COPD. *Chest*. 1992; 102(5):1419-1425
- 33 593 Griffiths C, Feder G, Wedzicha J, Foster G, Livingstone A, Marlowe GS. Feasibility of  
34 spirometry and reversibility testing for the identification of patients with chronic  
35 obstructive pulmonary disease on asthma registers in general practice. *Respiratory*  
36 *Medicine*. 1999; 93(12):903-908
- 37 594 Gronke L, Kannies F, Holz O, Jorres RA, Magnussen H. The relationship between  
38 airway hyper-responsiveness, markers of inflammation and lung function depends on  
39 the duration of the asthmatic disease. *Clinical and Experimental Allergy*. 2002;  
40 32(1):57-63

- 1 595 Gruchalla RS, Gan V, Roy L, Bokovoy J, McDermott S, Lawrence G et al. Results of an  
2 inner-city school-based asthma and allergy screening pilot study: a combined  
3 approach using written questionnaires and step testing. *Annals of Allergy, Asthma and*  
4 *Immunology*. 2003; 90(5):491-499
- 5 596 Gruchalla RS, Sampson HA, Matsui E, David G, Gergen PJ, Calatroni A et al. Asthma  
6 morbidity among inner-city adolescents receiving guidelines-based therapy: role of  
7 predictors in the setting of high adherence. *Journal of Allergy and Clinical Immunology*.  
8 2009; 124(2):213-221
- 9 597 Gruffydd-Jones K, Hollinghurst S, Ward S, Taylor G. Targeted routine asthma care in  
10 general practice using telephone triage. *British Journal of General Practice*. 2005;  
11 55:918-923
- 12 598 Grzelewska-Rzymowska I, Rozniecki J, Szmidt M, Kowalski ML. Asthma with aspirin  
13 intolerance. Clinical entity or coincidence of nonspecific bronchial hyperreactivity and  
14 aspirin intolerance. *Allergologia Et Immunopathologia*. 1981; 9(6):533-538
- 15 599 Grzelewski T, Grzelewska A, Majak P, Stelmach W, Kowalska A, Stelmach R et al.  
16 Fractional exhaled nitric oxide (FeNO) may predict exercise-induced  
17 bronchoconstriction (EIB) in schoolchildren with atopic asthma. *Nitric Oxide*. 2012;  
18 27(2):82-87
- 19 600 Grzelewski T, Witkowski K, Makandjou-Ola E, Grzelewska A, Majak P, Jerzynska J et al.  
20 Diagnostic value of lung function parameters and FeNO for asthma in schoolchildren in  
21 large, real-life population. *Pediatric Pulmonology*. 2014; 49(7):632-640
- 22 601 Gudelj I, Mrkic Kobal I, Munivrana Skvorc H, Mise K, Vrbica Z, Plavec D et al.  
23 Intraregional differences in asthma prevalence and risk factors for asthma among  
24 adolescents in Split-Dalmatia County, Croatia. *Medical Science Monitor*. 2012;  
25 18(4):H43-H50
- 26 602 Guendelman S, Meade K, Benson M, Chen YQ, Samuels S. Improving asthma outcomes  
27 and self-management behaviors of inner-city children: a randomized trial of the Health  
28 Buddy interactive device and an asthma diary. *Archives of Pediatrics and Adolescent*  
29 *Medicine*. 2002; 156(2):114-120
- 30 603 Guendelman S, Meade K, Chen YQ, Benson M. Asthma control and hospitalizations  
31 among inner-city children: results of a randomized trial. *Telemedicine Journal and E-*  
32 *Health*. 2004; 10 Suppl 2:S-14
- 33 604 Guerra F, Galan Carmen C, Daza JC, Miguel R, Moreno C, Gonzalez J et al. Study of  
34 sensitivity to the pollen of *Fraxinus* spp. (Oleaceae) in Cordoba, Spain. *Journal of*  
35 *Investigational Allergology and Clinical Immunology*. 1995; 5(3):166-170
- 36 605 Guerra S, Wright AL, Morgan WJ, Sherrill DL, Holberg CJ, Martinez FD. Persistence of  
37 asthma symptoms during adolescence: role of obesity and age at the onset of puberty.  
38 *American Journal of Respiratory and Critical Care Medicine*. 2004; 170(1):78-85
- 39 606 Guilbert T. Persistent and relapsed wheezing is associated with sensitivity to domestic  
40 allergens, gender and smoking status. *Evidence-Based Healthcare*. 2004; 8(2):92-94

- 1 607 Guilbert TW, Morgan WJ, Zeiger RS, Bacharier LB, Boehmer SJ, Krawiec M et al. Atopic  
2 characteristics of children with recurrent wheezing at high risk for the development of  
3 childhood asthma. *Journal of Allergy and Clinical Immunology*. 2004; 114(6):1282-1287
- 4 608 Guilbert TW, Singh AM, Danov Z, Evans MD, Jackson DJ, Burton R et al. Decreased lung  
5 function after preschool wheezing rhinovirus illnesses in children at risk to develop  
6 asthma. *Journal of Allergy and Clinical Immunology*. 2011; 128(3):532-10
- 7 609 Gulsvik A. Prevalence and manifestations of obstructive lung disease in the city of  
8 Oslo. *Scandinavian Journal of Respiratory Diseases*. 1979; 60(5):286-296
- 9 610 Gustafson D, Wise M, Bhattacharya A, Pulvermacher A, Shanovich K, Phillips B et al.  
10 The effects of combining web-based eHealth with telephone nurse case management  
11 for pediatric asthma control: A randomized controlled trial. *Journal of Medical Internet  
12 Research*. 2012; 14(4):41-59
- 13 611 Gustafsson D, Sjoberg O, Foucard T. Development of allergies and asthma in infants  
14 and young children with atopic dermatitis--a prospective follow-up to 7 years of age.  
15 *Allergy*. 2000; 55(3):240-245
- 16 612 Haahtela T, Jaakonmaki I. Relationship of allergen-specific IgE antibodies, skin prick  
17 tests and allergic disorders in unselected adolescents. *Allergy*. 1981; 36(4):251-256
- 18 613 Habbick BF, Pizzichini MM, Taylor B, Rennie D, Senthilselvan A, Sears MR. Prevalence  
19 of asthma, rhinitis and eczema among children in 2 Canadian cities: the International  
20 Study of Asthma and Allergies in Childhood. *CMAJ*. 1999; 160(13):1824-1828
- 21 614 Haby MM, Peat JK, Marks GB, Woolcock AJ, Leeder SR. Asthma in preschool children:  
22 prevalence and risk factors. *Thorax*. 2001; 56(8):589-595
- 23 615 Hafkamp-de Groen E, Lingsma HF, Caudri D, Levie D, Wijga A, Koppelman GH et al.  
24 Predicting asthma in preschool children with asthma-like symptoms: validating and  
25 updating the PIAMA risk score. *Journal of Allergy and Clinical Immunology*. 2013;  
26 132(6):1303-1310
- 27 616 Hafkamp-de Groen E, Mohangoo AD, Landgraf JM, de Jongste JC, Duijts L, Moll HA et  
28 al. The impact of preschool wheezing patterns on health-related quality of life at age 4  
29 years. *European Respiratory Journal*. 2013; 41(4):952-959
- 30 617 Hafkamp-de Groen E, Sonnenschein-van der Voort A, Mackenbach JP, Duijts L, Jaddoe  
31 VWV, Moll HA et al. Socioeconomic and sociodemographic factors associated with  
32 asthma related outcomes in early childhood: the generation R study. *PloS One*. 2013;  
33 8(11):e78266
- 34 618 Hafkamp-de Groen E, van Rossem L, de Jongste JC, Mohangoo AD, Moll HA, Jaddoe  
35 VWV et al. The role of prenatal, perinatal and postnatal factors in the explanation of  
36 socioeconomic inequalities in preschool asthma symptoms: the Generation R Study.  
37 *Journal of Epidemiology and Community Health*. 2012; 66(11):1017-1024
- 38 619 Hahn DL, Beasley JW, Andres J, Will I, Angoncillo J, Jackson J et al. Diagnosed and  
39 possible undiagnosed asthma: A Wisconsin Research Network (WRen) study. *Journal  
40 of Family Practice*. 1994; 38(4):373-379

- 1 620 Halbert RJ, Tinkelman DG, Globe DR, Lin SL. Measuring asthma control is the first step  
2 to patient management: a literature review. *Journal of Asthma*. 2009; 46(7):659-664
- 3 621 Hall IP, Blakey JD, Al Balushi KA, Wheatley A, Sayers I, Pembrey ME et al. Beta2-  
4 adrenoceptor polymorphisms and asthma from childhood to middle age in the British  
5 1958 birth cohort: a genetic association study. *Lancet*. 2006; 368(9537):771-779
- 6 622 Hallden G, Hellman C, Gronneberg R, Lundahl J. Increased levels of IL-5 positive  
7 peripheral blood eosinophils and lymphocytes in mild asthmatics after allergen  
8 inhalation provocation. *Clinical and Experimental Allergy*. 1999; 29(5):595-603
- 9 623 Halliday JA, Henry RL, Hankin RG, Hensley MJ. Increased wheeze but not bronchial  
10 hyperreactivity near power stations. *Journal of Epidemiology and Community Health*.  
11 1993; 47(4):282-286
- 12 624 Halonen M, Stern DA, Lohman C, Wright AL, Brown MA, Martinez FD. Two  
13 subphenotypes of childhood asthma that differ in maternal and paternal influences on  
14 asthma risk. *American Journal of Respiratory and Critical Care Medicine*. 1999;  
15 160(2):564-570
- 16 625 Halonen M, Lohman IC, Stern DA, Ellis WL, Rothers J, Wright AL. Perinatal tumor  
17 necrosis factor-alpha production, influenced by maternal pregnancy weight gain,  
18 predicts childhood asthma. *American Journal of Respiratory and Critical Care  
19 Medicine*. 2013; 188(1):35-41
- 20 626 Halterman JS, Sauer J, Fagnano M, Montes G, Fisher S, Tremblay P et al. Working  
21 toward a sustainable system of asthma care: Development of the School-Based  
22 Preventive Asthma Care Technology (SB-PACT) trial. *Journal of Asthma*. 2012;  
23 49(4):395-400
- 24 627 Halvani A, Tahghighi F, Nadooshan HH. Evaluation of correlation between airway and  
25 serum inflammatory markers in asthmatic patients. *Lung India*. 2012; 29(2):143-146
- 26 628 Hancox RJ, Milne BJ, Taylor DR, Greene JM, Cowan JO, Flannery EM et al. Relationship  
27 between socioeconomic status and asthma: a longitudinal cohort study. *Thorax*. 2004;  
28 59(5):376-380
- 29 629 Hancox RJ, Milne BJ, Poulton R, Taylor DR, Greene JM, McLachlan CR et al. Sex  
30 differences in the relation between body mass index and asthma and atopy in a birth  
31 cohort. *American Journal of Respiratory and Critical Care Medicine*. 2005; 171(5):440-  
32 445
- 33 630 Hancox RJ, Poulton R, Taylor DR, Greene JM, McLachlan CR, Cowan JO et al.  
34 Associations between respiratory symptoms, lung function and gastro-oesophageal  
35 reflux symptoms in a population-based birth cohort. *Respiratory Research*. 2006;  
36 7:142
- 37 631 Hannu T, Lindstrom I, Palmroos P, Kuuliala O, Sauni R. Prediction of obeche wood-  
38 induced asthma by specific skin prick testing. *Occupational Medicine*. 2013; 63(6):429-  
39 431



- 1 632 Hansel NN, Matsui EC, Rusher R, McCormack MC, Curtin-Brosnan J, Peng RD et al.  
2 Predicting future asthma morbidity in preschool inner-city children. *Journal of Asthma*.  
3 2011; 48(8):797-803
- 4 633 Hansen KK, Mosfeldt LE, Backer V, Bach-Mortensen N, Prahl P, Koch C. Bronchial  
5 responsiveness in children and adolescents: A comparison between previously  
6 asthmatic, currently asthmatic, and normal subjects. *Journal of Asthma*. 1994;  
7 31(2):99-107
- 8 634 Hargreave FE, Nair P. The definition and diagnosis of Asthma. *Clinical and Experimental*  
9 *Allergy*. 2009; 39(11):1652-1658
- 10 635 Hargreave FE, Ramsdale EH, Kirby JG, O'Byrne PM. Asthma and the role of  
11 inflammation. *European Journal of Respiratory Diseases Supplement*. 1986; 147:16-21
- 12 636 Hargreave FE, Ryan G, Thomson NC, O'Byrne PM, Latimer K, Juniper EF. Bronchial  
13 responsiveness to histamine or methacholine in asthma: measurement and clinical  
14 significance. *European Journal of Respiratory Diseases Supplement*. 1982; 121:79-88
- 15 637 Harnan S, Tappenden P, Essat M, Gomersall T, Minton J, Wong R et al. Measurement  
16 of exhaled nitric oxide concentration in asthma - NIOX MINO and NObreath, 2013.  
17 Available from: <http://guidance.nice.org.uk/DT/13>
- 18 638 Hart MA, Kercksmar CM. Is it asthma, postnasal drip, or reflux? Chronic cough in  
19 children: Pursuing specific causes. *Journal of Respiratory Diseases*. 2002; 4(1):22-27
- 20 639 Hashimoto S, Ten BA, Roldaan AC, Van Veen IH, Möller GM, Sont JK et al. Internet-  
21 based tapering of oral corticosteroids in severe asthma: A pragmatic randomised  
22 controlled trial. *Thorax*. 2011; 66(6):514-520
- 23 640 Hastie AT, Moore WC, Li H, Rector BM, Ortega VE, Pascual RM et al. Biomarker  
24 surrogates do not accurately predict sputum eosinophil and neutrophil percentages in  
25 asthmatic subjects. *Journal of Allergy and Clinical Immunology*. 2013; 132(1):72-80
- 26 641 Hathaway JA, Molenaar DM, Cassidy LD, Feeley TM, Cummings BJ. Cross-sectional  
27 survey of workers exposed to aliphatic diisocyanates using detailed respiratory  
28 medical history and questions regarding accidental skin and respiratory exposures.  
29 *Journal of Occupational and Environmental Medicine*. 2014; 56(1):52-57
- 30 642 Hayati F, Maghsoodloo S, DeVivo MJ, Carnahan BJ. Control chart for monitoring  
31 occupational asthma. *Journal of Safety Research*. 2006; 37(1):17-26
- 32 643 Hayati F, Maghsoodloo S, DeVivo MJ, Thomas RE, Lemiere C. Quality control chart  
33 method for analyzing PEF variability in occupational asthma. *American Journal of*  
34 *Industrial Medicine*. 2008; 51(3):223-228
- 35 644 HAYES. Mannitol bronchial provocation challenge for asthma. HAYES, Inc, 2012
- 36 645 Hayes J, Jhaveri MA, Mannino DM, Strawbridge H, Temprano J. The effect of mold  
37 sensitization and humidity upon allergic asthma. *Clinical Respiratory Journal*. 2013;  
38 7(2):135-144

- 1 646 Hedenstrom H, Malmberg P. Optimal combinations of lung function tests in the  
2 detection of various types of early lung disease. *European Journal of Respiratory*  
3 *Diseases*. 1987; 71(4):273-285
- 4 647 Hedman J, Poussa T, Nieminen MM. A rapid dosimetric methacholine challenge in  
5 asthma diagnostics: a clinical study of 230 patients with dyspnoea, wheezing or a  
6 cough of unknown cause. *Respiratory Medicine*. 1998; 92(1):32-39
- 7 648 Heffler E, Guida G, Marsico P, Bergia R, Bommarito L, Ferrero N et al. Exhaled nitric  
8 oxide as a diagnostic test for asthma in rhinitic patients with asthmatic symptoms.  
9 *Respiratory Medicine*. 2006; 100(11):1981-1987
- 10 649 Heidenfelder B, Johnson M, Hudgens E, Inmon J, Hamilton RG, Neas L et al. Increased  
11 plasma reactive oxidant levels and their relationship to blood cells, total IgE, and  
12 allergen-specific IgE levels in asthmatic children. *Journal of Asthma*. 2010; 47(1):106-  
13 111
- 14 650 Heinrich J, Hoelscher B, Frye C, Meyer I, Wjst M, Wichmann HE. Trends in prevalence  
15 of atopic diseases and allergic sensitization in children in Eastern Germany. *European*  
16 *Respiratory Journal*. 2002; 19(6):1040-1046
- 17 651 Heinrich J, Hoelscher B, Wjst M, Ritz B, Cyrus J, Wichmann H. Respiratory diseases and  
18 allergies in two polluted areas in East Germany. *Environmental Health Perspectives*.  
19 1999; 107(1):53-62
- 20 652 Heinrich J, Richter K, Magnussen H, Wichmann HE. Is the prevalence of atopic diseases  
21 in East and West Germany already converging? *European Journal of Epidemiology*.  
22 1998; 14(3):239-245
- 23 653 Hellinckx J, De Boeck K, Bande-Knops J, van der Poel M, Demedts M. Bronchodilator  
24 response in 3-6.5 years old healthy and stable asthmatic children. *European*  
25 *Respiratory Journal*. 1998; 12(2):438-443
- 26 654 Henderson AJ, Carswell F. Circadian rhythm of peak expiratory flow in asthmatic and  
27 normal children. *Thorax*. 1989; 44(5):410-414
- 28 655 Henderson FW, Henry MM, Ivins SS, Morris R, Neebe EC, Leu SY et al. Correlates of  
29 recurrent wheezing in school-age children. The Physicians of Raleigh Pediatric  
30 Associates. *American Journal of Respiratory and Critical Care Medicine*. 1995;  
31 151(6):1786-1793
- 32 656 Henderson J, Granell R, Heron J, Sherriff A, Simpson A, Woodcock A et al. Associations  
33 of wheezing phenotypes in the first 6 years of life with atopy, lung function and airway  
34 responsiveness in mid-childhood. *Thorax*. 2008; 63(11):974-980
- 35 657 Henderson J, Hilliard TN, Sherriff A, Stalker D, Al Shammari N, Thomas HM.  
36 Hospitalization for RSV bronchiolitis before 12 months of age and subsequent asthma,  
37 atopy and wheeze: a longitudinal birth cohort study. *Pediatric Allergy and*  
38 *Immunology*. 2005; 16(5):386-392
- 39 658 Henderson J, Northstone K, Lee SP, Liao H, Zhao Y, Pembrey M et al. The burden of  
40 disease associated with filaggrin mutations: a population-based, longitudinal birth  
41 cohort study. *Journal of Allergy and Clinical Immunology*. 2008; 121(4):872-877

- 1 659 Henriksen AH, Holmen TL, Bjermer L. Sensitization and exposure to pet allergens in  
2 asthmatics versus non-asthmatics with allergic rhinitis. *Respiratory Medicine*. 2001;  
3 95(2):122-129
- 4 660 Henriksen AH, Holmen TL, Bjermer L. Gender differences in asthma prevalence may  
5 depend on how asthma is defined. *Respiratory Medicine*. 2003; 97(5):491-497
- 6 661 Henriksen AH, Tveit KH, Holmen TL, Sue-Chu M, Bjermer L. A study of the association  
7 between exercise-induced wheeze and exercise versus methacholine-induced  
8 bronchoconstriction in adolescents. *Pediatric Allergy and Immunology*. 2002;  
9 13(3):203-208
- 10 662 Hensley MJ, Chalmers A, Clover K, Gibson PG, Toneguzzi R, Lewis PR. Symptoms of  
11 asthma: comparison of a parent-completed retrospective questionnaire with a  
12 prospective daily symptom diary. *Pediatric Pulmonology*. 2003; 36(6):509-513
- 13 663 Herr M, Just J, Nikasinovic L, Foucault C, Le Marec AM, Giordanella JP et al. Influence  
14 of host and environmental factors on wheezing severity in infants: findings from the  
15 PARIS birth cohort. *Clinical and Experimental Allergy*. 2012; 42(2):275-283
- 16 664 Herr M, Just J, Nikasinovic L, Foucault C, Le Marec AM, Giordanella JP et al. Risk factors  
17 and characteristics of respiratory and allergic phenotypes in early childhood. *Journal of  
18 Allergy and Clinical Immunology*. 2012; 130(2):389-396
- 19 665 Hervas D, Milan JM, Garde J. Differences in exhaled nitric oxide in atopic children.  
20 *Allergologia Et Immunopathologia*. 2008; 36(6):331-335
- 21 666 Hetlevik O, Ploen O, Nystad W, Magnus P. The wheezing schoolchild--an undiagnosed  
22 asthmatic. A follow-up of children with parentally reported episodes of wheeze  
23 without diagnosed asthma. *Scandinavian Journal of Primary Health Care*. 2000;  
24 18(2):122-126
- 25 667 Hetzel MR, Clark TJH. Comparison of normal and asthmatic circadian rhythms in peak  
26 expiratory flow rate. *Thorax*. 1980; 35(10):732-738
- 27 668 Hickson DA, Wilhite RL, Petrini MF, White WB, Burchfiel C. Asthma and asthma  
28 severity among African American adults in the Jackson Heart Study. *Journal of Asthma*.  
29 2009; 46(4):421-428
- 30 669 Higgins BG, Britton JR, Chinn S, Cooper S, Burney PG, Tattersfield AE. Comparison of  
31 bronchial reactivity and peak expiratory flow variability measurements for  
32 epidemiologic studies. *American Review of Respiratory Disease*. 1992; 145(3):588-593
- 33 670 Higgins BG, Britton JR, Chinn S, Jones TD, Jenkinson D, Burney PG et al. The distribution  
34 of peak expiratory flow variability in a population sample. *American Review of  
35 Respiratory Disease*. 1989; 140(5):1368-1372
- 36 671 Hildebrand K, Przybylowski T, Maskey-Warzechowska M, Chazan R. Usefulness of  
37 selected tests in the diagnosis of exercise induced bronchoconstriction.  
38 *Pneumonologia i Alergologia Polska*. 2011; 79(6):397-406
- 39 672 Hill DJ, Bannister DG, Hosking CS, Kemp AS. Cow milk allergy within the spectrum of  
40 atopic disorders. *Clinical and Experimental Allergy*. 1994; 24(12):1137-1143

- 1 673 Hirsch S, Frank TL, Shapiro JL, Hazell ML, Frank PI. Development of a questionnaire  
2 weighted scoring system to target diagnostic examinations for asthma in adults: a  
3 modelling study. *BMC Family Practice*. 2004; 5(1):30
- 4 674 Hirsch T, Weiland SK, von Mutius E, Safeca AF, Grafe H, Csaplovics E et al. Inner city air  
5 pollution and respiratory health and atopy in children. *European Respiratory Journal*.  
6 1999; 14(3):669-677
- 7 675 Hodge L, Salome CM, Peat JK, Haby MM, Xuan W, Woolcock AJ. Consumption of oily  
8 fish and childhood asthma risk. *Medical Journal of Australia*. 1996; 164(3):137-140
- 9 676 Hoek G, Pattenden S, Willers S, Antova T, Fabianova E, Braun-Fahrlander C et al. PM10,  
10 and children's respiratory symptoms and lung function in the PATY study. *European  
11 Respiratory Journal*. 2012; 40(3):538-547
- 12 677 Hoffmann-Petersen B, Host A, Larsen KT, Bergstein KR, Thomsen ML, Braendholt V et  
13 al. Prevalence of IgE sensitization in Danish children with suspected asthma. *Pediatric  
14 Allergy and Immunology*. 2013; 24(8):727-733
- 15 678 Hogarth-Scott RS, McNicol RN, Williams HE. Diagnosis of allergy in vitro. A comparison  
16 between skin sensitivity testing and serum levels of specific IgE antibody in children.  
17 *Medical Journal of Australia*. 1973; 1(26):1293-1297
- 18 679 Hogman M, Holmkvist T, Wegener T, Emtner M, Andersson M, Hedenstrom H et al.  
19 Extended NO analysis applied to patients with COPD, allergic asthma and allergic  
20 rhinitis. *Respiratory Medicine*. 2002; 96(1):24-30
- 21 680 Hogman M, Ludviksdottir D, Anderson SD, George S, Hakansson L, Chan HK et al.  
22 Inhaled mannitol shifts exhaled nitric oxide in opposite directions in asthmatics and  
23 healthy subjects. *Respiration Physiology*. 2001; 124(2):141-150
- 24 681 Holguin F, Rojas M, Brown LA, Fitzpatrick AM. Airway and plasma leptin and  
25 adiponectin in lean and obese asthmatics and controls. *Journal of Asthma*. 2011;  
26 48(3):217-223
- 27 682 Holster IL, Vila AM, Caudri D, den Hoed CM, Perez-Perez GI, Blaser MJ et al. The impact  
28 of *Helicobacter pylori* on atopic disorders in childhood. *Helicobacter*. 2012; 17(3):232-  
29 237
- 30 683 Holt EW, Tan J, Hosgood III HD. The impact of spirometry on pediatric asthma  
31 diagnosis and treatment. *Journal of Asthma*. 2006; 43(7):489-493
- 32 684 Holt PG, Rowe J, Kusel M, Parsons F, Hollams EM, Bosco A et al. Toward improved  
33 prediction of risk for atopy and asthma among preschoolers: a prospective cohort  
34 study. *Journal of Allergy and Clinical Immunology*. 2010; 125(3):653-659
- 35 685 Holt S, Perrin K. Using the asthma control test to improve asthma outcomes. *New  
36 Zealand Medical Journal*. 2010; 123(1323):43-47
- 37 686 Holzer K, Anderson SD, Chan HK, Douglass J. Mannitol as a challenge test to identify  
38 exercise-induced bronchoconstriction in elite athletes. *American Journal of  
39 Respiratory and Critical Care Medicine*. 2003; 167(4):534-537

- 1 687 Holzer K, Anderson SD, Douglass J. Exercise in elite summer athletes: Challenges for  
2 diagnosis. *Journal of Allergy and Clinical Immunology*. 2002; 110(3):374-380
- 3 688 Homnick DN, DeJong SR. Parent-reported physician diagnosis is an important factor in  
4 asthma management: an elementary school survey. *Clinical Pediatrics*. 2007;  
5 46(5):431-436
- 6 689 Hong SP, Park HS, Lee MK, Hong CS. Oral provocation tests with aspirin and food  
7 additives in asthmatic patients. *Yonsei Medical Journal*. 1989; 30(4):339-345
- 8 690 Honkoop P, Loijmans R, Termeer E, Snoeck-Stroband J, Assendelft P, Sterk P et al. A  
9 cluster randomized trial comparing strict, partial, and FeNO-guided asthma control  
10 strategies in primary care [Abstract]. *European Respiratory Society Annual Congress*,  
11 2013 Sept 7-11, Barcelona, Spain. 2013; 42(Suppl 57):397s
- 12 691 Honkoop PJ, Loijmans RJ, Termeer EH, Snoeck-Stroband JB, van den Hout WB, Bakker  
13 MJ et al. Symptom- and fraction of exhaled nitric oxide-driven strategies for asthma  
14 control: A cluster-randomized trial in primary care. *Journal of Allergy and Clinical  
15 Immunology*. 2014; Epublication
- 16 692 Honkoop PJ, Loymans RJ, Termeer EH, Snoeck-Stroband JB, Bakker MJ, Assendelft WJ  
17 et al. Asthma control cost-utility randomized trial evaluation (ACCURATE): the goals of  
18 asthma treatment. *BMC Pulmonary Medicine*. England 2011; 11:53
- 19 693 Hopp RJ, Bewtra AK, Nair NM, Townley RG. Specificity and sensitivity of methacholine  
20 inhalation challenge in normal and asthmatic children. *Journal of Allergy and Clinical  
21 Immunology*. 1984; 74(2):154-158
- 22 694 Hopp RJ, Biven RE, Degan JA, Bewtra AK, Townley RG. The usefulness of questionnaire-  
23 derived information to predict the degree of nonspecific bronchial  
24 hyperresponsiveness. *Allergy Proceedings*. 1995; 16(3):129-134
- 25 695 Hopper JL, Jenkins MA, Carlin JB, Giles GG. Increase in the self-reported prevalence of  
26 asthma and hay fever in adults over the last generation: a matched parent-offspring  
27 study. *Australian Journal of Public Health*. 1995; 19(2):120-124
- 28 696 Hopper JL, Bui QM, Erbas B, Matheson MC, Gurrin LC, Burgess JA et al. Does eczema in  
29 infancy cause hay fever, asthma, or both in childhood? Insights from a novel  
30 regression model of sibling data. *Journal of Allergy and Clinical Immunology*. 2012;  
31 130(5):1117-1122
- 32 697 Horak E, Lanigan A, Roberts M, Welsh L, Wilson J, Carlin JB et al. Longitudinal study of  
33 childhood wheezy bronchitis and asthma: outcome at age 42. *BMJ*. 2003;  
34 326(7386):422-423
- 35 698 Horak E, Morass B, Ulmer H. Association between environmental tobacco smoke  
36 exposure and wheezing disorders in Austrian preschool children. *Swiss Medical  
37 Weekly*. 2007; 137(43-44):608-613
- 38 699 Horak E, Murr C, Streif W, Schroecksnadel K, Schennach H, Fuchs D. Association  
39 between neopterin in cord blood, urinary neopterin in early childhood and the  
40 development of atopic dermatitis, asthma and hay fever. *Pediatric Allergy and  
41 Immunology*. 2006; 17(1):11-16

- 1 700 Horie T, Enomoto S, Inazawa T, Okuma A, Hosokawa Y, Okayasu M. Comparison of  
2 airway responsiveness to exercise and histamine inhalation in asthmatics. *Japanese*  
3 *Journal of Medicine*. 1983; 22(1):26-30
- 4 701 Horvath I, Donnelly LE, Kiss A, Balint B, Kharitonov SA, Barnes PJ. Exhaled nitric oxide  
5 and hydrogen peroxide concentrations in asthmatic smokers. *Respiration*. 2004;  
6 71(5):463-468
- 7 702 Horwood LJ, Fergusson DM, Shannon FT. Social and familial factors in the development  
8 of early childhood asthma. *Pediatrics*. 1985; 75(5):859-868
- 9 703 Hovi S. Exhaled nitric oxide in asthma diagnosis and treatment monitoring. Helsinki.  
10 Finnish Office for Health Care Technology Assessment (FinOHTA), 2010
- 11 704 Hsu JY, Huang CM, King SL, Chiang CD. Importance of sputum differential cell counting  
12 in the diagnosis of airway diseases. *Journal of the Formosan Medical Association*.  
13 1997; 96(5):330-335
- 14 705 Hsu J-Y, Huang W-C, Huang P-L, Cheng Y-W, Chou M-C. Usefulness of offline fractional  
15 exhaled nitric oxide measurements in the elderly asthmatic patients. *Allergy and*  
16 *Asthma Proceedings*. 2013; 35(5):434-438
- 17 706 Hu FB, Persky V, Flay BR, Richardson J. An epidemiological study of asthma prevalence  
18 and related factors among young adults. *Journal of Asthma*. 1997; 34(1):67-76
- 19 707 Hu FB, Persky V, Flay BR, Zelli A, Cooksey J, Richardson J. Prevalence of asthma and  
20 wheezing in public schoolchildren: association with maternal smoking during  
21 pregnancy. *Annals of Allergy, Asthma and Immunology*. 1997; 79(1):80-84
- 22 708 Huang J-L, Chen S-H, Yeh K-W. Health outcomes, education, healthcare delivery and  
23 quality-3056. Constructed supporting program improves asthma treatment outcomes  
24 in children. *World Allergy Organization Journal*.: Lippincott Williams and Wilkins. 2013;  
25 6(Suppl 1):224
- 26 709 Huang TT, Li YT, Wang CH. Individualized programme to promote self-care among  
27 older adults with asthma: randomized controlled trial. *Journal of Advanced Nursing*.  
28 2009; 65(2):348-358
- 29 710 Hublet A, Andersen A, Godeau E, Vereecken C, Valimaa R, Tynjala J et al. Asthma and  
30 wheezing symptoms in young people in six Western countries. *Revue D'Epidemiologie*  
31 *Et De Sante Publique*. 2006; 54(4):305-312
- 32 711 Huertas AJ, Lopez-Saez MP, Carnes J. Clinical profile of a Mediterranean population  
33 sensitised to date palm pollen (*Phoenix dactylifera*). A retrospective study. *Allergologia*  
34 *Et Immunopathologia*. 2011; 39(3):145-149
- 35 712 Hunger T, Rzehak P, Wichmann HE, Heinrich J. Prognostic values of specific respiratory  
36 sounds for asthma in adolescents. *European Journal of Pediatrics*. 2010; 169(1):39-46
- 37 713 Hunter CJ, Brightling CE, Woltmann G, Wardlaw AJ, Pavord ID. A comparison of the  
38 validity of different diagnostic tests in adults with asthma. *Chest*. 2002; 121(4):1051-  
39 1057

- 1 714 Hur G, Moon J, Kim H, Ha E, Lee K, Jung K et al. The effectiveness of mannitol challenge  
2 test for diagnosis of bronchial asthma. *American Journal of Respiratory and Critical*  
3 *Care Medicine*. 2010; 181(1 MeetingAbstracts)
- 4 715 Hur GY, Koh DH, Choi GS, Park HJ, Choi SJ, Ye YM et al. Clinical and immunologic  
5 findings of methylene diphenyl diisocyanate-induced occupational asthma in a car  
6 upholstery factory. *Clinical and Experimental Allergy*. 2008; 38(4):586-593
- 7 716 Hur G-Y, Moon J-Y, Kim H-O, Lee K-J, Lee S-Y, Shim J-J et al. Comparison of  
8 methacholine and mannitol challenge test for diagnosis of bronchial asthma.  
9 *Respirology*. 2009; 14:A137
- 10 717 Hussein A. The incidence of analgesics intolerance in asthmatic children detected by  
11 history and inhalation challenge with lysine acetylsalicylate. *Klinische Padiatrie*. 1989;  
12 201(1):1-5
- 13 718 Huszar E, Vass G, Vizi E, Csoma Z, Barat E, Molnar Vilagos G et al. Adenosine in exhaled  
14 breath condensate in healthy volunteers and in patients with asthma. *European*  
15 *Respiratory Journal*. 2002; 20(6):1393-1398
- 16 719 Hyvarinen MK, Kotaniemi-Syrjanen A, Reijonen TM, Korhonen K, Kiviniemi V, Korppi M.  
17 Responses to inhaled bronchodilators in infancy are not linked with asthma in later  
18 childhood. *Pediatric Pulmonology*. 2006; 41(5):420-427
- 19 720 Hyvarinen MK, Kotaniemi-Syrjanen A, Reijonen TM, Piippo-Savolainen E, Korppi M.  
20 Eosinophil activity in infants hospitalized for wheezing and risk of persistent childhood  
21 asthma. *Pediatric Allergy and Immunology*. 2010; 21(1 Pt 1):96-103
- 22 721 Ignacio JM, González P. Educational program on medication auto-control in asthmatic  
23 patients with peak flow [PEF] home-monitoring. *Neumosur*. 1993; 5(2):33-43
- 24 722 Ignacio-Garcia JM, Gonzalez-Santos P. Asthma self-management education program by  
25 home monitoring of peak expiratory flow. *American Journal of Respiratory and Critical*  
26 *Care Medicine*. 1995; 151(2 Pt 1):353-359
- 27 723 Iio M, Takenaka K, Narita M, Futamura M, Hamaguchi M, Fukushima K et al.  
28 [Development and effectiveness of a tailored education program for caregivers of  
29 asthmatic children]. *Arerugi. Japan* 2014; 63(2):187-203
- 30 724 Illi S, von Mutius E, Lau S, Bergmann R, Niggemann B, Sommerfeld C et al. The role of  
31 early childhood infectious diseases in the development of asthma up to school age.  
32 *Allergy and Clinical Immunology International*. 2001; 13(3):99-106
- 33 725 Illi S, von Mutius E, Lau S, Bergmann R, Niggemann B, Sommerfeld C et al. Early  
34 childhood infectious diseases and the development of asthma up to school age: a birth  
35 cohort study. *BMJ*. 2001; 322(7283):390-395
- 36 726 Illi S, von Mutius E, Lau S, Nickel R, Gruber C, Niggemann B et al. The natural course of  
37 atopic dermatitis from birth to age 7 years and the association with asthma. *Journal of*  
38 *Allergy and Clinical Immunology*. 2004; 113(5):925-931

- 1 727 Illi S, von Mutius E, Lau S, Niggemann B, Gruber C, Wahn U et al. Perennial allergen  
2 sensitisation early in life and chronic asthma in children: a birth cohort study. *Lancet*.  
3 2006; 368(9537):763-770
- 4 728 Imai C, Yamazaki H, Tanaka Y, Matsunaga M, Numata O, Torigoe K. Ratio of eosinophil  
5 cationic protein/eosinophil count as a new marker in children with acute asthma.  
6 *Pediatrics International*. 1999; 41(2):142-146
- 7 729 Imbeau SA, Geller M. *Dermatophagoides farinae* antigen skin test sensitivity in  
8 Wisconsin. *Annals of Allergy*. 1978; 41(5):283-284
- 9 730 Inkley SR, Oseasohn RO. A study of illness in a group of Cleveland families. 23.  
10 Ventilatory function in young adults a decade after repeated wheezing in childhood.  
11 *American Review of Respiratory Disease*. 1967; 96(3):408-410
- 12 731 Irwin RS, Curley FJ, French CL. Chronic cough. The spectrum and frequency of causes,  
13 key components of the diagnostic evaluation, and outcome of specific therapy.  
14 *American Review of Respiratory Disease*. 1990; 141(3):640-647
- 15 732 Irwin RS, French CT, Smyrnios NA, Curley FJ. Interpretation of positive results of a  
16 methacholine inhalation challenge and 1 week of inhaled bronchodilator use in  
17 diagnosing and treating cough-variant asthma. *Archives of Internal Medicine*. 1997;  
18 157(17):1981-1987
- 19 733 Ishizuka T, Matsuzaki S, Aoki H, Yatomi M, Kamide Y, Hisada T et al. Prevalence of  
20 asthma symptoms based on the European Community Respiratory Health Survey  
21 questionnaire and FENO in university students: gender differences in symptoms and  
22 FENO. *Allergy, Asthma, and Clinical Immunology*. 2011; 7(1):15
- 23 734 Islam T, Gauderman WJ, Berhane K, McConnell R, Avol E, Peters JM et al. Relationship  
24 between air pollution, lung function and asthma in adolescents. *Thorax*. 2007;  
25 62(11):957-963
- 26 735 Iversen L, Hannaford PC, Price DB, Godden DJ. Is living in a rural area good for your  
27 respiratory health? Results from a cross-sectional study in Scotland. *Chest*. 2005;  
28 128(4):2059-2067
- 29 736 Iwamoto I, Yamazaki H, Kimura A, Ochiai K, Tomioka H, Yoshida S. Comparison of a  
30 multi-allergen dipstick IgE assay to skin-prick test and RAST. *Clinical and Experimental*  
31 *Allergy*. 1990; 20(2):175-179
- 32 737 Jaakkola MS, Ieromnimon A, Jaakkola JJK. Are atopy and specific IgE to mites and  
33 molds important for adult asthma? *Journal of Allergy and Clinical Immunology*. 2006;  
34 117(3):642-648
- 35 738 Jackola DR, Blumenthal MN, Rosenberg A. Evidence for two independent distributions  
36 of serum immunoglobulin E in atopic families: cognate and non-cognate IgE. *Human*  
37 *Immunology*. 2004; 65(1):20-30
- 38 739 Jackson DJ, Gangnon RE, Evans MD, Roberg KA, Anderson EL, Pappas TE et al.  
39 Wheezing rhinovirus illnesses in early life predict asthma development in high-risk  
40 children. *American Journal of Respiratory and Critical Care Medicine*. 2008;  
41 178(7):667-672



- 1 740 Jacobs JH, Fuertes E, Krop EJM, Spithoven J, Tromp P, Heederik DJJ. Swimming pool  
2 attendance and respiratory symptoms and allergies among Dutch children.  
3 Occupational and Environmental Medicine. 2012; 69(11):823-830
- 4 741 Jain P, Kavuru MS, Emerman CL, Ahmad M. Utility of peak expiratory flow monitoring.  
5 Chest. 1998; 114(3):861-876
- 6 742 Jain VV, Abejie B, Bashir MH, Tyner T, Vempilly J. Lung volume abnormalities and its  
7 correlation to spirometric and demographic variables in adult asthma. Journal of  
8 Asthma. 2013; 50(6):600-605
- 9 743 James A, Lougheed D, Pearce-Pinto G, Ryan G, Musk B. Maximal airway narrowing in a  
10 general population. American Review of Respiratory Disease. 1992; 146(4):895-899
- 11 744 James A, Ryan G. Testing airway responsiveness using inhaled methacholine or  
12 histamine. Respirology. 1997; 2(2):97-105
- 13 745 James AL, Knuiman MW, Divitini ML, Hui J, Hunter M, Palmer LJ et al. Changes in the  
14 prevalence of asthma in adults since 1966: the Busselton health study. European  
15 Respiratory Journal. 2010; 35(2):273-278
- 16 746 James AL, Knuiman MW, Divitini ML, Hui J, Hunter ML, Mulrennan SA et al. Risk factors  
17 for respiratory symptoms in adults: The Busselton Health Study. Respirology. 2013;  
18 18(8):1256-1260
- 19 747 Jamison JP, McKinley RK. Validity of peak expiratory flow rate variability for the  
20 diagnosis of asthma. Clinical Science. 1993; 85(3):367-371
- 21 748 Jamrozik E, Knuiman MW, James A, Divitini M, Musk AWB. Risk factors for adult-onset  
22 asthma: a 14-year longitudinal study. Respirology. 2009; 14(6):814-821
- 23 749 Jan RL, Wang JY, Huang MC, Tseng SM, Su HJ, Liu LF. An internet-based interactive  
24 telemonitoring system for improving childhood asthma outcomes in Taiwan.  
25 Telemedicine Journal and E-Health. 2007; 13(3):257-268
- 26 750 Jang AS, Park JS, Lee JH, Park SW, Kim DJ, Park CS. Autologous serum skin test for  
27 autoantibodies is associated with airway hyperresponsiveness in patients with asthma.  
28 Respiration. 2007; 74(3):293-296
- 29 751 Jang AS, Yeum CH, Choi IS. Nitric oxide metabolites, eosinophils, and eosinophilic  
30 cationic protein in patients with asthma: sputum versus blood. Journal of Korean  
31 Medical Science. 2003; 18(4):489-493
- 32 752 Janson C, Chinn S, Jarvis D, Burney P. Determinants of cough in young adults  
33 participating in the European Community Respiratory Health Survey. European  
34 Respiratory Journal. 2001; 18(4):647-654
- 35 753 Janson C, Chinn S, Jarvis D, Zock JP, Toren K, Burney P et al. Effect of passive smoking  
36 on respiratory symptoms, bronchial responsiveness, lung function, and total serum IgE  
37 in the European Community Respiratory Health Survey: a cross-sectional study. Lancet.  
38 2001; 358(9299):2103-2109

- 1 754 Janson SL. Encouraging communication between doctors and patients to improve  
2 adherence to asthma medication. *ClinicalTrials Gov.* 2005;
- 3 755 Janson SL, McGrath KW, Covington JK, Baron RB, Lazarus SC. Objective airway  
4 monitoring improves asthma control in the cold and flu season: a cluster randomized  
5 trial. *Chest.* 2010; 138(5):1148-1155
- 6 756 Janson-Bjerklie S, Shnell S. Effect of peak flow information on patterns of self-care in  
7 adult asthma. *Heart and Lung: Journal of Critical Care.* 1988; 17(5):543-549
- 8 757 Jares EJ, Baena-Cagnani CE, Gomez RM. Diagnosis of occupational asthma: an update.  
9 *Current Allergy and Asthma Reports.* 2012; 12(3):221-231
- 10 758 Jartti T, Lee WM, Pappas T, Evans M, Lemanske RFJ, Gern JE. Serial viral infections in  
11 infants with recurrent respiratory illnesses. *European Respiratory Journal.* 2008;  
12 32(2):314-320
- 13 759 Jarvis D, Chinn S, Luczynska C, Burney P. Association of respiratory symptoms and lung  
14 function in young adults with use of domestic gas appliances. *Lancet.* 1996;  
15 347(8999):426-431
- 16 760 Jarvis D, Chinn S, Potts J, Burney P, European Community. Association of body mass  
17 index with respiratory symptoms and atopy: results from the European Community  
18 Respiratory Health Survey. *Clinical and Experimental Allergy.* 2002; 32(6):831-837
- 19 761 Jarvis D, Lai E, Luczynska C, Chinn S, Burney P. Prevalence of asthma and asthma-like  
20 symptoms in young adults living in three east Anglian towns. *British Journal of General  
21 Practice.* 1994; 44(388):493-497
- 22 762 Jatakanon A, Lim S, Kharitonov SA, Chung KF, Barnes PJ. Correlation between exhaled  
23 nitric oxide, sputum eosinophils, and methacholine responsiveness in patients with  
24 mild asthma. *Thorax.* 1998; 53(2):91-95
- 25 763 Jeffs D, Grainger R, Powell P. Is childhood allergy more common amongst an island  
26 population? *Journal of the Royal Society for the Promotion of Health.* 2000;  
27 120(4):236-241
- 28 764 Jenkins MA, Clarke JR, Carlin JB, Robertson CF, Hopper JL, Dalton MF et al. Validation  
29 of questionnaire and bronchial hyperresponsiveness against respiratory physician  
30 assessment in the diagnosis of asthma. *International Journal of Epidemiology.* 1996;  
31 25(3):609-616
- 32 765 Jenkins MA, Dharmage SC, Flander LB, Douglass JA, Ugoni AM, Carlin JB et al. Parity  
33 and decreased use of oral contraceptives as predictors of asthma in young women.  
34 *Clinical and Experimental Allergy.* 2006; 36(5):609-613
- 35 766 Jenkins MA, Hopper JL, Bowes G, Carlin JB, Flander LB, Giles GG. Factors in childhood  
36 as predictors of asthma in adult life. *BMJ.* 1994; 309(6947):90-93
- 37 767 Jentzsch NS, le Bourgeois M, de Blic J, Scheinmann P, Waernessyckle S, Camargos  
38 PAM. Nitric oxide in children with persistent asthma. *Jornal De Pediatria.* 2006;  
39 82(3):193-196

- 1 768 Jerzynska J, Majak P, Janas A, Stelmach R, Stelmach W, Smejda K et al. Predictive value  
2 of fractional nitric oxide in asthma diagnosis-subgroup analyses. *Nitric Oxide*. 2014;  
3 40:87-91
- 4 769 Jia CE, Zhang HP, Lv Y, Liang R, Jiang YQ, Powell H et al. The Asthma Control Test and  
5 Asthma Control Questionnaire for assessing asthma control: Systematic review and  
6 meta-analysis. *Journal of Allergy and Clinical Immunology*. 2013; 131(3):695-703
- 7 770 Jindal SK, Aggarwal AN, Gupta D. Diurnal variability of peak expiratory flow. *Journal of*  
8 *Asthma*. 2002; 39(5):363-373
- 9 771 Johnson KT, Funahashi A. Clinical characteristics and methacholine sensitivity in  
10 patients with suspected bronchial asthma. *Wisconsin Medical Journal*. 1987; 86(4):17-  
11 19
- 12 772 Johnson L, Shah I, Loh AX, Vinall LE, Teixeira AS, Rousseau K et al. MUC5AC and  
13 inflammatory mediators associated with respiratory outcomes in the British 1946 birth  
14 cohort. *Respirology*. 2013; 18(6):1003-1010
- 15 773 Johnston ID, Strachan DP, Anderson HR. Effect of pneumonia and whooping cough in  
16 childhood on adult lung function. *New England Journal of Medicine*. 1998; 338(9):581-  
17 587
- 18 774 Jones A. Asymptomatic bronchial hyperreactivity and the development of asthma and  
19 other respiratory tract illnesses in children. *Thorax*. 1994; 49(8):757-761
- 20 775 Jones A, Bowen M. Screening for childhood asthma using an exercise test. *British*  
21 *Journal of General Practice*. 1994; 44(380):127-131
- 22 776 Jones KP, Mullee MA, Middleton M, Chapman E, Holgate ST. Peak flow based asthma  
23 self-management: a randomised controlled study in general practice. *Thorax*. 1995;  
24 50(8):851-857
- 25 777 Jones R, Lin S, Munsie JP, Radigan M, Hwang SA. Racial/ethnic differences in asthma-  
26 related emergency department visits and hospitalizations among children with wheeze  
27 in Buffalo, New York. *Journal of Asthma*. 2008; 45(10):916-922
- 28 778 Joos GF, O'Connor B, Anderson SD, Chung F, Cockcroft DW, Dahlen B et al. Indirect  
29 airway challenges. *European Respiratory Journal*. 2003; 21(6):1050-1068
- 30 779 Joos GF. Bronchial hyperresponsiveness: too complex to be useful? *Current Opinion in*  
31 *Pharmacology*. 2003; 3(3):233-238
- 32 780 Joseph CL, Foxman B, Leickly FE, Peterson E, Ownby D. Prevalence of possible  
33 undiagnosed asthma and associated morbidity among urban schoolchildren. *Journal of*  
34 *Pediatrics*. 1996; 129(5):735-742
- 35 781 Joseph CL, Foxman B, Leickly FE, Peterson E, Ownby D. Sensitivity and specificity of  
36 asthma definitions and symptoms used in a survey of childhood asthma. *Journal of*  
37 *Asthma*. 1999; 36(7):565-573

- 1 782 Joseph J, Escobar A, Bashir M, Claes D. Abnormal RV/TLC ratio is a better criterion to  
2 diagnose obstruction in patients with asthma. *Chest*. 2011; 140(4 Meeting  
3 Abstracts):226A
- 4 783 Joseph-Bowen J, de Klerk NH, Firth MJ, Kendall GE, Holt PG, Sly PD. Lung function,  
5 bronchial responsiveness, and asthma in a community cohort of 6-year-old children.  
6 *American Journal of Respiratory and Critical Care Medicine*. 2004; 169(7):850-854
- 7 784 Juhn YJ, Weaver A, Katusic S, Yunginger J. Mode of delivery at birth and development  
8 of asthma: a population-based cohort study. *Journal of Allergy and Clinical  
9 Immunology*. 2005; 116(3):510-516
- 10 785 Julia JC, Martorell A, Ventas P, Cerda JC, Torro I, Carreira J et al. *Lepidoglyphus*  
11 *destructor* acarus in the urban house environment. *Journal of Investigational  
12 Allergology and Clinical Immunology*. 1995; 5(6):318-321
- 13 786 Jung KH, Hsu SI, Yan B, Moors K, Chillrud SN, Ross J et al. Childhood exposure to fine  
14 particulate matter and black carbon and the development of new wheeze between  
15 ages 5 and 7 in an urban prospective cohort. *Environment International*. 2012; 45:44-  
16 50
- 17 787 Jung KH, Yan B, Moors K, Chillrud SN, Perzanowski MS, Whyatt RM et al. Repeated  
18 exposure to polycyclic aromatic hydrocarbons and asthma: effect of seroatopy. *Annals  
19 of Allergy, Asthma and Immunology*. 2012; 109(4):249-254
- 20 788 Jung YG, Kim KH, Kim HY, Dhong HJ, Chung SK. Predictive capabilities of serum  
21 eosinophil cationic protein, percentage of eosinophils and total immunoglobulin E in  
22 allergic rhinitis without bronchial asthma. *Journal of International Medical Research*.  
23 2011; 39(6):2209-2216
- 24 789 Juniper EF, Buist AS, Cox FM, Ferrie PJ, King DR. Validation of a standardized version of  
25 the Asthma Quality of Life Questionnaire. *Chest*. 1999; 115(5):1265-1270
- 26 790 Juniper EF, Gruffydd-Jones K, Ward S, Svensson K. Asthma Control Questionnaire in  
27 children: validation, measurement properties, interpretation. *European Respiratory  
28 Journal*. 2010; 36(6):1410-1416
- 29 791 Juniper EF, Guyatt GH, Cox FM, Ferrie PJ, King DR. Development and validation of the  
30 Mini Asthma Quality of Life Questionnaire. *European Respiratory Journal*. 1999;  
31 14(1):32-38
- 32 792 Juniper EF, Guyatt GH, Feeny DH, Ferrie PJ, Griffith LE, Townsend M. Measuring quality  
33 of life in children with asthma. *Quality of Life Research*. 1996; 5(1):35-46
- 34 793 Juniper EF, Guyatt GH, Feeny DH, Griffith LE, Ferrie PJ. Minimum skills required by  
35 children to complete health-related quality of life instruments for asthma: comparison  
36 of measurement properties. *European Respiratory Journal*. 1997; 10(10):2285-2294
- 37 794 Juniper EF, Guyatt GH, Ferrie PJ, Griffith LE. Measuring quality of life in asthma.  
38 *American Review of Respiratory Disease*. 1993; 147(4):832-838

- 1 795 Juniper EF, Norman GR, Cox FM, Roberts JN. Comparison of the standard gamble,  
2 rating scale, AQLQ and SF-36 for measuring quality of life in asthma. *European*  
3 *Respiratory Journal*. 2001; 18(1):38-44
- 4 796 Juniper EF, O'Byrne PM, Ferrie PJ, King DR, Roberts JN. Measuring asthma control.  
5 Clinic questionnaire or daily diary? *American Journal of Respiratory and Critical Care*  
6 *Medicine*. 2000; 162(4 Pt 1):1330-1334
- 7 797 Juniper EF, O'Byrne PM, Guyatt GH, Ferrie PJ, King DR. Development and validation of  
8 a questionnaire to measure asthma control. *European Respiratory Journal*. 1999;  
9 14(4):902-907
- 10 798 Juniper EF, O'Byrne PM, Roberts JN. Measuring asthma control in group studies: do we  
11 need airway calibre and rescue beta2-agonist use? *Respiratory Medicine*. 2001;  
12 95(5):319-323
- 13 799 Juniper EF, Svensson K, Mork AC, Stahl E. Measurement properties and interpretation  
14 of three shortened versions of the asthma control questionnaire. *Respiratory*  
15 *Medicine*. 2005; 99(5):553-558
- 16 800 Juniper EF, Svensson K, Mork AC, Stahl E. Modification of the asthma quality of life  
17 questionnaire (standardised) for patients 12 years and older. *Health and Quality of Life*  
18 *Outcomes*. 2005; 3:58
- 19 801 Just J, Belfar S, Wanin S, Pribil C, Grimfeld A, Duru G. Impact of innate and  
20 environmental factors on wheezing persistence during childhood. *Journal of Asthma*.  
21 2010; 47(4):412-416
- 22 802 Just J, Saint-Pierre P, Gouvis-Echraghi R, Boutin B, Panayotopoulos V, Chebahi N et al.  
23 Wheeze phenotypes in young children have different courses during the preschool  
24 period. *Annals of Allergy, Asthma and Immunology*. 2013; 111(4):256-261
- 25 803 Kabesch M, Hoefler C, Carr D, Leupold W, Weiland SK, von Mutius E. Glutathione S  
26 transferase deficiency and passive smoking increase childhood asthma. *Thorax*. 2004;  
27 59(7):569-573
- 28 804 Kabir Z, Manning PJ, Holohan J, Keogan S, Goodman PG, Clancy L. Second-hand smoke  
29 exposure in cars and respiratory health effects in children. *European Respiratory*  
30 *Journal*. 2009; 34(3):629-633
- 31 805 Kable S, Henry R, Sanson-Fisher R, Ireland M, Corkrey R, Cockburn J. Childhood  
32 asthma: can computers aid detection in general practice? *British Journal of General*  
33 *Practice*. 2001; 51(463):112-116
- 34 806 Kagen Z, Ledbetter J, Hamm J, Wilson E. The pediatric diagnostic conundrum of chronic  
35 respiratory symptoms. *Journal of Allergy and Clinical Immunology*. 2014; 68(2  
36 Suppl.1):AB179
- 37 807 Kalyoncu AF, Coplu L, Selcuk ZT, Emri AS, Kolacan B, Kocabas A et al. Survey of the  
38 allergic status of patients with bronchial asthma in Turkey: A multicenter study.  
39 *Allergy*. 1995; 50(5):451-455

