

Asthma

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

Clinical guideline

Methods, evidence and recommendations

January 2015

Draft for Consultation

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

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Funding

National Institute for Health and Care Excellence

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1

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Acknowledgements

The development of this guideline was greatly assisted by the following people:

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1 Introduction

Asthma is a chronic inflammatory respiratory disease. It can affect people of any age, but often starts in childhood. It is characterised by attacks (also known as exacerbations) of breathlessness and wheezing, with the severity and frequency of attacks varying from person to person. The attacks are associated with variable airflow obstruction and inflammation within the lungs, which if left untreated can be life-threatening, however with the appropriate treatment can be reversible.

The World Health Organization estimates that 235 million people suffer from asthma worldwide, and it is the most common chronic condition to affect children. In the UK, 4.1 million people receive treatment for asthma.

The causes of asthma are not well understood. A number of risk factors are associated with the condition, often in combination. These influences can be genetic (the condition clusters in families) and/or environmental (such as inhalation of allergens or chemical irritants). Occupational causes of asthma in adults are often under-recognised.

There is currently no gold standard test available to diagnose asthma; diagnosis is principally based on a thorough history taken by an experienced clinician. It is therefore not surprising that studies of adults diagnosed with asthma suggest that up to 30% do not have clear evidence of asthma. Some may have had asthma in the past, but it is likely that many have been given an incorrect diagnosis. The typical wheeze found in a person with asthma is a continuous, polyphonic whistling sound produced in the airways during expiration and is related to obstruction of the airways on breathing out. Expiratory polyphonic wheeze is a characteristic clinical symptom and sign in people with asthma or other obstructive airways diseases.

Initial clinical assessment should include 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 can definitively diagnose asthma.

A number of methods and assessments are available to determine the likelihood of asthma. These include measuring airflow obstruction (spirometry and peak flow) and assessment of reversibility with bronchodilators, with both methods being widely used in current clinical practice. However, normal results do not exclude asthma and abnormal results do not always mean it is asthma, as they could be indicators of other respiratory diseases or spurious readings.

Testing for airway inflammation is increasingly used as a diagnostic strategy in clinical practice. This includes measuring fractional exhaled nitric oxide (FeNO). However, there is some uncertainty about both the sensitivity and specificity of FeNO, particularly in regard to whether it can distinguish general atopy from asthma.

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 or mannitol challenge tests. However, it is debatable which test or measure, or combination of them, is the most effective to accurately diagnose asthma.

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 obstruction or inflammation and by using validated questionnaires, but the most effective monitoring strategy is unclear.

1 The aim of this guideline is, therefore, to determine the most clinical and cost-effective way to
2 effectively diagnose people with asthma and determine the most effective monitoring strategy to
3 ensure optimum asthma control.

4 The scope of this guideline covers the diagnosis and monitoring of asthma and excludes other
5 aspects of management. This is because there is evidence that incorrect diagnosis is a significant
6 problem.

7 This guideline covers infants and young children 0–5 years old, children 5–16 years old and adults
8 over the age of 16 who are being investigated for suspected asthma, or who have been diagnosed
9 with asthma and are having their condition monitored. The guideline applies to all primary,
10 secondary and community care settings in which NHS-funded care is provided for people with
11 asthma.

12 This guideline offers best practice advice on the care of people with suspected asthma presenting
13 with respiratory symptoms, and monitoring asthma control in people with a confirmed diagnosis of
14 asthma. Chapters 6 to 10 review the diagnostic accuracy of the initial clinical assessment questions
15 for the diagnosis of asthma in people with suspected asthma presenting with respiratory symptoms.
16 Chapters 11 to 20 review the diagnostic test accuracy of objective tests for the diagnosis of asthma in
17 people with suspected asthma presenting with respiratory symptoms. The diagnostic pathway can be
18 found in section 4.1. Chapters 23 to 30 review the clinical and cost-effectiveness of interventions
19 used to monitor asthma control.

20 Patients and healthcare professionals have rights and responsibilities as set out in the NHS
21 Constitution for England – all NICE guidance is written to reflect these. Treatment and care should
22 take into account individual needs and preferences. Patients should have the opportunity to make
23 informed decisions about their care and treatment, in partnership with their healthcare
24 professionals. If the patient is under 16, their family or carers should also be given information and
25 support to help the child or young person to make decisions about their treatment. Healthcare
26 professionals should follow the Department of Health’s advice on consent. If someone does not have
27 capacity to make decisions, healthcare professionals should follow the code of practice that
28 accompanies the Mental Capacity Act and the supplementary code of practice on deprivation of
29 liberty safeguards. In Wales, healthcare professionals should follow advice on consent from the
30 Welsh Government.

31 NICE has produced guidance on the components of good patient experience in adult NHS services. All
32 healthcare professionals should follow the recommendations in Patient experience in adult NHS
33 services.

2 Development of the guideline

2.1 What is a NICE clinical guideline?

NICE clinical guidelines are recommendations for the care of individuals in specific clinical conditions or circumstances within the NHS – from prevention and self-care through primary and secondary care to more specialised services. We base our clinical guidelines on the best available research evidence, with the aim of improving the quality of health care. We use predetermined and systematic methods to identify and evaluate the evidence relating to specific review questions.

NICE clinical guidelines can:

- provide recommendations for the treatment and care of people by health professionals
- be used to develop standards to assess the clinical practice of individual health professionals
- be used in the education and training of health professionals
- help patients to make informed decisions
- improve communication between patients and health professionals.

While guidelines assist the practice of healthcare professionals, they do not replace their knowledge and skills.

We produce our guidelines using the following steps:

- Guideline topic is referred to NICE from the Department of Health.
- Stakeholders register an interest in the guideline and are consulted throughout the development process.
- The scope is prepared by the National Clinical Guideline Centre (NCGC).
- The NCGC establishes a Guideline Development Group.
- A draft guideline is produced after the group assesses the available evidence and makes recommendations.
- There is a consultation on the draft guideline.
- The final guideline is produced.

The NCGC and NICE produce a number of versions of this guideline:

- the ‘full guideline’ contains all the recommendations, plus details of the methods used and the underpinning evidence
- the ‘NICE guideline’ lists the recommendations
- ‘information for the public’ is written using suitable language for people without specialist medical knowledge
- NICE Pathways brings together all connected NICE guidance.

This version is the full version. The other versions can be downloaded from NICE at www.nice.org.uk.

2.2 Remit

NICE received the remit for this guideline from the Department of Health. They commissioned the NCGC to produce the guideline.

The remit for this guideline is:

‘to prepare a guideline on the diagnosis and management of asthma’.

1 **2.3 Who developed this guideline?**

2 The group includes health professionals and researchers as well as lay members.

3 A multidisciplinary Guideline Development Group (GDG) comprising health professionals and
4 researches as well as lay members developed this guideline (see the list of Guideline Development
5 Group members and the acknowledgements).

6 The National Institute for Health and Care Excellence (NICE) funds the National Clinical Guideline
7 Centre (NCGC) and thus supported the development of this guideline. The GDG was convened by the
8 NCGC and chaired by Dr Andrew Menzies-Gow in accordance with guidance from NICE.

9 The group met every 5-6 weeks during the development of the guideline. At the start of the guideline
10 development process all GDG members declared interests including consultancies, fee-paid work,
11 share-holdings, fellowships and support from the healthcare industry. At all subsequent GDG
12 meetings, members declared arising conflicts of interest.

13 Members were either required to withdraw completely or for part of the discussion if their declared
14 interest made it appropriate. The details of declared interests and the actions taken are shown in
15 Appendix B.

16 Staff from the NCGC provided methodological support and guidance for the development process.
17 The team working on the guideline included a project manager, systematic reviewers, health
18 economists and information scientists. They undertook systematic searches of the literature,
19 appraised the evidence, conducted meta-analysis and cost-effectiveness analysis where appropriate
20 and drafted the guideline in collaboration with the GDG.

21 **(a) What this guideline covers**

22 This guideline covers adults, children and young people who are being investigated for suspected
23 asthma, or who have been diagnosed with asthma and are having their condition monitored. For
24 further details please refer to the scope in Appendix A and the review questions in chapters 6 to 30.

25 **(b) What this guideline does not cover**

26 This guideline does not cover:

- 27
- 28 • severe or difficult-to-control asthma
 - 29 • treating asthma.

29 For further details please refer to the scope in Appendix A.

30 **(c) Relationships between the guideline and other NICE guidance**

31 **Related NICE clinical guidelines:**

- 32
- 33 • Patient experience in adult NHS services. NICE clinical guideline 138 (2012).
 - 34 • Chronic obstructive pulmonary disease (updated). NICE clinical guideline 101 (2009).
 - 35 • Respiratory tract infections. NICE clinical guideline 69 (2008).

36 **Related NICE diagnostic assessment guidance:**

- 37
- 38 • Measuring fractional exhaled nitric oxide concentration in asthma: NIOX MINO, NIOX VERO and
39 NObreath. NICE diagnostics guidance 12 (2014).

38 **Related NICE interventional procedures guidance:**

- 39
- 40 • Bronchial thermoplasty for severe asthma. NICE interventional procedure guidance 419 (2012).

40 **Related NICE quality standards:**

- 1 • Quality standard for asthma. NICE quality standard 25 (2013).

2 **Related NICE technology appraisals:**

- 3 • Omalizumab for the treatment of severe persistent allergic asthma in children aged 6 and over
4 and adults (review of TA133 and TA201) NICE technology appraisal guidance 278 (2013).
- 5 • Roflumilast for the management of severe chronic obstructive pulmonary disease. NICE
6 technology appraisal guidance 244 (2012).
- 7 • Inhaled corticosteroids for the treatment of chronic asthma in adults and in children aged 12
8 years and over. NICE technology appraisal guidance 138 (2008).
- 9 • Inhaled corticosteroids for the treatment of chronic asthma in children under the age of 12 years.
10 NICE technology appraisal guidance 131 (2007).
- 11 • Inhaler devices for routine treatment of chronic asthma in older children (aged 5–15 years). NICE
12 technology appraisal guidance 38 (2002).
- 13 • Guidance on the use of inhaler systems (devices) in children under the age of 5 years with chronic
14 asthma. NICE technology appraisal guidance 10 (2000).

15 **Related NICE guidance currently in development:**

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

3 Methods

This chapter sets out in detail the methods used to review the evidence and to generate the recommendations that are presented in subsequent chapters. This guidance was developed in accordance with the methods outlined in the NICE guidelines manual 2012¹⁰⁶.

3.1 Developing the review questions and outcomes

Review questions were developed in a PICO framework (patient, intervention, comparison and outcome) for intervention reviews in a framework of population, index tests, reference standard and target condition for reviews of diagnostic test accuracy; and using population, presence or absence of factors under investigation (for example prognostic factors) and outcomes for prognostic reviews.

This use of a framework guided the literature searching process, critical appraisal and synthesis of evidence, and facilitated the development of recommendations by the Guideline Development Group (GDG). The review questions were drafted by the NCGC technical team and refined and validated by the GDG. The questions were based on the key clinical areas identified in the scope (Appendix A).

A total of 23 review questions were identified.

Full literature searches, critical appraisals and evidence reviews were completed for all the specified review questions.

Table 1: Review questions

Chapter	Type of review	Review questions	Outcomes
6	Diagnostic	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"> • wheezing • cough • breathlessness • nocturnal symptoms • diurnal and seasonal variations 	Critical outcomes: <ul style="list-style-type: none"> • Sensitivity (%) and specificity (%)
7	Diagnostic	In people under investigation for asthma, what is the diagnostic accuracy of taking a personal/family history of atopic disorders?	Critical outcomes: <ul style="list-style-type: none"> • Sensitivity (%) and specificity (%)
8	Diagnostic	In people under investigation for asthma, what is the diagnostic accuracy of a clinical history of symptoms in response to exercise?	Critical outcomes: <ul style="list-style-type: none"> • Sensitivity (%) and specificity (%)
9	Diagnostic	In people under investigation for asthma, what is the diagnostic accuracy of a clinical history of symptoms after taking the following drugs: <ol style="list-style-type: none"> a) in adults - beta blockers, aspirin, or other NSAIDs b) in children – ibuprofen? 	Critical outcomes: <ul style="list-style-type: none"> • Sensitivity (%) and specificity (%)
10	Diagnostic	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?	Critical outcomes: <ul style="list-style-type: none"> • Sensitivity (%) and specificity (%)

Chapter	Type of review	Review questions	Outcomes
11	Diagnostic	In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of spirometry / flow volume loop measures?	Critical outcomes: <ul style="list-style-type: none"> • Sensitivity (%) and specificity (%) at pre-specified thresholds
12	Diagnostic	In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of bronchodilator response (using PEF or FEV1)?	Critical outcomes: <ul style="list-style-type: none"> • Sensitivity (%) and specificity (%) at pre-specified thresholds
13	Diagnostic	In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of peak expiratory flow (PEF) variability?	Critical outcomes: <ul style="list-style-type: none"> • Sensitivity (%) and specificity (%) at pre-specified thresholds
14	Diagnostic	In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of skin prick tests?	Critical outcomes: <ul style="list-style-type: none"> • Sensitivity (%) and specificity (%) at pre-specified thresholds
15	Diagnostic	In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of total and specific serum IgE measures?	Critical outcomes: <ul style="list-style-type: none"> • Sensitivity (%) and specificity (%) at pre-specified thresholds
16	Diagnostic	In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of fractional exhaled nitric oxide (FeNO) measures?	Critical outcomes: <ul style="list-style-type: none"> • Sensitivity (%) and specificity (%) at pre-specified thresholds
17	Diagnostic	In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of eosinophil blood count measures?	Critical outcomes: <ul style="list-style-type: none"> • Sensitivity (%) and specificity (%) at pre-specified thresholds
18	Diagnostic	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?	Critical outcomes: <ul style="list-style-type: none"> • Sensitivity (%) and specificity (%) at pre-specified thresholds
19	Diagnostic	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?	Critical outcomes: <ul style="list-style-type: none"> • Sensitivity (%) and specificity (%) at pre-specified thresholds
20	Diagnostic	In people under investigation for asthma, what is the diagnostic accuracy of bronchoconstriction in response to an exercise challenge?	Critical outcomes: <ul style="list-style-type: none"> • Sensitivity (%) and specificity (%) at pre-specified thresholds
23	Intervention	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?	Critical outcomes <ul style="list-style-type: none"> • Mortality • Unscheduled healthcare utilisation (UHU) • Exacerbations (defined as need for course of oral steroids) • Asthma control questionnaires

Chapter	Type of review	Review questions	Outcomes
			<ul style="list-style-type: none"> • QoL <p>Important outcomes</p> <ul style="list-style-type: none"> • Lung function • Symptoms • Dose of regular preventer medication (ICS dose) • Rescue medication (SABA use) • Time off school or work
24	Intervention	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?	<p>Critical outcomes</p> <ul style="list-style-type: none"> • Mortality • UHU • Exacerbations (defined as need for course of oral steroids) • Asthma control questionnaires • QoL <p>Important outcomes</p> <ul style="list-style-type: none"> • Lung function • Symptoms • Dose of regular preventer medication (ICS dose) • Rescue medication (SABA use) • Time off school or work
25	Intervention	In people with asthma, what is the clinical and cost-effectiveness of using fractional exhaled nitric oxide (FeNO) measures for monitoring asthma control?	<p>Critical outcomes</p> <ul style="list-style-type: none"> • Mortality • UHU • Exacerbations (defined as need for course of oral steroids) • Asthma control questionnaires • QoL <p>Important outcomes</p> <ul style="list-style-type: none"> • Lung function • Symptoms • Dose of regular preventer medication (ICS dose) • Rescue medication (SABA use) • Time off school or work
26	Intervention	In people with asthma, what is the clinical and cost-effectiveness of using the peripheral blood eosinophil count for monitoring asthma control?	<p>Critical outcomes</p> <ul style="list-style-type: none"> • Mortality • UHU • Exacerbations (defined as need for course of oral

Chapter	Type of review	Review questions	Outcomes
			steroids) <ul style="list-style-type: none"> • Asthma control questionnaires • QoL Important outcomes <ul style="list-style-type: none"> • Lung function • Symptoms • Dose of regular preventer medication (ICS dose) • Rescue medication (SABA use) • Time off school or work
27	Intervention	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?	Critical outcomes <ul style="list-style-type: none"> • Mortality • UHU • Exacerbations (defined as need for course of oral steroids) • Asthma control questionnaires • QoL Important outcomes <ul style="list-style-type: none"> • Lung function • Symptoms • Dose of regular preventer medication (ICS dose) • Rescue medication (SABA use) • Time off school or work
28	Intervention	In people with asthma, what is the clinical and cost-effectiveness of monitoring adherence to treatment?	Critical outcomes <ul style="list-style-type: none"> • Mortality • UHU • Exacerbations (defined as need for course of oral steroids) • Asthma control questionnaires • QoL • Adherence Important outcomes <ul style="list-style-type: none"> • Lung function • Symptoms • Dose of regular preventer medication (ICS dose) • Rescue medication (SABA use) • Time off school or work
29	Intervention	In people with asthma, what is the optimal	Critical outcomes

Chapter	Type of review	Review questions	Outcomes
		frequency and method for monitoring inhaler technique?	<ul style="list-style-type: none"> • Mortality • UHU • Exacerbations (defined as need for course of oral steroids) • Asthma control questionnaires • QoL Important outcomes <ul style="list-style-type: none"> • Lung function • Symptoms • Dose of regular preventer medication (ICS dose) • Rescue medication (SABA use) • Time off school or work
30	Intervention	In people with asthma, what is the clinical and cost-effectiveness of tele-healthcare to monitor asthma control?	Critical outcomes <ul style="list-style-type: none"> • Mortality • Exacerbations requiring hospitalisation • Exacerbations (defined as need for course of oral steroids) • UHU • QOL • Asthma Control Questionnaires Important outcomes <ul style="list-style-type: none"> • Lung function • Symptoms

1 3.2 Searching for evidence

2 3.2.1 Clinical literature search

3 Systematic literature searches were undertaken to systematically identify all published clinical
 4 evidence relevant to the review questions. Searches were undertaken according to the parameters
 5 stipulated within The guidelines manual 2012.¹⁰⁶ Databases were searched using relevant medical
 6 subject headings, free-text terms and study-type filters where appropriate. Studies published in
 7 languages other than English were not reviewed. Where possible, searches were restricted to articles
 8 published in English. All searches were conducted in MEDLINE, Embase, and The Cochrane Library. All
 9 searches were updated on 1 October 2014. No papers published after this date were considered.

10 Search strategies were quality assured by cross-checking reference lists of highly relevant papers,
 11 analysing search strategies in other systematic reviews, and asking GDG members to highlight any
 12 additional studies. The questions, the study types applied, the databases searched and the years
 13 covered can be found in Appendix F.

1 The titles and abstracts of records retrieved by the searches were sifted for relevance, with
2 potentially significant publications obtained in full text. These were assessed against the inclusion
3 criteria.

4 During the scoping stage, a search was conducted for guidelines and reports on the websites listed
5 below and on organisations relevant to the topic. Searching for grey literature or unpublished
6 literature was not undertaken. All references sent by stakeholders were considered.

- 7 • Guidelines International Network database (www.g-i-n.net)
- 8 • National Guideline Clearing House (www.guideline.gov)
- 9 • National Institute for Health and Care Excellence (NICE) (www.nice.org.uk)
- 10 • NICE evidence search (www.evidence.nhs.uk).

11 **3.2.2 Health economic literature search**

12 Systematic literature searches were also undertaken to identify health economic evidence within
13 published literature relevant to the review questions. The evidence was identified by conducting a
14 broad search relating to asthma in the NHS Economic Evaluation Database (NHS EED), the Health
15 Technology Assessment database (HTA) and the Health Economic Evaluations Database (HEED) with
16 no date restrictions. Additionally, the search was run on MEDLINE and Embase using a specific
17 economic filter, from 2012 to ensure recent publications that had not yet been indexed by the
18 economic databases were identified. Studies published in languages other than English were not
19 reviewed. Where possible, searches were restricted to articles published in English.

20 The health economic search strategies are included in Appendix F. All searches were updated on 1
21 October 2014. No papers published after this date were considered.

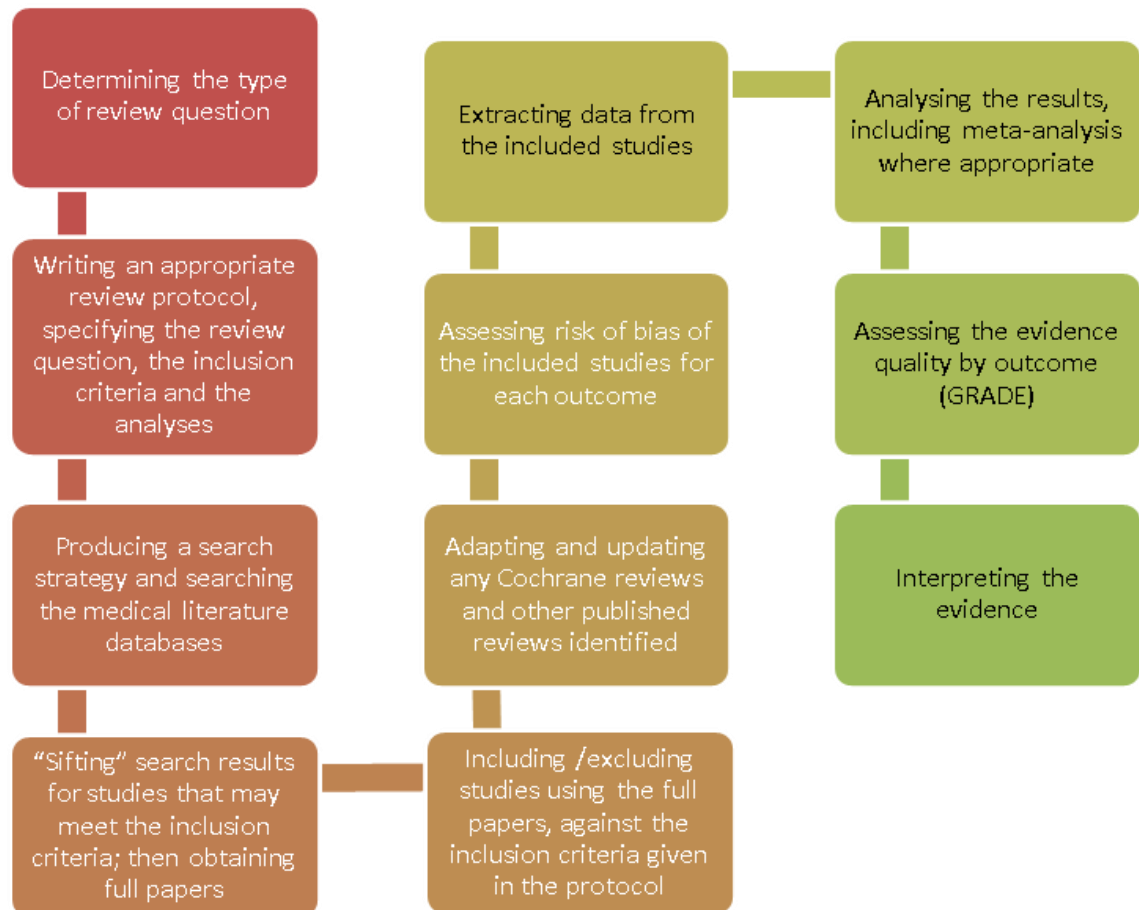
22 **3.3 Evidence of effectiveness**

23 The evidence was reviewed following the steps shown schematically in Figure 1:

- 24 • Potentially relevant studies were identified for each review question from the relevant search
25 results by reviewing titles and abstracts. Full papers were then obtained.
- 26 • Full papers were reviewed against pre-specified inclusion and exclusion criteria to identify studies
27 that addressed the review question in the appropriate population (review protocols are included
28 in Appendix C).
- 29 • Relevant studies were critically appraised using the appropriate checklist as specified in The
30 guidelines manual.¹⁰⁶ For diagnostic questions, the QUADAS-2 checklist was followed
31 (<http://www.bris.ac.uk/quadas/quadas-2/>).
- 32 • Key information was extracted on the study's methods, PICO factors and results. These were
33 presented in summary tables (in each review chapter) and evidence tables (in Appendix G).
- 34 • Summaries of evidence were generated by outcome (included in the relevant review chapters)
35 and were presented in GDG meetings:
 - 36 o Randomised studies: data were meta-analysed where appropriate and reported in GRADE
37 profiles (for intervention reviews).
 - 38 o Observational studies: data were presented as a range of values in GRADE profiles.
 - 39 o Prognostic studies: data were presented as a range of values, usually in terms of the relative
40 effect as reported by the authors.
 - 41 o Diagnostic studies were presented as measures of diagnostic test accuracy (sensitivity,
42 specificity, positive and negative predictive value). Coupled values of sensitivity and specificity
43 were summarised in Receiver Operating Curves (ROC) to investigate heterogeneity more
44 effectively, where evidence was available from five or more studies for any one index test. A

- 1 meta-analysis of the summary operating point, (i.e. summary values for sensitivity and
2 specificity) could not be conducted for any of the index tests, because the studies reported
3 data at various thresholds and because data at any one threshold were not available from five
4 or more studies.
- 5 o Qualitative studies: each study was summarised in a table where possible, otherwise
6 presented in a narrative.
- 7 A 20% sample of each of the above stages of the reviewing process was quality assured by a
8 second reviewer to eliminate any potential of reviewer bias or error.

9 **Figure 1: Step-by-step process of review of evidence in the guideline**



10

11 3.3.1 Inclusion and exclusion criteria

12 The inclusion and exclusion of studies was based on the review protocols, which can be found in
13 Appendix C. Excluded studies by review question (with the reasons for their exclusion) are listed in
14 Appendix K. The GDG was consulted about any uncertainty regarding inclusion or exclusion.

15 Randomised trials, non-randomised trials, and observational studies (including diagnostic or
16 prognostic studies) were included in the evidence reviews as appropriate.

17 For diagnostic reviews, the guideline population was defined as people with suspected asthma
18 (presenting with respiratory symptoms). The GDG agreed that general population studies, or studies
19 using a questionnaire to identify people with symptoms in the general population, should be
20 excluded unless there was no other evidence. This is because the diagnostic tests under investigation
21 would be performed in people with suspected asthma presenting to their GP, not as screening tests
22 in the general population.

1 For diagnostic reviews, the reference standard was defined as physician diagnosis of asthma based
2 on symptoms plus an objective test. The GDG agreed that studies using a reference standard of
3 physician diagnosis only (without an objective test), or studies using an affirmative answer on a
4 questionnaire to the question ‘Has your doctor ever diagnosed you with asthma?’ should be
5 excluded. This is due to concerns about the over-diagnosis of asthma and the accuracy of a reference
6 standard test that does not include an objective test. The GDG specified the following objective tests
7 and cut-off values and prioritised studies using a reference standard that included one of these:

- 8 • peak flow variability (cut-off value of more than 20% variability as indication of a positive test);
- 9 • bronchodilator reversibility (cut-off value of an improvement in FEV1 of more than or equal to
10 12%, and an increase in volume of more than or equal to 200mls as indication of a positive test);
- 11 • bronchial hyper-reactivity (histamine or methacholine challenge test, cut-off value of PC20 less
12 than or equal to 8mg/ml as indication of a positive test)

13 For reviews including one of the above three objective tests as the index test under investigation, the
14 respective tests were excluded from the reference standard for that review.