- 1 808 Kanazawa H, Asai K, Hirata K, Yoshikawa J. Vascular involvement in exercise-induced  
2 airway narrowing in patients with bronchial asthma. *Chest*. 2002; 122(1):166-170
- 3 809 Kanazawa H, Nomura S, Yoshikawa J. Role of microvascular permeability on  
4 physiologic differences in asthma and eosinophilic bronchitis. *American Journal of  
5 Respiratory and Critical Care Medicine*. 2004; 169(10):1125-1130
- 6 810 Kang H, Koh YY, Yoo Y, Yu J, Kim DK, Kim CK. Maximal airway response to methacholine  
7 in cough-variant asthma: comparison with classic asthma and its relationship to peak  
8 expiratory flow variability. *Chest*. 2005; 128(6):3881-3887
- 9 811 Kannisto S, Vanninen E, Korppi M. Evaluation of the interrupter technique in  
10 measuring post-exercise bronchodilator responses in children. *Clinical Physiology*.  
11 2000; 20(1):62-68
- 12 812 Kappelle L, Brand PLP. Severe episodic viral wheeze in preschool children: High risk of  
13 asthma at age 5-10years. *European Journal of Pediatrics*. 2012; 171(6):947-954
- 14 813 Karadag B, Ege MJ, Scheynius A, Waser M, Van Hage M, Pershagen G et al.  
15 Environmental determinants of atopic eczema phenotypes in relation to asthma and  
16 atopic sensitization. *Allergy*. 2007; 62(12):1387-1393
- 17 814 Karakaya G, Demir AU, Kalyoncu AF. From analgesic intolerance to analgesic induced  
18 asthma: are there some determinants? *Allergologia Et Immunopathologia*. 2000;  
19 28(4):229-237
- 20 815 Karakaya G, Kalyoncu AF. The natural course of atopy determined by skin prick tests in  
21 patients with bronchial asthma and/or rhinitis. *Allergologia Et Immunopathologia*.  
22 2006; 34(6):257-262
- 23 816 Karakaya G, Ozturk AB, Kalyoncu AF. Prediction of atopy by skin prick tests in patients  
24 with asthma and/or persistent rhinitis. *Allergologia Et Immunopathologia*. 2012;  
25 40(1):37-40
- 26 817 Karakoc F, Remes ST, Martinez FD, Wright AL. The association between persistent  
27 eosinophilia and asthma in childhood is independent of atopic status. *Clinical and  
28 Experimental Allergy*. 2002; 32(1):51-56
- 29 818 Kartasamita CB, Rosmayudi O, Demedts M. Total serum IgE and eosinophil count in  
30 children with and without a history of asthma, wheezing, or atopy in an urban  
31 community in Indonesia. The Respiratory Disease Working Group. *Journal of Allergy  
32 and Clinical Immunology*. 1994; 94(6 Pt 1):981-988
- 33 819 Karvala K, Toskala E, Luukkonen R, Lappalainen S, Uitti J, Nordman H. New-onset adult  
34 asthma in relation to damp and moldy workplaces. *International Archives of  
35 Occupational and Environmental Health*. 2010; 83(8):855-865
- 36 820 Katsoulis K, Ganavias L, Michailopoulos P, Bikas C, Dinapogias E, Kontakiotis T et al.  
37 Exhaled nitric oxide as screening tool in subjects with suspected asthma without  
38 reversibility. *International Archives of Allergy and Immunology*. 2013; 162(1):58-64

- 1 821 Katz PP, Eisner MD, Henke J, Shiboski S, Yelin EH, Blanc PD. The Marks Asthma Quality  
2 of Life Questionnaire: further validation and examination of responsiveness to change.  
3 Journal of Clinical Epidemiology. 1999; 52(7):667-675
- 4 822 Kauffmann F, Annesi I, Chwalow J. Validity of subjective assessment of changes in  
5 respiratory health status: A 30 year epidemiological study of workers in Paris.  
6 European Respiratory Journal. 1997; 10(11):2508-2514
- 7 823 Kauffmann F, Varraso R. The epidemiology of cough. Pulmonary Pharmacology and  
8 Therapeutics. 2011; 24(3):289-294
- 9 824 Kaufman HS, Kelly PT, Modin GW. Antigen recognition in Chinese and Caucasians.  
10 Annals of Allergy. 1984; 53(2):135-137
- 11 825 Kaugars AS, Klinnert MD, Robinson J, Ho M. Reciprocal influences in children's and  
12 families' adaptation to early childhood wheezing. Health Psychology. 2008; 27(2):258-  
13 267
- 14 826 Kavut AB, Kalpakoglu AF. Impact of asthma education meeting on asthma control level  
15 assessed by asthma control test. World Allergy Organization Journal. 2010; 3(1):6-8
- 16 827 Kaya Z, Erkan F, Ozkan M, Ozkan S, Kocaman N, Ertekin BA et al. Self-management  
17 plans for asthma control and predictors of patient compliance. Journal of Asthma.  
18 2009; 46(3):270-275
- 19 828 Kayhan S, Tutar U, Cinarka H, Gumus A, Koksall N. Prevalence of occupational asthma  
20 and respiratory symptoms in foundry workers. Pulmonary Medicine. 2013;  
21 2013:370138
- 22 829 Keall MD, Crane J, Baker MG, Wickens K, Howden-Chapman P, Cunningham M. A  
23 measure for quantifying the impact of housing quality on respiratory health: a cross-  
24 sectional study. Environmental Health. 2012; 11:33
- 25 830 Kearney PM, Kearney PJ. The prevalence of asthma in schoolboys of travellers'  
26 families. Irish Medical Journal. 1998; 91(6):203-206
- 27 831 Keen C, Olin AC, Wennergren G, Gustafsson P. Small airway function, exhaled NO and  
28 airway hyper-responsiveness in paediatric asthma. Respiratory Medicine. 2011;  
29 105(10):1476-1484
- 30 832 Keil T, Kulig M, Simpson A, Custovic A, Wickman M, Kull I et al. European birth cohort  
31 studies on asthma and atopic diseases: II. Comparison of outcomes and exposures - A  
32 GA2LEN initiative. Allergy. 2006; 61(9):1104-1111
- 33 833 Keil U, Weiland SK, Duhme H, Chambless L. The International Study of Asthma and  
34 Allergies in Childhood (ISAAC): objectives and methods; results from German ISAAC  
35 centres concerning traffic density and wheezing and allergic rhinitis. Toxicology  
36 Letters. 1996; 86(2-3):99-103
- 37 834 Kelly WJ, Hudson I, Phelan PD, Pain MC, Olinsky A. Childhood asthma in adult life: a  
38 further study at 28 years of age. BMJ. 1987; 294(6579):1059-1062

- 1 835 Kelly YJ, Brabin BJ, Milligan P, Heaf DP, Reid J, Pearson MG. Maternal asthma,  
2 premature birth, and the risk of respiratory morbidity in schoolchildren in Merseyside.  
3 *Thorax*. 1995; 50(5):525-530
- 4 836 Kelly YJ, Brabin BJ, Milligan PJ, Reid JA, Heaf D, Pearson MG. Clinical significance of  
5 cough and wheeze in the diagnosis of asthma. *Archives of Disease in Childhood*. 1996;  
6 75(6):489-493
- 7 837 Kelso JM. Peak flow monitoring for guided self-management in childhood asthma: A  
8 randomized controlled trial. *Pediatrics*. 2005; 116(2):558-559
- 9 838 Kelso JM, Sodhi N, Gosselin VA, Yunginger JW. Diagnostic performance characteristics  
10 of the standard Phadebas RAST, modified RAST, and Pharmacia CAP system versus skin  
11 testing. *Annals of Allergy*. 1991; 67(5):511-514
- 12 839 Kemple T, Rogers C. A mailed personalised self-management plan improves  
13 attendance and increases patients' understanding of asthma. *Primary Care Respiratory*  
14 *Journal*. 2003; 12(4):110-114
- 15 840 Kercksmar CM. Chronic cough in children: Pursuing specific causes. *Journal of*  
16 *Respiratory Diseases*. 1996; 17(6):484-493
- 17 841 Kercksmar CM. Meeting the challenges of asthma: Conference summary. *Respiratory*  
18 *Care*. 2008; 53(6):787-795
- 19 842 Kerkhof M, Dubois AEJ, Postma DS, Schouten JP, De Monchy JGR. Role and  
20 interpretation of total serum IgE measurements in the diagnosis of allergic airway  
21 disease in adults. *Allergy*. 2003; 58(9):905-911
- 22 843 Kerkhof M, Wijga AH, Brunekreef B, Smit HA, De Jongste JC, Aalberse RC et al. Effects  
23 of pets on asthma development up to 8 years of age: the PIAMA study. *Allergy*. 2009;  
24 64(8):1202-1208
- 25 844 Kersten ETG, Driessen JMM, van der Berg JD, Thio BJ. Mannitol and exercise challenge  
26 tests in asthmatic children. *Pediatric Pulmonology*. 2009; 44(7):655-661
- 27 845 Kesten S, Rebeck AS. Is the short-term response to inhaled beta-adrenergic agonist  
28 sensitive or specific for distinguishing between asthma and COPD? *Chest*. 1994;  
29 105(4):1042-1045
- 30 846 Khadadah ME, Onadeko BO, Ezeamuzie CI, Maroof R, Mustafa HS, Sugathan TN.  
31 Studies of the relationship between allergen-specific IgE antibodies and skin test  
32 reactivity in patients with asthma in Kuwait. *Medical Principles and Practice*. 2000;  
33 9(4):260-267
- 34 847 Khakzad MR, Mirsadraee M, Sankian M, Varasteh A, Meshkat M. Is serum or sputum  
35 eosinophil cationic protein level adequate for diagnosis of mild asthma? *Iranian*  
36 *Journal of Allergy, Asthma and Immunology*. 2009; 8(3):155-160
- 37 848 Khalid I, Morris ZQ, Digiovine B. Specific conductance criteria for a positive  
38 methacholine challenge test: are the American Thoracic Society guidelines rather  
39 generous? *Respiratory Care*. 2009; 54(9):1168-1174



- 1 849 Khan MSR, O'Meara M, Stevermuer TL, Henry RL. Randomized controlled trial of  
2 asthma education after discharge from an emergency department. *Journal of*  
3 *Paediatrics and Child Health*. 2004; 40(12):674-677
- 4 850 Kharitonov SA, Gonio F, Kelly C, Meah S, Barnes PJ. Reproducibility of exhaled nitric  
5 oxide measurements in healthy and asthmatic adults and children. *European*  
6 *Respiratory Journal*. 2003; 21(3):433-438
- 7 851 Kharitonov SA, Yates DH, Chung KF, Barnes PJ. Changes in the dose of inhaled steroid  
8 affect exhaled nitric oxide levels in asthmatic patients. *European Respiratory Journal*.  
9 1996; 9(2):196-201
- 10 852 Kheir NM, Emmerton L, Shaw JP. Assessing the responsiveness of the Asthma Quality  
11 of Life Questionnaire with pharmaceutical care. *Pharmacy World and Science*. 2008;  
12 30(4):322-328
- 13 853 Khoo KT, Connolly CK. A comparison of three methods of measuring broncholability in  
14 asthmatics, bronchitic cigarette smokers and normal subjects. *Respiration*. 1984;  
15 45(3):219-224
- 16 854 Khoshoo V, Edell D, Mohnot S, Haydel RJ, Saturno E, Kobernick A. Associated factors in  
17 children with chronic cough. *Chest*. 2009; 136(3):811-815
- 18 855 Kieft-de Jong JC, de Vries JH, Franco OH, Jaddoe VWV, Hofman A, Raat H et al. Fish  
19 consumption in infancy and asthma-like symptoms at preschool age. *Pediatrics*. 2012;  
20 130(6):1060-1068
- 21 856 Kielbasa B, Moeller A, Sanak M, Hamacher J, Hutterli M, Cmiel A et al. Eicosanoids in  
22 exhaled breath condensates in the assessment of childhood asthma. *Pediatric Allergy*  
23 *and Immunology*. 2008; 19(7):660-669
- 24 857 Kilpelainen M, Terho EO, Helenius H, Koskenvuo M. Validation of a new questionnaire  
25 on asthma, allergic rhinitis, and conjunctivitis in young adults. *Allergy*. 2001; 56(5):377-  
26 384
- 27 858 Kim HY, Shin YH, Yum HY, Jee HM, Jang SJ, Yoon JW et al. Patterns of sensitisation to  
28 common food and inhalant allergens and allergic symptoms in pre-school children.  
29 *Journal of Paediatrics and Child Health*. 2013; 49(4):272-277
- 30 859 Kim KT, Safadi GS, Sheikh KM. Diagnostic evaluation of type I latex allergy. *Annals of*  
31 *Allergy, Asthma and Immunology*. 1998; 80(1):66-70
- 32 860 Kim M-H, Song W-J, Kim T-W, Jin H-J, Sin Y-S, Ye Y-M et al. Diagnostic properties of the  
33 methacholine and mannitol bronchial challenge tests: A comparison study.  
34 *Respirology*. 2014; 19(6):852-856
- 35 861 Kim TB, Oh YM, Chang YS, Cho YS, Jang AS, Cho SH et al. The reality of an intermediate  
36 type between asthma and COPD in practice. *Respiratory Care*. 2012; 57(8):1248-1253
- 37 862 Kim YH, Kim MJ, Lee HS, Han YK, Park YA, Kim K-E et al. Extended nitric oxide analysis  
38 and bronchial hyperresponsiveness in children with asthma according to atopy.  
39 *Journal of Allergy and Clinical Immunology*. 2014; 133(2 SUPPL. 1):AB84

- 1 863 Kim YK, Kim SH, Tak YJ, Jee YK, Lee BJ, Kim SH et al. High prevalence of current asthma  
2 and active smoking effect among the elderly. *Clinical and Experimental Allergy*. 2002;  
3 32(12):1706-1712
- 4 864 Kim YH, Kim KW, Baek J, Park HB, Kim H, Song KJ et al. Usefulness of impulse  
5 oscillometry and fractional exhaled nitric oxide in children with Eosinophilic bronchitis.  
6 *Pediatric Pulmonology*. 2013; 48(3):221-228
- 7 865 King D. Asthma diagnosis by spirometry. Sensitive or specific? *Australian Family*  
8 *Physician*. 1998; 27(3):183-185
- 9 866 King DK, Thompson BT, Johnson DC. Wheezing on maximal forced exhalation in the  
10 diagnosis of atypical asthma. Lack of sensitivity and specificity. *Annals of Internal*  
11 *Medicine*. 1989; 110(6):451-455
- 12 867 King MJ, Bukantz SC, Phillips S, Mohapatra SS, Tamulis T, Lockey RF. Serum total IgE  
13 and specific IgE to *Dermatophagoides pteronyssinus*, but not eosinophil cationic  
14 protein, are more likely to be elevated in elderly asthmatic patients. *Allergy and*  
15 *Asthma Proceedings*. 2004; 25(5):321-325
- 16 868 Kiss D, Veegh W, Schragel D, Bachl C, Stollberger C, Sertl K. Bronchial asthma causing  
17 symptoms suggestive of angina pectoris. *European Respiratory Journal*. 2003;  
18 21(3):473-477
- 19 869 Kitani H, Kajimoto K, Sugimoto K, Mifune T, Mitsunobu F, Yokota S et al. IgE-mediated  
20 allergic reaction in drug-induced asthma. *Acta Medica Okayama*. 1993; 47(5):317-321
- 21 870 Kivastik J, Gibson AM, Primhak RA. Methacholine challenge in pre-school children--  
22 which outcome measure? *Respiratory Medicine*. 2007; 101(12):2555-2560
- 23 871 Kiviloog J. The correlation between exercise-induced bronchoconstriction and  
24 bronchial methacholine sensitivity in asthma. *Pediatrics*. 1975; 56(5 pt-2 suppl):908-  
25 909
- 26 872 Kjaer HF, Eller E, Bindslev-Jensen C, Host A. Spirometry in an unselected group of 6-  
27 year-old children: the DARC birth cohort study. *Pediatric Pulmonology*. 2008;  
28 43(8):806-814
- 29 873 Kjaer HF, Eller E, Host A, Andersen KE, Bindslev-Jensen C. The prevalence of allergic  
30 diseases in an unselected group of 6-year-old children. The DARC birth cohort study.  
31 *Pediatric Allergy and Immunology*. 2008; 19(8):737-745
- 32 874 Klaassen EMM, van de Kant KDG, Jobsis Q, Hovig STP, van Schayck CP, Rijkers GT et al.  
33 Symptoms, but not a biomarker response to inhaled corticosteroids, predict asthma in  
34 preschool children with recurrent wheeze. *Mediators of Inflammation*. 2012;  
35 2012:162571
- 36 875 Klein JJ, van der Palen J, Uil SM, Zielhuis GA, Seydel ER, van Herwaarden CL. Benefit  
37 from the inclusion of self-treatment guidelines to a self-management programme for  
38 adults with asthma. *European Respiratory Journal*. 2001; 17(3):386-394
- 39 876 Kleis S, Chanez P, Delvaux M, Louis R. Perception of dyspnea in mild smoking  
40 asthmatics. *Respiratory Medicine*. 2007; 101(7):1426-1430

- 1 877 Klepac-Pulanic T, Macan J, Plavec D, Kanceljak-Macan B. Exercise and allergic diseases.  
2 Archives of Industrial Hygiene and Toxicology. 2004; 55(2-3):197-204
- 3 878 Klinkanova M, Lyutskanova T, Ivancheva D, Genkova N, Lyutakova E. Increased IgE--  
4 diagnostic value of the index in children with bronchial obstruction. Folia Medica.  
5 1995; 37(4A Suppl):54
- 6 879 Klinnert MD, Nelson HS, Price MR, Adinoff AD, Leung DY, Mrazek DA. Onset and  
7 persistence of childhood asthma: predictors from infancy. Pediatrics. 2001; 108(4):E69
- 8 880 Klinnert MD, Kaugars AS, Strand M, Silveira L. Family psychological factors in relation  
9 to children's asthma status and behavioral adjustment at age 4. Family Process. 2008;  
10 47(1):41-61
- 11 881 Kljakovic M. The change in prevalence of wheeze in seven year old children over 19  
12 years. New Zealand Medical Journal. 1991; 104(919):378-380
- 13 882 Kneyber MCJ, Steyerberg EW, de Groot R, Moll HA. Long-term effects of respiratory  
14 syncytial virus (RSV) bronchiolitis in infants and young children: a quantitative review.  
15 Acta Paediatrica. 2000; 89(6):654-660
- 16 883 Knox AJ, Coleman HE, Britton JR, Tattersfield AE. A comparison of three measures of  
17 the response to inhaled methacholine. European Respiratory Journal. 1989; 2(8):736-  
18 740
- 19 884 Ko FWS, Leung TF, Hui DSC, Chu HY, Wong GWK, Wong E et al. Asthma Control Test  
20 correlates well with the treatment decisions made by asthma specialists. Respirology.  
21 2009; 14(4):559-566
- 22 885 Koenig SM, Murray JJ, Wolfe J, Andersen L, Yancey S, Prillaman B et al. Does measuring  
23 BHR add to guideline derived clinical measures in determining treatment for patients  
24 with persistent asthma? Respiratory Medicine. 2008; 102(5):665-673
- 25 886 Koh YY, Jeong JH, Jin SM, Kim CK, Min KU. The occurrence of late asthmatic response  
26 to exercise after allergen challenge. Annals of Allergy, Asthma and Immunology. 1998;  
27 81(4):366-372
- 28 887 Koh YY, Lim HS, Min KU, Kim YY. Maximal airway narrowing on the dose-response  
29 curve to methacholine is increased after exercise-induced bronchoconstriction. Journal  
30 of Asthma. 1996; 33(1):55-65
- 31 888 Koh YY, Kang H, Yoo Y, Yu J, Nah KM, Kim CK. Peak expiratory flow variability and  
32 exercise responsiveness in methacholine-hyperresponsive adolescents with asthma  
33 remission. Journal of Asthma. 2005; 42(1):17-23
- 34 889 Koivikko A, Viander M, Lanner A. Use of the extended Phadebas RAST panel in the  
35 diagnosis of mould allergy in asthmatic children. Allergy. 1991; 46(2):85-91
- 36 890 Kokubu F, Nakajima S, Ito K, Makino S, Kitamura S, Fukuchi Y et al. [Hospitalization  
37 reduction by an asthma tele-medicine system]. Arerugi. 2000; 49(1):19-31
- 38 891 Kokubu F, Suzuki H, Sano Y, Kihara N, Adachi M. [Tele-medicine system for high-risk  
39 asthmatic patients]. Arerugi. 1999; 48(7):700-712

- 1 892 Kolbe J, Richards G, Mercer-Fenwick J, Rea H. Relationship of non-specific airway  
2 hyperresponsiveness (AHR) to measures of peak expiratory flow (PEF) variability.  
3 Australian and New Zealand Journal of Medicine. 1996; 26(1):59-65
- 4 893 Koller DY, Wojnarowski C, Herkner KR, Weinlander G, Raderer M, Eichler I et al. High  
5 levels of eosinophil cationic protein in wheezing infants predict the development of  
6 asthma. Journal of Allergy and Clinical Immunology. 1997; 99(6 Pt 1):752-756
- 7 894 Kolnaar BG, Janssen JL, Folgering H, van den Hoogen HJ, Van Weel C. The relationship  
8 between respiratory symptoms and bronchial hyperresponsiveness in a population-  
9 based sample of adolescents and young adults. Respiratory Medicine. 1995; 89(2):93-  
10 100
- 11 895 Komakula S, Khatri S, Mermis J, Savill S, Haque S, Rojas M et al. Body mass index is  
12 associated with reduced exhaled nitric oxide and higher exhaled 8-isoprostanes in  
13 asthmatics. Respiratory Research. 2007; 8:32
- 14 896 Komarow HD, Skinner J, Young M, Gaskins D, Nelson C, Gergen PJ et al. A study of the  
15 use of impulse oscillometry in the evaluation of children with asthma: analysis of lung  
16 parameters, order effect, and utility compared with spirometry. Pediatric  
17 Pulmonology. 2012; 47(1):18-26
- 18 897 Konderak J, Pinter E, Witos Y, Balo Banga JM. Large scale serum IgE determination  
19 from various patients with suspicion of allergy within one year covering Hungary.  
20 Allergy. 2013; 68:573-574
- 21 898 Kondo R, Haniuda M, Yamanda T, Sato E, Fujimoto K, Kubo K et al. Effects of expiratory  
22 pressure on nitric oxide in exhaled breath. Is exhaled nitric oxide really unaffected by  
23 pressure? Respiratory Physiology and Neurobiology. 2003; 139(1):33-40
- 24 899 Kongerud J, Soyseth V, Burge S. Serial measurements of peak expiratory flow and  
25 responsiveness to methacholine in the diagnosis of aluminium potroom asthma.  
26 Thorax. 1992; 47(4):292-297
- 27 900 Konstantinou G, Xepapadaki P, Manousakis E, Makrinioti C, Kouloufakou-Gratsia K,  
28 Kafetzis D et al. Episodic viral wheeze in preschool children: Is it asthma? Allergy. 2010;  
29 65:16
- 30 901 Koponen P, Helminen M, Paasilta M, Luukkaala T, Korppi M. Preschool asthma after  
31 bronchiolitis in infancy. European Respiratory Journal. 2012; 39(1):76-80
- 32 902 Korol D, Tobolczyk J, Hofman J. Differentiation of IgE-dependent and IgE-independent  
33 reactions in children with bronchial asthma on the basis of TOP CAST Paediatric  
34 Allergen Mix test. Advances in Medical Sciences. 2006; 51:232-236
- 35 903 Koshy G, Delpisheh A, Brabin BJ. Trends in prevalence of childhood and parental  
36 asthma in Merseyside, 1991-2006. Journal of Public Health. 2010; 32(4):488-495
- 37 904 Koskela HO, Purokivi MK, Kontra KM, Taivainen AH, Tukiainen HO. Hypertonic saline  
38 cough provocation test with salbutamol pre-treatment: evidence for sensorineural  
39 dysfunction in asthma. Clinical and Experimental Allergy. 2008; 38(7):1100-1107

- 1 905 Koskela HO, Hyvarinen L, Brannan JD, Chan HK, Anderson SD. Responsiveness to three  
2 bronchial provocation tests in patients with asthma. *Chest*. 2003; 124(6):2171-2177
- 3 906 Kostikas K, Papaioannou AI, Tanou K, Koutsokera A, Papala M, Gourgoulialis KI.  
4 Portable exhaled nitric oxide as a screening tool for asthma in young adults during  
5 pollen season. *Chest*. 2008; 133(4):906-913
- 6 907 Kotaniemi-Syrjanen A, Reijonen TM, Korhonen K, Korppi M. Wheezing requiring  
7 hospitalization in early childhood: predictive factors for asthma in a six-year follow-up.  
8 *Pediatric Allergy and Immunology*. 2002; 13(6):418-425
- 9 908 Kotses H, Stout C, McConnaughy K, Winder JA, Creer TL. Evaluation of individualized  
10 asthma self-management programs. *Journal of Asthma*. 1996; 33(2):113-118
- 11 909 Kotses H, Thurber L, Mosby A, McLacklan A, Harver A. Effects of home monitoring on  
12 subjective and objective indicators of asthma in pediatric patients: caregivers'  
13 perceived symptoms and child peak flow. American Thoracic Society International  
14 Conference, May 18-23, 2007, San Francisco, California, USA. 2007;Poster
- 15 910 Koutsoupias P, Meng Q, Bielory L. Increased allergy skin test reactivity in asthmatics:  
16 Results from the second and third national health and nutrition examination survey  
17 (1976-1994). *Annals of Allergy, Asthma and Immunology*. 2013; 111(5 Suppl.1):A44-  
18 A45
- 19 911 Kovac K, Dodig S, Tjesic-Drinkovic D, Raos M. Correlation between asthma severity and  
20 serum IgE in asthmatic children sensitized to *Dermatophagoides pteronyssinus*.  
21 *Archives of Medical Research*. 2007; 38(1):99-105
- 22 912 Kovesi TA, Dales RE. Effects of the indoor environment on the fraction of exhaled nitric  
23 oxide in school-aged children. *Canadian Respiratory Journal*. 2009; 16(3):e18-e23
- 24 913 Kovesi T, Dales R. Exhaled nitric oxide and respiratory symptoms in a community  
25 sample of school aged children. *Pediatric Pulmonology*. 2008; 43(12):1198-1205
- 26 914 Kowal K, Bodzenta-Lukaszyk A, Zukowski S. Exhaled nitric oxide in evaluation of young  
27 adults with chronic cough. *Journal of Asthma*. 2009; 46(7):692-698
- 28 915 Kozyrskyj AL, Kendall GE, Zubrick SR, Newnham JP, Sly PD. Frequent nocturnal  
29 awakening in early life is associated with nonatopic asthma in children. *European  
30 Respiratory Journal*. 2009; 34(6):1288-1295
- 31 916 Kozyrskyj AL, Mustard CA, Becker AB. Childhood wheezing syndromes and healthcare  
32 data. *Pediatric Pulmonology*. 2003; 36(2):131-136
- 33 917 Kozyrskyj AL, Mustard CA, Becker AB. Identifying children with persistent asthma from  
34 health care administrative records. *Canadian Respiratory Journal*. 2004; 11(2):141-145
- 35 918 Kraw M, Tarlo SM. Isocyanate medical surveillance: respiratory referrals from a foam  
36 manufacturing plant over a five-year period. *American Journal of Industrial Medicine*.  
37 1999; 35(1):87-91
- 38 919 Krishnan JA, Bender BG, Wamboldt FS, Szeffler SJ, Adkinson NFJ, Zeiger RS et al.  
39 Adherence to inhaled corticosteroids: an ancillary study of the Childhood Asthma

- 1 Management Program clinical trial. *Journal of Allergy and Clinical Immunology*. 2012;  
2 129(1):112-118
- 3 920 Kroegel C, Schuler M, Forster M, Braun R, Grahmann PR. Evidence for eosinophil  
4 activation in bronchiectasis unrelated to cystic fibrosis and bronchopulmonary  
5 aspergillosis: discrepancy between blood eosinophil counts and serum eosinophil  
6 cationic protein levels. *Thorax*. 1998; 53(6):498-500
- 7 921 Kuehni CE, Brooke AM, Silverman M. Prevalence of wheeze during childhood:  
8 retrospective and prospective assessment. *European Respiratory Journal*. 2000;  
9 16(1):81-85
- 10 922 Kuehni CE, Davis A, Brooke AM, Silverman M. Are all wheezing disorders in very young  
11 (preschool) children increasing in prevalence? *Lancet*. 2001; 357(9271):1821-1825
- 12 923 Kuehr J, Frischer T, Barth R, Karmaus W, Kruger S, Meinert R et al. Eosinophils and  
13 eosinophil cationic protein in children with and without sensitization to inhalant  
14 allergens. *European Journal of Pediatrics*. 1994; 153(10):739-744
- 15 924 Kuehr J, Frischer T, Meinert R, Barth R, Schraub S, Urbanek R et al. Sensitization to  
16 mite allergens is a risk factor for early and late onset of asthma and for persistence of  
17 asthmatic signs in children. *Journal of Allergy and Clinical Immunology*. 1995;  
18 95(3):655-662
- 19 925 Kuethe MC, Vaessen-Verberne Anja APH, Elbers RG, Van Aalderen Wim MC. Nurse  
20 versus physician-led care for the management of asthma. *Cochrane Database of  
21 Systematic Reviews*. 2013; Issue 2:CD009296. DOI:10.1002/14651858.CD009296.pub2
- 22 926 Kuehni CE, Sennhauser FH. The Yentl syndrome in childhood asthma: risk factors for  
23 undertreatment in Swiss children. *Pediatric Pulmonology*. 1995; 19(3):156-160
- 24 927 Kumar DSA, Adepu R, Parthasarathi G, Mahesh PA. Impact of community pharmacist  
25 provided patient education in asthma patients on treatment outcomes - A study.  
26 *Indian Journal of Pharmaceutical Education and Research*. 2009; 43(2):125-133
- 27 928 Kumar R. Association of sensitization to food and inhalant allergens in patients of  
28 asthma and rhinitis. *Clinical and Translational Allergy*. 2011; 1
- 29 929 Kumar R, Kumari D, Srivastava P, Khare V, Fakhr H, Arora N et al. Identification of IgE-  
30 mediated food allergy and allergens in older children and adults with asthma and  
31 allergic rhinitis. *Indian Journal of Chest Diseases and Allied Sciences*. 2010; 52(4):217-  
32 224
- 33 930 Kumar R, Yu Y, Story RE, Pongracic JA, Gupta R, Pearson C et al. Prematurity,  
34 chorioamnionitis, and the development of recurrent wheezing: a prospective birth  
35 cohort study. *Journal of Allergy and Clinical Immunology*. 2008; 121(4):878-884
- 36 931 Kumari D, Kumar R, Sridhara S, Arora N, Gaur SN, Singh BP. Sensitization to blackgram  
37 in patients with bronchial asthma and rhinitis: clinical evaluation and characterization  
38 of allergens. *Allergy*. 2006; 61(1):104-110
- 39 932 Kunzli N, Stutz EZ, Perruchoud AP, Brandli O, Tschopp JM, Bolognini G et al. Peak flow  
40 variability in the SAPALDIA study and its validity in screening for asthma-related

- 1 conditions. The SPALDIA Team. *American Journal of Respiratory and Critical Care*  
2 *Medicine*. 1999; 160(2):427-434
- 3 933 Kurimoto Y, Baba S. Specific IgE estimations by RAST in Japanese asthmatics compared  
4 with skin, passive transfer and bronchial provocation tests. *Clinical Allergy*. 1978;  
5 8(2):175-185
- 6 934 Kurukulaaratchy RJ, Fenn M, Matthews S, Arshad SH. Characterisation of atopic and  
7 non-atopic wheeze in 10 year old children. *Thorax*. 2004; 59(7):563-568
- 8 935 Kurukulaaratchy RJ, Fenn M, Twiselton R, Matthews S, Arshad SH. The prevalence of  
9 asthma and wheezing illnesses amongst 10-year-old schoolchildren. *Respiratory*  
10 *Medicine*. 2002; 96(3):163-169
- 11 936 Kurukulaaratchy RJ, Matthews S, Arshad SH. Defining childhood atopic phenotypes to  
12 investigate the association of atopic sensitization with allergic disease. *Allergy*. 2005;  
13 60(10):1280-1286
- 14 937 Kurukulaaratchy RJ, Matthews S, Holgate ST, Arshad SH. Predicting persistent disease  
15 among children who wheeze during early life. *European Respiratory Journal*. 2003;  
16 22(5):767-771
- 17 938 Kurukulaaratchy RJ, Matthews S, Arshad SH. Does environment mediate earlier onset  
18 of the persistent childhood asthma phenotype? *Pediatrics*. 2004; 113(2):345-350
- 19 939 Kurukulaaratchy RJ, Matthews S, Waterhouse L, Arshad SH. Factors influencing  
20 symptom expression in children with bronchial hyperresponsiveness at 10 years of  
21 age. *Journal of Allergy and Clinical Immunology*. 2003; 112(2):311-316
- 22 940 Kurukulaaratchy RJ, Waterhouse L, Matthews SM, Arshad SH. Are influences during  
23 pregnancy associated with wheezing phenotypes during the first decade of life? *Acta*  
24 *Paediatrica*. 2005; 94(5):553-558
- 25 941 Kwon N, Shim J, Lee Y, Uh S, Jung K, Park S et al. Longitudinal validation of the asthma  
26 control test in moderate persistent asthma [Abstract]. *Journal of Allergy and Clinical*  
27 *Immunology*. 2008; 21(2 Suppl 1):S161
- 28 942 La Grutta S, Gagliardo R, Mirabella F, Pajno GB, Bonsignore G, Bousquet J et al. Clinical  
29 and biological heterogeneity in children with moderate asthma. *American Journal of*  
30 *Respiratory and Critical Care Medicine*. 2003; 167(11):1490-1495
- 31 943 Labbe A, Aublet-Cuvelier B, Jouaville L, Beaugeon G, Fiani L, Petit I et al. Prospective  
32 longitudinal study of urinary eosinophil protein X in children with asthma and chronic  
33 cough. *Pediatric Pulmonology*. 2001; 31(5):354-362
- 34 944 Labrecque M, Malo JL, Alaoui KM, Rabhi K. Medical surveillance programme for  
35 diisocyanate exposure. *Occupational and Environmental Medicine*. 2011; 68(4):302-  
36 307
- 37 945 Labruzzo BA, Edgerton L, Rideout S. What is the preferred treatment for a child with  
38 mild persistent asthma? *Journal of Family Practice*. 2007; 56(2):137-139

- 1 946 Lahdensuo A, Haahtela T, Herrala J, Kava T, Kiviranta K, Kuusisto P et al. Randomised  
2 comparison of cost effectiveness of guided self management and traditional treatment  
3 of asthma in Finland. *BMJ*. 1998; 316(7138):1138-1139
- 4 947 Lahdensuo A, Haahtela T, Herrala J, Kava T, Kiviranta K, Kuusisto P et al. Randomised  
5 comparison of guided self management and traditional treatment of asthma over one  
6 year. *BMJ*. 1996; 312(7033):748-752
- 7 948 Lai CK, Chan JK, Chan A, Wong G, Ho A, Choy D et al. Comparison of the ISAAC video  
8 questionnaire (AVQ3.0) with the ISAAC written questionnaire for estimating asthma  
9 associated with bronchial hyperreactivity. *Clinical and Experimental Allergy*. 1997;  
10 27(5):540-545
- 11 949 Lai CKW, Beasley R, Crane J, Foliaki S, Shah J, Weiland S et al. Global variation in the  
12 prevalence and severity of asthma symptoms: phase three of the International Study  
13 of Asthma and Allergies in Childhood (ISAAC). *Thorax*. 2009; 64(6):476-483
- 14 950 Lai CL, Shyur SD, Wu CY, Chang CL, Chu SH. Specific IgE to 5 different major house dust  
15 mites among asthmatic children. *Acta Paediatrica Taiwanica*. 2002; 43(5):265-270
- 16 951 Lam A. Practice innovations: delivering medication therapy management services via  
17 Videoconference interviews. *Consultant Pharmacist : the Journal of the American  
18 Society of Consultant Pharmacists*. 2011; 26(10):764-774
- 19 952 Lambert A, Bradley DM, Wei C, McCormack M, Wise R. Accuracy of using FEV1/FVC Z-  
20 score thresholds to diagnose asthma. *Chest*. 2013; 144(4 Meeting Abstract)
- 21 953 Lange NE, Rifas-Shiman SL, Camargo CAJ, Gold DR, Gillman MW, Litonjua AA. Maternal  
22 dietary pattern during pregnancy is not associated with recurrent wheeze in children.  
23 *Journal of Allergy and Clinical Immunology*. 2010; 126(2):250-254
- 24 954 Langley SJ, Goldthorpe S, Custovic A, Woodcock A. Relationship among pulmonary  
25 function, bronchial reactivity, and exhaled nitric oxide in a large group of asthmatic  
26 patients. *Annals of Allergy, Asthma and Immunology*. 2003; 91(4):398-404
- 27 955 Laprise C, Boulet LP. Asymptomatic airway hyperresponsiveness: a three-year follow-  
28 up. *American Journal of Respiratory and Critical Care Medicine*. 1997; 156(2 Pt 1):403-  
29 409
- 30 956 Lara A, Khatri SB, Wang Z, Comhair SAA, Xu W, Dweik RA et al. Alterations of the  
31 arginine metabolome in asthma. *American Journal of Respiratory and Critical Care  
32 Medicine*. 2008; 178(7):673-681
- 33 957 Larsson L, Boethius G. Differences in utilization of asthma drugs between two  
34 neighbouring Swedish provinces: Relation to treatment in individuals with airway  
35 disease. *Journal of Internal Medicine*. 1995; 238(4):307-316
- 36 958 Larsson L, Boethius G, Uddenfeldt M. Differences in utilisation of asthma drugs  
37 between two neighbouring Swedish provinces: relation to prevalence of obstructive  
38 airway disease. *Thorax*. 1994; 49(1):41-49



- 1 959 Laske N, Bunikowski R, Niggemann B. Extraordinarily high serum IgE levels and  
2 consequences for atopic phenotypes. *Annals of Allergy, Asthma and Immunology*.  
3 2003; 91(2):202-204
- 4 960 Lau S, Illi S, Platts-Mills TAE, Riposo D, Nickel R, Gruber C et al. Longitudinal study on  
5 the relationship between cat allergen and endotoxin exposure, sensitization, cat-  
6 specific IgG and development of asthma in childhood--report of the German  
7 Multicentre Allergy Study (MAS 90). *Allergy*. 2005; 60(6):766-773
- 8 961 Lau S, Illi S, Sommerfeld C, Niggemann B, Bergmann R, von Mutius E et al. Early  
9 exposure to house-dust mite and cat allergens and development of childhood asthma:  
10 a cohort study. Multicentre Allergy Study Group. *Lancet*. 2000; 356(9239):1392-1397
- 11 962 Lau S, Illi S, Sommerfeld C, Niggemann B, Volkel K, Madloch C et al. Transient early  
12 wheeze is not associated with impaired lung function in 7-yr-old children. *European  
13 Respiratory Journal*. 2003; 21(5):834-841
- 14 963 Lau S, Nickel R, Niggemann B, Gruber C, Sommerfeld C, Illi S et al. The development of  
15 childhood asthma: lessons from the German Multicentre Allergy Study (MAS).  
16 *Paediatric Respiratory Reviews*. 2002; 3(3):265-272
- 17 964 Laubereau B, Grote V, Holscher G, Holscher B, Frye C, Wichmann HE et al. Vaccination  
18 against *Haemophilus influenzae* type b and atopy in east German schoolchildren.  
19 *European Journal of Medical Research*. 2002; 7(9):387-392
- 20 965 Laufenberg-Horstmann E, DeVore E, Bassuener K. The Coulee Region Community  
21 Pharmacy Asthma Intervention study. *Journal of the American Pharmacists  
22 Association*. 2006; 46(6):738-7
- 23 966 Laurent J, Decoux L, Ickovic MR, Le Gall C, Gacouin JC, Sauvaget J et al. Winter  
24 pollinosis in Paris. *Allergy*. 1994; 49(9):696-701
- 25 967 Lawson JA, Dosman JA, Rennie DC, Beach J, Newman SC, Senthilselvan A. Relationship  
26 of endotoxin and tobacco smoke exposure to wheeze and diurnal peak expiratory flow  
27 variability in children and adolescents. *Respirology*. 2011; 16(2):332-339
- 28 968 Lazo-Velasquez JC, Lozada AR, Cruz HM. Evaluation of severity of bronchial asthma  
29 through an bronchial challenge. *Pediatric Pulmonology*. 2005; 40(5):457-463
- 30 969 Le Souef PN, Sears MR, Sherrill D. The effect of size and age of subject on airway  
31 responsiveness in children. *American Journal of Respiratory and Critical Care  
32 Medicine*. 1995; 152(2):576-579
- 33 970 Lebecque P, Kiakulanda P, Coates AL. Spirometry in the asthmatic child: is FEF25-75 a  
34 more sensitive test than FEV1/FVC? *Pediatric Pulmonology*. 1993; 16(1):19-22
- 35 971 Lebowitz MD, Krzyzanowski M, Quackenboss JJ, O'Rourke MK. Diurnal variation of PEF  
36 and its use in epidemiological studies. *European Respiratory Journal, Supplement*.  
37 1997; 24:49S-56S
- 38 972 Leckie MJ, ten Brinke A, Khan J, Diamant Z, O'Connor BJ, Walls CM et al. Effects of an  
39 interleukin-5 blocking monoclonal antibody on eosinophils, airway hyper-  
40 responsiveness, and the late asthmatic response. *Lancet*. 2000; 356(9248):2144-2148

- 1 973 Lee J, Yun I, Park H, Cho J, Oh T, Park J et al. Clinical characteristics of airway  
2 hyperresponsiveness in allergic airway diseases. *Journal of Allergy and Clinical*  
3 *Immunology*. 2011; 127(2 Suppl. 1):AB8
- 4 974 Leermakers ETM, Sonnenschein-van der Voort AMM, Heppe DHM, De Jongste JC, Moll  
5 HA, Franco OH et al. Maternal fish consumption during pregnancy and risks of  
6 wheezing and eczema in childhood: the Generation R Study. *European Journal of*  
7 *Clinical Nutrition*. 2013; 67(4):353-359
- 8 975 Lefevre F, Piper M, Weiss K, Mark D, Clark N, Aronson N. Do written action plans  
9 improve patient outcomes in asthma? An evidence-based analysis. *Journal of Family*  
10 *Practice*. 2002; 51(10):842-848
- 11 976 Lehmann S, Bakke PS, Eide GE, Gulsvik A. Clinical data discriminating between adults  
12 with positive and negative results on bronchodilator testing. *International Journal of*  
13 *Tuberculosis and Lung Disease*. 2008; 12(2):205-213
- 14 977 Lehtimäki L, Kankaanranta H, Saarelainen S, Turjanmaa V, Moilanen E. Increased  
15 alveolar nitric oxide concentration in asthmatic patients with nocturnal symptoms.  
16 *European Respiratory Journal*. 2002; 20(4):841-845
- 17 978 Lemiere C, Begin D, Forget A, Boulet L-P, Camus M, Gerin M. Occupational exposures  
18 of workers with occupational asthma and work-exacerbated asthma. *American Journal of*  
19 *Respiratory and Critical Care Medicine*. 2011; 183(1 MeetingAbstracts)
- 20 979 Lemiere C, Boulet L-P, Blais L, Villeneuve H, Forget A, Chaboillez S. Do work-  
21 exacerbated asthma and occupational asthma differ? *American Journal of Respiratory*  
22 *and Critical Care Medicine*. 2011; 183(1 MeetingAbstracts)
- 23 980 Lemiere C, Pizzichini MM, Balkissoon R, Clelland L, Efthimiadis A, O'Shaughnessy D et  
24 al. Diagnosing occupational asthma: use of induced sputum. *European Respiratory*  
25 *Journal*. 1999; 13(3):482-488
- 26 981 Leon de la Barra S, Smith AD, Cowan JO, Peter Herbison G, Robin Taylor D. Predicted  
27 versus absolute values in the application of exhaled nitric oxide measurements.  
28 *Respiratory Medicine*. 2011; 105(11):1629-1634
- 29 982 Leonardi NA, Spycher BD, Strippoli MP, Frey U, Silverman M, Kuehni CE. Validation of  
30 the Asthma Predictive Index and comparison with simpler clinical prediction rules.  
31 *Journal of Allergy and Clinical Immunology*. 2011; 127(6):1466-1472
- 32 983 Leone N, Courbon D, Berr C, Barberger-Gateau P, Tzourio C, Alperovitch A et al.  
33 Abdominal obesity and late-onset asthma: cross-sectional and longitudinal results: the  
34 3C study. *Obesity*. 2012; 20(3):628-635
- 35 984 Lerdlueedeporn P, Suwanjutha S, Preutthipan A. Pulmonary function and exercise  
36 challenge test in Thai children: 10 years post respiratory syncytial virus infection.  
37 *Journal of the Medical Association of Thailand*. 1999; 82 Suppl 1:S149-S153
- 38 985 Letz KL, Schlie AR, Smits WL. A randomized trial comparing peak expiratory flow versus  
39 symptom self-management plans for children with persistent asthma. *Pediatric*  
40 *Asthma, Allergy and Immunology*. 2004; 17(3):177-190

- 1 986 Leung RC, Carlin JB, Burdon JG, Czarny D. Asthma, allergy and atopy in Asian  
2 immigrants in Melbourne. *Medical Journal of Australia*. 1994; 161(7):418-425
- 3 987 Leung TF, Ko FWS, Wong GWK. Recent advances in asthma biomarker research.  
4 *Therapeutic Advances in Respiratory Disease*. 2013; 7(5):297-308
- 5 988 Leuppi JD, Downs SH, Downie SR, Marks GB, Salome CM. Exhaled nitric oxide levels in  
6 atopic children: relation to specific allergic sensitisation, AHR, and respiratory  
7 symptoms. *Thorax*. 2002; 57(6):518-523
- 8 989 Levesque B, Rhainds M, Ernst P, Grenier AM, Kosatsky T, Audet N et al. Asthma and  
9 allergic rhinitis in Quebec children. *Canadian Respiratory Journal*. 2004; 11(5):343-348
- 10 990 Levin ME, Muloiwa R, Motala C. Associations between asthma and bronchial hyper-  
11 responsiveness with allergy and atopy phenotypes in urban black South African  
12 teenagers. *South African Medical Journal*. 2011; 101(7):472-476
- 13 991 Lewis HM, Haeney M, Jeacock J, Thomas H. Chronic cough in a hospital population; its  
14 relationship to atopy and defects in host defence. *Archives of Disease in Childhood*.  
15 1989; 64(11):1593-1598
- 16 992 Lewis S, Butland B, Strachan D, Bynner J, Richards D, Butler N et al. Study of the  
17 aetiology of wheezing illness at age 16 in two national British birth cohorts. *Thorax*.  
18 1996; 51(7):670-676
- 19 993 Lewis S, Richards D, Bynner J, Butler N, Britton J. Prospective study of risk factors for  
20 early and persistent wheezing in childhood. *European Respiratory Journal*. 1995;  
21 8(3):349-356
- 22 994 Lewis SA, Weiss ST, Britton JR. Airway responsiveness and peak flow variability in the  
23 diagnosis of asthma for epidemiological studies. *European Respiratory Journal*. 2001;  
24 18(6):921-927
- 25 995 Lex C, Dymek S, Heying R, Kovacevic A, Kramm CM, Schuster A. Value of surrogate  
26 tests to predict exercise-induced bronchoconstriction in atopic childhood asthma.  
27 *Pediatric Pulmonology*. 2007; 42(3):225-230
- 28 996 Li AM, Tsang TWT, Chan DFY, Lam HS, So HK, Sung RYT et al. Cough frequency in  
29 children with mild asthma correlates with sputum neutrophil count. *Thorax*. 2006;  
30 61(9):747-750
- 31 997 Li AM, Tsang TWT, Chan DFY, Lam HS, So HK, Sung RYT et al. Sputum induction in  
32 children with asthma: a tertiary-center experience. *Pediatric Pulmonology*. 2006;  
33 41(8):720-725
- 34 998 Li Y-F, Gauderman WJ, Avol E, Dubeau L, Gilliland FD. Associations of tumor necrosis  
35 factor G-308A with childhood asthma and wheezing. *American Journal of Respiratory  
36 and Critical Care Medicine*. 2006; 173(9):970-976
- 37 999 Liam CK, Goh CT, Isahak M, Lim KH, Wong CM. Relationship between symptoms and  
38 objective measures of airway obstruction in asthmatic patients. *Asian Pacific Journal of  
39 Allergy and Immunology*. 2001; 19(2):79-83

- 1 1000 Liang Z, Zhao H, Lv Y, Li R, Dong H, Liu L et al. Moderate accuracy of peripheral  
2 eosinophil count for predicting eosinophilic phenotype in steroid-naive non-atopic  
3 adult asthmatics. *Internal Medicine*. 2012; 51(7):717-722
- 4 1001 Liem JJ, Huq SI, Ekuma O, Becker AB, Kozyrskyj AL. Transient tachypnea of the  
5 newborn may be an early clinical manifestation of wheezing symptoms. *Journal of*  
6 *Pediatrics*. 2007; 151(1):29-33
- 7 1002 Liem JJ, Kozyrskyj AL, Cockcroft DW, Becker AB. Diagnosing asthma in children: what is  
8 the role for methacholine bronchoprovocation testing? *Pediatric Pulmonology*. 2008;  
9 43(5):481-489
- 10 1003 Lim D, Kim J, Son B. Atopic biomarkers for bronchial hyper-responsiveness in Korean  
11 child with asthma. *Allergy*. 2010; 65:666-667
- 12 1004 Lim KG, Morgenthaler TI. Pulmonary function tests, part 1: Applying the basics. *Journal of*  
13 *Respiratory Diseases*. 2005; 26(1):26-40
- 14 1005 Lim S, Jatakanon A, Meah S, Oates T, Chung KF, Barnes PJ. Relationship between  
15 exhaled nitric oxide and mucosal eosinophilic inflammation in mild to moderately  
16 severe asthma. *Thorax*. 2000; 55(3):184-188
- 17 1006 Lin CC, Wu JL, Huang WC, Lin CY. A bronchial response comparison of exercise and  
18 methacholine in asthmatic subjects. *Journal of Asthma*. 1991; 28(1):31-40
- 19 1007 LindenSmith J, Morrison D, Deveau C, Hernandez P. Overdiagnosis of asthma in the  
20 community. *Canadian Respiratory Journal*. 2004; 11(2):111-116
- 21 1008 Linehan MF, Niven RM, Baxter DN, Morris JA, Frank TL. Prevalence of respiratory  
22 symptoms at two time points in a population of children in Manchester - A cohort  
23 study. *BMJ Open*. 2012; 2(5)
- 24 1009 Linehan MF, Frank PI, Niven R, Hazell ML, Morris JA, Francis H et al. Prevalence of  
25 respiratory symptoms, features of asthma, and characteristics associated with  
26 respiratory disease, in 6-11 year olds in Manchester. *Primary Care Respiratory Journal*.  
27 2009; 18(1):21-26
- 28 1010 Linehan MF, Frank TL, Hazell ML, Francis HC, Morris JA, Baxter DN et al. Is the  
29 prevalence of wheeze in children altered by neonatal BCG vaccination? *Journal of*  
30 *Allergy and Clinical Immunology*. 2007; 119(5):1079-1085
- 31 1011 Linn WS, Rappaport EB, Berhane KT, Bastain TM, Avol EL, Gilliland FD. Exhaled nitric  
32 oxide in a population-based study of southern California schoolchildren. *Respiratory*  
33 *Research*. 2009; 10:28
- 34 1012 Linna O. Spirometry, bronchodilator test or symptom scoring for the assessment of  
35 childhood asthma. *Acta Paediatrica*. 1996; 85(5):564-569
- 36 1013 Linna O. Sensitivity of peak expiratory flow rate for diagnosing bronchial obstruction  
37 on methacholine inhalation challenge in school-aged asthmatic children. *Acta*  
38 *Paediatrica*. 1998; 87(6):635-637

- 1 1014 Linna OV. Twice-daily peak expiratory flow rate monitoring for the assessment of  
2 childhood asthma. *Allergy Proceedings*. 1993; 14(1):33-36
- 3 1015 Linneberg A, Husemoen LLN, Nielsen NH, Madsen F, Frolund L, Johansen N. Screening  
4 for allergic respiratory disease in the general population with the ADVIA Centaur  
5 Allergy Screen Assay. *Allergy*. 2006; 61(3):344-348
- 6 1016 Liou TG, Kanner RE. Spirometry. *Clinical Reviews in Allergy and Immunology*. 2009;  
7 37(3):137-152
- 8 1017 Lipinska A, Wittczak T, Wiszniewska M, Palczynski C, Nieradka A, Walusiak-Skorupa J.  
9 Cleaners' asthma - Does it really exist? *Allergy*. 2011; 66:595-596
- 10 1018 Lipworth BJ, Short PM, Williamson PA, Clearie KL, Fardon TC, Jackson CM. A  
11 randomized primary care trial of steroid titration against mannitol in persistent  
12 asthma: STAMINA trial. *Chest*. 2012; 141(3):607-615
- 13 1019 Liu AH, Zeiger R, Sorkness C, Mahr T, Ostrom N, Burgess S et al. Development and  
14 cross-sectional validation of the Childhood Asthma Control Test. *Journal of Allergy and  
15 Clinical Immunology*. 2007; 119(4):817-825
- 16 1020 Liu WT, Huang CD, Wang CH, Lee KY, Lin SM, Kuo HP. A mobile telephone-based  
17 interactive self-care system improves asthma control. *European Respiratory Journal*.  
18 2011; 37(2):310-317
- 19 1021 Lloyd A, Price D, Brown R. The impact of asthma exacerbations on health-related  
20 quality of life in moderate to severe asthma patients in the UK. *Primary Care  
21 Respiratory Journal*. 2007; 16(1):22-27
- 22 1022 Lobo ES, Revicki D, Grant W, Turk F, Massanari M. Assessment of the psychometric  
23 properties of the paediatric asthma quality of life questionnaire (PAQLQ) in moderate  
24 to severe pediatric asthma patients [Abstract]. *Journal of Allergy and Clinical  
25 Immunology*. 2007; 119(1 Suppl):S151
- 26 1023 Lodrup Carlsen KC, Soderstrom L, Mowinckel P, Haland G, Pettersen M, Munthe Kaas  
27 MC et al. Asthma prediction in school children; The value of combined IgE-antibodies  
28 and obstructive airways disease severity score. *Allergy*. 2010; 65(9):1134-1140
- 29 1024 Loerbroks A, Herr RM, Subramanian S, Bosch JA. The association of asthma and  
30 wheezing with major depressive episodes: an analysis of 245 727 women and men  
31 from 57 countries. *International Journal of Epidemiology*. 2012; 41(5):1436-1444
- 32 1025 Lombardi C, Canonica GW, Passalacqua G, IGRAM Italian Group on Respiratory Allergy  
33 in Migrants. The possible influence of the environment on respiratory allergy: a survey  
34 on immigrants to Italy. *Annals of Allergy, Asthma and Immunology*. 2011; 106(5):407-  
35 411
- 36 1026 Lombardi C, Penagos M, Senna G, Canonica GW, Passalacqua G. The clinical  
37 characteristics of respiratory allergy in immigrants in northern Italy. *International  
38 Archives of Allergy and Immunology*. 2008; 147(3):231-234

- 1 1027 Lopez-Vina A, del Castillo-Arevalo E. Influence of peak expiratory flow monitoring on  
2 an asthma self-management education programme. *Respiratory Medicine*. 2000;  
3 94(8):760-766
- 4 1028 Lorber DB, Kaltenborn W, Burrows B. Responses to isoproterenol in a general  
5 population sample. *American Review of Respiratory Disease*. 1978; 118(5):855-861
- 6 1029 Louhelainen N, Ryttila P, Obase Y, Makela M, Haahtela T, Kinnula VL et al. The value of  
7 sputum 8-isoprostane in detecting oxidative stress in mild asthma. *Journal of Asthma*.  
8 2008; 45(2):149-154
- 9 1030 Lowhagen O. Asthma and asthma-like disorders. *Respiratory Medicine*. 1999;  
10 93(12):851-855
- 11 1031 Löwhagen O, Wever AM, Lusuardi M, Moscato G, Backer WA, Gandola L et al. The  
12 inflammatory marker serum eosinophil cationic protein (ECP) compared with PEF as a  
13 tool to decide inhaled corticosteroid dose in asthmatic patients. *Respiratory Medicine*.  
14 2002; 96(2):95-101
- 15 1032 Ludviksdottir D, Diamant Z, Alving K, Bjermer L, Malinovschi A. Clinical aspects of using  
16 exhaled NO in asthma diagnosis and management. *Clinical Respiratory Journal*. 2012;  
17 6(4):193-207
- 18 1033 Luisi F, Pinto LA, Marostica L, Jones MH, Stein RT, Pitrez PM. Persistent pulmonary  
19 function impairment in children and adolescents with asthma. *Jornal Brasileiro De*  
20 *Pneumologia*. 2012; 38(2):158-166
- 21 1034 Lukrafka JL, Fuchs SC, Moreira LB, Picon RV, Fischer GB, Fuchs FD. Performance of the  
22 ISAAC questionnaire to establish the prevalence of asthma in adolescents: a  
23 population-based study. *Journal of Asthma*. 2010; 47(2):166-169
- 24 1035 Lumelli D, Garcia Del PM, Manso L, Fernandez-Nieto M, Sastre J. Comparison of  
25 bronchial hyperresponsiveness to methacholine and adenosine in clinical practice.  
26 *Journal of Allergy and Clinical Immunology*. 2010; 125(2 Suppl.1):AB2
- 27 1036 Luntsov A, Skorokhodkina O. A diagnostic program for bronchial asthma including  
28 allergen challenge and exercise bronchoprovocation testing in young patients. *Allergy*.  
29 2012; 67:454
- 30 1037 Lurà MP, Inci D, Staffelbach S, Wildhaber J, Möller A. Exhaled nitric oxide and its role in  
31 monitoring asthma control in atopic children [Abstract]. *European Respiratory Society*  
32 *Annual Congress, Barcelona, Spain, September 18-22. 4/10 2010;4774*
- 33 1038 Lutfi MF. Acceptable alternatives for forced vital capacity in the spirometric diagnosis  
34 of bronchial asthma. *International Journal of Applied and Basic Medical Research*.  
35 2011; 1(1):20-23
- 36 1039 Luyt DK, Bourke AM, Lambert P, Burton P, Simpson H. Wheeze in preschool children:  
37 who is followed-up, who is treated and who is hospitalized? *European Respiratory*  
38 *Journal*. 1995; 8(10):1736-1741