15 Where no evidence was available using the cut-off values specified above, evidence was included
16 from studies using a reference standard of physician diagnosis with an objective test using an
17 alternative threshold. Where no evidence was available from studies using physician diagnosis and
18 an objective test, evidence was included from studies using physician diagnosis based on symptoms
19 alone, or patient report of a previous physician diagnosis.

20 In children aged 1-<5 years, objective tests cannot be performed so the reference standard was
21 defined as physician diagnosis based on recurrent and persistent wheezing.

22 For the monitoring reviews, the GDG agreed that the most appropriate type of study design is one
23 that involves a test and treat approach, comparing two strategies in a randomised design. People
24 with asthma are randomised to receive the monitoring intervention plus appropriate change in
25 treatment versus the comparator plus appropriate change in treatment, and the impact on patient
26 outcomes is investigated.

27 For the monitoring reviews, the guideline population was people with asthma (defined as physician
28 diagnosis with an objective test). The GDG acknowledged that individual studies may not provide
29 details on how the asthma population were diagnosed. Therefore, evidence was also included from
30 studies in people with asthma (where the diagnosis criteria was unclear) or from studies including
31 people on asthma medication.

32 Severe, difficult to control asthma is excluded from the scope of this guideline. Therefore, for
33 monitoring reviews severe asthma was an exclusion criteria, defined as in the International ERS/ATS
34 guidelines³⁴ and summarised below:

- 35 • Definition of severe asthma for patients aged 6 years or more: asthma which requires treatment
36 with guidelines suggested medications for GINA steps 4–5 asthma (high dose ICS and LABA or
37 leukotriene modifier/theophylline) for the previous year or systemic CS for 50% or more of the
38 previous year to prevent it from becoming ‘uncontrolled’ or which remains ‘uncontrolled’ despite
39 this therapy. Uncontrolled asthma defined as at least one of the following: 1) poor symptom
40 control: ACQ consistently >1.5, ACT <20 (or “not well controlled” by NAEPP/GINA guidelines); 2)
41 frequent severe exacerbations: two or more bursts of systemic CS (>3 days each) in the previous
42 year; 3) serious exacerbations: at least one hospitalisation, ICU stay or mechanical ventilation in
43 the previous year; 4) airflow limitation: after appropriate bronchodilator withhold FEV1 <80%
44 predicted (in the face of reduced FEV1/FVC defined as less than the lower limit of normal).
45 Controlled asthma that worsens on tapering of these high doses of ICS or systemic CS (or
46 additional biologics). Note: the definition of high dose ICS is age-specific.

1 Conference abstracts were not automatically excluded from the review but were initially assessed
2 against the inclusion criteria and then further processed only if no other full publication was available
3 for that review question, in which case the authors of the selected abstracts were contacted for
4 further information. No clinical evidence was identified for two reviews (chapter 9: symptoms after
5 drugs; and chapter 25: monitoring peripheral blood eosinophil count). However, no conference
6 abstracts were identified which matched the review protocol. Therefore, no review included
7 conference abstracts.

8 Literature reviews, posters, letters, editorials, comment articles, unpublished studies and studies not
9 in English were excluded.

10 The review protocols are presented in Appendix C.

11 **3.3.2 Methods of combining clinical studies**

12 **3.3.2.1 Data synthesis for intervention reviews**

13 Where possible, meta-analyses were conducted to combine the results of studies for each review
14 question using Cochrane Review Manager (RevMan5) software. Fixed-effects (Mantel-Haenszel)
15 techniques were used to calculate risk ratios (relative risk) for the binary outcomes.

16 For continuous outcomes, measures of central tendency (mean) and variation (standard deviation)
17 were required for meta-analysis. Data for continuous outcomes were analysed using an inverse
18 variance method for pooling weighted mean differences and, where the studies had different scales,
19 standardised mean differences were used. A generic inverse variance option in RevMan5 was used if
20 any studies reported solely the summary statistics and 95% confidence interval (95% CI) or standard
21 error; this included any hazard ratios reported. However, in cases where standard deviations were
22 not reported per intervention group, the standard error (SE) for the mean difference was calculated
23 from other reported statistics (p values or 95% CIs); meta-analysis was then undertaken for the mean
24 difference and SE using the generic inverse variance method in RevMan5. When the only evidence
25 was based on studies that summarised results by presenting medians (and interquartile ranges), or
26 only p values were given, this information was assessed in terms of the study's sample size and was
27 included in the GRADE tables without calculating the relative or absolute effects. Consequently,
28 aspects of quality assessment such as imprecision of effect could not be assessed for evidence of this
29 type. Where reported, time-to-event data were presented as a hazard ratio.

30 Stratified analyses were predefined for some review questions at the protocol stage when the GDG
31 identified that these strata are different in terms of biological and clinical characteristics and the
32 interventions were expected to have a different effect on subpopulations. For example, objective
33 tests of lung function used for both asthma diagnosis and for monitoring asthma control are known
34 to perform differently in children, and three population strata were identified: children (1-<5 years
35 old); children/ young people (5-16 years old); and adults (>16 years old).

36 Statistical heterogeneity was assessed by visually examining the forest plots, and by considering the
37 chi-squared test for significance at $p < 0.1$ or an I-squared inconsistency statistic (with an I-squared
38 value of more than 50% indicating considerable heterogeneity). Where considerable heterogeneity
39 was present, we carried out predefined subgroup analyses – see protocols in appendix C.
40 Assessments of potential differences in effect between subgroups were based on the chi-squared
41 tests for heterogeneity statistics between subgroups. If no sensitivity analysis was found to
42 completely resolve statistical heterogeneity then a random-effects (DerSimonian and Laird) model
43 was employed to provide a more conservative estimate of the effect.

44 The means and standard deviations of continuous outcomes were required for meta-analysis.
45 However, in cases where standard deviations were not reported, the standard error was calculated if
46 the p values or 95% CIs were reported and meta-analysis was undertaken with the mean and

1 standard error using the generic inverse variance method in RevMan5. Where p values were
2 reported as 'less than', a conservative approach was undertaken. For example, if p value was
3 reported as ' $p \leq 0.001$ ', the calculations for standard deviations will be based on a p value of 0.001. If
4 these statistical measures were not available then the methods described in Section 16.1.3 of the
5 Cochrane Handbook (September 2009) 'Missing standard deviations' were applied as the last resort.

6 For interpretation of the binary outcome results, differences in the absolute event rate were
7 calculated using the GRADEpro software, for the median event rate across the control arms of the
8 individual studies in the meta-analysis. Absolute risk differences were presented in the GRADE
9 profiles and in clinical summary of findings tables, for discussion with the GDG.

10 For binary outcomes, absolute event rates were also calculated using the GRADEpro software using
11 event rate in the control arm of the pooled results.

12 3.3.2.2 Data synthesis for diagnostic test accuracy review

13 Data and outcomes

14 For the reviews of diagnostic test accuracy, a positive result on the index test was found if the patient
15 had values of the measured quantity above a threshold value, and different thresholds could be
16 used. Diagnostic test accuracy measures used in the analysis were: area under the Receiver
17 Operating Characteristics (ROC) curve, and, for different thresholds, sensitivity, specificity, positive
18 and negative predictive value. The threshold of a diagnostic test is defined as the value at which the
19 test can best differentiate between those with and without the target condition and, in practice, it
20 varies amongst studies. For this guideline, sensitivity and specificity were considered equally
21 important. A high sensitivity (true positives) of a test can pick up the majority of the correct cases
22 with asthma; conversely, a high specificity (true negatives) can correctly exclude people without
23 asthma. The GDG recognised that a test with a high sensitivity is important in order to not miss cases.
24 However, the GDG was also concerned about the over-diagnosis of asthma, and the importance of
25 being able to correctly exclude people without asthma.

26 Data synthesis

27 Coupled forest plots of sensitivity and specificity with their 95% CIs across studies (at various
28 thresholds) were produced for each test, using RevMan5. In order to do this, 2x2 tables (the number
29 of true positives, false positives, true negatives and false negatives) were directly taken from the
30 study if given, or else were derived from raw data.

31 To allow comparison between tests, summary ROC curves were generated for each diagnostic index
32 test from the pairs of sensitivity and specificity calculated from the 2x2 tables, selecting 1 threshold
33 per study. This was performed when sensitivity and specificity values were available from five or
34 more studies for the index test, selecting only 1 threshold per study. A ROC plot shows true positive
35 rate (sensitivity) as a function of false positive rate (1 minus specificity) and a summary ROC curve
36 can be used to see how sensitivity and specificity trade-off with each other as thresholds vary. Data
37 were entered into RevMan5 and summary ROC curves were fitted using the Moses Littenburg
38 approach. In this guideline, evidence was only available from enough studies to generate a summary
39 ROC curve for the index test for FeNO (chapter 16). Therefore, it was not possible to plot two or
40 more tests on the same graph in order to compare the performance of the diagnostic tests visually,
41 and therefore a meta-analysis of the summary ROC curves was not performed. However, the GDG
42 was interested in the placement of the index tests in a diagnostic algorithm, and not just the
43 performance of each diagnostic test in isolation. The paired sensitivity and specificity values from the
44 diagnostic tests were used to inform the placement of index tests in the diagnostic algorithm.

1 Heterogeneity or inconsistency amongst studies was visually inspected in the forest plots where
 2 appropriate (only when there were similar thresholds). A diagnostic meta-analysis of the summary
 3 operating point, (i.e. summary values for sensitivity and specificity) was not conducted because data
 4 were not available from five or more studies at the same cut-off threshold for any of the index tests,
 5 in order to estimate a summary sensitivity and specificity point at a chosen threshold. Instead, at
 6 each threshold, the median sensitivity value and its corresponding specificity were presented, along
 7 with the range of values.

8 3.3.3 Type of studies

9 For monitoring reviews in this guideline, parallel randomised controlled trials (RCTs) were included
 10 because they are considered the most robust type of study design that could produce an unbiased
 11 estimate of the monitoring intervention effects. Crossover RCTs were not appropriate for the
 12 monitoring reviews due to the nature of the intervention, adjustment of treatment based on
 13 monitoring. Please refer to Appendix C for full details on the study design of studies selected for each
 14 review question.

15 For diagnostic reviews, cross-sectional and retrospective studies were included. Case-control studies
 16 were not included for reviews of diagnostic test accuracy.

17 3.3.4 Appraising the quality of evidence by outcomes

18 The evidence for outcomes from the included RCTs and, where appropriate, observational studies
 19 were evaluated and presented using an adaptation of the ‘Grading of Recommendations Assessment,
 20 Development and Evaluation (GRADE) toolbox’ developed by the international GRADE working group
 21 (<http://www.gradeworkinggroup.org/>). The software developed by the GRADE working group
 22 (GRADEpro) was used to assess the quality of each outcome, taking into account individual study
 23 quality factors and the meta-analysis results. Results were presented in GRADE profiles (‘GRADE
 24 tables’), which consist of 2 sections: the ‘Clinical evidence profile’ table includes details of the quality
 25 assessment while the ‘Clinical evidence summary of findings’ table includes pooled outcome data,
 26 where appropriate, an absolute measure of intervention effect and the summary of quality of
 27 evidence for that outcome. In this table, the columns for intervention and control indicate summary
 28 measures and measures of dispersion (such as mean and standard deviation or median and range)
 29 for continuous outcomes and frequency of events (n/N: the sum across studies of the number of
 30 patients with events divided by sum of the number of completers) for binary outcomes. Reporting or
 31 publication bias was only taken into consideration in the quality assessment and included in the
 32 ‘Clinical evidence profile’ table if it was apparent.

33 The evidence for each outcome was examined separately for the quality elements listed and defined
 34 in Table 2. Each element was graded using the quality levels listed in Table 3. The main criteria
 35 considered in the rating of these elements are discussed below (see Section 3.3.5 Grading of
 36 evidence). Footnotes were used to describe reasons for grading a quality element as having serious
 37 or very serious problems. The ratings for each component were summed to obtain an overall
 38 assessment for each outcome (Table 4).

39 The GRADE toolbox is currently designed only for randomised trials and observational studies but we
 40 adapted the quality assessment elements and outcome presentation for diagnostic accuracy studies.

41 **Table 2: Description of the elements in GRADE used to assess the quality of intervention studies**

Quality element	Description
Risk of bias (‘Study limitations’)	Limitations in the study design and implementation may bias the estimates of the treatment effect. High risk of bias for the majority of the evidence decreases confidence in the estimate of the effect

Quality element	Description
Inconsistency	Inconsistency refers to an unexplained heterogeneity of results
Indirectness	Indirectness refers to differences in study population, intervention, comparator and outcomes between the available evidence and the review question, or recommendation made, such that the effect estimate is changed
Imprecision	Results are imprecise when studies include relatively few patients and few events and thus have wide confidence intervals around the estimate of the effect. Imprecision results if the confidence interval includes the clinically important threshold
Publication bias	Publication bias is a systematic underestimate or an overestimate of the underlying beneficial or harmful effect due to the selective publication of studies

1 **Table 3: Levels of quality elements in GRADE**

Level	Description
None	There are no serious issues with the evidence
Serious	The issues are serious enough to downgrade the outcome evidence by 1 level
Very serious	The issues are serious enough to downgrade the outcome evidence by 2 levels

2 **Table 4: Overall quality of outcome evidence in GRADE**

Level	Description
High	Further research is very unlikely to change our confidence in the estimate of effect
Moderate	Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate
Low	Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate
Very low	Any estimate of effect is very uncertain

3 3.3.5 Grading the quality of clinical evidence

4 After results were pooled, the overall quality of evidence for each outcome was considered. The
5 following procedure was adopted when using GRADE:

- 6 1. A quality rating was assigned, based on the study design. RCTs start as High, observational studies
7 as Low, and uncontrolled case series as Low or Very low.
- 8 2. The rating was then downgraded for the specified criteria: risk of bias (study limitations),
9 inconsistency, indirectness, imprecision and publication bias. These criteria are detailed below.
10 Evidence from observational studies (which had not previously been downgraded) was upgraded
11 if there was: a large magnitude of effect, a dose–response gradient, and if all plausible
12 confounding would reduce a demonstrated effect or suggest a spurious effect when results
13 showed no effect. Each quality element considered to have ‘serious’ or ‘very serious’ risk of bias
14 was rated down by 1 or 2 points respectively.
- 15 3. The downgraded or upgraded marks were then summed and the overall quality rating was
16 revised. For example, all RCTs started as High and the overall quality became Moderate, Low or
17 Very low if 1, 2 or 3 points were deducted respectively.
- 18 4. The reasons or criteria used for downgrading were specified in the footnotes.

19 The details of the criteria used for each of the main quality elements are discussed further in the
20 following sections 3.3.6 to 3.3.9.

1 3.3.6 Risk of bias

2 Bias can be defined as anything that causes a consistent deviation from the truth. Bias can be
3 perceived as a systematic error, for example, if a study was carried out several times and there was a
4 consistently wrong answer, the results would be inaccurate.

5 The risk of bias for a given study and outcome is associated with the risk of over- or underestimation
6 of the true effect.

7 Potential causes of bias are listed in Table 5.

8 A study with a poor methodological design does not automatically imply high risk of bias; the bias is
9 considered individually for each outcome and it is assessed whether this poor design will impact on
10 the estimation of the intervention effect.

11 The GDG accepted that patient and investigator blinding in monitoring intervention studies was
12 impossible to achieve in most situations. Nevertheless, open-label studies for monitoring were
13 downgraded for subjective or patient reported outcomes to maintain a consistent approach in
14 quality rating across the guideline, as these outcomes are highly subjected to bias in an open label
15 setting.

16 **Table 5: Risk of bias in randomised controlled trials**

Risk of bias	Explanation
Allocation concealment	Those enrolling patients are aware of the group to which the next enrolled patient will be allocated (this is a major problem in 'pseudo' or 'quasi' randomised trials with, for example, allocation by day of week, birth date, chart number)
Lack of blinding	Patient, caregivers, those recording outcomes, those adjudicating outcomes, or data analysts are aware of the arm to which patients are allocated
Incomplete accounting of patients and outcome events	Missing data not accounted for and failure of the trialists to adhere to the intention-to-treat principle when indicated
Selective outcome reporting	Reporting of some outcomes and not others on the basis of the results
Other risks of bias	For example: <ul style="list-style-type: none"> • Stopping early for benefit observed in randomised trials, in particular in the absence of adequate stopping rules • Use of unvalidated patient-reported outcomes • Recruitment bias in cluster-randomised trials

17 3.3.6.1 Diagnostic studies

18 For diagnostic accuracy studies, the Quality Assessment of Diagnostic Accuracy Studies version 2
19 (QUADAS-2) checklist was used (see Appendix F in The guidelines manual¹⁰⁶). Risk of bias and
20 applicability in primary diagnostic accuracy studies in QUADAS-2 consists of 4 domains (see Figure 2):

- 21 • Patient selection
- 22 • Index test
- 23 • Reference standard
- 24 • Flow and timing

1 **Figure 2: Summary of QUADAS-2 checklist**

DOMAIN	PATIENT SELECTION	INDEX TEST	REFERENCE STANDARD	FLOW AND TIMING
Description	Describe methods of patient selection: Describe included patients (prior testing, presentation, intended use of index test and setting):	Describe the index test and how it was conducted and interpreted:	Describe the reference standard and how it was conducted and interpreted:	Describe any patients who did not receive the index test(s) and/or reference standard or who were excluded from the 2x2 table (refer to flow diagram): Describe the time interval and any interventions between index test(s) and reference standard:
Signalling questions (yes/no/unclear)	Was a consecutive or random sample of patients enrolled?	Were the index test results interpreted without knowledge of the results of the reference standard?	Is the reference standard likely to correctly classify the target condition?	Was there an appropriate interval between index test(s) and reference standard?
	Was a case-control design avoided?	If a threshold was used, was it pre-specified?	Were the reference standard results interpreted without knowledge of the results of the index test?	Did all patients receive a reference standard?
	Did the study avoid inappropriate exclusions?			Did all patients receive the same reference standard?
				Were all patients included in the analysis?
Risk of bias: High/low/unclear	Could the selection of patients have introduced bias?	Could the conduct or interpretation of the index test have introduced bias?	Could the reference standard, its conduct, or its interpretation have introduced bias?	Could the patient flow have introduced bias?
Concerns regarding applicability: High/low/unclear	Are there concerns that the included patients do not match the review question?	Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Are there concerns that the target condition as defined by the reference standard does not match the review question?	

2
3 Source: QUADAS-2 website, University of Bristol¹⁷¹

4 Optional domain, multiple test accuracy is applicable when a single study examined more than 1
5 diagnostic test (head-to-head comparison between 2 or more index tests reported within the same
6 study). This optional domain contains 3 questions relating to risk of bias:

- 7
- 8 • Did all patients undergo all index tests or were the index tests appropriately randomised amongst the patients?
 - 9 • Were index tests conducted within a short time interval?
 - 10 • Are index test results unaffected when undertaken together on the same patient?

11 **3.3.6.2 Additional considerations**

12 The GDG raised a number of issues that needed to be taken into consideration when assessing study
13 quality and they are listed as follows:

14 Patient selection (concerns regarding applicability): the population was defined as people with
15 suspected asthma (presenting with respiratory symptoms). The GDG agreed that general population
16 studies, or studies using a questionnaire to identify people with symptoms in the general population,
17 should only be included if there was no other evidence, and downgraded for applicability. This is
18 because the diagnostic tests under investigation would be performed in people with suspected
19 asthma presenting to their GP, not as screening tests in the general population.

20 Index test: the GDG thought that the interpretation of the index tests was unlikely to be influenced
21 by the knowledge of the results of the reference standard, as they are not subjective tests.

22 Reference standard (concerns regarding applicability): the GDG agreed that the reference standard
23 should be physician diagnosis of asthma based on symptoms plus an objective test, as described in
24 section 3.3.1. Studies with a different reference standard were only included if there was no other
25 evidence, and downgraded for applicability.

1 **3.3.7 Inconsistency**

2 Inconsistency refers to an unexplained heterogeneity of results. When estimates of the treatment
3 effect across studies differ widely (that is, there is heterogeneity or variability in results), this
4 suggests true differences in underlying treatment effect.

5 Heterogeneity in meta-analyses was examined and sensitivity and subgroup analyses performed as
6 pre-specified in the protocols (Appendix C).

7 When heterogeneity exists (chi-squared $p < 0.1$, I-squared inconsistency statistic of $> 50\%$, or evidence
8 from examining forest plots), but no plausible explanation can be found (for example, duration of
9 intervention or different follow-up periods), the quality of evidence was downgraded by 1 or 2 levels,
10 depending on the extent of uncertainty to the results contributed by the inconsistency in the results.
11 In addition to the I-squared and chi-squared values, the decision for downgrading was also
12 dependent on factors such as whether the intervention is associated with benefit in all other
13 outcomes or whether the uncertainty about the magnitude of benefit (or harm) of the outcome
14 showing heterogeneity would influence the overall judgment about net benefit or harm (across all
15 outcomes).

16 **3.3.8 Indirectness**

17 Directness refers to the extent to which the populations, intervention, comparisons and outcome
18 measures are similar to those defined in the inclusion criteria for the reviews. Indirectness is
19 important when these differences are expected to contribute to a difference in effect size, or may
20 affect the balance of harms and benefits considered for an intervention.

21 For diagnostic review, indirectness was assessed using the applicability domains of the QUADAS II
22 checklist (see Figure 2).

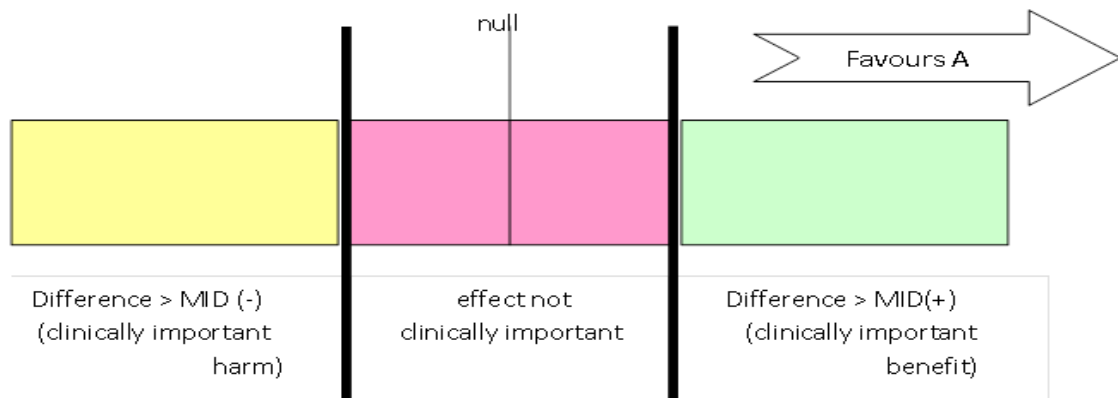
23 **3.3.9 Imprecision**

24 Imprecision in guidelines concerns whether the uncertainty (confidence interval) around the effect
25 estimate means that it is not clear whether there is a clinically important difference between
26 interventions or not. Therefore, imprecision differs from the other aspects of evidence quality, in
27 that it is not really concerned with whether the point estimate is accurate or correct (has internal or
28 external validity), rather it is concerned with uncertainty about what the point estimate is. This
29 uncertainty is reflected in the width of the confidence interval.

30 The 95% confidence interval (95% CI) is defined as the range of values that contain the population
31 value with 95% probability. The larger the trial, the smaller the 95% CI and the more certain the
32 effect estimate.

33 Imprecision in the evidence reviews was assessed by considering whether the width of the 95% CI of
34 the effect estimate is relevant to decision-making, considering each outcome in isolation. Figure 3
35 considers a positive outcome for the comparison of treatment A versus B. Three decision-making
36 zones can be identified, bounded by the thresholds for clinical importance (minimal important
37 difference – MID) for benefit and for harm. The MID for harm for a positive outcome means the
38 threshold at which drug A is less effective than drug B by an amount that is clinically important to
39 patients (favours B).

1 **Figure 3: Illustration of precise and imprecise outcomes based on the confidence interval of**
 2 **outcomes in a forest plot**



3 When the confidence interval of the effect estimate is wholly contained in one of the 3 zones (for
 4 example, clinically important benefit), we are not uncertain about the size and direction of effect
 5 (whether there is a clinically important benefit, or the effect is not clinically important, or there is a
 6 clinically important harm), so there is no imprecision.

7 When a wide confidence interval lies partly in each of 2 zones, it is uncertain in which zone the true
 8 value of effect estimate lies, and therefore there is uncertainty over which decision to make (based
 9 on this outcome alone). The confidence interval is consistent with 2 decisions and so this is
 10 considered to be imprecise in the GRADE analysis and the evidence is downgraded by 1 level
 11 ('serious imprecision').

12 If the confidence interval of the effect estimate crosses into 3 zones, this is considered to be very
 13 imprecise evidence because the confidence interval is consistent with 3 clinical decisions and there is
 14 a considerable lack of confidence in the results. The evidence is therefore downgraded by 2 levels in
 15 the GRADE analysis ('very serious imprecision').

16 Implicitly, assessing whether the confidence interval is in, or partially in, a clinically important zone,
 17 requires the GDG to estimate an MID or to say whether they would make different decisions for the
 18 2 confidence limits.

19 The GDG was asked whether they were aware of any acceptable MIDs in the clinical community. The
 20 GDG provided established MIDs which were used for the following outcomes:

- 21 • AQLQ, child AQLQ, carer AQLQ and mini AQLQ: 0.5⁷⁵
- 22 • ACT: 3.0¹⁴¹
- 23 • FEV1 litres: 0.23L¹³⁹
- 24 • PEF L/min: 20L/min¹³⁹

25 Finally, the GDG considered it clinically acceptable to use the GRADE default MID to assess
 26 imprecision: a 25% relative risk reduction or relative risk increase was used, which corresponds to
 27 clinically important thresholds for a risk ratio of 0.75 and 1.25 respectively. This default MID was
 28 used for all other outcomes in the monitoring evidence reviews.

29 **3.3.10 Assessing clinical importance**

30 The GDG assessed the evidence by outcome in order to determine if there was, or potentially was, a
 31 clinically important benefit, a clinically important harm or no clinically important difference between
 32 interventions. To facilitate this, binary outcomes were converted into absolute risk differences
 33 (ARDs) using GRADEpro software: the median control group risk across studies was used to calculate
 34 the ARD and its 95% CI from the pooled risk ratio.

1 The assessment of benefit, harm, or no benefit or harm was based on the point estimate of absolute
2 effect for intervention studies which was standardised across the reviews. The GDG considered for
3 most of the outcomes in the intervention reviews that if at least 100 participants per 1000 (10%)
4 achieved (if positive) the outcome of interest in the intervention group compared to the comparison
5 group then this intervention would be considered beneficial. The same point estimate but in the
6 opposite direction would apply if the outcome was negative.

7 This assessment was carried out by the GDG for each critical outcome, and an evidence summary
8 table was produced to compile the GDG's assessments of clinical importance per outcome, alongside
9 the evidence quality and the uncertainty in the effect estimate (imprecision).

10 **3.3.11 Evidence statements**

11 Evidence statements are summary statements that are presented after the GRADE profiles,
12 summarising the key features of the clinical effectiveness evidence presented. The wording of the
13 evidence statements reflects the certainty or uncertainty in the estimate of effect. The evidence
14 statements are presented by outcome and encompass the following key features of the evidence:

- 15 • the number of studies and the number of participants for a particular outcome
- 16 • a brief description of the participants
- 17 • an indication of the direction of effect (if one treatment is beneficial or harmful compared to the
18 other, or whether there is no difference between the 2 tested treatments)
- 19 • a description of the overall quality of evidence (GRADE overall quality).