- 1 1040 Luyt DK, Burton P, Brooke AM, Simpson H. Wheeze in preschool children and its  
2 relation with doctor diagnosed asthma. *Archives of Disease in Childhood*. 1994;  
3 71(1):24-30
- 4 1041 Luyt DK, Burton PR, Simpson H. Epidemiological study of wheeze, doctor diagnosed  
5 asthma, and cough in preschool children in Leicestershire. *BMJ*. 1993; 306(6889):1386-  
6 1390
- 7 1042 Maas T, Kaper J, Sheikh A, Knottnerus JA, Wesseling G, Dompeling E et al. Mono and  
8 multifaceted inhalant and/or food allergen reduction interventions for preventing  
9 asthma in children at high risk of developing asthma. *Cochrane Database of Systematic  
10 Reviews*. 2009; Issue 3:CD006480. DOI:10.1002/14651858.CD006480.pub2
- 11 1043 Macleod KA, Horsley AR, Bell NJ, Greening AP, Innes JA, Cunningham S. Ventilation  
12 heterogeneity in children with well controlled asthma with normal spirometry  
13 indicates residual airways disease. *Thorax*. 2009; 64(1):33-37
- 14 1044 Madsen F, Holstein-Rathlou NH, Frolund L, Weeke B, Svendsen UG. Bronchial  
15 histamine challenge in the diagnosis of asthma. The predictive value of changes in  
16 airway resistance determined by the interrupter method. *Allergy*. 1986; 41(3):187-195
- 17 1045 Madsen F, Holstein-Rathlou NH, Mosbech H, Weeke B, Svendsen UG. The predictive  
18 value of bronchial histamine challenge in the diagnosis of bronchial asthma.  
19 *Scandinavian Journal of Clinical and Laboratory Investigation*. 1985; 45(5):453-460
- 20 1046 Magar Y, Vervloet D, Steenhouwer F, Smaga S, Mechin H, Rocca Serra JP et al.  
21 Assessment of a therapeutic education programme for asthma patients: "un souffle  
22 nouveau". *Patient Education and Counseling*. 2005; 58(1):41-46
- 23 1047 Magdelijns FJH, Mommers M, Penders J, Smits L, Thijs C. Folic acid use in pregnancy  
24 and the development of atopy, asthma, and lung function in childhood. *Pediatrics*.  
25 2011; 128(1):e135-e144
- 26 1048 Magnan A. Tools to assess (and achieve?) long-term asthma control. *Respiratory  
27 Medicine*. 2004; 98(Suppl.2):S16-S21
- 28 1049 Magnan A, Fourre-Jullian C, Jullian H, Badier M, Lanteaume A, Vervloet D et al. Rhinitis  
29 alone or rhinitis plus asthma: what makes the difference? *European Respiratory  
30 Journal*. 1998; 12(5):1073-1078
- 31 1050 Magyar P. The significance of lung function tests in the differential diagnosis of  
32 bronchial asthma. *Acta Microbiologica Et Immunologica Hungarica*. 1998; 45(1):95-100
- 33 1051 Maher JE, Mullooly JP, Drew L, DeStefano F. Infant vaccinations and childhood asthma  
34 among full-term infants. *Pharmacoepidemiology and Drug Safety*. 2004; 13(1):1-9
- 35 1052 Mahmoud H, Elqady M. Relationship between skin prick test, peripheral eosinophilic  
36 count, serum total and specific ige, and severity of asthma in atopic asthma. *Chest*.  
37 2013; 144(4 Meeting Abstracts):78A
- 38 1053 Mahmoud H, Elqady M, Mohamed H. Relationship between skin prick test, peripheral  
39 eosinophil counts, serum total & specific IgE and severity in atopic asthma. *Allergy*.  
40 2011; 66:578

- 1 1054 Maitra A, Sherriff A, Strachan D, Henderson J, ALSPAC Study Team. Mode of delivery is  
2 not associated with asthma or atopy in childhood. *Clinical and Experimental Allergy*.  
3 2004; 34(9):1349-1355
- 4 1055 Majak P, Cichalewski L, Ozarek-Hanc A, Stelmach W, Jerzynska J, Stelmach I. Airway  
5 response to exercise measured by area under the expiratory flow-volume curve in  
6 children with asthma. *Annals of Allergy, Asthma and Immunology*. 2013; 111(6):512-  
7 515
- 8 1056 Makowska JS, Grzegorzczak J, Bienkiewicz B, Wozniak M, Kowalski ML. Systemic  
9 responses after bronchial aspirin challenge in sensitive patients with asthma. *Journal*  
10 *of Allergy and Clinical Immunology*. 2008; 121(2):348-354
- 11 1057 Malby Schoos AM, Chawes BLK, Bonnelykke K, Bisgaard H. Fraction of exhaled nitric  
12 oxide and bronchial responsiveness are associated and continuous traits in young  
13 children independent of asthma. *Chest*. 2012; 142(6):1562-1568
- 14 1058 Malerba M, Ragnoli B, Radaeli A, Tantucci C. Usefulness of exhaled nitric oxide and  
15 sputum eosinophils in the long-term control of eosinophilic asthma. *Chest*. 2008;  
16 134(4):733-739
- 17 1059 Malinowski A, Backer V, Harving H, Porsbjerg C. The value of exhaled nitric oxide to  
18 identify asthma in smoking patients with asthma-like symptoms. *Respiratory Medicine*.  
19 2012; 106(6):794-801
- 20 1060 Malinowski A, Janson C, Hogman M, Rolla G, Toren K, Norback D et al. Both allergic  
21 and nonallergic asthma are associated with increased FE(NO) levels, but only in never-  
22 smokers. *Allergy*. 2009; 64(1):55-61
- 23 1061 Malinowski A, Fonseca JA, Jacinto T, Alving K, Janson C. Exhaled nitric oxide levels and  
24 blood eosinophil counts independently associate with wheeze and asthma events in  
25 National Health and Nutrition Examination Survey subjects. *Journal of Allergy and*  
26 *Clinical Immunology*. 2013; 132(4):821-825
- 27 1062 Mallol J, Garcia-Marcos L, Sole D, Brand P, EISL Study Group. International prevalence  
28 of recurrent wheezing during the first year of life: variability, treatment patterns and  
29 use of health resources. *Thorax*. 2010; 65(11):1004-1009
- 30 1063 Malmberg LP, Nikander K, Pelkonen AS, Syvanen P, Koljonen T, Haahtela T et al.  
31 Acceptability, reproducibility, and sensitivity of forced expiratory volumes and peak  
32 expiratory flow during bronchial challenge testing in asthmatic children. *Chest*. 2001;  
33 120(6):1843-1849
- 34 1064 Malmberg LP, Pelkonen AS, Haahtela T, Turpeinen M. Exhaled nitric oxide rather than  
35 lung function distinguishes preschool children with probable asthma. *Thorax*. 2003;  
36 58(6):494-499
- 37 1065 Malmberg LP, Pelkonen AS, Mattila PS, Hammaren-Malmi S, Makela MJ. Exhaled nitric  
38 oxide and exercise-induced bronchoconstriction in young wheezy children -  
39 interactions with atopy. *Pediatric Allergy and Immunology*. 2009; 20(7):673-678



- 1 1066 Malo JL, Cote J, Cartier A, Boulet LP, L'Archeveque J, Chan-Yeung M. How many times  
2 per day should peak expiratory flow rates be assessed when investigating occupational  
3 asthma? *Thorax*. 1993; 48(12):1211-1217
- 4 1067 Malo JL, Ghezzi H, L'Archeveque J, Lagier F, Perrin B, Cartier A. Is the clinical history a  
5 satisfactory means of diagnosing occupational asthma? *American Review of  
6 Respiratory Disease*. 1991; 143(3):528-532
- 7 1068 Malo JL, L'Archeveque J, Trudeau C, d'Aquino C, Cartier A. Should we monitor peak  
8 expiratory flow rates or record symptoms with a simple diary in the management of  
9 asthma? *Journal of Allergy and Clinical Immunology*. 1993; 91(3):702-709
- 10 1069 Malo JL, Trudeau C, Ghezzi H, L'Archeveque J, Cartier A. Do subjects investigated for  
11 occupational asthma through serial peak expiratory flow measurements falsify their  
12 results? *Journal of Allergy and Clinical Immunology*. 1995; 96(5 Pt 1):601-607
- 13 1070 Mandhane PJ, Greene JM, Cowan JO, Taylor DR, Sears MR. Sex differences in factors  
14 associated with childhood- and adolescent-onset wheeze. *American Journal of  
15 Respiratory and Critical Care Medicine*. 2005; 172(1):45-54
- 16 1071 Manfreda J, Becklake MR, Sears MR, Chan-Yeung M, Dimich-Ward H, Siersted HC et al.  
17 Prevalence of asthma symptoms among adults aged 20-44 years in Canada. *CMAJ*.  
18 2001; 164(7):995-1001
- 19 1072 Manning PJ, Goodman P, O'Sullivan A, Clancy L. Rising prevalence of asthma but  
20 declining wheeze in teenagers (1995-2003): ISAAC protocol. *Irish Medical Journal*.  
21 2007; 100(10):614-615
- 22 1073 Mannino F, Mariotta S, Anticoli S, Lambert-Gardini S, Terzano C. Sensitivity of FEV1  
23 and indices of flow volume curve in the methacholine test. *Allergologia Et  
24 Immunopathologia*. 1996; 24(2):75-80
- 25 1074 Manso L, Madero MF, Ruiz-Garcia M, Fernandez-Nieto M, Sastre J. Comparison of  
26 bronchial hyperresponsiveness to methacholine and adenosine and airway  
27 inflammation markers in patients with suspected asthma. *Journal of Asthma*. 2011;  
28 48(4):335-340
- 29 1075 Mansournia MA, Jamali M, Mansournia N, Yunesian M, Moghadam KG. Exercise-  
30 induced bronchospasm among students of Tehran University of Medical Sciences in  
31 2004. *Allergy and Asthma Proceedings*. 2007; 28(3):348-352
- 32 1076 Marbury MC, Maldonado G, Waller L. The indoor air and children's health study:  
33 methods and incidence rates. *Epidemiology*. 1996; 7(2):166-174
- 34 1077 Marinovic MA, Duarte P, Tordecilla R, Zuniga MD. Usefulness of aeroallergen atopy  
35 patch test in the diagnosis of atopic respiratory and skin diseases. *Allergy*. 2013;  
36 68:641-642
- 37 1078 Marks GB, Dunn SM, Woolcock AJ. An evaluation of an asthma quality of life  
38 questionnaire as a measure of change in adults with asthma. *Journal of Clinical  
39 Epidemiology*. 1993; 46(10):1103-1111

- 1 1079 Marossy AE, Strachan DP, Rudnicka AR, Anderson HR. Childhood chest illness and the  
2 rate of decline of adult lung function between ages 35 and 45 years. *American Journal*  
3 *of Respiratory and Critical Care Medicine*. 2007; 175(4):355-359
- 4 1080 Martindale S, McNeill G, Devereux G, Campbell D, Russell G, Seaton A. Antioxidant  
5 intake in pregnancy in relation to wheeze and eczema in the first two years of life.  
6 *American Journal of Respiratory and Critical Care Medicine*. 2005; 171(2):121-128
- 7 1081 Martinez FD, Wright AL, Taussig LM, Holberg CJ, Halonen M, Morgan WJ. Asthma and  
8 wheezing in the first six years of life. *The Group Health Medical Associates. New*  
9 *England Journal of Medicine*. 1995; 332(3):133-138
- 10 1082 Martinez P, Weiss BD. Unchanged asthma prevalence during 1990-1999 in rural Alaska  
11 Natives. *International Journal of Circumpolar Health*. 2006; 65(4):341-346
- 12 1083 Martins P, Caires I, Rosado Pinto J, Lopes da Mata P, Torres S, Valente J et al. The  
13 clinical use of exhaled nitric oxide in wheezing children. *Revista Portuguesa De*  
14 *Pneumologia*. 2008; 14(2):195-218
- 15 1084 Mascia K, Haselkorn T, Deniz YM, Miller DP, Bleecker ER, Borish L et al. Aspirin  
16 sensitivity and severity of asthma: evidence for irreversible airway obstruction in  
17 patients with severe or difficult-to-treat asthma. *Journal of Allergy and Clinical*  
18 *Immunology*. 2005; 116(5):970-975
- 19 1085 Masuko H, Sakamoto T, Kaneko Y, Iijima H, Naito T, Noguchi E et al. Lower FEV1  
20 in non-COPD, nonasthmatic subjects: association with smoking, annual decline in FEV1,  
21 total IgE levels, and TSLP genotypes. *International Journal of Chronic Obstructive*  
22 *Pulmonary Disease*. 2011; 6:181-189
- 23 1086 Masullo M, Mariotta S, Torrelli L, Graziani E, Anticoli S, Mannino F. Respiratory allergy  
24 to parietaria pollen in 348 subjects. *Allergologia Et Immunopathologia*. 1996; 24(1):3-6
- 25 1087 Matheson MC, Ellis JA, Raven J, Johns DP, Walters EH, Abramson MJ. Beta2-adrenergic  
26 receptor polymorphisms are associated with asthma and COPD in adults. *Journal of*  
27 *Human Genetics*. 2006; 51(11):943-951
- 28 1088 Matricardi PM, Bockelbrink A, Keil T, Gruber C, Niggemann B, Hamelmann E et al.  
29 Dynamic evolution of serum immunoglobulin e to airborne allergens throughout  
30 childhood: Results from the Multi-Centre Allergy Study birth cohort. *Clinical and*  
31 *Experimental Allergy*. 2009; 39(10):1551-1557
- 32 1089 Matricardi PM, Illi S, Gruber C, Keil T, Nickel R, Wahn U et al. Wheezing in childhood:  
33 incidence, longitudinal patterns and factors predicting persistence. *European*  
34 *Respiratory Journal*. 2008; 32(3):585-592
- 35 1090 Matricardi PM, Nisini R, Pizzolo JG, D'Amelio R. The use of Phadiatop in mass-screening  
36 programmes of inhalant allergies: Advantages and limitations. *Clinical and*  
37 *Experimental Allergy*. 1990; 20(2):151-155
- 38 1091 Matsui EC, Sampson HA, Bahnson HT, Gruchalla RS, Pongracic JA, Teach SJ et al.  
39 Allergen-specific IgE as a biomarker of exposure plus sensitization in inner-city  
40 adolescents with asthma. *Allergy*. 2010; 65(11):1414-1422

- 1 1092 Matsunaga K, Yanagisawa S, Hirano T, Ichikawa T, Koarai A, Akamatsu K et al.  
2 Associated demographics of persistent exhaled nitric oxide elevation in treated  
3 asthmatics. *Clinical and Experimental Allergy*. 2012; 42(5):775-781
- 4 1093 Matsunaga K, Hirano T, Akamatsu K, Koarai A, Sugiura H, Minakata Y et al. Exhaled  
5 nitric oxide cutoff values for asthma diagnosis according to rhinitis and smoking status  
6 in Japanese subjects. *Allergology International*. 2011; 60(3):331-337
- 7 1094 Matsunaga K, Kanda M, Hayata A, Yanagisawa S, Ichikawa T, Akamatsu K et al. Peak  
8 expiratory flow variability adjusted by forced expiratory volume in one second is a  
9 good index for airway responsiveness in asthmatics. *Internal Medicine*. 2008;  
10 47(12):1107-1112
- 11 1095 Matui P, Wyatt JC, Pinnock H, Sheikh A, McLean S. Computer decision support systems  
12 for asthma: a systematic review. *NPJ Primary Care Respiratory Medicine*. 2014;  
13 24:14005
- 14 1096 May KL. Allergy to *Artemisia vulgaris* in the region of Warsaw. *Allergologia Et*  
15 *Immunopathologia*. 1990; 18(1):57-60
- 16 1097 Maziak W, von Mutius E, Beimfohr C, Hirsch T, Leupold W, Keil U et al. The  
17 management of childhood asthma in the community. *European Respiratory Journal*.  
18 2002; 20(6):1476-1482
- 19 1098 Maziak W, von Mutius E, Keil U, Hirsch T, Leupold W, Rzehak P et al. Predictors of  
20 health care utilization of children with asthma in the community. *Pediatric Allergy and*  
21 *Immunology*. 2004; 15(2):166-171
- 22 1099 McClean MA, Htun C, King GG, Berend N, Salome CM. Cut-points for response to  
23 mannitol challenges using the forced oscillation technique. *Respiratory Medicine*.  
24 2011; 105(4):533-540
- 25 1100 McClure LA, Harrington KF, Graham H, Gerald LB. Internet-based monitoring of asthma  
26 symptoms, peak flow meter readings, and absence data in a school-based clinical trial.  
27 *Clinical Trials*. 2008; 5(1):31-37
- 28 1101 McConnell R, Berhane K, Gilliland F, London SJ, Vora H, Avol E et al. Air pollution and  
29 bronchitic symptoms in Southern California children with asthma. *Environmental*  
30 *Health Perspectives*. 1999; 107(9):757-760
- 31 1102 McConnell R, Berhane K, Gilliland F, Islam T, Gauderman WJ, London SJ et al. Indoor  
32 risk factors for asthma in a prospective study of adolescents. *Epidemiology*. 2002;  
33 13(3):288-295
- 34 1103 McDonald E, Clarke FJ, Zhou Q, Freitag A, Cox G, Whitehead L. Validation of the  
35 asthma control questionnaire in children. American Thoracic Society International  
36 Conference, May 15-20, 2009, San Diego. 2009;A4321
- 37 1104 McEldowney SJ, Bush RK. House dust mite specific IgA and exhaled nitric acid are  
38 elevated in allergic asthma and rhinitis patients with positive methacholine challenges  
39 [Abstract]. *Journal of Allergy and Clinical Immunology*. 2008; 21(2 Suppl 1):S198

- 1 1105 McElnay JC, Scott MG, Armstrong AP, Stanford CF. Audiovisual demonstration for  
2 patient counselling in the use of pressurised aerosol bronchodilator inhalers. *Journal*  
3 *of Clinical Pharmacy and Therapeutics*. 1989; 14(2):135-144
- 4 1106 McGarvey LP, Heaney LG, Lawson JT, Johnston BT, Scally CM, Ennis M et al. Evaluation  
5 and outcome of patients with chronic non-productive cough using a comprehensive  
6 diagnostic protocol. *Thorax*. 1998; 53(9):738-743
- 7 1107 McGrath AM, Gardner DM, McCormack J. Is home peak expiratory flow monitoring  
8 effective for controlling asthma symptoms? *Journal of Clinical Pharmacy and*  
9 *Therapeutics*. 2001; 26(5):311-317
- 10 1108 Mchedlishvili N, Siradze N, Tsertsvadze S, Giorgobiani A, Kiknadze N. Wheezing  
11 phenotypes and lung function in pre-school children. *Allergy: European Journal of*  
12 *Allergy and Clinical Immunology*. 2013; 68:535-536
- 13 1109 McKeever TM, Lewis SA, Smith C, Hubbard R. The importance of prenatal exposures on  
14 the development of allergic disease: a birth cohort study using the West Midlands  
15 General Practice Database. *American Journal of Respiratory and Critical Care*  
16 *Medicine*. 2002; 166(6):827-832
- 17 1110 McKinlay L, Jackson CM, Williamson PA, Fardon TC, Burns P, Clearie K et al. Steroid  
18 titration against mannitol in mild to moderate asthma: The stamina community study.  
19 *Journal of Allergy and Clinical Immunology*. 2011; 127(2 SUPPL. 1):AB5
- 20 1111 McLean S, Chandler D, Nurmatov U, Liu JLY, Pagliari C, Car J et al. Telehealthcare for  
21 asthma. *Cochrane Database of Systematic Reviews*. 2010; Issue 10:CD007717.  
22 DOI:10.1002/14651858.CD007717.pub2
- 23 1112 McMullen AH, Yoos HL, Kitzman H. Peak flow meters in childhood asthma: parent  
24 report of use and perceived usefulness. *Journal of Pediatric Health Care*. 2002;  
25 16(2):67-72
- 26 1113 McTaggart-Cowan HM, Marra CA, Yang Y, Brazier JE, Kopec JA, Fitzgerald JM et al. The  
27 validity of generic and condition-specific preference-based instruments: the ability to  
28 discriminate asthma control status. *Quality of Life Research*. 2008; 17(3):453-462
- 29 1114 Meer V, Stel HF, Bakker MJ, Roldaan AC, Assendelft WJ, Sterk PJ et al. Weekly self-  
30 monitoring and treatment adjustment benefit patients with partly controlled and  
31 uncontrolled asthma: an analysis of the SMASHING study. *Respiratory Research*. 2010;  
32 11:74
- 33 1115 Mehrparvar AH, Hossein DM, Salmani NM, Hashemi SH, Mostaghaci M,  
34 Mirmohammadi SJ. Assessment of bronchodilator response in various spirometric  
35 patterns. *Tanaffos*. 2013; 12(2):28-33
- 36 1116 Mehuys E, Van Bortel L, De Bolle L, Van Tongelen I, Annemans L, Remon JP et al.  
37 Effectiveness of pharmacist intervention for asthma control improvement. *European*  
38 *Respiratory Journal*. 2008; 31(4):790-799
- 39 1117 Melbye H, Drivenes E, Dalbak LG, Leinan T, Hoegh-Henrichsen S, Ostrem A. Asthma,  
40 chronic obstructive pulmonary disease, or both? Diagnostic labeling and spirometry in

- 1 primary care patients aged 40 years or more. *International Journal of Chronic*  
2 *Obstructive Pulmonary Disease*. 2011; 6:597-603
- 3 1118 Mele L, Sly PD, Calogero C, Bernardini R, Novembre E, Azzari C et al. Assessment and  
4 validation of bronchodilation using the interrupter technique in preschool children.  
5 *Pediatric Pulmonology*. 2010; 45(7):633-638
- 6 1119 Melillo G, Padovano A, Masi C, Melillo E, Cocco G. Aspirin-induced asthma and  
7 bronchial hyperresponsiveness. *Allergie Et Immunologie*. 1991; 23(10):423-427
- 8 1120 Meltzer AA, Smolensky MH, D'Alonzo GE, Harrist RB, Scott PH. An assessment of peak  
9 expiratory flow as a surrogate measurement of FEV1 in stable asthmatic children.  
10 *Chest*. 1989; 96(2):329-333
- 11 1121 Mendonca NT, Kenyon J, LaPrad AS, Syeda SN, O'Connor GT, Lutchen KR. Airway  
12 resistance at maximum inhalation as a marker of asthma and airway  
13 hyperresponsiveness. *Respiratory Research*. 2011; 12:96
- 14 1122 Menzies D, Nair A, Lipworth BJ. Portable exhaled nitric oxide measurement:  
15 Comparison with the "gold standard" technique. *Chest*. 2007; 131(2):410-414
- 16 1123 Merchant R, Inamdar R, Quade R, Van SD, Maenner M, Patmas M. Interim results from  
17 a randomized, controlled trial of remote monitoring of inhaled bronchodilator use on  
18 asthma control and management [Abstract]. *Chest: American College of Chest*  
19 *Physicians*. 2013; 144(4 Meeting Abstracts):71A
- 20 1124 Merget R, Schultze-Werninghaus G, Bode F, Bergmann EM, Zachgo W, Meier-Sydow J.  
21 Quantitative skin prick and bronchial provocation tests with platinum salt. *British*  
22 *Journal of Industrial Medicine*. 1991; 48(12):830-837
- 23 1125 Meslier N, Racineux JL, Six P, Lockhart A. Diagnostic value of reversibility of chronic  
24 airway obstruction to separate asthma from chronic bronchitis: a statistical approach.  
25 *European Respiratory Journal*. 1989; 2(6):497-505
- 26 1126 Metso T, Kilpio K, Bjorksten F, Kiviranta K, Haahtela T. Can early asthma be confirmed  
27 by laboratory tests? *Allergy*. 1996; 51(4):226-231
- 28 1127 Metso T, Kilpio K, Bjorksten F, Kiviranta K, Haahtela T. Detection and treatment of  
29 early asthma. *Allergy*. 2000; 55(5):505-509
- 30 1128 Meyer N, Nuss SJ, Rothe T, Siebenhuner A, Akdis CA, Menz G. Differential serum  
31 protein markers and the clinical severity of asthma. *Journal of Asthma and Allergy*.  
32 2014; 7:67-75
- 33 1129 Michel G, Silverman M, Strippoli M-PF, Zwahlen M, Brooke AM, Grigg J et al. Parental  
34 understanding of wheeze and its impact on asthma prevalence estimates. *European*  
35 *Respiratory Journal*. 2006; 28(6):1124-1130
- 36 1130 Michoud MC, Ghezzi H, Amyot R. A comparison of pulmonary function tests used for  
37 bronchial challenges. *Clinical Respiratory Physiology*. 1982; 18(4):609-621
- 38 1131 Midodzi WK, Rowe BH, Majaesic CM, Saunders LD, Senthilselvan A. Early life factors  
39 associated with incidence of physician-diagnosed asthma in preschool children: results

- 1 from the Canadian Early Childhood Development cohort study. *Journal of Asthma*.  
2 2010; 47(1):7-13
- 3 1132 Miedinger D, Burge C, Burge S, To B, Luthiger J, Yereaztian C. The pef-logger  
4 application for the diagnosis of work-related asthma (WRA). *Respiration*. 2013;  
5 85(6):618
- 6 1133 Miedinger D, Mosimann N, Meier R, Karli C, Florek P, Frey F et al. Asthma tests in the  
7 assessment of military conscripts. *Clinical and Experimental Allergy*. 2010; 40(2):224-  
8 231
- 9 1134 Miedinger D, Chhajed PN, Tamm M, Stolz D, Surber C, Leuppi JD. Diagnostic tests for  
10 asthma in firefighters. *Chest*. 2007; 131(6):1760-1767
- 11 1135 Miguères M, Fontaine JF, Haddad T, Grosclaude M, Saint-Martin F, Bem David D et al.  
12 Characteristics of patients with respiratory allergy in France and factors influencing  
13 immunotherapy prescription: a prospective observational study (REALIS). *International*  
14 *Journal of Immunopathology and Pharmacology*. 2011; 24(2):387-400
- 15 1136 Milam J, McConnell R, Yao L, Berhane K, Jerrett M, Richardson J. Parental stress and  
16 childhood wheeze in a prospective cohort study. *Journal of Asthma*. 2008; 45(4):319-  
17 323
- 18 1137 Milenkovic BA, Stankovic IJ, Ilic AM, Petrovic VI. Peak expiratory flow-guided self-  
19 management treatment of asthma in Serbia. *Journal of Asthma*. 2007; 44(9):699-704
- 20 1138 Milewski M, Mastalerz L, Nizankowska E, Szczeklik A. Nasal provocation test with  
21 lysine-aspirin for diagnosis of aspirin-sensitive asthma. *Journal of Allergy and Clinical*  
22 *Immunology*. 1998; 101(5):581-586
- 23 1139 Miller A. A simple spirometric clue to asthma: Airways obstruction suggested by  
24 negative or reduced forced expiratory reserve volume despite normal FEV1-FVC ratio.  
25 *Mount Sinai Journal of Medicine*. 1990; 57(2):85-92
- 26 1140 Miller B, Mirakian R, Gane S, Larco J, Sannah AA, Darby Y et al. Nasal lysine aspirin  
27 challenge in the diagnosis of aspirin - exacerbated respiratory disease. *Clinical and*  
28 *Experimental Allergy*. 2013; 43(8):874-880
- 29 1141 Miller CJ, Joseph J, Safa W, Flood PE, Dunn EV, Shaheen HM. Accuracy of Arabic  
30 versions of three asthma symptoms questionnaires against the clinical diagnosis of  
31 asthma. *Journal of Asthma*. 2007; 44(1):29-34
- 32 1142 Millstein J, Gilliland F, Berhane K, Gauderman WJ, McConnell R, Avol E et al. Effects of  
33 ambient air pollutants on asthma medication use and wheezing among fourth-grade  
34 school children from 12 Southern California communities enrolled in The Children's  
35 Health Study. *Archives of Environmental Health*. 2004; 59(10):505-514
- 36 1143 Minakata Y, Sugiura H, Yamagata T, Yanagisawa S, Ichikawa T, Koarai A et al.  
37 Prevalence of COPD in primary care clinics: Correlation with non-respiratory diseases.  
38 *Internal Medicine*. 2008; 47(2):77-82

- 1 1144 Miraglia Del Giudice M, Pedulla M, Piacentini GL, Capristo C, Brunese FP, Decimo F et  
2 al. Atopy and house dust mite sensitization as risk factors for asthma in children.  
3 *Allergy*. 2002; 57(2):169-172
- 4 1145 Mirakian R, Miller B, Gane S, Larco J, Al SA, Darby Y et al. Lysine aspirin nasal challenge  
5 in the diagnosis of aspirin exacerbated respiratory disease-suitable for outpatient  
6 practice? *Clinical and Experimental Allergy*. 2012; 42(12):1834
- 7 1146 Miravittles M, Andreu I, Romero Y, Sitjar S, Altes A, Anton E. Difficulties in differential  
8 diagnosis of COPD and asthma in primary care. *British Journal of General Practice*.  
9 2012; 62(595):e68-e75
- 10 1147 Mirmohammadi SJ, Mehrparvar AH, Gharavi M, Fathi F. A comparison between  
11 Venables standardized respiratory questionnaire and pre-shift spirometry in screening  
12 of occupational asthma in a steel industry. *International Journal of Occupational and  
13 Environmental Medicine*. 2010; 1(4):191-197
- 14 1148 Mitchell EA, Asher MI. Prevalence, severity and medical management of asthma in  
15 European school children in 1985 and 1991. *Journal of Paediatrics and Child Health*.  
16 1994; 30(5):398-402
- 17 1149 Mitchell EA, Didsbury PB, Kruithof N, Robinson E, Milmine M, Barry M et al. A  
18 randomized controlled trial of an asthma clinical pathway for children in general  
19 practice. *Acta Paediatrica*. 2005; 94(2):226-233
- 20 1150 Mitchell EA, Stewart AW, Pattermore PK, Asher MI, Harrison AC, Rea HH.  
21 Socioeconomic status in childhood asthma. *International Journal of Epidemiology*.  
22 1989; 18(4):888-890
- 23 1151 Mitchell EA, Stewart AW, Clayton T, Asher MI, Ellwood P, Mackay R et al. Cross-  
24 sectional survey of risk factors for asthma in 6-7-year-old children in New Zealand:  
25 International Study of Asthma and Allergy in Childhood Phase Three. *Journal of  
26 Paediatrics and Child Health*. 2009; 45(6):375-383
- 27 1152 Mitchell H, Senturia Y, Gergen P, Baker D, Joseph C, McNiff-Mortimer K et al. Design  
28 and methods of the National Cooperative Inner-City Asthma Study. *Pediatric  
29 Pulmonology*. 1997; 24(4):237-252
- 30 1153 Mitsufuji H, Kobayashi H, Imasaki T, Ichikawa T, Kawakami T, Tomita T. Acute changes  
31 in bronchoconstriction influences exhaled nitric oxide level. *Japanese Journal of  
32 Physiology*. 2001; 51(2):151-157
- 33 1154 Modl M, Eber E, Steinbrugger B, Weinhandl E, Zach MS. Comparing methods for  
34 assessing bronchial responsiveness in children: single step cold air challenge, multiple  
35 step cold air challenge, and histamine provocation. *European Respiratory Journal*.  
36 1995; 8(10):1742-1747
- 37 1155 Modrykamien AM, Gudavalli R, McCarthy K, Liu X, Stoller JK. Detection of upper airway  
38 obstruction with spirometry results and the flow-volume loop: a comparison of  
39 quantitative and visual inspection criteria. *Respiratory Care*. 2009; 54(4):474-479

- 1 1156 Mogi G, Maeda S, Yoshida T, Watanabe N. IgE in respiratory tract allergies.  
2 Transactions Section on Otolaryngology American Academy of Ophthalmology and  
3 Otolaryngology. 1977; 84(2):272-284
- 4 1157 Mogi G, Maeda S, Yoshida T, Watanabe N. IgE studies on respiratory tract allergies.  
5 Archives of Otolaryngology. 1977; 103(5):251-257
- 6 1158 Mohammadien HA, Mohamed HA, Elqady MA. Relationship between skin prich test,  
7 peripheral eosinophilic count, serum total and specific IgE and severity of asthma in  
8 atopic asthma. Annals of Thoracic Medicine. 2009; 4(2):99
- 9 1159 Mohangoo AD, de Koning HJ, Hafkamp-de Groen E, van der Wouden JC, Jaddoe VVW,  
10 Moll HA et al. A comparison of parent-reported wheezing or shortness of breath  
11 among infants as assessed by questionnaire and physician-interview: The Generation R  
12 study. Pediatric Pulmonology. 2010; 45(5):500-507
- 13 1160 Momas I, Dartiguenave C, Fauroux B, Bourdais M, Poinard R, Grimfeld A et al.  
14 Prevalence of asthma or respiratory symptoms among children attending primary  
15 schools in Paris. Pediatric Pulmonology. 1998; 26(2):106-112
- 16 1161 Mommers M, Jongmans-Liedekerken AW, Derkx R, Dott W, Mertens P, van Schayck CP  
17 et al. Indoor environment and respiratory symptoms in children living in the Dutch-  
18 German borderland. International Journal of Hygiene and Environmental Health. 2005;  
19 208(5):373-381
- 20 1162 Montnemery P, Hansson L, Lanke J, Lindholm LH, Nyberg P, Lofdahl CG et al. Accuracy  
21 of a first diagnosis of asthma in primary health care. Family Practice. 2002; 19(4):365-  
22 368
- 23 1163 Montuschi P, Santonico M, Mondino C, Pennazza G, Mantini G, Martinelli E et al.  
24 Diagnostic performance of an electronic nose, fractional exhaled nitric oxide, and lung  
25 function testing in asthma. Chest. 2010; 137(4):790-796
- 26 1164 Moore VC, Jaakkola MS, Burge CBSG, Pantin CFA, Robertson AS, Burge PS. Do long  
27 periods off work in peak expiratory flow monitoring improve the sensitivity of  
28 occupational asthma diagnosis? Occupational and Environmental Medicine. 2010;  
29 67(8):562-567
- 30 1165 Moore VC, Jaakkola MS, Burge CBSG, Robertson AS, Pantin CFA, Vellore AD et al. A  
31 new diagnostic score for occupational asthma: the area between the curves (ABC  
32 score) of peak expiratory flow on days at and away from work. Chest. 2009;  
33 135(2):307-314
- 34 1166 Morass B, Kiechl-Kohlendorfer U, Horak E. The impact of early lifestyle factors on  
35 wheezing and asthma in Austrian preschool children. Acta Paediatrica. 2008;  
36 97(3):337-341
- 37 1167 Morgan WJ. Factors predicting the persistence of asthma insights from the Tucson  
38 children's respiratory study. Revue Francaise D'Allergologie Et D'Immunologie Clinique.  
39 2005; 45(7):542-546
- 40 1168 Mosbech H, Dirksen A, Madsen F. House dust mite asthma. Correlation between  
41 allergen sensitivity in various organs. Allergy. 1987; 42(6):456-463



- 1 1169 Moscato G, Dellabianca A, Corsico A, Biscaldi G, Gherson G, Vinci G. Bronchial  
2 responsiveness to ultrasonic fog in occupational asthma due to toluene diisocyanate.  
3 Chest. 1993; 104(4):1127-1132
- 4 1170 Mosfeldt Laursen E, Kaae Hansen K, Backer V, Bach-Mortensen N, Prah P, Koch C.  
5 Pulmonary function in adolescents with childhood asthma. Allergy. 1993; 48(4):267-  
6 272
- 7 1171 Mosterd A, Cost B, Hoes AW, de Bruijne MC, Deckers JW, Hofman A et al. The  
8 prognosis of heart failure in the general population: The Rotterdam Study. European  
9 Heart Journal. 2001; 22(15):1318-1327
- 10 1172 Moullec G, Gour-Provencal G, Bacon SL, Campbell TS, Lavoie KL. Efficacy of  
11 interventions to improve adherence to inhaled corticosteroids in adult asthmatics:  
12 impact of using components of the chronic care model. Respiratory Medicine. 2012;  
13 106(9):1211-1225
- 14 1173 Mouthuy J, Detry B, Sohy C, Pirson F, Pilette C. Presence in sputum of functional dust  
15 mite-specific IgE antibodies in intrinsic asthma. American Journal of Respiratory and  
16 Critical Care Medicine. 2011; 184(2):206-214
- 17 1174 Moverare R, Westritschnig K, Svensson M, Hayek B, Bende M, Pauli G et al. Different  
18 IgE reactivity profiles in birch pollen-sensitive patients from six European populations  
19 revealed by recombinant allergens: an imprint of local sensitization. International  
20 Archives of Allergy and Immunology. 2002; 128(4):325-335
- 21 1175 Muers MF. Diurnal variation in asthma. Archives of Disease in Childhood. 1984;  
22 59(9):898-901
- 23 1176 Muller BA, Leick CA, Smith RM, Suelzer MT, Richerson HB. Comparisons of specific and  
24 nonspecific bronchoprovocation in subjects with asthma, rhinitis, and healthy subjects.  
25 Journal of Allergy and Clinical Immunology. 1993; 91(3):758-772
- 26 1177 Mulloy E, Donaghy D, Quigley C, McNicholas WT. A one-year prospective audit of an  
27 asthma education programme in an out-patient setting. Irish Medical Journal. 1996;  
28 89(6):226-228
- 29 1178 Mundy L and Hiller JE. Smartinhaler? with audiovisual reminder for asthma  
30 medication. Adelaide Health Technology Assessment (AHTA), 2007. Available from:  
31 <http://www.horizonscanning.gov.au/internet/horizon/publishing.nsf/Content/6B81AE>  
32 [B3E7EE0001CA2575AD0080F344/\\$File/Vol%2018%20-%20Smartinhaler.pdf](http://www.horizonscanning.gov.au/internet/horizon/publishing.nsf/Content/6B81AE)
- 33 1179 Munnik P, van der Lee I, Fijn J, van Eijsden LJ, Lammers J-WJ, Zanen P. Comparison of  
34 eNO and histamine hyperresponsiveness in diagnosing asthma in new referrals.  
35 Respiratory Medicine. 2010; 104(6):801-807
- 36 1180 Munoz-Cano R, Bartra J, Sanchez-Lopez J, Picado C, Bissinger I, Valero A. Acoustic  
37 rhinometry and aspirin nasal challenge in the diagnosis of aspirin-intolerant asthma:  
38 clinical finding and safety aspects. International Archives of Allergy and Immunology.  
39 2013; 160(3):307-312

- 1 1181 Murphy AC, Proeschal A, Brightling CE, Wardlaw AJ, Pavord I, Bradding P et al. The  
2 relationship between clinical outcomes and medication adherence in difficult-to-  
3 control asthma. *Thorax*. 2012; 67(8):751-753
- 4 1182 Murphy E, Harrison J, Beach J. Implementation of statutory occupational respiratory  
5 health surveillance. *Occupational Medicine*. 2002; 52(8):497-502
- 6 1183 Murphy JC. Telemedicine offers new way to manage asthma. *American Journal of*  
7 *Health-System Pharmacy : AJHP : Official Journal of the American Society of Health-*  
8 *System Pharmacists*. 2001; 58(18):1693, 1696
- 9 1184 Murray AB, Ferguson AC, Morrison BJ. Sensitization to house dust mites in different  
10 climatic areas. *Journal of Allergy and Clinical Immunology*. 1985; 76(1):108-112
- 11 1185 Musk AW, Knuiaman M, Hunter M, Hui J, Palmer LJ, Beilby J et al. Patterns of airway  
12 disease and the clinical diagnosis of asthma in the Busselton population. *European*  
13 *Respiratory Journal*. 2011; 38(5):1053-1059
- 14 1186 Musken H, Fernandez-Caldas E, Maranon F, Franz JT, Masuch G, Bergmann KC. In vivo  
15 and in vitro sensitization to domestic mites in German urban and rural allergic  
16 patients. *Journal of Investigational Allergology and Clinical Immunology*. 2002;  
17 12(3):177-181
- 18 1187 Mussaffi H, Springer C, Godfrey S. Increased bronchial responsiveness to exercise and  
19 histamine after allergen challenge in children with asthma. *Journal of Allergy and*  
20 *Clinical Immunology*. 1986; 77(1 Pt 1):48-52
- 21 1188 Mustonen K, Orivuori L, Keski-Nisula L, Hyvarinen A, Pfefferle PI, Riedler J et al.  
22 Inflammatory response and IgE sensitization at early age. *Pediatric Allergy and*  
23 *Immunology*. 2013; 24(4):395-401
- 24 1189 Mvula M, Larzelere M, Kraus M, Moisiewicz K, Morgan C, Pierce S et al. Prevalence of  
25 asthma and asthma-like symptoms in inner-city schoolchildren. *Journal of Asthma*.  
26 2005; 42(1):9-16
- 27 1190 Mygind N, Dirksen A, Johnsen NJ, Weeke B. Perennial rhinitis: an analysis of skin  
28 testing, serum IgE, and blood and smear eosinophilia in 201 patients. *Clinical*  
29 *Otolaryngology and Allied Sciences*. 1978; 3(2):189-196
- 30 1191 Nadaskic R, Celeketic D, Ivanovic A. Bronchial reactivity in patients with allergic rhinitis.  
31 *Allergy*. 2010; 65:537
- 32 1192 Nadif R, Matran R, Maccario J, Bechet M, Le Moual N, Scheinmann P et al. Passive and  
33 active smoking and exhaled nitric oxide levels according to asthma and atopy in adults.  
34 *Annals of Allergy, Asthma and Immunology*. 2010; 104(5):385-393
- 35 1193 Nagel G, Buchele G, Weinmayr G, Bjorksten B, Chen YZ, Wang H et al. Effect of  
36 breastfeeding on asthma, lung function and bronchial hyperreactivity in ISAAC Phase  
37 II. *European Respiratory Journal*. 2009; 33(5):993-1002
- 38 1194 Nagel G, Weinmayr G, Flohr C, Kleiner A, Strachan DP, ISAAC Phase Two Study Group.  
39 Association of pertussis and measles infections and immunizations with asthma and

- 1 allergic sensitization in ISAAC Phase Two. *Pediatric Allergy and Immunology*. 2012;  
2 23(8):737-746
- 3 1195 Nagel G, Weinmayr G, Kleiner A, Garcia-Marcos L, Strachan DP, ISAAC Phase Two Study  
4 Group. Effect of diet on asthma and allergic sensitisation in the International Study on  
5 Allergies and Asthma in Childhood (ISAAC) Phase Two. *Thorax*. 2010; 65(6):516-522
- 6 1196 Nankani JN, Northfield M, Beran YM, Richardson PD. Changes in asthmatic patients'  
7 symptoms and lifestyles on institution of inhaled budesonide therapy. *Current Medical*  
8 *Research and Opinion*. 1990; 12(3):198-206
- 9 1197 Nantanda R, Ostergaard MS, Ndeezi G, Tumwine JK. Factors associated with asthma  
10 among under-fives in Mulago hospital, Kampala Uganda: a cross sectional study. *BMC*  
11 *Pediatrics*. 2013; 13:141
- 12 1198 Narang I, Ersu R, Wilson NM, Bush A. Nitric oxide in chronic airway inflammation in  
13 children: diagnostic use and pathophysiological significance. *Thorax*. 2002; 57(7):586-  
14 589
- 15 1199 Nasir S, Sanchez-Vazquez M, Dick F. Cross-sectional survey of respiratory symptoms  
16 and exposures in scottish health service cleaners. *Occupational and Environmental*  
17 *Medicine*. 2011; 68:A91
- 18 1200 Nathan RA, Sorkness CA, Kosinski M, Schatz M, Li JT, Marcus P et al. Development of  
19 the asthma control test: a survey for assessing asthma control. *Journal of Allergy and*  
20 *Clinical Immunology*. 2004; 113(1):59-65
- 21 1201 National Clinical Guideline Centre. Chronic Obstructive Pulmonary Disease:  
22 Management of Chronic Obstructive Pulmonary Disease in Adults in Primary and  
23 Secondary Care. London. National Institute for Health and Care Excellence, 2010.  
24 Available from: [http://www.nice.org.uk/guidance/cg101/resources/guidance-chronic-](http://www.nice.org.uk/guidance/cg101/resources/guidance-chronic-obstructive-pulmonary-disease-pdf)  
25 [obstructive-pulmonary-disease-pdf](http://www.nice.org.uk/guidance/cg101/resources/guidance-chronic-obstructive-pulmonary-disease-pdf)
- 26 1202 National Clinical Guideline Centre. Acute Heart Failure: Diagnosing and Managing  
27 Acute Heart Failure in Adults. London. National Institute for Health and Care  
28 Excellence, 2014. Available from:  
29 <https://www.nice.org.uk/guidance/cg187/resources/guidance-acute-heart-failure-pdf>
- 30 1203 National Institute for Health and Clinical Excellence. Social value judgements:  
31 principles for the development of NICE guidance. 2nd edition. London: National  
32 Institute for Health and Clinical Excellence; 2008. Available from:  
33 <http://www.nice.org.uk/media/C18/30/SVJ2PUBLICATION2008.pdf>
- 34 1204 National Institute for Health and Clinical Excellence. The guidelines manual. London:  
35 National Institute for Health and Clinical Excellence; 2012. Available from:  
36 <http://publications.nice.org.uk/the-guidelines-manual-pmg6/>
- 37 1205 Navratil M, Plavec D, Dodig S, Jelcic Z, Nogalo B, Erceg D et al. Markers of systemic and  
38 lung inflammation in childhood asthma. *Journal of Asthma*. 2009; 46(8):822-828
- 39 1206 Negrini AC, Arobba D. Allergenic pollens and pollinosis in Italy: Recent advances.  
40 *Allergy*. 1992; 47(4 II):371-379

- 1 1207 Neijens HJ, Duiverman EJ, Kerrebijn KF. Bronchial responsiveness in children. *Pediatric*  
2 *Clinics of North America*. 1983; 30(5):829-846
- 3 1208 Nejjari C, Tessier JF, Barberger-Gateau P, Jacqmin H, Dartigues JF, Salamon R.  
4 Functional status of elderly people treated for asthma-related symptoms: A population  
5 based case-control study. *European Respiratory Journal*. 1994; 7(6):1077-1083
- 6 1209 Nelson BV, Sears S, Woods J, Ling CY, Hunt J, Clapper LM et al. Expired nitric oxide as a  
7 marker for childhood asthma. *Journal of Pediatrics*. 1997; 130(3):423-427
- 8 1210 Neuman A, Hohmann C, Orsini N, Pershagen G, Eller E, Kjaer HF et al. Maternal  
9 smoking in pregnancy and asthma in preschool children: a pooled analysis of eight  
10 birth cohorts. *American Journal of Respiratory and Critical Care Medicine*. 2012;  
11 186(10):1037-1043
- 12 1211 Neve V, Matran R, Baquet G, Methlin CM, Delille C, Boulenguez C et al. Quantification  
13 of shape of flow-volume loop of healthy preschool children and preschool children  
14 with wheezing disorders. *Pediatric Pulmonology*. 2012; 47(9):884-894
- 15 1212 Neville RG, Bryce FP, Robertson FM, Crombie IK, Clark RA. Diagnosis and treatment of  
16 asthma in children: Usefulness of a review of medical records. *British Journal of*  
17 *General Practice*. 1992; 42(365):501-503
- 18 1213 Neville RG, McCowan C, Hoskins G, Thomas G. Cross-sectional observations on the  
19 natural history of asthma. *British Journal of General Practice*. 2001; 51(466):361-365
- 20 1214 Ng Man Kwong G, Das C, Proctor AR, Whyte MKB, Primhak RA. Diagnostic and  
21 treatment behaviour in children with chronic respiratory symptoms: relationship with  
22 socioeconomic factors. *Thorax*. 2002; 57(8):701-704
- 23 1215 Ng Man Kwong G, Proctor A, Billings C, Duggan R, Das C, Whyte MK et al. Increasing  
24 prevalence of asthma diagnosis and symptoms in children is confined to mild  
25 symptoms. *Thorax*. 2001; 56(4):312-314
- 26 1216 Nguyen JM, Holbrook JT, Wei CY, Gerald LB, Teague WG, Wise RA et al. Validation and  
27 psychometric properties of the Asthma Control Questionnaire among children. *Journal*  
28 *of Allergy and Clinical Immunology*. 2014; 133(1):91-96
- 29 1217 NHLBI. Peak flow monitoring in older adults with asthma. 2005. Available from:  
30 <http://www.clinicaltrials.gov/ct/show/NCT00149474> [Last accessed: 4 June 2014]
- 31 1218 NHS Business Services Authority. NHS electronic drug tariff. 2011. Available from:  
32 <http://www.nhsbsa.nhs.uk/924.aspx> [Last accessed: 24 November 2014]
- 33 1219 Nickels A, Lim KG, Scanlon P, Parker K. Exhaled nitric oxide performance compared to  
34 methacholine challenge in asthma. *Journal of Allergy and Clinical Immunology*. 2014;  
35 133(2 Suppl.1):AB148
- 36 1220 Nickels A, Parker K, Scanlon P, Lim K. The role of a positive exhaled nitric oxide in  
37 evaluating the pulmonary patient: Exhaled nitric oxide versus methacholine challenge?  
38 *Chest*. 2014; 145(3 Meeting Abstracts):467A

- 1 1221 Nicklas RA. Detection of aspirin sensitivity by pulmonary function tests. *Medical Annals*  
2 of the District of Columbia. 1973; 42(2):59-61
- 3 1222 Nicolai T, Carr D, Weiland SK, Duhme H, von Ehrenstein O, Wagner C et al. Urban  
4 traffic and pollutant exposure related to respiratory outcomes and atopy in a large  
5 sample of children. *European Respiratory Journal*. 2003; 21(6):956-963
- 6 1223 Nicolai T, Mutius EV, Reitmeir P, Wjst M. Reactivity to cold-air hyperventilation in  
7 normal and in asthmatic children in a survey of 5,697 schoolchildren in southern  
8 Bavaria. *American Review of Respiratory Disease*. 1993; 147(3):565-572
- 9 1224 Nicolaou NC, Lowe LA, Murray CS, Woodcock A, Simpson A, Custovic A. Exhaled breath  
10 condensate pH and childhood asthma: unselected birth cohort study. *American*  
11 *Journal of Respiratory and Critical Care Medicine*. 2006; 174(3):254-259
- 12 1225 Nides MA, Tashkin DP, Simmons MS, Wise RA, Li VC, Rand CS. Improving inhaler  
13 adherence in a clinical trial through the use of the Nebulizer Chronolog. *Chest*. 1993;  
14 104(2):501-507
- 15 1226 Niedozytko M, Chelminska M, Jassem E, Czestochowska E. Association between  
16 sensitization to *Aureobasidium pullulans* (*Pullularia* sp) and severity of asthma. *Annals*  
17 *of Allergy, Asthma and Immunology*. 2007; 98(2):153-156
- 18 1227 Nielsen JP, Ostergaard PA, Harris RI, Gammelby P. Comparison of CLA with BPT, SPT,  
19 and RAST in children with asthma. *Allergy*. 1992; 47(1):30-34
- 20 1228 Niemeijer NR, De Monchy JGR. Age-dependency of sensitization to aero-allergens in  
21 asthmatics. *Allergy*. 1992; 47(4 II):431-435
- 22 1229 Nieminen MM. Unimodal distribution of bronchial hyperresponsiveness to  
23 methacholine in asthmatic patients. *Chest*. 1992; 102(5):1537-1543
- 24 1230 Niggemann B, Illi S, Madloch C, Volkel K, Lau S, Bergmann R et al. Histamine challenges  
25 discriminate between symptomatic and asymptomatic children. MAS-Study Group.  
26 Multicentre Allergy Study. *European Respiratory Journal*. 2001; 17(2):246-253
- 27 1231 Niggemann B, Nilsson M, Friedrichs F. Paediatric allergy diagnosis in primary care is  
28 improved by in vitro allergen-specific IgE testing. *Pediatric Allergy and Immunology*.  
29 2008; 19(4):325-331
- 30 1232 Niimi A, Matsumoto H. Serum measurement of eosinophil cationic protein in the  
31 management of asthma. *Current Opinion in Pulmonary Medicine*. 1999; 5(2):111-117
- 32 1233 Nikkhah M, Amra B, Eshaghian A, Fardad S, Asadian A, Roshanzamir T et al.  
33 Comparison of impulse osillometry system and spirometry for diagnosis of obstructive  
34 lung disorders. *Tanaffos*. 2011; 10(1):19-25
- 35 1234 Nimmo CJ, Chen DN, Martinusen SM, Ustad TL, Ostrow DN. Assessment of patient  
36 acceptance and inhalation technique of a pressurized aerosol inhaler and two breath-  
37 actuated devices. *Annals of Pharmacotherapy*. 1993; 27(7-8):922-927
- 38 1235 Ninan TK, Macdonald L, Russell G. Persistent nocturnal cough in childhood: a  
39 population based study. *Archives of Disease in Childhood*. 1995; 73(5):403-407

- 1 1236 Ninan TK, Russell G. Is exercise testing useful in a community based asthma survey?  
2 Thorax. 1993; 48(12):1218-1221
- 3 1237 Nish WA, Schwietz LA. Underdiagnosis of asthma in young adults presenting for USAF  
4 basic training. Annals of Allergy. 1992; 69(3):239-242
- 5 1238 Nishio K, Odajima H, Motomura C, Nakao F, Nishima S. Exhaled nitric oxide and  
6 exercise-induced bronchospasm assessed by FEV1, FEF25-75% in childhood asthma.  
7 Journal of Asthma. 2007; 44(6):475-478
- 8 1239 Nizankowska E, Bestynska-Krypel A, Cmiel A, Szczeklik A. Oral and bronchial  
9 provocation tests with aspirin for diagnosis of aspirin-induced asthma. European  
10 Respiratory Journal. 2000; 15(5):863-869
- 11 1240 Nja F, Roksund OD, Carlsen KH. Eosinophil cationic protein (ECP) in school children  
12 living in a mountainous area of Norway: a population-based study of ECP as a tool for  
13 diagnosing asthma in children with reference values. Allergy. 2001; 56(2):138-144
- 14 1241 Nogami H, Shoji S, Nishima S. Exhaled nitric oxide as a simple assessment of airway  
15 hyperresponsiveness in bronchial asthma and chronic cough patients. Journal of  
16 Asthma. 2003; 40(6):653-659
- 17 1242 Nogueira JM, de Almeida MM, Santa Marta C, Pinto PL, Bastos G, Boavida MR et al.  
18 Quantitative skin prick tests and specific IgE (CAP System) for D. pteronissynus--  
19 correlation of results in a paediatric population. Allergie Et Immunologie. 1994;  
20 26(3):102-106
- 21 1243 Nolles G, Hoekstra MO, Schouten JP, Gerritsen J, Kauffman HF. Prevalence of  
22 immunoglobulin E for fungi in atopic children. Clinical and Experimental Allergy. 2001;  
23 31(10):1564-1570
- 24 1244 Nolte H, Storm K, Schioltz PO. Diagnostic value of a glass fibre-based histamine analysis  
25 for allergy testing in children. Allergy. 1990; 45(3):213-223
- 26 1245 Nordlund B, Konradsen JR, Kull I, Borres MP, Onell A, Hedlin G et al. IgE antibodies to  
27 animal-derived lipocalin, kallikrein and secretoglobulin are markers of bronchial  
28 inflammation in severe childhood asthma. Allergy. 2012; 67(5):661-669
- 29 1246 Nordvall SL, Janson C, Kalm-Stephens P, Foucard T, Toren K, Alving K. Exhaled nitric  
30 oxide in a population-based study of asthma and allergy in schoolchildren. Allergy.  
31 2005; 60(4):469-475
- 32 1247 Nowak D, Heinrich J, Jorres R, Wassmer G, Berger J, Beck E et al. Prevalence of  
33 respiratory symptoms, bronchial hyperresponsiveness and atopy among adults: West  
34 and East Germany. European Respiratory Journal. 1996; 9(12):2541-2552
- 35 1248 Nuijsink M, Hop WCJ, Sterk PJ, Duiverman EJ, De Jongste JC. Long-term asthma  
36 treatment guided by airway hyperresponsiveness in children: a randomised controlled  
37 trial. European Respiratory Journal. 2007; 30(3):457-466
- 38 1249 Nuijsink M, Vaessen-Verberne AAPH, Hop WCJ, Sterk PJ, Duiverman EJ, de Jongste JC  
39 et al. Long-term follow-up after two years of asthma treatment guided by airway  
40 responsiveness in children. Respiratory Medicine. 2013; 107(7):981-986