20 **3.4 Evidence of cost-effectiveness**

21 The GDG is required to make decisions based on the best available evidence of both clinical and cost-
22 effectiveness. Guideline recommendations should be based on the expected costs of the different
23 options in relation to their expected health benefits (that is, their 'cost-effectiveness') rather than
24 the total implementation cost.¹⁰⁶ Thus, if the evidence suggests that a strategy provides significant
25 health benefits at an acceptable cost per patient treated, it should be recommended even if it would
26 be expensive to implement across the whole population.

27 Evidence on cost-effectiveness related to the key clinical issues being addressed in the guideline was
28 sought. The health economist:

- 29 • Undertook a systematic review of the published economic literature.
- 30 • Undertook new cost-effectiveness analysis in priority areas.

31 **3.4.1 Literature review**

32 The health economist:

- 33 • Identified potentially relevant studies for each review question from the economic search results
34 by reviewing titles and abstracts. Full papers were then obtained.
- 35 • Reviewed full papers against pre-specified inclusion and exclusion criteria to identify relevant
36 studies (see below for details).
- 37 • Critically appraised relevant studies using the economic evaluations checklist as specified in The
38 guidelines manual.¹⁰⁶
- 39 • Extracted key information about the studies' methods and results into evidence tables (included
40 in Appendix H).
- 41 • Generated summaries of the evidence in NICE economic evidence profiles (included in the
42 relevant chapter for each review question) – see below for details.

1 3.4.1.1 Inclusion and exclusion criteria

2 Full economic evaluations (studies comparing costs and health consequences of alternative courses
3 of action: cost–utility, cost-effectiveness, cost–benefit and cost–consequence analyses) and
4 comparative costing studies that addressed the review question in the relevant population were
5 considered potentially includable as economic evidence.

6 Studies that only reported cost per hospital (not per patient), or only reported average cost-
7 effectiveness without disaggregated costs and effects, were excluded. Literature reviews, abstracts,
8 posters, letters, editorials, comment articles, unpublished studies and studies not in English were
9 excluded.

10 Remaining studies were prioritised for inclusion based on their relative applicability to the
11 development of this guideline and the study limitations. For example, if a high quality, directly
12 applicable UK analysis was available, then other less relevant studies may not have been included.
13 Where exclusions occurred on this basis, this is noted in the relevant section.

14 For more details about the assessment of applicability and methodological quality see the economic
15 evaluation checklist (Appendix F of The guidelines manual.¹⁰⁶ and the health economics review
16 protocol in Appendix C).

17 When no relevant economic studies were found from the economic literature review, relevant UK
18 NHS unit costs related to the compared interventions were presented to the GDG to inform the
19 possible economic implications of the recommendations.

20 3.4.1.2 NICE economic evidence profiles

21 The NICE economic evidence profile has been used to summarise cost and cost-effectiveness
22 estimates. The economic evidence profile shows an assessment of applicability and methodological
23 quality for each economic evaluation, with footnotes indicating the reasons for the assessment.
24 These assessments were made by the health economist using the economic evaluation checklist from
25 The guidelines manual.¹⁰⁶ It also shows the incremental costs, incremental effects (for example,
26 quality-adjusted life years [QALYs]) and incremental cost-effectiveness ratio for the base case
27 analysis in the evaluation, as well as information about the assessment of uncertainty in the analysis.
28 See Table 6 for more details.

29 If a non-UK study was included in the profile, the results were converted into pounds sterling using
30 the appropriate purchasing power parity.¹¹²

31 **Table 6: Content of NICE economic evidence profile**

Item	Description
Study	First author name, reference, date of study publication and country perspective.
Applicability	An assessment of applicability of the study to the clinical guideline, the current NHS situation and NICE decision-making ^(a) : <ul style="list-style-type: none"> • Directly applicable – the study meets all applicability criteria, or fails to meet one or more applicability criteria but this is unlikely to change the conclusions about cost-effectiveness. • Partially applicable – the study fails to meet one or more applicability criteria, and this could change the conclusions about cost-effectiveness. • Not applicable – the study fails to meet one or more of the applicability criteria, and this is likely to change the conclusions about cost-effectiveness. Such studies would usually be excluded from the review.
Limitations	An assessment of methodological quality of the study ^(a) : <ul style="list-style-type: none"> • Minor limitations – the study meets all quality criteria, or fails to meet one or

Item	Description
	<p>more quality criteria, but this is unlikely to change the conclusions about cost-effectiveness.</p> <ul style="list-style-type: none"> • Potentially serious limitations – the study fails to meet one or more quality criteria, and this could change the conclusions about cost-effectiveness. • Very serious limitations – the study fails to meet one or more quality criteria, and this is highly likely to change the conclusions about cost-effectiveness. Such studies would usually be excluded from the review.
Other comments	Particular issues that should be considered when interpreting the study.
Incremental cost	The mean cost associated with one strategy minus the mean cost of a comparator strategy.
Incremental effects	The mean QALYs (or other selected measure of health outcome) associated with one strategy minus the mean QALYs of a comparator strategy.
Cost-effectiveness	Incremental cost-effectiveness ratio (ICER): the incremental cost divided by the incremental effects.
Uncertainty	A summary of the extent of uncertainty about the ICER reflecting the results of deterministic or probabilistic sensitivity analyses, or stochastic analyses of trial data, as appropriate.

1 (a) *Applicability and limitations were assessed using the economic evaluation checklist in Appendix G of The guidelines*
 2 *manual (2012)*¹⁰⁶

3 3.4.2 Undertaking new health economic analysis

4 As well as reviewing the published economic literature for each review question, as described above,
 5 new economic analysis was undertaken by the health economist in selected areas. Priority areas for
 6 new health economic analysis were agreed by the GDG after formation of the review questions and
 7 consideration of the available health economic evidence.

8 The GDG identified the diagnosis of asthma in adults as the highest priority area for original
 9 economic modelling. Further details are available in Appendix M.

10 The following general principles were adhered to in developing the cost-effectiveness analysis:

- 11 • Methods were consistent with the NICE reference case.¹⁰⁷
- 12 • The GDG was involved in the design of the model, selection of inputs and interpretation of the
 13 results.
- 14 • Model inputs were based on the systematic review of the clinical literature supplemented with
 15 other published data sources where possible.
- 16 • When published data were not available GDG expert opinion was used to populate the model.
- 17 • Model inputs and assumptions were reported fully and transparently.
- 18 • The results were subject to sensitivity analysis and limitations were discussed.
- 19 • The model was peer-reviewed by another health economist at the NCGC.

20 Full methods for the cost-effectiveness analysis for diagnosis of asthma in adults are described in
 21 Appendix M.

22 3.4.3 Cost-effectiveness criteria

23 NICE's report 'Social value judgements: principles for the development of NICE guidance' sets out the
 24 principles that GDGs should consider when judging whether an intervention offers good value for
 25 money.¹⁰⁵ In general, an intervention was considered to be cost-effective if either of the following
 26 criteria applied (given that the estimate was considered plausible):

- 1 • the intervention dominated other relevant strategies (that is, it was both less costly in terms of
2 resource use and more clinically effective compared with all the other relevant alternative
3 strategies), or
4 • the intervention cost less than £20,000 per QALY gained compared with the next best strategy.

5 If the GDG recommended an intervention that was estimated to cost more than £20,000 per QALY
6 gained, or did not recommend one that was estimated to cost less than £20,000 per QALY gained,
7 the reasons for this decision are discussed explicitly in the ‘Recommendations and link to evidence’
8 section of the relevant chapter, with reference to issues regarding the plausibility of the estimate or
9 to the factors set out in ‘Social value judgements: principles for the development of NICE
10 guidance’.¹⁰⁵

11 **3.4.4 In the absence of economic evidence**

12 When no relevant published studies were found, and a new analysis was not prioritised, the GDG
13 made a qualitative judgement about cost-effectiveness by considering expected differences in
14 resource use between options and relevant UK NHS unit costs, alongside the results of the clinical
15 review of effectiveness evidence.

16 **3.5 Developing recommendations**

17 Over the course of the guideline development process, the GDG was presented with:

- 18 • Evidence tables of the clinical and economic evidence reviewed from the literature. All evidence
19 tables are in Appendices H and I.
20 • Summary of clinical and economic evidence and quality (as presented in chapters 6 to 30).
21 • Forest plots and summary ROC curves (Appendix J).
22 • A description of the methods and results of the cost-effectiveness analysis undertaken for the
23 guideline (Appendix M).

24 Recommendations were drafted on the basis of the GDG interpretation of the available evidence,
25 taking into account the balance of benefits, harms and costs between different courses of action.
26 This was either done formally in an economic model, or informally. Firstly, the net benefit over harm
27 (clinical effectiveness) was considered, focusing on the critical outcomes. When this was done
28 informally, the GDG took into account the clinical benefits and harms when one intervention was
29 compared with another. The assessment of net benefit was moderated by the importance placed on
30 the outcomes (the GDG’s values and preferences), and the confidence the GDG had in the evidence
31 (evidence quality). Secondly, it was assessed whether the net benefit justified any differences in
32 costs.

33 When clinical and economic evidence was of poor quality, conflicting or absent, the GDG drafted
34 recommendations based on their expert opinion. The considerations for making consensus-based
35 recommendations include the balance between potential harms and benefits, the economic costs
36 compared to the economic benefits, current practices, recommendations made in other relevant
37 guidelines, patient preferences and equality issues. The consensus recommendations were agreed
38 through discussions in the GDG. The GDG also considered whether the uncertainty was sufficient to
39 justify delaying making a recommendation to await further research, taking into account the
40 potential harm of failing to make a clear recommendation (see Section 3.5.1 below).

41 The wording of recommendations was agreed by the GDG and focused on the following factors:

- 42 • The actions health professionals need to take.
43 • The information readers need to know.

- 1 • The strength of the recommendation (for example the word ‘offer’ was used for strong
2 recommendations and ‘consider’ for weak recommendations).
3 • The involvement of patients (and their carers if needed) in decisions on treatment and care.
4 • Consistency with NICE’s standard advice on recommendations about drugs, waiting times and
5 ineffective interventions.

6 The main considerations specific to each recommendation are outlined in the ‘Recommendations
7 and link to evidence’ sections within each chapter.

8 **3.5.1 Research recommendations**

9 When areas were identified for which good evidence was lacking, the GDG considered making
10 recommendations for future research. Decisions about inclusion were based on factors such as:

- 11 • the importance to patients or the population
12 • national priorities
13 • potential impact on the NHS and future NICE guidance
14 • ethical and technical feasibility.

15 **3.5.2 Validation process**

16 This guidance is subject to a 6-week public consultation and feedback as part of the quality assurance
17 and peer review of the document. All comments received from registered stakeholders are
18 responded to in turn and posted on the NICE website when the pre-publication check of the full
19 guideline occurs.

20 **3.5.3 Updating the guideline**

21 A formal review of the need to update a guideline is usually undertaken by NICE after its publication.
22 NICE will conduct a review to determine whether the evidence base has progressed significantly to
23 alter the guideline recommendations and warrant an update.

24 **3.5.4 Disclaimer**

25 Healthcare providers need to use clinical judgement, knowledge and expertise when deciding
26 whether it is appropriate to apply guidelines. The recommendations cited here are a guide and may
27 not be appropriate for use in all situations. The decision to adopt any of the recommendations cited
28 here must be made by practitioners in light of individual patient circumstances, the wishes of the
29 patient, clinical expertise and resources.

30 The National Clinical Guideline Centre disclaims any responsibility for damages arising out of the use
31 or non-use of this guideline and the literature used in support of this guideline.

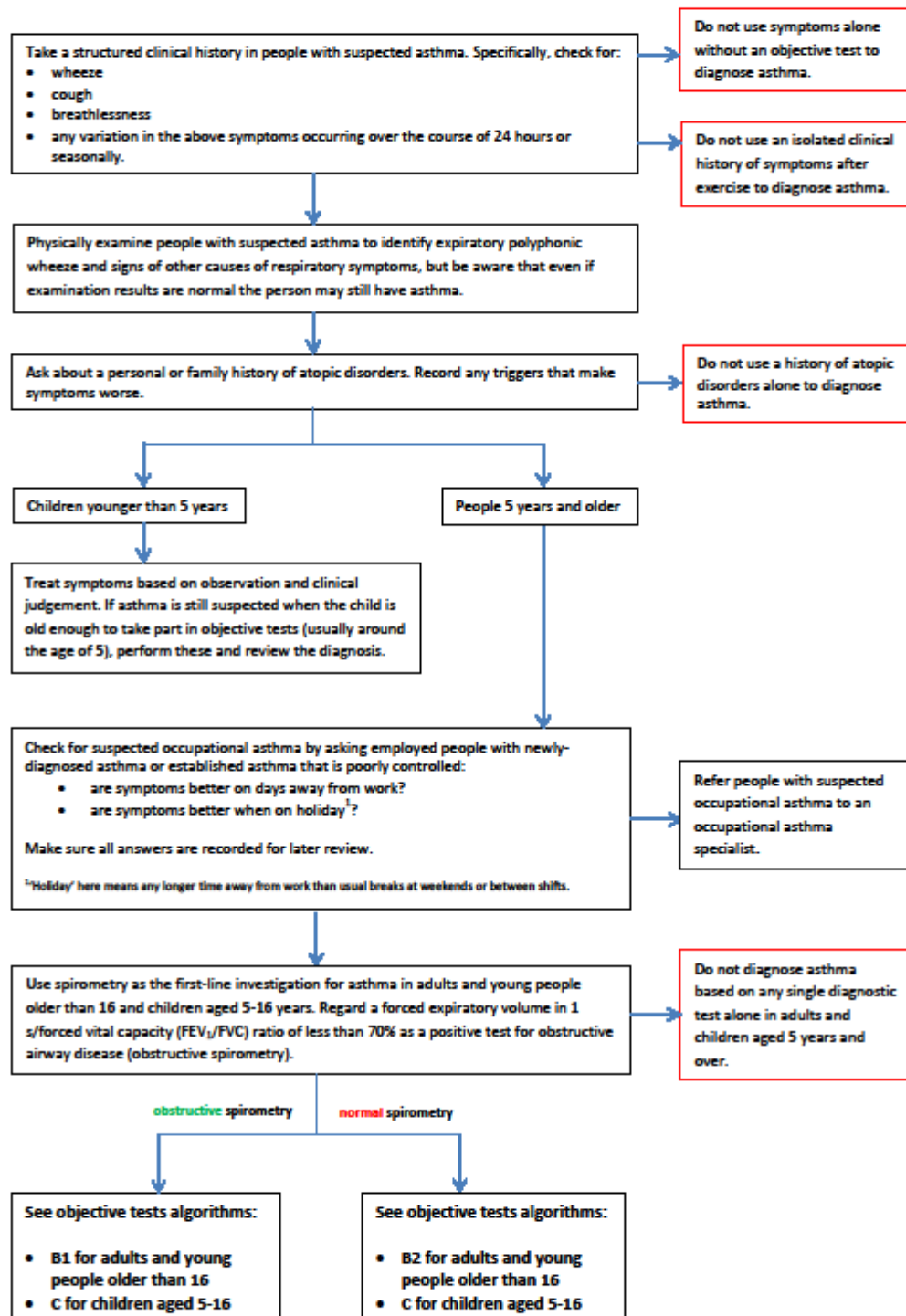
32 **3.5.5 Funding**

33 The National Clinical Guideline Centre was commissioned by the National Institute for Health and
34 Care Excellence to undertake the work on this guideline.

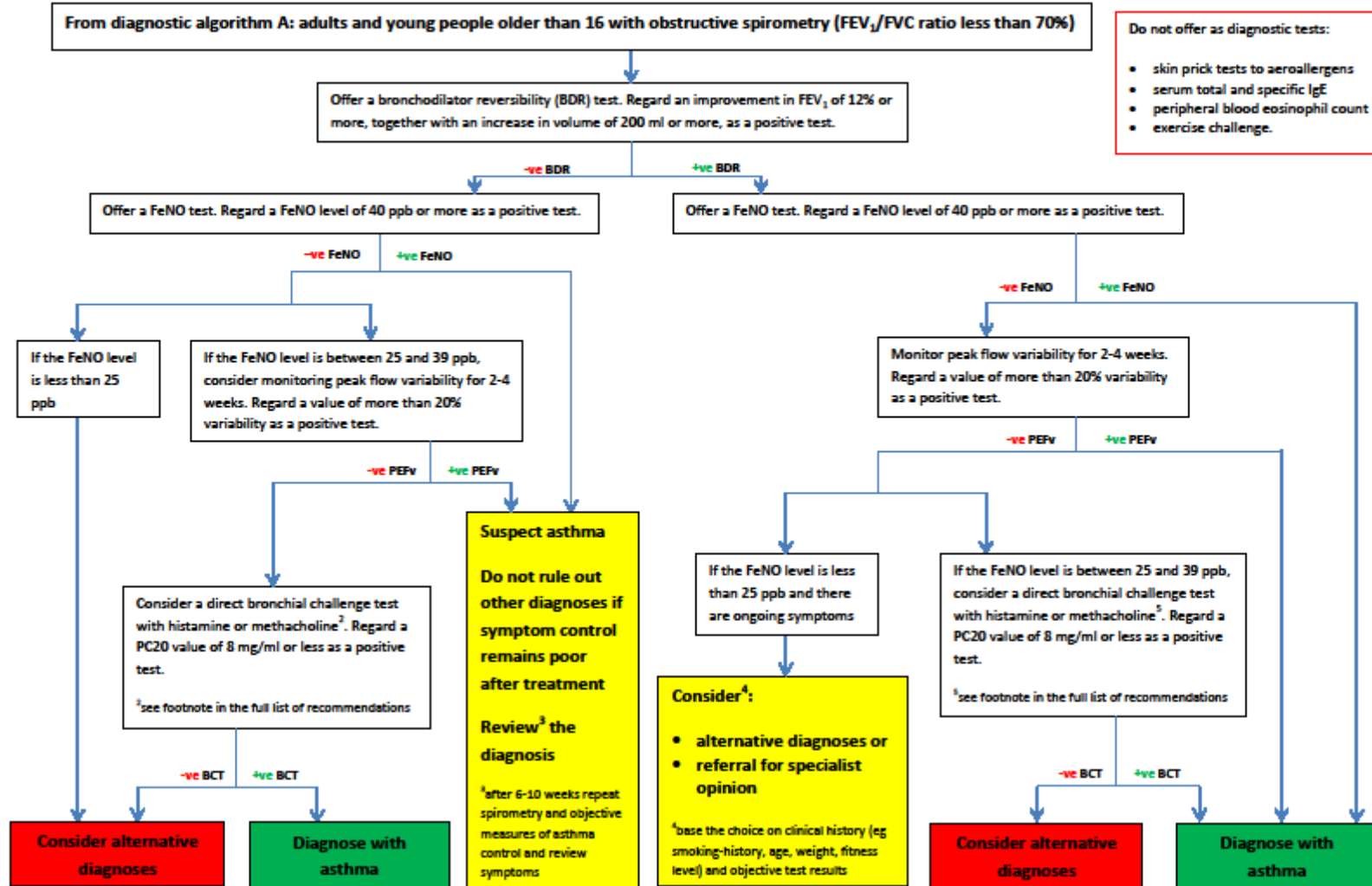
4 Guideline summary

4.1 Diagnostic algorithms

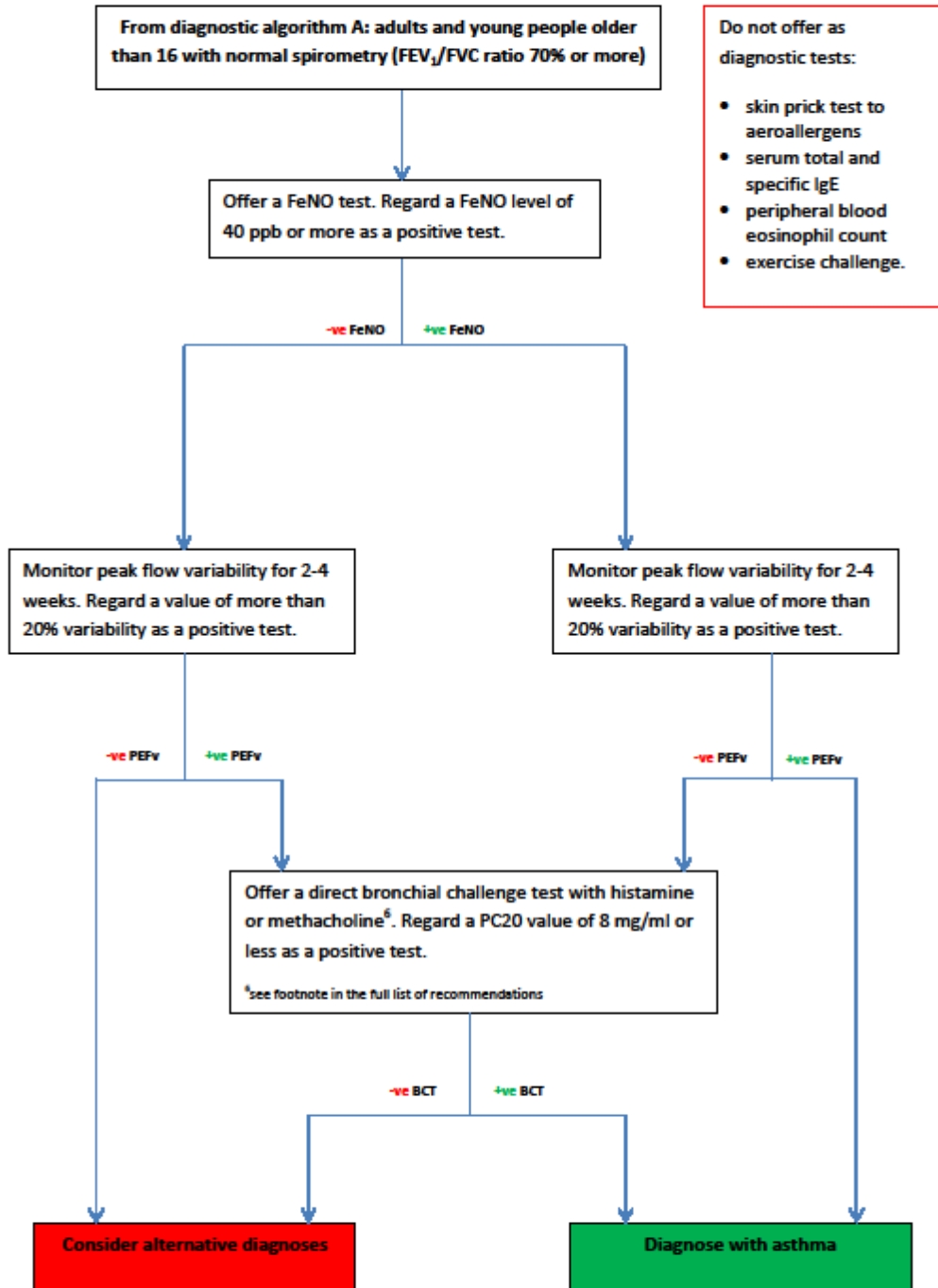
Diagnostic algorithm A – initial clinical assessment and first-line objective test for adults and children



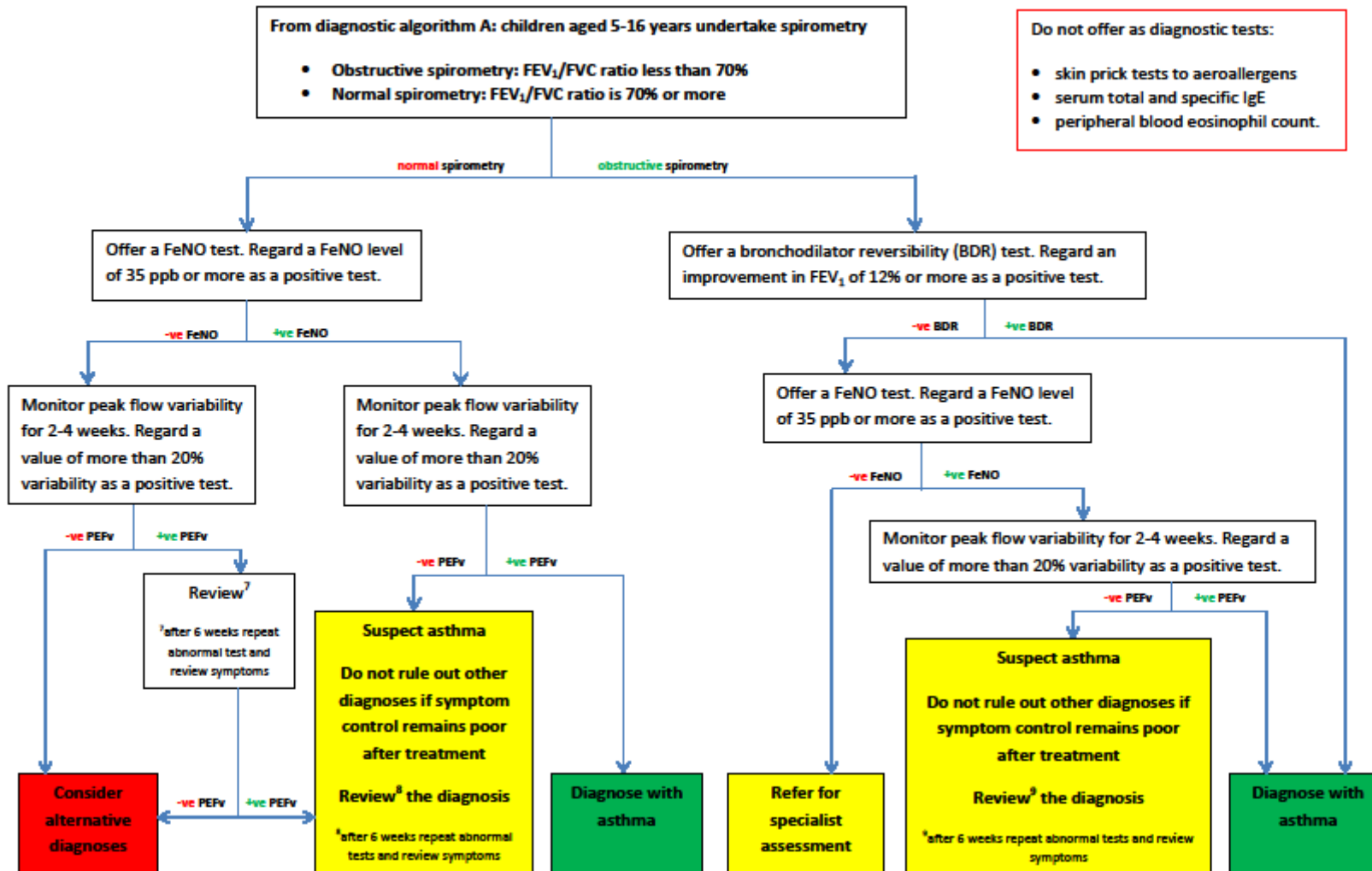
Diagnostic algorithm B1 – objective tests for adults and young people older than 16 with obstructive spirometry



Diagnostic algorithm B2 – objective tests for adults and young people older than 16 with normal spirometry



Diagnostic algorithm C – objective tests for children aged 5-16 years



1 4.2 Key priorities for implementation

2 From the full set of recommendations, the GDG selected 10 key priorities for implementation. The
3 criteria used for selecting these recommendations are listed in detail in The guidelines manual.¹⁰⁶ The
4 reasons that each of these recommendations was chosen are shown in the table linking the evidence
5 to the recommendation in the relevant chapter.