- 1 1250 Nusslein HG, Zimmermann T, Baum M, Fuchs C, Kolble K, Kalden JR. Improved in vitro  
2 diagnosis of allergy to *Alternaria tenuis* and *Cladosporium herbarum*. *Allergy*. 1987;  
3 42(6):414-422
- 4 1251 Nwaru BI, Craig LCA, Allan K, Prabhu N, Turner SW, McNeill G et al. Breastfeeding and  
5 introduction of complementary foods during infancy in relation to the risk of asthma  
6 and atopic diseases up to 10years. *Clinical and Experimental Allergy*. 2013;  
7 43(11):1263-1273
- 8 1252 O'Connor GT, Sparrow D, Weiss ST. Normal range of methacholine responsiveness in  
9 relation to prechallenge pulmonary function. *The Normative Aging Study*. *Chest*. 1994;  
10 105(3):661-666
- 11 1253 Obata T, Iikura Y. Comparison of bronchial reactivity to ultrasonically nebulized  
12 distilled water, exercise and methacholine challenge test in asthmatic children. *Annals  
13 of Allergy*. 1994; 72(2):167-172
- 14 1254 Oberle D, Von ME, Von KR. Childhood asthma and continuous exposure to cats since  
15 the first year of life with cats allowed in the child's bedroom. *Allergy*. 2003;  
16 58(10):1033-1036
- 17 1255 Oddy WH. Breastfeeding and asthma in children: findings from a West Australian  
18 study. *Breastfeeding Review*. 2000; 8(1):5-11
- 19 1256 Oddy WH, de Klerk NH, Sly PD, Holt PG. The effects of respiratory infections, atopy,  
20 and breastfeeding on childhood asthma. *European Respiratory Journal*. 2002;  
21 19(5):899-905
- 22 1257 Oddy WH, Holt PG, Sly PD, Read AW, Landau LI, Stanley FJ et al. Association between  
23 breast feeding and asthma in 6 year old children: findings of a prospective birth cohort  
24 study. *BMJ*. 1999; 319(7213):815-819
- 25 1258 Oddy WH, Peat JK, de Klerk NH. Maternal asthma, infant feeding, and the risk of  
26 asthma in childhood. *Journal of Allergy and Clinical Immunology*. 2002; 110(1):65-67
- 27 1259 Oddy WH, Sherriff JL, de Klerk NH, Kendall GE, Sly PD, Beilin LJ et al. The relation of  
28 breastfeeding and body mass index to asthma and atopy in children: a prospective  
29 cohort study to age 6 years. *American Journal of Public Health*. 2004; 94(9):1531-1537
- 30 1260 Office for National Statistics. Life tables 2011 - 2013. London. Office for National  
31 Statistics, 2014. Available from: [http://www.ons.gov.uk/ons/dcp171778\\_377972.pdf](http://www.ons.gov.uk/ons/dcp171778_377972.pdf)
- 32 1261 Oh MJ, Lee JY, Lee BJ, Choi DC. Exhaled nitric oxide measurement is useful for the  
33 exclusion of nonasthmatic eosinophilic bronchitis in patients with chronic cough.  
34 *Chest*. 2008; 134(5):990-995
- 35 1262 Ohkura N, Fujimura M, Tani M, Okazaki A, Hara J, Nishitsuji M et al. The measurement  
36 of cough sensitivity to methacholine for discrimination of cough variant asthma.  
37 *Respirology*. 2013; 18:155
- 38 1263 Ohkura N, Fujimura M, Tokuda A, Furusho S, Abo M, Katayama N. Evaluation of airway  
39 hyperresponsiveness and exhaled nitric oxide as risk factors for airway remodeling in  
40 patients with stable asthma. *Allergy and Asthma Proceedings*. 2009; 30(4):419-423

- 1 1264 Ojoo JC, Mulrennan SA, Kastelik JA, Morice AH, Redington AE. Exhaled breath  
2 condensate pH and exhaled nitric oxide in allergic asthma and in cystic fibrosis. *Thorax*.  
3 2005; 60(1):22-26
- 4 1265 Okudaira H, Hongo O, Ogita T, Haida M, Yamauchi N, Miyamoto T. Serum IgE and IgE  
5 antibody levels in patients with bronchial asthma, atopic dermatitis, eosinophilic  
6 granulomas of the soft tissue (Kimura's disease) and other diseases. *Annals of Allergy*.  
7 1983; 50(1):51-54
- 8 1266 Okupa AY, Jackson DJ, Sorkness CA, Rajamanickam VP, Kang TJ, Awoyinka IA et al.  
9 Mannitol bronchoprovocation in the evaluation of airway reactivity in a high-risk  
10 pediatric cohort. *Journal of Allergy and Clinical Immunology*. 2012; 129(2 SUPPL.  
11 1):AB2
- 12 1267 Olaguibel JM, Basomba A. Occupational asthma induced by chromium salts.  
13 *Allergologia Et Immunopathologia*. 1989; 17(3):133-136
- 14 1268 Olin AC, Rosengren A, Thelle DS, Lissner L, Bake B, Toren K. Height, age, and atopy are  
15 associated with fraction of exhaled nitric oxide in a large adult general population  
16 sample. *Chest*. 2006; 130(5):1319-1325
- 17 1269 Onur E, Kabaroglu C, Gunay O, Var A, Yilmaz O, Dundar P et al. The beneficial effects of  
18 physical exercise on antioxidant status in asthmatic children. *Allergologia Et*  
19 *Immunopathologia*. 2011; 39(2):90-95
- 20 1270 Onyirimba F, Apter A, Reisine S, Litt M, McCusker C, Connors M et al. Direct clinician-  
21 to-patient feedback discussion of inhaled steroid use: its effect on adherence. *Annals*  
22 *of Allergy, Asthma and Immunology*. 2003; 90(4):411-415
- 23 1271 Oostveen E, Dom S, Desager K, Hagendorens M, De Backer W, Weyler J. Lung function  
24 and bronchodilator response in 4-year-old children with different wheezing  
25 phenotypes. *European Respiratory Journal*. 2010; 35(4):865-872
- 26 1272 Organisation for Economic Co-operation and Development (OECD). Purchasing power  
27 parities (PPP). 2013. Available from: <http://www.oecd.org/std/ppp> [Last accessed: 27  
28 November 2013]
- 29 1273 Oryszczyn MP, van Ree R, Maccario J, Nadif R, Kauffmann F, EGEA Cooperative Group.  
30 Cat sensitization according to cat window of exposure in adult asthmatics. *Clinical and*  
31 *Experimental Allergy*. 2009; 39(10):1515-1521
- 32 1274 Osman LM, Calder C, Godden DJ, Friend JAR, McKenzie L, Legge JS et al. A randomised  
33 trial of self-management planning for adult patients admitted to hospital with acute  
34 asthma. *Thorax*. 2002; 57(10):869-874
- 35 1275 Osman M, Tagiyeva N, Wassall HJ, Ninan TK, Devenny AM, McNeill G et al. Changing  
36 trends in sex specific prevalence rates for childhood asthma, eczema, and hay fever.  
37 *Pediatric Pulmonology*. 2007; 42(1):60-65
- 38 1276 Osterballe O, Malling HJ, Weeke B. Specific diagnosis of exogenous bronchial asthma in  
39 adults. Comparison between case history, intracutaneous test, RAST, histamine release  
40 from basophil leucocytes, and bronchial provocation. *Allergy*. 1979; 34(3):175-185



- 1 1277 Ostergaard PA, Ebbesen F, Nolte H, Skov PS. Basophil histamine release in the  
2 diagnosis of house dust mite and dander allergy of asthmatic children. Comparison  
3 between prick test, RAST, basophil histamine release and bronchial provocation.  
4 *Allergy*. 1990; 45(3):231-235
- 5 1278 Ostojic V, Cvoriscec B, Ostojic SB, Reznikoff D, Stipic-Markovic A, Tudjman Z. Improving  
6 asthma control through telemedicine: A study of short-message service. *Telemedicine*  
7 *Journal and E-Health*. 2005; 11(1):28-35
- 8 1279 Otsuki M, Eakin MN, Rand CS, Butz AM, Hsu VD, Zuckerman IH et al. Adherence  
9 feedback to improve asthma outcomes among inner-city children: a randomized trial.  
10 *Pediatrics*. 2009; 124(6):1513-1521
- 11 1280 Ozarek-Hanc A, Olczak S, Majak P, Jerzynska J, Smejda K, Stelmach I. Usefulness of  
12 bronchial reversibility test in asthma diagnosis in children. *Alergia Astma Immunologia*.  
13 2012; 17(2):83-88
- 14 1281 Padovano A, D'Agostino F, Schiano MM, Martino P, Cocco G. Identification of high  
15 risk asthma patients by methacholine bronchial provocation tests (MBPT). *American*  
16 *Journal of Respiratory and Critical Care Medicine*. 2000; 161(3 Suppl):A102
- 17 1282 Paggiaro PL, Moscato G, Giannini D, Di PF, Bertoletti R, Bacci E et al. The Italian  
18 Working Group on the use of peak expiratory flow rate (PEFR) in asthma. *European*  
19 *Respiratory Review*. 1993; 3(14):438-443
- 20 1283 Palma-Carlos AG, Palma-Carlos ML, Costa AC. "Minor" hemoglobinopathies: a risk  
21 factor for asthma. *European Annals of Allergy and Clinical Immunology*. 2005;  
22 37(5):177-182
- 23 1284 Palmeiro EM, Hopp RJ, Biven RE, Bewtra AK, Nair NN, Townley RG. Probability of  
24 asthma based on methacholine challenge. *Chest*. 1992; 101(3):630-633
- 25 1285 Palmer LJ, Rye PJ, Gibson NA, Burton PR, Landau LI, Lesouef PN. Airway responsiveness  
26 in early infancy predicts asthma, lung function, and respiratory symptoms by school  
27 age. *American Journal of Respiratory and Critical Care Medicine*. 2001; 163(1):37-42
- 28 1286 Palmer LJ, Valinsky L, Pikora T, Landau LI. Do regular check ups and preventive drug  
29 use reduce asthma severity in school children? *Australian Family Physician*. 2004;  
30 33(7):573-576
- 31 1287 Panaszek B, Liebhart E, Liebhart J, Pawlowicz R, Fal AM. Serum concentration of C-  
32 reactive protein is not a good marker of bronchial hyperresponsiveness. *Archivum*  
33 *Immunologiae Et Therapiae Experimentalis*. 2007; 55(5):341-345
- 34 1288 Panichwattana W, Piboonpocanun O, Veskitkul J, Visitsunthorn N, Pacharn P,  
35 Vichyanond P. Cat sensitisation increases risk of asthma and allergic rhinitis among  
36 mite sensitive children. *Allergy*. 2013; 68:457
- 37 1289 Panico L, Bartley M, Marmot M, Nazroo JY, Sacker A, Kelly YJ. Ethnic variation in  
38 childhood asthma and wheezing illnesses: findings from the Millennium Cohort Study.  
39 *International Journal of Epidemiology*. 2007; 36(5):1093-1102

- 1 1290 Panzani RC, Mercier P, Delord Y, Riva G, Falagiani P, Reviron D et al. Prevalence of  
2 patent and latent atopy among a general normal adult population in the south east of  
3 France by RAST investigation and correlation with circulating total IgE levels.  
4 *Allergologia Et Immunopathologia*. 1993; 21(6):211-219
- 5 1291 Papa G, Romano A, Quaratino D, Di Fonso M, Viola M, Artesani MC et al. Prevalence of  
6 sensitization to *Cupressus sempervirens*: a 4-year retrospective study. *Science of the*  
7 *Total Environment*. 2001; 270(1-3):83-87
- 8 1292 Parameswaran K, Allen CJ, Kamada D, Efthimiadis A, Anvari M, Hargreave FE. Sputum  
9 cell counts and exhaled nitric oxide in patients with gastroesophageal reflux, and  
10 cough or asthma. *Canadian Respiratory Journal*. 2001; 8(4):239-244
- 11 1293 Parameswaran K, Belda J, Sears MR. Use of peak flow variability and methacholine  
12 responsiveness in predicting changes from pre-test diagnosis of asthma. *European*  
13 *Respiratory Journal*. 1999; 14(6):1358-1362
- 14 1294 Parameswaran K, Sasikumar P. Blood eosinophil count to assess compliance to inhaled  
15 corticosteroid therapy in asthma. *American Journal of Respiratory and Critical Care*  
16 *Medicine*. 2000; 161(3 Suppl):A711
- 17 1295 Pararajasingam CD, Sittampalam L, Damani P, Pattermore PK, Holgate ST. Comparison  
18 of the prevalence of asthma among Asian and European children in Southampton.  
19 *Thorax*. 1992; 47(7):529-532
- 20 1296 Paredi P, Kharitonov SA, Barnes PJ. Faster rise of exhaled breath temperature in  
21 asthma: A novel marker of airway inflammation? *American Journal of Respiratory and*  
22 *Critical Care Medicine*. 2002; 165(2):181-184
- 23 1297 Paredi P, Kharitonov SA, Barnes PJ. Correlation of exhaled breath temperature with  
24 bronchial blood flow in asthma. *Respiratory Research*. 2005; 6:15
- 25 1298 Park ES, Golding J, Carswell F, Stewart-Brown S. Preschool wheezing and prognosis at  
26 10. *Archives of Disease in Childhood*. 1986; 61(7):642-646
- 27 1299 Park HS, Nahm DH, Suh CH, Lee SM, Choi SY, Jung KS et al. Evidence of Hop Japanese  
28 pollinosis in Korea: IgE sensitization and identification of allergenic components.  
29 *Journal of Allergy and Clinical Immunology*. 1997; 100(4):475-479
- 30 1300 Park S, Jee H, Park Y, Choi B, Song T, Lee H et al. Airway hyperresponsiveness with  
31 Delta;FEV0.5 and FEV0.75 in children. *Journal of Allergy and Clinical Immunology*.  
32 2009; 123(2 SUPPL. 1):S6
- 33 1301 Park YB, Yoo KH, Lee W-Y. Characteristics of difficult to treat asthma in Korea; pilot  
34 study. *Allergy*. 2013; 68:373
- 35 1302 Parker AL. Airway reactivity is a determinant of bronchodilator responsiveness after  
36 methacholine-induced bronchoconstriction. *Journal of Asthma*. 2004; 41(6):671-677
- 37 1303 Parkerson J, Ledford D. Mannitol as an indirect bronchoprovocation test for the 21st  
38 century. *Annals of Allergy, Asthma and Immunology*. 2011; 106(2):91-96

- 1 1304 Pastorello EA, Incorvaia C, Ortolani C, Bonini S, Canonica GW, Romagnani S et al.  
2 Studies on the relationship between the level of specific IgE antibodies and the clinical  
3 expression of allergy: I. Definition of levels distinguishing patients with symptomatic  
4 from patients with asymptomatic allergy to common aeroallergens. *Journal of Allergy*  
5 *and Clinical Immunology*. 1995; 96(5 Pt 1):580-587
- 6 1305 Paterson NA, Peat JK, Mellis CM, Xuan W, Woolcock AJ. Accuracy of asthma treatment  
7 in schoolchildren in NSW, Australia. *European Respiratory Journal*. 1997; 10(3):658-  
8 664
- 9 1306 Paton JY. Asthma in childhood - making the diagnosis. *Current Pediatric Reviews*. 2010;  
10 6(2):112-120
- 11 1307 Pattemore PK, Asher MI, Harrison AC, Mitchell EA, Rea HH, Stewart AW. The  
12 interrelationship among bronchial hyperresponsiveness, the diagnosis of asthma, and  
13 asthma symptoms. *American Review of Respiratory Disease*. 1990; 142(3):549-554
- 14 1308 Pearlman AN, Chandra RK, Chang D, Conley DB, Tripathi-Peters A, Grammer LC et al.  
15 Relationships between severity of chronic rhinosinusitis and nasal polyposis, asthma,  
16 and atopy. *American Journal of Rhinology and Allergy*. 2009; 23(2):145-148
- 17 1309 Pearlman DS, Berger WE, Kerwin E, Laforce C, Kundu S, Banerji D. Once-daily  
18 ciclesonide improves lung function and is well tolerated by patients with mild-to-  
19 moderate persistent asthma. *Journal of Allergy and Clinical Immunology*. 2005;  
20 116(6):1206-1212
- 21 1310 Peat JK, Salome CM, Berry G, Woolcock AJ. Relation of dose-response slope to  
22 respiratory symptoms in a population of Australian schoolchildren. *American Review*  
23 *of Respiratory Disease*. 1991; 144(3 Pt 1):663-667
- 24 1311 Peat JK, Toelle BG, Dermand J, van den Berg R, Britton WJ, Woolcock AJ. Serum IgE  
25 levels, atopy, and asthma in young adults: results from a longitudinal cohort study.  
26 *Allergy*. 1996; 51(11):804-810
- 27 1312 Peat JK, Tovey E, Mellis CM, Leeder SR, Woolcock AJ. Importance of house dust mite  
28 and *Alternaria* allergens in childhood asthma: an epidemiological study in two climatic  
29 regions of Australia. *Clinical and Experimental Allergy*. 1993; 23(10):812-820
- 30 1313 Peat JK, van den Berg RH, Green WF, Mellis CM, Leeder SR, Woolcock AJ. Changing  
31 prevalence of asthma in Australian children. *BMJ*. 1994; 308(6944):1591-1596
- 32 1314 Pecoud A, Ochsner M, Arrendal H, Frei PC. Improvement of the radioallergosorbent  
33 test (RAST) sensitivity by using an antibody specific for the determinant D epsilon 2.  
34 *Clinical Allergy*. 1982; 12(1):75-81
- 35 1315 Pedrosa M, Barranco P, Caminoa M, Botello MD, Quirce S. Comparison of  
36 methacholine and adenosine inhalation challenge in patients with suspected asthma.  
37 *Journal of Asthma*. 2009; 46(8):773-776
- 38 1316 Pedrosa M, Cancelliere N, Barranco P, Lopez-Carrasco V, Quirce S. Usefulness of  
39 exhaled nitric oxide for diagnosing asthma. *Journal of Asthma*. 2010; 47(7):817-821

- 1 1317 Peirsman EJ, Carvelli TJ, Hage PY, Hanssens LS, Pattyn L, Raes MM et al. Exhaled nitric  
2 oxide in childhood allergic asthma management a randomised controlled trial.  
3 *Pediatric Pulmonology*. 2013;
- 4 1318 Pekkarinen PT, von Hertzen L, Laatikainen T, Makela MJ, Jousilahti P, Kosunen TU et al.  
5 A disparity in the association of asthma, rhinitis, and eczema with allergen-specific IgE  
6 between Finnish and Russian Karelia. *Allergy*. 2007; 62(3):281-287
- 7 1319 Pelikan Z, Pelikan-Filipek M. A diagnostic study of immediate hypersensitivity in  
8 asthmatic patients: A comparison of bronchial challenge and serum RAST. *Annals of*  
9 *Allergy*. 1982; 49(2):112-117
- 10 1320 Pepys J, Roth A, Carroll KB. RAST, skin and nasal tests and the history in grass pollen  
11 allergy. *Clinical Allergy*. 1975; 5(4):431-442
- 12 1321 Pereira EAL, Silva DAO, Cunha-Junior JP, Almeida KC, Alves R, Sung SJ et al. IgE, IgG1,  
13 and IgG4 antibody responses to *Blomia tropicalis* in atopic patients. *Allergy*. 2005;  
14 60(3):401-406
- 15 1322 Perpina M, Pellicer C, De Diego A, Compte L, Macian V. Diagnostic value of the  
16 bronchial provocation test with methacholine in asthma. A Bayesian analysis  
17 approach. *Chest*. 1993; 104(1):149-154
- 18 1323 Perrin B, Lagier F, L'Archeveque J, Cartier A, Boulet LP, Cote J et al. Occupational  
19 asthma: validity of monitoring of peak expiratory flow rates and non-allergic bronchial  
20 responsiveness as compared to specific inhalation challenge. *European Respiratory*  
21 *Journal*. 1992; 5(1):40-48
- 22 1324 Perrin LF, Sroussi J, Cea-Gil F, Deviller P, Lasne Y. Serum IgE levels and specific IgE  
23 antibodies in house dust mite allergy: predictive value. *Journal of Asthma*. 1983;  
24 20(2):93-96
- 25 1325 Persaud DI, Barnett SE, Weller SC, Baldwin CD, Niebuhr V, McCormick DP. An asthma  
26 self-management program for children, including instruction in peak flow monitoring  
27 by school nurses. *Journal of Asthma*. 1996; 33(1):37-43
- 28 1326 Persky VW, Slezak J, Contreras A, Becker L, Hernandez E, Ramakrishnan V et al.  
29 Relationships of race and socioeconomic status with prevalence, severity, and  
30 symptoms of asthma in Chicago school children. *Annals of Allergy, Asthma and*  
31 *Immunology*. 1998; 81(3):266-271
- 32 1327 Pertseva TO, Botvinikova LA. Quality of life in patients with bronchial asthma impact of  
33 regular monitoring and good compliance [Abstract]. *European Respiratory Journal*.  
34 2004; 24(Suppl 48):285s
- 35 1328 Perzanowski MS, Canfield SM, Chew GL, Mellins RB, Hoepner LA, Jacobson JS et al.  
36 Birth order, atopy, and symptoms of allergy and asthma among inner-city children  
37 attending Head Start in New York City. *Clinical and Experimental Allergy*. 2008;  
38 38(6):968-976
- 39 1329 Perzanowski MS, Divjan A, Mellins RB, Canfield SM, Rosa MJ, Chew GL et al. Pediatric -  
40 Exhaled NO among inner-city children in New York City. *Journal of Asthma*. 2010;  
41 47(9):1015-1021

- 1 1330 Perzanowski MS, Sporik R, Squillace SP, Gelber LE, Call R, Carter M et al. Association of  
2 sensitization to Alternaria allergens with asthma among school-age children. *Journal of*  
3 *Allergy and Clinical Immunology*. 1998; 101(5):626-632
- 4 1331 Perzanowski MS, Divjan A, Mellins RB, Canfield SM, Rosa MJ, Chew GL et al. Exhaled  
5 NO among inner-city children in New York City. *Journal of Asthma*. 2010; 47(9):1015-  
6 1021
- 7 1332 Petanjek BB, Grle SP, Pelicarić D, Vranković D. Bronchodilator response in patients with  
8 persistent allergic asthma could not predict airway hyperresponsiveness. *Allergy,*  
9 *Asthma, and Clinical Immunology*. 2007; 3(4):123-127
- 10 1333 Peters JM, Avol E, Navidi W, London SJ, Gauderman WJ, Lurmann F et al. A study of  
11 twelve Southern California communities with differing levels and types of air pollution.  
12 I. Prevalence of respiratory morbidity. *American Journal of Respiratory and Critical*  
13 *Care Medicine*. 1999; 159(3):760-767
- 14 1334 Petitto J, Jones SM. Adherence to inhaled corticosteroids: An ancillary study of the  
15 Childhood Asthma Management Program clinical trial. *Pediatrics*. 2012;  
16 130(SUPPL.1):S37-S38
- 17 1335 Petrie KJ, Perry K, Broadbent E, Weinman J. A text message programme designed to  
18 modify patients' illness and treatment beliefs improves self-reported adherence to  
19 asthma preventer medication. *British Journal of Health Psychology*.: British  
20 Psychological Society, United Kingdom. 2012; 17(1):74-84
- 21 1336 Petsky H, Li AM, Kynaston JA, Turner C, Chang, AB. Dual-centre randomised trial on  
22 tailored asthma therapy based on exhaled nitric oxide (FeNO) [Abstract]. *Paediatric*  
23 *Respiratory Reviews*. 3/10 2010; 11(Suppl 1):S80-S81
- 24 1337 Petsky HL. Dual-centre randomised trial on tailored asthma therapy based on exhaled  
25 nitric oxide (FeNO) vs routine clinical care. *Pediatric Pulmonology*. 2014; 49:S57
- 26 1338 Petsky HL, Cates CJ, Lasserson TJ, Li AM, Turner C, Kynaston JA et al. A systematic  
27 review and meta-analysis: tailoring asthma treatment on eosinophilic markers  
28 (exhaled nitric oxide or sputum eosinophils). *Thorax*. 2012; 67(3):199-208
- 29 1339 Petsky HL, Kynaston JA, Turner C, Li AM, Cates CJ, Lasserson TJ et al. Tailored  
30 interventions based on sputum eosinophils versus clinical symptoms for asthma in  
31 children and adults. *Cochrane Database of Systematic Reviews*. 2007; Issue  
32 2:CD005603. DOI:10.1002/14651858.CD005603.pub2.
- 33 1340 Petsky HL, Li AM, Au CT, Kynaston JA, Turner C, Chang AB. Management based on  
34 exhaled nitric oxide levels adjusted for atopy reduces asthma exacerbations in  
35 children: A dual centre randomized controlled trial. *Pediatric Pulmonology*. 2014;
- 36 1341 Phakthongsuk P, Sangsupawanich P, Musigsan A, Thammakumpee G. Work-related  
37 respiratory symptoms among cotton-fabric sewing workers. *International Journal of*  
38 *Occupational Medicine and Environmental Health*. 2007; 20(1):17-24
- 39 1342 Piacentini GL, Bodini A, Costella S, Suzuki Y, Zerman L, Peterson CG et al. Exhaled nitric  
40 oxide, serum ECP and airway responsiveness in mild asthmatic children. *European*  
41 *Respiratory Journal*. 2000; 15(5):839-843

- 1 1343 Piacentini GL, Bodini A, Costella S, Vicentini L, Mazzi P, Sperandio S et al. Exhaled nitric  
2 oxide and sputum eosinophil markers of inflammation in asthmatic children. *European*  
3 *Respiratory Journal*. 1999; 13(6):1386-1390
- 4 1344 Piippo-Savolainen E, Remes S, Korppi M. Does blood eosinophilia in wheezing infants  
5 predict later asthma? A prospective 18-20-year follow-up. *Allergy and Asthma*  
6 *Proceedings*. 2007; 28(2):163-169
- 7 1345 Pijnenburg MW, Bakker EM, Hop WC, De Jongste JC. Titrating inhaled steroids on  
8 exhaled nitric oxide improves FEV1 in allergic asthmatic children. *American Thoracic*  
9 *Society 2005 International Conference*; May 20-25; San Diego, California. 2005;C47
- 10 1346 Pike K, Selby A, Price S, Warner J, Connett G, Legg J et al. Exhaled nitric oxide  
11 monitoring does not reduce exacerbation frequency or inhaled corticosteroid dose in  
12 paediatric asthma: a randomised controlled trial. *Clinical Respiratory Journal*. 2012;
- 13 1347 Pinnock H, Adlem L, Gaskin S, Harris J, Snellgrove C, Sheikh A. Accessibility, clinical  
14 effectiveness, and practice costs of providing a telephone option for routine asthma  
15 reviews: phase IV controlled implementation study. *British Journal of General Practice*.  
16 *United Kingdom* 2007; 57:714-722
- 17 1348 Pinnock H, Bawden R, Proctor S, Wolfe S, Scullion J, Price D et al. Accessibility,  
18 acceptability, and effectiveness in primary care of routine telephone review of asthma:  
19 pragmatic, randomised controlled trial. *BMJ*. 2003; 326(7387):477-479
- 20 1349 Pinnock H, McKenzie L, Price D, Sheikh A. Cost-effectiveness of telephone or surgery  
21 asthma reviews: economic analysis of a randomised controlled trial. *British Journal of*  
22 *General Practice*. 2005; 55:119-124:119-124
- 23 1350 Pinnock H, Burton C, Campbell S, Gruffydd-Jones K, Hannon K, Hoskins G et al. Clinical  
24 implications of the Royal College of Physicians three questions in routine asthma care:  
25 a real-life validation study. *Primary Care Respiratory Journal*. 2012; 21(3):288-294
- 26 1351 Pino JM, Garcia-Rio F, Prados C, Alvarez-Sala R, Diaz S, Villasante C et al. Value of the  
27 peak expiratory flow in bronchodynamic tests. *Allergologia Et Immunopathologia*.  
28 1996; 24(2):54-57
- 29 1352 Pinto LA, Depner M, Klopp N, Illig T, Vogelberg C, von Mutius E et al. MMP-9 gene  
30 variants increase the risk for non-atopic asthma in children. *Respiratory Research*.  
31 2010; 11:23
- 32 1353 Pizzichini MM, Rennie D, Senthilselvan A, Taylor B, Habbick BF, Sears MR. Limited  
33 agreement between written and video asthma symptom questionnaires. *Pediatric*  
34 *Pulmonology*. 2000; 30(4):307-312
- 35 1354 Plaschke P, Janson C, Norrman E, Björnsson E, Ellbjär S, Järholm B. Association  
36 between atopic sensitization and asthma and bronchial hyperresponsiveness in  
37 swedish adults: pets, and not mites, are the most important allergens. *Journal of*  
38 *Allergy and Clinical Immunology*. 1999; 104(1):58-65
- 39 1355 Plaschke P, Janson C, Norrman E, Björnsson E, Lundback B, Lindholm N et al. Skin prick  
40 tests and specific IgE in adults from three different areas of Sweden. *Allergy*. 1996;  
41 51(7):461-472

- 1 1356 Plebani M, Borghesan F, Faggian D. Clinical efficiency of in vitro and in vivo tests for  
2 allergic diseases. *Annals of Allergy, Asthma and Immunology*. 1995; 74(1):23-28
- 3 1357 Pless-Mullooli T, Howel D, King A, Stone I, Merefield J, Bessell J et al. Living near  
4 opencast coal mining sites and children's respiratory health. *Occupational and*  
5 *Environmental Medicine*. 2000; 57(3):145-151
- 6 1358 Pless-Mullooli T, Howel D, Prince H. Prevalence of asthma and other respiratory  
7 symptoms in children living near and away from opencast coal mining sites.  
8 *International Journal of Epidemiology*. 2001; 30(3):556-563
- 9 1359 Poder G, Kelemen J, Mezei G, Borzsonyi L. Results of bronchial challenge after infantile  
10 obstructive bronchitis. *Acta Paediatrica Hungarica*. 1987; 28(3-4):201-207
- 11 1360 Pogson ZEK, McKeever TM, Lewis SA, Britton JR, Fogarty AW. An evaluation of the use  
12 of bronchoconstriction induced by deep inspiration as a new epidemiological measure  
13 for asthma. *Journal of Asthma*. 2009; 46(4):319-321
- 14 1361 Pohunek P, Warner JO, Turzikova J, Kudrman J, Roche WR. Markers of eosinophilic  
15 inflammation and tissue re-modelling in children before clinically diagnosed bronchial  
16 asthma. *Pediatric Allergy and Immunology*. 2005; 16(1):43-51
- 17 1362 Ponsonby AL, Couper D, Dwyer T, Carmichael A, Kemp A, Cochrane J. The relation  
18 between infant indoor environment and subsequent asthma. *Epidemiology*. 2000;  
19 11(2):128-135
- 20 1363 Ponsonby AL, Couper D, Dwyer T, Carmichael A, Wood-Baker R. Exercise-induced  
21 bronchial hyperresponsiveness and parental ISAAC questionnaire responses. *European*  
22 *Respiratory Journal*. 1996; 9(7):1356-1362
- 23 1364 Ponsonby AL, Dwyer T, Trevillian L, Kemp A, Cochrane J, Couper D et al. The bedding  
24 environment, sleep position, and frequent wheeze in childhood. *Pediatrics*. 2004;  
25 113(5):1216-1222
- 26 1365 Ponsonby AL, Glasgow N, Pezic A, Dwyer T, Cizek K, Kljakovic M. A temporal decline in  
27 asthma but not eczema prevalence from 2000 to 2005 at school entry in the Australian  
28 Capital Territory with further consideration of country of birth. *International Journal of*  
29 *Epidemiology*. 2008; 37(3):559-569
- 30 1366 Popa V, Singleton J. Provocation dose and discriminant analysis in histamine  
31 bronchoprovocation. Are the current predictive data satisfactory? *Chest*. 1988;  
32 94(3):466-475
- 33 1367 Popovic-Grle S, Mehulic M, Pavicic F, Babic I, Beg-Zec Z. Clinical validation of bronchial  
34 hyperresponsiveness, allergy tests and lung function in the diagnosis of asthma in  
35 persons with dyspnea. *Collegium Antropologicum*. 2002; 26 Suppl:119-127
- 36 1368 Porsbjerg C, Rasmussen L, Thomsen SF, Brannan JD, Anderson SD, Backer V. Response  
37 to mannitol in asymptomatic subjects with airway hyper-responsiveness to  
38 methacholine. *Clinical and Experimental Allergy*. 2007; 37(1):22-28

- 1 1369 Porsbjerg C, Backer V, Joos G, Kerstjens HAM, Rodriguez-Roisin R. Current and future  
2 use of the mannitol bronchial challenge in everyday clinical practice. *Clinical*  
3 *Respiratory Journal*. 2009; 3(4):189-197
- 4 1370 Postma DS, Lebowitz MD. Persistence and new onset of asthma and chronic bronchitis  
5 evaluated longitudinally in a community population sample of adults. *Archives of*  
6 *Internal Medicine*. 1995; 155(13):1393-1399
- 7 1371 Powell CV, Nolan TM, Carlin JB, Bennett CM, Johnson PD. Respiratory symptoms and  
8 duration of residence in immigrant teenagers living in Melbourne, Australia. *Archives*  
9 *of Disease in Childhood*. 1999; 81(2):159-162
- 10 1372 Powell CV, Primhak RA. Asthma treatment, perceived respiratory disability, and  
11 morbidity. *Archives of Disease in Childhood*. 1995; 72(3):209-213
- 12 1373 Powell CV, Primhak RA. Stability of respiratory symptoms in unlabelled wheezy illness  
13 and nocturnal cough. *Archives of Disease in Childhood*. 1996; 75(5):385-391
- 14 1374 Powell H, Murphy VE, Taylor DR, Hensley MJ, Mccaffery K, Giles W et al. Management  
15 of asthma in pregnancy guided by measurement of fraction of exhaled nitric oxide: a  
16 double-blind, randomised controlled trial. *Lancet*. 2011; 378(9795):983-990
- 17 1375 Powell H, Gibson PG. Options for self-management education for adults with asthma.  
18 *Cochrane Database of Systematic Reviews*. 2002; Issue 3:CD004107.  
19 DOI:10.1002/14651858.CD004107
- 20 1376 Power C, Manor O. Asthma, enuresis, and chronic illness: long term impact on height.  
21 *Archives of Disease in Childhood*. 1995; 73(4):298-304
- 22 1377 Prabhakaran L, Chee J, Chua KC, Mun WW. The Use of Text Messaging to Improve  
23 Asthma Control: A Study of Short Message Service (SMS). *Respirology*. 2009; 14(Suppl  
24 3):A217
- 25 1378 Prabhakaran L, Chee WY, Chua KC, Abisheganaden J, Wong WM. The use of text  
26 messaging to improve asthma control: a pilot study using the mobile phone short  
27 messaging service (SMS). *Journal of Telemedicine and Telecare*. 2010; 16(5):286-290
- 28 1379 Prabhu N, Smith N, Campbell D, Craig LC, Seaton A, Helms PJ et al. First trimester  
29 maternal tobacco smoking habits and fetal growth. *Thorax*. 2010; 65(3):235-240
- 30 1380 Prado OS, Perez-Yarza EG, Ruiz AA, Murua JK, Elosegui PC, Aramburu JM et al. Fraction  
31 of exhaled nitric oxide and asthma predictive index in infants less than two years-old.  
32 *Archivos De Bronconeumologia*. 2011; 47(5):234-238
- 33 1381 Prasad A, Langford B, Stradling JR, Ho LP. Exhaled nitric oxide as a screening tool for  
34 asthma in school children. *Respiratory Medicine*. 2006; 100(1):167-173
- 35 1382 Pratter MR, Curley FJ, Dubois J, Irwin RS. Cause and evaluation of chronic dyspnea in a  
36 pulmonary disease clinic. *Archives of Internal Medicine*. 1989; 149(10):2277-2282
- 37 1383 Pratter MR, Hingston DM, Irwin RS. Diagnosis of bronchial asthma by clinical  
38 evaluation. An unreliable method. *Chest*. 1983; 84(1):42-47



- 1 1384 Prehn A, Seger RA, Torresani T, Molinari L, Sennhauser FH. Evaluation of a clinical  
2 algorithm involving serum eosinophil cationic protein for guiding the anti-  
3 inflammatory treatment of bronchial asthma in childhood. *Pediatric Allergy and*  
4 *Immunology*. 2000; 11(2):87-94
- 5 1385 Press VG, Arora VM, Shah LM, Lewis SL, Charbeneau J, Naureckas ET et al. Teaching  
6 the use of respiratory inhalers to hospitalized patients with asthma or COPD: a  
7 randomized trial. *Journal of General Internal Medicine*. 2012; 27(10):1317-1325
- 8 1386 Price D, Saralaya D, Britton M, Ike T, Ohn H, Hilary P et al. Asthma Costs In The UK By  
9 Asthma Control Status And Exacerbations. *American Journal of Respiratory and Critical*  
10 *Care Medicine*. American Thoracic Society International Conference Abstracts:  
11 American Thoracic Society. 2013; 187:A2145
- 12 1387 Price D, Berg J, Lindgren P. An economic evaluation of NIOX MINO airway  
13 inflammation monitor in the United Kingdom. *Allergy*. 2009; 64(3):431-438
- 14 1388 Price JA, Reiser J, Longbottom JL, Warner JO. Inhalant allergy in asthmatic children:  
15 skin prick test, radioallergosorbent test and chemiluminescent assay compared with  
16 allergen levels in their mattress dusts. *International Archives of Allergy and Applied*  
17 *Immunology*. 1989; 88(1-2):183-184
- 18 1389 Prichard MG, Ryan G, Walsh BJ, Musk AW. Skin test and RAST responses to wheat and  
19 common allergens and respiratory disease in bakers. *Clinical Allergy*. 1985; 15(2):203-  
20 210
- 21 1390 Prieto L, Gutierrez V, Morales C, Marin J. Differences in sensitivity, maximal response  
22 and position of the concentration-response curve to methacholine between  
23 asthmatics, patients with allergic rhinitis and healthy subjects. *Respiratory Medicine*.  
24 1998; 92(1):88-94
- 25 1391 Prieto L, Gutierrez V, Morales C, Perpignan J, Inchaurreaga I. Variability of peak  
26 expiratory flow rate in allergic rhinitis and mild asthma: relationship to maximal airway  
27 narrowing. *Annals of Allergy, Asthma and Immunology*. 1998; 80(2):151-158
- 28 1392 Prieto L, Sanchez-Toril F, Brotons B, Soriano S, Casan R, Belenguer JL. Airway  
29 responsiveness to acetaldehyde in patients with asthma: relationship to methacholine  
30 responsiveness and peak expiratory flow variation. *Clinical and Experimental Allergy*.  
31 2000; 30(1):71-78
- 32 1393 Prieto L, Esnal S, Lopez V, Barato D, Rojas R, Marin J. Maximal response plateau to  
33 adenosine 5'-monophosphate in asthma. Relationship with the response to  
34 methacholine, exhaled nitric oxide, and exhaled breath condensate pH. *Chest*. 2009;  
35 135(6):1521-1526
- 36 1394 Profita M, Montuschi P, Bonanno A, Riccobono L, Montalbano AM, Ciabattini G et al.  
37 Novel perspectives in the detection of oral and nasal oxidative stress and inflammation  
38 in pediatric united airway diseases. *International Journal of Immunopathology and*  
39 *Pharmacology*. 2010; 23(4):1211-1219
- 40 1395 Pronk-Admiraal CJ, Haitjema T, Horikx P, Bartels PC. Surplus value of eosinophil count  
41 and ECP to diagnose and monitor asthmatic patients. *Netherlands Journal of Medicine*.  
42 2001; 58(1):9-17

- 1 1396 Prosperini G, Rajakulasingam K, Cacciola RR, Spicuzza L, Rorke S, Holgate ST et al.  
2 Changes in sputum counts and airway hyperresponsiveness after budesonide:  
3 monitoring anti-inflammatory response on the basis of surrogate markers of airway  
4 inflammation. *Journal of Allergy and Clinical Immunology*. 2002; 110(6):855-861
- 5 1397 Pruitt B. Spirometry and Response to Bronchodilator Studies. *Journal of Asthma and  
6 Allergy Educators*. 2012; 3(2):73-77
- 7 1398 Pujades-Rodriguez M, Lewis S, McKeever T, Britton J, Venn A. Effect of living close to a  
8 main road on asthma, allergy, lung function and chronic obstructive pulmonary  
9 disease. *Occupational and Environmental Medicine*. 2009; 66(10):679-684
- 10 1399 Pujades-Rodriguez M, McKeever T, Lewis S, Whyatt D, Britton J, Venn A. Effect of  
11 traffic pollution on respiratory and allergic disease in adults: cross-sectional and  
12 longitudinal analyses. *BMC Pulmonary Medicine*. 2009; 9:42
- 13 1400 Puolijoki H, Impivaara O, Liippo K, Tala E. Later development of asthma in patients with  
14 a negative methacholine inhalation challenge examined for suspected asthma. *Lung*.  
15 1992; 170(4):235-241
- 16 1401 Purokivi M, Koskela HO, Koistinen T, Magga J, Peuhkurinen K, Kiviniemi V et al. Utility  
17 of hypertonic histamine challenge in distinguishing difficult-to-diagnose asthma.  
18 *Clinical Respiratory Journal*. 2007; 1(2):91-98
- 19 1402 Quadrelli SA, Roncoroni AJ, Montiel GC. Evaluation of bronchodilator response in  
20 patients with airway obstruction. *Respiratory Medicine*. 1999; 93(9):630-636
- 21 1403 Quiralte J, Llanes E, Barral P, Arias de Saavedra JM, Saenz de San Pedro B, Villalba M et  
22 al. Ole e 2 and Ole e 10: new clinical aspects and genetic restrictions in olive pollen  
23 allergy. *Allergy*. 2005; 60(3):360-365
- 24 1404 Quirce S, Contreras G, Dybuncio A, Chan-Yeung M. Peak expiratory flow monitoring is  
25 not a reliable method for establishing the diagnosis of occupational asthma. *American  
26 Journal of Respiratory and Critical Care Medicine*. 1995; 152(3):1100-1102
- 27 1405 Rachelefsky GS, Coulson A, Siegel SC, Stiehm ER. Aspirin intolerance in chronic  
28 childhood asthma: Detected by oral challenge. *Pediatrics*. 1975; 56(3):443-448
- 29 1406 Radon K, Busching K, Heinrich J, Wichmann HE, Jorres RA, Magnussen H et al. Passive  
30 smoking exposure: a risk factor for chronic bronchitis and asthma in adults? *Chest*.  
31 2002; 122(3):1086-1090
- 32 1407 Radulovic M, Schilero GJ, Wecht JM, La Fontaine M, Rosado-Rivera D, Bauman WA.  
33 Exhaled nitric oxide levels are elevated in persons with tetraplegia and comparable to  
34 that in mild asthmatics. *Lung*. 2010; 188(3):259-262
- 35 1408 Raheison C, Nejjari C, Marty ML, Filleul L, Barberger-Gateau P, Dartigues JF et al. IgE  
36 level and Phadiatop in an elderly population from the PAQUID cohort: relationship to  
37 respiratory symptoms and smoking. *Allergy*. 2004; 59(9):940-945
- 38 1409 Raheison C, Abouelfath A, Le Gros V, Taytard A, Molimard M. Underdiagnosis of  
39 nocturnal symptoms in asthma in general practice. *Journal of Asthma*. 2006;  
40 43(3):199-202

- 1 1410 Ram G, Puthenpura V, Cianferoni A. Prevalence of pediatric drug allergy based on drug  
2 provocation testing. *Journal of Allergy and Clinical Immunology*. 2013; 131(2  
3 Suppl.1):AB175
- 4 1411 Ramirez D, Patel P, Casillas A, Cotelingam J, Boggs P, Bahna SL. Assessment of high-  
5 sensitivity C-reactive protein as a marker of airway inflammation in asthma. *Annals of  
6 Allergy, Asthma and Immunology*. 2010; 104(6):485-489
- 7 1412 Ramirez F, Pavon GF, Reyna JM, Garcia ML, Gonzalez MR, Ruiz K et al. Reliability of  
8 nasal provocation test using gradual increases of 25mg of lysine aspirin  
9 for aspirin exacerbated respiratory disease diagnostic experience at the national  
10 institute of respiratory diseases. *Annals of Allergy, Asthma and Immunology*. 2011;  
11 107(5 Suppl.1):A110
- 12 1413 Ramser M, Hammer J, Amacher A, Trachsel D. The value of exhaled nitric oxide in  
13 predicting bronchial hyperresponsiveness in children. *Journal of Asthma*. 2008;  
14 45(3):191-195
- 15 1414 Rand CS, Wise RA. Measuring adherence to asthma medication regimens. *American  
16 Journal of Respiratory and Critical Care Medicine*. 1994; 149(2 Pt 2):S69-8
- 17 1415 Randolph C. Diagnostic exercise challenge testing. *Current Allergy and Asthma  
18 Reports*. 2011; 11(6):482-490
- 19 1416 Randolph C, Fraser B, Matasavage C. The free running athletic screening test as a  
20 screening test for exercise-induced asthma in high school. *Allergy and Asthma  
21 Proceedings*. 1997; 18(2):93-98
- 22 1417 Randolph CC. Treadmill challenge for confirmation of exercise-induced  
23 bronchoconstriction. *Journal of Allergy and Clinical Immunology*. 2011; 127(2  
24 Suppl.1):AB9
- 25 1418 Randolph CC, Dreyfus DH, Kearney DM, Fraser BA. Mannitol challenge for diagnosis of  
26 exercise-induced bronch constriction. *Journal of Allergy and Clinical Immunology*.  
27 2013; 131(2 Suppl. 1):AB195
- 28 1419 Randolph CC, Kaplan C, Randolph M, Asevic S. Mannitol challenge for diagnosis of  
29 exercise-induced bronchoconstriction: Experience in practice. *Journal of Allergy and  
30 Clinical Immunology*. 2012; 129(2 Suppl.1):AB3
- 31 1420 Rasmussen F, Taylor DR, Flannery EM, Cowan JO, Greene JM, Herbison GP et al.  
32 Outcome in adulthood of asymptomatic airway hyperresponsiveness in childhood: a  
33 longitudinal population study. *Pediatric Pulmonology*. 2002; 34(3):164-171
- 34 1421 Rasmussen LM, Phanareth K, Nolte H, Backer V. Can internet-based management  
35 improve asthma control? A long term randomised clinical study of 300 asthmatics.  
36 *European Respiratory Journal*. 2005; 26(Suppl.49)
- 37 1422 Ratnawati, Morton J, Henry RL, Thomas PS. Exhaled breath condensate nitrite/nitrate  
38 and pH in relation to pediatric asthma control and exhaled nitric oxide. *Pediatric  
39 Pulmonology*. 2006; 41(10):929-936

- 1 1423 Raza A, Kurukulaaratchy RJ, Grundy JD, Clayton CB, Mitchell FA, Roberts G et al. What  
2 does adolescent undiagnosed wheeze represent? Findings from the Isle of Wight  
3 Cohort. *European Respiratory Journal*. 2012; 40(3):580-588
- 4 1424 Razi E, Moosavi GA. Serum total IgE levels and total eosinophil counts: relationship  
5 with treatment response in patients with acute asthma. *Jornal Brasileiro De*  
6 *Pneumologia*. 2010; 36(1):23-28
- 7 1425 Razi SP, Piroozmand N, Zolfaghari M, Kazemnejad A, Firoozbakhsh S. Education of  
8 How-to-Use Peak Flow Meter and Following up via SMS on Asthma Self-Management.  
9 *Hayat*. 2012; 18(4):19-27
- 10 1426 Reddel HK. Peak flow monitoring in clinical practice and clinical asthma trials. *Current*  
11 *Opinion in Pulmonary Medicine*. 2006; 12(1):75-81
- 12 1427 Redline S, Larkin EK, Kercksmar C, Berger M, Siminoff LA. Development and validation of  
13 school-based asthma and allergy screening instruments for parents and students.  
14 *Annals of Allergy, Asthma and Immunology*. 2003; 90(5):516-528
- 15 1428 Reed CE. Asthma in the elderly: diagnosis and management. *Journal of Allergy and*  
16 *Clinical Immunology*. 2010; 126(4):681-689
- 17 1429 Regnier SA, Huels J. Association between respiratory syncytial virus hospitalizations in  
18 infants and respiratory sequelae: Systematic review and meta-analysis. *Pediatric*  
19 *Infectious Disease Journal*. 2013; 32(8):820-826
- 20 1430 Reid DW, Johns DP, Feltis B, Ward C, Walters EH. Exhaled nitric oxide continues to  
21 reflect airway hyperresponsiveness and disease activity in inhaled corticosteroid-  
22 treated adult asthmatic patients. *Respirology*. 2003; 8(4):479-486
- 23 1431 Reijula K, Leino M, Mussalo-Rauhamaa H, Nikulin M, Alenius H, Mikkola J et al. IgE-  
24 mediated allergy to fungal allergens in Finland with special reference to *Alternaria*  
25 *alternata* and *Cladosporium herbarum*. *Annals of Allergy, Asthma and Immunology*.  
26 2003; 91(3):280-287
- 27 1432 Remes ST, Castro-Rodriguez JA, Holberg CJ, Martinez FD, Wright AL. Dog exposure in  
28 infancy decreases the subsequent risk of frequent wheeze but not of atopy. *Journal of*  
29 *Allergy and Clinical Immunology*. 2001; 108(4):509-515
- 30 1433 Remes ST, Pekkanen J, Remes K, Salonen RO, Korppi M. In search of childhood asthma:  
31 questionnaire, tests of bronchial hyperresponsiveness, and clinical evaluation. *Thorax*.  
32 2002; 57(2):120-126
- 33 1434 Rennie DC, Lawson JA, Cockcroft DW, Senthilselvan A, McDuffie HH. Differences in  
34 respiratory symptoms and pulmonary function in children in 2 Saskatchewan  
35 communities. *Annals of Allergy, Asthma and Immunology*. 2004; 92(1):52-59
- 36 1435 Rensen ELJ, Straathof KCM, Veselic M, Zwinderman AH, Sterk PJ. Comparison of  
37 changes in exhaled nitric oxide, sputum eosinophils and histamine  
38 hyperresponsiveness in patients with mild asthma treated with inhaled steroids.  
39 *American Journal of Respiratory and Critical Care Medicine*. 1998; 157(3 Suppl):A608

- 1 1436 Renwick DS, Connolly MJ. Prevalence and treatment of chronic airways obstruction in  
2 adults over the age of 45. *Thorax*. 1996; 51(2):164-168
- 3 1437 Resano A, Sanz ML, Oehling A. Sensitization to *Alternaria* and *Cladosporium* in  
4 asthmatic patients and its in vitro diagnostic confirmation. *Journal of Investigational*  
5 *Allergology and Clinical Immunology*. 1998; 8(6):353-358
- 6 1438 Rhee CK, Lee HY, Kwon SS, Lee SY. The clinical features between asthma and overlap  
7 syndrome. *Respirology*. 2013; 18:26
- 8 1439 Ricci A, Barosi G, Gelmetti A, Esposito R, Tzialla C, Napoli A et al. A system of  
9 teleassistance for in-house monitoring respiratory function in children with bronchial  
10 asthma. *Minerva Pediatrica*. 2001; 53(5):466-467
- 11 1440 Riccioni G, Bucciarelli V, Verini M, Consilvio NP, Gallina S, Martini F et al. ADMA,  
12 SDMA, L-Arginine and nitric oxide in allergic pediatric bronchial asthma. *Journal of*  
13 *Biological Regulators and Homeostatic Agents*. 2012; 26(3):561-566
- 14 1441 Richter DC, Joubert JR, Nell H, Schuurmans MM, Irusen EM. Diagnostic value of post-  
15 bronchodilator pulmonary function testing to distinguish between stable, moderate to  
16 severe COPD and asthma. *International Journal of Chronic Obstructive Pulmonary*  
17 *Disease*. 2008; 3(4):693-699
- 18 1442 Riedler J. Nonpharmacological challenges in the assessment of bronchial  
19 responsiveness. *European Respiratory Monograph*. 1997; 2(5):115-135
- 20 1443 Riedler J, Golser A, Huttegger I. Is 'free running' as a form of exercise challenge  
21 sensitive to assess bronchial hyperreactivity in children with mild asthma? *Klinische*  
22 *Padiatrie*. 1992; 204(5):373-377
- 23 1444 Riedler J, Reade T, Dalton M, Holst D, Robertson C. Hypertonic saline challenge in an  
24 epidemiologic survey of asthma in children. *American Journal of Respiratory and*  
25 *Critical Care Medicine*. 1994; 150(6 Pt 1):1632-1639
- 26 1445 Rietveld S, Dooijes EH. Characteristics and diagnostic significance of wheezes during  
27 exercise-induced airway obstruction in children with asthma. *Chest*. 1996; 110(3):624-  
28 631
- 29 1446 Rietveld S, Rijssenbeek-Nouwens LH. Diagnostics of spontaneous cough in childhood  
30 asthma: results of continuous tracheal sound recording in the homes of children.  
31 *Chest*. 1998; 113(1):50-54
- 32 1447 Rijcken B, Schouten JP, Weiss ST, Meinesz AF, De Vries K, van der Lende R. The  
33 distribution of bronchial responsiveness to histamine in symptomatic and in  
34 asymptomatic subjects. A population-based analysis of various indices of  
35 responsiveness. *American Review of Respiratory Disease*. 1989; 140(3):615-623
- 36 1448 Rikkers-Mutsaerts ERVM, Winters AE, Bakker MJ, van Stel HF, Jongste JC. Internet-  
37 based self-management compared with usual care in adolescents with asthma: A  
38 randomised controlled trial. *European Respiratory Society Annual Congress, Barcelona,*  
39 *Spain, September 18-22 2010*. 2010;5396

- 1 1449 Rijkers-Mutsaerts ERVM, Winters AE, Bakker MJ, van Stel HF, van der Meer V, De  
2 Jongste JC et al. Internet-based self-management compared with usual care in  
3 adolescents with asthma: a randomized controlled trial. *Pediatric Pulmonology*. 2012;  
4 47(12):1170-1179
- 5 1450 Rizwan S, Reid J, Kelly Y, Bundred PE, Pearson M, Brabin BJ. Trends in childhood and  
6 parental asthma prevalence in Merseyside, 1991-1998. *Journal of Public Health*. 2004;  
7 26(4):337-342
- 8 1451 Robinson C, Baumann L, Gilman RH, Hansel NN, Gonzalez G, Garcia H et al.  
9 Epidemiology of asthma in two peruvian cities: Differences in symptom reporting,  
10 spirometry, allergy skin testing, exhaled nitric oxide, and indoor air quality. *American  
11 Journal of Respiratory and Critical Care Medicine*. 2010; 181(1 MeetingAbstracts)
- 12 1452 Robinson CL, Baumann LM, Gilman RH, Romero K, Combe JM, Cabrera L et al. The Peru  
13 urban versus rural asthma (PURA) study: Methods and baseline quality control data  
14 from a cross-sectional investigation into the prevalence, severity, genetics,  
15 immunology and environmental factors affecting asthma in adolescence in Peru. *BMJ  
16 Open*. 2012; 2(1)
- 17 1453 Robroeks CMHH, van de Kant KDG, Jobsis Q, Hendriks HJE, van Gent R, Wouters EFM  
18 et al. Exhaled nitric oxide and biomarkers in exhaled breath condensate indicate the  
19 presence, severity and control of childhood asthma. *Clinical and Experimental Allergy*.  
20 2007; 37(9):1303-1311
- 21 1454 Rodrigo GJ, Castro-Rodriguez JA. Daily vs. intermittent inhaled corticosteroids for  
22 recurrent wheezing and mild persistent asthma: a systematic review with meta-  
23 analysis. *Respiratory Medicine*. 2013; 107(8):1133-1140
- 24 1455 Rodriguez O, Celio R, Aboukhair F, Lurrabaquio AM, Tinoco IO, Cuevas HU et al. Skin  
25 test with allergen extracts from pollens and relation to clinical signs of allergic rhinitis  
26 and bronchial asthma in Camaguey, Cuba. *VacciMonitor*. 2013; 22(2):9-13
- 27 1456 Roduit C, Scholtens S, De Jongste JC, Wijga AH, Gerritsen J, Postma DS et al. Asthma at  
28 8 years of age in children born by caesarean section. *Thorax*. 2009; 64(2):107-113
- 29 1457 Rogers L, Cassino C, Berger KI, Goldring RM, Norman RG, Klugh T et al. Asthma in the  
30 elderly: Cockroach sensitization and severity of airway obstruction in elderly  
31 nonsmokers. *Chest*. 2002; 122(5):1580-1586
- 32 1458 Rolla G, Guida G, Heffler E, Badiu I, Bommarito L, De Stefani A et al. Diagnostic  
33 classification of persistent rhinitis and its relationship to exhaled nitric oxide and  
34 asthma: a clinical study of a consecutive series of patients. *Chest*. 2007; 131(5):1345-  
35 1352
- 36 1459 Romberg K, Tufvesson E, Bjermer L. Including variability as a criteria, increases  
37 diagnostic accuracy in elite asthmatic swimmers after mannitol and exercise challenge.  
38 *Allergy*. 2011; 66:670
- 39 1460 Romberg K, Tufvesson E, Bjermer L. Extended diagnostic criteria used for indirect  
40 challenge testing in elite asthmatic swimmers. *Respiratory Medicine*. 2012; 106(1):15-  
41 24