6 **Diagnosing asthma: Initial clinical assessment**

- 7 • Check for suspected occupational asthma by asking employed people with newly-diagnosed
8 asthma or established asthma that is poorly controlled:
 - 9 o are symptoms better on days away from work?
 - 10 o are symptoms better when on holiday^a?

11 Make sure all answers are recorded for later review.

12 **Diagnosing asthma: Objective tests**

- 13 • Use spirometry as the first-line investigation for asthma in adults and young people older than 16
14 and children aged 5–16 years. Regard a forced expiratory volume in 1 s/forced vital capacity
15 (FEV1/FVC) ratio of less than 70% as a positive test for obstructive airway disease (obstructive
16 spirometry). See also recommendation 23.
- 17 • Offer a bronchodilator reversibility (BDR) test to adults and young people older than 16 with
18 obstructive spirometry (FEV1/FVC ratio less than 70%). Regard an improvement in FEV1 of 12% or
19 more, together with an increase in volume of 200 ml or more, as a positive test.
- 20 • Offer a BDR test to children aged 5–16 years with obstructive spirometry (FEV1/FVC ratio less
21 than 70%). Regard an improvement in FEV1 of 12% or more as a positive test.
- 22 • Offer a FeNO test in adults and young people older than 16 if a diagnosis of asthma is being
23 considered. Regard a FeNO level of 40 parts per billion (ppb) or more as a positive test.
- 24 • Offer a direct bronchial challenge test with histamine or methacholine^b in adults and young
25 people older than 16 if there is diagnostic uncertainty after a normal spirometry and either a:
 - 26 o FeNO level of 40 ppb or more and no variability in peak flow readings or
 - 27 o FeNO level of 39 ppb or less with variability in peak flow readings.
- 28 Regard a PC20 value of 8 mg/ml or less as a positive test.

29 **Diagnosing asthma in children younger than 5 years**

- 30 • Treat symptoms based on observation and clinical judgement in children younger than 5 years. If
31 asthma is still suspected when the child is old enough to take part in objective tests (usually
32 around the age of 5), perform these and review the diagnosis.

33 **Monitoring asthma control**

- 34 • Consider using a validated questionnaire (the Asthma Control Questionnaire or Asthma Control
35 Test) to monitor asthma control in adults and young people older than 16.

^a 'Holiday' here means any longer time away from work than usual breaks at weekends or between shifts.

^b At the time of consultation (January 2015), methacholine did not have a 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.

- 1 • Use either spirometry (FEV1) or peak flow variability to monitor asthma control at each review in
- 2 adults and children aged 5 years and over.
- 3 • Monitor the inhaler technique of people with asthma (in line with the NICE quality standard on
- 4 asthma):
- 5 o after every asthma attack
- 6 o when the device is changed
- 7 o at every annual review.

8 **4.3 Full list of recommendations**

9 **Diagnosing asthma**

10 ***Initial clinical assessment***

11 **Signs and symptoms**

- 12 1. Take a structured clinical history in people with suspected asthma.
- 13 Specifically, check for:
- 14 • wheeze
- 15 • cough
- 16 • breathlessness
- 17 • any variation in the above symptoms occurring over the course of
- 18 24 hours or seasonally.
- 19 2. Do not use symptoms alone without an objective test to diagnose asthma.
- 20 3. Physically examine people with suspected asthma to identify expiratory
- 21 polyphonic wheeze and signs of other causes of respiratory symptoms, but
- 22 be aware that even if the examination results are normal the person may still
- 23 have asthma.

24 **History of atopic disorders**

- 25 4. Ask about a personal or family history of atopic disorders. Record any triggers
- 26 that make symptoms worse.
- 27 5. Do not use a history of atopic disorders alone to diagnose asthma.

28 **Symptoms after exercise**

- 29 6. Do not use an isolated clinical history of symptoms after exercise to diagnose
- 30 asthma.

31 **Occupational asthma**

- 32 7. Check for suspected occupational asthma by asking employed people with
- 33 newly-diagnosed asthma or established asthma that is poorly controlled:
- 34 • are symptoms better on days away from work?
- 35 • are symptoms better when on holiday^c?
- 36 Make sure all answers are recorded for later review.
- 37 8. Refer people with suspected occupational asthma to an occupational asthma
- 38 specialist.

^c 'Holiday' here means any longer time away from work than usual breaks at weekends or between shifts.

1 **Objective tests**

2 **Lung function tests**

3 **Spirometry**

- 4 9. Use spirometry as the first-line investigation for asthma in adults and young
5 people older than 16 and children aged 5-16 years. Regard a forced
6 expiratory volume in 1 s/forced vital capacity (FEV₁/FVC) ratio of less than
7 70% as a positive test for obstructive airway disease (obstructive spirometry).
8 See also recommendation 23.

9 **Bronchodilator reversibility**

- 10 10. Offer a bronchodilator reversibility (BDR) test to adults and young people
11 older than 16 with obstructive spirometry (FEV₁/FVC ratio less than 70%).
12 Regard an improvement in FEV₁ of 12% or more, together with an increase in
13 volume of 200 ml or more, as a positive test.
- 14 11. Offer a BDR test to children aged 5–16 years with obstructive spirometry
15 (FEV₁/FVC ratio less than 70%). Regard an improvement in FEV₁ of 12% or
16 more as a positive test.

17 **Peak expiratory flow variability**

- 18 12. Monitor peak flow variability for 2-4 weeks in adults and young people older
19 than 16 if there is diagnostic uncertainty after initial assessment and they
20 have either:
- 21 • normal spirometry and the results of a fractional exhaled nitric oxide
22 (FeNO) test **or**
 - 23 • obstructive spirometry, reversible airways obstruction (positive BDR) and
24 a FeNO level of 39 parts per billion (ppb) or less.
- 25 Regard a value of more than 20% variability as a positive test.
- 26 13. Consider monitoring peak flow variability for 2-4 weeks in adults and young
27 people older than 16 if there is diagnostic uncertainty after initial assessment
28 and they have:
- 29 • obstructive spirometry **and**
 - 30 • irreversible airways obstruction (negative BDR) **and**
 - 31 • a FeNO level between 25 and 39 ppb.
- 32 Regard a value of more than 20% variability as a positive test.
- 33 14. Monitor peak flow variability for 2-4 weeks in children aged 5-16 years if
34 there is diagnostic uncertainty after initial assessment and they have either:
- 35 • normal spirometry and the results of a FeNO test **or**
 - 36 • obstructive spirometry, irreversible airways obstruction (negative BDR)
37 and a FeNO level of 35 ppb or more.
- 38 Regard a value of more than 20% variability as a positive test.

39 **Allergy testing**

- 40 15. Do not offer the following as diagnostic tests for asthma:
- 41 • skin prick tests to aeroallergens
 - 42 • serum total and specific IgE.
- 43

1 **Airway inflammation measures**

2 **Fractional exhaled nitric oxide**

3 16. Offer a FeNO test in adults and young people older than 16 if a diagnosis of
4 asthma is being considered. Regard a FeNO level of 40 parts per billion (ppb)
5 or more as a positive test.

6 17. Offer a FeNO test in children aged 5–16 years if there is diagnostic
7 uncertainty after initial assessment and they have either:

- 8
- 9 • normal spirometry **or**
 - 10 • obstructive spirometry with negative BDR.

11 Regard a FeNO level of 35 ppb or more as a positive test.

12 **Peripheral blood eosinophil count**

13 18. Do not offer a peripheral blood eosinophil count as a diagnostic test for
14 asthma.

15 **Airway hyper-reactivity measures**

16 **Direct bronchial challenge test with histamine or methacholine**

17 19. Offer a direct bronchial challenge test with histamine or methacholine^d in
18 adults and young people older than 16 if there is diagnostic uncertainty after
19 a normal spirometry and either a:

- 20
- 21 • FeNO level of 40 ppb or more and no variability in peak flow readings **or**
 - 22 • FeNO level of 39 ppb or less with variability in peak flow readings.

23 Regard a PC20 value of 8 mg/ml or less as a positive test.

24 20. Consider a direct bronchial challenge test with histamine or methacholine^d in
25 adults and young people older than 16 with:

- 26
- 27 • obstructive spirometry **and**
 - 28 • a FeNO level between 25 and 39 ppb **and**
 - 29 • no variability in peak flow readings (less than 20% variability over a 2-4
30 week period).

31 Regard a PC20 value of 8 mg/ml or less as a positive test.

32 **Indirect bronchial challenge test with exercise**

33 21. Do not offer adults and young people older than 16 an exercise challenge test
34 as a diagnostic test for asthma.

35 **Diagnostic summaries**

36 These recommendations should be used together with the diagnostic algorithms and the detailed
37 descriptions of the investigations and tests.

38 **Children younger than 5 years (algorithm A)**

22. Treat symptoms based on observation and clinical judgement in children
younger than 5 years. If asthma is still suspected when the child is old enough

^d At the time of consultation (January 2015), methacholine did not have a 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.

1 to take part in objective tests (usually around the age of 5), perform these
2 and review the diagnosis.

3 **Adults and children aged 5 years and over (algorithm A)**

4 23. Do not diagnose asthma based on any single diagnostic test alone in adults
5 and children aged 5 years and over.

6 **Adults and young people older than 16 with obstructive spirometry (algorithm B1)**

7 24. Diagnose asthma in adults and young people older than 16 if they have
8 obstructive spirometry and:

- 9 • negative bronchodilator reversibility, a FeNO level between 25 and
10 39 ppb, negative peak flow variability and a positive direct bronchial
11 challenge test **or**
- 12 • positive bronchodilator reversibility and a FeNO level of 40 ppb or more
13 **or**
- 14 • positive bronchodilator reversibility, a FeNO level of 39 ppb or less and
15 positive peak flow variability test **or**
- 16 • positive bronchodilator reversibility, a FeNO level between 25 and
17 39 ppb, negative peak flow variability and a positive direct bronchial
18 challenge test.

19 25. Suspect asthma in adults and young people older than 16 with obstructive
20 spirometry, negative bronchodilator reversibility and:

- 21 • a FeNO level of 40 ppb or more **or**
- 22 • a FeNO level between 25 and 39 ppb and positive peak flow variability.

23 Do not rule out other diagnoses if symptom control continues to remain poor
24 after treatment. Review the diagnosis after 6–10 weeks by repeating
25 spirometry and objective measures of asthma control and reviewing
26 symptoms.

27 26. In adults and young people older than 16 with obstructive spirometry,
28 positive bronchodilator reversibility, negative peak flow variability and a
29 FeNO level less than 25 ppb and ongoing symptoms, consider:

- 30 • alternative diagnoses **or**
- 31 • referral for specialist opinion.

32 Base the choice on the person's clinical history (for example whether they
33 are a smoker, age, weight, how fit they are) together with their objective test
34 results.

35 27. Consider alternative diagnoses in adults and young people older than 16 with
36 obstructive spirometry and:

- 37 • negative bronchodilator reversibility and a FeNO level less than 25 ppb
38 **or**
- 39 • positive bronchodilator reversibility, a FeNO level between 25 and
40 39 ppb, negative peak flow variability and a negative direct bronchial
41 challenge test.

42 **Adults and young people older than 16 with normal spirometry (algorithm B2)**

43 28. Diagnose asthma in adults and young people older than 16 if they have
44 normal spirometry and:

- 1
- a FeNO level of 40 ppb or more and positive peak flow variability **or**
- 2
- a FeNO level of 40 ppb or more, negative peak flow variability and a
- 3
- positive direct bronchial challenge test **or**
- 4
- a FeNO level of 39 ppb or less, positive peak flow variability and a
- 5
- positive direct bronchial challenge test.
- 6
29. Consider alternative diagnoses in adults and young people older than 16 if
- 7
- they have normal spirometry and:
- 8
- a FeNO level of 39 ppb or less and negative peak flow variability **or**
- 9
- a FeNO level of 39 ppb or less, positive peak flow variability and a
- 10
- negative direct bronchial challenge test **or**
- 11
- a FeNO level of 40 ppb or more, negative peak flow variability and a
- 12
- negative direct bronchial challenge test.

Children aged 5–16 (algorithm C)

- 14
30. Diagnose asthma in children aged 5–16 if they have:
- 15
- normal spirometry, a FeNO level of 35 ppb or more and positive peak
- 16
- flow variability **or**
- 17
- obstructive spirometry and positive bronchodilator reversibility **or**
- 18
- obstructive spirometry, negative bronchodilator reversibility, a FeNO
- 19
- level of 35 ppb or more and positive peak flow variability.
- 20
31. Refer children aged 5–16 for specialist assessment if they have obstructive
- 21
- spirometry, negative bronchodilator reversibility and a FeNO level of 34 ppb
- 22
- or less.
- 23
32. Suspect asthma in children aged 5–16 if they have:
- 24
- normal spirometry, a FeNO level of 35 ppb or more and negative peak
- 25
- flow variability **or**
- 26
- obstructive spirometry, negative bronchodilator reversibility, a FeNO
- 27
- level of 35 ppb or more and negative peak flow variability **or**
- 28
- normal spirometry, a FeNO level of 34 ppb or less and positive peak flow
- 29
- variability confirmed by a retest after 6 weeks.
- 30
- Do not rule out other diagnoses if symptom control continues to remain poor
- 31
- after treatment. Review the diagnosis after 6 weeks by repeating any
- 32
- abnormal tests and reviewing symptoms.
- 33
33. Consider alternative diagnoses in children aged 5–16 if they have normal
- 34
- spirometry, a FeNO level of 34 ppb or less and:
- 35
- negative peak flow variability **or**
- 36
- positive peak flow variability that is negative on retest after 6 weeks.

Monitoring asthma control

- 38
34. Monitor asthma control at every review.
- 39
35. Consider using a validated questionnaire (the Asthma Control Questionnaire
- 40
- or Asthma Control Test) to monitor asthma control in adults and young
- 41
- people older than 16.
- 42
36. Monitor asthma control at each review in adults and children aged 5 years
- 43
- and over using either spirometry (FEV₁) or peak flow variability.

- 1 37. Do not routinely use FeNO to monitor asthma control.
- 2 38. Consider FeNO measurement as an option to support asthma management in
3 people who are symptomatic despite using inhaled corticosteroids [This
4 recommendation is from Measuring fractional exhaled nitric oxide concentration
5 in asthma (DG12) [2014].
- 6 39. Do not use challenge testing to monitor asthma control.
- 7 40. Monitor the inhaler technique of people with asthma (in line with the NICE
8 quality standard on asthma):
- 9 • after every asthma attack
- 10 • when the device is changed
- 11 • at every annual review.

12 **4.4 Key research recommendations**

13 **Diagnosing asthma in children aged 5–16 years**

- 14 • What is the acceptability and diagnostic accuracy of objective tests that could be used to
15 comprise a diagnostic pathway for asthma in children aged 5–16 years old (for example, exercise
16 challenge, direct bronchial challenge with histamine or methacholine, indirect bronchial challenge
17 with mannitol and peripheral blood eosinophil count)?

18 **Diagnosing asthma in adults and young people older than 16**

- 19 • What is the clinical and cost effectiveness of using an indirect bronchial challenge test with
20 mannitol to diagnose asthma in adults and young people older than 16?

21 **Monitoring adherence to treatment**

- 22 • What is the clinical and cost effectiveness of using electronic alert systems designed to monitor
23 and improve adherence with regular inhaled maintenance therapy in people with asthma?

24 **Monitoring inhaler technique**

- 25 • What is the current frequency and the current method being used to check the inhaler technique
26 of people with asthma? What is the optimal frequency and the best method of checking inhaler
27 technique to improve clinical outcomes for people with asthma?

28 **Monitoring asthma control using tele-healthcare**

- 29 • What is the long-term (more than 12 months) clinical and cost effectiveness of using tele-
30 healthcare as a means to monitor asthma control in children, young people and adults?
31 Modalities of tele-healthcare can include telephone interview (healthcare professional
32 involvement) and internet or smartphone-based monitoring support (no healthcare professional
33 involvement).

1 **5 Diagnosing asthma**

2 **5.1 Initial clinical assessment**

3 Chapters 6 to 10 review the diagnostic accuracy of the initial clinical assessment questions for the
4 diagnosis of asthma in people with suspected asthma presenting with respiratory symptoms.

5 **5.2 Objective tests**

6 Chapters 11 to 20 review the diagnostic test accuracy of objective tests for the diagnosis of asthma in
7 people with suspected asthma presenting with respiratory symptoms.

6 Diagnosis: Signs and symptoms

6.1 Introduction

There are several signs and symptoms associated with (but not specific for) asthma. Although at one time these symptoms were likely to have been under-interpreted (leading to under-diagnosis or delayed diagnosis), now they are over-interpreted (leading to over-diagnosis if not supported by objective tests). It is important to identify asthma-related signs and symptoms from the history of presenting complaints. However, the diagnostic test accuracy of asking about asthma signs and symptoms is currently uncertain. Asthma signs and symptoms can vary from mild, moderate to severe. They can also vary throughout the year depending on the season or exposure to variable environmental triggers, such as viral infections, allergens and air pollution. They also vary with age; asthma is most common in younger age groups. The early identification of asthma-related signs and symptoms allows early diagnostic testing and appropriate treatment decisions.

6.2 Review question: 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

For full details see review protocol in Appendix C.

Table 7: Characteristics of review question

Component	Description
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"> • Children (1-<5 years old) • Children/young people (5-16 years old) • Adults (>16 years old)
Index test	Signs and symptoms of asthma Each of the following symptoms alone or in combination: <ul style="list-style-type: none"> • Wheezing (current or persistent or triggered) • Cough (including nocturnal cough) • Breathlessness • Nocturnal symptoms • Diurnal and seasonal variations
Reference standard	Physician diagnosis of asthma based on symptoms plus an objective test 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"> • Diagnostic accuracy (sensitivity and specificity)

1 **6.3 Clinical evidence**

2 We searched for cross sectional studies, cohort studies, case series (including both retrospective and
3 prospective analyses) assessing the diagnostic test accuracy of signs or symptoms of asthma to
4 identify whether the condition is present (as indicated by the reference standard) in people under
5 investigation for asthma.

6 Six studies^{32,142-144,166,181} were included in the review (see Table 8 and Table 9). Evidence from these
7 are summarised in the clinical evidence profile below (Table 10). See also the study selection flow
8 chart in Appendix D, sensitivity / specificity forest plots in Appendix J, study evidence tables in
9 Appendix G and exclusion list in Appendix K. All studies were conducted in adults, except for
10 Weverhess 1999, which was in children <5 years old. No evidence was identified for the strata of
11 children aged 5-16 years. Data have been separated for each age group.

12 A variety of index tests symptoms or combinations of symptoms were used (Table 8 and Table 9). The
13 accuracy of individual symptoms in the diagnosis of asthma are analysed and reported separately
14 (unless combined into a symptom score by the individual study) as the GDG was interested in which
15 individual symptoms indicate asthma.

16 None of the studies reported the diagnostic accuracy of signs.

17 The reference standard was physician's diagnosis of asthma with an objective test, with the
18 exception of the study in children <5 years, as objective tests cannot be performed in this age group.
19 A variety of objective tests and thresholds were used for the reference standard (see Table 8 and
20 Table 9).

21 In anticipation of there being a large number of studies retrieved from the search, inclusion was
22 limited to studies of populations in the UK, USA, Australia, Canada, New Zealand and Western
23 Europe. These countries were expected to be similar to the UK in terms of how people report
24 symptoms and the impact of language. If relevant studies were identified from other review
25 questions reporting populations outside these countries, then these were included.

Summary of included studies

Table 8: Summary of studies included in the review: diagnostic accuracy of symptoms vs. physician Dx with an objective test (adults)

Study	Presentation	Target condition	Index test	Reference standard	Comments
CHOI 2007 ³²	<ul style="list-style-type: none"> Adults Respiratory symptoms such as dyspnoea, cough or wheezing 	Asthma	Symptoms (questionnaire)	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)	
SCHLEICH 2012 ¹⁴²	<ul style="list-style-type: none"> Adults Patients referred to chest physicians for methacholine challenge test for asthma diagnosis; bronchodilator test failed to show reversible airway obstruction or baseline spirometry normal. 	Asthma	Symptoms (questionnaire)	Methacholine challenge (cut off PC20 <16mg/mL).	
SCHNEIDER 2009A ¹⁴⁴	<ul style="list-style-type: none"> Adults Visiting GP for the first time with complaints of suggested obstructive airway disease (OAD). Symptoms such as dyspnoea, coughing, or expectoration 	Asthma	Symptoms (questionnaire)	Dx by respiratory physician 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)	
SCHNEIDER 2012 ¹⁴³	<ul style="list-style-type: none"> Adults GPs: first time visit with complaints of suggested OAD or RAD; symptoms for >2 months (data presented in Schneider 2009) Respiratory physician: 1st visit for Dx work-up to include or exclude OAD or 	Asthma	Symptoms (questionnaire)	Dx by respiratory physician 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). Most asthma patients were identified by the BPT.	

Study	Presentation	Target condition	Index test	Reference standard	Comments
	RAD; other criteria as for GPs. Hospital: Patients with suspected OAD who were hospitalised for the first time.				
TOMITA 2013 ¹⁶⁶	<ul style="list-style-type: none"> Adults Outpatients with non-specific respiratory symptoms including wheeze, shortness of breath, and cough 	Asthma	Symptoms (questionnaire/ interview)	Relevant symptom history (all patients) and BDR (FEV1 <200ml and 12%) and/or BHR (methacholine PC20 <8mg/ml)	

Table 9: Summary of studies included in the review: diagnostic accuracy of symptoms vs. physician Dx with an objective test (children <5 years)

Study	Presentation	Target condition	Index test	Reference standard	Comments
WEVERHESS 1999 ¹⁸¹	<ul style="list-style-type: none"> Children aged 0-4 years Symptoms that were suggestive of asthma 	Asthma	Symptoms (visit and questionnaire)	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).	

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Table 10: Clinical evidence profile: Symptoms vs Reference Standard (physician Dx and objective test where appropriate to the age group)

Index Test (Threshold)	No of studies	n	Risk of bias(a)	Inconsistency	Indirectness	Imprecision	Sensitivity % (range)	Specificity % (range)	Area Under Curve (range)	Quality
ADULTS >16 years										
Paroxysmal coughing	1	302	Serious risk of bias ^(a)	No serious inconsistency	No serious indirectness	n/a ^(c)	16	42	-	MODERATE
Dyspnoea without wheeze	1	302	Serious risk of bias ^(a)	No serious inconsistency	No serious indirectness	n/a ^(c)	11	71	-	MODERATE
Wheeze without dyspnoea	1	302	Serious risk of bias ^(a)	No serious inconsistency	No serious indirectness	n/a ^(c)	9	79	-	MODERATE
Diurnal cough	1	174	Serious risk of bias ^(a)	No serious inconsistency	Serious indirectness ^{(d)(e)}	n/a ^(c)	66	26	-	LOW
Nocturnal cough	1	174	Serious risk of bias ^(a)	No serious inconsistency	Serious indirectness ^{(d)(e)}	n/a ^(c)	37	65	-	LOW
Diurnal wheeze	1	174	Serious risk of bias ^(a)	No serious inconsistency	Serious indirectness ^{(d)(e)}	n/a ^(c)	57	62	-	LOW
Nocturnal wheeze	1	174	Serious risk of bias ^(a)	No serious inconsistency	Serious indirectness ^{(d)(e)}	n/a ^(c)	56	79	-	LOW
Dyspnoea	2	393	Serious risk of bias ^(a)	Serious inconsistency ^(b)	Serious indirectness ^(e)	n/a ^(c)	Range 61 – 73	Range 38 – 55	-	LOW
Wheeze	2	785	Serious risk of bias ^(a)	Serious inconsistency ^(b)	No serious indirectness	n/a ^(c)	Range 30 – 52	Range 53 – 87	-	LOW
Cough	1	219	Serious risk of bias ^(a)	No serious inconsistency	Serious indirectness ^(e)	n/a ^(c)	43	33	-	LOW
Nocturnal dyspnoea	1	219	Serious risk of bias ^(a)	No serious inconsistency	Serious indirectness ^(e)	n/a ^(c)	30	81	-	LOW

Index Test (Threshold)	No of studies	n	Risk of bias(a)	Inconsistency	Indirectness	Imprecision	Sensitivity % (range)	Specificity % (range)	Area Under Curve (range)	Quality
Diurnal symptoms	1	566	Serious risk of bias ^(a)	No serious inconsistency	No serious indirectness	n/a ^(c)	54	69	-	MODERATE
Total symptom score ≥5	1	302	Serious risk of bias ^(a)	No serious inconsistency	No serious indirectness	n/a ^(c)	74	48	-	MODERATE
Dyspnoea attacks	1	219	No risk of bias ^(a)	No serious inconsistency	Very serious indirectness ^{(e)(f)}	n/a ^(c)	40	78	-	LOW
Dyspnoea going upstairs	1	219	No risk of bias ^(a)	No serious inconsistency	Very serious indirectness ^{(e)(f)}	n/a ^(c)	47	49	-	LOW
Dyspnoea when walking	1	219	No risk of bias ^(a)	No serious inconsistency	Very serious indirectness ^{(e)(f)}	n/a ^(c)	4.8	93.2	-	LOW
Dyspnoea on minimal exercise	1	219	No risk of bias ^(a)	No serious inconsistency	Very serious indirectness ^{(e)(f)}	n/a ^(c)	2.5	94	-	LOW
CHILDREN 5-16 years										
No evidence identified	0									
CHILDREN <5 years										
Cough and wheeze	1	188	Serious risk of bias ^(a)	No serious inconsistency	No serious indirectness	n/a ^(c)	49	59	-	MODERATE
Dyspnoea	1	188	Serious risk of bias ^(a)	No serious inconsistency	No serious indirectness	n/a ^(c)	76	52	-	MODERATE
Wheeze	1	188	Serious risk of bias ^(a)	No serious inconsistency	No serious indirectness	n/a ^(c)	54	57	-	MODERATE
Cough	1	188	Serious risk of bias ^(a)	No serious inconsistency	No serious indirectness	n/a ^(c)	88	7	-	MODERATE

(a) Risk of bias was assessed using the QUADAS-II checklist. Outcomes were downgraded by one if the weighted (by sample size (n)) average number of QUADAS-II domains (patient selection, index test, reference standard and flow and timing) with methodological limitations was one. Outcomes were downgraded by two if the weighted average number of QUADAS-II domains with methodological limitations was more than one.

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- (b) Inconsistency was assessed by inspection of the sensitivity / specificity values in each of the studies in relation to a high ($\geq 75\%$), moderate (50-74%) or low ($< 50\%$) effect estimate. Inconsistency was considered high if the point estimates from individual studies were within two areas, and very high if they were in 3 areas or both high and low areas.
- (c) The judgement of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis, where performed.
- (d) Population included people with a normal spirometry or a normal BDR.
- (e) Reference standard objective test cut-off threshold did not match protocol.
- (f) Population included people who had been hospitalised due to suspected obstructive airways disease. Index test was based on anamnestic data.

1 **6.4 Economic evidence**

2 **Published literature**

3 No relevant economic evaluations were identified.

4 See also the economic article selection flow diagram in Appendix E.

5 **6.5 Evidence statements**

6 **Clinical**

- 7 • One study with 302 adults showed that symptoms of paroxysmal coughing has a sensitivity of 0.16
8 and a corresponding specificity of 0.42 for diagnosing asthma in people presenting with
9 respiratory signs and symptoms. (MODERATE QUALITY)
- 10 • One study with 302 adults showed that symptoms of dyspnoea without wheeze has a sensitivity
11 of 0.11 and a corresponding specificity of 0.71 for diagnosing asthma in people presenting with
12 respiratory signs and symptoms. (MODERATE QUALITY)
- 13 • One study with 302 adults showed that symptoms of wheeze without dyspnoea has a sensitivity
14 of 0.09 and a corresponding specificity of 0.79 for diagnosing asthma in people presenting with
15 respiratory signs and symptoms. (MODERATE QUALITY)
- 16 • One study with 174 adults showed that symptoms of diurnal cough has a sensitivity of 0.66 and a
17 corresponding specificity of 0.26 for diagnosing asthma in people presenting with respiratory
18 signs and symptoms. (LOW QUALITY)
- 19 • One study with 174 adults showed that symptoms of nocturnal cough has a sensitivity of 0.37 and
20 a corresponding specificity of 0.65 for diagnosing asthma in people presenting with respiratory
21 signs and symptoms. (LOW QUALITY)
- 22 • One study with 174 adults showed that symptoms of diurnal wheeze has a sensitivity of 0.57 and
23 a corresponding specificity of 0.62 for diagnosing asthma in people presenting with respiratory
24 signs and symptoms. (LOW QUALITY)
- 25 • One study with 174 adults showed that symptoms of nocturnal wheeze has a sensitivity of 0.56
26 and a corresponding specificity of 0.79 for diagnosing asthma in people presenting with
27 respiratory signs and symptoms. (LOW QUALITY)
- 28 • Two studies with 393 adults showed that symptoms of dyspnoea has a sensitivity range of 0.61 to
29 0.73 and a corresponding specificity range of 0.38 to 0.55 for diagnosing asthma in people
30 presenting with respiratory signs and symptoms. (LOW QUALITY)
- 31 • Two studies with 785 adults showed that symptoms of wheeze has a sensitivity range of 0.30 to
32 0.52 and a corresponding specificity range of 0.53 to 0.87 for diagnosing asthma in people
33 presenting with respiratory signs and symptoms. (LOW QUALITY)
- 34 • One study with 219 adults showed that symptoms of cough has a sensitivity of 0.43 and a
35 corresponding specificity of 0.33 for diagnosing asthma in people presenting with respiratory
36 signs and symptoms. (LOW QUALITY)
- 37 • One study with 219 adults showed that symptoms of nocturnal dyspnoea has a sensitivity of 0.30
38 and a corresponding specificity of 0.81 for diagnosing asthma in people presenting with
39 respiratory signs and symptoms. (LOW QUALITY)
- 40 • One study with 566 adults showed that diurnal symptoms has a sensitivity of 0.54 and a
41 corresponding specificity of 0.69 for diagnosing asthma in people presenting with respiratory
42 signs and symptoms. (MODERATE QUALITY)

- 1 • One study with 302 adults showed that a total symptom score ≥ 5 has a sensitivity of 0.74 and a
 2 corresponding specificity of 0.48 for diagnosing asthma in people presenting with respiratory
 3 signs and symptoms. (MODERATE QUALITY)
- 4 • One study with 219 adults showed that symptoms of dyspnoea attacks has a sensitivity of 0.40
 5 and a corresponding specificity of 0.78 for diagnosing asthma in people presenting with
 6 respiratory signs and symptoms. (LOW QUALITY)
- 7 • One study with 219 adults showed that symptoms of dyspnoea going upstairs has a sensitivity of
 8 0.47 and a corresponding specificity of 0.49 for diagnosing asthma in people presenting with
 9 respiratory signs and symptoms. (LOW QUALITY)
- 10 • One study with 219 adults showed that symptoms of dyspnoea when walking has a sensitivity of
 11 0.05 and a corresponding specificity of 0.93 for diagnosing asthma in people presenting with
 12 respiratory signs and symptoms. (LOW QUALITY)
- 13 • One study with 219 adults showed that symptoms of dyspnoea on minimal exercise has a
 14 sensitivity of 0.03 and a corresponding specificity of 0.94 for diagnosing asthma in people
 15 presenting with respiratory signs and symptoms. (LOW QUALITY)
- 16 • One study with 188 children <5 years showed that symptoms of cough and wheeze has a
 17 sensitivity of 0.49 and a corresponding specificity of 0.59 for diagnosing asthma in people
 18 presenting with respiratory signs and symptoms. (MODERATE QUALITY)
- 19 • One study with 188 children <5 years showed that symptoms of dyspnoea has a sensitivity of 0.76
 20 and a corresponding specificity of 0.52 for diagnosing asthma in people presenting with
 21 respiratory signs and symptoms. (MODERATE QUALITY)
- 22 • One study with 188 children <5 years showed that symptoms of wheeze has a sensitivity of 0.54
 23 and a corresponding specificity of 0.57 for diagnosing asthma in people presenting with
 24 respiratory signs and symptoms. (MODERATE QUALITY)
- 25 • One study with 188 children <5 years showed that symptoms of cough has a sensitivity of 0.88
 26 and a corresponding specificity of 0.07 for diagnosing asthma in people presenting with
 27 respiratory signs and symptoms. (MODERATE QUALITY)
- 28 • No evidence was identified in children aged 5-16 years.

29 **Economic**

- 30 • No relevant economic evaluations were identified.

31 **6.6 Recommendations and link to evidence**

Recommendations	<ol style="list-style-type: none"> 1. Take a structured clinical history in people with suspected asthma. Specifically, check for: <ul style="list-style-type: none"> • wheeze • cough • breathlessness • any variation in the above symptoms occurring over the course of 24 hours or seasonally. 2. Do not use symptoms alone without an objective test to diagnose asthma. 3. 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 the examination results are normal the person
------------------------	---

	may still have asthma.
Relative values of different diagnostic measures and outcomes	<p>The GDG was interested in the diagnostic test accuracy of signs and symptoms in the diagnosis of asthma. One of the concerns that set the scope of this guideline is the over-diagnosis of asthma leading to inappropriate treatment; therefore, the GDG was interested in both the sensitivity and specificity of diagnostic tests and prioritised studies which reported these outcomes.</p> <p>Diagnostic studies were found comparing the sensitivity and specificity of symptoms (individual symptoms or total symptoms scores) for the diagnosis of asthma vs. the reference standard (physician's diagnosis based on symptoms plus an objective test). The symptoms covered by the studies included coughing, dyspnoea (breathlessness), wheeze, nocturnal symptoms, diurnal symptoms, as well as various combinations of these. No studies assessed seasonal variations in symptoms. No evidence was found on the signs of asthma.</p>
Trade-off between clinical benefits and harms	<p>There is no direct harm associated with asking symptom questions and the trade-off between benefit and harm will depend on their reliability as a means of indicating asthma. There was a large variation in the sensitivity and specificity values across the different individual symptoms. The sensitivities and specificities for the majority of the individual symptoms were moderate or low. None of the symptoms had a combination of both sensitivities and specificities that were high. Evidence was available from one study for the diagnostic accuracy of a combined symptom score. Although this had a moderate sensitivity, the specificity was low.</p> <p>The sensitivity and specificity was not high enough for the GDG to recommend using symptoms in isolation to diagnose asthma. In addition, the GDG considered that many of the symptoms are also common to a variety of other respiratory conditions, and so to make a diagnosis of asthma based on symptoms alone would be both inaccurate and inappropriate.</p>
Economic considerations	<p>No economic evaluations were found on this question.</p> <p>The sensitivity and specificity of diagnosing asthma with symptoms alone was shown to be low for the majority of individual symptoms. Therefore, an asthma diagnosis based on individual symptoms alone would lead to a large number of false negatives and false positives. This would be of clinical harm to individuals who have asthma and who would go untreated for a period of time as well as those without asthma who would receive unnecessary treatment. Therefore, even though the costs of this diagnostic method are very low, using it as a stand-alone diagnostic test would lead to more harm than good because it will lead to inappropriate over-treatment, waste of resources and lack of a correct diagnosis.</p>
Quality of evidence	<p>Most of the evidence found for the diagnostic value for each symptom was based on single studies. The quality of the evidence ranged from low to moderate in adults. There was limited evidence with the ideal reference standard, therefore evidence was included from studies using an alternative reference standard (four studies included a methacholine test with a cut-off value of 16mg/ml as part of the index test). This will affect the number of people diagnosed with asthma using the reference standard, and therefore the accuracy of the index test. Therefore the evidence quality was downgraded for indirectness. One study included people who had been hospitalised with suspected obstructive airways disease and reflects the diagnostic accuracy of symptoms in a different population. Again, the evidence quality was downgraded for indirectness and these limitations were taken into account by the GDG when interpreting the evidence quality.</p> <p>The quality of the evidence in children aged <5 years was moderate, but evidence was only available from one study. The GDG discussed the reference standard for this study and agreed it was an appropriate reference standard for the diagnosis of asthma in this age group.</p>

	In children aged 5-16 years, no diagnostic studies were found.
Other considerations	The GDG pointed out that respiratory symptoms occur in other conditions and asthma diagnosis should not be made on the basis of symptoms alone. Therefore, the GDG did not recommend future research for the use of single or combined symptom questionnaires in the diagnosis of asthma. However, the GDG discussed the importance of taking a clinical history of symptoms at initial presentation and at each asthma review, in order to document asthma control and to identify triggers. The GDG agreed that this should be done using a structured template and referred to the recent NRAD recommendations ¹³⁵ for a standard national asthma template to facilitate a structured, thorough asthma review. No evidence was identified on the diagnostic accuracy of signs. However, the GDG also discussed the importance of physically examining people with suspected asthma to identify expiratory polyphonic wheeze and signs of other causes of respiratory symptoms.

7 Diagnosis: History of atopic disorders

7.1 Introduction

The term atopy refers to allergic conditions which include allergic rhinitis (hay fever), atopic dermatitis (eczema), allergic asthma and other specific and non-specific allergic problems like food allergies. There is considerable overlap between these conditions; however, the link between these different atopic disorders is not well understood. As these conditions often co-exist in the same individual and tend to cluster in families, it is of interest to know whether taking a personal or family history of atopic disorders is accurate in the diagnosis of asthma in people with asthma symptoms.

7.2 Review question: In people under investigation for asthma, what is the diagnostic accuracy of taking a personal/family history of atopic disorders?

For full details see review protocol in Appendix C.

Table 11: Characteristics of review question

Population	People with suspected asthma (presenting with respiratory symptoms). All ages, stratified into the following 3 different groups: <ul style="list-style-type: none"> • Children (1-<5 years old) • Children/young people (5-16 years old) • Adults (>16 years old)
Index test	Personal/family history of atopic disorders. <ul style="list-style-type: none"> • This is likely to be ascertained by a questionnaire. <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: 1st degree relatives.</p> <p>NOTE: atopic disorders are defined as: eczema, hay fever, allergic rhinitis, food allergy, asthma.</p>
Reference standard	Physician diagnosis of asthma based on symptoms plus an objective test <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.</p>
Statistical measures	Diagnostic accuracy (sensitivity and specificity)

7.3 Clinical evidence

We searched for cross sectional studies, cohort studies, case series (including both retrospective and prospective analyses) assessing the diagnostic test accuracy of a taking a personal or family history of atopic disorders to identify whether the condition is present (as indicated by the reference standard) in people under investigation for asthma.

Five studies were included in the review^{36,42,166,172,181} (see Table 12). Evidence from these studies is summarised in the clinical evidence profile below (Table 13). See also the study selection flow chart in Appendix D, sensitivity / specificity forest plots in Appendix J, study evidence tables in Appendix G and exclusion list in Appendix K.

1 All included studies looked at a personal/family history of atopic disorders in patients with signs and
2 symptoms. The reference standard was physician's diagnosis of asthma with an objective test, with
3 the exception of the study in children <5 years, as objective tests cannot be performed in this age
4 group. In adults, evidence was available from three studies^{36,42,166}, in children aged 5-16 years
5 evidence was available from one study¹⁷² and in children aged <5 years evidence was available from
6 one study¹⁸¹.

Summary of included studies

Table 12: Summary of studies included in the review

Study	Population	Index test & cut-off	Reference standard
Index test vs Reference Standard			
CORDEIRO 2011 ³⁶	N = 114 Adults and children/young people Referrals to allergy clinic with symptoms of nasal or ocular complaints; pulmonary complaints; skin complaints and general complaints.	Family history (unclear if first degree relatives)	History of typical respiratory symptoms and FEV1 improvement >12% and >200mL with salbutamol 400µg or PC20 histamine ≤8mg/mL according to GINA.
Deilami 2009 ⁴²	N = 81 Adults Suffering from cough for at least 8 weeks and went to the pulmonary disease clinic. Normal spirometry	Personal history of allergy NB Family history of asthma sensitivity/specificity data were not extracted as was not first class relatives only	Only objective test (not physician Dx with objective test). Methacholine challenge test: PC20 ≤4mg/ml
TOMITA 2013 ¹⁶⁶	N = 566 Adults Adult outpatients with non-specific respiratory symptoms including wheeze, shortness of breath, and cough.	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?'	Relevant symptom history (all patients) and BDR (FEV1 <200ml and 12%) and/or BHR (methacholine PC20 <8mg/ml) NB. 64/367 were diagnosed on the basis of reactivity to ICS without BDR or BHR)
WEVER-HESS 1999 ¹⁸¹	N = 188 Children (including aged 2-4yr subgroup only) Aged 0-4 years with symptoms that were suggestive of asthma	History taken at initial visit: a) Past or present rhinitis b) past or present eczema c) family history	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.
VANDERMA RK 2014 ¹⁷²	N = 438 Children aged 1-5 years included in longitudinal	a) Family history of asthma (parents and/or siblings)	At age 6 years, spirometry and BHR obtained in children with wheezing, shortness of breath, recurrent coughing or

Study	Population	Index test & cut-off	Reference standard
	study (asthma Dx at age 6 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)		use of asthma medication during the previous 12 months. Dx defined as having persistent symptoms and/or using asthma medication in the last year in combination with BHR (methacholine $< 8\text{mg.ml}$) or BDR ($> 10\%$ increase in FEV1).

Table 13: Clinical evidence profile: Index test vs Reference Standard (physician Dx and objective test)

Index Test (Threshold)	No of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity %	Specificity %	Area Under Curve (range)	Quality
ADULTS										
Personal history of atopic disorders	2	656	Serious risk of bias ^(a)	No serious inconsistency ^(b)	No serious indirectness	n/a ^(c)	Range 54.2 - 55	Range 67.8 - 73.7	-	MODERATE
Family history of atopic disorders	2	680	Serious risk of bias ^(a)	Serious inconsistency ^(b)	No serious indirectness	n/a ^(c)	Range 25.9 - 59.5	Range 55.6 - 82.9	-	LOW
CHILDREN 5-16 years										
Family history of asthma	1	438	Serious risk of bias ^(a)	No serious inconsistency ^(b)	No serious indirectness	n/a ^(c)	43.8	69.7	-	MODERATE
CHILDREN <5 years										
Family history of atopic disorders	1	188	Serious risk of bias ^(a)	No serious inconsistency ^(b)	No serious indirectness	n/a ^(c)	43.8	56.8	-	MODERATE
Personal history of atopic disorders – rhinitis only	1	188	Serious risk of bias ^(a)	No serious inconsistency ^(b)	No serious indirectness	n/a ^(c)	61.8	20.5	-	MODERATE
Personal history of atopic disorders – eczema only	1	188	Serious risk of bias ^(a)	No serious inconsistency ^(b)	No serious indirectness	n/a ^(c)	46.5	75.0	-	MODERATE

(a) Risk of bias was assessed using the QUADAS-II checklist. Outcomes were downgraded by one if the weighted (by sample size (n)) average number of QUADAS-II domains (patient selection, index test, reference standard and flow and timing) with methodological limitations was one. Outcomes were downgraded by two if the weighted average number of QUADAS-II domains with methodological limitations was more than one.

(b) Inconsistency was assessed by inspection of the sensitivity / specificity values in each of the studies in relation to a high (≥75%), moderate (50-74%) or low (<50%) effect estimate. Inconsistency was considered high if the point estimates from individual studies were within two areas, and very high if they were in 3 areas or both high and low areas

(c) The judgement of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis, where performed.

7.4 Economic evidence

Published literature

No relevant economic evaluations were identified.

See also the economic article selection flow diagram in Appendix E.

7.5 Evidence statements

Clinical

- Two studies with 656 adults showed that a personal history of atopic disorders has a sensitivity range of 54.2-55% and a corresponding specificity range of 67.8-73.7% for diagnosing asthma in people presenting with respiratory signs and symptoms. (MODERATE QUALITY)
- Two studies with 680 adults showed that a family history of atopic disorders has a sensitivity range of 25.9-59.5% and a corresponding specificity range of 55.6-82.9% for diagnosing asthma in people presenting with respiratory signs and symptoms. (LOW QUALITY)
- One study with 438 children 5-16 years showed that a family history of asthma has a sensitivity of 43.8% and a corresponding specificity of 69.7% for diagnosing asthma in people presenting with respiratory signs and symptoms. (MODERATE QUALITY)
- One study with 188 children <5 years showed that a family history of atopic disorders has a sensitivity of 43.8% and a corresponding specificity of 56.8% for diagnosing asthma in people presenting with respiratory signs and symptoms. (MODERATE QUALITY)
- One study with 188 children <5 years showed that a personal history of rhinitis has a sensitivity of 61.8% and a corresponding specificity of 20.5% for diagnosing asthma in people presenting with respiratory signs and symptoms. (MODERATE QUALITY)
- One study with 188 children <5 years showed that a personal history of eczema has a sensitivity of 46.5% and a corresponding specificity of 75.0% for diagnosing asthma in people presenting with respiratory signs and symptoms. (MODERATE QUALITY)

Economic

- No relevant economic evaluations were identified.

7.6 Recommendations and link to evidence

	4. Ask about a personal or family history of atopic disorders. Record any triggers that make symptoms worse.
Recommendations	5. Do not use a history of atopic disorders alone to diagnose asthma.
Relative values of different outcomes	The GDG wished to know whether asking about a personal or family history of atopic disorders was an accurate method of diagnosing (or contributing to the diagnosis) of asthma. Atopic disorders are known to have a hereditary component and it has been suggested that taking a family history of atopic disorders in a person with suspected asthma may aid diagnosis. Allergic asthma is an IgE-driven disease similar to conditions like eczema and seasonal rhinitis. Together, these conditions form the atopic spectrum of disorders and these frequently co-exist in individuals with confirmed asthma. We therefore considered whether the presence or absence of eczema and allergic rhinitis in patients with recurrent respiratory symptoms predicts the presence or absence of asthma in these people.

	<p>Atopic disorders were defined by the GDG as eczema, hay fever, allergic rhinitis, food allergy and asthma. Evidence for these atopic disorders was considered separately for personal history and family history.</p>
Trade-off between clinical benefits and harms	<p>There is no direct harm associated with asking these questions (aside from the time taken) and the trade-off between benefit and harm will depend on the reliability of the clinical history questions as a means of indicating atopic asthma.</p> <p>The GDG noted that the evidence demonstrates the following when asking questions about:</p> <p>Personal history</p> <p>Adults:</p> <ul style="list-style-type: none"> • Low to moderate sensitivity and moderate to high specificity. <p>Children:</p> <ul style="list-style-type: none"> • Rhinitis had moderate sensitivity and low specificity. • Eczema had moderate sensitivity and high specificity. <p>Family history</p> <p>Adults:</p> <ul style="list-style-type: none"> • Low to moderate sensitivity and moderate to high specificity. <p>Children:</p> <ul style="list-style-type: none"> • Low sensitivity and moderate specificity. <p>The GDG acknowledged that the prevalence of atopy is high in people with asthma and the GDG consensus opinion was that around 1 in 3 people in the UK are atopic.</p> <p>Overall, the GDG agreed that the sensitivity and specificity of asking these questions was not high enough for the GDG to recommend using these questions in isolation to diagnose atopic asthma. The GDG discussed the importance of asking these questions as part of a diagnostic assessment that includes clinical history, taking in addition to performing other objective tests. The GDG noted that these questions will help to identify people with atopic asthma only, and that taking a history of atopic disorders would be of little benefit in adults with occupational asthma or late onset of non-atopic asthma.</p> <p>Importantly, the group acknowledged that in young children the use of objective tests to diagnose atopic asthma is limited and until further research is available in relation to these tests, more weight would need to be placed on clinical history questions.</p>
Economic considerations	<p>No economic evaluations were found on this question.</p> <p>The sensitivity of diagnosing asthma using a history of atopic disorders was shown to be low for the majority of individual symptoms. Therefore, an asthma diagnosis based on a history of atopic disorders alone would lead to a large number of false negatives. This would be of clinical harm to individuals who have asthma and who would go untreated for a period of time. Therefore, even though the costs of this diagnostic method are very low, using it as a stand-alone diagnostic test would lead to more harm than good.</p> <p>However as the cost of asking questions related to atopy are negligible and there may be some value in the information gained, the GDG recognised this as a useful tool to inform management once the diagnosis is made.</p>
Quality of evidence	<p>In adults, evidence from three studies was included^{36,42,166}. In one study⁴², the reference standard was symptoms plus a positive methacholine test with a cut-off of</p>

	<p>4mg/ml. The remaining studies used physician diagnosis plus an objective test as the reference standard. Although one study (Cordeiro 2011) had an indirect population with general allergic symptoms rather than respiratory symptoms, this did not affect the overall quality of the evidence as the study did not contribute the majority of the evidence. Evidence for a family history of atopic disorders was of low quality and for a personal history of atopic disorders was of moderate quality.</p> <p>In children aged 5-16 years evidence from one moderate quality study was included¹⁷².</p> <p>In children aged <5 years, evidence from one moderate quality study was included¹⁸¹. This study used a reference standard diagnosis made by a paediatrician on clinical grounds, based on recurrence of symptoms, and need for and response to therapy in accordance with guidelines for the diagnosis of asthma in young children (statement from an international paediatric asthma consensus group). This longitudinal study looked at prognostic factors for asthma, and the final diagnosis was made at two-year follow-up after initial assessment. The GDG agreed that this study was appropriate to include given that in children <5 years of age the diagnosis is usually made at follow-up based on reoccurrence of symptoms and response to therapy (rather than objective lung function tests which young children are unable to perform accurately). The Wever-Hess et al. study provided evidence for a family history of atopic disorders and a personal history of rhinitis and/or eczema.</p>
Other considerations	<p>The GDG discussed whether asking these questions to identify patients with atopic asthma would guide treatment decisions. Treatment would be similar regardless of atopic status; however, this information may be useful in guiding the monitoring of asthma, for example, avoidance of allergens.</p> <p>A key finding of the RCP National Review of Asthma Deaths (NRAD) report¹³⁵, published in May 2014, was that exacerbating factors or triggers, such as atopy, were documented in the records of less than half of the patients in the review. In light of this, the GDG made a recommendation to address poor documentation (aligning with the report findings). The GDG agreed that it is vitally important to ensure that a personal or family history of atopic disorders is accurately and comprehensively documented in the medical records of all people presenting with potential atopic asthma. Whilst this information is insufficient to make a diagnosis, it is important for trigger identification and subsequent monitoring of asthma.</p>

8 Diagnosis: Symptoms after exercise

8.1 Introduction

Symptoms of cough, wheeze and chest tightness suggestive of bronchoconstriction occur after exercise in many people with asthma, and also in some people who do not have asthma. The symptoms are associated with prolonged exercise, such as long-distance running, rather than short bursts of intensive exercise. Classically, symptoms occur a few minutes after stopping exercise rather than during exercise, and can vary from mild symptoms to an acute asthma attack. Treatment with beta-2-agonists prior to exercise reduces or eliminates symptoms of exercise-induced bronchoconstriction. However, the diagnostic test accuracy of asking about a history of symptoms after exercise to diagnose asthma is currently unclear.

8.2 Review question: In people under investigation for asthma, what is the diagnostic accuracy of a clinical history of symptoms in response to exercise?

For full details see review protocol in Appendix C.

Table 14: Characteristics of review question

Population	People with suspected asthma (presenting with respiratory symptoms). All ages, stratified into the following 3 different groups: <ul style="list-style-type: none">• Children (1- <5 years old)• Children/young people (5-16 years old)• Adults (>16 years old)
Index test	<ul style="list-style-type: none">• 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 In children 1-<5 years, objective tests cannot be performed so the reference standard will be physician diagnosis based on recurrent and persistent wheezing.
Statistical measures	Diagnostic accuracy (sensitivity, specificity)

8.3 Clinical evidence

We searched for cross sectional studies, cohort studies, case series (including both retrospective and prospective analyses) assessing the diagnostic test accuracy of a clinical history of symptoms in response to exercise to identify whether the condition is present (as indicated by the reference standard) in people under investigation for asthma.

One study was included in the review³² (see Table 15). Evidence from this study is summarised in the clinical evidence profile below (Table 16). See also the study selection flow chart in Appendix D, sensitivity / specificity forest plots in Appendix J, study evidence tables in Appendix G and exclusion list in Appendix K. The population consisted of adults only. No studies were identified in children or young people.

- 1 The included study³² was a cross-sectional study, and looked at the diagnostic accuracy of a clinical
- 2 history of symptoms after exercise in patients with signs and symptoms of asthma. The reference
- 3 standard was physician's diagnosis of asthma with an objective test.

Summary of included studies

Table 15: Summary of studies included in the review

Study	Population	Index test & cut-off	Reference standard	Comparator test
Index test vs Reference Standard				
CHOI 2007 ³²	N = 302 Adults Respiratory symptoms such as dyspnoea, cough or wheezing	Symptoms after exercise Questionnaire consisting of 11 questions regarding symptoms. Affirmative answer to Q3 = Have you had wheezing associated with dyspnoea (provoking factor – exercise)?	Physician Dx with objective test Patients with an FEV1 >70% had MCT, all other patients had BDR. Definite Dx of asthma made using test (MCh PC20 <16mg/ml or BDR FEV1 increase >12% and 200ml)	None

Table 16: Clinical evidence profile: Symptoms in response to exercise vs Reference Standard (physician Dx and objective test)

Index Test (Threshold)	No of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity %	Specificity %	Area Under Curve (range)	Quality
Symptoms in response to exercise - Adults										
Affirmative answer to questionnaire – exercise as a provoking factor	1	302	Serious risk of bias ^(a)	No serious inconsistency ^(b)	Serious indirectness ^(c)	n/a ^(d)	40.0	78.3	n/a	LOW

(a) Risk of bias was assessed using the QUADAS-II checklist. Outcomes were downgraded by one if the weighted (by sample size (n)) average number of QUADAS-II domains (patient selection, index test, reference standard and flow and timing) with methodological limitations was one. Outcomes were downgraded by two if the weighted average number of QUADAS-II domains with methodological limitations was more than one.

(b) Inconsistency was assessed by inspection of the sensitivity / specificity values in each of the studies in relation to a high (≥75%), moderate (50-74%) or low (<50%) effect estimate. Inconsistency was considered high if the point estimates from individual studies were within two areas, and very high if they were in 3 areas or both high and low areas.

(c) The cut-off threshold for the reference standard objective test was not performed at the optimal cut-off for objective tests as determined by this guideline

(d) The judgement of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis, where performed.

8.4 Economic evidence

Published literature

No relevant economic evaluations were identified.