- 1 1461 Rona RJ, Chinn S, Burney PG. Trends in the prevalence of asthma in Scottish and  
2 English primary school children 1982-92. *Thorax*. 1995; 50(9):992-993
- 3 1462 Roorda RJ, Mezei G, Bisgaard H, Maden C. Response of preschool children with asthma  
4 symptoms to fluticasone propionate. *Journal of Allergy and Clinical Immunology*. 2001;  
5 108(4):540-546
- 6 1463 Rootmensen GN, van Keimpema ARJ, Looyen EE, van der Schaaf L, de Haan RJ, Jansen  
7 HM. The effects of additional care by a pulmonary nurse for asthma and COPD  
8 patients at a respiratory outpatient clinic: results from a double blind, randomized  
9 clinical trial. *Patient Education and Counseling*. 2008; 70(2):179-186
- 10 1464 Roquet A, Hallden G, Ihre E, Hed J, Zetterstrom O. Eosinophil activity markers in  
11 peripheral blood have high predictive value for bronchial hyperreactivity in patients  
12 with suspected mild asthma. *Allergy*. 1996; 51(7):482-488
- 13 1465 Rosa MJ, Divjan A, Hoepner L, Sheares BJ, Diaz D, Gauvey-Kern K et al. Fractional  
14 exhaled nitric oxide exchange parameters among 9-year-old inner-city children.  
15 *Pediatric Pulmonology*. 2011; 46(1):83-91
- 16 1466 Rosario NA, Vilela MM. Quantitative skin prick tests and serum IgE antibodies in atopic  
17 asthmatics. *Journal of Investigational Allergology and Clinical Immunology*. 1997;  
18 7(1):40-45
- 19 1467 Rosias PPR, Dompeling E, Dentener MA, Pennings HJ, Hendriks HJE, Van Iersel MPA et  
20 al. Childhood asthma: exhaled markers of airway inflammation, asthma control score,  
21 and lung function tests. *Pediatric Pulmonology*. 2004; 38(2):107-114
- 22 1468 Rosier MJ, Bishop J, Nolan T, Robertson CF, Carlin JB, Phelan PD. Measurement of  
23 functional severity of asthma in children. *American Journal of Respiratory and Critical  
24 Care Medicine*. 1994; 149(6):1434-1441
- 25 1469 Ross JA, Clark NM, Baptist A. An asthma self-management intervention can improve  
26 outcomes for older adults. *Journal of Allergy and Clinical Immunology*. 2012; 129(2  
27 Suppl.1):AB142
- 28 1470 Rottoli L, Rottoli P, Beltrami V, Murgia M, Carriero G. Hypersensitivity to pets in Italy.  
29 *Allergologia Et Immunopathologia*. 1989; 17(1):7-9
- 30 1471 Rouhos A, Ekroos H, Karjalainen J, Sarna S, Haahtela T, Sovijarvi ARA. Smoking  
31 attenuates increase in exhaled nitric oxide in atopic but not in nonatopic young adults  
32 with asthma. *International Archives of Allergy and Immunology*. 2010; 152(3):226-232
- 33 1472 Rouhos A, Kainu A, Karjalainen J, Lindqvist A, Piirila P, Sarna S et al. Atopic sensitization  
34 to common allergens without symptoms or signs of airway disorders does not increase  
35 exhaled nitric oxide. *Clinical Respiratory Journal*. 2008; 2(3):141-148
- 36 1473 Royal College of Physicians of London. Why asthma still kills: The national review of  
37 asthma deaths (NRAD) confidential enquiry report May 2014. London. Royal College of  
38 Physicians, 2014. Available from:  
39 <https://www.rcplondon.ac.uk/sites/default/files/why-asthma-still-kills-full-report.pdf>

- 1 1474 Rudzki E, Litewska D. RAST and PRIST in children with atopic dermatitis.  
2 Dermatologica. 1990; 180(2):82-85
- 3 1475 Rugina M, Serrano E, Klossek JM, Crampette L, Stoll D, Bebear JP et al. Epidemiological  
4 and clinical aspects of nasal polyposis in France; the ORLI group experience. Rhinology.  
5 2002; 40(2):75-79
- 6 1476 Rundell KW, Anderson SD, Spiering BA, Judelson DA. Field exercise vs laboratory  
7 eucapnic voluntary hyperventilation to identify airway hyperresponsiveness in elite  
8 cold weather athletes. Chest. 2004; 125(3):909-915
- 9 1477 Ruppel GL. What is the clinical value of lung volumes? Respiratory Care. 2012;  
10 57(1):26-28
- 11 1478 Ryan D, Price D, Musgrave SD, Malhotra S, Lee AJ, Ayansina D et al. Clinical and cost  
12 effectiveness of mobile phone supported self monitoring of asthma: multicentre  
13 randomised controlled trial. BMJ. 2012; 344:e1756
- 14 1479 Rydjord B, Marton JH, Stromsnes H, Granum B, Bolle R, Nystad W et al. Mould-specific  
15 immunoglobulin antibodies quantified by flow cytometry reflect mould exposure in  
16 Norwegian children. Clinical and Experimental Allergy. 2008; 38(3):430-437
- 17 1480 Rydman RJ, Sonenthal K, Tadimeti L, Butki N, McDermott MF. Evaluating the outcome  
18 of two teaching methods of breath actuated inhaler in an inner city asthma clinic.  
19 Journal of Medical Systems. 1999; 23(5):349-356
- 20 1481 Ryttila P, Metso T, Heikkinen K, Saarelainen P, Helenius IJ, Haahtela T. Airway  
21 inflammation in patients with symptoms suggesting asthma but with normal lung  
22 function. European Respiratory Journal. 2000; 16(5):824-830
- 23 1482 Sachs-Olsen C, Lodrup Carlsen KC, Mowinckel P, Haland G, Devulapalli CS, Munthe-  
24 Kaas MC et al. Diagnostic value of exhaled nitric oxide in childhood asthma and allergy.  
25 Pediatric Allergy and Immunology. 2010; 21(1 Pt 2):e213-e221
- 26 1483 Sachs-Olsen C, Berntsen S, Lodrup Carlsen KC, Anderssen SA, Mowinckel P, Carlsen KH.  
27 Time spent in vigorous physical activity is associated with increased exhaled nitric  
28 oxide in non-asthmatic adolescents. Clinical Respiratory Journal. 2013; 7(1):64-73
- 29 1484 Saito J, Inoue K, Sugawara A, Yoshikawa M, Watanabe K, Ishida T et al. Exhaled nitric  
30 oxide as a marker of airway inflammation for an epidemiologic study in schoolchildren.  
31 Journal of Allergy and Clinical Immunology. 2004; 114(3):512-516
- 32 1485 Sakai T, Sugiyama N, Hirai K, Muramatsu R, Hagiwara S, Oh Y et al. Consistently high  
33 levels of exhaled nitric oxide in children with asthma. Pediatrics International. 2010;  
34 52(5):801-805
- 35 1486 Salam MT, Li YF, Langholz B, Gilliland FD, Children's Health Study. Early-life  
36 environmental risk factors for asthma: findings from the Children's Health Study.  
37 Environmental Health Perspectives. 2004; 112(6):760-765
- 38 1487 Sallaway K, Rae R, Road JD, Fitzgerald JM. The utility of a walk-in spirometry laboratory  
39 in the diagnosis of asthma and COPD. American Journal of Respiratory and Critical Care  
40 Medicine. 2011; 183(1 Meeting Abstracts)



- 1 1488 Salome CM, Peat JK, Britton WJ, Woolcock AJ. Bronchial hyperresponsiveness in two  
2 populations of Australian schoolchildren. I. Relation to respiratory symptoms and  
3 diagnosed asthma. *Clinical Allergy*. 1987; 17(4):271-281
- 4 1489 Salome CM, Roberts AM, Brown NJ, Dermand J, Marks GB, Woolcock AJ. Exhaled nitric  
5 oxide measurements in a population sample of young adults. *American Journal of  
6 Respiratory and Critical Care Medicine*. 1999; 159(3):911-916
- 7 1490 Sanchez-Garcia S, Fermin I, Andregnette V, Del Rio PR, Escudero C, Ibanez MD.  
8 Bronchial hyperresponsiveness in children with suggestive asthma symptoms. *World  
9 Allergy Organization Journal*. 2012; 5:S183-S184
- 10 1491 Sanchez-Sindin G, Barreiro-De AM, Iglesias-Rey M, Garcia CN, Ferreiro R, Lorenzo A et  
11 al. Asthma prevalence in patients with inflammatory bowel disease. *Journal of Crohn's  
12 and Colitis*. 2013; 7:S277
- 13 1492 Sandrini A, Taylor DR, Thomas PS, Yates DH. Fractional exhaled nitric oxide in asthma:  
14 an update. *Respirology*. 2010; 15(1):57-70
- 15 1493 Sangha HS, Kapoor BK, Kishan J. Effectiveness of self management plan of bronchial  
16 asthma using peak flow meter and symptom profile: a randomized controlled study  
17 [Abstract]. *Chest*. 2004; 126(4 Suppl):706S-706b
- 18 1494 Sano T, Ueda H, Bando H. A preliminary study of PEFr monitoring in patients with  
19 chronic cough. *Lung*. 2004; 182(5):285-295
- 20 1495 Santos DdO, Martins MC, Cipriano SL, Pinto RMC, Cukier A, Stelmach R.  
21 Pharmaceutical care for patients with persistent asthma: assessment of treatment  
22 compliance and use of inhaled medications. *Jornal Brasileiro De Pneumologia*. 2010;  
23 36(1):14-22
- 24 1496 Santoso H. The value of a single skin prick testing for specific IgE *Dermatophagoides*  
25 *pteronyssinus* to distinguish atopy from non-atopic asthmatic children in the tropics.  
26 *Asian Pacific Journal of Allergy and Immunology*. 1998; 16(2-3):69-74
- 27 1497 Saraiva-Romanholo BM, Machado FS, Almeida FM, Nunes MdP, Martins MA, Vieira JE.  
28 Non-asthmatic patients show increased exhaled nitric oxide concentrations. *Clinics*.  
29 2009; 64(1):5-10
- 30 1498 Sastre J, Ibanez MD, Lombardero M, Laso MT, Lehrer S. Allergy to cockroaches in  
31 patients with asthma and rhinitis in an urban area (Madrid). *Allergy*. 1996; 51(8):582-  
32 586
- 33 1499 Sato S, Saito J, Sato Y, Ishii T, Xintao W, Tanino Y et al. Clinical usefulness of fractional  
34 exhaled nitric oxide for diagnosing prolonged cough. *Respiratory Medicine*. 2008;  
35 102(10):1452-1459
- 36 1500 Satouchi M, Maeda H, Yu Y, Yokoyama M. Clinical significance of the increased peak  
37 levels of exhaled nitric oxide in patients with bronchial asthma. *Internal Medicine*.  
38 1996; 35(4):270-275

- 1 1501 Sauro A, Scalzitti F, Buono N, Siringano R, Petrazzuoli F, Diodati G et al. Spirometry is  
2 really useful and feasible in the GP's daily practice but guidelines alone are not.  
3 European Journal of General Practice. 2005; 11(1):29-31
- 4 1502 Savage I, Goodyear L. Providing information on metered dose inhaler technique: Is  
5 multimedia as effective as print? Family Practice. 2003; 20(5):552-557
- 6 1503 Savenije OE, Granell R, Caudri D, Koppelman GH, Smit HA, Wijga A et al. Comparison of  
7 childhood wheezing phenotypes in 2 birth cohorts: ALSPAC and PIAMA. Journal of  
8 Allergy and Clinical Immunology. 2011; 127(6):1505-1512
- 9 1504 Scarlett JF, Griffiths JM, Strachan DP, Anderson HR. Effect of ambient levels of smoke  
10 and sulphur dioxide on the health of a national sample of 23 year old subjects in 1981.  
11 Thorax. 1995; 50(7):764-768
- 12 1505 Schachter EN, Doyle CA, Beck GJ. A prospective study of asthma in a rural community.  
13 Chest. 1984; 85(5):623-630
- 14 1506 Schachter LM, Peat JK, Salome CM. Asthma and atopy in overweight children. Thorax.  
15 2003; 58(12):1031-1035
- 16 1507 Schachter LM, Salome CM, Peat JK, Woolcock AJ. Obesity is a risk for asthma and  
17 wheeze but not airway hyperresponsiveness. Thorax. 2001; 56(1):4-8
- 18 1508 Schaper C, Glaser S, Obst A, Schmidt CO, Volzke H, Felix SB et al. Symptoms and  
19 diagnosis of asthma in a general population - longitudinal results from the SHIP  
20 database. Journal of Asthma. 2010; 47(8):860-864
- 21 1509 Schatz M, Zeiger RS. Ineffectiveness of telephone-based environmental control  
22 intervention to improve asthma outcomes. Journal of Allergy and Clinical Immunology.  
23 2010; 126(4):873-875
- 24 1510 Schermer TRJ, Folgering HTM, Bottema BJAM, Jacobs JE, van Schayck CP, Van WC. The  
25 value of spirometry for primary care: Asthma and COPD. Primary Care Respiratory  
26 Journal. 2000; 9(3):51-55
- 27 1511 Schermer TR, Thoonen BP, van den Boom G, Akkermans RP, Grol RP, Folgering HT et al.  
28 Randomized controlled economic evaluation of asthma self-management in primary  
29 health care. American Journal of Respiratory and Critical Care Medicine. 2002;  
30 166(8):1062-1072
- 31 1512 Schernhammer ES, Vutuc C, Waldhor T, Haidinger G. Time trends of the prevalence of  
32 asthma and allergic disease in Austrian children. Pediatric Allergy and Immunology.  
33 2008; 19(2):125-131
- 34 1513 Scherr A, Jochmann A, Miedinger D, Maier S, Torok SS, Chhajed P. Airway  
35 hyperresponsiveness to mannitol as a predictor of treatment response to ciclesonide  
36 in patients with suspected asthma: A double-blind, randomised, placebo-controlled  
37 trial [Abstract]. European Respiratory Journal: European Respiratory Society Annual  
38 Congress, Vienna, Austria, September 1-5. 2012; 40(Suppl 56):862s

- 1 1514 Schleich FN, Asandei R, Manise M, Sele J, Seidel L, Louis R. Is FENO50 useful diagnostic  
2 tool in suspected asthma? *International Journal of Clinical Practice*. 2012; 66(2):158-  
3 165
- 4 1515 Schlunssen V, Kespohl S, Jacobsen G, Raulf-Heimsoth M, Schaumburg I, Sigsgaard T.  
5 Immunoglobulin E-mediated sensitization to pine and beech dust in relation to wood  
6 dust exposure levels and respiratory symptoms in the furniture industry. *Scandinavian*  
7 *Journal of Work, Environment and Health*. 2011; 37(2):159-167
- 8 1516 Schmidt LE, Thorne PS, Watt JL, Schwartz DA. Is an abbreviated bronchial challenge  
9 with histamine valid? *Chest*. 1992; 101(1):141-145
- 10 1517 Schneider A, Ay M, Faderl B, Linde K, Wagenpfeil S. Diagnostic accuracy of clinical  
11 symptoms in obstructive airway diseases varied within different health care sectors.  
12 *Journal of Clinical Epidemiology*. 2012; 65(8):846-854
- 13 1518 Schneider A, Faderl B, Schwarzbach J, Welker L, Karsch-Volk M, Jorres RA. Prognostic  
14 value of bronchial provocation and FENO measurement for asthma diagnosis --results  
15 of a delayed type of diagnostic study. *Respiratory Medicine*. 2014; 108(1):34-40
- 16 1519 Schneider A, Gindner L, Tilemann L, Schermer T, Dinant GJ, Meyer FJ et al. Diagnostic  
17 accuracy of spirometry in primary care. *BMC Pulmonary Medicine*. 2009; 9:31
- 18 1520 Schneider A, Schwarzbach J, Faderl B, Welker L, Karsch-Volk M, Jorres RA. FENO  
19 measurement and sputum analysis for diagnosing asthma in clinical practice.  
20 *Respiratory Medicine*. 2013; 107(2):209-216
- 21 1521 Schneider A, Tilemann L, Schermer T, Gindner L, Laux G, Szecsenyi J et al. Diagnosing  
22 asthma in general practice with portable exhaled nitric oxide measurement--results of  
23 a prospective diagnostic study: FENO < or = 16 ppb better than FENO < or =12 ppb to  
24 rule out mild and moderate to severe asthma. *Respiratory Research*. 2009; 10:15
- 25 1522 Schoefer Y, Schafer T, Meisinger C, Wichmann HE, Heinrich J, KORA study group.  
26 Predictivity of allergic sensitization (RAST) for the onset of allergic diseases in adults.  
27 *Allergy*. 2008; 63(1):81-86
- 28 1523 Scholtens S, Wijga AH, Brunekreef B, Kerkhof M, Hoekstra MO, Gerritsen J et al. Breast  
29 feeding, parental allergy and asthma in children followed for 8 years. The PIAMA birth  
30 cohort study. *Thorax*. 2009; 64(7):604-609
- 31 1524 Scholtens S, Wijga AH, Brunekreef B, Kerkhof M, Postma DS, Oldenwening M et al.  
32 Maternal overweight before pregnancy and asthma in offspring followed for 8 years.  
33 *International Journal of Obesity*. 2010; 34(4):606-613
- 34 1525 Scholtens S, Wijga AH, Seidell JC, Brunekreef B, de Jongste JC, Gehring U et al.  
35 Overweight and changes in weight status during childhood in relation to asthma  
36 symptoms at 8 years of age. *Journal of Allergy and Clinical Immunology*. 2009;  
37 123(6):1312-1318
- 38 1526 Schonberger H, van Schayck O, Muris J, Bor H, van den Hoogen H, Knottnerus A et al.  
39 Towards improving the accuracy of diagnosing asthma in early childhood. *European*  
40 *Journal of General Practice*. 2004; 10(4):138-151

- 1 1527 Schulze J, Reinmuller W, Herrmann E, Rosewich M, Rose MA, Zielen S. Bronchial  
2 allergen challenges in children - safety and predictors. *Pediatric Allergy and*  
3 *Immunology*. 2013; 24(1):19-27
- 4 1528 Schumpert JC, Noonan CW, Sylvester J, Vanek D, Ward T, Holian A. Patterns of asthma  
5 symptoms and perceptions of harm from seasonal atmospheric events in rural  
6 Western Montana. *International Journal of Occupational and Environmental Health*.  
7 2006; 12(1):52-58
- 8 1529 Schwaiblmair M, Vogelmeier C, Fruhmann G. Occupational asthma in hairdressers:  
9 results of inhalation tests with bleaching powder. *International Archives of*  
10 *Occupational and Environmental Health*. 1997; 70(6):419-423
- 11 1530 Schwartz J, Weiss ST. Relationship of skin test reactivity to decrements in pulmonary  
12 function in children with asthma or frequent wheezing. *American Journal of*  
13 *Respiratory and Critical Care Medicine*. 1995; 152(6 I):2176-2180
- 14 1531 Sciamanna C, Poger JM, Pool A, Stuckey H, Lehman EB, Craig T. Improving the quality  
15 of asthma care using the Internet. *Journal of General Internal Medicine*.: Springer New  
16 York. 2013; 28:S106-S107
- 17 1532 Scollo M, Zanconato S, Ongaro R, Zaramella C, Zacchello F, Baraldi E. Exhaled nitric  
18 oxide and exercise-induced bronchoconstriction in asthmatic children. *American*  
19 *Journal of Respiratory and Critical Care Medicine*. 2000; 161(3 Pt 1):1047-1050
- 20 1533 Scordamaglia A, Passalacqua G, Pisati P, Moscato G, Bertoletti R, Ruffoni S et al. A  
21 multi-allergen ELISA screening method. Comparison with Pharmacia CAP system and  
22 Phazet skin prick test. *Allergologia Et Immunopathologia*. 1992; 20(5):179-183
- 23 1534 Scott M, Raza A, Karmaus W, Mitchell F, Grundy J, Kurukulaaratchy RJ et al. Influence  
24 of atopy and asthma on exhaled nitric oxide in an unselected birth cohort study.  
25 *Thorax*. 2010; 65(3):258-262
- 26 1535 Scott S, Currie J, Albert P, Calverley P, Wilding JPH. Risk of misdiagnosis, health-related  
27 quality of life, and BMI in patients who are overweight with doctor-diagnosed asthma.  
28 *Chest*. 2012; 141(3):616-624
- 29 1536 Scottish Intercollegiate Guidelines Network. British guideline on the management of  
30 asthma: a national clinical guideline 101. London / Edinburgh. British Thoracic Society /  
31 Scottish Intercollegiate Guidelines Network, 2012. Available from:  
32 <http://www.sign.ac.uk/pdf/SIGN101.pdf>
- 33 1537 Searing DA, Bender BG. Short message service (SMS) for asthma management: a pilot  
34 study utilizing text messaging to promote asthma self-management. *Journal of Allergy*  
35 *and Clinical Immunology*. 2012; 129(2 Suppl.):AB142
- 36 1538 Sears MR, Holdaway MD, Flannery EM, Herbison GP, Silva PA. Parental and neonatal  
37 risk factors for atopy, airway hyper-responsiveness, and asthma. *Archives of Disease in*  
38 *Childhood*. 1996; 75(5):392-398
- 39 1539 See KC, Christiani DC. Normal values and thresholds for the clinical interpretation of  
40 exhaled nitric oxide levels in the US general population: results from the National  
41 Health and Nutrition Examination Survey 2007-2010. *Chest*. 2013; 143(1):107-116

- 1 1540 Seear M, Wensley D, West N. How accurate is the diagnosis of exercise induced  
2 asthma among Vancouver schoolchildren? *Archives of Disease in Childhood*. 2005;  
3 90(9):898-902
- 4 1541 Seid M, D'Amico EJ, Varni JW, Munafo JK, Britto MT, Kerckmar CM et al. The In Vivo  
5 adherence intervention for at risk adolescents with asthma: Report of a randomized  
6 pilot study. *Journal of Pediatric Psychology*. United States 2012; 37(4):390-403
- 7 1542 Sekerel BE, Saraclar Y, Kalayci O, Cetinkaya F, Tuncer A, Adalioglu G. Comparison of  
8 four different measures of bronchial responsiveness in asthmatic children. *Allergy*.  
9 1997; 52(11):1106-1109
- 10 1543 Selassie FG, Stevens RH, Cullinan P, Pritchard D, Jones M, Harris J et al. Total and  
11 specific IgE (house dust mite and intestinal helminths) in asthmatics and controls from  
12 Gondar, Ethiopia. *Clinical and Experimental Allergy*. 2000; 30(3):356-358
- 13 1544 Sennhauser FH, Kuhni CE. Prevalence of respiratory symptoms in Swiss children: is  
14 bronchial asthma really more prevalent in boys? *Pediatric Pulmonology*. 1995;  
15 19(3):161-166
- 16 1545 Senthilselvan A, Chen Y, Dosman JA. Predictors of asthma and wheezing in adults.  
17 Grain farming, sex, and smoking. *American Review of Respiratory Disease*. 1993;  
18 148(3):667-670
- 19 1546 Sethi JM, White AM, Patel SA, Dinella JV, Calhoun WJ, Choi AMK. Bronchoprovocation  
20 testing in asthma: effect on exhaled monoxides. *Journal of Breath Research*. 2010;  
21 4(4):047104
- 22 1547 Shaheen SO, Newson RB, Henderson AJ, Headley JE, Stratton FD, Jones RW et al.  
23 Prenatal paracetamol exposure and risk of asthma and elevated immunoglobulin E in  
24 childhood. *Clinical and Experimental Allergy*. 2005; 35(1):18-25
- 25 1548 Shaheen SO, Newson RB, Sherriff A, Henderson AJ, Heron JE, Burney PGJ et al.  
26 Paracetamol use in pregnancy and wheezing in early childhood. *Thorax*. 2002;  
27 57(11):958-963
- 28 1549 Shaheen SO, Sterne JA, Montgomery SM, Azima H. Birth weight, body mass index and  
29 asthma in young adults. *Thorax*. 1999; 54(5):396-402
- 30 1550 Shaheen SO, Sterne JA, Songhurst CE, Burney PG. Frequent paracetamol use and  
31 asthma in adults. *Thorax*. 2000; 55(4):266-270
- 32 1551 Shaheen SO, Sterne JA, Tucker JS, Florey CD. Birth weight, childhood lower respiratory  
33 tract infection, and adult lung function. *Thorax*. 1998; 53(7):549-553
- 34 1552 Shakeri J, Paknejad O, Moghadam KG, Taherzadeh M. Logistic regression model for  
35 prediction of airway reversibility using peak expiratory flow. *Tanaffos*. 2012; 11(1):49-  
36 54
- 37 1553 Shankardass K, McConnell R, Jerrett M, Milam J, Richardson J, Berhane K. Parental  
38 stress increases the effect of traffic-related air pollution on childhood asthma  
39 incidence. *Proceedings of the National Academy of Sciences of the United States of  
40 America*. 2009; 106(30):12406-12411

- 1 1554 Shanovich K, Sorkness CA, Wise M, Pulvermacher A, Bhattacharya A, Gustafson D.  
2 Internet telehealth for pediatric nurse case management improves asthma control.  
3 *Journal of Allergy and Clinical Immunology*. 2009; 123(2 Suppl.1):S43
- 4 1555 Shapiro GG, Furukawa CT, Pierson WE, Bierman CW. Methacholine bronchial challenge  
5 in children. *Journal of Allergy and Clinical Immunology*. 1982; 69(4):365-369
- 6 1556 Sharma S, Kathuria PC, Gupta CK, Nordling K, Ghosh B, Singh AB. Total serum  
7 immunoglobulin E levels in a case-control study in asthmatic/allergic patients, their  
8 family members, and healthy subjects from India. *Clinical and Experimental Allergy*.  
9 2006; 36(8):1019-1027
- 10 1557 Shavit O, Swern A, Dong Q, Newcomb K, Sazonov Kocevar V, Taylor SD. Impact of  
11 smoking on asthma symptoms, healthcare resource use, and quality of life outcomes  
12 in adults with persistent asthma. *Quality of Life Research*. 2007; 16(10):1555-1565
- 13 1558 Shaw DE, Berry MA, Thomas M, Green RH, Brightling CE, Wardlaw AJ et al. The use of  
14 exhaled nitric oxide to guide asthma management: a randomized controlled trial.  
15 *American Journal of Respiratory and Critical Care Medicine*. 2007; 176(3):231-237
- 16 1559 Sherriff A, Maitra A, Ness AR, Mattocks C, Riddoch C, Reilly JJ et al. Association of  
17 duration of television viewing in early childhood with the subsequent development of  
18 asthma. *Thorax*. 2009; 64(4):321-325
- 19 1560 Sherrill DL, Stein R, Halonen M, Holberg CJ, Wright A, Martinez FD. Total serum IgE and  
20 its association with asthma symptoms and allergic sensitization among children.  
21 *Journal of Allergy and Clinical Immunology*. 1999; 104(1):28-36
- 22 1561 Shibasaki M, Noguchi E, Takeda K, Takita H. Distribution of IgE and IgG antibody levels  
23 against house dust mites in schoolchildren, and their relation with asthma. *Journal of*  
24 *Asthma*. 1997; 34(3):235-242
- 25 1562 Shields MD, Brown V, Stevenson EC, Fitch PS, Schock BC, Turner G et al. Serum  
26 eosinophilic cationic protein and blood eosinophil counts for the prediction of the  
27 presence of airways inflammation in children with wheezing. *Clinical and Experimental*  
28 *Allergy*. 1999; 29(10):1382-1389
- 29 1563 Shimoda T, Obase Y, Kishikawa R, Iwanaga T, Miyatake A, Kasayama S. The fractional  
30 exhaled nitric oxide and serum high sensitivity C-reactive protein levels in cough  
31 variant asthma and typical bronchial asthma. *Allergology International*. 2013;  
32 62(2):251-257
- 33 1564 Shin B, Cole SL, Park SJ, Ledford DK, Lockey RF. A new symptom-based questionnaire  
34 for predicting the presence of asthma. *Journal of Investigational Allergology and*  
35 *Clinical Immunology*. 2010; 20(1):27-34
- 36 1565 Shin HW, Schwindt CD, Aledia AS, Rose-Gottron CM, Larson JK, Newcomb RL et al.  
37 Exercise-induced bronchoconstriction alters airway nitric oxide exchange in a pattern  
38 distinct from spirometry. *American Journal of Physiology Regulatory, Integrative and*  
39 *Comparative Physiology*. 2006; 291(6):R1741-R1748

- 1 1566 Shirahata K, Fujimoto K, Arioka H, Shouda R, Kudo K, Ikeda S-I. Prevalence and clinical  
2 features of cough variant asthma in a general internal medicine outpatient clinic in  
3 Japan. *Respirology*. 2005; 10(3):354-358
- 4 1567 Shofer S, Haus BM, Kuschner WG. Quality of occupational history assessments in  
5 working age adults with newly diagnosed asthma. *Chest*. 2006; 130(2):455-462
- 6 1568 Shome GP, Starnes III JD, Shearer M, Kennedy R, Way A, Arif A et al. Exhaled nitric  
7 oxide in asthma: Variability, relation to asthma severity, and peripheral blood  
8 lymphocyte cytokine expression. *Journal of Asthma*. 2006; 43(2):95-99
- 9 1569 Short PM, McKinlay L, Jackson CM, Williamson PA, Burns P, Fardon TC et al. Steroid  
10 titration against mannitol PD10 confers benefits in mild to moderate asthmatics with  
11 no adverse effects on safety outcomes. *American Journal of Respiratory and Critical  
12 Care Medicine*. 2011; 183(1 MeetingAbstracts)
- 13 1570 Short PM, Lipworth SIW, Lipworth BJ. Relationships between airway  
14 hyperresponsiveness, inflammation, and calibre in asthma. *Lung*. 2011; 189(6):493-497
- 15 1571 Shrewsbury S, Pyke S, Britton M. Meta-analysis of increased dose of inhaled steroid or  
16 addition of salmeterol in symptomatic asthma (MIASMA). *BMJ*. 2000; 320(7246):1368-  
17 1373
- 18 1572 Sibbald B, Anderson HR, McGuigan S. Asthma and employment in young adults.  
19 *Thorax*. 1992; 47(1):19-24
- 20 1573 Siersted HC, Hansen HS, Hansen NC, Hyldebrandt N, Mostgaard G, Oxhøj H. Evaluation  
21 of peak expiratory flow variability in an adolescent population sample. The Odense  
22 Schoolchild Study. *American Journal of Respiratory and Critical Care Medicine*. 1994;  
23 149(3 Pt 1):598-603
- 24 1574 Siersted HC, Mostgaard G, Hyldebrandt N, Hansen HS, Boldsen J, Oxhøj H.  
25 Interrelationships between diagnosed asthma, asthma-like symptoms, and abnormal  
26 airway behaviour in adolescence: The Odense Schoolchild Study. *Thorax*. 1996;  
27 51(5):503-509
- 28 1575 Silkoff PE, Sylvester JT, Zamel N, Permutt S. Airway nitric oxide diffusion in asthma:  
29 Role in pulmonary function and bronchial responsiveness. *American Journal of  
30 Respiratory and Critical Care Medicine*. 2000; 161(4 Pt 1):1218-1228
- 31 1576 Silver EJ, Crain EF, Weiss KB. Burden of wheezing illness among U.S. children reported  
32 by parents not to have asthma. *Journal of Asthma*. 1998; 35(5):437-443
- 33 1577 Silvers KM, Frampton CM, Wickens K, Epton MJ, Pattemore PK, Ingham T et al.  
34 Breastfeeding protects against adverse respiratory outcomes at 15 months of age.  
35 *Maternal and Child Nutrition*. 2009; 5(3):243-250
- 36 1578 Silvers KM, Frampton CM, Wickens K, Pattemore PK, Ingham T, Fishwick D et al.  
37 Breastfeeding protects against current asthma up to 6 years of age. *Journal of  
38 Pediatrics*. 2012; 160(6):991-996

- 1 1579 Silvestri IC, Pereira CA dC, Rodrigues SCS. Comparison of spirometric changes in the  
2 response to bronchodilators of patients with asthma or chronic obstructive pulmonary  
3 disease. *Jornal Brasileiro De Pneumologia*. 2008; 34(9):675-682
- 4 1580 Silvestri M, Bontempelli M, Giacomelli M, Malerba M, Rossi GA, Di Stefano A et al.  
5 High serum levels of tumour necrosis factor-alpha and interleukin-8 in severe asthma:  
6 markers of systemic inflammation? *Clinical and Experimental Allergy*. 2006;  
7 36(11):1373-1381
- 8 1581 Silvestri M, Oddera S, Crimi P, Rossi GA. Frequency and specific sensitization to  
9 inhalant allergens within nuclear families of children with asthma and/or rhinitis.  
10 *Annals of Allergy, Asthma and Immunology*. 1997; 79(6):512-516
- 11 1582 Silvestri M, Oddera S, Rossi GA, Crimi P. Sensitization to airborne allergens in children  
12 with respiratory symptoms. *Annals of Allergy, Asthma and Immunology*. 1996;  
13 76(3):239-244
- 14 1583 Silvestri M, Sabatini F, Spallarossa D, Fregonese L, Battistini E, Biraghi MG et al.  
15 Exhaled nitric oxide levels in non-allergic and allergic mono- or polysensitized children  
16 with asthma. *Thorax*. 2001; 56(11):857-862
- 17 1584 Silvestri M, Spallarossa D, Battistini E, Brusasco V, Rossi GA. Dissociation between  
18 exhaled nitric oxide and hyperresponsiveness in children with mild intermittent  
19 asthma. *Thorax*. 2000; 55(6):484-488
- 20 1585 Silvestri M, Spallarossa D, Battistini E, Fregonese B, Rossi GA. How can we best read  
21 exhaled nitric oxide flow curves in asthmatic children? *Monaldi Archives for Chest  
22 Disease*. 2001; 56(5):384-389
- 23 1586 Silvestri M, Sabatini F, Sale R, Defilippi AC, Fregonese L, Battistini E et al. Correlations  
24 between exhaled nitric oxide levels, blood eosinophilia, and airway obstruction  
25 reversibility in childhood asthma are detectable only in atopic individuals. *Pediatric  
26 Pulmonology*. 2003; 35(5):358-363
- 27 1587 Simon MR, Chinchilli VM, Phillips BR, Sorkness CA, Lemanske RFJ, Szefer SJ et al.  
28 Forced expiratory flow between 25% and 75% of vital capacity and FEV1/forced vital  
29 capacity ratio in relation to clinical and physiological parameters in asthmatic children  
30 with normal FEV1 values. *Journal of Allergy and Clinical Immunology*. 2010;  
31 126(3):527-528
- 32 1588 Simoni M, Biavati P, Baldacci S, Carrozzi L, Pedreschi M, Di Pede F et al. The Po River  
33 Delta epidemiological survey: reference values of total serum IgE levels in a normal  
34 population sample of North Italy (8-78 yrs). *European Journal of Epidemiology*. 2001;  
35 17(3):231-239
- 36 1589 Simpson A, Soderstrom L, Ahlstedt S, Murray CS, Woodcock A, Custovic A. IgE antibody  
37 quantification and the probability of wheeze in preschool children. *Journal of Allergy  
38 and Clinical Immunology*. 2005; 116(4):744-749
- 39 1590 Simpson A, Tan VYF, Winn J, Svensen M, Bishop CM, Heckerman DE et al. Beyond  
40 atopy: multiple patterns of sensitization in relation to asthma in a birth cohort study.  
41 *American Journal of Respiratory and Critical Care Medicine*. 2010; 181(11):1200-1206



- 1 1591 Simpson JL, Wark PAB. The role of exhaled nitric oxide and exhaled breath  
2 condensates in evaluating airway inflammation in asthma. *Expert Opinion on Medical*  
3 *Diagnostics*. 2008; 2(6):607-620
- 4 1592 Sin BA, Akkoca O, Saryal S, Oner F, Misirligil Z. Differences between asthma and COPD  
5 in the elderly. *Journal of Investigational Allergology and Clinical Immunology*. 2006;  
6 16(1):44-50
- 7 1593 Sin BA, Yildiz OA, Dursun AB, Misirligil Z, Demirel YS. Airway hyperresponsiveness: a  
8 comparative study of methacholine and exercise challenges in seasonal allergic rhinitis  
9 with or without asthma. *Journal of Asthma*. 2009; 46(5):486-491
- 10 1594 Sin DD, Jones RL, Man SFP. Obesity is a risk factor for dyspnea but not for airflow  
11 obstruction. *Archives of Internal Medicine*. 2002; 162(13):1477-1481
- 12 1595 Sinclair DG, Sims MM, Hoad NA, Winfield CR. Exercise-induced airway narrowing in  
13 army recruits with a history of childhood asthma. *European Respiratory Journal*. 1995;  
14 8(8):1314-1317
- 15 1596 Singh D, Richards D, Knowles RG, Schwartz S, Woodcock A, Langley S et al. Selective  
16 inducible nitric oxide synthase inhibition has no effect on allergen challenge in asthma.  
17 *American Journal of Respiratory and Critical Care Medicine*. 2007; 176(10):988-993
- 18 1597 Singh V, Meena P, Sharma BB. Asthma-like peak flow variability in various lung  
19 diseases. *Lung India*. 2012; 29(1):15-18
- 20 1598 Sippel JM, Holden WE, Tilles SA, O'Hollaren M, Cook J, Thukkani N et al. Exhaled nitric  
21 oxide levels correlate with measures of disease control in asthma. *Journal of Allergy*  
22 *and Clinical Immunology*. 2000; 106(4):645-650
- 23 1599 Siroux V, Oryszczyn MP, Paty E, Kauffmann F, Pison C, Vervloet D et al. Relationships of  
24 allergic sensitization, total immunoglobulin E and blood eosinophils to asthma severity  
25 in children of the EGEA Study. *Clinical and Experimental Allergy*. 2003; 33(6):746-751
- 26 1600 Sistek D, Tschopp J-M, Schindler C, Brutsche M, Ackermann-Liebrich U, Perruchoud A-P  
27 et al. Clinical diagnosis of current asthma: Predictive value of respiratory symptoms in  
28 the SAPALDIA study. *European Respiratory Journal*. 2001; 17(2):214-219
- 29 1601 Sistek D, Wickens K, Armstrong R, D'Souza W, Town I, Crane J. Predictive value of  
30 respiratory symptoms and bronchial hyperresponsiveness to diagnose asthma in New  
31 Zealand. *Respiratory Medicine*. 2006; 100(12):2107-2111
- 32 1602 Sivan Y, Gadish T, Fireman E, Soferman R. The use of exhaled nitric oxide in the  
33 diagnosis of asthma in school children. *Journal of Pediatrics*. 2009; 155(2):211-216
- 34 1603 Skaer TL, Wilson CB, Sclar DA, Arnold TA, Garcia CF, Schmidt LN et al. Metered-dose  
35 inhaler technique and quality of life with airways disease: assessing the value of the  
36 Vitalograph in educational intervention. *Journal of International Medical Research*.  
37 1996; 24(4):369-375
- 38 1604 Skovsted TA, Schlunssen V, Schaumburg I, Wang P, Staun-Olsen P, Skov PS. Only few  
39 workers exposed to wood dust are detected with specific IgE against pine wood.  
40 *Allergy*. 2003; 58(8):772-779

- 1 1605 Slader CA, Reddel HK, Spencer LM, Belousova EG, Armour CL, Bosnic-Anticevich SZ et  
2 al. Double blind randomised controlled trial of two different breathing techniques in  
3 the management of asthma. *Thorax*. 2006; 61(8):651-656
- 4 1606 Slader CA, Belousova EG, Reddel HK. Measuring peak flow enhances adherence to  
5 monitoring in asthma. *Thorax*. 2007; 62(8):741-742
- 6 1607 Slieker MG, van der Ent CK. The diagnostic and screening capacities of peak expiratory  
7 flow measurements in the assessment of airway obstruction and bronchodilator  
8 response in children with asthma. *Monaldi Archives for Chest Disease*. 2003;  
9 59(2):155-159
- 10 1608 Smeeton NC, Rona RJ, Oyarzun M, Diaz PV. Agreement between responses to a  
11 standardized asthma questionnaire and a questionnaire following a demonstration of  
12 asthma symptoms in adults. *American Journal of Epidemiology*. 2006; 163(4):384-391
- 13 1609 Smit LAM, Heederik D, Doekes G, Wouters IM. Exhaled nitric oxide in endotoxin-  
14 exposed adults: effect modification by smoking and atopy. *Occupational and  
15 Environmental Medicine*. 2009; 66(4):251-255
- 16 1610 Smith AB, Bernstein DI, Aw TC, Gallagher JS, London M, Kopp S et al. Occupational  
17 asthma from inhaled egg protein. *American Journal of Industrial Medicine*. 1987;  
18 12(2):205-218
- 19 1611 Smith AD, Cowan JO, Brassett KP, Herbison GP, Taylor DR. Use of exhaled nitric oxide  
20 measurements to guide treatment in chronic asthma. *New England Journal of  
21 Medicine*. 2005; 352(21):2163-2173
- 22 1612 Smith AD, Cowan JO, Brassett KP, Filsell S, McLachlan C, Monti-Sheehan G et al.  
23 Exhaled nitric oxide: a predictor of steroid response. *American Journal of Respiratory  
24 and Critical Care Medicine*. 2005; 172(4):453-459
- 25 1613 Smith AD, Cowan JO, Filsell S, McLachlan C, Monti-Sheehan G, Jackson P et al.  
26 Diagnosing asthma: comparisons between exhaled nitric oxide measurements and  
27 conventional tests. *American Journal of Respiratory and Critical Care Medicine*. 2004;  
28 169(4):473-478
- 29 1614 Smith CM, Anderson SD. Inhalational challenge using hypertonic saline in asthmatic  
30 subjects: a comparison with responses to hyperpnoea, methacholine and water.  
31 *European Respiratory Journal*. 1990; 3(2):144-151
- 32 1615 Smith HE, Hogger C, Lallemand C, Crook D, Frew AJ. Is structured allergy history  
33 sufficient when assessing patients with asthma and rhinitis in general practice? *Journal  
34 of Allergy and Clinical Immunology*. 2009; 123(3):646-650
- 35 1616 Snider GL. Distinguishing among asthma, chronic bronchitis, and emphysema. *Chest*.  
36 1985; 87(1 Suppl):35S-39S
- 37 1617 Snijders BEP, Thijs C, Dagnelie PC, Stelma FF, Mommers M, Kummeling I et al. Breast-  
38 feeding duration and infant atopic manifestations, by maternal allergic status, in the  
39 first 2 years of life (KOALA study). *Journal of Pediatrics*. 2007; 151(4):347-2

- 1 1618 Sobol BJ. Response to bronchodilator in the asthmatic: An alternative method of  
2 analysis. *Annals of Allergy*. 1985; 55(2):114-115
- 3 1619 Sockrider MM, Tortolero SR, Bartholomew LK, Markham CM, Abramson SL, Fernandez  
4 M et al. Pilot study of a screening questionnaire for asthma. *Pediatric Asthma, Allergy  
5 and Immunology*. 2001; 15(1):15-24
- 6 1620 Solomon C, Poole J, Jarup L, Palmer K, Coggon D. Cardio-respiratory morbidity and  
7 long-term exposure to particulate air pollution. *International Journal of Environmental  
8 Health Research*. 2003; 13(4):327-335
- 9 1621 Sonnappa S, Bastardo CM, Saglani S, Bush A, Aurora P. Relationship between past  
10 airway pathology and current lung function in preschool wheezers. *European  
11 Respiratory Journal*. 2011; 38(6):1431-1436
- 12 1622 Sonnappa S, Bastardo CM, Wade A, Saglani S, McKenzie SA, Bush A et al. Symptom-  
13 pattern phenotype and pulmonary function in preschool wheezers. *Journal of Allergy  
14 and Clinical Immunology*. 2010; 126(3):519-7
- 15 1623 Sonnenschein-van der Voort AMM, Jaddoe VWV, van der Valk RJP, Willemsen SP,  
16 Hofman A, Moll HA et al. Duration and exclusiveness of breastfeeding and childhood  
17 asthma-related symptoms. *European Respiratory Journal*. 2012; 39(1):81-89
- 18 1624 Sonnenschein-van der Voort A, Jaddoe VWV, Raat H, Moll HA, Hofman A, de Jongste JC  
19 et al. Fetal and infant growth and asthma symptoms in preschool children: the  
20 Generation R Study. *American Journal of Respiratory and Critical Care Medicine*. 2012;  
21 185(7):731-737
- 22 1625 Sont JK, Willems LN, Bel EH, van Krieken JH, Vandenbroucke JP, Sterk PJ. Clinical  
23 control and histopathologic outcome of asthma when using airway  
24 hyperresponsiveness as an additional guide to long-term treatment. The AMPUL Study  
25 Group. *American Journal of Respiratory and Critical Care Medicine*. 1999; 159(4 Pt  
26 1):1043-1051
- 27 1626 Sordillo JE, Webb T, Kwan D, Kamel J, Hoffman E, Milton DK et al. Allergen exposure  
28 modifies the relation of sensitization to fraction of exhaled nitric oxide levels in  
29 children at risk for allergy and asthma. *Journal of Allergy and Clinical Immunology*.  
30 2011; 127(5):1165-1172
- 31 1627 Soriano JB, Anto JM, Sunyer J, Tobias A, Kogevinas M, Almar E et al. Risk of asthma in  
32 the general Spanish population attributable to specific immunoresponse. Spanish  
33 Group of the European Community Respiratory Health Survey. *International Journal of  
34 Epidemiology*. 1999; 28(4):728-734
- 35 1628 Soriano JB, Anto JM, Sunyer J, Tobias A, Kogevinas M, Almar E et al. Risk of asthma in  
36 the general Spanish population attributable to specific immunoresponse. *International  
37 Journal of Epidemiology*. 1999; 28(4):728-734
- 38 1629 Soriano JB, Rabe KF, Vermeire PA. Predictors of poor asthma control in European  
39 adults. *Journal of Asthma*. 2003; 40(7):803-813

- 1 1630 Sotir M, Yeatts K, Miller W, Shy C. Comparison of asthma-related functional  
2 consequences and health care utilization among children with and without upper  
3 respiratory infection-triggered wheezing. *Journal of Asthma*. 2006; 43(8):629-632
- 4 1631 Soto-Ramirez N, Ziyab AH, Karmaus W, Zhang H, Kurukulaaratchy RJ, Ewart S et al.  
5 Epidemiologic methods of assessing asthma and wheezing episodes in longitudinal  
6 studies: measures of change and stability. *Journal of Epidemiology*. 2013; 23(6):399-  
7 410
- 8 1632 Soto-Ramos M, Castro-Rodriguez JA, Hinojos-Gallardo LC, Hernandez-Saldana R,  
9 Cisneros-Castolo M, Carrillo-Rodriguez V. Fractional exhaled nitric oxide has a good  
10 correlation with asthma control and lung function in latino children with asthma.  
11 *Journal of Asthma*. 2013; 50(6):590-594
- 12 1633 Souma R, Watanabe H, Wakayama T, Ochiai A, Sagara H. Comprehensive evaluation of  
13 coughing, transforming growth factor-beta, interleukin- 13, interleukin-8, and airway  
14 reversibility can facilitate the differential diagnosis of asthma. *Allergy*. 2011; 66:579
- 15 1634 Sovijarvi AR. Flow-volume response to inhaled methacholine in asthmatics;  
16 comparison of area under the curve (AFV) with conventional parameters. *European*  
17 *Journal of Respiratory Diseases Supplement*. 1986; 143:18-21
- 18 1635 Spallarossa D, Sacco O, Girosi D, Rossi GA. Blood eosinophil counts and arterial oxygen  
19 tension in acute asthma. *Archives of Disease in Childhood*. 1995; 73(4):333-337
- 20 1636 Spallarossa D, Battistini E, Silvestri M, Sabatini F, Fregonese L, Brazzola G et al. Steroid-  
21 naive adolescents with mild intermittent allergic asthma have airway  
22 hyperresponsiveness and elevated exhaled nitric oxide levels. *Journal of Asthma*. 2003;  
23 40(3):301-310
- 24 1637 Spector SL, Tan RA. Is a single blood eosinophil count a reliable marker for  
25 "eosinophilic asthma?". *Journal of Asthma*. 2012; 49(8):807-810
- 26 1638 Spee-van der Wekke J, Meulmeester JF, Radder JJ, Verloove-Vanhorick SP. School  
27 absence and treatment in school children with respiratory symptoms in The  
28 Netherlands: data from the Child Health Monitoring System. *Journal of Epidemiology*  
29 *and Community Health*. 1998; 52(6):359-363
- 30 1639 Spencer M, Briggs AH, Grossman RF, Rance L. Development of an economic model to  
31 assess the cost effectiveness of treatment interventions for chronic obstructive  
32 pulmonary disease. *Pharmacoeconomics*. 2005; 23(6):619-637
- 33 1640 Spiering BA, Judelson DA, Rundell KW. An evaluation of standardizing target  
34 ventilation for eucapnic voluntary hyperventilation using FEV1. *Journal of Asthma*.  
35 2004; 41(7):745-749
- 36 1641 Spiropoulos K, Stevens J, Eigen H, Spiropoulos A. Specificity and sensitivity of  
37 methacholine challenge test in children with normal and hyperreactive airways. *Acta*  
38 *Paediatrica Scandinavica*. 1986; 75(5):737-743
- 39 1642 Spitale N, Popat N, Mclvor A. Update on exhaled nitric oxide in pulmonary disease.  
40 *Expert Review of Respiratory Medicine*. 2012; 6(1):105-115

- 1 1643 Sposato B, Mariotta S, Ricci A. When should a reversibility test be performed on  
2 patients with early stages of asthma and normal spirometry? *Journal of Asthma*. 2008;  
3 45(6):479-483
- 4 1644 Sposato B, Scalese M, Migliorini MG, Di Tomassi M, Scala R. Small airway impairment  
5 and bronchial hyperresponsiveness in asthma onset. *Allergy, Asthma and Immunology*  
6 *Research*. 2014; 6(3):242-251
- 7 1645 Springer C, Godfrey S, Picard E, Uwyedy K, Rotschild M, Hananya S et al. Efficacy and  
8 safety of methacholine bronchial challenge performed by auscultation in young  
9 asthmatic children. *American Journal of Respiratory and Critical Care Medicine*. 2000;  
10 162(3 Pt 1):857-860
- 11 1646 Spycher BD, Silverman M, Brooke AM, Minder CE, Kuehni CE. Distinguishing  
12 phenotypes of childhood wheeze and cough using latent class analysis. *European*  
13 *Respiratory Journal*. 2008; 31(5):974-981
- 14 1647 Spycher BD, Henderson J, Granell R, Evans DM, Smith GD, Timpson NJ et al. Genome-  
15 wide prediction of childhood asthma and related phenotypes in a longitudinal birth  
16 cohort. *Journal of Allergy and Clinical Immunology*. 2012; 130(2):503-509
- 17 1648 Spycher BD, Silverman M, Egger M, Zwahlen M, Kuehni CE. Routine vaccination against  
18 pertussis and the risk of childhood asthma: a population-based cohort study.  
19 *Pediatrics*. 2009; 123(3):944-950
- 20 1649 Sritipsukho P. Aeroallergen sensitivity among Thai children with allergic respiratory  
21 diseases: a hospital-based study. *Asian Pacific Journal of Allergy and Immunology*.  
22 2004; 22(2-3):91-95
- 23 1650 Stafanger G, Kock AJ, Koch C. Specific diagnosis of exogenous bronchial asthma in  
24 children. *Allergy*. 1986; 41(2):110-117
- 25 1651 Stahl MC, Arora R, Tucker M, Johnson T, Calabria C. A prospective evaluation of the  
26 fraction of exhaled nitric oxide and the subsequent diagnosis of asthma in military  
27 basic trainees. *Annals of Allergy, Asthma and Immunology*. 2009; 103(5 SUPPL. 3):A72
- 28 1652 Stahlman JE, Alghamdi K, Salmun LM, Borrás IM, Bailey E, Schneider LC. Adherence  
29 with a hand-held electronic device versus conventional peak expiratory flow rate  
30 monitoring in children with asthma. *Pediatric Asthma, Allergy and Immunology*. 2006;  
31 19(2):118-125
- 32 1653 Staikuniene J, Vaitkus S, Japertiene LM, Ryskiene S. Association of chronic  
33 rhinosinusitis with nasal polyps and asthma: clinical and radiological features, allergy  
34 and inflammation markers. *Medicina*. 2008; 44(4):257-265
- 35 1654 Stein RT, Holberg CJ, Morgan WJ, Wright AL, Lombardi E, Taussig L et al. Peak flow  
36 variability, methacholine responsiveness and atopy as markers for detecting different  
37 wheezing phenotypes in childhood. *Thorax*. 1997; 52(11):946-952
- 38 1655 Stelmach I, Jerzynska J, Stelmach W, Majak P, Chew G, Gorski P et al. Cockroach allergy  
39 and exposure to cockroach allergen in Polish children with asthma. *Allergy*. 2002;  
40 57(8):701-705

- 1 1656 Stenius BS, Lemola M. Hypersensitivity to acetylsalicylic acid (ASA) and tartrazine in  
2 patients with asthma. *Clinical Allergy*. 1976; 6(2):119-129
- 3 1657 Stenton SC, Beach JR, Avery AJ, Hendrick DJ. The value of questionnaires and  
4 spirometry in asthma surveillance programmes in the workplace. *Occupational*  
5 *Medicine*. 1993; 43(4):203-206
- 6 1658 Stern DA, Morgan WJ, Halonen M, Wright AL, Martinez FD. Wheezing and bronchial  
7 hyper-responsiveness in early childhood as predictors of newly diagnosed asthma in  
8 early adulthood: a longitudinal birth-cohort study. *Lancet*. 2008; 372(9643):1058-1064
- 9 1659 Stevens W, Addo-Yobo E, Roper J, Woodcock A, James H, Platts-Mills T et al.  
10 Differences in both prevalence and titre of specific immunoglobulin E among children  
11 with asthma in affluent and poor communities within a large town in Ghana. *Clinical*  
12 *and Experimental Allergy*. 2011; 41(11):1587-1594
- 13 1660 Stevens WJ, van Schil L, Vermeire PA. Discriminatory role of history, skin testing and  
14 radio-allergo-sorbent test (RAST) in type I-mediated respiratory disease. *Allergologia Et*  
15 *Immunopathologia*. 1983; 11(4):243-249
- 16 1661 Stickland MK, Rowe BH, Spooner CH, Vandermeer B, Dryden DM. Accuracy of eucapnic  
17 hyperpnea or mannitol to diagnose exercise-induced bronchoconstriction: a  
18 systematic review. *Annals of Allergy, Asthma and Immunology*. 2011; 107(3):229-234
- 19 1662 Stingone JA, Claudio L. Disparities in allergy testing and health outcomes among urban  
20 children with asthma. *Journal of Allergy and Clinical Immunology*. 2008; 122(4):748-  
21 753
- 22 1663 Stingone JA, Ramirez OF, Svensson K, Claudio L. Prevalence, demographics, and health  
23 outcomes of comorbid asthma and overweight in urban children. *Journal of Asthma*.  
24 2011; 48(9):876-885
- 25 1664 Stoddard JJ, Miller T. Impact of parental smoking on the prevalence of wheezing  
26 respiratory illness in children. *American Journal of Epidemiology*. 1995; 141(2):96-102
- 27 1665 Stokes JR, Hartel R, Ford LB, Casale TB. Cannabis (hemp) positive skin tests and  
28 respiratory symptoms. *Annals of Allergy, Asthma and Immunology*. 2000; 85(3):238-  
29 240
- 30 1666 Storms WW. Exercise-induced asthma: Making the diagnosis. *Journal of Respiratory*  
31 *Diseases*. 2000; 21(8):491-494
- 32 1667 Stout JW, Smith K, Zhou C, Solomon C, Dozor AJ, Garrison MM et al. Learning from a  
33 distance: effectiveness of online spirometry training in improving asthma care.  
34 *Academic Pediatrics*. 2012; 12(2):88-95
- 35 1668 Strachan DP. Wheezing presenting in general practice. *Archives of Disease in*  
36 *Childhood*. 1985; 60(5):457-460
- 37 1669 Strachan DP, Anderson HR, Bland JM, Peckham C. Asthma as a link between chest  
38 illness in childhood and chronic cough and phlegm in young adults. *BMJ*. 1988;  
39 296(6626):890-893