See also the economic article selection flow diagram in Appendix E.

8.5 Evidence statements

Clinical

- One study with 302 adults showed that a clinical history of symptoms after exercise has a sensitivity of 40.0% and a corresponding specificity of 78.3% for diagnosing asthma in people presenting with respiratory signs and symptoms. (LOW QUALITY)

Economic

- No relevant economic evaluations were identified.

8.6 Recommendations and link to evidence

Recommendations	6. Do not use an isolated clinical history of symptoms after exercise to diagnose asthma.
Relative values of different outcomes	<p>The outcome of interest is the diagnostic test accuracy of taking a clinical history of symptoms after exercise. Exercise is known to exacerbate asthma in a proportion of patients and it has been suggested that taking a history of symptoms after exercise in a patient with suspected asthma may aid diagnosis.</p> <p>A number of studies were excluded as they reported the diagnostic accuracy of taking a history of symptoms after exercise in the general population as a screening tool for asthma. The GDG was only interested in studies where the population consisted of patients presenting with respiratory signs and symptoms under investigation for asthma.</p>
Trade-off between clinical benefits and harms	<p>There is no direct harm associated with taking a clinical history of symptoms after exercise and the trade-off between benefit and harm will depend on the reliability of the question as a means of indicating asthma. Taking a clinical history of symptoms after exercise to diagnose asthma had a low sensitivity and a high specificity.</p> <p>The GDG discussed that symptoms of breathlessness (over and above what one would normally expect) after exercise can occur for other reasons other than asthma, and a diagnosis of asthma should not be made on the basis of a positive history of symptoms after exercise in isolation. The GDG also noted the low sensitivity and the high number of false negatives suggesting the question should not be used as a 'rule out' test.</p>
Economic considerations	<p>No relevant economic evaluations were identified.</p> <p>The clinical evidence showed that symptoms after exercise had a low diagnostic accuracy.</p> <p>This would be of clinical harm to individuals who have asthma and who would go untreated for a period of time, and also to individuals who are falsely diagnosed and treated for asthma. Therefore, even though the costs of this diagnostic method are very low, using it as a stand-alone diagnostic test would lead to more harm than</p>

	good because it will lead to inappropriate over-treatment, waste of resources and lack of a correct diagnosis.
Quality of evidence	<ul style="list-style-type: none"> • In children aged <5 years, no studies were identified. • In children aged 5-16 years, no studies were identified. • In adults >16 years, one study was identified³² using the reference standard (physician diagnosis plus an objective test) that addressed the diagnostic test accuracy of a history of symptoms after exercise in the diagnosis of asthma. The included study used a symptom questionnaire, and in this case an affirmative answer to the question 'Have you had wheezing associated with dyspnoea with exercise as the provoking factor (within 1 year)' was taken as a positive index question. The evidence was downgraded for indirectness as the cut-off threshold for the reference standard objective test was not performed at the optimal cut-off for objective tests as determined by this guideline. Evidence was of low quality.
Other considerations	<p>The GDG recommendation is based on review of the evidence in adults and consensus opinion of the GDG in children.</p> <p>The GDG did not make a future research recommendation.</p>

9 Diagnosis: Symptoms after drugs

9.1 Introduction

Certain drugs are known to exacerbate asthma in a proportion of patients. The two classes of drugs that are commonly associated with worsening of underlying asthma are non-steroidal anti-inflammatories (NSAIDs), including aspirin and ibuprofen, and beta-blockers.

Cross-sectional studies suggest that less than 10% of people with asthma have worsening of their respiratory symptoms after ingestion of NSAIDs. The exact mechanism by which NSAIDs exacerbate asthma is uncertain, but it is believed to be related to their effect on the metabolism of inflammatory mediators, known as leukotrienes.

Beta-blockers are currently contra-indicated in asthma because of the potential to block the beta-receptors in the smooth muscle within the airways. Stimulation of the beta-receptors normally leads to dilatation of the bronchi and blockade of these receptors may worsen the bronchoconstriction that is commonly associated with asthma, as well as preventing beta2 agonists, such as salbutamol, from dilating the asthmatic airway.

Associated respiratory symptoms following ingestion of these drugs can sometimes indicate a person may have asthma, this raises the question of whether taking a clinical history of symptoms after drugs is a good diagnostic test, in the diagnosis of asthma in people presenting with symptoms.

9.2 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?

For full details see review protocol in Appendix C.

Table 17: PICO characteristics of review question

Population	People with suspected asthma (presenting with respiratory symptoms). All ages, stratified into the following 3 different groups: <ul style="list-style-type: none">• Children (1-<5 years old) - for ibuprofen only• Children/young people (5-16 years old) – for ibuprofen only• Adults (>16 years old) – for beta blockers, aspirin or other NSAIDs
Index test	<ul style="list-style-type: none">• 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
Outcomes	<ul style="list-style-type: none">• Diagnostic accuracy (sensitivity, specificity)

9.3 Clinical evidence

There were no relevant clinical studies identified of clinical history of symptoms after taking aspirin, NSAIDs or beta blockers compared with the reference standard of physician diagnosis or other objective tests in adults. There were also no studies found in children for ibuprofen.

The majority of the evidence did not address the review question. Most studies compared the diagnostic accuracy of the index test with aspirin challenge tests in the diagnosis of aspirin-sensitive asthma in people with a confirmed diagnosis of asthma. No studies compared the diagnostic accuracy of the index test with the reference standard in the diagnosis of asthma in patients with suspected asthma (see excluded studies in Appendix K).

9.4 Economic evidence

Published literature

No relevant economic evaluations were identified.

See also the economic article selection flow diagram in Appendix E.

9.5 Evidence statements

Clinical

- No evidence identified.

Economic

- No relevant economic evaluations were identified.

9.6 Recommendations and link to evidence

Recommendations	No clinical recommendation.
Relative values of different outcomes	The GDG was interested in the diagnostic test accuracy of taking a clinical history of symptoms after drugs in adults (beta-blockers, aspirin or other NSAIDs) and children (ibuprofen only). These drugs are known to exacerbate asthma in a proportion of patients and it has been suggested that taking a history of symptoms after drugs in a patient with suspected asthma may aid diagnosis. One of the concerns that set the scope of this guideline is the over-diagnosis of asthma leading to inappropriate treatment; therefore, the GDG was interested in both the sensitivity and specificity of diagnostic tests.
Trade-off between clinical benefits and harms	No clinical evidence was identified in order to assess the diagnostic test accuracy (sensitivity and specificity) of a clinical history of symptoms after taking aspirin, NSAIDs or beta blockers compared with the reference standard in the diagnosis of asthma. There were also no studies found in children for ibuprofen. The majority of the evidence assessed the sensitivity and specificity of a clinical history of symptoms after drugs in the diagnosis of aspirin-sensitive asthma in people with a confirmed diagnosis of asthma. Although the GDG looked for all evidence of ibuprofen use in children, they acknowledged that children under 12 are not routinely exposed to either beta-blockers or NSAID (due to concern about Reyes Syndrome) and thus no evidence was expected in this age range.
Economic	No relevant economic evaluations were identified.

considerations	As there were no clinical studies identified there was no way of identifying whether symptoms after certain drugs was a cost-effective tool to aid in the diagnosis of asthma.
Quality of evidence	No clinical evidence was identified.
Other considerations	<p>The GDG acknowledged that the utility of this question is hampered by the information that patients are given by pharmacists or healthcare professionals. People with asthma are often told they should avoid NSAIDs and are allergic to them, without evidence of a reaction to drugs. This is particularly pertinent when considering treatment for osteoarthritis in adults where NSAIDs are a mainstay of treatment.</p> <p>The GDG suggested that the lack of evidence derives from the fact that taking a clinical history of symptoms after drugs is not routinely used in the diagnosis of asthma; rather, it is used to characterise a particular asthma phenotype in order to guide management, e.g. for the avoidance of certain drugs. The GDG stated that around 1 in 12 people with severe asthma have a response to drugs and further research may be beneficial to determine the diagnostic test accuracy of taking a clinical history of symptoms after drugs. Anecdotally, clinicians may find a history of respiratory symptoms in response to specific drug exposure useful in increasing the suspicion of a diagnosis of asthma; however, mandating to ask or not ask the question is not possible based on current evidence.</p>

10 Diagnosis: Occupational asthma

10.1 Introduction

Occupational asthma is a form of asthma attributable to a particular exposure in the workplace and not due to stimuli encountered outside the workplace. The true frequency is unknown, but there are concerns that it is under-reported. Published evidence estimates that occupational asthma may account for between 9 and 15% of adult onset asthma. Occupational asthma is the commonest industrial lung disease in the developed world with over 400 reported causes.

Occupational asthma should therefore be considered in all workers with adult onset asthma. The current BTS/SIGN guidelines for asthma state that all adults with airflow obstruction should be asked whether they are better on days away from work or on holiday. However, currently there is a lack of certainty about the diagnostic accuracy of asking about symptoms away from work.

10.2 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?

For full details see review protocol in Appendix C.

Table 18: PICO characteristics of review question

Population / Target condition	Adults (>16 years old) with suspected occupational asthma.
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	<ul style="list-style-type: none">Diagnostic accuracy (sensitivity, specificity)

10.3 Clinical evidence

We searched for cross sectional studies, cohort studies, case series (including both retrospective and prospective analyses) assessing the diagnostic test accuracy of asking whether symptoms are better away from work to identify whether occupational asthma is present (as indicated by the reference standard) in people under investigation for occupational asthma. The reference standard for occupational asthma was physician’s diagnosis supported by an objective test (e.g. specific inhalation challenge).

Four studies were included in the review^{15,99,174,175}. Evidence from these are summarised in Table 19 and the clinical evidence profile (Table 20) below. See also the study selection flow chart in Appendix D, forest plots in Appendix J, study evidence tables in Appendix G and exclusion list in Appendix K.

All the studies were cross-sectional diagnostic studies in adults^{15,99,174,175} and included symptomatic samples (i.e. referred for possible occupational asthma). The reference standard was a physician’s diagnosis of occupational asthma supported by an objective test (e.g. specific inhalation challenge). The GDG was interested in the diagnostic accuracy of asking this question for all causal agents

1 combined. Due to heterogeneity in the results, they also considered the accuracy of asking this
2 question for individual causal agents.

3 Summary of included studies

4 **Table 19: Summary of studies included in the review**

Study	N	Index test/reference standard	Index test/reference standard cut-off for positivity	Population	Age
Asking whether symptoms are better away from work vs. reference standard (physician diagnosis)					
BAUR 1998 ¹⁵	62 healthcare workers (airborne latex; 12 asthma) 28 bakers (flour, baking enzymes; 7 asthma) 114 isocyanate workers (isocyanates; 21 asthma)	ATS-DLD questionnaire and experienced physician medical and occupational case history Bronchial challenge with occupational agents	Reversible airways narrowing (SOB, wheeze) causally related to exposure in the working environment occurred repeatedly Specific conductance (sG_{aw}) dropped $\geq 40\%$ from baseline and absolute value $\leq 0.5(\text{kPa} \cdot \text{s})^{-1}$	Healthcare workers with contact with latex gloves, bakers or isocyanate workers presenting with suspected occupational asthma (excluded if challenge tests contraindicated or declined)	Healthcare workers 31 (8.1); bakers 32 (11.9); isocyanate workers 39 (11.1) years
Malo 1991 ⁹⁹	162 (75 occupational asthma)	Questionnaire/ chest physician (SOB, cough, wheezing or chest tightness present and timings) Final diagnosis including specific inhalation challenges, serial monitoring of peak flow at work and away from work or both	Whether symptoms worse during or after work and improved during weekends and holidays Fall in FEV1 $> 20\%$ (or $\geq 15\%$ in late component of dual reactions) on specific challenge or patterns	Consecutive cases referred for possible occupational asthma	Mean 39.6 (11.8) years

Study	N	Index test/reference standard	Index test/reference standard cut-off for positivity	Population	Age
			suggestive of work-related asthma using graphs of individual, mean, maximum and minimum daily values using Burge criteria		
Vandenplas 2001 ¹⁷⁴	45 (31 occupational asthma)	Questionnaire/physician Clinical diagnosis including objective test: SICs with natural rubber latex gloves;	Symptoms present only on work days SICs with natural rubber latex gloves; FEV1 fell by more than 20%	Consecutive patients referred for investigation of possible OA caused by latex; exposed at work to airborne natural rubber latex (NRL) allergens from NRL gloves.	Mean 33.6 years
Vandenplas 2005 ¹⁷⁴	212 (72 occupational asthma)	Questionnaire Specific inhalation challenge	a) Improvement or disappearance of symptoms at weekends; b) Improvement or disappearance of symptoms during vacations A sustained fall in FEV ₁ of 20%	Prospectively assessed in outpatient clinics of four hospital centres and who underwent objective testing with specific inhalation challenges	38.8 (10.7) years

1

OA = occupational asthma

Table 20: Clinical evidence profile: Question of whether symptoms better away from work vs. Physician Dx of occupational asthma with objective test

Question whether symptoms better away from work (Yes/No)	No of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Median Sensitivity % (range)	Median Specificity % (range) ^e	Area Under Curve (range)	Quality
Question whether symptoms better away from work (all causal agents)	4	623	Serious risk of bias ^b	Very serious inconsistency ^a	No serious indirectness	N/A ^c	range 0.48 to 1.0	range 0.32 to 0.71	-	VERY LOW
Improvement or disappearance of symptoms during weekend (many causal agents)	1	212	No risk of bias	No serious inconsistency	No serious indirectness	N/A ^c	0.76	0.54	-	HIGH
Improvement or disappearance of symptoms during vacations (many causal agents)	1	212	No risk of bias	No serious inconsistency	No serious indirectness	N/A ^c	0.74	0.57	-	HIGH
Symptoms better away from work (flour).	1	28	Serious risk of bias ^b	No serious inconsistency	No serious indirectness	N/A ^c	1.00	0.62	-	MODERATE
Symptoms better away from work (isocyanate).	1	114	Serious risk of bias ^b	No serious inconsistency	No serious indirectness	N/A ^c	0.67	0.66	-	MODERATE
Symptoms better away from work (latex).	2	107	Serious risk of bias ^b	Very serious inconsistency ^a	No serious indirectness	N/A ^c	Range 0.48 to 0.92	Range 0.32 to 0.71	-	VERY LOW
Symptoms better away from work (many causal agents).	2	374	No risk of bias	Serious inconsistency ^a	No serious indirectness	N/A ^c	Range 0.74 to 0.87	Range 0.55 to 0.57	-	MODERATE

a) Inconsistency was assessed by inspection of the sensitivity / specificity values in each of the studies in relation to a high ($\geq 75\%$), moderate (50-74%) or low ($< 50\%$) effect estimate.

Inconsistency was considered high if the point estimates from individual studies were within two areas, and very high if they were in 3 areas or both high and low areas.

b) Risk of bias was assessed using the QUADAS-II checklist. Outcomes were downgraded by one if the weighted (by sample size (n)) average number of QUADAS-II domains (patient selection, index test, reference standard and flow and timing) with methodological limitations was one. Outcomes were downgraded by two if the weighted average number of QUADAS-II domains with methodological limitations was more than one.

c) The judgement of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis, where performed.

1 10.4 Economic evidence

2 Published literature

3 No relevant economic evaluations were identified.

4 See also the economic article selection flow diagram in Appendix E.

5 10.5 Evidence statements

6 Clinical

- 7 • Four studies with 623 adults showed that question of whether symptoms are better away from
8 work (question: whether symptoms better away from work, all causal agents) has a sensitivity
9 range of 0.48 to 1.0 and a corresponding specificity range of 0.32 to 0.71 for diagnosing
10 occupational asthma in people presenting signs and symptoms of possible occupational asthma.
11 (VERY LOW QUALITY)
- 12 • One study with 212 adults showed that question of whether symptoms are better away from
13 work (question: improvement or disappearance of symptoms during the weekend, many casual
14 agents) has a sensitivity of 0.76 and a corresponding specificity of 0.54 for diagnosing
15 occupational asthma in people presenting signs and symptoms of possible occupational asthma.
16 (HIGH QUALITY)
- 17 • One study with 212 adults showed that question of whether symptoms are better away from
18 work (question: improvement or disappearance of symptoms during vacations, many casual
19 agents) has a sensitivity of 0.74 and a corresponding specificity of 0.57 for diagnosing
20 occupational asthma in people presenting signs and symptoms of possible occupational asthma.
21 (HIGH QUALITY)
- 22 • One study with 28 adults showed that question of whether symptoms are better away from work
23 (question: symptoms better away from work, causal agent flour) has a sensitivity of 1.00 and a
24 corresponding specificity of 0.62 for diagnosing occupational asthma in people presenting signs
25 and symptoms of possible occupational asthma. (MODERATE QUALITY)
- 26 • One study with 114 adults showed that question of whether symptoms are better away from
27 work (question: symptoms better away from work, causal agent isocyanate) has a sensitivity of
28 0.67 and a corresponding specificity of 0.66 for diagnosing occupational asthma in people
29 presenting signs and symptoms of possible occupational asthma. (MODERATE QUALITY)
- 30 • Two studies with 107 adults showed that question of whether symptoms are better away from
31 work (question: symptoms better away from work, latex) has a sensitivity range of 0.48 to 0.92
32 and a corresponding specificity range of 0.32 to 0.71 for diagnosing occupational asthma in
33 people presenting signs and symptoms of possible occupational asthma. (VERY LOW QUALITY)
- 34 • Two studies with 374 adults showed that question of whether symptoms are better away from
35 work (question: symptoms better away from work, many casual agents) has a sensitivity range of
36 0.74 to 0.87 and a corresponding specificity range of 0.55 to 0.57 for diagnosing occupational
37 asthma in people presenting signs and symptoms of possible occupational asthma. (MODERATE
38 QUALITY)

39 Economic

- 40 • No relevant economic evaluations were identified.

1 **10.6 Recommendations and link to evidence**

Recommendations	<p>7. Check for suspected occupational asthma by asking employed people with newly-diagnosed asthma or established asthma that is poorly controlled:</p> <ul style="list-style-type: none"> • are symptoms better on days away from work? • are symptoms better when on holiday^e? <p>Make sure all answers are recorded for later review.</p> <p>8. Refer people with suspected occupational asthma to an occupational asthma specialist.</p>
Relative values of different outcomes	<p>The GDG was interested in the sensitivity and specificity of two simple questions which have been previously put forward as a good means of indicating people whose asthma might be of occupational aetiology. The diagnosis of occupational asthma is of considerable significance for an individual both for health and economic reasons, and would need expert confirmation with further, occasionally complex, assessment (beyond the scope of this guideline). The GDG was aware that the questions may pick up people whose asthma is worse at work because of non-specific irritants to which they might be exposed in the workplace, but this circumstance should be distinguishable once the patient has undergone further assessment. They were therefore particularly interested in the sensitivity of the questions (rather than the specificity) since it would be important not to miss potential cases.</p>
Trade off between clinical benefits and harms	<ul style="list-style-type: none"> • There is no direct harm associated with asking these questions. The trade-off between benefit and harm will depend on their reliability as a means of indicating possible cases of occupational asthma. • Are symptoms better away from work?: Overall, the sensitivity was ‘high’ (less false negatives) and the specificity was ‘moderate’ (more false positives). This pattern was true for all the specific causative agents considered, with the exception of isocyanates and latex. For latex there were two studies (Baur 1998 and Vandenplas 2001): one study showed high specificity but low sensitivity, while this pattern was reversed in the other study. There was no obvious reason for this difference in comparison to other agents; the GDG speculated that latex exposure, unlike agents such as isocyanates, might occur outside the workplace. The numbers studied for each specific agent were small. • The trend was similar for the other questions (high sensitivity and a moderate specificity): <ul style="list-style-type: none"> ○ Symptoms better at weekend ○ Symptoms better during vacation.
Economic considerations	<p>No relevant economic evaluations were identified.</p> <p>The two questions to detect occupational asthma are asked by the healthcare professional and in itself has a negligible cost. However, this question may trigger further investigations which could be costly (for example, other tests or referral to specialist care). As occupational asthma is the only potentially curable type of asthma, there are considerable health benefits associated with the correct diagnosis of this type of asthma: people are able to eliminate the source of asthma, may return to a normal quality of life, and unnecessary treatment is averted. For this reason, the GDG considered a high sensitivity (i.e. minimisation of false negatives) more important than a high specificity (minimisation of false positives). The clinical evidence has shown that asking these questions helps identify people with</p>

^e ‘Holiday’ here means any longer time away from work than usual breaks at weekends or between shifts.

	occupational asthma, i.e. this question has a high sensitivity, and therefore it is considered to be cost-effective.
Quality of evidence	The evidence ranged from very low to high quality. Only four studies were identified, and the sample sizes and number of people with a final diagnosis of occupational asthma were generally small. The heterogeneity for the sensitivity and specificity for the question of whether symptoms better away from work considering all causal agents was very serious. The GDG also considered the evidence for different causal agents separately.
Other considerations	The GDG concluded that these simple questions were of value in raising the possibility of occupational asthma. They debated when and how frequently they should be asked. There was agreement that they should be used in all working adults with a new diagnosis of asthma. In established asthma there was a view among some of the GDG that the questions should be part of an annual asthma review, but their use in this fashion has not been tested, and it was felt possible that repeated use of the questions was more likely to result in falsely positive answers and consequent unnecessary detailed investigation. The GDG agreed by consensus that it is appropriate to repeat the questions to adults with asthma when asthma control is found to be poor, whether this be at annual review or on other occasion; however, it is not necessary as a routine review question when control is good.

11 Diagnosis: Spirometry

11.1 Introduction

Asthma is characterised by variation in airflow obstruction over time, greater than that seen in healthy populations. In asthma, lung function may vary between completely normal and severely obstructed in the same patient. Poorly controlled asthma is associated with greater variability in lung function than well-controlled asthma.

Spirometry is a physiological test that measures how an individual inhales or exhales volumes of air as a function of time. The primary signal measured in spirometry may be volume or flow.

The most important aspects of spirometry are the forced vital capacity (FVC), which is the volume delivered during an expiration made as forcefully and completely as possible starting from full inspiration, and the forced expiratory volume (FEV) in one second, which is the volume delivered in the first second of an FVC manoeuvre. A reduced ratio of FEV1 to FVC indicates airflow obstruction.

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.

Further explanation on lung function measurement and interpretation is given in the European Respiratory Society and American Thoracic Society (ERS/ATS) guidelines³⁴ on standards of spirometry.

Spirometry is recommended for the diagnosis and management of asthma in national and international guidelines^{21,58}.

11.2 Review question: In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of spirometry/flow volume loop measures?

For full details see review protocol in Appendix C.

Table 21: Characteristics of review question

Population	People with suspected asthma (presenting with respiratory symptoms). Ages stratified into the following 2 groups: <ul style="list-style-type: none">• Children/young people (5-16 years old)• Adults (>16 years old)
Index test	Spirometry measures (report separately) <ul style="list-style-type: none">• FEV1/FVC ratio (<70%)• Flow volume loop (graph)• FEV1 (<80%) – if limited evidence from the above two measures Pre bronchodilator values (applies for all above measures) FEV1 and FVC should be performed using the following criteria: <ul style="list-style-type: none">• 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.• 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.
Reference standard	Physician diagnosis of asthma based on symptoms plus an objective test.
Statistical measures	Diagnostic accuracy (sensitivity and specificity).

1 11.3 Clinical evidence

2 We searched for cross sectional studies, cohort studies, case series (including both retrospective and
3 prospective analyses) assessing the diagnostic test accuracy of spirometry to identify whether the
4 condition is present (as indicated by the reference standard) in people under investigation for
5 asthma.

6 Six studies were included in the review^{54,127,129,144,153,155} (see Table 22 and Table 23). Evidence from
7 these studies is summarised in the summary tables and the clinical evidence profile below (Table 24).
8 See also the study selection flow chart in Appendix D, sensitivity / specificity forest plots in Appendix
9 J, study evidence tables in Appendix G and exclusion list in Appendix K.

10 All six studies were cross-sectional studies^{54,127,129,144,153,155}, and looked at the diagnostic accuracy of
11 spirometry in patients with signs and symptoms. Evidence was available from one study for the ideal
12 index test measure of FEV1/FVC ratio <70%. No evidence was available for the index test of flow
13 volume loop measures. Due to limited evidence for FEV1/FVC ratio, evidence was included for
14 studies reporting FEV1/FVC ratio <70% and/or FEV1 <80% (2 studies) and for studies reporting FEV1
15 <80% only (3 studies). The reference standard was physician's diagnosis of asthma with an objective
16 test. A variety of objective tests and thresholds were used for the reference standard objective test
17 (see Table 12). In children and young people, evidence was only available for the index test of
18 FEV1<80% from one study¹⁵³. In one study¹⁵⁵, evidence was available from adults, and children and
19 young people combined (age range 8-75 years). This evidence was included in the review with the
20 data in adults due to the mean age, and was downgraded as the combined age range is indirect to
21 the protocol.

Summary of included studies

Table 22: Summary of studies included in the review: ADULTS Spirometry

Study	Population	Index test & cut-off	Reference standard	Comparator test
Index test vs Reference Standard				
FORTUNA 2007 ⁵⁴	N=50 Adults Referred with a clinical history suggestive of asthma (dry cough, wheezing, and shortness of breath) No mention of other respiratory defects. No BMI reported.	Spirometry FEV1<80%	Methacholine challenge test (PD20 ≤16mg/ml) following guidelines of the GINA	None
PINO 1996 ¹²⁷	N=84 Adults Clinically suspected of bronchial asthma No mention of other respiratory defects. No BMI reported.	Spirometry FEV1/FVC<70% and FEV1<80%	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	None
POPOVIC 2002 ¹²⁹	N=195 Adults Referred by GP with suspected asthma and symptoms of breathlessness / dyspnoea. No mention of other respiratory defects. No BMI reported.	Spirometry FEV1 <80% predicted	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)	None
SCHNEIDER 2009A ¹⁴⁴	N=219 Adults Visiting GP for the first time with complaints of suggested obstructive airway disease (OAD). Symptoms such as dyspnoea, coughing, or expectoration No mention of other respiratory defects. BMI	Spirometry at GP. FEV1/VC ≤70% and/or FEV1 <80%	Dx by respiratory physician 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)	None

Study	Population	Index test & cut-off	Reference standard	Comparator test
	reported, mean SD 25.3 (4.4)			
SMITH ¹⁵⁵ 2004	N=47 Adults and Children 8-75 years Referred to hospital pulmonary function lab by GP for possible asthma. Respiratory symptoms for a minimum of 6 weeks No mention of other respiratory defects. No BMI reported.	1. FEV1 <80% pred 2. FEV1/FVC <70%	Relevant symptom history (all patients) and a positive hypertonic saline challenge test (PD15<20ml) or BDR increase in FEV1 ≥12%	None

Table 23: Summary of studies included in the review: CHILDREN Spirometry

Study	Population	Index test & cut-off	Reference standard	Comparator test
Index test vs Reference Standard				
SIVAN 2009 ¹⁵³	N=133 Children 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. No mention of other respiratory defects. No BMI reported.	Spirometry FEV1 <80%	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.	None

Table 24: Clinical evidence profile: Index test vs Reference Standard (physician Dx and objective test)

Index Test (Threshold)	No of studies n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity %	Specificity %	Area Under Curve (range)	Quality

Index Test (Threshold)	No of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity %	Specificity %	Area Under Curve (range)	Quality
Spirometry ADULTS										
FEV1/FVC <70%	1	47	No risk of bias ^(a)	No serious inconsistency ^(b)	Serious indirectness ^(c)	n/a ^(e)	35.3	100	-	MODERATE
Flow volume loop	0									
FEV1/FVC <70% and/or FEV1<80%	2	303	Serious risk of bias ^(a)	Serious inconsistency ^(b)	Serious indirectness ^(d)	n/a ^(e)	Range 29 - 47	Range 41 - 59	-	VERY LOW
FEV1 <80%	3	292	Serious risk of bias ^(a)	Very serious inconsistency ^(b)	Serious indirectness ^(c)	n/a ^(e)	Median 29.4 (range 23-45)	Corresponding 100 (range 31-100)	-	VERY LOW
Spirometry CHILDREN										
FEV1/FVC <70%	0									
Flow volume loop	0									
FEV1 <80%	1	133	Very serious risk of bias ^(a)	No serious inconsistency ^(b)	No serious indirectness ^(c)	n/a ^(e)	52.0	72.0	-	LOW

(a) Risk of bias was assessed using the QUADAS-II checklist. Outcomes were downgraded by one if the weighted (by sample size (n)) average number of QUADAS-II domains (patient selection, index test, reference standard and flow and timing) with methodological limitations was one. Outcomes were downgraded by two if the weighted average number of QUADAS-II domains with methodological limitations was more than one.

(b) Inconsistency was assessed by inspection of the sensitivity / specificity values in each of the studies in relation to a high (≥75%), moderate (50-74%) or low (<50%) effect estimate. Inconsistency was considered high if the point estimates from individual studies were within two areas, and very high if they were in 3 areas or both high and low areas.

(c) Mixed population of adults and children/young people in one study. Reference standard was saline challenge test in one study

(d) Indirectness in the reference standard objective test cut-off

(e) The judgement of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis, where performed.

11.4 Economic evidence

Published literature

No relevant economic evaluations were identified.

See also the economic article selection flow diagram in Appendix E.

New cost-effectiveness analysis

An original health economic model was built for adults to assess the cost-effectiveness of several diagnostic pathways, which included spirometry. Full details of the model can be found in Appendix M. A summary of the model can be found in section 18.4.

Unit cost of performing a spirometry on children

As an economic model was not feasible for children, the GDG considered the unit cost of performing a spirometry to evaluate its cost-effectiveness as part of a pathway for diagnosing asthma. This unit cost is presented below in Table 25.

Table 25: Cost of spirometry

Item	Quantity ^(c)	Unit cost	Total Cost (quantity*unit cost)	Source of unit cost
Time of GP practice nurse to conduct the test ^(a)	10-15 minutes	£0.73 per minute	£7.30 - £10.95	PSSRU ³⁹
Micro-lab spirometer ^(b)	1/1500	£1498.90 per spirometer	£1.00	NHS supply catalogue ⁴⁶
Bacterial filter, 3-litre syringe for calibration ^(b)	1/1500	£295.77 per syringe	£0.20	NHS supply catalogue ⁴⁶
Bacterial filter	1	£0.99 per filter	£0.99	NHS supply catalogue ⁴⁶
Total			£9.49 - £13.14	

(a) This range reflects the differing levels of experience of the nurse conducting the test but also the age of the child. The test is likely to be conducted quicker in older children.

(b) 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.

(c) Based on GDG opinion.

The GDG also acknowledged the annual cost of drugs for the management of asthma in children. Preventing these costs from occurring in children without asthma would be a large benefit derived from a diagnostic strategy with a high specificity. This cost was estimated to be £201 from a study by Main et al.^{98,98}

11.5 Evidence statements

Clinical

Adults

- 1 • One study with 47 adults showed that spirometry (FEV1/FVC <70%) has a sensitivity of 35.3% and
2 a corresponding specificity of 100% for diagnosing asthma in people presenting with respiratory
3 signs and symptoms. (MODERATE QUALITY).
- 4 • No evidence was available for flow volume loop
- 5 • Two studies with 303 adults showed that spirometry (FEV1/FVC <70% and/or FEV1<80%) has a
6 sensitivity range of 29-47% and a corresponding specificity range of 41-59% for diagnosing asthma
7 in people presenting with respiratory signs and symptoms. (VERY LOW QUALITY)
- 8 • Three studies with 292 adults showed that spirometry (FEV1<80%) has a median sensitivity of
9 29.4% and a corresponding specificity of 100% for diagnosing asthma in people presenting with
10 respiratory signs and symptoms. (VERY LOW QUALITY)

11 Children

- 12 • No evidence was available for FEV1/FVC <70% in children
- 13 • No evidence was available for flow volume loop
- 14 • One study with 133 children showed that spirometry (FEV1 <80%) has a sensitivity of 52% and a
15 corresponding specificity of 72% for diagnosing asthma in people presenting with respiratory
16 signs and symptoms. (LOW QUALITY).

17 Economic

- 18 • No relevant economic evaluations were identified.
- 19 • An original health economic model found that spirometry (together with bronchodilator
20 reversibility, FeNO, peak expiratory flow variability and histamine or methacholine challenge test)
21 was part of the most cost-effective diagnostic pathway used to diagnose asthma in adults aged 16
22 and over (see diagnostic algorithm in section 4.1). This evidence is directly applicable with minor
23 limitations.

24 **11.6 Recommendations and link to evidence**

Recommendations	9. Use spirometry as the first-line investigation for asthma in adults and young people older than 16 and children aged 5-16 years. Regard a forced expiratory volume in 1 s/forced vital capacity (FEV₁/FVC) ratio of less than 70% as a positive test for obstructive airway disease (obstructive spirometry). See also recommendation 23.
Relative values of different outcomes	<p>The GDG was interested in the utility of spirometry in the diagnosis of asthma in patients >5 years presenting with signs and symptoms.</p> <p>One of the concerns that set the scope of this guideline is the over-diagnosis of asthma leading to inappropriate treatment; therefore, the GDG was interested in both the sensitivity and specificity of diagnostic tests and prioritised studies which reported these outcomes. Sensitivity and specificity values will depend on the chosen cut-off point. The GDG included studies with a FEV1/FVC ratio cut-off value of less than 70%. Cut-off values higher than this were excluded as they are likely to occur in some healthy individuals and the GDG was concerned about a high number of false positives at higher cut-off values.</p> <p>Due to the limited evidence identified using the FEV1/FVC ratio as the spirometric measure, the GDG also considered evidence from studies reporting the FEV1 alone. As the FEV1 can be influenced by conditions which cause restrictive respiratory defects, for example, obesity, details on any exclusion criteria for other conditions or BMI were extracted from the studies into the evidence tables and considered by the GDG.</p>

	<p>FEV1 and FEV1/FVC ratio were considered separately due to the limitations of looking at the FEV1 alone.</p>
<p>Trade-off between clinical benefits and harms</p>	<p>The studies included in the analysis demonstrated that a FEV1/FVC ratio <70% has a low sensitivity and a high specificity. A FEV1/FVC ratio <70% and/or a FEV1 <80% had a low sensitivity and a low to moderate specificity. In adults, FEV1 alone had a low sensitivity and a high specificity and, in children, FEV1 alone had a moderate sensitivity and specificity.</p> <p>The GDG agreed spirometry should not be used in isolation for the diagnosis of asthma due to the low sensitivity of the test, and due to the fact that obstruction also occurs in other conditions such as COPD. When considering the placement of spirometry in a diagnostic pathway, the GDG noted the importance of spirometry as a first line investigation in all patients, to detect the presence or absence of obstruction, which then determines which other tests are appropriate (for example, the recommendation to use BDR only if obstruction is present).</p> <p>It was also noted that spirometry might offer an alternative explanation for a person's symptoms (if restrictive spirometry is found).</p> <p>The contraindications for spirometry should be considered (e.g., recent MI, recent eye surgery, etc.) when testing lung function. The FEV1 alone should not be used as it will be influenced by other conditions which cause restrictive respiratory defects, for example, obesity. The FEV1/FVC ratio should be used to detect obstructive lung disease.</p> <p>The GDG recognised that it is technically difficult for some young children to breathe out for long enough to achieve an accurate FVC, making it difficult to obtain the FEV1/FVC ratio cut off. However, the ability to perform spirometry will vary from child to child and the GDG agreed that spirometry should be attempted in children aged 5 years and older. In young children the GDG would recommend devices that show the visual trace.</p>
<p>Economic considerations</p>	<p>No economic evaluations were found which assessed the use of spirometry as part of a diagnostic pathway. Therefore, an original health economic model was built to assess the cost-effectiveness of different diagnostic pathways for asthma. The model assessed the additional costs of tests against cost-savings from unnecessary asthma medication, and the increased health outcomes from providing correct treatment.</p> <p>The GDG agreed that spirometry should be used as the first line diagnostic test in all assessed diagnostic pathways. The reason is that it is a widely available test that can also help with the diagnosis of other conditions such as COPD. It is also used to determine whether the patient can undergo a BDR test. However the strategy with the fewest diagnostic tests that included spirometry produced lower health outcomes at a higher cost than other strategies. This shows the cost-effectiveness of spirometry is contingent on its use as part of an extensive pathway and therefore if used in practice it should always be followed up by the appropriate recommended tests. Not doing so could lead to higher costs to the NHS and lower health outcomes.</p> <p>The most cost-effective strategy involved using spirometry, bronchodilator reversibility (BDR), FeNO, peak expiratory flow variability (PEFv) and a methacholine challenge test (MCT) to diagnose asthma. In this strategy everybody with symptoms of asthma would undergo a spirometry and FeNO test, those who had an obstructive spirometry would also receive a BDR test. Only those who had non-obstructive spirometry and conflicting FeNO and PEFv test results would receive a MCT. Adopting this strategy dominated all other strategies apart from those which performed challenge tests at more points in the pathway. The ICERs of adopting</p>

	<p>these further strategies were above £20,000 per QALY.</p> <p>For children the GDG considered the unit cost of performing a spirometry. The GDG agreed that the cost was low relative to information gained which was crucial in determining a diagnosis. Performing a spirometry is necessary to determine whether it is appropriate to perform a bronchodilator reversibility test. In children the GDG noted that a positive result from this test is strong evidence that the child has asthma. As with adults the GDG noted that the use of spirometry on its own could lead to worse outcomes as the clinical evidence showed spirometry to have a moderate sensitivity. Therefore the cost-effectiveness of spirometry is contingent on its use as part of the recommended diagnostic pathway (see section 21).</p>
Quality of evidence	<p>The quality of studies ranged from very low to moderate. The main limitation of the included studies was the reference standard. Due to the limited evidence, studies were considered where the reference standard objective test cut-off threshold used to identify a positive diagnosis did not match the one considered by the GDG as the optimal cut-off threshold. The GDG also considered evidence from one study¹⁵⁵ where the objective test was a hypertonic saline challenge test, a test not commonly used in clinical practice.</p> <ul style="list-style-type: none"> • In children aged <5 years, we did not search for studies as spirometry is not able to be performed in this age-group. • In children aged 5-16 years, one study was included¹⁵³; however, this study only reported the diagnostic accuracy of FEV1 alone and not the ratio. The evidence was of low quality. • In adults, there were five included studies; however, only one study reported the diagnostic accuracy of the FEV1/FVC ratio alone. The evidence was of moderate quality. <p>The economic evidence was assessed as directly applicable with minor limitations.</p>
Other considerations	<p>Spirometry is only useful if a good quality spirogram is obtained that is both accurate and reproducible, which will require training of personnel performing the test. The GDG discussed the need for patients to have access to high quality spirometry tests, but how this is achieved may depend on local procedures.</p>

12 Diagnosis: Bronchodilator reversibility

12.1 Introduction

The aim of this review was to assess the clinical and cost-effectiveness of bronchial reversibility testing in those with obstructive spirometry in the diagnosis of asthma in adults and children. A determination of airflow-limitation reversibility with drug administration is commonly undertaken as part of lung function testing in those in whom obstruction is observed. There is no clear consensus about what constitutes reversibility in subjects with airflow obstruction, although the ATS/ERS Task Force: Standardisation of lung function testing currently provides the clearest guidance and is most widely used.

The first step in interpreting any bronchodilator test is to determine if any change greater than random variation has occurred¹¹⁸. The patient should undergo baseline function testing when not taking any drugs prior to the test. Short-acting inhaled drugs (e.g. the β 2-agonist albuterol/salbutamol or the anticholinergic agent ipratropium bromide) should not be used within four hours of testing. Long-acting beta-agonist bronchodilators (e.g. salmeterol or formoterol) and oral therapy with aminophylline or slow-release β -agonists should be stopped for at least 12 hours prior to the test, and for 24 hours for ultra-long acting agents with a long half-life (e.g. indecaterol, vilanterol). Smoking should be avoided for >1 hour prior to testing and throughout the duration of the test procedure.

The ATS/ERS Task Force recommended procedure for assessing bronchodilator response are:

- Assess lung function at baseline. If obstruction is present (FEV1/FVC ratio <70%): Administer four separate doses of 100mcg salbutamol through a spacer and re-assess lung function after 15 minutes.
- An increase in FEV1 \geq 12% and \geq 200ml above baseline FEV1 after short-acting β 2 agonist constitutes a positive bronchodilator response.
- The lack of a spirometric bronchodilator response in the laboratory does not preclude a clinical response to bronchodilator therapy.

12.2 Review question: In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of bronchodilator response (using PEF or FEV1)?

For full details see review protocol in Appendix C.

Table 26: PICO characteristics of review question

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
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">• Children/ young people (5-16 years old)• Adults (>16 years old)
Index test	Bronchodilator response, measured using the following: <ul style="list-style-type: none">• PEF

	<ul style="list-style-type: none"> • FEV1 <ul style="list-style-type: none"> ○ change in FEV1 % initial and change in FEV1 litres <p>Exclusions:</p> <ul style="list-style-type: none"> • Change in FEV1 % initial alone • Change in FEV1 absolute litres alone • Change in FEV1 % predicted (ΔFEV1 %pred) • Standardised residual (SR)-FEV1 • Change in FEV1 % of possible maximal response (ΔFEV1 %max)
Reference standard	Physician diagnosis of asthma based on symptoms plus an objective test
Outcomes	<ul style="list-style-type: none"> • Diagnostic accuracy (sensitivity and specificity)

1 12.3 Clinical evidence

2 We searched for cross sectional studies, cohort studies, case series (including both retrospective and
3 prospective analyses) assessing the diagnostic test accuracy of bronchodilator response to identify
4 whether the condition is present (as indicated by the reference standard) in people under
5 investigation for asthma.

6 Four studies were included in the review^{20,31,81,132} (see Table 27). Evidence from these are
7 summarised in the clinical evidence profile below (Table Table 28). See also Appendix D, sensitivity
8 and specificity plots in Appendix J, clinical evidence tables in Appendix G and excluded studies in
9 Appendix K.

10 All studies were in adults and no evidence was identified for the 5-16 year age group.

11 The included population of all the included studies was people with asthma or COPD, rather than
12 suspected asthma. These studies aimed to assess the diagnostic accuracy of BDR in distinguishing
13 between asthma and COPD. These studies were included in the review due to limited evidence in the
14 suspected asthma population. The reference standard in the included studies was physician
15 diagnosis. With the exception of two studies^{20,132}, it was unclear if the reference standard included an
16 objective test for asthma. In the Quadrelli 1999 study, it was unclear whether all people received the
17 objective test. Again, due to limited evidence these studies were included but the quality of the
18 evidence was downgraded for population and reference standard indirectness.

Summary of included studies

Table 27: Summary of studies included in the review: Bronchodilator reversibility vs. reference standard (physician diagnosis): adults

Study	N	Index test/reference standard	Index test cut-off for positivity (measures in 'bold' are those specified in the protocol, and thus used in the analyses)	Population	Age
Brand 1992 ²⁰	150	<ul style="list-style-type: none"> 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; f) FEV1 post-bronchodilator [pb] %pred <p>Standardised history using criteria of ATS: 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-reactivity to inhaled histamine</p>	a) ΔFEV1 % init>15%; b) ΔFEV1[l]> 0.200; c) ΔFEV1 % init and ΔFEV1[l]:>15% and > 0.200; d) ΔFEV1 %pred>9%; e) SR-FEV1> 0.5; f) FEV1 pb %pred>80%	Adults with chronic respiratory symptoms (asthma 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	18-60 years
Chhabra 2005 ³¹	354	<ul style="list-style-type: none"> 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% <p>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,</p>	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%; d) ΔFEV1 and ΔFEV1%init: ≥0.2l and ≥12%	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. Participants were already on corticosteroid treatment.	Asthma mean 35.60 (12.47); COPD mean 56.28 (9.57) years

Study	N	Index test/reference standard	Index test cut-off for positivity (measures in 'bold' are those specified in the protocol, and thus used in the analyses)	Population	Age
		cough with expectoration for at least 3 consecutive months in a year for 2 years or more and progressive dyspnoea on exertion).			
Kim 2012 ⁸¹	514	<ul style="list-style-type: none"> Bronchodilator response to salbutamol 400µg <p>Clinical decision (no definite diagnostic criteria) by specialists in allergy or pulmonary departments</p>	Increase in FEV1 >200mL and >12% above baseline	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	48 (16) years for asthma and 65 (8) years for COPD
Quadrelli 1999 ¹³²	119	<ul style="list-style-type: none"> 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) <p>Clinical diagnosis: asthma = attacks of breathlessness or wheeze according to ATS criteria (smokers excluded) and at least 2 of: 1; history of symptoms since childhood or adolescence; 2. symptomatic-free periods of >3 months; 3. spontaneous variations in FEV1 during the year of >20% of baseline value; 4. histamine challenge test <8mg/mL. COPD = heavy current or ex-smokers with no history of asthma reporting chronic cough or sputum (non-smokers excluded)</p>	a) ΔFEV1[L]: 200mL; b) ΔFEV1%init: 15%; c) ΔFEV1[L] and ΔFEV1%init: >200mL and >15%; d) ΔFEV1%pred: 9%; e) ΔFEV1%max (% of maximal possible response): 50%	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).	Overall asthma : 55.4 (19.0) years; COPD 67.3 (7.0) years

Table 28: Clinical evidence profile: Bronchodilator reversibility vs. Physician Dx of asthma

Bronchodilator reversibility (Threshold)	No of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Median Sensitivity % (range)	Median Specificity % (range) ^e	Area Under Curve (range)	Quality
ADULTS										
ΔFEV1%init ≥12% and ΔFEV1[L] ≥0.2L	2	868	Serious risk of bias ^a	Serious inconsistency ^b	Serious indirectness ^{d,e}	N/A ^c	Range 0.17-0.65	Range 0.61-0.81	-	VERY LOW
ΔFEV1%init >15% and ΔFEV1[L] >0.2L	2	269	Serious risk of bias ^a	No serious inconsistency ^b	Serious indirectness ^{d,e}	N/A ^c	Range 0.69-0.69	Range 0.55-0.71	-	LOW
CHILDREN 5-16 years										
No evidence identified	0									

12.4 Economic evidence

Published literature

No relevant economic evaluations were identified.

See also the economic article selection flow chart in Appendix E.

New cost-effectiveness analysis

An original health economic model was built for adults to assess the cost-effectiveness of several diagnostic pathways, which included bronchodilator reversibility. Full details of the model can be found in Appendix M. A summary of the model can be found in section 18.4.

Unit cost of performing bronchodilator reversibility on children

As an economic model was not feasible for children, the GDG considered the unit cost of performing bronchodilator reversibility to evaluate its cost-effectiveness as part of a pathway for diagnosing asthma. This unit cost is presented below in Table 29.

Table 29: Cost of bronchodilator reversibility

Item	Quantity ^(c)	Unit cost	Total Cost (quantity*unit cost)	Source of unit cost
Time taken to administer bronchodilator and check for reversibility ^(a)	8-17 minutes	£0.73 per minute	£5.84-£12.41	PSSRU ³⁹
Volumatic spacer	1	£3.81 per spacer	£3.81	NHS supply catalogue ⁴⁶
MDI	1	£5.50 per MDI	£5.50	NHS supply catalogue ⁴⁶
Spirometry equipment to check for reversibility ^(b)	1	£2.20	£2.20	NHS supply catalogue ⁴⁶
Total			£17.35-£23.92	

(a) This range reflects the differing levels of experience of the nurse conducting the test but also the age of the child. The test is likely to be conducted quicker in older children.

(b) When a bronchodilator reversibility test is being performed the first spirometry reading will have already been taken.

(c) Based on GDG opinion.

The GDG also acknowledged the annual cost of drugs for the management of asthma in children. Preventing these costs from occurring in children without asthma would be a large benefit derived from a diagnostic strategy with a high specificity. This cost was estimated to be £201 from a study by Main et al.^{98,98}

1 12.5 Evidence statements

2 Clinical

- 3 • Two studies with 868 adults showed that bronchodilator reversibility ($\Delta FEV_1\%_{init} \geq 12\%$ and $\Delta FEV_1[L] \geq 0.2L$) has a sensitivity range of 0.17 to 0.65 and a corresponding specificity range of 0.61 to 0.81 for diagnosing asthma in people presenting with respiratory signs and symptoms and obstructive airways disease. (VERY LOW QUALITY)
- 4
- 5
- 6
- 7 • Two studies with 269 adults showed that bronchodilator reversibility ($\Delta FEV_1\%_{init} > 15\%$ and $\Delta FEV_1[L] > 0.2L$) has a sensitivity range of 0.69 to 0.69 and a corresponding specificity range of 0.55 to 0.71 for diagnosing asthma in people presenting with respiratory signs and symptoms and obstructive airways disease. (LOW QUALITY)
- 8
- 9
- 10
- 11 • No evidence was identified in children aged 5-16 years

12 Economic

- 13 • No relevant economic evaluations were identified.
- 14 • An original health economic model found that bronchodilator reversibility (together with spirometry, FeNO, peak expiratory flow variability and histamine or methacholine challenge test) was part of the most cost-effective diagnostic pathway used to diagnose asthma in adults aged 16 and over (see diagnostic algorithm in section 4.1). This evidence is directly applicable with minor limitations.
- 15
- 16
- 17
- 18

19 12.6 Recommendations and link to evidence

Recommendations	<p>10. Offer a bronchodilator reversibility (BDR) test to adults and young people older than 16 with obstructive spirometry (FEV_1/FVC ratio less than 70%). Regard an improvement in FEV_1 of 12% or more, together with an increase in volume of 200 ml or more, as a positive test.</p> <p>11. Offer a BDR test to children aged 5-16 years with obstructive spirometry (FEV_1/FVC ratio less than 70%). Regard an improvement in FEV_1 of 12% or more as a positive test.</p>
Relative values of different outcomes	<p>The GDG was interested in the utility of BDR for the diagnosis of asthma in adults and children over the age of 5.</p> <p>One of the concerns that set the scope of this guideline is the over-diagnosis of asthma leading to inappropriate treatment; therefore, the GDG was interested in both the sensitivity and specificity of diagnostic tests and prioritised studies which reported these outcomes. Sensitivity and specificity values will depend on the chosen cut-off point.</p> <p>The GDG considered the combination of a change in FEV_1 as percentage initial and an absolute change in volume in litres in response to a standard dose of bronchodilator to be more appropriate than either measure alone. This is in accordance with the ERS/ATS taskforce 2006 guideline. The GDG did not consider percentage change in FEV_1 alone because there is a risk of over-diagnosis in people with small initial lung volumes. The GDG did not consider absolute change in FEV_1 in litres alone because the relevance of this measure will depend on a patient's starting FEV_1. A gold standard test therefore would include both the percentage change in FEV_1 and the absolute change in FEV_1 in mls. The BDR test should always be performed following standard spirometry procedures (if there is an obstructive spirometry). The GDG discussed the diagnostic cut-offs used to identify a positive test, evidence was available for a threshold of 12% and 200ml and for a threshold of 15% and 200ml.</p>

	<p>No studies were identified using PEF to measure the extent of bronchodilator reversibility.</p>
Trade-off between clinical benefits and harms	<p>The studies included in the analysis demonstrated that BDR at a change in FEV1 threshold of 12% and 200ml has a moderate to high specificity and generally a lower sensitivity in the diagnosis of asthma. At this threshold, BDR could therefore be used reasonably well as a rule-in test. BDR at a change in FEV1 threshold of 15% and 200ml had both a moderate sensitivity and specificity.</p> <p>The GDG considered a change in FEV1 of $\geq 12\%$ and a change in volume of ≥ 200mls to be a more appropriate threshold as evidence of a positive test in response to a standard dose of bronchodilator. This is in accordance with the ERS/ATS taskforce 2006 guideline.</p> <p>All the studies included in the analysis were conducted in a population with obstructive spirometry. Therefore, the recommendation has been made specifically for this population. The GDG could not comment on the use of BDR in the context of normal spirometry.</p> <p>A BDR test is considered safe, quick and non-invasive, with no significant harms to the patient. A meaningful result will be useful, but will only be obtained if the test is correctly performed to standard spirometric guidance techniques by a trained professional. In particular, the GDG noted that in children the technique can be variable, and often needs repeating to ensure reliability. If small numbers for FEV1 are obtained, then they should be interpreted with caution. Children <5 years of age are unlikely to be able to perform the test reliably and thus the literature was not searched for this age group.</p>
Economic considerations	<p>No economic evaluations were found which assessed the use of bronchodilator reversibility as part of a diagnostic pathway. Therefore, an original health economic model was built to assess the cost-effectiveness of different diagnostic pathways for asthma. The model assessed the additional costs of tests against cost-savings from unnecessary asthma medication, and the increased health outcomes from providing correct treatment.</p> <p>The GDG agreed that bronchodilator reversibility tests should be used on all patients with an obstructive spirometry in all assessed diagnostic pathways. The reason is that a bronchodilator reversibility test can be performed at a low cost immediately after a spirometry and a positive result is recognised as strong indication that the individual has asthma. However the GDG noted that the clinical evidence showed it did not have a high specificity and that there were other obstructive airway diseases, such as COPD, that could produce a positive result. Due to this the GDG decided to assess diagnostic strategies where further testing is conducted after positive and negative BDR results and another strategy where no further testing is conducted after a positive BDR.</p> <p>The model results showed that the strategy that did no further testing after a positive BDR test was dominated. Therefore the cost-effectiveness of bronchodilator reversibility testing is contingent on the recommended diagnostic pathway being completed after the results are produced. Stopping the diagnostic pathway after the BDR is conducted will lead to higher costs and poorer health outcomes.</p> <p>The most cost-effective strategy involved using spirometry, bronchodilator reversibility (BDR), FeNO, peak expiratory flow variability (PEFv) and a methacholine challenge test (MCT) to diagnose asthma. In this strategy, everybody with symptoms of asthma would undergo a spirometry and FeNO test, those who had an obstructive spirometry would also receive a BDR test. Only those who had non-obstructive</p>

	<p>spirometry and conflicting FeNO and PEFv test results would receive a MCT. Adopting this strategy dominated all other strategies apart from those which performed challenge tests at more points in the pathway. The ICERs of adopting these further strategies were above £20,000 per QALY gained.</p> <p>For children the GDG considered the unit cost of conducting a bronchodilator reversibility test. The GDG noted that, unlike adults, there are far fewer diseases that would lead to an obstructive spirometry that does not reverse in children. Although there was no diagnostic accuracy evidence available for children the general consensus of the GDG, as well as the recommendations from other guidelines, suggests that a positive bronchodilator reversibility test is enough to confirm the diagnosis of asthma in children. Therefore in children a bronchodilator reversibility test has high value relative to its low cost. The GDG noted that a negative BDR test would not rule out the diagnosis of asthma and therefore there was value in further testing beyond this point to prevent false-negative diagnoses.</p>
Quality of evidence	<p>The quality of the evidence ranged from very low to low. Unfortunately, none of the studies available to assess the utility of BDR in diagnosing asthma were purpose-designed with this aim. The included population of the majority of the studies was people with asthma or COPD, rather than suspected asthma. These studies aimed to assess the diagnostic accuracy of BDR in distinguishing between asthma and COPD. These studies were included in the review due to limited evidence in the suspected asthma population. This was deemed relevant by the GDG as only populations with obstructive airways would be tested using BDR in the diagnostic algorithm. These people with either have asthma or COPD, and the task from this point onwards is to distinguish between them. The reference standard in the included studies was physician diagnosis. With the exception of two studies^{20,132}, it was unclear if the reference standard included an objective test for asthma. In one study¹³², it was unclear whether all people received the objective test. Again, due to limited evidence, these studies were included, but the quality of the evidence was downgraded for population and reference standard indirectness.</p> <p>The GDG noted that the dose and bronchodilator used for the BDR test varied between studies; however, they thought that this should not negate the results.</p> <ul style="list-style-type: none"> • In children aged <5 years, we did not search for studies as BDR is not able to be performed very well in this age group. • In children aged 5-16 years, there were no included studies that addressed the use of BDR in this age group. • In adults, there were four included studies that addressed the use of BDR in this age group. Evidence was of low and very low quality. <p>The economic evidence was assessed as directly applicable with minor limitations.</p>
Other considerations	<p>The GDG felt there was sufficient evidence to make a recommendation, based on the evidence. The GDG was interested in the place of BDR in an algorithm of tests to diagnose asthma.</p> <p>BDR is a commonly used, simple-to-perform test, that could be carried out in primary or secondary care by a trained professional to standard techniques, and most patients should have no difficulty performing the test.</p> <p>Children under 5 years old will be unable to perform this test reliably.</p> <p>There were no studies included for children 5-16 years old; for this reason, the recommendation is based on extrapolation from the adult data and thus limited by its directness.</p>

13 Diagnosis: Peak expiratory flow variability

13.1 Introduction

The peak expiratory flow (PEF) is an objective measure of lung function that has been widely used in the diagnosis and monitoring of asthma for many years. It is a measure of the maximum rate of expiration, generally expressed in litres/minute, and reduces as the airways become narrowed due to bronchoconstriction. Variations in PEF occurring in an individual over time, either spontaneously or in response to medication or to challenges with allergens or inhaled bronchoconstrictors, can be useful in demonstrating variable bronchoconstriction in diagnosing asthma and in assessing the degree of bronchoconstriction. It is assessed with a peak flow meter, a small, inexpensive hand-held device. A variety of peak flow meters are available, and they can be provided to individual patients for home monitoring. The level of peak flow variability (assessed typically as the best of 3 recordings measured between twice and four times a day) over a period of self-monitoring (e.g. 2 weeks) can be used as a diagnostic test for asthma, and similar monitoring during days at work and days away from work in the diagnosis of occupational asthma. Personal asthma action plans based on monitoring of the percentage of best PEF recorded are widely used. Although other measures of lung function can provide more detailed information, the ease of use and simple, inexpensive nature of the monitoring equipment have made PEF monitoring common and popular.