- 1 1670 Strachan DP, Anderson HR, Limb ES, O'Neill A, Wells N. A national survey of asthma  
2 prevalence, severity, and treatment in Great Britain. *Archives of Disease in Childhood*.  
3 1994; 70(3):174-178
- 4 1671 Strachan DP, Butland BK, Anderson HR. Incidence and prognosis of asthma and  
5 wheezing illness from early childhood to age 33 in a national British cohort. *BMJ*. 1996;  
6 312(7040):1195-1199
- 7 1672 Strachan DP, Griffiths JM, Johnston ID, Anderson HR. Ventilatory function in British  
8 adults after asthma or wheezing illness at ages 0-35. *American Journal of Respiratory  
9 and Critical Care Medicine*. 1996; 154(6 Pt 1):1629-1635
- 10 1673 Strandbygaard U, Thomsen SF, Backer V. A daily SMS reminder increases adherence to  
11 asthma treatment: a three-month follow-up study. *Respiratory Medicine*. 2010;  
12 104(2):166-171
- 13 1674 Strunk RC, Sternberg AL, Bacharier LB, Szefer SJ. Nocturnal awakening caused by  
14 asthma in children with mild-to-moderate asthma in the childhood asthma  
15 management program. *Journal of Allergy and Clinical Immunology*. 2002; 110(3):395-  
16 403
- 17 1675 Strunk RC, Szefer SJ, Phillips BR, Zeiger RS, Chinchilli VM, Larsen G et al. Relationship  
18 of exhaled nitric oxide to clinical and inflammatory markers of persistent asthma in  
19 children. *Journal of Allergy and Clinical Immunology*. 2003; 112(5):883-892
- 20 1676 Suarathana E, Vergouwe Y, Moons KG, de Monchy J, Grobbee D, Heederik D et al. A  
21 diagnostic model for the detection of sensitization to wheat allergens was developed  
22 and validated in bakery workers. *Journal of Clinical Epidemiology*. 2010; 63(9):1011-  
23 1019
- 24 1677 Subira ML, Oehling A, Crisci CD, Martin-Gil D. Evaluation of total IgE in diverse  
25 allergosis. Comparative study with other techniques. Part II. *Allergologia Et  
26 Immunopathologia*. 1976; 4(1):51-66
- 27 1678 Suetsugu S, Sakakibara H, Ishikawa H. A study on aspirin-induced asthma - its clinical  
28 feature and diagnosis. *Japanese Journal of Medicine*. 1981; 20(4):No
- 29 1679 Suman LG, Vijaya L, V, Surekha RH, Murthy KJR. Use of specific IgE to fractions of  
30 Gynandropsis gynandra pollen in in vitro diagnostic test. *Indian Journal of Clinical  
31 Biochemistry*. 2005; 20(2):170-173
- 32 1680 Sun Y, Sundell J. On associations between housing characteristics, dampness and  
33 asthma and allergies among children in Northeast Texas. *Indoor and Built  
34 Environment*. 2013; 22(4):678-684
- 35 1681 Sun Y, Sundell J. Life style and home environment are associated with racial disparities  
36 of asthma and allergy in Northeast Texas children. *Science of the Total Environment*.  
37 2011; 409(20):4229-4234
- 38 1682 Sunyer J, Anto JM, Castellsague J, Soriano JB, Roca J. Total serum IgE is associated with  
39 asthma independently of specific IgE levels. The Spanish Group of the European Study  
40 of Asthma. *European Respiratory Journal*. 1996; 9(9):1880-1884

- 1 1683 Sunyer J, Jarvis D, Pekkanen J, Chinn S, Janson C, Leynaert B et al. Geographic  
2 variations in the effect of atopy on asthma in the European Community Respiratory  
3 Health Study. *Journal of Allergy and Clinical Immunology*. 2004; 114(5):1033-1039
- 4 1684 Surange N, Hoyle J. Occupational asthma; Is this the cause of excess respiratory  
5 symptoms and COPD described in bitumen exposed workers? *Thorax*. 2011; 66:A5-A6
- 6 1685 Sutherland TJT, Taylor DR, Sears MR, Cowan JO, McLachlan CR, Filsell S et al.  
7 Association between exhaled nitric oxide and systemic inflammatory markers. *Annals of  
8 Allergy, Asthma and Immunology*. 2007; 99(6):534-539
- 9 1686 Sverrild A, Malinowski A, Porsbjerg C, Backer V, Alving K. Predicting airway  
10 hyperreactivity to mannitol using exhaled nitric oxide in an unselected sample of  
11 adolescents and young adults. *Respiratory Medicine*. 2013; 107(1):150-152
- 12 1687 Sverrild A, Porsbjerg C, Backer V. The use of inhaled mannitol in the diagnosis and  
13 management of asthma. *Expert Opinion on Pharmacotherapy*. 2012; 13(1):115-123
- 14 1688 Sverrild A, Porsbjerg C, Thomsen SF, Backer V. Airway hyperresponsiveness to  
15 mannitol and methacholine and exhaled nitric oxide: a random-sample population  
16 study. *Journal of Allergy and Clinical Immunology*. 2010; 126(5):952-958
- 17 1689 Sverrild A, Porsbjerg C, Thomsen SF, Backer V. Diagnostic properties of inhaled  
18 mannitol in the diagnosis of asthma: a population study. *Journal of Allergy and Clinical  
19 Immunology*. 2009; 124(5):928-932
- 20 1690 Syk J, Malinowski A, Johansson G, Undén A-L, Alving K. Improved asthma outcomes  
21 with FENO-guided anti-inflammatory treatment: A randomised controlled trial. 6th  
22 IPCRG World Conference, April 25-28, Edinburgh. 2012;Abstract
- 23 1691 Syk J, Malinowski A, Johansson G, Undén A-L, Alving K. Lower incidence of asthma  
24 exacerbations with FENO-guided anti-inflammatory treatment: A randomised  
25 controlled trial [Abstract]. *European Respiratory Journal*. 2012; 40(Suppl 56):797s
- 26 1692 Syk J, Malinowski A, Johansson G, Undén A-L, Andreasson A, Lekander M et al. Anti-  
27 inflammatory treatment of atopic asthma guided by exhaled nitric oxide: A  
28 randomized, controlled trial. *Journal of Allergy and Clinical Immunology: In Practice*.  
29 2013; 1(6):639-648
- 30 1693 Szeffler SJ, Mitchell H, Sorkness CA, Gergen PJ, O'Connor GT, Morgan WJ et al.  
31 Management of asthma based on exhaled nitric oxide in addition to guideline-based  
32 treatment for inner-city adolescents and young adults: a randomised controlled trial.  
33 *Lancet*. 2008; 372(9643):1065-1072
- 34 1694 Tagaya E, Tamaoki J, Nagai A, Murasugi H, Igi H. The role of a self-management  
35 program in the control of mild to moderate asthma: A randomized controlled study.  
36 *Allergology International*. 2005; 54(4):527-531
- 37 1695 Tagiyeva N, Devereux G, Semple S, Sherriff A, Henderson J, Elias P et al. Parental  
38 occupation is a risk factor for childhood wheeze and asthma. *European Respiratory  
39 Journal*. 2010; 35(5):987-993



- 1 1696 Tai A, Volkmer R, Burton A. Association between asthma symptoms and obesity in  
2 preschool (4-5 year old) children. *Journal of Asthma*. 2009; 46(4):362-365
- 3 1697 Taitel M, Jiang JZ, Rudkin K. Impact of pharmacist-call intervention program on new-  
4 to-therapy patients' medication adherence. *Value in Health.: Elsevier Ltd*. 2014;  
5 17(3):A138-A139
- 6 1698 Taji B, Dolatabadi M, Fereidouni M. Determination of PEF and FEV1 normal volumes  
7 and assessment of portable digital peak flow meter in diagnosis of asthma in  
8 elementary school students of birjand city. *Iranian Journal of Allergy, Asthma and  
9 Immunology*. 2013; 12(1):S103-S104
- 10 1699 Takami S, Mochizuki H, Muramatsu R, Hagiwara S, Arakawa H. Relationship between  
11 bronchial hyperresponsiveness and lung function in children age 5 and 6 with and  
12 without asthma. *Respirology*. 2013; 18(4):682-687
- 13 1700 Takenoue Y, Kaneko T, Miyamae T, Mori M, Yokota S. Influence of outdoor NO2  
14 exposure on asthma in childhood: meta-analysis. *Pediatrics International*. 2012;  
15 54(6):762-769
- 16 1701 Tal A, Pasterkamp H, Serrette C, Leahy F, Chernick V. Response to cold air  
17 hyperventilation in normal and in asthmatic children. *Journal of Pediatrics*. 1984;  
18 104(4):516-521
- 19 1702 Talini D, Benvenuti A, Carrara M, Vagheti E, Martin LB, Paggiaro PL. Diagnosis of flour-  
20 induced occupational asthma in a cross-sectional study. *Respiratory Medicine*. 2002;  
21 96(4):236-243
- 22 1703 Tamasi L, Bohacs A, Bikov A, Andorka C, Rigo JJ, Losonczy G et al. Exhaled nitric oxide  
23 in pregnant healthy and asthmatic women. *Journal of Asthma*. 2009; 46(8):786-791
- 24 1704 Tamura G, Satoh K, Chao C-L, Inoue H, Takishima T. Do diagnostic procedures other  
25 than inhalation challenge predict immediate bronchial responses to inhaled allergen?  
26 *Clinical and Experimental Allergy*. 1991; 21(4):497-502
- 27 1705 Tan WC, Bourbeau J, Hernandez P, Chapman KR, Cowie R, FitzGerald JM et al.  
28 Bronchodilator responsiveness and reported respiratory symptoms in an adult  
29 population. *PLoS One*. 2013; 8(3):e58932
- 30 1706 Tang H, Fang Z, Sun Y, Li B, Shi Z, Chen J et al. YKL-40 in asthmatic patients, and its  
31 correlations with exacerbation, eosinophils and immunoglobulin E. *European  
32 Respiratory Journal*. 2010; 35(4):757-760
- 33 1707 Tang RB, Wu KK. Total serum IgE, allergy skin testing, and the radioallergosorbent test  
34 for the diagnosis of allergy in asthmatic children. *Annals of Allergy*. 1989; 62(5):432-  
35 435
- 36 1708 Tapp S, Lasserson TJ, Rowe BH. Education interventions for adults who attend the  
37 emergency room for acute asthma. *Cochrane Database of Systematic Reviews*. 2007;  
38 Issue 3:CD003000. DOI:10.1002/14651858.CD003000.pub2
- 39 1709 Tarlo SM, Broder I. Outcome of assessments for occupational asthma. *Chest*. 1991;  
40 100(2):329-335

- 1 1710 Tarlo SM, Leung K, Broder I, Silverman F, Holness DL. Asthmatic subjects  
2 symptomatically worse at work: prevalence and characterization among a general  
3 asthma clinic population. *Chest*. 2000; 118(5):1309-1314
- 4 1711 Tarlo SM, Balmes J, Balkissoon R, Beach J, Beckett W, Bernstein D et al. Diagnosis and  
5 management of work-related asthma: American College Of Chest Physicians  
6 Consensus Statement. *Chest*. 2008; 134(3 Suppl):1S-41S
- 7 1712 Tarlo SM, Liss GM, Blanc PD. How to diagnose and treat work-related asthma: key  
8 messages for clinical practice from the American college of chest physicians consensus  
9 statement. *Polskie Archiwum Medycyny Wewnetrznej*. 2009; 119(10):660-666
- 10 1713 Taskinen T, Meklin T, Nousiainen M, Husman T, Nevalainen A, Korppi M. Moisture and  
11 mould problems in schools and respiratory manifestations in schoolchildren: clinical  
12 and skin test findings. *Acta Paediatrica*. 1997; 86(11):1181-1187
- 13 1714 Tauber E, Halmerbauer G, Frischer T, Gartner C, Horak FJ, Veiter A et al. Urinary  
14 eosinophil protein X in children: the relationship to asthma and atopy and normal  
15 values. *Allergy*. 2000; 55(7):647-652
- 16 1715 Taussig LM, Wright AL, Holberg CJ, Halonen M, Morgan WJ, Martinez FD. Tucson  
17 Children's Respiratory Study: 1980 to present. *Journal of Allergy and Clinical  
18 Immunology*. 2003; 111(4):661-676
- 19 1716 Taveras EM, Camargo CAJ, Rifas-Shiman SL, Oken E, Gold DR, Weiss ST et al.  
20 Association of birth weight with asthma-related outcomes at age 2 years. *Pediatric  
21 Pulmonology*. 2006; 41(7):643-648
- 22 1717 Taylor B, Wadsworth J, Golding J, Butler N. Breast feeding, eczema, asthma, and  
23 hayfever. *Journal of Epidemiology and Community Health*. 1983; 37(2):95-99
- 24 1718 Taylor DR, Cowan JO, Greene JM, Willan AR, Sears MR. Asthma in remission: can  
25 relapse in early adulthood be predicted at 18 years of age? *Chest*. 2005; 127(3):845-  
26 850
- 27 1719 Tee RD, Cullinan P, Welch J, Burge PS, Newman-Taylor AJ. Specific IgE to isocyanates: a  
28 useful diagnostic role in occupational asthma. *Journal of Allergy and Clinical  
29 Immunology*. 1998; 101(5):709-715
- 30 1720 Teeter JG. Use of pulmonary function tests in the diagnosis and management of  
31 asthma. *Clinical Pulmonary Medicine*. 1999; 6(4):211-217
- 32 1721 Terada A, Fujisawa T, Togashi K, Miyazaki T, Katsumata H, Atsuta J et al. Exhaled nitric  
33 oxide decreases during exercise-induced bronchoconstriction in children with asthma.  
34 *American Journal of Respiratory and Critical Care Medicine*. 2001; 164(10 Pt 1):1879-  
35 1884
- 36 1722 Terblanche E, Stewart RI. The prevalence of exercise-induced bronchoconstriction in  
37 Cape Town schoolchildren. *South African Medical Journal*. 1990; 78(12):744-747
- 38 1723 Ternesten-Hasseus E, Farbroth A, Lowhagen O, Millqvist E. Sensitivity to methacholine  
39 and capsaicin in patients with unclear respiratory symptoms. *Allergy*. 2002; 57(6):501-  
40 507

- 1 1724 Ternesten-Hasseus E, Johansson EL, Bende M, Millqvist E. Dyspnea from exercise in  
2 cold air is not always asthma. *Journal of Asthma*. 2008; 45(8):705-709
- 3 1725 Terzioglu E, Sin A, Kokuludag A, Kirmaz C, Erdem N, Sebik F et al. Sensitivity to  
4 Parietaria pollen in Izmir, Turkey as determined by skin prick and serum specific IgE  
5 values. *Journal of Investigational Allergology and Clinical Immunology*. 1998; 8(3):180-  
6 183
- 7 1726 Thiadens HA, De Bock GH, Dekker FW, Huysman JA, Van Houwelingen JC, Springer MP  
8 et al. Identifying asthma and chronic obstructive pulmonary disease in patients with  
9 persistent cough presenting to general practitioners: descriptive study. *BMJ*. 1998;  
10 316(7140):1286-1290
- 11 1727 Thiadens HA, De Bock GH, Dekker FW, Huysman JA, Van Houwelingen JC, Springer MP  
12 et al. Value of measuring diurnal peak flow variability in the recognition of asthma: a  
13 study in general practice. *European Respiratory Journal*. 1998; 12(4):842-847
- 14 1728 Thiadens HA, De Bock GH, Van Houwelingen JC, Dekker FW, De Waal MW, Springer MP  
15 et al. Can peak expiratory flow measurements reliably identify the presence of airway  
16 obstruction and bronchodilator response as assessed by FEV(1) in primary care  
17 patients presenting with a persistent cough? *Thorax*. 1999; 54(12):1055-1060
- 18 1729 Thomas M, Gruffydd-Jones K, Stonham C, Ward S, Macfarlane TV. Assessing asthma  
19 control in routine clinical practice: use of the Royal College of Physicians '3 questions'.  
20 *Primary Care Respiratory Journal*. 2009; 18(2):83-88
- 21 1730 Thomas M, Murray-Thomas T, Fan T, Williams T, Taylor S. Prescribing patterns of  
22 asthma controller therapy for children in UK primary care: a cross-sectional  
23 observational study. *BMC Pulmonary Medicine*. 2010; 10:29
- 24 1731 Thomas PS, Gibson PG, Wang H, Shah S, Henry RL. The relationship of exhaled nitric  
25 oxide to airway inflammation and responsiveness in children. *Journal of Asthma*. 2005;  
26 42(4):291-295
- 27 1732 Thomson CD, Wickens K, Miller J, Ingham T, Lampshire P, Epton MJ et al. Selenium  
28 status and allergic disease in a cohort of New Zealand children. *Clinical and  
29 Experimental Allergy*. 2012; 42(4):560-567
- 30 1733 Thoonen BPA, Schermer TRJ, van Den Boom G, Molema J, Folgering H, Akkermans RP  
31 et al. Self-management of asthma in general practice, asthma control and quality of  
32 life: A randomised controlled trial. *Thorax*. 2003; 58(1):30-36
- 33 1734 Thorne PS, Kulhankova K, Yin M, Cohn R, Arbes SJJ, Zeldin DC. Endotoxin exposure is a  
34 risk factor for asthma: the national survey of endotoxin in United States housing.  
35 *American Journal of Respiratory and Critical Care Medicine*. 2005; 172(11):1371-1377
- 36 1735 Thurber LA, Kotses H, Zuber P, Evavold S, Harver A. Compliance with daily monitoring  
37 of asthma symptoms diary vs. electronic peak flow recordings [Abstract]. *Proceedings  
38 of the American Thoracic Society*. 2006;A599
- 39 1736 Tie ST, Wong JL, Beniyamin A, Ho A, Kannan SKK, Jamalul Azizi AR. Methacholine  
40 challenge test as an adjunctive investigative tool in patients with asthma-like  
41 symptoms: the Sabah experience. *Medical Journal of Malaysia*. 2012; 67(2):204-206

- 1 1737 Tilemann L, Gindner L, Meyer F, Szecsenyi J, Schneider A. Differences in local and  
2 systemic inflammatory markers in patients with obstructive airways disease. *Primary*  
3 *Care Respiratory Journal*. 2011; 20(4):407-414
- 4 1738 Timonen KL, Nielsen J, Schwartz J, Gotti A, Vondra V, Gratziou C et al. Chronic  
5 respiratory symptoms, skin test results, and lung function as predictors of peak flow  
6 variability. *American Journal of Respiratory and Critical Care Medicine*. 1997; 156(3 Pt  
7 1):776-782
- 8 1739 Timonen KL, Schwartz J, Nielsen J, Brunekreef B. Associations between markers of  
9 respiratory morbidity in European children. *European Respiratory Journal*. 2002;  
10 19(3):479-486
- 11 1740 Tinkelman DG, Price DB, Nordyke RJ, Halbert RJ, Isonaka S, Nonikov D et al. Symptom-  
12 based questionnaire for differentiating COPD and asthma. *Respiration*. 2006;  
13 73(3):296-305
- 14 1741 To T, Dell S, Tassoudji M, Wang C. Health outcomes in low-income children with  
15 current asthma in Canada. *Chronic Diseases in Canada*. 2009; 29(2):49-55
- 16 1742 To T, Stanojevic S, Moores G, Gershon AS, Bateman ED, Cruz AA et al. Global asthma  
17 prevalence in adults: findings from the cross-sectional world health survey. *BMC Public*  
18 *Health*. 2012; 12:204
- 19 1743 To T, Vydykhan TN, Dell S, Tassoudji M, Harris JK. Is obesity associated with asthma in  
20 young children? *Journal of Pediatrics*. 2004; 144(2):162-168
- 21 1744 Toda R, Hoshino T, Kawayama T, Imaoka H, Sakazaki Y, Tsuda T et al. Validation of  
22 "lung age" measured by spirometry and handy electronic FEV1/FEV6 meter in  
23 pulmonary diseases. *Internal Medicine*. 2009; 48(7):513-521
- 24 1745 Todd DC, Davis BE, Hurst TS, Cockcroft DW. Dosimeter methacholine challenge:  
25 comparison of maximal versus submaximal inhalations. *Journal of Allergy and Clinical*  
26 *Immunology*. 2004; 114(3):517-519
- 27 1746 Toelle BG, Peat JK, Salome CM, Mellis CM, Woolcock AJ. Toward a definition of asthma  
28 for epidemiology. *American Review of Respiratory Disease*. 1992; 146(3):633-637
- 29 1747 Toelle B, Ram Felix SF. Written individualised management plans for asthma in  
30 children and adults. *Cochrane Database of Systematic Reviews*. 2011; Issue  
31 7:CD002171. DOI:10.1002/14651858.CD002171.pub3
- 32 1748 Tokuyama K, Shigeta M, Maeda S, Takei K, Hoshino M, Morikawa A. Diurnal variation  
33 of peak expiratory flow in children with cough variant asthma. *Journal of Asthma*.  
34 1998; 35(2):225-229
- 35 1749 Tollerud DJ, O'Connor GT, Sparrow D, Weiss ST. Asthma, hay fever, and phlegm  
36 production associated with distinct patterns of allergy skin test reactivity, eosinophilia,  
37 and serum IgE levels. *The Normative Aging Study*. *American Review of Respiratory*  
38 *Disease*. 1991; 144(4):776-781

- 1 1750 Tolppanen AM, Sayers A, Granell R, Fraser WD, Henderson J, Lawlor DA. Prospective  
2 association of 25-hydroxyvitamin d3 and d2 with childhood lung function, asthma,  
3 wheezing, and flexural dermatitis. *Epidemiology*. 2013; 24(2):310-319
- 4 1751 Tomasiak-Lozowska MM, Zietkowski Z, Przeslaw K, Tomasiak M, Skiepkowski R, Bodzenta-  
5 Lukaszuk A. Inflammatory markers and acid-base equilibrium in exhaled breath  
6 condensate of stable and unstable asthma patients. *International Archives of Allergy  
7 and Immunology*. 2012; 159(2):121-129
- 8 1752 Tomassen P, Jarvis D, Newson R, van Ree R, Forsberg B, Howarth P et al.  
9 *Staphylococcus aureus* enterotoxin-specific IgE is associated with asthma in the  
10 general population: a GA(2)LEN study. *Allergy*. 2013; 68(10):1289-1297
- 11 1753 Tomita K, Sano H, Chiba Y, Sato R, Sano A, Nishiyama O et al. A scoring algorithm for  
12 predicting the presence of adult asthma: a prospective derivation study. *Primary Care  
13 Respiratory Journal*. 2013; 22(1):51-58
- 14 1754 Toop LJ. Active approach to recognising asthma in general practice. *BMJ*. 1985;  
15 290(6482):1629-1631
- 16 1755 Toren K, Brisman J, Jarvholm B. Asthma and asthma-like symptoms in adults assessed  
17 by questionnaires. A literature review. *Chest*. 1993; 104(2):600-608
- 18 1756 Torrent M, Sunyer J, Munoz L, Cullinan P, Iturriaga MV, Figueroa C et al. Early-life  
19 domestic aeroallergen exposure and IgE sensitization at age 4 years. *Journal of Allergy  
20 and Clinical Immunology*. 2006; 118(3):742-748
- 21 1757 Torrent M, Sunyer J, Garcia R, Harris J, Iturriaga MV, Puig C et al. Early-life allergen  
22 exposure and atopy, asthma, and wheeze up to 6 years of age. *American Journal of  
23 Respiratory and Critical Care Medicine*. 2007; 176(5):446-453
- 24 1758 Torres Da CJ, Ferreira JA, Castro E, Vaz M, Barros H, Agostinho MJ et al. Occupational  
25 asthma in the cotton textile industry: Assessment by bronchial hyperreactivity and  
26 peak expiratory flow recording. *Revista Portuguesa De Pneumologia*. 2002; 8(2):115-  
27 129
- 28 1759 Torres-Rodriguez JM, Pulido-Marrero Z, Vera-Garcia Y. Respiratory allergy to fungi in  
29 Barcelona, Spain: clinical aspects, diagnosis and specific treatment in a general allergy  
30 unit. *Allergologia Et Immunopathologia*. 2012; 40(5):295-300
- 31 1760 Toungossova O, Foschino Barbaro MP, Esposito LM, Carpagnano GE, Salerno FG, Dal  
32 Negro RW et al. Brittle asthma. *Monaldi Archives for Chest Disease - Pulmonary Series*.  
33 2007; 67(2):102-105
- 34 1761 Townley RG, Hopp RJ, Bewtra AK, Nair NM. Predictive value of airway reactivity.  
35 *Journal of Allergy and Clinical Immunology*. 1990; 86(4 Pt 2):650-652
- 36 1762 Townley RG, Ryo UY, Kolotkin BM, Kang B. Bronchial sensitivity to methacholine in  
37 current and former asthmatic and allergic rhinitis patients and control subjects.  
38 *Journal of Allergy and Clinical Immunology*. 1975; 56(6):429-442
- 39 1763 Tran N, Coffman JM, Sumino K, Cabana MD. Patient reminder systems and asthma  
40 medication adherence: a systematic review. *Journal of Asthma*. 2014; 51(54):536-543

- 1 1764 Travers J, Marsh S, Aldington S, Williams M, Shirtcliffe P, Pritchard A et al. Reference  
2 ranges for exhaled nitric oxide derived from a random community survey of adults.  
3 American Journal of Respiratory and Critical Care Medicine. 2007; 176(3):238-242
- 4 1765 TreeAge Software Inc. TreeAge Pro 2009. 2009. Available from:  
5 <http://www.treeage.com>. [Last accessed: 24 November 2014]
- 6 1766 Troise C, Voltolini S, Delbono G, Negrini AC. Allergy to pollens from Betulaceae and  
7 Corylaceae in a Mediterranean area (Genoa, Italy)--a ten-year retrospective study.  
8 Journal of Investigational Allergology and Clinical Immunology. 1992; 2(6):313-317
- 9 1767 Tromp IIM, Kiefte-de Jong JC, de Vries JH, Jaddoe VWV, Raat H, Hofman A et al. Dietary  
10 patterns and respiratory symptoms in pre-school children: the Generation R Study.  
11 European Respiratory Journal. 2012; 40(3):681-689
- 12 1768 Tschopp JM, Sistek D, Schindler C, Leuenberger P, Perruchoud AP, Wuthrich B et al.  
13 Current allergic asthma and rhinitis: diagnostic efficiency of three commonly used  
14 atopic markers (IgE, skin prick tests, and Phadiatop). Results from 8329 randomized  
15 adults from the SAPALDIA Study. Swiss Study on Air Pollution and Lung Diseases in  
16 Adults. Allergy. 1998; 53(6):608-613
- 17 1769 Tse M, Cooper C, Bridges-Webb C, Bauman A. Asthma in general practice.  
18 Opportunities for recognition and management. Australian Family Physician. 1993;  
19 22(5):736-741
- 20 1770 Tse SM, Gold DR, Sordillo JE, Hoffman EB, Gillman MW, Rifas-Shiman SL et al.  
21 Diagnostic accuracy of the bronchodilator response in children. Journal of Allergy and  
22 Clinical Immunology. 2013; 132(3):554
- 23 1771 Tsujino I, Nishimura M, Kamachi A, Makita H, Munakata M, Miyamoto K et al. Exhaled  
24 nitric oxide--is it really a good marker of airway inflammation in bronchial asthma?  
25 Respiration. 2000; 67(6):645-651
- 26 1772 Tsybulkina V, Kurmaeva N, Tsybulkin N, DuBuske L. Assessment of allergen  
27 sensitisation and bronchial reactivity in young patients with asthma. Allergy. 2011;  
28 66:347-348
- 29 1773 Tsybulkina V, Kurmaeva N, Tsybulkin N, DuBuske LM. Allergen sensitization and  
30 bronchial reactivity in young patients with atopic asthma. Annals of Allergy, Asthma and  
31 Immunology. 2012; 109:A59
- 32 1774 Tsybulkina V, Skorohodkina O, Luntsov A, Tsybulkin N, DuBuske L. Diagnostic value of  
33 exercise testing in young patients with atopic asthma [Abstract]. European Respiratory  
34 Society Annual Congress, Berlin, Germany, October 4-8. 2008;1097
- 35 1775 Tsybulkina V, Skorohodkina O, Luntsov N, Tsybulkin N, DuBuske LM. Assessment of  
36 bronchial reactivity in young patients with atopic asthma. Journal of Allergy and  
37 Clinical Immunology. 2009; 123(2 Suppl.1):S5
- 38 1776 Tu Y-L, Tsai H-J, Chang S-W, Cheng J-H, Huang J-L, Yao T-C. Reference values of total  
39 serum IgE and their significance in the diagnosis of allergy in Asian children: PATCH  
40 study. Allergy. 2013; 68:447

- 1 1777 Tuchinda M, Habananada S, Vareenil J, Srimaruta N, Piromrat K. Asthma in Thai  
2 children: a study of 2000 cases. *Annals of Allergy*. 1987; 59(3):207-211
- 3 1778 Tufvesson E, Aronsson D, Ankerst J, George SC, Bjermer L. Peripheral nitric oxide is  
4 increased in rhinitic patients with asthma compared to bronchial hyperresponsiveness.  
5 *Respiratory Medicine*. 2007; 101(11):2321-2326
- 6 1779 Turbyville J, Gada S, Payne K, Laubach S, Callahan CW, Nelson M. Posttussive emesis as  
7 a symptom of asthma in children. *Annals of Allergy, Asthma and Immunology*. 2011;  
8 106(2):140-145
- 9 1780 Turcotte H, Langdeau JB, Bowie DM, Boulet LP. Are questionnaires on respiratory  
10 symptoms reliable predictors of airway hyperresponsiveness in athletes and sedentary  
11 subjects? *Journal of Asthma*. 2003; 40(1):71-80
- 12 1781 Turgeon JP, St-Laurent-Gagnon T, Chabot G, Allard-Dansereau C, Gaudreault P,  
13 Thivierge RL et al. Teaching inhalation techniques to asthmatic children: A randomized  
14 clinical trial. *Ambulatory Child Health*. 1996; 1(3):205-213
- 15 1782 Turktas H, Oguzulgen K, Kokturk N, Memis L, Erbas D. Correlation of exhaled nitric  
16 oxide levels and airway inflammation markers in stable asthmatic patients. *Journal of  
17 Asthma*. 2003; 40(4):425-430
- 18 1783 Turner MO, Taylor D, Bennett R, Fitzgerald JM. A randomized trial comparing peak  
19 expiratory flow and symptom self-management plans for patients with asthma  
20 attending a primary care clinic. *American Journal of Respiratory and Critical Care  
21 Medicine*. 1998; 157(2):540-546
- 22 1784 Turner S, McNamee R, Roberts C, Bradshaw L, Curran A, Francis M et al. Agreement in  
23 diagnosing occupational asthma by occupational and respiratory physicians who  
24 report to surveillance schemes for work-related ill-health. *Occupational and  
25 Environmental Medicine*. 2010; 67(7):471-478
- 26 1785 Turner SW, Craig LCA, Harbour PJ, Forbes SH, McNeill G, Seaton A et al. Early rattles,  
27 purrs and whistles as predictors of later wheeze. *Archives of Disease in Childhood*.  
28 2008; 93(8):701-704
- 29 1786 Turner SW, Campbell D, Smith N, Craig LCA, McNeill G, Forbes SH et al. Associations  
30 between fetal size, maternal {alpha}-tocopherol and childhood asthma. *Thorax*. 2010;  
31 65(5):391-397
- 32 1787 Turner-Warwick M. Epidemiology of nocturnal asthma. *American Journal of Medicine*.  
33 1988; 85(1B):6-8
- 34 1788 Uasuf CG, Jatakanon A, James A, Kharitonov SA, Wilson NM, Barnes PJ. Exhaled carbon  
35 monoxide in childhood asthma. *Journal of Pediatrics*. 1999; 135(5):569-574
- 36 1789 Ulrik CS, Postma DS, Backer V. Recognition of asthma in adolescents and young adults:  
37 which objective measure is best? *Journal of Asthma*. 2005; 42(7):549-554
- 38 1790 Uysal MA, Mungan D, Yorgancioglu A, Yildiz F, Akgun M, Gemicioglu B et al. Asthma  
39 control test via text messaging: could it be a tool for evaluating asthma control?

- 1 Journal of Asthma. England: Informa Healthcare (52 Vanderbilt Ave., New York 10017,  
2 United States). 2013; 50(10):1083-1089
- 3 1791 Vagic D, Ferencic Z, Drvis P, Geber G, Dzidic S, Baudoin T et al. Local IgE and  
4 inflammation in chronic rhinosinusitis of asthmatics and non-asthmatics. *European*  
5 *Archives of Oto-Rhino-Laryngology*. 2008; 265(10):1205-1209
- 6 1792 Vaidyanathan S, Williamson PA, Lipworth BJ. Is a positive nasal lysine-aspirin challenge  
7 test associated with a more severe phenotype of chronic rhinosinusitis and asthma?  
8 *American Journal of Rhinology and Allergy*. 2012; 26(3):e89-e93
- 9 1793 Valencia M, Randazzo L, Tapias G, Granel C, Olive A. Allergy to *Alternaria*. II. Diagnostic  
10 comparison of skin-tests and RAST. *Allergologia Et Immunopathologia*. 1993; 21(2):84-  
11 87
- 12 1794 Valery PC, Chang AB, Shibasaki S, Gibson O, Purdie DM, Shannon C et al. High  
13 prevalence of asthma in five remote indigenous communities in Australia. *European*  
14 *Respiratory Journal*. 2001; 17(6):1089-1096
- 15 1795 Valery PC, Masters IB, Chang AB. Snoring and its association with asthma in Indigenous  
16 children living in the Torres Strait and Northern Peninsula Area. *Journal of Paediatrics*  
17 *and Child Health*. 2004; 40(8):461-465
- 18 1796 Valery PC, Purdie DM, Chang AB, Masters IB, Green A. Assessment of the diagnosis and  
19 prevalence of asthma in Australian indigenous children. *Journal of Clinical*  
20 *Epidemiology*. 2003; 56(7):629-635
- 21 1797 van Amsterdam JGC, Janssen NAH, De MG, Fischer PH, Nierkens S, Van LH et al. The  
22 relationship between exhaled nitric oxide and allergic sensitization in a random sample  
23 of school children. *Clinical and Experimental Allergy*. 2003; 33(2):187-191
- 24 1798 Van Asch CJJ, Balemans WAF, Rovers MM, Schilder AGM, van der Ent CK. Atopic  
25 disease and exhaled nitric oxide in an unselected population of young adults. *Annals of*  
26 *Allergy, Asthma and Immunology*. 2008; 100(1):59-65
- 27 1799 Van Bever HP, Wieringa MH, Weyler JJ, Nelen VJ, Fortuin M, Vermeire PA. Croup and  
28 recurrent croup: their association with asthma and allergy. An epidemiological study  
29 on 5-8-year-old children. *European Journal of Pediatrics*. 1999; 158(3):253-257
- 30 1800 Van De Ven MOM, van den Eijnden RJJM, Engels RCME. Atopic diseases and related  
31 risk factors among Dutch adolescents. *European Journal of Public Health*. 2006;  
32 16(5):549-558
- 33 1801 van der Gugten AC, Koopman M, Evelein AMV, Verheij TJM, Uiterwaal CSPM, van der  
34 Ent CK. Rapid early weight gain is associated with wheeze and reduced lung function in  
35 childhood. *European Respiratory Journal*. 2012; 39(2):403-410
- 36 1802 van der Mark LB, van Wonderen KE, Mohrs J, van Aalderen WMC, Ter Riet G, Bindels  
37 PJE. Predicting asthma in preschool children at high risk presenting in primary care:  
38 development of a clinical asthma prediction score. *Primary Care Respiratory Journal*.  
39 2014; 23(1):52-59



- 1 1803 van der Meer V, Bakker MJ, van den Hout WB, Rabe KF, Sterk PJ, Kievit J et al. Internet-  
2 based self-management plus education compared with usual care in asthma: a  
3 randomized trial. *Annals of Internal Medicine*. 2009; 151(2):110-120
- 4 1804 van der Palen J, Klein JJ, Kerkhoff AH, van Herwaarden CL, Seydel ER. Evaluation of the  
5 long-term effectiveness of three instruction modes for inhaling medicines. *Patient*  
6 *Education and Counseling*. 1997; 32(1 Suppl):S87-S95
- 7 1805 van der Palen J, Klein JJ, Zielhuis GA, Van Herwaarden CLA. The role of self-treatment  
8 guidelines in self-management education for adult asthmatics. *Respiratory Medicine*.  
9 1998; 92(4):668-675
- 10 1806 van der Palen J, Klein JJ, Zielhuis GA, Van Herwaarden CLA, Seydel ER. Behavioural  
11 effect of self-treatment guidelines in a self-management program for adults with  
12 asthma. *Patient Education and Counseling*. 2001; 43(2):161-169
- 13 1807 van der Valk RJP, Baraldi E, Stern G, Frey U, De Jongste JC. Daily exhaled nitric oxide  
14 measurements and asthma exacerbations in children. *Allergy*. 2012; 67(2):265-271
- 15 1808 van der Valk RJP, Caudri D, Savenije O, Koppelman GH, Smit HA, Wijga AH et al.  
16 Childhood wheezing phenotypes and FeNO in atopic children at age8. *Clinical and*  
17 *Experimental Allergy*. 2012; 42(9):1329-1336
- 18 1809 van der Valk RJP, Duijts L, Kerkhof M, Willemsen SP, Hofman A, Moll HA et al.  
19 Interaction of a 17q12 variant with both fetal and infant smoke exposure in the  
20 development of childhood asthma-like symptoms. *Allergy*. 2012; 67(6):767-774
- 21 1810 van der Valk RJP, Kieft-de Jong JC, Sonnenschein-van der Voort AMM, Duijts L,  
22 Hafkamp-de Groen E, Moll HA et al. Neonatal folate, homocysteine, vitamin B12 levels  
23 and methylenetetrahydrofolate reductase variants in childhood asthma and eczema.  
24 *Allergy*. 2013; 68(6):788-795
- 25 1811 van Gaalen JL, Bakker MJ, van Bodegom-Vos L, Snoeck-Stroband JB, Assendelft WJJ,  
26 Kaptein AA et al. Implementation strategies of internet-based asthma self-  
27 management support in usual care. Study protocol for the IMPASSE cluster  
28 randomized trial. *Implementation Science*. 2012; 7:113
- 29 1812 van Gaalen JL, Beerhuizen T, van der Meer V, van Reisen P, Redelijkheid GW, Snoeck-  
30 Stroband JB et al. Long-term outcomes of internet-based self-management support in  
31 adults with asthma. *Journal of Medical Internet Research*. 2013; 15(9):e188
- 32 1813 van Gent R, van Essen-Zandvliet LEM, Rovers MM, Kimpen JLL, de Meer G, van der Ent  
33 CK. Poor perception of dyspnoea in children with undiagnosed asthma. *European*  
34 *Respiratory Journal*. 2007; 30(5):887-891
- 35 1814 Van Gysel D, Govaere E, Verhamme K, Doli E, De Baets F. The influence of bedroom  
36 environment on sensitization and allergic symptoms in schoolchildren. *Journal of*  
37 *Investigational Allergology and Clinical Immunology*. 2007; 17(4):227-235
- 38 1815 van Maanen A, Wijga AH, Gehring U, Postma DS, Smit HA, Oort FJ et al. Sleep in  
39 children with asthma: results of the PIAMA study. *European Respiratory Journal*. 2013;  
40 41(4):832-837

- 1 1816 van Nimwegen FA, Penders J, Stobberingh EE, Postma DS, Koppelman GH, Kerkhof M  
2 et al. Mode and place of delivery, gastrointestinal microbiota, and their influence on  
3 asthma and atopy. *Journal of Allergy and Clinical Immunology*. 2011; 128(5):948-3
- 4 1817 van Schayck CP. Diagnosis of asthma and chronic obstructive pulmonary disease in  
5 general practice. *British Journal of General Practice*. 1996; 46(404):193-197
- 6 1818 van Schayck CP, van Der Heijden FM, van Den Boom G, Tirimanna PR, van Herwaarden  
7 CL. Underdiagnosis of asthma: is the doctor or the patient to blame? The DIMCA  
8 project. *Thorax*. 2000; 55(7):562-565
- 9 1819 van Schayck CP, Van Weel C, Harbers HJ, van Herwaarden CL. Do physical signs reflect  
10 the degree of airflow obstruction in patients with asthma or chronic obstructive  
11 pulmonary disease? *Scandinavian Journal of Primary Health Care*. 1991; 9(4):232-238
- 12 1820 van Zaane B, Droog RP, Stouthard MEA, van Aalderen WMC. QUOTAC: QUestionnaire  
13 On day and night Time respiratory symptoms in Asthmatic Children -- a validity study.  
14 *Journal of Asthma*. 2007; 44(2):107-111
- 15 1821 Vandenplas O, Binard-Van Cangh F, Brumagne A, Caroyer JM, Thimpont J, Sohy C et al.  
16 Occupational asthma in symptomatic workers exposed to natural rubber latex:  
17 evaluation of diagnostic procedures. *Journal of Allergy and Clinical Immunology*. 2001;  
18 107(3):542-547
- 19 1822 Vanto T, Viander M, Koivikko A, Schwartz B, Lowenstein H. RAST in the diagnostic of  
20 dog dander allergy. A comparison between three allergen preparations using two  
21 variants of RAST. *Allergy*. 1982; 37(2):75-85
- 22 1823 Varela S, Mendez J, Gonzalez de la Cuesta C, Iglesias I, Gonzalez C, Menendez M.  
23 Characteristics of pollinosis caused by *Betula* in patients from Ourense (Galicia, Spain).  
24 *Journal of Investigational Allergology and Clinical Immunology*. 2003; 13(2):124-130
- 25 1824 Vargas MH, Ruiz-Gutierrez HH, Espinosa-Serafin C, Zuniga-Vazquez G, Furuya MEY.  
26 Underestimation of the peak flow variability in asthmatic children: Evaluation of a new  
27 formula. *Pediatric Pulmonology*. 2005; 39(4):325-331
- 28 1825 Vargas PA, Perry TT, Robles E, Jo CH, Simpson PM, Magee JM et al. Relationship of  
29 body mass index with asthma indicators in head start children. *Annals of Allergy,  
30 Asthma and Immunology*. 2007; 99(1):22-28
- 31 1826 Vasar M, Braback L, Julge K, Knutsson A, Riikjarv MA, Bjorksten B. Prevalence of  
32 bronchial hyperreactivity as determined by several methods among Estonian  
33 schoolchildren. *Pediatric Allergy and Immunology*. 1996; 7(3):141-146
- 34 1827 Vasbinder EC, Janssens HM, Rutten-van Molken MPMH, van Dijk L, de Winter BCM, de  
35 Groot RCA et al. e-Monitoring of Asthma Therapy to Improve Compliance in children  
36 using a real-time medication monitoring system (RTMM): the e-MATIC study protocol.  
37 *BMC Medical Informatics and Decision Making*. 2013; 13(1):38
- 38 1828 Vazquez MI, Buceta JM. Effectiveness of self-management programmes and relaxation  
39 training in the treatment of bronchial asthma: relationships with trait anxiety and  
40 emotional attack triggers. *Journal of Psychosomatic Research*. 1993; 37(1):71-81

- 1 1829 Vedal S, Petkau J, White R, Blair J. Acute effects of ambient inhalable particles in  
2 asthmatic and nonasthmatic children. *American Journal of Respiratory and Critical*  
3 *Care Medicine*. 1998; 157(4 Pt 1):1034-1043
- 4 1830 Vellinga A, Droste JHJ, Vermeire PA, Desager K, De Backer WA, Nelen VJ et al. Changes  
5 in respiratory and allergic symptoms in schoolchildren from 1996 to 2002, results from  
6 the ISAAC surveys in Antwerp (Belgium). *Acta Clinica Belgica*. 2005; 60(5):219-225
- 7 1831 Venables KM, Burge PS, Davison AG, Newman Taylor AJ. Peak flow rate records in  
8 surveys: reproducibility of observers' reports. *Thorax*. 1984; 39(11):828-832
- 9 1832 Venables KM, Farrer N, Sharp L, Graneek BJ, Newman Taylor AJ. Respiratory symptoms  
10 questionnaire for asthma epidemiology: validity and reproducibility. *Thorax*. 1993;  
11 48(3):214-219
- 12 1833 Venn A, Lewis S, Cooper M, Hubbard R, Hill I, Boddy R et al. Local road traffic activity  
13 and the prevalence, severity, and persistence of wheeze in school children: combined  
14 cross sectional and longitudinal study. *Occupational and Environmental Medicine*.  
15 2000; 57(3):152-158
- 16 1834 Venn AJ, Lewis SA, Cooper M, Hubbard R, Britton J. Living near a main road and the  
17 risk of wheezing illness in children. *American Journal of Respiratory and Critical Care*  
18 *Medicine*. 2001; 164(12):2177-2180
- 19 1835 Ventura MT, Gelardi M, Di Gioia R, Buquicchio R, Accettura G, Tummolo RA et al.  
20 Statistical evaluation and parameters of phlogosis in patients sensitized to cypress.  
21 *Journal of Biological Regulators and Homeostatic Agents*. 2007; 21(1-2):41-48
- 22 1836 Verini M, Consilvio NP, Di PS, Cingolani A, Spagnuolo C, Rapino D et al. FeNO as a  
23 marker of airways inflammation: The possible implications in childhood asthma  
24 management. *Journal of Allergy*. 2010; 2010:691425
- 25 1837 Verleden GM, Dupont LJ, Verpeut AC, Demedts MG. The effect of cigarette smoking on  
26 exhaled nitric oxide in mild steroid-naive asthmatics. *Chest*. 1999; 116(1):59-64
- 27 1838 Verver S, Poelman M, Bogels A, Chisholm SL, Dekker FW. Effects of instruction by  
28 practice assistants on inhaler technique and respiratory symptoms of patients. A  
29 controlled randomized videotaped intervention study. *Family Practice*. 1996; 13(1):35-  
30 40
- 31 1839 Vervloet D, de Andrade AD, Pascal L, Lanteaume A, Dutau H, Armengaud A et al. The  
32 prevalence of reported asthma is independent of exposure in house dust mite-  
33 sensitized children. *European Respiratory Journal*. 1999; 13(5):983-987
- 34 1840 Vial Dupuy A, Amat F, Pereira B, Labbe A, Just J. A simple tool to identify infants at high  
35 risk of mild to severe childhood asthma: the persistent asthma predictive score.  
36 *Journal of Asthma*. 2011; 48(10):1015-1021
- 37 1841 Viander M, Valovirta E, Vanto T, Koivikko A. Cross-reactivity of cat and dog allergen  
38 extracts. RAST inhibition studies with special reference to the allergenic activity in  
39 saliva and urine. *International Archives of Allergy and Applied Immunology*. 1983;  
40 71(3):252-260

- 1 1842 Vieira T, Fonseca J, Cruz L, Silva R, Ferreira A, Leblanc A et al. Results of a school-based  
2 asthma assessment from the upKids questionnaire validation study. *Allergy*. 2009;  
3 64:441-442
- 4 1843 Vieira T, Fonseca JA, Silva R, Cruz L, Ferreira AR, Leblanc A et al. Validity of a  
5 questionnaire in a school-based allergic asthma screening- comparison with exhaled  
6 nitric oxide fraction and skin prick tests. *Revista Portuguesa De Imunoalergologia*.  
7 2011; 19(4):215-221
- 8 1844 Vila-Indurain B, Munoz-Lopez F, Martin-Mateos M. Evaluation of blood eosinophilia  
9 and the eosinophil cationic protein (ECP) in the serum of asthmatic children with  
10 varying degree of severity. *Allergologia Et Immunopathologia*. 1999; 27(6):304-308
- 11 1845 Vilozni D, Bentur L, Efrati O, Barak A, Szeinberg A, Shoseyov D et al. Exercise challenge  
12 test in 3- to 6-year-old asthmatic children. *Chest*. 2007; 132(2):497-503
- 13 1846 Vilozni D, Livnat G, Dabbah H, Elias N, Hakim F, Bentur L. The potential use of  
14 spirometry during methacholine challenge test in young children with respiratory  
15 symptoms. *Pediatric Pulmonology*. 2009; 44(7):720-727
- 16 1847 Visser MJ, de Wit MC, van Aalderen WM, Postma DS, Brand PL. Exhaled nitric oxide in  
17 children measured by tidal breathing method: differences between asthmatics and  
18 nonasthmatic controls. *Pediatric Pulmonology*. 2000; 29(6):434-437
- 19 1848 Vogelmeier C, Baur X, Fruhmann G. Isocyanate-induced asthma: results of inhalation  
20 tests with TDI, MDI and methacholine. *International Archives of Occupational and  
21 Environmental Health*. 1991; 63(1):9-13
- 22 1849 Vogelmeier CF, Hering T, Lewin T, Sander P, Bethke TD. Efficacy and safety of  
23 ciclesonide in the treatment of 24,037 asthmatic patients in routine medical care.  
24 *Respiratory Medicine*. 2011; 105(2):186-194
- 25 1850 Volbeda F, Broekema M, Lodewijk ME, Hylkema MN, Reddel HK, Timens W et al.  
26 Clinical control of asthma associates with measures of airway inflammation. *Thorax*.  
27 2013; 68(1):19-24
- 28 1851 Volkmer RE, Ruffin RE, Wigg NR, Davies N. The prevalence of respiratory symptoms in  
29 South Australian preschool children. II. Factors associated with indoor air quality.  
30 *Journal of Paediatrics and Child Health*. 1995; 31(2):116-120
- 31 1852 Vollmer WM, Kirshner M, Peters D, Drane A, Stibolt T, Hickey T et al. Use and impact of  
32 an automated telephone outreach system for asthma in a managed care setting.  
33 *American Journal of Managed Care*. 2006; 12(12):725-733
- 34 1853 Vollmer WM, Feldstein A, Smith DH, Dubanoski JP, Waterbury A, Schneider JL et al.  
35 Use of health information technology to improve medication adherence. *American  
36 Journal of Managed Care*. 2011; 17(12 Spec No.):SP79-SP87
- 37 1854 Von Ehrenstein OS, von Mutius E, Illi S, Baumann L, Bohm O, von Kries R. Reduced risk  
38 of hay fever and asthma among children of farmers. *Clinical and Experimental Allergy*.  
39 2000; 30(2):187-193

- 1 1855 von Mutius E, Illi S, Hirsch T, Leupold W, Keil U, Weiland SK. Frequency of infections  
2 and risk of asthma, atopy and airway hyperresponsiveness in children. *European*  
3 *Respiratory Journal*. 1999; 14(1):4-11
- 4 1856 Vooren PH, Kramps JA, Franken C, Dijkman JH. Diagnostic relevance of the modified  
5 RAST using D epsilon 2 specific anti-IgE antibodies. *European Journal of Respiratory*  
6 *Diseases*. 1983; 64(2):90-101
- 7 1857 Voorend-van BS, Vaessen-Verberne A, Landstra A, Brackel H, van den Berg N, De JJ et  
8 al. FeNO and web-based monitoring in paediatric asthma management; the BATMAN  
9 study [Abstract]. *European Respiratory Society Annual Congress*, 2013 Sept 7-11,  
10 Barcelona, Spain. 2013; 42(Suppl 57):629s
- 11 1858 Voutilainen M, Malmberg LP, Vasankari T, Haahtela T. Exhaled nitric oxide indicates  
12 poorly athlete's asthma. *Clinical Respiratory Journal*. 2013; 7(4):347-353
- 13 1859 Vries TW, Berg PB, Duiverman EJ, Jong-van Den Berg LTW. Effect of a minimal  
14 pharmacy intervention on adherence to asthma medication guidelines for children.  
15 *Pharmaceutisch Weekblad*. 2010; 145(50):195-197
- 16 1860 Vugt Sv, Broekhuizen L, Zuithoff N, Butler C, Hood K, Coenen S et al. Airway  
17 obstruction and bronchodilator responsiveness in adults with acute cough. *Annals of*  
18 *Family Medicine*. 2012; 10(6):523-529
- 19 1861 Wakamori T, Katoh N, Hirano S, Kishimoto S, Ozasa K. Atopic dermatitis, dry skin and  
20 serum IgE in children in a community in Japan. *International Archives of Allergy and*  
21 *Immunology*. 2009; 149(2):103-110
- 22 1862 Wake M, Clifford SA, Patton GC, Waters E, Williams J, Canterford L et al. Morbidity  
23 patterns among the underweight, overweight and obese between 2 and 18 years:  
24 population-based cross-sectional analyses. *International Journal of Obesity*. 2013;  
25 37(1):86-93
- 26 1863 Walamies MA. Diagnostic role of residual volume in paediatric patients with chronic  
27 symptoms of the lower airways. *Clinical Physiology*. 1998; 18(1):49-54
- 28 1864 Walders N, Kercksmar C, Schluchter M, Redline S, Kirchner HL, Drotar D. An  
29 interdisciplinary intervention for undertreated pediatric asthma. *Chest*. 2006;  
30 129(2):292-299
- 31 1865 Walraven GE, Nyan OA, Van Der Sande MA, Banya WA, Ceesay SM, Milligan PJ et al.  
32 Asthma, smoking and chronic cough in rural and urban adult communities in The  
33 Gambia. *Clinical and Experimental Allergy*. 2001; 31(11):1679-1685
- 34 1866 Walters GI, Moore VC, Robertson AS, Burge CBSG, Vellore AD, Burge PS. An outbreak  
35 of occupational asthma due to chromium and cobalt. *Occupational Medicine*. 2012;  
36 62(7):533-540
- 37 1867 Wang C, Salam MT, Islam T, Wenten M, Gauderman J, Gilliland FD. Effects of in utero  
38 and childhood tobacco smoke exposure and beta2-adrenergic receptor genotype on  
39 childhood asthma and wheezing. *Pediatrics*. 2008; 122(1):e107-e114

- 1 1868 Wang HY, Pizzichini MMM, Becker AB, Duncan JM, Ferguson AC, Greene JM et al.  
2 Disparate geographic prevalences of asthma, allergic rhinoconjunctivitis and atopic  
3 eczema among adolescents in five Canadian cities. *Pediatric Allergy and Immunology*.  
4 2010; 21(5):867-877
- 5 1869 Wang HY, Wong GWK, Chen YZ, Ferguson AC, Greene JM, Ma Y et al. Prevalence of  
6 asthma among Chinese adolescents living in Canada and in China. *CMAJ*. 2008;  
7 179(11):1133-1142
- 8 1870 Wang J, Visness CM, Calatroni A, Gergen PJ, Mitchell HE, Sampson HA. Effect of  
9 environmental allergen sensitization on asthma morbidity in inner-city asthmatic  
10 children. *Clinical and Experimental Allergy*. 2009; 39(9):1381-1389
- 11 1871 Wang JY, Chen WY. Inhalant allergens in asthmatic children in Taiwan: comparison  
12 evaluation of skin testing, radioallergosorbent test and multiple allergosorbent  
13 chemiluminescent assay for specific IgE. *Journal of the Formosan Medical Association*.  
14 1992; 91(12):1127-1132
- 15 1872 Wang W, Huang K, Wu B, Wang Y, Wang D. Correlation of eosinophil counts in induced  
16 sputum and fractional concentration of exhaled nitric oxide and lung functions in  
17 patients with mild to moderate asthma. *Chinese Medical Journal*. 2012; 125(17):3157-  
18 3160
- 19 1873 Wanich NH, Kaplan MS. Management of asthma based on exhaled nitric oxide in  
20 addition to guideline-based treatment for inner-city adolescents and young adults: A  
21 randomised controlled trial. *Pediatrics*. United States: American Academy of Pediatrics  
22 (141 Northwest Point Blvd, P.O. Box 927, Elk Grove Village IL 60007-1098, United  
23 States). 2009; 124(SUPPL. 2):S147
- 24 1874 Wardman AG, Binns V, Clayden AD, Cooke NJ. The diagnosis and treatment of adults  
25 with obstructive airways disease in general practice. *British Journal of Diseases of the  
26 Chest*. 1986; 80(1):19-26
- 27 1875 Warke TJ, Fitch PS, Brown V, Taylor R, Lyons JDM, Ennis M et al. Exhaled nitric oxide  
28 correlates with airway eosinophils in childhood asthma. *Thorax*. 2002; 57(5):383-387
- 29 1876 Wassall HJ, Devenny AM, Daud Khan S, Ninan TK, Russell G. A comparison of virus-  
30 associated and multi-trigger wheeze in school children. *Journal of Asthma*. 2005;  
31 42(9):737-744
- 32 1877 Watelet JB, Van Zele T, Brusselle G. Chronic cough in upper airway diseases.  
33 *Respiratory Medicine*. 2010; 104(5):652-657
- 34 1878 Weber RW, Hoffman M, Raine DAJ, Nelson HS. Incidence of bronchoconstriction due  
35 to aspirin, azo dyes, non-azo dyes, and preservatives in a population of perennial  
36 asthmatics. *Journal of Allergy and Clinical Immunology*. 1979; 64(1):32-37
- 37 1879 Wedner HJ, Zenger VE, Lewis WH. Allergic reactivity of *Parthenium hysterophorus*  
38 (Santa Maria feverfew) pollen: An unrecognized allergen. *International Archives of  
39 Allergy and Applied Immunology*. 1987; 84(2):116-122

- 1 1880 Weinberger M, Murray MD, Marrero DG, Brewer N, Lykens M, Harris LE et al.  
2 Effectiveness of pharmacist care for patients with reactive airways disease: a  
3 randomized controlled trial. *JAMA*. 2002; 288(13):1594-1602
- 4 1881 Weinmayr G, Gehring U, Genuneit J, Buchele G, Kleiner A, Siebers R et al. Dampness  
5 and moulds in relation to respiratory and allergic symptoms in children: results from  
6 Phase Two of the International Study of Asthma and Allergies in Childhood (ISAAC  
7 Phase Two). *Clinical and Experimental Allergy*. 2013; 43(7):762-774
- 8 1882 Weinmayr G, Weiland SK, Bjorksten B, Brunekreef B, Buchele G, Cookson WOC et al.  
9 Atopic sensitization and the international variation of asthma symptom prevalence in  
10 children. *American Journal of Respiratory and Critical Care Medicine*. 2007;  
11 176(6):565-574
- 12 1883 Weintraub JM, Sparrow D, Weiss ST. Receiver operating characteristics curve analysis  
13 of cutaneous skin test reactions to predict hay fever and asthma symptoms in the  
14 Normative Aging Study. *Allergy*. 2001; 56(3):243-246
- 15 1884 Welsh L, Lercher P, Horak E. Exhaled nitric oxide: interactions between asthma,  
16 hayfever, and atopic dermatitis in school children. *Pediatric Pulmonology*. 2007;  
17 42(8):693-698
- 18 1885 Wensley D, Silverman M. Peak flow monitoring for guided self-management in  
19 childhood asthma: a randomized controlled trial. *American Journal of Respiratory and  
20 Critical Care Medicine*. 2004; 170(6):606-612
- 21 1886 West JV, Robertson CF, Roberts R, Olinsky A. Evaluation of bronchial responsiveness to  
22 exercise in children as an objective measure of asthma in epidemiological surveys.  
23 *Thorax*. 1996; 51(6):590-595
- 24 1887 Wever-Hess J, Kouwenberg JM, Duiverman EJ, Hermans J, Wever AM. Prognostic  
25 characteristics of asthma diagnosis in early childhood in clinical practice. *Acta  
26 Paediatrica*. 1999; 88(8):827-834
- 27 1888 White SK, Cox-Ganser JM, Benaise LG, Kreiss K. Work-related peak flow and asthma  
28 symptoms in a damp building. *Occupational Medicine*. 2013; 63(4):287-290
- 29 1889 Whitrow MJ, Harding S. Asthma in Black African, Black Caribbean and South Asian  
30 adolescents in the MRC DASH study: a cross sectional analysis. *BMC Pediatrics*. 2010;  
31 10:18
- 32 1890 Wickens K, Barry D, Friezema A, Rhodius R, Bone N, Purdie G et al. Fast foods - are they  
33 a risk factor for asthma? *Allergy*. 2005; 60(12):1537-1541
- 34 1891 Wickens K, Ingham T, Epton M, Pattermore P, Town I, Fishwick D et al. The association  
35 of early life exposure to antibiotics and the development of asthma, eczema and atopy  
36 in a birth cohort: confounding or causality? *Clinical and Experimental Allergy*. 2008;  
37 38(8):1318-1324
- 38 1892 Wickman M, Lilja G, Soderstrom L, van Hage-Hamsten M, Ahlstedt S. Quantitative  
39 analysis of IgE antibodies to food and inhalant allergens in 4-year-old children reflects  
40 their likelihood of allergic disease. *Allergy*. 2005; 60(5):650-657

- 1 1893 Wieslander G, Janson C, Norback D, Bjornsson E, Stalenheim G, Edling C. Occupational  
2 exposure to water-based paints and self-reported asthma, lower airway symptoms,  
3 bronchial hyperresponsiveness, and lung function. *International Archives of*  
4 *Occupational and Environmental Health*. 1994; 66(4):261-267
- 5 1894 Wijga AH, Smit HA, Kerkhof M, De Jongste JC, Gerritsen J, Neijens HJ et al. Association  
6 of consumption of products containing milk fat with reduced asthma risk in pre-school  
7 children: the PIAMA birth cohort study. *Thorax*. 2003; 58(7):567-572
- 8 1895 Willems DC, Joore MA, Hendriks JJ, van Duurling RA, Wouters EF, Severens JL. Process  
9 evaluation of a nurse-led telemonitoring programme for patients with asthma. *Journal*  
10 *of Telemedicine and Telecare*. 2007; 13(6):310-317
- 11 1896 Willems DC, Joore MA, Hendriks JJ, Wouters EF, Severens JL. Cost-effectiveness of a  
12 nurse-led telemonitoring intervention based on peak expiratory flow measurements in  
13 asthmatics: results of a randomised controlled trial. *Cost Effectiveness and Resource*  
14 *Allocation*. 2007; 5:10
- 15 1897 Willers SM, Devereux G, Craig LCA, McNeill G, Wijga AH, Abou El-Magd W et al.  
16 Maternal food consumption during pregnancy and asthma, respiratory and atopic  
17 symptoms in 5-year-old children. *Thorax*. 2007; 62(9):773-779
- 18 1898 Willers SM, Wijga AH, Brunekreef B, Kerkhof M, Gerritsen J, Hoekstra MO et al.  
19 Maternal food consumption during pregnancy and the longitudinal development of  
20 childhood asthma. *American Journal of Respiratory and Critical Care Medicine*. 2008;  
21 178(2):124-131
- 22 1899 Williams LK, Peterson EL, Wells K, Campbell J, Wang M, Chowdhry VK et al. A cluster-  
23 randomized trial to provide clinicians inhaled corticosteroid adherence information for  
24 their patients with asthma. *Journal of Allergy and Clinical Immunology*. 2010;  
25 126(2):225-4
- 26 1900 Williamson PA, Vaidyanathan S, Clearie K, Stewart M, Lipworth BJ. Relationship  
27 between fractional exhaled nitric oxide and nasal nitric oxide in airways disease.  
28 *Annals of Allergy, Asthma and Immunology*. 2010; 105(2):162-167
- 29 1901 Wing A, Upton J, Svensson K, Weller P, Fletcher M, Walker S. The standardized and  
30 mini versions of the PAQLQ are valid, reliable, and responsive measurement tools.  
31 *Journal of Clinical Epidemiology*. 2012; 65(6):643-650
- 32 1902 Wismol P, Putivoranat P, Buranapraditkun S, Pinnobphun P, Ruxrungham K,  
33 Klaewsongkram J. The values of nasal provocation test and basophil activation test in  
34 the different patterns of ASA/NSAID hypersensitivity. *Allergologia Et*  
35 *Immunopathologia*. 2012; 40(3):156-163
- 36 1903 Withers NJ, Low L, Holgate ST, Clough JB. The natural history of respiratory symptoms  
37 in a cohort of adolescents. *American Journal of Respiratory and Critical Care Medicine*.  
38 1998; 158(2):352-357
- 39 1904 Wittczak T, Dudek W, Walusiak-Skorupa J, Swierczynska-Machura D, Cader W,  
40 Kowalczyk M et al. Metal-induced asthma and chest X-ray changes in welders.  
41 *International Journal of Occupational Medicine and Environmental Health*. 2012;  
42 25(3):242-250



- 1 1905 Witteman AM, Stapel SO, Perdok GJ, Sjamsoedin DHS, Jansen HM, Aalberse RC et al.  
2 The relationship between RAST and skin test results in patients with asthma or rhinitis:  
3 A quantitative study with purified major allergens. *Journal of Allergy and Clinical*  
4 *Immunology*. 1996; 97(1 I):16-25
- 5 1906 Wjst M, Dold S, Roell G, Reitmeir P, Fritzsche C, Von ME et al. Bronchial hyperreactivity  
6 and history of wheezing in children. *European Journal of Pediatrics*. 1994; 153(9):682-  
7 686
- 8 1907 Wjst M, Hoelscher B, Frye C, Wichmann HE, Dold S, Heinrich J. Early antibiotic  
9 treatment and later asthma. *European Journal of Medical Research*. 2001; 6(6):263-  
10 271
- 11 1908 Wjst M, Popescu M, Trepka MJ, Heinrich J, Wichmann HE. Pulmonary function in  
12 children with initial low birth weight. *Pediatric Allergy and Immunology*. 1998; 9(2):80-  
13 90
- 14 1909 Wojnarowski C, Storm Van's GK, Riedler J, Eichler I, Gartner C, Frischer T. Comparison  
15 of bronchial challenge with ultrasonic nebulized distilled water and hypertonic saline  
16 in children with mild-to-moderate asthma. *European Respiratory Journal*. 1996;  
17 9(9):1896-1901
- 18 1910 Wolf RL, Berry CA, Quinn K. Development and validation of a brief pediatric screen for  
19 asthma and allergies among children. *Annals of Allergy, Asthma and Immunology*.  
20 2003; 90(5):500-507
- 21 1911 Wolfe I, Cass H, Thompson MJ, Craft A, Peile E, Wiegersma PA et al. Improving child  
22 health services in the UK: insights from Europe and their implications for the NHS  
23 reforms. *BMJ*. 2011; 342:d1277
- 24 1912 Wolff PT, Arison L, Rahajamiakatra A, Raserijaona F, Niggemann B. High asthma  
25 prevalence and associated factors in urban malagasy schoolchildren. *Journal of*  
26 *Asthma*. 2012; 49(6):575-580
- 27 1913 Wongtim S, Mogmeud S, Limthongkul S, Chareonlap P, Udompanich V, Nuchprayoon C  
28 et al. The role of the methacholine inhalation challenge in adult patients presenting  
29 with chronic cough. *Asian Pacific Journal of Allergy and Immunology*. 1997; 15(1):9-14
- 30 1914 Woo SI, Lee JH, Kim H, Kang JW, Sun YH, Hahn YS. Utility of fractional exhaled nitric  
31 oxide (F(E)NO) measurements in diagnosing asthma. *Respiratory Medicine*. 2012;  
32 106(8):1103-1109
- 33 1915 Woodmansee D. CAP-RAST vs. skin prick testing in suspected aeroallergen  
34 sensitization. *Annals of Allergy, Asthma and Immunology*. 2009; 103(5 Suppl.3):A54-  
35 A55
- 36 1916 Woods RK, Abramson M, Bailey M, Walters EH. International prevalences of reported  
37 food allergies and intolerances. Comparisons arising from the European Community  
38 Respiratory Health Survey (ECRHS) 1991-1994. *European Journal of Clinical Nutrition*.  
39 2001; 55(4):298-304

- 1 1917 Woods RK, Burton DL, Wharton C, McKenzie GH, Walters EH, Comino EJ et al. Asthma  
2 is more prevalent in rural New South Wales than metropolitan Victoria, Australia.  
3 *Respirology*. 2000; 5(3):257-263
- 4 1918 Woods RK, Walters EH, Wharton C, Watson N, Abramson M. The rising prevalence of  
5 asthma in young Melbourne adults is associated with improvement in treatment.  
6 *Annals of Allergy, Asthma and Immunology*. 2001; 87(2):117-123
- 7 1919 Woods RK, Thien F, Raven J, Walters EH, Abramson M. Prevalence of food allergies in  
8 young adults and their relationship to asthma, nasal allergies, and eczema. *Annals of*  
9 *Allergy, Asthma and Immunology*. 2002; 88(2):183-189
- 10 1920 Woolcock AJ, Salome CM, Yan K. The shape of the dose-response curve to histamine in  
11 asthmatic and normal subjects. *American Review of Respiratory Disease*. 1984;  
12 130(1):71-75
- 13 1921 Wright AL, Holberg CJ, Taussig LM, Martinez FD. Factors influencing the relation of  
14 infant feeding to asthma and recurrent wheeze in childhood. *Thorax*. 2001; 56(3):192-  
15 197
- 16 1922 Wright AL, Stern DA, Kauffmann F, Martinez FD. Factors influencing gender differences  
17 in the diagnosis and treatment of asthma in childhood: the Tucson Children's  
18 *Respiratory Study*. *Pediatric Pulmonology*. 2006; 41(4):318-325
- 19 1923 Wu F, Gao Y, An J-Y, Xie Y-Q, Liu W-T, Yu X-X et al. Is bronchial provocation test  
20 induced by adenosine monophosphate (AMP) superior to histamine for identifying  
21 patients with asthma? *Respirology*. 2011; 16:221
- 22 1924 Wuthrich B, Schindler C, Leuenberger P, Ackermann-Liebrich U. Prevalence of atopy  
23 and pollinosis in the adult population of Switzerland (SAPALDIA study). *Swiss Study on*  
24 *Air Pollution and Lung Diseases in Adults*. *International Archives of Allergy and*  
25 *Immunology*. 1995; 106(2):149-156
- 26 1925 Xu F, Zou Z, Yan S, Li F, Kan H, Norback D et al. Fractional exhaled nitric oxide in  
27 relation to asthma, allergic rhinitis, and atopic dermatitis in Chinese children. *Journal*  
28 *of Asthma*. 2011; 48(10):1001-1006
- 29 1926 Xu X, Niu T, Chen C, Wang B, Jin Y, Yang J et al. Association of airway responsiveness  
30 with asthma and persistent wheeze in a Chinese population. *Chest*. 2001; 119(3):691-  
31 700
- 32 1927 Yang CL, Simons E, Foty RG, Marshall L, Nelligan K, To T et al. Questionnaire diagnosis  
33 of asthma leads to misclassification compared to guideline-based diagnosis. *American*  
34 *Journal of Respiratory and Critical Care Medicine*. 2011; 183(1 Meeting Abstracts)
- 35 1928 Yang YW, Tseng KC, Chen YH, Yang JY. Associations among eczema, asthma, serum  
36 immunoglobulin E and depression in adults: a population-based study. *Allergy*. 2010;  
37 65(6):801-802
- 38 1929 Yao TC, Ou LS, Lee WI, Yeh KW, Chen LC, Huang JL et al. Exhaled nitric oxide  
39 discriminates children with and without allergic sensitization in a population-based  
40 study. *Clinical and Experimental Allergy*. 2011; 41(4):556-564

- 1 1930 Yartsev SS. Analysis of diagnostic efficiency of lung ventilation parameters in patients  
2 with bronchial asthma. *Biomedical Engineering*. 2006; 40(1):21-24
- 3 1931 Yavuz ST, Civelek E, Sahiner UM, Buyuktiryaki AB, Tuncer A, Karabulut E et al.  
4 Identifying uncontrolled asthma in children with the childhood asthma control test or  
5 exhaled nitric oxide measurement. *Annals of Allergy, Asthma and Immunology*. 2012;  
6 109(1):36-40
- 7 1932 Yazicioglu M, Sayinbas P, Ones U, Saltik A, Tugrul M. Alatorp: a new in vitro screening  
8 test for atopy. *Journal of International Medical Research*. 1994; 22(6):313-322
- 9 1933 Yeatts K, Maier W, Shy C. Asthma inhaler use and barriers in a population-based  
10 sample of African-American and white adolescents. *Annals of Allergy, Asthma and  
11 Immunology*. 2000; 84(1):94-100
- 12 1934 Yeatts K, Shy C, Wiley J, Music S. Statewide adolescent asthma surveillance. *Journal of  
13 Asthma*. 2000; 37(5):425-434
- 14 1935 Yeatts K, Davis KJ, Sotir M, Herget C, Shy C. Who gets diagnosed with asthma?  
15 Frequent wheeze among adolescents with and without a diagnosis of asthma.  
16 *Pediatrics*. 2003; 111(5 Pt 1):1046-1054
- 17 1936 Yoo Y, Kim DK, Yu J, Choi SH, Kim CK, Koh YY. Relationships of methacholine and AMP  
18 responsiveness with peak expiratory flow variability in children with asthma. *Clinical  
19 and Experimental Allergy*. 2007; 37(8):1158-1164
- 20 1937 Yoo Y, Ko HK, Han JJ, Lee Y, Seo KJ, Choung JT et al. The prevalence of atopy and  
21 asthma among university freshmen in Seoul, Korea: association with obesity. *Journal  
22 of Asthma*. 2007; 44(1):45-49
- 23 1938 Yoon J-Y, Woo S-I, Kim H, Sun Y-H, Hahn Y-S. Fractional exhaled nitric oxide and forced  
24 expiratory flow between 25% and 75% of vital capacity in children with controlled  
25 asthma. *Korean Journal of Pediatrics*. 2012; 55(9):372-379
- 26 1939 Yoon R, McKenzie DK, Bauman A, Miles DA. Controlled trial evaluation of an asthma  
27 education programme for adults. *Thorax*. 1993; 48(11):1110-1116
- 28 1940 Yoos HL, Kitzman H, McMullen A, Henderson C, Sidora K. Symptom monitoring in  
29 childhood asthma: a randomized clinical trial comparing peak expiratory flow rate with  
30 symptom monitoring. *Annals of Allergy, Asthma and Immunology*. 2002; 88(3):283-291
- 31 1941 Young HN, Havican SN, Griesbach S, Thorpe JM, Chewning BA, Sorkness CA. Patient  
32 and pharmacist telephonic encounters (PARTE) in an underserved rural patient  
33 population with asthma: results of a pilot study. *Telemedicine Journal and E-Health*.  
34 2012; 18(6):427-433
- 35 1942 Yu ITS, Wong TW, Li W. Using child reported respiratory symptoms to diagnose asthma  
36 in the community. *Archives of Disease in Childhood*. 2004; 89(6):544-548
- 37 1943 Yun TJ, Arriaga RI. A text message a day keeps the pulmonologist away. *Proceedings of  
38 the SIGCHI Conference on Human Factors in Computing Systems 2013*;1769-1778

- 1 1944 Yunginger JW, Reed CE, O'Connell EJ, Melton LJ, O'Fallon WM, Silverstein MD. A  
2 community-based study of the epidemiology of asthma. Incidence rates, 1964-1983.  
3 *American Review of Respiratory Disease*. 1992; 146(4):888-894
- 4 1945 Yurdakul AS, Dursun B, Canbakan S, Cakaloglu A, Capan N. The assessment of validity  
5 of different asthma diagnostic tools in adults. *Journal of Asthma*. 2005; 42(10):843-846
- 6 1946 Zacharasiewicz A, Erin EM, Bush A. Noninvasive monitoring of airway inflammation  
7 and steroid reduction in children with asthma. *Current Opinion in Allergy and Clinical  
8 Immunology*. 2006; 6(3):155-160
- 9 1947 Zaghoul MA, Barakat MM, Khalifah MA, Khattab G. Diagnostic evaluation of patients  
10 with chronic non-productive cough: Saudi experience. *Annals of Thoracic Medicine*.  
11 2009; 4(2):101
- 12 1948 Zambonino MA, Torres MJ, Munoz C, Requena G, Mayorga C, Posadas T et al. Drug  
13 provocation tests in the diagnosis of hypersensitivity reactions to non-steroidal anti-  
14 inflammatory drugs in children. *Journal of Allergy and Clinical Immunology*. 2013; 131(2  
15 Suppl.1):AB168
- 16 1949 Zaragoza RH. Update in the prevalence of atopic conditions, IgE levels and skin test  
17 sensitization to aeroallergens in Northern Puerto Rico. *Journal of Allergy and Clinical  
18 Immunology*. 2014; 133(2 Suppl.1):AB188
- 19 1950 Zedan M, Settin A, El-Chennawi F, El-Desouky T, Nasef N, Fouda A. Eosinophilic cationic  
20 protein: is it useful in assessing control of childhood asthma? *Eastern Mediterranean  
21 Health Journal*. 2010; 16(10):1045-1049
- 22 1951 Zemek RL, Bhogal SK, Ducharme FM. Systematic review of randomized controlled trials  
23 examining written action plans in children: what is the plan? *Archives of Pediatrics and  
24 Adolescent Medicine*. 2008; 162(2):157-163
- 25 1952 Zetterquist W, Marteus H, Hedlin G, Alving K. Increased exhaled nitrite in children with  
26 allergic asthma is not related to nitric oxide formation. *Clinical Respiratory Journal*.  
27 2008; 2(3):166-174
- 28 1953 Zetterström O, Fagerberg E, Wide L. An investigation of pollen extracts from different  
29 deciduous trees in patients with springtime allergy in Sweden. *Acta Allergologica*.  
30 1972; 27(1):15-21
- 31 1954 Zhao Z, Huang C, Zhang X, Xu F, Kan H, Song W et al. Fractional exhaled nitric oxide in  
32 Chinese children with asthma and allergies--a two-city study. *Respiratory Medicine*.  
33 2013; 107(2):161-171
- 34 1955 Zhou C, Baiz N, Banerjee S, Charpin DA, Caillaud D, De BF et al. The relationships  
35 between ambient air pollutants and childhood asthma and eczema are modified by  
36 emotion and conduct problems. *Annals of Epidemiology*. 2013; 23(12):778-783
- 37 1956 Ziaee V, Nourian R, Mehrkhani F. Sensitivity and specificity of self-reported symptoms  
38 for exercise-induced bronchospasm diagnosis in children. *Annals of Allergy, Asthma  
39 and Immunology*. 2009; 103(5 Suppl.3):A63-A64

- 1 1957 Zietkowski Z, Bodzenta-Lukaszyk A, Tomasiak MM, Skiepkowski R, Szmitkowski M.  
2 Comparison of exhaled nitric oxide measurement with conventional tests in steroid-  
3 naive asthma patients. *Journal of Investigational Allergology and Clinical Immunology*.  
4 2006; 16(4):239-246
- 5 1958 Zietkowski Z, Skiepkowski R, Tomasiak MM, Bodzenta-Lukaszyk A. Endothelin-1 in exhaled  
6 breath condensate of stable and unstable asthma patients. *Respiratory Medicine*.  
7 2008; 102(3):470-474
- 8 1959 Zietkowski Z, Skiepkowski R, Tomasiak MM, Bodzenta-Lukaszyk A. Soluble CD40 ligand and  
9 soluble P-selectin in allergic asthma patients during exercise-induced  
10 bronchoconstriction. *Journal of Investigational Allergology and Clinical Immunology*.  
11 2008; 18(4):272-278
- 12 1960 Zietkowski Z, Skiepkowski R, Tomasiak-Lozowska MM, Mroczko B, Szmitkowski M,  
13 Bodzenta-Lukaszyk A. RANTES in exhaled breath condensate of allergic asthma  
14 patients with exercise-induced bronchoconstriction. *Respiration*. 2010; 80(6):463-471
- 15 1961 Zietkowski Z, Tomasiak MM, Skiepkowski R, Bodzenta-Lukaszyk A. RANTES in exhaled  
16 breath condensate of stable and unstable asthma patients. *Respiratory Medicine*.  
17 2008; 102(8):1198-1202
- 18 1962 Zietkowski Z, Tomasiak-Lozowska MM, Skiepkowski R, Zietkowska E, Bodzenta-Lukaszyk A.  
19 Eotaxin-1 in exhaled breath condensate of stable and unstable asthma patients.  
20 *Respiratory Research*. 2010; 11:110
- 21 1963 Zietkowski Z, Skiepkowski R, Tomasiak MM, Bodzenta-Lukaszyk A. Endothelin-1 in exhaled  
22 breath condensate of allergic asthma patients with exercise-induced  
23 bronchoconstriction. *Respiratory Research*. 2007; 8:76
- 24 1964 Zietkowski Z, Tomasiak-Lozowska MM, Skiepkowski R, Mroczko B, Szmitkowski M,  
25 Bodzenta-Lukaszyk A. High-sensitivity C-reactive protein in the exhaled breath  
26 condensate and serum in stable and unstable asthma. *Respiratory Medicine*. 2009;  
27 103(3):379-385
- 28 1965 Zilmer M, Steen NP, Zachariassen G, Duus T, Kristiansen B, Halken S. Prevalence of  
29 asthma and bronchial hyperreactivity in Danish schoolchildren: no change over 10  
30 years. *Acta Paediatrica*. 2011; 100(3):385-389
- 31 1966 Zimmerman B, Forsyth S. Diagnosis of allergy in different age groups of children: use of  
32 mixed allergen RAST discs, Phadiatop and Paediatric Mix. *Clinical Allergy*. 1988;  
33 18(6):581-587
- 34 1967 Zollner IK, Weiland SK, Piechotowski I, Gabrio T, von Mutius E, Link B et al. No increase  
35 in the prevalence of asthma, allergies, and atopic sensitisation among children in  
36 Germany: 1992-2001. *Thorax*. 2005; 60(7):545-548
- 37 1968 Zuidgeest MGP, van Dijk L, Smit HA, van der Wouden JC, Brunekreef B, Leufkens HGM  
38 et al. Prescription of respiratory medication without an asthma diagnosis in children: a  
39 population based study. *BMC Health Services Research*. 2008; 8:16

1 1969 Zuidgeest MGP, van Dijk L, Spreeuwenberg P, Smit HA, Brunekreef B, Arets HGM et al.  
2 What drives prescribing of asthma medication to children? A multilevel population-  
3 based study. *Annals of Family Medicine*. 2009; 7(1):32-40

4 1970 Zureik M, Liard R, Segala C, Henry C, Korobaeff M, Neukirch F. Peak expiratory flow  
5 rate variability in population surveys: Does the number of assessments matter? *Chest*.  
6 1995; 107(2):418-423

7 1971 Zwar NA, Marks GB, Hermiz O, Middleton S, Comino EJ, Hasan I et al. Predictors of  
8 accuracy of diagnosis of chronic obstructive pulmonary disease in general practice.  
9 *Medical Journal of Australia*. 2011; 195(4):168-171

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## Appendix Q: Feasibility report

**NICE** National Institute for  
Health and Care Excellence

# Asthma: diagnosis and monitoring guideline Primary care implementation feasibility project

January 2017

## 1. Background and aims

In January 2015, NICE issued a [draft guideline](#) on asthma diagnosis and monitoring. During consultation, stakeholders suggested a large investment in training and equipment would be needed to bring current practice in line with the guideline's diagnostic test recommendations, and that this was likely to be a major burden for primary care services and a barrier to implementation.

In August 2015 the guideline was paused to allow additional time to work with primary care professionals to assess the feasibility of adopting the diagnostic recommendations. These recommendations included use of 2 objective tests; spirometry and fractional exhaled nitric oxide (FeNO).

The [interim findings](#) guideline was published in January 2016. This made some revisions to the diagnostic algorithms, with advice to treat acutely unwell people on presentation immediately without waiting for objective tests, but to not make a formal diagnosis of asthma until objective tests have been done.

The Adoption and Impact team at NICE ran a feasibility project to test the diagnostic algorithms published in the interim findings guideline:

- Assess the impact and feasibility of adopting the technical diagnostic tests (spirometry and FeNO) recommended in the proposed asthma diagnostic guideline into primary care.
- Report the field testing findings back to NICE's Centre for Guidelines and the Guideline Development Group by the end of 2016. The findings would be used to help guide their review of the guideline recommendations in time for publication alongside the asthma management guideline in July 2017.
- Demonstrate that NICE has proactively responded to their comments.

An asthma feasibility project team was formed within the NICE Adoption and Impact team. The project team designed the feasibility project and worked with 7 primary care sites across England, who agreed to implement the revised diagnostic recommendations (including the 2 objective tests) and algorithms. Outcome data was collected for the 6-month period May to October 2016. This report is the findings from this work.



## 2. Methods

### ***Site recruitment***

On 25 January 2016, NICE advertised for GP practices in England interested in taking part in the primary care implementation feasibility project. This was done using the following communication channels:

- a dedicated project webpage on the NICE website
- the NICE Update for Primary Care newsletter
- the NICE GP newsletter
- the NICE Twitter feed
- NICE implementation field team contacts in local clinical commissioning groups (CCGs)
- a Primary Care Respiratory Society and Asthma UK member update.

In all, 78 expressions of interest were received before the closing date (27 February 2016). Of these, 69 were from individual GP practices and 9 were from sites which covered 2 or more practices. The practices and sites were spread across England: Yorkshire and Humber (6), West Midlands (9), South West (24), East Midlands (5), East of England (4), London (3), North East (4), North West (17), South East (6).

### ***Site selection***

Shortlisting criteria was focused around demographic characteristics to ensure feasibility was tested in a variety of settings. Consideration was given to:

- the size of the site or practice (patient numbers)
- geographical location (across England)
- the percentage of patients with an existing asthma diagnosis
- the practice's current care pathway for diagnosis of asthma
- registered patient characteristics (deprivation scores, ethnicity and age)
- the application form being fully completed and no conflicts of interest given
- the site or practice being able to provide retrospective baseline data.

Applications were automatically rejected if there were any relevant conflicts of interest in relation to this project (for example, any commercial interests with FeNO

1 testing), if retrospective baseline data was not available or if application forms were  
2 incomplete.

3 Shortlisted sites had a phone interview with 2 members of the asthma feasibility  
4 project team. The eventual cohort was selected on the basis of practice  
5 characteristics, rather than the perceived quality of their asthma service (see table 1).

### 6 ***Selected sites***

7 A total of 7 sites across England were selected (see figure 1). Some sites consisted  
8 of more than 1 individual practice. Their identity was kept confidential both internally  
9 and externally during the project to allow the sites to implement the  
10 recommendations without any external influences.

11 **Figure 1: Geographical location of each site**



12  
13

### 14 ***Site preparation***

15 Sites were asked to implement the diagnostic recommendations and algorithms from  
16 the interim findings guideline, with a specific focus on the spirometry and FeNO  
17 recommendations.

1 Sites were advised that NICE would not influence or dictate how they should  
2 implement these recommendations in terms of service model or staffing, and that the  
3 purpose of the project was to evaluate the feasibility of implementation only.

4 All sites were visited by 2 members of the asthma feasibility project team before the  
5 project started, and were given a full information pack including instructions for data  
6 collection. During this visit current service provision and levels of training were  
7 discussed and recorded.

### 8 ***Financial support***

9 Financial support of £3,000 per project site was made available to help with local  
10 data collection, payable upon completion of the project.

### 11 ***Diagnostic tests***

#### 12 **Spirometry**

13 Spirometry is a physiological test that measures how much air a person can breathe  
14 in and out (volume), and how quickly they can do this (flow). The primary  
15 measurement in spirometry may be volume or flow. All sites had their own spirometry  
16 equipment.

17 The draft NICE guideline does not specify any minimum requirements for spirometry  
18 training<sup>a</sup> and so no minimum training standard was imposed for this project.

19 Because access to [quality-assured diagnostic spirometry](#) was an issue highlighted  
20 during consultation, NICE offered to reimburse funding for accredited [Association for  
21 Respiratory Technology and Physiology \(ARTP\)/British Thoracic Society \(BTS\)](#)  
22 spirometry training and registration for certification for key staff at the project sites.  
23 This funding was given if the training element was completed by the end of the  
24 delivery part of the project, and was in addition to the financial payment made. Sites  
25 were given the contact details of their nearest ARTP training centres and [online  
26 training options](#), and were asked to organise this themselves.

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<sup>a</sup> The full guideline states that tests of pulmonary function should be carried out by appropriately trained staff with appropriate equipment, who are able to assess the correct performance of the test by the patient and the quality of the results.

1 Sites were under no obligation to take this training regardless of their current level of  
2 competence. This was because variation in competency reflects real-world variation.

3 In September 2016 [‘Improving the quality of diagnostic spirometry in adults: the  
4 National Register of certified professionals and operators’](#) was published. This  
5 competency assessment framework for diagnostic spirometry was co-produced by a  
6 stakeholder group and endorsed by NHS England. This states that diagnostic  
7 spirometry should be quality assured and only performed and interpreted by  
8 professionals assessed as competent against recognised standards. The framework  
9 sets out the new arrangements for diagnostic spirometry, which will be phased in  
10 from April 2017 to March 2021. Key to this framework is the establishment of a  
11 national register of certified healthcare professionals and operators. This register will  
12 ensure that commissioners, employers, and patients can be assured that healthcare  
13 staff performing and/or interpreting diagnostic spirometry hold a valid, current  
14 certificate of competence.

### 15 **Fractional exhaled nitric oxide (FeNO)**

16 NICE produced diagnostics guidance on [Measuring fractional exhaled nitric oxide  
17 concentration in asthma: NIOX MINO, NIOX VERO and NObreath](#) in April 2014.  
18 FeNO devices are used for measuring the amount of nitric oxide in the breath. Nitric  
19 oxide is produced in the lungs, and increased levels of nitric oxide in the breath are  
20 thought to be related to lung inflammation and asthma. The draft clinical guideline  
21 acknowledges that FeNO challenge testing has only recently been introduced in  
22 primary care, and because of this the availability of FeNO testing equipment is  
23 patchy.

24 The project team contacted the manufacturers of the recommended devices  
25 (Circassia and Bedfont Scientific), who offered to supply a FeNO device and all  
26 consumables needed for the duration of the project to each site at no charge. Sites  
27 were given the manufacturer’s contact details for both devices, and asked to follow  
28 their usual processes and considerations for choosing equipment to select the device  
29 they wished to use. Sites liaised directly with their chosen manufacturer to arrange  
30 delivery and training.

1       **Peak flow**

2       Peak expiratory flow (PEF) is an objective measure of lung function that has been  
3       widely used in the diagnosis and monitoring of asthma for many years. It is a  
4       measure of the maximum rate of expiration, generally expressed in litres/minute, and  
5       falls as the airways become narrowed because of bronchoconstriction. All sites were  
6       already measuring peak flow for some or all people with suspected asthma.

7       **Direct bronchial challenge test with histamine and methacholine**

8       Hyper-reactivity of the airways to non-specific stimuli (triggers) is a key feature of  
9       asthma. Bronchial hyper-reactivity (BHR) can be measured in a number of different  
10      ways. Inhalation of the bronchoconstrictors histamine and methacholine can be used  
11      to measure BHR. The draft clinical guideline acknowledged that the  
12      recommendations on bronchial challenge testing are a significant change to the  
13      diagnostic pathway. This test is only usually available in secondary and tertiary care,  
14      and it is likely only a few primary care professionals will have access to it on referral  
15      to secondary care at present. Sites were asked to note how many patients reached  
16      this point in the algorithms and what action they took.

17      **Data collection**

18      To establish the burden of asthma diagnosis in primary care, sites were asked to  
19      describe and record their existing pathway to diagnosis and to submit data for the  
20      equivalent 6-month calendar period in the previous year (May to October 2015). The  
21      baseline datasheet is shown in Appendix 1.

22      For the 6-month duration of the project (May to October 2016), sites were asked to  
23      implement the guideline and objective tests, follow the algorithms, and record the  
24      same information as was collected for the baseline. The metrics recorded during the  
25      6-month project are shown in Appendix 2.

26      The project attempted to answer the following questions:

Question	Measure
Burden of asthma diagnosis to practices	<ul style="list-style-type: none"><li data-bbox="568 1888 1318 1955">• number of patients presenting to GP with asthma symptoms<sup>1</sup></li><li data-bbox="568 1977 1334 2024">• number of patients receiving an asthma diagnosis<sup>1</sup></li></ul>

	<ul style="list-style-type: none"> <li>• time spent on diagnosis appointments<sup>1</sup></li> <li>• time from first presentation to diagnosis (including number of appointments)</li> <li>• for patients receiving an asthma diagnosis, the number diagnosed and their ages: <ul style="list-style-type: none"> <li>○ in primary care</li> <li>○ after referral to secondary care</li> <li>○ during hospital admission.</li> </ul> </li> </ul>
Feasibility of introducing quality-assured spirometry into practice	<ul style="list-style-type: none"> <li>• length of time to train practice staff to competency</li> <li>• type and grade of staff undertaking testing</li> <li>• time taken to undertake testing</li> <li>• clinic capacity needed</li> <li>• facilities needed</li> <li>• equipment cost</li> <li>• staff feedback</li> </ul>
Feasibility of introducing FeNO into practice	<ul style="list-style-type: none"> <li>• length of time to train practice staff to competency</li> <li>• type and grade of staff undertaking testing</li> <li>• time taken to undertake testing</li> <li>• clinic capacity needed</li> <li>• facilities needed</li> <li>• equipment cost</li> <li>• staff feedback</li> </ul>
<sup>1</sup> 6 months of project duration and 6-month equivalent calendar period in previous year	

1 **Site monitoring and reporting arrangements**

2 Sites were asked to submit data every month to the project team, using an excel  
3 spreadsheet on a secure site. Bi-monthly telephone calls were held to discuss  
4 progress and any issues, and a final site meeting was held to summarise and capture  
5 qualitative feedback.

6 During the 6-month delivery period of the project, sites were asked to:

- 7

8   - attend an initial face-to-face meeting with 2 members of the asthma feasibility project team, held at each practice

- 1 • attend bi-monthly semi-structured phone interviews with the asthma feasibility  
2 project team
- 3 • attend a final face-to-face meeting with 2 members of the asthma feasibility  
4 project team, held at each practice.

5 They were also asked to comment when the algorithm was not followed and give  
6 reasons for this.

7 At the final meeting, sites were asked 2 questions:

- 8 • Can the algorithm, as it currently stands, be implemented in a primary care  
9 setting?
- 10 • Would they continue with the algorithm if it remained unchanged at  
11 publication?

### 12 **3. Stakeholder engagement**

13 The asthma feasibility project team organised an update meeting for the stakeholders  
14 that were most active in providing consultation comments on the draft guideline. This  
15 meeting was held on 3 June 2016, and aimed to give stakeholders information about  
16 the projects' aims, objectives and progress. In all, 10 representatives attended from  
17 the following organisations: Association for Respiratory Technology & Physiology,  
18 Asthma UK, British Paediatric Respiratory Society, British Thoracic Society, Royal  
19 College of GPs, Royal College of Nursing, Royal College of Physicians. Apologies  
20 were received from: Association of Respiratory Nurse Specialists, Primary Care  
21 Respiratory Society UK, Royal College of Paediatrics and Child Health.

22 Thirteen stakeholders from the organisations listed above (apologies received from  
23 British Paediatric Respiratory Society and Royal College of Nursing) and 18  
24 representatives from the participating sites attended a project closure meeting held  
25 on 21 December 2016. The aim of the meeting was to:

- 26 • give an overview of the high-level findings to representatives from the national  
27 organisations that were most active in providing consultation comments on the  
28 draft guideline

- 1           • provide the participating sites the opportunity to share their experiences of  
2           implementing the diagnostic algorithms with each other and with the invited  
3           stakeholders
- 4           • give stakeholder representatives an opportunity to ask questions of the sites  
5           involved in the project
- 6           • update the project sites and national stakeholder organisations about next  
7           steps.

## 8           **4. Results**

### 9           ***Demographic characteristics of the 7 project sites***

10          The 7 project sites covered a total of 95,872 registered persons. Of these, 18,287  
11          (19.1%) were under 18 (all England: 20.7%) and 16,570 (17.3%) were aged 65 or  
12          over (all England: 20.9%). The mean deprivation scale was 5 (SD 1.4) and 16,466  
13          people (17.2%) were from non-white ethnic groups. Table 1 gives a full breakdown of  
14          characteristics by project site.

15



1 **Table 1: Demographic characteristics by project site**

Site	Location of site (England)	Individual practices within site	Registered persons	% aged under 18	% aged 65 or over	Deprivation decile <sup>1</sup>	Ethnicity estimate <sup>2</sup> % non-white ethnic groups
1	East Midlands	3	14,120	21.9	18.4	6	6.6
2	East of England	4	17,500	15.9	29.1	6	1.1
3	London	1	7,302	15.1	6.0	6	36.0
4	North East	1	3,093	17.0	18.5	5	1.4
5	North West	2	10,985	18.2	3.6	2	46.5
6	South West	4	18,678	18.0	17.0	6	2.5
7	West Midlands	2	24,598	22.2	17.5	4	29.7

2 <sup>1</sup> Deprivation decile detailed on the [National General Practice Profiles](#) 2016 population tab for each practice.  
3 Taken from the Index of multiple deprivation score (IMD 2015). Scale 1-10. 1 = more deprived.

4 <sup>2</sup> Ethnicity estimate detailed on the [National General Practice Profiles](#) 2016 population tab for each practice.  
5 This is the estimated proportion of non-white ethnic groups in the practice population.

## 6 **Baseline data**

7 All sites stated that they would be able to provide baseline data in their project  
8 application. However, all sites struggled with identifying patients who had presented  
9 with 'suspected asthma'. While there is a read code for 'asthma suspected', sites  
10 reported this is rarely used in practice and so they had to rely on other codes and  
11 inhaler prescriptions without an asthma diagnosis to give them a 'proxy' estimation.  
12 Sites reported that this may be an overestimation of numbers of people actually  
13 presenting with suspected asthma. Two sites were unable to identify 'suspected  
14 asthma' cases with any accuracy, but all sites were able to identify those patients  
15 who had been coded as diagnosed with asthma in the baseline period.

16 All sites said they previously referred to [BTS/SIGN guideline 141](#) on management of  
17 asthma (October 2014). For adults this recommends initial diagnosis based on a  
18 careful assessment of symptoms and a measure of airflow obstruction. In those  
19 patients with a high probability of asthma this included moving straight to a trial of  
20 treatment, with a recommendation for further testing for people whose response to a  
21 trial of treatment was poor.

22 All sites felt that a review of their baseline had been really helpful in focussing their  
23 efforts on improving the care pathway to diagnosis for their patients.

## 1 **Project data**

2 As the project information was being collected in real time, the accuracy of the data  
3 was superior to the retrospective baseline data. No proxy data was used by any site.

4 The ages of people on presentation are shown in Appendix 3 for both baseline and  
5 project data collection periods.

## 6 **Burden of asthma diagnoses to practices**

7 During the baseline period 42 new diagnoses of asthma were made compared with  
8 35 during the project period. Table 2 shows the numbers presenting and the numbers  
9 diagnosed.

10 **Table 2: Baseline and project suspected asthma and asthma diagnoses**

		Baseline		Project		Comparison
Site	Registered persons	Suspected asthma <sup>1</sup> (n)	Asthma diagnoses (n)	Suspected asthma (n)	Asthma diagnoses (n)	Change in number of asthma diagnoses (%)
1	14,098	62	8	27	6	-25%
2	17,500	62	8	19	4	-50%
3	7,300	28	1	21	1	0
4 <sup>2</sup>	3,074	8	2	15	7	+250%
5	10,900	30	1	18	2	+50%
6	19,000	N/A	7	19	7	0
7	24,000	N/A	15	24	8	-47%
<b>TOTAL</b>		<b>190</b>	<b>42</b>	<b>143</b>	<b>35</b>	<b>-17%</b>

11 <sup>1</sup> Proxy measure based on symptoms and prescribing. N/A = Not available

12 <sup>2</sup> Practice 4 employed an experienced part-time respiratory nurse between the baseline data period and project  
13 period

14 Across the 5 sites that were able to estimate full baseline data (sites 1–5), the  
15 number of people presenting with suspected asthma dropped from 190 to 100 in the  
16 baseline versus project period, but the percentage of asthma diagnoses increased  
17 from 11% to 20%, respectively. Across the 7 sites during the project period this  
18 proportion increased to 24.5% (35/143). In terms of overall numbers of asthma  
19 diagnoses, 3 sites decreased, 2 stayed the same and 2 increased, with a 17%  
20 decrease overall.

1 The dramatic increase in practice 4 was reported by the site to be because an  
2 experienced respiratory nurse practitioner had been taken on just before the project  
3 started. This practice had already identified asthma as a practice priority for  
4 improvement.

5 Because of the difficulty all sites experienced when gathering baseline data, and the  
6 approximate nature of this information, this cannot be considered an accurate  
7 reflection of the burden of asthma diagnosis before the project.

8 The mean number of days to diagnosis for the project, as shown in table 3, was  
9 greater than during the baseline period. This result is to be expected as all patients  
10 received an assessment appointment in the project period but this did not happen  
11 consistently during the baseline period.

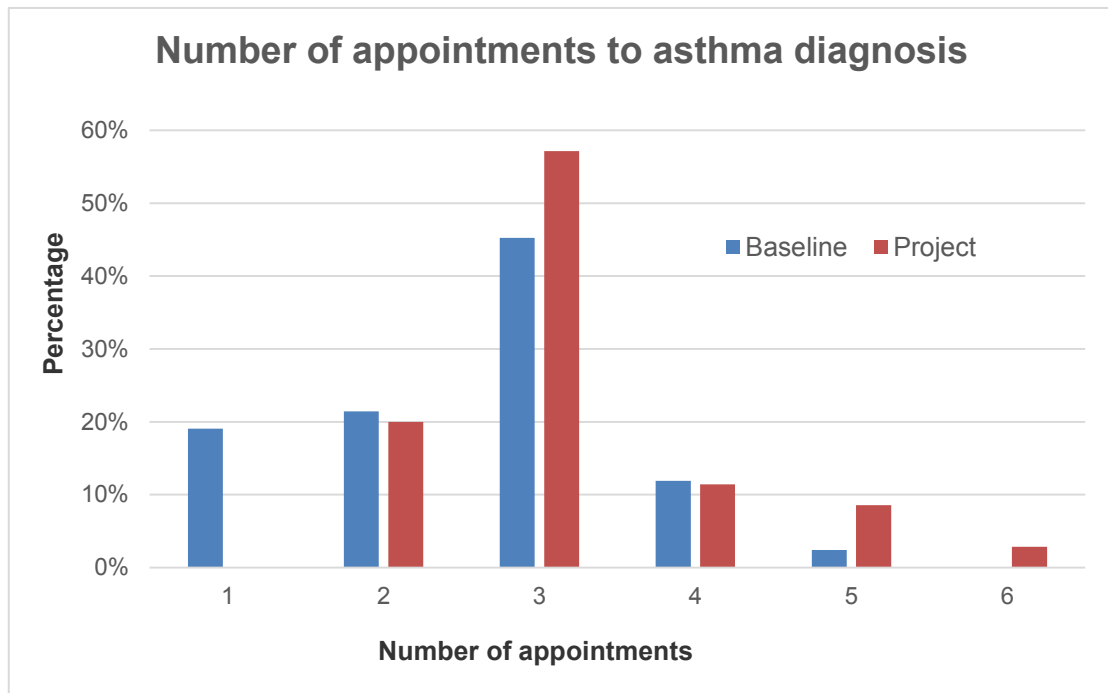
12 **Table 3: Time from presentation to asthma diagnosis**

<b>Period</b>	<b>Mean time to diagnosis (days)</b>	<b>Range (days)</b>	<b>Standard deviation</b>
Baseline	35	0–128	31.7
Project	53	3–141	33.1

13 Figures 2 and 3 show the difference in number of appointments and number of days  
14 to reach an asthma diagnosis between the baseline and project periods achieved  
15 within the 6-month data collection periods. During the baseline period an asthma  
16 diagnosis was more likely to be made at first or second presentation than during the  
17 project period.

1

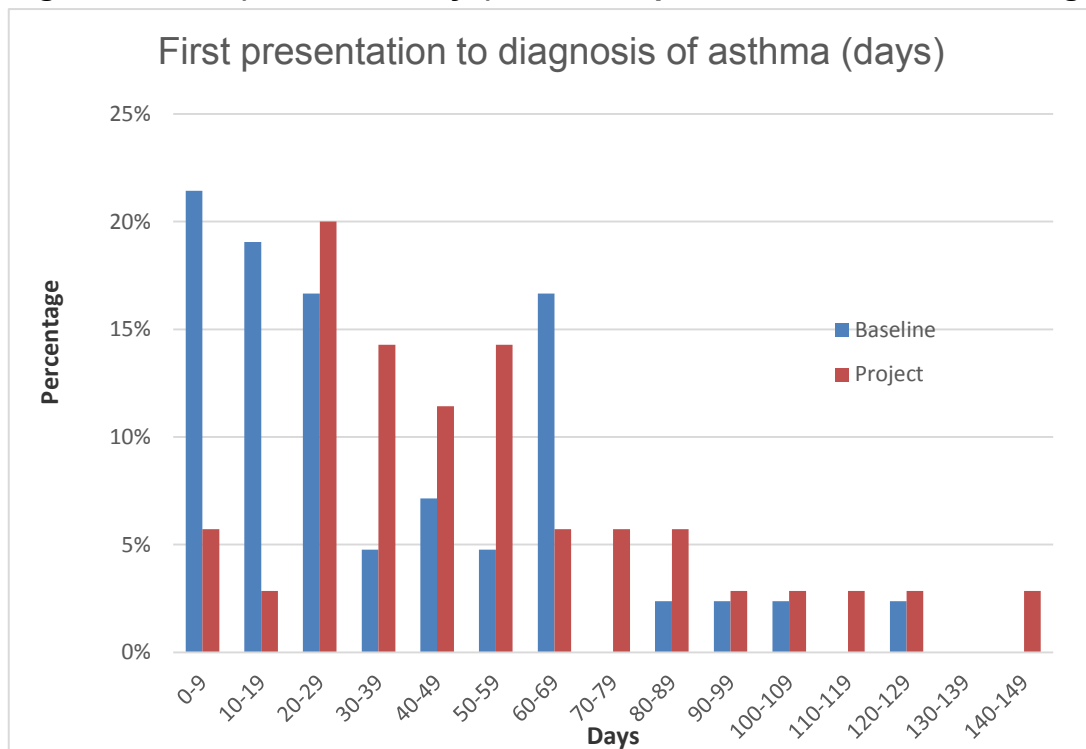
**Figure 2: Number of appointments to asthma diagnosis**



2

3

**Figure 3: Time (number of days) from first presentation to asthma diagnosis**



4

5

6

7

A further 11 people who had an ‘uncertain’ diagnosis at the end of the baseline period went on to be diagnosed with asthma at a later date. Their mean time to diagnosis was 219 days (range 20–379, SD 131).

1 Table 4 shows the diagnostic outcomes between the 5 sites that were able to identify  
2 people presenting with suspected asthma at baseline and all 7 sites for the project  
3 period.

4 **Table 4: Diagnostic outcomes of people presenting with suspected asthma**

	<b>Baseline (5 sites)</b>	<b>Project (7 sites)</b>
Asthma	20 (10.5%)	35 (24.5%)
Other	35 (18.4%)	19 (16.1%)
Uncertain	135 (71.1%)	85 (59.4%)
Total	190	143

5 Practices reported a higher level of confidence in the diagnosis of asthma during the  
6 project period. The project data may also reflect that GPs gave more thought to who  
7 they referred as 'suspected asthma' for diagnostic testing and assessment by the  
8 practice nurse.

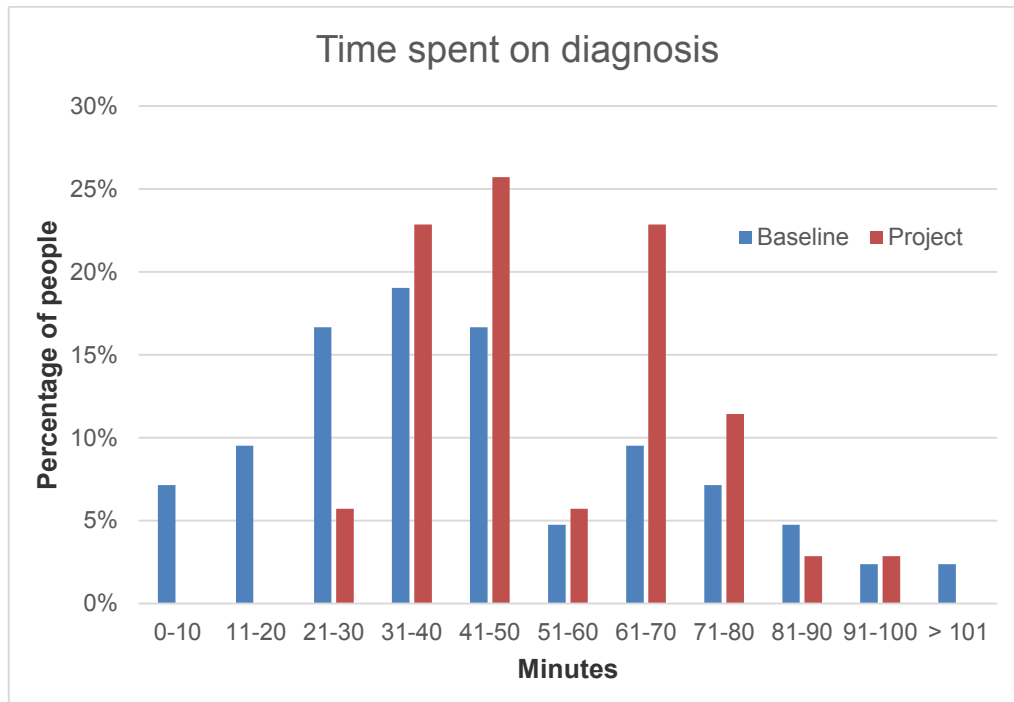
9 During the project data collection period, of the 85 patients that were classed as  
10 'uncertain' at the end of the data collection period:

- 11 • 32 (37.6%) had not yet completed the algorithm (for example, they had not yet  
12 had a follow-up appointment after the diagnostic tests)
- 13 • 25 (29.4%) failed to attend for follow-up; for 16 of the 25 (64%) this was after  
14 receiving a peak flow diary
- 15 • 28 (32.9%) had completed the algorithm and attended all appointments but  
16 the clinician was still uncertain of the final diagnosis.

### 17 ***Time taken for assessment***

18 Sites were asked to identify the total time spent on appointments to reach an asthma  
19 diagnosis at baseline and during the project. Figure 4 shows the range across all  
20 patients. The average time to reach a diagnosis rose from 49 minutes (range 10–  
21 140, SD 27) during the baseline period to 57 minutes (range 30–100, SD 18) during  
22 the project. This result reflects that all patients received a diagnostic assessment  
23 appointment within the project period.

1 **Figure 4: Time spent on diagnosis appointments (including initial presentation**  
 2 **appointment) all sites**



3  
 4 Time allocated to asthma assessment varied between sites both before and during  
 5 the project, as shown in table 5. This also reflects the variation during the project  
 6 shown in figure 4.

7 **Table 5: Time allocated for asthma assessment appointments following initial**  
 8 **presentation appointment (by site)**

Site	Baseline <sup>1</sup>	Project	
		Spirometry and FeNO	BDR
1	10 mins GP, 2 x 20 mins nurse	60 mins nurse	
2	30–40 mins nurse	70 mins nurse	
3	2 x 15 mins nurse	15 mins nurse	15 mins nurse
4	20 mins nurse	40 mins nurse	
5	2 x 20 mins nurse	20 mins nurse	20 mins nurse
6	30 mins nurse	30 mins nurse	
7	2 x 30 mins nurse	30 mins nurse	30 mins nurse

9 <sup>1</sup> During the baseline all sites reported that not all patients followed this pathway, with many not  
 10 receiving a referral for a nurse assessment.  
 11 The methods used for allocating diagnostic assessment appointments varied. Some  
 12 practices already had nurse-led respiratory clinics that had been set up before the  
 13 project, and used these. Others set up clinics as part of implementing the project.  
 14 Some sites allocated routine slots into practice nurse sessions. Two sites also used

1 healthcare assistants to undertake the spirometry and FeNO testing, and 1 site is  
2 planning to do this.

3 The interpretation of test results was done by the nurses at all but 1 site, which sent  
4 results to the GP for final interpretation.

5 Three sites took the opportunity to redesign their asthma appointments before the  
6 project started, allocating more time to the nurse assessment appointment. These  
7 sites felt that spending more time on assessment would prevent future 'revolving  
8 door' presentations with the GP.

9 Some sites reported high non-attendance rates for the assessment appointments,  
10 particularly if the person's symptoms had improved with use of an inhaler.

## 11 ***Spirometry***

### 12 **Training and competency**

13 At baseline, 6 out of 7 sites had nurses who already did spirometry as a routine part  
14 of their asthma diagnosis pathway, and all sites used spirometry to diagnose chronic  
15 obstructive pulmonary disease (COPD).

16 Of the 7 sites, 3 already had staff fully certified in spirometry. Five sites attempted to  
17 access [ARTP-accredited spirometry training](#) in the 6-month project timescale:

- 18 • One site chose an [Education for Health level 5 module in performing quality-](#)  
19 [assured spirometry](#) for 2 practice nurses (£598 per person). This involved 4  
20 months e-learning and attendance at 1 study day and 1 assessment day  
21 leading to foundation level entry on the [ARTP national register](#).
- 22 • Two sites accessed [classroom based ARTP accredited](#) performance and  
23 interpretation training (2 day course):
  - 24 ○ 1 site accessed local training for 2 GPs and a practice nurse (course fee  
25 £250 per person)
  - 26 ○ 1 site could only access training 350 miles away, meaning 2 nurses had to  
27 take 2 additional days out of work time for travel (course fee £200 per  
28 person, plus £200 per person for full certification).
- 29 • Two sites could not access any ARTP training locally:

- 1           ○ 1 site opted for [ARTP e-learning](#) for a GP and practice nurse (course fee
- 2                   £275 per person)
- 3           ○ 1 site opted for non-ARTP local public health team spirometry training for
- 4                   their healthcare assistant (free of charge).

5           All sites commented that spirometry testing can be difficult because of the time  
6           practitioners and patients need to perform it correctly. Sites were made aware by the  
7           project team of the recently published competency assessment framework for  
8           diagnostic spirometry, and had questions about how this was going to be  
9           implemented and monitored.

10          Sites agreed that spirometry should be improved and quality assured and reflected  
11          that the competency assessment seemed a good initiative that should be  
12          implemented. They also indicated that many practices may struggle to achieve this,  
13          creating a major adoption challenge. They also all agreed that there are patient-  
14          related motivational, comprehension and cultural issues in getting this right, and that  
15          these all present potential adoption challenges.

16          It should be noted that the challenges facing quality-assured diagnostic spirometry  
17          would also apply to a number of other conditions, most notably COPD.

18          The classroom-based ARTP training received by 2 sites (2-day course for performing  
19          and interpreting) was reported as being really helpful, with participants saying they  
20          learnt a lot that would improve their practice. Only 2 nurses (from the same site)  
21          opted to register for [full certification](#) (completion of a portfolio, an assignment, a  
22          practical and oral exam). This was reported to be time consuming and difficult (but  
23          worthwhile) by certified staff at other sites, and a barrier to implementing the NICE  
24          guideline by other non-certified staff. Sites suggested that the training should be  
25          given by practitioners with experience of working in a primary care setting. Feedback  
26          from training given in secondary and tertiary centres was that this did not necessarily  
27          meet the needs of a primary care audience.

28          The ARTP also offer an [experienced practitioner scheme](#) for people who are already  
29          highly experienced at performing spirometry so do not need further  
30          training/experience. Candidates have to meet stringent criteria to be eligible for the



1 scheme, and if suitable can take a practical assessment to obtain the Foundation or  
2 Full Certificate.

### 3 **Spirometry outcomes in project period**

4 Of the 143 people who presented with suspected asthma during the project period,  
5 algorithms were started in 137 people (the remaining 6 people were still awaiting the  
6 diagnostic assessment appointment at the end of the project). Table 6 shows the  
7 spirometry outcome results during this time.

8 **Table 6: Spirometry results for all people during the project period**

Status	All people	People diagnosed with asthma
Assessment completed	137/143	35/137
Spirometry successfully completed	124/137 (90.5%)	33/35 (94.2%)
Person not able to do spirometry	9/137 (6.6%)	1/35 (2.9%)
Spirometry contraindicated	4/137 (2.9%)	1/35 (2.9%)
Spirometry result normal	102/124 (82.3%) of completed	24/33 (72.7%) of completed
Spirometry result obstructive	22/124 (17.7%) of completed	9/33 (27.3%) of completed

9 All clinicians involved commented that because of the nature of the disease,  
10 spirometry may not pick up airway obstruction as this only happens if the person is  
11 symptomatic at the time of testing. Of the 33 people diagnosed with asthma during  
12 the project, whose spirometry was successfully completed, only 9 had an obstructive  
13 result.

14 Some nurses continued to do bronchodilator reversibility testing for patients with  
15 suspected asthma who had a lower than expected spirometry result that was still  
16 classed as 'normal' by the algorithm.

17 One site was sceptical about the use of spirometry to diagnose asthma, and did not  
18 change their view as a result of completing the project.

1 Two sites commented that the guideline does not make allowances for patients who  
2 are unable to perform, or are contraindicated for, the diagnostic tests. While this may  
3 be a relatively small proportion of people with suspected asthma (2.9% in the  
4 project), it could work out to be a significant number nationally.

5 All sites commented on the difficulty of performing spirometry on very young children,  
6 and many commented that they thought the diagnostic algorithm for children should  
7 be for those aged 8 years and over. During the project period 6 children (4.2%) aged  
8 5 to 7 years presented with asthma symptoms. Two of these children were unable to  
9 perform spirometry, and 1 child (aged 5) could not perform either spirometry or  
10 FeNO.

### 11 **FeNO**

12 None of the sites had any previous experience of using a FeNO device and all 7  
13 were keen to try it: 5 sites opted to use the [NIOX VERO](#) device and 2 sites chose the  
14 [NObreath](#) device. All sites reported that the devices and consumables are expensive,  
15 and that widescale adoption is unlikely to occur without financial incentive. CCG bulk  
16 buying of spirometers and point-of-care coagulometers were cited as examples of  
17 how this might be achieved. The costs of the 2 devices and associated consumables  
18 are shown in table 7.

19

1 **Table 7: FeNO device costs**

Device	Device cost	Other cost	Filters (each)
NIOX VERO	£2,540	NIOX Apps (optional software) £138	£8.75 (pack 100) £5.32 (pack 300) £4.62 (pack 1,000)
NObreath	£1,495	Bi-annual service £540	£3.00

2 All sites received training from the manufacturer on use of the device and how to  
3 interpret results. There is no formal assessment of competency for the use of the  
4 FeNO devices, but this was reported to be straightforward by the sites and training  
5 took less than 1 hour. Sites felt that an improved knowledge and understanding of  
6 the FeNO test and results would be necessary if this test becomes part of routine  
7 practice in asthma diagnosis.

8 Six sites stated that FeNO was a welcome addition to the diagnostic process and an  
9 easy test to carry out, with positive feedback from patients. It was also reported that  
10 using FeNO gives additional confidence in prescribing decisions at an earlier stage.

11 One site suggested that FeNO should be the first-line test as it is easier to perform  
12 than spirometry. People who failed to successfully complete spirometry and FeNO,  
13 may have been able to complete the FeNO if this had been the first-line test due to  
14 the effort involved in performing spirometry.

15 The read code some practices used to record the test is XaRCB (exhaled nitric oxide  
16 test). The result was then written in a free text box on the electronic patient record  
17 and an explanation given if necessary. The clinicians involved in the project thought  
18 that, as FeNO is a new test to general practice, it was important to record and explain  
19 test results for other members of staff.

20 Sites were concerned about the accuracy and usefulness of FeNO in people who  
21 smoke. It was reported that the manufacturers advise patients to not smoke for 48  
22 hours before the test, as smoking can depress FeNO levels. Sites reported poor  
23 patient compliance with this. This may present a significant adoption issue for this  
24 group of patients.

1 Opinions on FeNO differed between the practices depending on the particular FeNO  
2 device used. Positive factors included high patient acceptance and aiding patient  
3 motivation and better clinician confidence in terms of prescribing decisions. Device  
4 issues raised included time to start up and calibrate between readings, subjectivity in  
5 performing the test and interpreting the result, a result being provided regardless of  
6 whether the test was carried out correctly or not, and results not being integrated into  
7 the practice system.

8 One site reported persistent operational problems that affected test results, meaning  
9 they were not consistent or reproducible. This site also reported that their device  
10 made an unacceptably loud noise during operation and the manufacturer performed  
11 a modification to reduce this. Because of these issues, they had little confidence in  
12 the use of FeNO in the diagnostic pathway.

13 A number of sites suggested that a 'hub and spoke' model for asthma diagnosis may  
14 improve the feasibility of widescale FeNO adoption as it would enable better use of  
15 resources.

### 16 ***Peak flow***

17 Issues with peak flow diaries were patient compliance and non-attendance at follow-  
18 up. This was reported to be an issue both before and during the project. One practice  
19 suggested that it may be better to give the peak flow diary to the patient at  
20 presentation so that this could be monitored throughout the acute and recovery  
21 phases. This may also shorten the time to diagnosis and reduce the likelihood of  
22 non-attendance. If a patient does not return to the practice with their peak flow diary  
23 for the final appointment the algorithm cannot be completed, creating a significant  
24 implementation issue. Of the 90 people who were supposed to return with a  
25 completed peak flow diary before the end of the project period, 18 (20%) did not  
26 attend and a further 6 (7%) did not complete the algorithm.

### 27 ***Direct bronchial challenge testing***

28 All sites reported that the algorithm comes to a dead end at direct bronchial  
29 challenge testing with histamine or methacholine. No sites were able to refer people  
30 for this test, as it was not available in their local secondary care respiratory clinic.  
31 During the project 14 people came to this point in the algorithm. Four people were

1 referred for a secondary care outpatient appointment as the only alternative option  
2 available, and have not yet received a diagnosis. Of the other 10 people kept in  
3 primary care, 4 were diagnosed with asthma following a trial of treatment and 6 were  
4 'other' or 'uncertain' by the end of the project period.

### 5 ***Other diagnosis data***

6 During the baseline period, 90.5% (38/42) of people received their asthma diagnosis  
7 in primary care. During the project period all asthma diagnoses were made in primary  
8 care.

9 The approach to formally diagnosing patients and coding this on IT systems during  
10 the project period varied between practices. At 3 sites GPs took responsibility for  
11 doing this. At the other 4 sites the nurses carrying out the diagnostic algorithm  
12 generally diagnosed and recorded the outcome. Two sites reported that nurses may  
13 not have the autonomy or feel comfortable diagnosing patients, and that the reason  
14 for this may be that diagnosis is a fairly new area of practice for some nurses.

### 15 ***Adherence to draft guideline algorithms***

16 During the project data collection period, 137 people attended an asthma  
17 assessment appointment. The remaining 6 people were waiting for an assessment  
18 appointment at the end of October 2016.

19 The algorithm was followed exactly in 75 people (54.7%), with the remaining 62  
20 people (45.3%) experiencing deviations from the algorithms because of either their  
21 ability to complete the tests (10) or alternative clinical judgement (52).

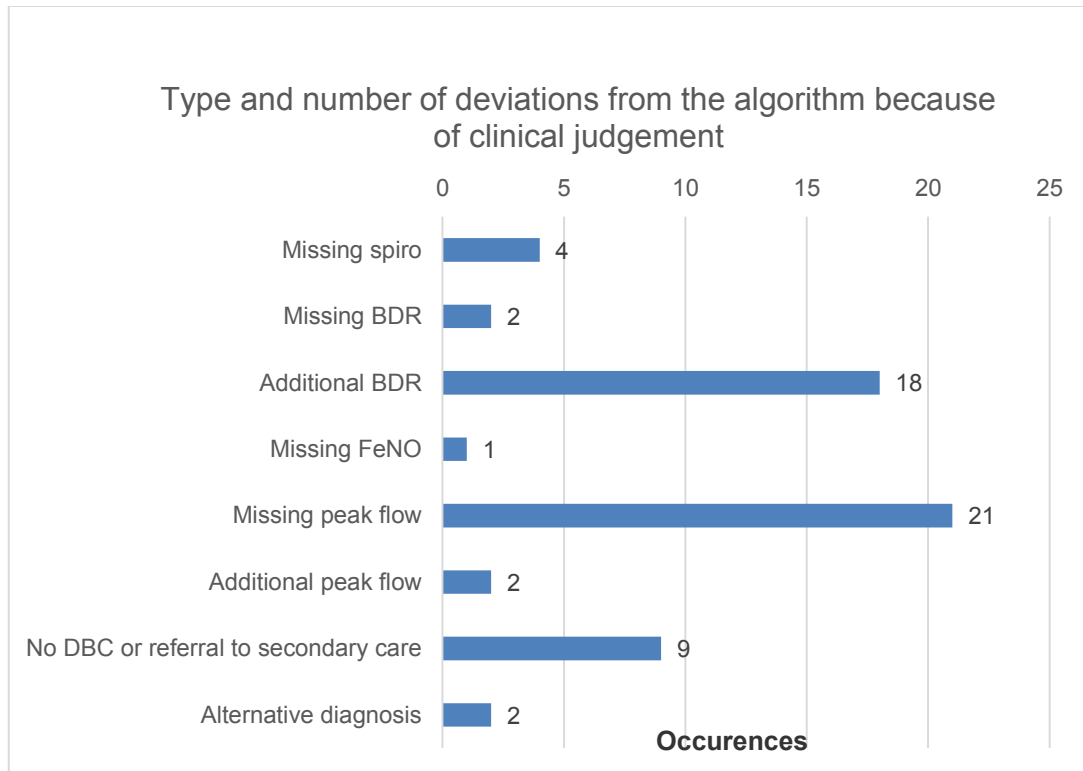
22 Of the 10 patients who were unable to complete the diagnostic tests:

- 23 • 5 were unable to do spirometry
- 24 • 1 was unable to do FeNO
- 25 • 4 were unable to do either spirometry or FeNO.

26 Reasons given were: too difficult (5 children, 3 adults) and issues with language  
27 barriers making it difficult to explain what to do (2).

28 For the remaining 52 patients, clinical judgement was the reason given for deviating  
29 from the algorithm (see figure 5).

1 **Figure 5: Deviations from algorithm**



2

3 **Site conclusions**

4 All sites agreed that the algorithm could be implemented into primary care as it  
5 stands, and that implementation is not an overwhelming burden for those patients  
6 who were already being referred appropriately for spirometry assessment by the  
7 practice nurse. All sites acknowledged that collecting the baseline data highlighted  
8 that, previous to the project, some patients were just being seen by the GP, given a  
9 beta<sub>2</sub> agonist inhaler and then not followed up. All sites reported that this was not  
10 their agreed pathway before the project and was not good practice.

11 All sites felt the algorithms were too busy, and the text size too small, making them  
12 difficult to use in clinics because of a lack of space to display them. Lack of familiarity  
13 with the algorithms was also raised as an issue, particularly if they were not being  
14 used every day. One site suggested merging the adult algorithms onto 1 page  
15 (normal and obstructive).

16 All sites stated that doing diagnostic testing with small children is very difficult. They  
17 considered a more reasonable age to attempt diagnostic testing to be 8 years and  
18 over.

1 Of the 7 sites, 6 said they would like to continue with the algorithm if it remained  
2 unchanged at publication. However all sites stated that this was helped by being  
3 given the FeNO device free of charge by the manufacturer. Reasons given were that  
4 the algorithms had improved time to diagnosis and confidence in diagnosis. The  
5 increased confidence came from the addition of the quantitative element to diagnosis  
6 and the avoidance of diagnosis at initial presentation.

7 One site is trying to gain partner agreement to continue using FeNO because of the  
8 ongoing cost of consumables.

9 The site that said they would not continue with the algorithm said they would revert to  
10 previous practice and did not find either the spirometry or FeNO testing particularly  
11 useful for asthma diagnosis.

## 12 **5. Implementation levers**

13 The following implementation/adoption levers were identified.

14 All practices reported that being part of the project has ensured that GPs have  
15 consistently referred patients with suspected asthma to the practice nurse for  
16 assessment, and that this is a great improvement on previous practice. Sites feel that  
17 this has helped prevent 'revolving door patients'. These are people who present with  
18 symptoms, are given an inhaler, and then not followed up or coded as suspected  
19 asthma. These patients may re-present to a GP during exacerbations on a number of  
20 occasions without receiving a formal diagnosis.

21 A number of sites commented that any increased time for assessment is offset by  
22 saving GP time with these patients in the future.

23 One site reported that, as a result of implementation of the algorithms, there are now  
24 fewer people being prescribed inhalers without a diagnosis. This same site indicated  
25 that they now start fewer people on beta<sub>2</sub> agonist inhalers.

26 Referral to a practice nurse for assessment and advice was not happening  
27 consistently at any site before the project. Some sites commented that adding  
28 structure to the diagnostic process had really helped improve consistency.

## 1 **6. Project team reflections**

2 If this project were to be repeated, competency with diagnostic spirometry would  
3 have to be established in line with the new recommendations from NHS England.  
4 This would likely make site recruitment more challenging, as only practices with  
5 appropriately certified staff could legitimately attempt implementation of the guideline.  
6 By default, this will also make real-world implementation of the guideline more  
7 challenging than has been reported here.

8 A key issue highlighted by sites was the confusion and disconnect in user  
9 understanding of the differences, overlap, benefits and drawbacks of having 2 sets of  
10 nationally-produced guidelines on diagnosing asthma, especially as they had  
11 conflicting advice. The project team were able to explain the different methodologies  
12 to the sites, and in particular the fact that NICE consider cost effectiveness as well as  
13 evidence of clinical effectiveness in developing guideline recommendations. All sites  
14 said they were unaware of these differences. An implementation aid to support  
15 uptake of this guideline could include a comparison of the scope, design and  
16 methods employed by different guideline developers or an annotated version  
17 explaining the rationale for differences to reduce user confusion.

18 Part of the selection criteria for site recruitment was the ability to provide baseline  
19 data. This may have put off some sites who had considered applying, particularly if  
20 they had already identified how complex this could be to do. This information has  
21 highlighted that being able to measure local success associated with implementing  
22 the guideline, using before and after data, could be a more commonplace barrier to  
23 implementation than previously thought. If the same project were to be delivered  
24 again, collecting real time data before and during the project would improve the  
25 accuracy of comparisons. Improvements in accurately coding for asthma are needed  
26 to allow for data collection and measuring local impact.

## 27 **7. Summary and conclusions**

28 This feasibility project set out to evaluate if the diagnostic elements of the draft  
29 asthma diagnosis and monitoring guideline could be implemented into practice in  
30 primary care, in response to concerns raised during guideline consultation.



1 The draft NICE guideline published in January 2015 identified that the 3 most  
2 important and challenging areas to adopt will be:

- 3 1 using spirometry
- 4 2 FeNO challenge testing
- 5 bronchial challenge testing.

6 In all, 7 sites implemented the diagnostic algorithms, collected data for comparison  
7 and reported back on their implementation experience. The findings identified in this  
8 work are summarised below:

### 9 **Algorithms**

- 10 • the diagnostic algorithms can be implemented into practice
- 11 • 5 out of 7 sites would continue to use the algorithms if the guideline were  
12 published as it is
- 13 • the algorithms could benefit from simplification
- 14 • the algorithms are impractical for many children under 8
- 15 • the recommendations do not cover what to do with patients who are  
16 contraindicated/unable to undergo diagnostic testing

### 17 **Spirometry**

- 18 • diagnostic spirometry takes time to do correctly
- 19 • the new competency recommendations create adoption issues around access  
20 to (and funding of) training but the importance of improving the quality  
21 assurance of spirometry nationally was recognised both for asthma and other  
22 respiratory conditions
- 23 • there is scepticism with spirometry picking up airway obstruction, as this only  
24 happens if the person is symptomatic at the time of testing

### 25 **FeNO**

- 26 • the cost of FeNO devices and consumables is a barrier to implementation
- 27 • positive clinician feedback and high patient acceptance with FeNO may act as  
28 a lever
- 29 • lack of clinician confidence in specific FeNO devices to produce consistent  
30 results may present an adoption issue

31

1       **Other**

- 2           • bronchial challenge testing is largely not available in secondary care making it  
3           difficult to refer patients for this when they reach the relevant part of the  
4           algorithm
- 5           • patient acceptance and compliance present challenges in the clinician’s ability  
6           to complete the full care pathway, for example:
- 7               ○ poor completion of peak flow diaries
- 8               ○ failure to abstain from smoking for 48 hours before tests
- 9               ○ failing to attend follow-up appointments (clinicians felt attendance was  
10              driven by patient symptoms)
- 11          • conflicting national guidelines on diagnosing asthma may present  
12          implementation issues.

13       The commissioning of this project demonstrates commitment and responsiveness on  
14       behalf of the guideline developers to explore concerns raised during consultation  
15       about its implementation. This is consistent with NICE’s wider accountability  
16       objectives. While this project has demonstrated the guideline can be implemented  
17       into practice, and will be by some, others may feel that in the current NHS climate the  
18       barriers identified will prevent them from doing so.

19       **8. Acknowledgements**

20       NICE would like to acknowledge and thank the following primary care organisations  
21       and staff for their valuable contribution to this feasibility project.

22       **Coastal Partnership**

- 23       3    Siobhan McGrath, Practice Nurse
- 24       4    Mary Weatherstone, Pharmacist
- 25       Anna Lindsey-Halls, Practice Nurse

26       **Cornbrook Medical Practice**

- 27       5    Murugesan Raja, GP and Respiratory lead
- 28       Karen Shelly, Practice Nurse

29       **Kensington Park Medical Centre**

- 30       6    Jas Dua, GP
- 31       7    Arash Kamvari, GP

1 Hannah Bindloss Gibb, Practice Nurse

2

3 **Lagan Surgery**

4 8 Lisa Johnson, Nurse Practitioner

5 Ruth Barker, Practice Manager

6

7 **Linden Medical Practice**

8 9 Simon Spooner, GP

9 10 Alison Moxey, Nurse Practitioner

10 11 Lesley Virgo, Nurse Practitioner

11 Peter Billingham, Practice Manager

12

13 **Lordswood Medical Group**

14 12 Liz Wison, Respiratory Nurse Specialist

15 13 Will Taylor, GP

16 Gopi Potluri, IT Manager

17

18 **Penryn Surgery**

19 14 Trish Rooney, Practice Nurse and Respiratory lead

20 15 Chrissey Dunne, GP and Respiratory Lead

21 16 Cate Holliday, Practice Nurse

22 17 Mandy Hackwell, Practice Nurse

23 18 Jenny Tregenza, Practice Nurse

24 Emma Berry, Practice Manager

25

26 ***NICE project team***

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2 Project Manager, Medical Technology Implementation Manager

3 **Louise Miller**

4 Analyst – Adoption and Impact

5 Sites involved in the development of this report have received training, equipment  
6 and consumables free of charge from the 2 companies that provide NICE-  
7 recommended FeNO technologies. The content of this report has been checked for  
8 factual accuracy, to ensure it is fair and balanced, and to ensure its compliance with  
9 appropriate regulations.

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**Appendix 1**

**ASTHMA FEASIBILITY PROJECT BASELINE DATA**

<b>TO BE COMPLETED FOR ALL PEOPLE PRESENTING WITH SUSPECTED ASTHMA MAY - OCTOBER 2015</b>									
Patient	Date of presentation	Age	Final diagnosis*	Date of asthma diagnosis	Time spent on diagnosis appointments (minutes)	Number of appointments to diagnosis	Place of diagnosis#	Practice	Comment
1									
2									
3									
4									
5									
6									

\* asthma/other/uncertain

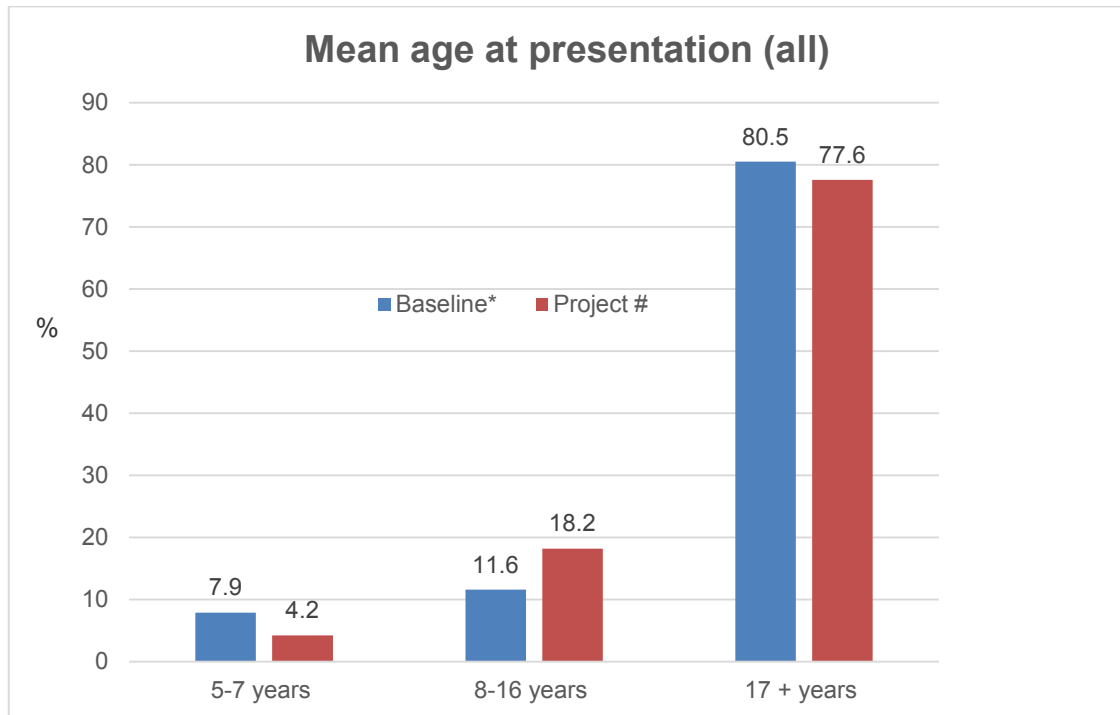
# primary care/secondary care OPD/secondary care admission

- 1           **1.    Appendix 2**
- 2           **ASTHMA FEASIBILITY PROJECT METRICS**
- 3
- 4           **Presentation**
- 5            • Date
- 6            • Age
- 7            • Appointment duration (minutes)
- 8           **Spirometry**
- 9            • Spirometry date
- 10           • Appointment duration (minutes)
- 11           • Spirometry result (obstructive/normal)
- 12           • Number of filters used
- 13           • Staff performing spirometry (HCA/nurse/GP)
- 14           • Staff interpreting spirometry (HCA/nurse/GP)
- 15           **Bronchodilator reversibility (BDR)**
- 16            • BDR test date
- 17            • Appointment duration (minutes)
- 18            • BDR result (positive/negative/N/A)
- 19            • Number of filters used
- 20            • Staff performing BDR(HCA/nurse/GP)
- 21            • Staff interpreting BDR (HCA/nurse/GP)
- 22           **FeNO**
- 23            • FeNO date
- 24            • Appointment duration (minutes)
- 25            • FeNo result (positive/negative/N/A)
- 26            • Number of filters used
- 27            • Staff performing FeNo (HCA/nurse/GP)
- 28            • Staff interpreting FeNo (HCA/nurse/GP)
- 29           **Peak flow variability**
- 30            • Peak flow variability monitored (Yes/No)
- 31            • Peak flow result (positive/negative/N/A)
- 32           **Direct bronchial challenge**
- 33            • Date referred for direct bronchial challenge test
- 34            • Date of test
- 35            • Bronchial challenge test result (positive/negative/N/A)
- 36           **Other onward referral**
- 37            • Other onward referral (Yes/No)
- 38            • Referred to
- 39           **Diagnosis**
- 40            • Date of diagnosis
- 41            • Diagnosis (Asthma/Other/Uncertain)
- 42            • Diagnosing clinician (Site nurse/Site GP/Secondary care)
- 43            • No. of practice appointments to reach diagnosis

1  
2

## 2. Appendix 3

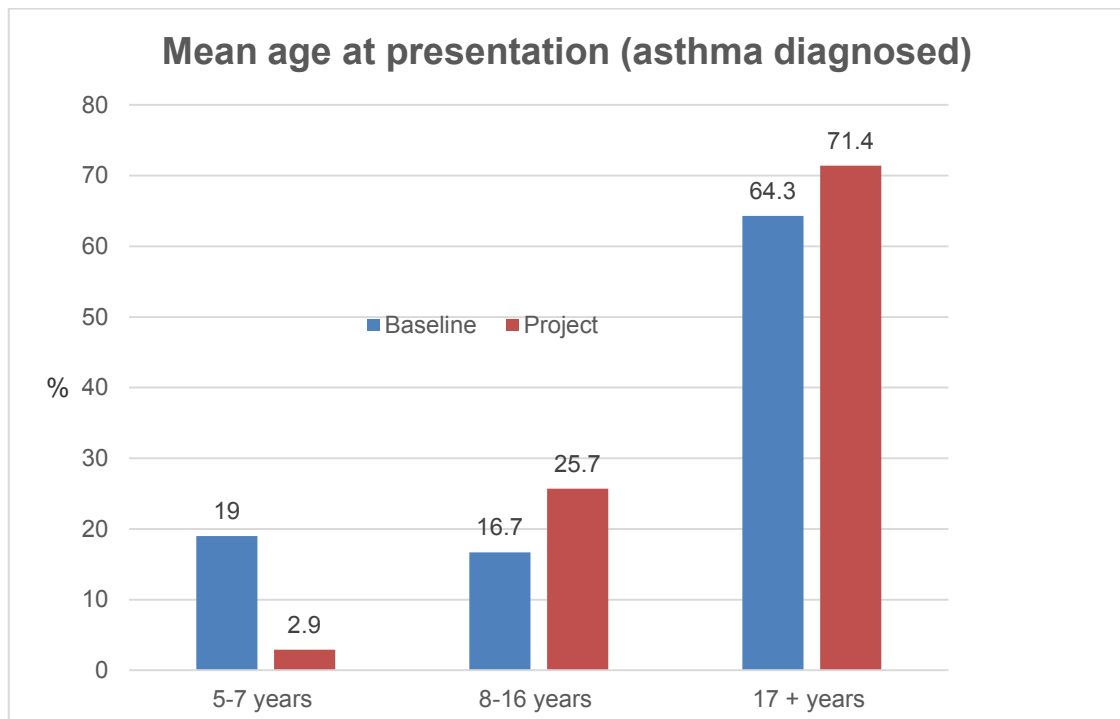
### Age of people on presentation with suspected asthma



3  
4  
5  
6

\* Baseline: 5 sites. # Project: 7 sites.

### Age of people on presentation who were diagnosed with asthma



7  
8  
9  
10

Data shown for all sites for baseline and project.

1  
2  
3

# Appendix R: Summary of evidence from 2017 updated searches for Asthma: diagnosis and monitoring

## Appendix R: Summary of evidence from 2017 updated searches for Asthma: diagnosis and monitoring

### Summary of evidence

#### *Diagnosis: Signs and symptoms*

**Q – 01** In people under investigation for asthma, what is the diagnostic accuracy of each of the following signs and symptoms: wheezing, cough, breathlessness, nocturnal symptoms, diurnal and seasonal variations?

#### Recommendations derived from this question

##### Initial clinical assessment

1. Treat people who are acutely unwell at presentation immediately, without delaying for objective tests.
2. Perform objective tests at the time of presentation (including spirometry and FeNO) whenever possible. If objective tests cannot be done immediately, they should be done when acute symptoms have been controlled.
3. Do not make a formal diagnosis of asthma until objective tests have been done.

##### Signs and symptoms

4. Take a structured clinical history in people with suspected asthma. Specifically, check for:
  - wheeze
  - cough
  - breathlessness
  - any variation in the above symptoms occurring over the course of 24 hours or seasonally.
5. Do not use symptoms alone without an objective test to diagnose asthma. See also recommendation 27.
6. Physically examine people with suspected asthma to identify expiratory polyphonic wheeze and signs of other causes of respiratory symptoms, but be aware that even if examination results are normal the person may still have asthma.

##### Update decision

No new information was identified.

---

##### *Initial clinical assessment*

##### Update summary

No relevant evidence was identified.

##### Committee feedback

No Committee feedback was relevant to this evidence.

4



---

*Signs and symptoms*

**Update summary**

No relevant evidence was identified.

**Committee feedback**

No Committee feedback was relevant to this evidence.

**Q – 02 In people under investigation for asthma, what is the diagnostic accuracy of taking a personal/family history of atopic disorders?**

**Recommendations derived from this question**

7. Ask about a personal or family history of atopic disorders. Record any triggers that make symptoms worse.
8. Do not use a history of atopic disorders alone to diagnose asthma.

**Update decision**

No new information was identified.

---

*Taking personal/family history*

**Update summary**

No relevant evidence was identified.

**Committee feedback**

No Committee feedback was relevant to this evidence.

**Q – 03 In people under investigation for asthma, what is the diagnostic accuracy of a clinical history of symptoms in response to exercise?**

**Recommendations derived from this question**

9. Do not use an isolated clinical history of symptoms after exercise to diagnose asthma.

**Update decision**

No new information was identified.

---

*Clinical history of symptoms in response to exercise*

**Update summary**

No relevant evidence was identified.

**Committee feedback**

No committee feedback was relevant to this evidence.

---

**Q – 04 In people under investigation for asthma, what is the diagnostic accuracy of a clinical history of symptoms after taking the following drugs: in adults (beta blockers, aspirin, or other NSAIDs) or in children (ibuprofen)?**

**Recommendations derived from this question**

No clinical recommendations.

**Update decision**

No new information was identified.

---

*Clinical history of symptoms after taking medication in adults*

**Update summary**

No relevant evidence was identified.

**Committee feedback**

No Committee feedback was relevant to this evidence.

---

*Clinical history of symptoms after taking medication in children*

**Update summary**

No relevant evidence was identified.

**Committee feedback**

No Committee feedback was relevant to this evidence

**Q – 05 In adults under investigation for occupational asthma, what is the diagnostic accuracy for case identification, of asking whether their symptoms are better away from work?**

**Recommendations derived from this question**

10. Check for suspected occupational asthma by asking employed people with newly-diagnosed asthma or established asthma that is poorly controlled:
  - are symptoms better on days away from work?
  - are symptoms better when on holiday<sup>1</sup>?

Make sure all answers are recorded for later review.
11. Refer people with suspected occupational asthma to an occupational asthma specialist.

---

<sup>1</sup> 'Holiday' here means any longer time away from work than usual breaks at weekends or between shifts.

1

**Update decision**

No new information was identified.

---

*Case identification*

**Update summary**

No relevant evidence was identified.

**Committee feedback**

No Committee feedback was relevant to this evidence

---

*Symptoms when away from work*

**Update summary**

No relevant evidence was identified.

**Committee feedback**

No Committee feedback was relevant to this evidence

---

**Q – 06 In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of spirometry/flow volume loop measures?**

**Recommendations derived from this question**

12. Use spirometry as the first investigation for asthma in adults and young people older than 16 and children aged 5-16 years. Regard a forced expiratory volume in 1 second/forced vital capacity (FEV<sub>1</sub>/FVC) ratio of less than 70%<sup>2</sup> as a positive test for obstructive airway disease (obstructive spirometry). See also recommendation 28.

**Update decision**

No new information was identified.

---

---

<sup>2</sup> Or the lower limit of normal if the calculation is available for children aged 5-16 years.

2

3

4

*Spirometry/flow volume loop measures*

**Update summary**

No relevant evidence was identified.

**Committee feedback**

No Committee feedback was relevant to this evidence

---

**Q – 07 In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of bronchodilator response (using PEF or FEV<sub>1</sub>)?**

**Recommendations derived from this question**

13. Offer a bronchodilator reversibility (BDR) test to adults and young people older than 16 with obstructive spirometry (FEV<sub>1</sub>/FVC ratio less than 70%). Regard an improvement in FEV<sub>1</sub> of 12% or more, together with an increase in volume of 200 ml or more, as a positive test.
14. Consider a BDR test in children aged 5-16 years with obstructive spirometry (FEV<sub>1</sub>/FVC ratio less than 70%). Regard an improvement in FEV<sub>1</sub> of 12%<sup>3</sup> or more as a positive test.

**Update decision**

No new information was identified.

---

---

<sup>3</sup> Or the lower limit of normal if the calculation is available for children aged 5-16 years.

*Bronchodilator response***Update summary**

No relevant evidence was identified.

**Committee feedback**

No Committee feedback was relevant to this evidence

**Q – 08 In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of peak expiratory flow (PEF) variability?**

**Recommendations derived from this question**

15. Monitor peak flow variability for 2-4 weeks in adults and young people older than 16 if there is diagnostic uncertainty after initial assessment and they have either:

- normal spirometry and the results of a fractional exhaled nitric oxide (FeNO) test or
- obstructive spirometry, reversible airways obstruction (positive BDR) and a FeNO level of 30 parts per billion (ppb) or less.

Regard a value of more than 20% variability as a positive test.

16. Consider monitoring peak flow variability for 2-4 weeks in adults and young people older than 16 if there is diagnostic uncertainty after initial assessment and they have:

- obstructive spirometry and
- irreversible airways obstruction (negative BDR) and
- a FeNO level between 25 and 30 ppb.

Regard a value of more than 20% variability as a positive test.

17. Monitor peak flow variability for 2-4 weeks in children aged 5-16 years if there is diagnostic uncertainty after initial assessment and they have either:

- normal spirometry and the results of a FeNO test or
- obstructive spirometry, irreversible airways obstruction (negative BDR) and a FeNO level of 35 ppb or more.

Regard a value of more than 20% variability as a positive test.

**Update decision**

No new information was identified.

*Peak expiratory flow (PEF) variability***Update summary**

No relevant evidence was identified.

**Committee feedback**

No Committee feedback was relevant to this evidence

**Q – 09 In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of skin prick tests?**

**Recommendations derived from this question**

Please see next question.

**Update decision**

No new information was identified.

---

*Skin prick test*

**Update summary**

No relevant evidence was identified.

**Committee feedback**

No Committee feedback was relevant to this evidence.

---

**Q – 10 In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of total and specific serum IgE measures?**

**Recommendations derived from this question**

18. Do not offer the following as diagnostic tests for asthma:
  - skin prick tests to aeroallergens
  - serum total and specific IgE.
19. Be aware that skin prick tests to aeroallergens or specific IgE tests may be used to identify triggers after a formal diagnosis of asthma has been made.

**Update decision**

No new information was identified.

---

*Specific serum IgE-measures*

**Update summary**

No relevant evidence was identified.

**Committee feedback**

No Committee feedback was relevant to this evidence.

---

**Q – 11 In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of fractional exhaled nitric oxide (FeNO) measures?**

**Recommendations derived from this question**

20. Be aware that a person's current smoking status can lower FeNO levels both acutely and cumulatively.
21. Offer a FeNO test to adults and young people older than 16 if a diagnosis of asthma is being considered. Regard a FeNO level of 40 parts per billion (ppb) or more as a positive test.
22. Consider a FeNO<sup>4</sup> test in children aged 5–16 years if there is diagnostic uncertainty after initial assessment and they have either:
  - normal spirometry or
  - obstructive spirometry with negative BDR.Regard a FeNO level of 35 ppb or more as a positive test.

**Update decision**

This review question should not be updated.

---

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<sup>4</sup> Children at the lower end of the age range may not be able to do the FeNO test adequately. In these cases, apply the principles in recommendation 27.

**Diagnostic test accuracy of FeNO for the diagnosis of asthma****Update summary**

A study<sup>8</sup> in 923 patients with suspected asthma assessed the diagnostic accuracy of FeNO to confirm or rule out asthma. The definite diagnosis of asthma was based on a positive bronchodilation or bronchoprovocation test result. All patients underwent both the index test and reference standard. FeNO levels were significantly higher in asthmatics than in non-asthmatics regardless of whether the asthma diagnosis was established using the bronchoprovocation or bronchodilation test. In patients with a positive bronchoprovocation test, the best cut-off value of FeNO to identify asthma was 64ppb with a sensitivity of 52% and a specificity of 94.35%. In patients with a

positive bronchodilation test, the best FeNO cut-off value was 41ppb with a sensitivity and specificity of 72.43% and 74.85%, respectively. The study also considered the influence of smoking history on FeNO levels. FeNO levels were significantly lower in men with a positive smoking history compared to men without any history of smoking (34.2ppb versus 43.6ppb,  $p=0.001$ ). There was no significant difference in FeNO levels based on smoking history in women (34.2ppb versus 31.5ppb,  $p=0.558$ ).

**Committee feedback**

No Committee feedback was relevant to this evidence.

New evidence is unlikely to change guideline recommendations.

**Q – 12 In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of eosinophil blood count measures?**

**Recommendations derived from this question**

23. Do not offer a peripheral blood eosinophil count as a diagnostic test for asthma.

**Update decision**

No new information was identified.

**Eosinophil blood count measures****Update summary**

No relevant evidence was identified.

**Committee feedback**

No Committee feedback was relevant to this evidence



**Q – 13 In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of airway hyper-reactivity (non-specific bronchial challenge) with histamine and methacholine?**

**Recommendations derived from this question**

24. Offer a direct bronchial challenge test with histamine or methacholine<sup>5</sup> to adults and young people older than 16 if there is diagnostic uncertainty after a normal spirometry and either a:
- FeNO level of 40 ppb or more and no variability in peak flow readings or
  - FeNO level of 30 ppb or less with variability in peak flow readings.
- Regard a PC20 value of 8 mg/ml or less as a positive test.
25. Consider a direct bronchial challenge test with histamine or methacholine<sup>5</sup> in adults and young people older than 16 with:
- obstructive spirometry and
  - a FeNO level between 25 and 30 ppb and
  - no variability in peak flow readings (less than 20% variability over a 2-4 week period).
- Regard a PC20 value of 8 mg/ml or less as a positive test.

**Update decision**

No new information was identified.

---

<sup>5</sup> At the time of interim publication (January 2016), histamine and methacholine did not have UK marketing authorisation for this use. The healthcare professional should follow relevant professional guidance, taking full responsibility for the decision to use this test. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.

**Q – 14 In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of airway hyper-reactivity (non-specific bronchial challenge) with mannitol?**

**Recommendations derived from this question**

No clinical recommendations.

**Update decision**

This review question should not be updated.

*Diagnostic test accuracy of a mannitol challenge test*

**Update summary**

One cross-sectional study<sup>5</sup> including 88 adults with asthma-related symptoms but no prior diagnosis of asthma was identified. The study evaluated the diagnostic accuracy of a mannitol challenge test. A diagnosis of asthma was made based on clinical symptoms and reversible airflow obstruction. The mannitol challenge test was considered positive if there

was a 15% fall in FEV1. Sixty-seven of the 88 patients received a definite diagnosis of asthma. The mannitol challenge test had a sensitivity and specificity of 64.17 (±47.34) and 95.23% (±22.94), respectively.

**Committee feedback**

No Committee feedback was relevant to this evidence.

New evidence is unlikely to change guideline recommendations.

**Q – 15 In people under investigation for asthma, what is the diagnostic accuracy of bronchoconstriction in response to an exercise challenge?**

**Recommendations derived from this question**

26. Do not offer adults and young people older than 16 an exercise challenge test as a diagnostic test for asthma.

**Update decision**

No new information was identified.

*Diagnostic test accuracy of bronchoconstriction*

**Update summary**

No relevant evidence was identified.

**Committee feedback**

No Committee feedback was relevant to this evidence

## Diagnostic algorithms

### Recommendations derived from this question

#### Children younger than 5 years (algorithm A1)

27. Treat symptoms based on observation and clinical judgement in children younger than 5 years, and plan to review when they reach age 5 using the following criteria:
- if the child still has symptoms, perform objective tests while on current treatment
  - if the child does not have symptoms on treatment, step down (and when appropriate, stop) treatment before performing objective tests.
- Review the diagnosis of asthma in children with normal test results.

#### Adults, young people and children aged 5 years and over (algorithm A2)

28. Do not diagnose asthma based on any single test alone in adults and children aged 5 years and over.

#### Adults and young people older than 16 with obstructive spirometry (algorithm B1)

29. Diagnose asthma in adults and young people older than 16 if they have obstructive spirometry and:
- negative bronchodilator reversibility, a FeNO level between 25 and 39 ppb, negative peak flow variability and a positive direct bronchial challenge test or
  - positive bronchodilator reversibility and a FeNO level of 40 ppb or more or
  - positive bronchodilator reversibility, a FeNO level of 39 ppb or less and positive peak flow variability test or
  - positive bronchodilator reversibility, a FeNO level between 25 and 39 ppb, negative peak flow variability and a positive direct bronchial challenge test.
30. Suspect asthma in adults and young people older than 16 with obstructive spirometry, negative bronchodilator reversibility and:
- a FeNO level of 40 ppb or more or
  - a FeNO level between 25 and 39 ppb and positive peak flow variability.
- Do not rule out other diagnoses if symptom control continues to remain poor after treatment. Review the diagnosis after 6-10 weeks by repeating spirometry and objective measures of asthma control and reviewing symptoms.
31. In adults and young people older than 16 with obstructive spirometry, positive bronchodilator reversibility, negative peak flow variability and a FeNO level less than 25 ppb and ongoing symptoms, consider:
- alternative diagnoses or
  - referral for specialist opinion.
- Base the choice on the person's clinical history (for example whether they smoke, their age, weight, how fit they are) together with their objective test results.
32. Consider alternative diagnoses in adults and young people older than 16 with obstructive spirometry and:
- negative bronchodilator reversibility and a FeNO level less than 25 ppb or
  - positive bronchodilator reversibility, a FeNO level between 25 and 39 ppb, negative peak flow variability and a negative direct bronchial challenge test.

**Adults and young people older than 16 with normal spirometry (algorithm B2)**

33. Diagnose asthma in adults and young people older than 16 if they have normal spirometry and:
- a FeNO level of 40 ppb or more and positive peak flow variability or
  - a FeNO level of 40 ppb or more, negative peak flow variability and a positive direct bronchial challenge test or
  - a FeNO level of 39 ppb or less, positive peak flow variability and a positive direct bronchial challenge test.
34. Consider alternative diagnoses in adults and young people older than 16 if they have normal spirometry and:
- a FeNO level of 39 ppb or less and negative peak flow variability or
  - a FeNO level of 39 ppb or less, positive peak flow variability and a negative direct bronchial challenge test or
  - a FeNO level of 40 ppb or more, negative peak flow variability and a negative direct bronchial challenge test.

**Children aged 5-16 (algorithm C)**

35. Diagnose asthma in children aged 5–16 if they have:
- normal spirometry, a FeNO level of 35 ppb or more and positive peak flow variability or
  - obstructive spirometry and positive bronchodilator reversibility or
  - obstructive spirometry, negative bronchodilator reversibility, a FeNO level of 35 ppb or more and positive peak flow variability.
36. Refer children aged 5–16 for specialist assessment if they have obstructive spirometry, negative bronchodilator reversibility and a FeNO level of 34 ppb or less.
37. Suspect asthma in children aged 5–16 if they have:
- normal spirometry, a FeNO level of 35 ppb or more and negative peak flow variability or
  - obstructive spirometry, negative bronchodilator reversibility, a FeNO level of 35 ppb or more and negative peak flow variability or
  - normal spirometry, a FeNO level of 34 ppb or less and positive peak flow variability.
- Do not rule out other diagnoses if symptom control continues to remain poor after treatment. Review the diagnosis after 6 weeks by repeating any abnormal tests and reviewing symptoms.
38. Consider alternative diagnoses and referral for specialist assessment in children aged 5–16 if they have normal spirometry, a FeNO level of 34 ppb or less and negative peak flow variability.

**People diagnosed with asthma**

39. Record the evidence that a person's diagnosis of asthma is based on in a single entry in their medical records, alongside the coded diagnostic entry.

**Update decision**

The diagnostic algorithms should not be updated.

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**Q – 16 In people with asthma, what is the clinical and cost-effectiveness of using symptom scores / diaries or validated questionnaires measuring symptom control (eg ACT, ACQ, CACT, RCP 3 questions) and / or health related quality of life (eg AQLQ, PAQLQ) to monitor asthma?**

#### Recommendations derived from this question

40. Monitor asthma control at every review. If control is suboptimal:
- confirm the person's adherence to prescribed treatment in line with recommendations 1.2.1, 1.2.2 and 1.2.3 in the NICE guideline on medicines adherence
  - review the person's inhaler technique
  - review if treatment needs to be changed
  - if relevant, ask about occupational asthma and/or other triggers.
41. Consider using a validated questionnaire (the Asthma Control Questionnaire or Asthma Control Test) to monitor asthma control in adults and young people older than 16.

#### Update decision

This review question should not be updated.

#### Questionnaires measuring symptom control

##### Update summary

A sub-study<sup>8</sup> of a multicentre randomised controlled trial comparing the Asthma APGAR System with the Asthma Control Test (ACT) was identified. The study included 209 children and young people aged 18 years or younger and 250 adults with physician-diagnosed asthma. Enrolled patients completed the ACT, the APGAR patient questionnaire, and the Asthma Quality of Life Questionnaire (AQLQ) at the time of enrolment and every 6 months thereafter for 2 years. Children-specific

versions of AQLQ and ACT were used. The ACT and APGAR system were found to similarly assess asthma control in the study (overall agreement was 84.4%). Of the 468 patients included in the study, 306 patients were classified as not controlled. Seventy-three of the 306 uncontrolled patients had no daily medications.

##### Committee feedback

No Committee feedback was relevant to this evidence.

New evidence is unlikely to change guideline recommendations.

**Q – 17 In people with asthma, what is the clinical and cost-effectiveness of using measures of pulmonary function assessing asthma control (for example, spirometry and peak expiratory flow) to monitor asthma?**

#### Recommendations derived from this question

42. Monitor asthma control at each review in adults and children aged 5 years and over by measuring either spirometry (FEV<sub>1</sub>) or peak flow.

**Update decision**

No new information was identified.

*Pulmonary function assessing asthma control***Update summary**

No relevant evidence was identified.

**Committee feedback**

No Committee feedback was relevant to this evidence

**Q – 18 In people with asthma, what is the clinical and cost-effectiveness of using fractional exhaled nitric oxide (FeNO) measures for monitoring asthma control?**

**Recommendations derived from this question**

43. Do not routinely use FeNO to monitor asthma control.
44. Consider FeNO measurement as an option to support asthma management in people who are symptomatic despite using inhaled corticosteroids. (This recommendation is from NICE's diagnostics guidance on measuring fractional exhaled nitric oxide concentration in asthma.)

**Update decision**

This review question should not be updated.

*Clinical effectiveness of FeNO monitoring***Update summary**

A randomised controlled trial<sup>7</sup> assessing the effectiveness of 4-monthly monitoring of FeNO and a web-based monthly monitoring strategy compared with standard care was identified. The study included 280 children with atopic asthma. The primary outcome was the change in symptom-free days at 1-year follow-up. There was no significant difference in change in the proportion of symptom-free days between the treatment arms. The proportion of symptom-free days decreased by 2.07% in the web-based group and increased by 8.90% and 7.40% in the FeNO and standard care groups, respectively. The mean difference between the

web-based group and the standard care group was -6.80% and 1.17% between the FeNO group and the standard care group. There was a significant decrease in inhaled corticosteroid use in both the web-based and FeNO groups. The difference between treatment groups was only significant when comparing the web-based strategy with standard care. There was no significant difference in ACT scores.

**Committee feedback**

No Committee feedback was relevant to this evidence.

New evidence is unlikely to change guideline recommendations.

*Cost-effectiveness of FeNO monitoring***Update summary**

One economic evaluation<sup>1</sup> assessing the cost effectiveness of 4-monthly monitoring of FeNO and a web-based monthly monitoring strategy compared with standard care was identified. The economic evaluation is based on the randomised controlled trial<sup>7</sup> mentioned above. Two hundred and seventy-two children with asthma were randomised to one of the three treatment arms. Asthma control was assessed using the Asthma Control Test (ACT) and the health economic outcome was the cost per quality adjusted life years (QALY) gained. QALYs were calculated using the Dutch tariff of the EQ-5D. Assuming the cost year to be 2015, the total cost per patient per year for standard care, web-based monitoring and FeNO monitoring were €839 [€703], €924 [€774] and

€837 [€701], respectively. At a generally acceptable willingness-to-pay threshold of €40,000 [€33,513] per QALY, the web-based strategy had a 77% chance of being most cost-effective from a healthcare perspective. FeNO monitoring and standard care had a chance of 3% and 20%, respectively, to be cost effective. The probability of these interventions to be cost-effective at a £20,000/QALY threshold is therefore significantly lower than the one stated above.

**Committee feedback**

No Committee feedback was relevant to this evidence.

New evidence is unlikely to change guideline recommendations.

**Q – 19 In people with asthma, what is the clinical and cost-effectiveness of using the peripheral blood eosinophil count for monitoring asthma control?**

**Recommendations derived from this question**

No clinical recommendations.

**Update decision**

No new information was identified.

*Blood eosinophil count***Update summary**

No relevant evidence was identified.

**Committee feedback**

No Committee feedback was relevant to this evidence

**Q – 20 In people with asthma, what is the clinical and cost-effectiveness of using indirect challenge tests with mannitol or direct challenge tests with histamine or methacholine for monitoring asthma control?**

**Recommendations derived from this question**

45. Do not use challenge testing to monitor asthma control.

**Update decision**

No new information was identified.

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*Indirect challenge tests*

**Update summary**

No relevant evidence was identified.

**Committee feedback**

No Committee feedback was relevant to this evidence

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*Direct challenge tests*

**Update summary**

No relevant evidence was identified.

**Committee feedback**

No Committee feedback was relevant to this evidence

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**Q – 21 In people with asthma, what is the clinical and cost-effectiveness of monitoring adherence to treatment?**

**Recommendations derived from this question**

No clinical recommendations.

**Update decision**

This review question should not be updated.

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**Adherence to treatment****Update summary**

A randomised controlled trial<sup>1</sup> comparing an online tool designed to encourage patients to ask their provider questions about their asthma care with no monitoring of adherence was identified. The study included 407 adults with persistent asthma. Patients in the intervention group answered questions online about their asthma symptoms, medications and care at least once a month and received tailored reminders to ask their health care providers specific questions that may improve asthma control. Patients in the control group received questions on preventive services unrelated to asthma. At the 12-month follow-up patients in the intervention group reported a greater mean improvement in the Asthma Control Test (ACT) score than patients in the control group (2.3 versus 1.2;  $p=0.02$ ). There were no differences in medication adherence, number of asthma controller medications or health care utilisation.

A randomised controlled trial<sup>2</sup> including 220 children aged 6-15 years with an asthma exacerbation was identified. Children received an electronic monitoring device for use with their preventer inhaler. Depending on whether a child was randomly allocated to the

intervention or the control group, the audiovisual reminder functions were either enabled or disabled. Participants were followed up every 2 months for a total of 6 months. Adherence to treatment and number of days absent from school for any reason were the primary outcomes. Asthma control was assessed as a secondary outcome. Adherence to treatment was defined as the proportion of preventer doses taken relative to the number of doses prescribed. Adherence to treatment was found to be significantly better in the intervention group (median adherence 84%) than in the control group (median adherence 30%). The intervention group also had a significantly greater reduction in asthma morbidity score from baseline than the control group with a reduction of 2 points and 1.2 points, respectively. There was no difference in the proportion of days absent from school between the two groups.

**Committee feedback**

No Committee feedback was relevant to this evidence.

New evidence is unlikely to change guideline recommendations.

**Q – 22 In people with asthma, what is the optimal frequency and method for monitoring inhaler technique?**

**Recommendations derived from this question**

46. Observe and give advice on the inhaler technique of people with asthma:
- at every consultation relating to an asthma attack, in all care settings
  - when there is deterioration in asthma control
  - when the device is changed
  - at every annual review
  - if the person asks for it to be checked.

**Update decision**

No new information was identified.

*Inhaler technique***Update summary**

No relevant evidence was identified.

**Committee feedback**

No Committee feedback was relevant to this evidence.

**Q – 23 In people with asthma, what is the clinical and cost-effectiveness of tele-healthcare to monitor asthma control?**

**Recommendations derived from this question**

No clinical recommendations.

**Update decision**

This review question should not be updated.

*Tele-healthcare***Update summary**

A randomised controlled trial<sup>9</sup> evaluated the efficacy of tele-healthcare in 72 pregnant women with asthma. Participants were either allocated to MASTERY, a programme using the COPD-6 device to measure lung function (forced expiratory volume in 6 seconds) daily and the Breathe-easy mobile phone app to record asthma symptoms and medications weekly, or a usual care group. Change in asthma control was measured by the Asthma Control Questionnaire (ACQ-7) and change in asthma-related quality of life was measured by the mini-Asthma Quality of Life Questionnaire (mAQLQ) at 3 and 6 months. At 6 months, patients in the MASTERY group had better asthma control and asthma-related quality of life than the usual care group. The mean difference was -0.36 (SD 0.15) on the ACQ and +0.72 (SD 0.22) on the mAQLQ.

A cluster-randomised trial<sup>3</sup> assessed the effectiveness of telephone peer coaching for parents on the reduction of asthma morbidity of

their children. A total of 948 families were recruited, 462 of which received telephone peer coaching. The remaining 486 families were allocated to usual care. The intervention included repeated telephone conversations with a peer trainer to clarify the programme's goals, gain feedback from parents to assess if the goals had been reached and further tailored guidance. After 12 months, there were 20.9 (95% CI, 9.1-32.7) more symptom-free days per child in the telephone peer coaching group than in the usual care group. After 24 months, children in the telephone peer coaching group had on average 0.28 fewer emergency department visits than children in the control group. There was no difference in emergency department visits at 12 months, indicating a delayed treatment effect.

**Committee feedback**

No Committee feedback was relevant to this evidence.

New evidence is unlikely to change guideline recommendations.

## References

1. Beerthuizen T, Voorend-van Bergen S, van den Hout WB, Vaessen-Verberne AA, Brackel HJ, Landstra AM et al. Cost-effectiveness of FENO-based and web-based monitoring in paediatric asthma management: a randomised controlled trial. *Thorax*. 2016; 71(7):807-813
2. Chan AHY, Stewart AW, Harrison J, Camargo CA, Black PN, Mitchell EA. The effect of an electronic monitoring device with audiovisual reminder function on adherence to inhaled corticosteroids and school attendance in children with asthma: A randomised controlled trial. *The Lancet Respiratory Medicine*. 2015; 3(3):210-219
3. Garbutt JM, Yan Y, Highstein G, Strunk RC. A cluster-randomized trial shows telephone peer coaching for parents reduces children's asthma morbidity. *Journal of Allergy and Clinical Immunology*. 2015; 135(5):1163-1170.e1161-1162
4. Pool AC, Kraschnewski JL, Poger JM, Smyth J, Stuckey HL, Craig TJ et al. Impact of online patient reminders to improve asthma care: A randomized controlled trial. *PLoS One*. 2017; 12(2):e0170447
5. Porpodis K, Domvri K, Kontakiotis T, Fouka E, Kontakioti E, Zarogoulidis K et al. Comparison of diagnostic validity of mannitol and methacholine challenges and relationship to clinical status and airway inflammation in steroid-naive asthmatic patients. *Journal of Asthma*. 2016; Epublication
6. Rank MA, Bertram S, Wollan P, Yawn RA, Yawn BP. Comparing the Asthma APGAR system and the Asthma Control Test? in a multicenter primary care sample. *Mayo Clinic Proceedings*. 2014; 89(7):917-925
7. Voorend-van Bergen S, Vaessen-Verberne AA, Brackel HJ, Landstra AM, van den Berg NJ, Hop WC et al. Monitoring strategies in children with asthma: a randomised controlled trial. *Thorax*. 2015; 70(6):543-550
8. Wang Y, Li L, Han R, Lei W, Li Z, Li K et al. Diagnostic value and influencing factors of fractional exhaled nitric oxide in suspected asthma patients. *International Journal of Clinical and Experimental Pathology*. 2015; 8(5):5570-5576
9. Zairina E, Abramson MJ, McDonald CF, Li J, Dharmasiri T, Stewart K. Telehealth to improve asthma control in pregnancy: A randomized controlled trial. *Respirology*. 2016; 21(5):867-874