13.2 Review question: In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of peak expiratory flow (PEF) variability?

For full details see review protocol in Appendix C.

Table 30: PICO characteristics of review question

Component	Description
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">• Children/ young people (5-16 years old)• Adults (>16 years old)
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	Physician diagnosis of asthma based on symptoms plus an objective test
Outcomes	<ul style="list-style-type: none">• Diagnostic accuracy (sensitivity, specificity)

13.3 Clinical evidence

We searched for cross sectional studies, cohort studies, case series (including both retrospective and prospective analyses) assessing the diagnostic test accuracy of peak expiratory flow (PEF) variability to identify whether the condition is present (as indicated by the reference standard) in people under investigation for asthma.

Four studies were included in the review^{22,43,163,170} (see Table 31). Evidence from these studies is summarised in the summary tables and the clinical evidence profile below (Table 32). See also the

1 study selection flow chart in Appendix D, sensitivity / specificity forest plots in Appendix J, study
2 evidence tables in Appendix G and exclusion list in Appendix K.

3 All four studies assessed the diagnostic accuracy of PEF variability versus a physician diagnosis of
4 asthma plus objective tests. Two studies provided evidence in adults^{43,163} and two studies provided
5 evidence in children aged 5-16 years^{22,170}. These age groups were analysed in the separate strata.

6 Summary of included studies

7 **Table 31: Summary of studies included in the review**

Study	N	Index test/reference standard	Index test cut-off for positivity	Population	Age
PEF variability vs. reference standard (physician diagnosis with objective test)					
BROUWER 2010²²	61	PEF variation Asthma diagnosed by paediatric pulmonologist including history, physical examination and lung function tests including methacholine challenge	>95 th centile for healthy children i.e. $\geq 12.3\%$	Children with non-specific respiratory symptoms such as cough and breathlessness in whom GP uncertain of diagnosis	6 to 16 years; mean 10.4 years
DENOTTER1997⁴³	323	PEF variability = $(PEF_{\text{highest}} - PEF_{\text{lowest}}) / PEF_{\text{mean}} \times 100\%$ = amplitude % mean (average over period) Reference standard = physician diagnosis plus BHR, defined as a PC20 histamine of ≤ 8 mg/ml	>5% or 10% or 15%	Adults with signs or symptoms indicating asthma (persistent or recurrent respiratory symptoms or signs of reversible bronchial obstruction)	Adults 25–70 years old; mean 43 (12) years
THIADENS1998¹⁶³	170	PEF variability (DPV) = $(PEF_{\text{highest}} - PEF_{\text{lowest}}) / PEF_{\text{highest}} \times 100\%$ = amplitude % highest (a) MDPV = mean over 2 week period (b) DPV more than threshold on 4 days or more (c) DPV more than	Cut-off values: (a) MDPV > 10% and MDPV >15% (b) DPV >15% on 4 days or more (c) DPV >20% on 3 days or more	18–75 yrs of age, who consulted their GP with coughing that had lasted for at least 2 weeks	Mean 44 (16) years

Study	N	Index test/reference standard	Index test cut-off for positivity	Population	Age
		<p>threshold on 3 days or more</p> <p>Reference standard: A patient was considered to have asthma if there had been a previous period of respiratory symptoms for >3weeks in the last year, accompanied by a provocative dose causing a 20% fall in FEV1 (PD20) $\leq 15.6 \mu\text{mol}$ methacholine and/or reversibility $\geq 9\%$ of predicted</p>			
ULRIK2005¹⁷⁰	74 people with asthma out of sample of 609 adolescents and young adults in survey	<p>PEF variability (amp%mean)</p> <p>Reference standard:</p> <ol style="list-style-type: none"> 1) Histamine challenge test; cut off PC20 <16.0mg/mL histamine (airways hyper-reactivity) 2) Bronchodilator reversibility: change in FEV1 ($\Delta\text{FEV1}\%$post) >10% 	PEF amp%mean $\geq 20\%$	Current asthma (symptoms of asthma, episodes of wheezing and/or treatment for asthma in preceding 12 months)	Aged 13-23 years (mean 18.5 (2.8) years)

Table 32: Clinical evidence profile: PEF variability vs. Physician Dx of asthma

PEF variability (Threshold)	No of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Median Sensitivity % (range)	Median Specificity % (range) ^e	Area Under Curve (range)	Quality
ADULTS >16 years										
Diurnal PEFv as amp%mean (mean over 3 weeks >5%)	1	323	Serious risk of bias ^a	No serious inconsistency ^b	No serious indirectness	N/A ^c	0.56	0.69	-	MODERATE
Diurnal PEFv as amp%mean (mean over 3 weeks >10%)	1	323	Serious risk of bias ^a	No serious inconsistency ^b	No serious indirectness	N/A ^c	0.14	0.96	-	MODERATE
Diurnal PEFv as amp%mean (mean over 3 weeks >15%)	1	323	Serious risk of bias ^a	No serious inconsistency ^b	No serious indirectness	N/A ^c	0.05	0.98	-	MODERATE
Diurnal PEFv as amp%highest (diurnal variation >15% on 4 or more days)	1	170	No risk of bias ^a	No serious inconsistency ^b	No serious indirectness	N/A ^c	0.20	0.97	-	HIGH
Diurnal PEFv as amp%highest (diurnal variation >20% on 3 or more days)	1	170	No risk of bias ^a	No serious inconsistency ^b	No serious indirectness	N/A ^c	0.12	0.99	-	HIGH
Diurnal PEFv as amp%highest (mean over 2 weeks >10%)	1	170	No risk of bias ^a	No serious inconsistency ^b	No serious indirectness	N/A ^c	0.14	0.97	-	HIGH
Diurnal PEFv as amp%highest (mean over 2 weeks >15%)	1	170	No risk of bias ^a	No serious inconsistency ^b	No serious indirectness	N/A ^c	0.03	0.99	-	HIGH
CHILDREN 5-16 years										
Diurnal PEFv as amp%mean (mean over 2 weeks >12.3%)	1	61	No risk of bias ^a	No serious inconsistency ^b	No serious indirectness	N/A ^c	0.50	0.72	-	HIGH
Amp%mean (>20% versus PC20 histamine >16mg/ml)	1	74	No risk of bias ^a	No serious inconsistency ^b	No serious indirectness	N/A ^c	0.46	0.80	-	HIGH
Amp%mean (>20% versus bronchodilator reversibility change in FEV1 >10%)	1	74	No risk of bias ^a	No serious inconsistency ^b	No serious indirectness	N/A ^c	0.71	0.58	-	HIGH

(a) Risk of bias was assessed using the QUADAS-II checklist. Outcomes were downgraded by one if the weighted (by sample size (n)) average number of QUADAS-II domains (patient selection, index test, reference standard and flow and timing) with methodological limitations was one. Outcomes were downgraded by two if the weighted average number of QUADAS-II domains with methodological limitations was more than one.

(b) Inconsistency was assessed by inspection of the sensitivity / specificity values in each of the studies in relation to a high (≥75%), moderate (50-74%) or low (<50%) effect estimate. Inconsistency was considered high if the point estimates from individual studies were within two areas, and very high if they were in 3 areas or both high and low areas.

(c) The judgement of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis, where performed

13.4 Economic evidence

Published literature

No relevant economic evaluations were identified.

See also the economic article selection flow chart in Appendix E.

New cost-effectiveness analysis

An original health economic model was built for adults to assess the cost-effectiveness of several diagnostic pathways, which included peak expiratory flow variability. Full details of the model can be found in Appendix M. A summary of the model can be found in section 18.4.

Unit costs of performing peak expiratory flow variability on children

As an economic model was not feasible for children, the GDG considered the unit cost of performing peak expiratory flow variability to evaluate its cost-effectiveness as part of a pathway for diagnosing asthma. This unit cost is presented below (Table 33).

Table 33: Cost of peak expiratory flow variability

Item	Quantity ^(a)	Unit cost	Total Cost (quantity*unit cost)	Source of unit cost
Time taken to instruct patient how to use test with GP practice nurse	10 minutes	£0.73 per minute	£7.30	PSSRU ³⁹
Time taken to interpret results by GP practice nurse	10 minutes	£0.73 per minute	£7.30	PSSRU ³⁹
Mini wright peak flow meter	1	£6.48 per meter	£6.48	NHS supply catalogue ⁴⁶
Total			£21.08	

(a) Based on GDG opinion.

The GDG also acknowledged the annual cost of drugs for the management of asthma in children. Preventing these costs from occurring in children without asthma would be a large benefit derived from a diagnostic strategy with a high specificity. This cost was estimated to be £201 from a study by Main et al.^{98,98}

13.5 Evidence statements

Clinical

- One study with 323 adults showed that PEF variability (mean amp%mean >5%) has a sensitivity of 0.56 and a corresponding specificity of 0.69 for diagnosing asthma in people presenting with respiratory signs and symptoms. (MODERATE QUALITY)
- One study with 323 adults showed that PEF variability (mean amp%mean >10%) has a sensitivity of 0.14 and a corresponding specificity of 0.96 for diagnosing asthma in people presenting with respiratory signs and symptoms. (MODERATE QUALITY)

- 1 • One study with 323 adults showed that PEF variability (mean amp%mean >15%) has a sensitivity
2 of 0.05 and a corresponding specificity of 0.98 for diagnosing asthma in people presenting with
3 respiratory signs and symptoms. (MODERATE QUALITY)
- 4 • One study with 170 adults showed that PEF variability (amp%highest >15% on 4 days or more) has
5 a sensitivity of 0.20 and a corresponding specificity of 0.97 for diagnosing asthma in people
6 presenting with respiratory signs and symptoms. (HIGH QUALITY)
- 7 • One study with 170 adults showed that PEF variability (amp%highest >20% on 3 days or more) has
8 a sensitivity of 0.12 and a corresponding specificity of 0.99 for diagnosing asthma in people
9 presenting with respiratory signs and symptoms. (HIGH QUALITY)
- 10 • One study with 170 adults showed that PEF variability (mean amp%highest >10%) has a sensitivity
11 of 0.14 and a corresponding specificity of 0.97 for diagnosing asthma in people presenting with
12 respiratory signs and symptoms. (HIGH QUALITY)
- 13 • One study with 170 adults showed that PEF variability (mean amp%highest >15%) has a sensitivity
14 of 0.03 and a corresponding specificity of 0.99 for diagnosing asthma in people presenting with
15 respiratory signs and symptoms. (HIGH QUALITY)
- 16 • One study with 61 children and young people showed that PEF variability (mean amp%mean
17 >12.3%) has a sensitivity of 0.50 and a corresponding specificity of 0.72 for diagnosing asthma in
18 people presenting with respiratory signs and symptoms. (HIGH QUALITY)
- 19 • One study with 74 children and young people showed that PEF variability (amp%mean >20%
20 versus PC20 histamine >16mg/mL) has a sensitivity of 0.46 and a corresponding specificity of 0.80
21 for diagnosing asthma in people presenting with respiratory signs and symptoms. (HIGH QUALITY)
- 22 • One study with 74 children and young people showed that PEF variability (amp%mean >20%
23 versus bronchodilator reversibility change in FEV1 >10%) has a sensitivity of 0.71 and a
24 corresponding specificity of 0.58 for diagnosing asthma in people presenting with respiratory
25 signs and symptoms. (HIGH QUALITY)

26 Economic

- 27 • No relevant economic evaluations were identified.
- 28 • An original health economic model found that peak expiratory flow variability (together with
29 spirometry, bronchodilator reversibility, FeNO and histamine or methacholine challenge test) was
30 part of the most cost-effective diagnostic pathway used to diagnose asthma in adults aged 16 and
31 over (see diagnostic algorithm in section 4.1). This evidence is directly applicable with minor
32 limitations.

33 13.6 Recommendations and link to evidence

Recommendations	<p>12. 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:</p> <ul style="list-style-type: none"> • 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 39 parts per billion (ppb) or less. <p>Regard a value of more than 20% variability as a positive test.</p> <p>13. 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:</p>
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	<ul style="list-style-type: none"> • obstructive spirometry and • irreversible airways obstruction (negative BDR) and • a FeNO level between 25 and 39 ppb. <p>Regard a value of more than 20% variability as a positive test.</p> <p>14. 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:</p> <ul style="list-style-type: none"> • 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. <p>Regard a value of more than 20% variability as a positive test.</p>
Relative values of different outcomes	<p>One of the concerns that set the scope of this guideline is the over-diagnosis of asthma leading to inappropriate treatment; therefore, the GDG was interested in both the sensitivity and specificity of diagnostic tests and prioritised studies which reported these outcomes. Sensitivity and specificity values will depend on the chosen cut-off point.</p> <p>Data were available from a wide range of PEF variability measures and cut-off thresholds. The GDG was primarily interested in diurnal PEFv as the amplitude as a percentage of the highest daily PEF. One study reported the diurnal variation as the amplitude as a percentage of the mean. It was acknowledged that this is slightly different to the amplitude as a percentage of the highest or lowest, and may give different estimates of accuracy, although the two indices will correlate closely since their derivation is so similar.</p> <p>Ideally, the diurnal variation should then be averaged over a period of 2 or more weeks. Recordings over only a few days have less chance of capturing the day to day variation which is classical of asthma. The traditional cut-off for normality is a variability of >20% (as recommended by the BTS/SIGN guideline). Some studies reported cut-off thresholds of >5%, >10% or >15%. However, the GDG was concerned that a lower cut-off threshold would lead to more false positives and over-diagnosis of asthma. As expected, higher percentage variability cut-off thresholds increased the specificity of the test. This is at the expense of a decreased sensitivity. However, the GDG was interested in PEFv as part of a diagnostic algorithm, and a negative result on its own would not be used to rule-out asthma.</p> <p>The GDG proposes a variability of greater than 20% in PEF readings in accordance with consensus practice. The GDG recognises that this cut-off is most appropriate when 4 readings a day are taken, but this may be compromised in routine practice due to patient concordance. The GDG noted that healthcare professionals will need to calculate the amplitude of variation of PEF. The common practice of looking at the pattern of variation in a diary is unlikely to be as accurate.</p>
Trade-off between clinical benefits and harms	<p>In adults, only one study reported a PEFv at the widely used cut-off threshold of >20%. However, this used a daily variability of >20% on 3 or more days as the cut-off threshold, rather than the mean variability over 2-3 weeks. This was considered acceptable as a person with asthma would not necessarily have >20% variation every single day, and it was the only available evidence at the 20% threshold. At this threshold, PEFv had a high specificity but a low sensitivity for the diagnosis of asthma. PEFv would therefore be a better rule-in than rule-out test.</p> <p>The GDG noted that within a research environment, PEFv is a relatively specific test and can be used to positively rule in asthma. However, in clinical practice it is likely</p>

	<p>that there will be more false positives, since inaccurate recording is less likely in a trial setting.</p> <p>The PEFv diary is simple, non-invasive and available in primary care, and there are no significant risks to the patient in performing PEF recording. The GDG noted that it is currently a mainstay of the primary care diagnostic process for asthma. However, its utility is limited in clinical practice as the test relies on patient technique, effort and concordance with the frequency of readings.</p> <p>The GDG discussed the use of PEFv in children. Children under 5 are unable to reliably perform the technique. In older children, PEF monitoring may be difficult to use given lower concordance in children and reliability of repeated readings. The available evidence suggested the specificity was lower in children aged 5-16 years than in adults, and although the sensitivity was higher, it was still moderate to low. The GDG noted that as not all children would receive a PEFv test the average unit cost of including PEFv in the proposed diagnostic algorithm would be less.</p>
Economic considerations	<p>No economic evaluations were found which assessed the use of PEFv as part of a diagnostic pathway. Therefore, an original health economic model was built to assess the cost-effectiveness of different diagnostic pathways for asthma. The model assessed the additional costs of tests against cost-savings from unnecessary asthma medication, and the increased health outcomes from providing correct treatment.</p> <p>The GDG decided that PEFv should appear further down a diagnostic pathway as FeNO had a higher sensitivity and specificity and could therefore confirm an asthma diagnosis sooner when combined with spirometry and BDR results. Due to this, there was not one pathway where PEFv was given to all patients; instead, it was reserved for patients who could not perform a BDR or did not have a clear diagnosis using the results from spirometry, BDR and FeNO. There were two strategies which did not include PEFv. The strategies which included PEFv dominated those without it; therefore, the model supports the notion that PEFv is a cost-effective test to use following certain diagnostic pathways.</p> <p>The most cost-effective strategy involved using spirometry, bronchodilator reversibility (BDR), FeNO, peak expiratory flow variability (PEFv) and a methacholine challenge test (MCT) to diagnose asthma. In this strategy, everybody with symptoms of asthma would undergo a spirometry and FeNO test, those who had an obstructive spirometry would also receive a BDR test. Only those who had non-obstructive spirometry and conflicting FeNO and PEFv test results would receive a MCT. Adopting this strategy dominated all other strategies apart from those which performed challenge tests at more points in the pathway. The ICERs of adopting these further strategies were above £20,000 per QALY gained.</p> <p>For children the GDG considered the unit cost of performing a PEFv test. The GDG noted from the clinical review that PEFv tests had a moderate/high specificity and a moderate sensitivity. Therefore a positive result was likely to indicate asthma whereas a negative result would not rule out asthma. The GDG therefore felt that due to its low cost conducting PEFv would have value in a diagnostic pathway as it would help differentiate those where asthma should be suspected from those who almost definitely have asthma. This would lead to fewer false positives and better health outcomes.</p>
Quality of evidence	<p>The quality of evidence ranged from moderate to high in adults. For the ideal cut-off threshold of 20%, evidence was of high quality, but the evidence was only available from one study. In children aged 5-16 years, the quality of the evidence was high; however, the evidence for each PEFv measure was only available from one small study. The included studies varied in terms of the length of diary monitoring. Most studies stipulated at least 4 readings a day, perhaps more than what would be</p>

	<p>expected in clinical practice. The GDG felt that within the limits mentioned above, the included studies could be interpreted with a degree of caution.</p> <ul style="list-style-type: none"> • In children aged <5 years, we did not search for studies as PEFv cannot be performed in this age group. • In children aged 5-16 years, there were two included studies (Brouwer 2010, Ulrik 2005) using the best reference standard (physician diagnosis with objective test) that addressed the use of PEFv in this age group. The evidence at the preferred cut-off value of 20% was of high quality. • In adults, there were two included studies (Thiadens 1998, and Denotter 1997) using the best reference standard (physician diagnosis with objective test) that addressed the use of PEFv in this age group. The evidence at the preferred cut-off value of 20% was of high quality. <p>The economic evidence was assessed as directly applicable with minor limitations.</p>
Other considerations	<p>The evidence suggests that PEF variability has some value as a rule-in test for asthma (specificity was high) and it has the advantage of being well-established for use in primary care. However, the studies did not give a clear indication of the optimal cut-off point for clinical use.</p> <p>The PEF diary is currently a key tool in primary care, particularly in adults. It is a good test to rule in asthma in children over the age of 5 as well as adults, but it is subject to wider variability in clinical practice than it is likely to be seen in clinical trials and thus the applicability of trial evidence is perhaps limited.</p> <p>PEF recording is not possible in children less than 5 and requires concordance of the patient and good technique to obtain reproducible accurate readings. Some patient groups may struggle with this.</p>

14 Diagnosis: Skin prick tests

14.1 Introduction

Asthma can be divided into extrinsic asthma (atopic or allergic), intrinsic asthma (non-atopic) and occupational asthma. Allergic asthma is the commonest type, is associated with atopy and usually develops in childhood or early adulthood. Atopy is defined as a genetic predisposition to produce immunoglobulin E (IgE) against common environmental aeroallergens such as house dust mites, animal dander, pollens and moulds. Approximately 80% of people with asthma are atopic compared with 30% of the general population.

People with allergic asthma are initially sensitised to allergens and subsequently develop symptoms on re-exposure. Continued exposure may lead to a chronic inflammatory response, which is characterised by persistent symptoms, airways hyper-reactivity and bronchospasm.

Skin prick tests for the most common aeroallergens can be performed to confirm the presence or absence of atopy to individual aeroallergens. However, the diagnostic test accuracy of skin prick tests to diagnose asthma is currently uncertain.

14.2 Review question: In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of skin prick tests?

For full details see review protocol in Appendix C.

Table 34: PICO characteristics of review question

Component	Description
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"> • Children (1-<5 years old) • Children/young people (5-16 years old) • Adults (>16 years old)
Index test	<p>Skin prick tests for the most common allergens (report separately)</p> <ul style="list-style-type: none"> • House dust mites • Cat • Dog • Grass pollen* (native UK grasses) • Tree pollen* (native UK trees) • Mixed pollens* (native UK species) • <i>Aspergillus</i> • <i>Alternaria</i> • <i>Cladosporium</i> <p>Cut off values: 3mm WHEAL (skin reaction) greater than the negative control in the presence of a positive control</p>
Reference standard	<p>Physician diagnosis of asthma based on symptoms plus an objective test.</p> <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.</p>

Outcomes	<ul style="list-style-type: none"> Diagnostic accuracy (sensitivity, specificity)
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1 14.3 Clinical evidence

2 We searched for cross sectional studies, cohort studies, case series (including both retrospective and
3 prospective analyses) assessing the diagnostic test accuracy of skin prick tests to identify whether the
4 condition is present (as indicated by the reference standard) in people under investigation for
5 asthma.

6 Six studies were included in the review^{50,57,100,103,129,158}. Evidence from these are summarised in Table
7 35 and the clinical evidence profile below (Table 36). See also the study selection flow chart in
8 Appendix D, forest plots in Appendix J, study evidence tables in Appendix G and exclusion list in
9 Appendix K.

10 Three of the studies^{50,129,158} fully complied with the protocol (ie. the reference standard included an
11 objective test for asthma). Out of these three studies, two were in adults and the other study was in
12 children, these strata were reported separately. The other three studies^{57,100,103} did not mention an
13 objective test as part of the reference standard. The reference standard was a physician diagnosis of
14 asthma. These studies were included since there was very little evidence otherwise, but were
15 reported separately in the analysis. Of these studies, two fell into the 5-16 years strata and one fell
16 into the adult strata, however the mean age was not reported in two of the studies. No evidence was
17 identified in children aged <5 years.

18 Summary of included studies

19 **Table 35: Summary of studies included in the review**

Study	N	Index test	Index test cut-off for positivity	Population	Age
Skin prick test vs. reference standard (physician diagnosis with objective test)					
DRKULEC 2013 ⁵⁰	131 (N=71 asthma)	<ul style="list-style-type: none"> SPT for Dust mite <i>D. pteronyssinus</i> <i>Ambrosia artemisifoliae</i> <i>Phleum pratense</i> 	Not stated. Each allergen separately or positive SPT to 1 or more allergens	Children with chronic cough	Median 7.5 years
POPOVIC 2002	N=195 (N=141 asthma)	<ul style="list-style-type: none"> SPT for ≥1 aeroallergen (dust mite <i>D. pteronyssinus</i>, grass pollen, tree pollen, cat fur, dog fur) 	Wheal ≥3mm	Suspected asthma: had dyspnoea and treated for breathlessness.	Mean 36.5 years
SORIANO 1999A	N=1816 (N=136 asthma)	<ul style="list-style-type: none"> SPT for ≥1 aeroallergen Also Individual allergens: <ul style="list-style-type: none"> Dust mite <i>D. pteronyssinus</i> <i>Cladosporium</i> <i>Alternaria</i> Timothy grass Birch pollen 	Wheal ≥3mm	Suspected asthma: subsample of general population who had respiratory symptoms	Mean 32 years

Study	N	Index test	Index test cut-off for positivity	Population	Age
		<ul style="list-style-type: none"> Cat 			
Skin prick test vs. reference standard (physician diagnosis without objective test)					
GAIG 1999 ⁵⁷	94 (N=41 asthma)	<ul style="list-style-type: none"> Dust mite <i>D. pteronyssinus</i> and <i>D. farina</i> 	Skin wheal diameter to at least one of the two mites 3mm larger than control	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)	Mean 16 years (range not reported)
MAY 1990 ¹⁰⁰	446 (N=190 asthma)	<ul style="list-style-type: none"> <i>Gramineae</i> (grasses both wild and cultivated) <i>Artemisia vulgaris</i> (weed: mugwort) 	3+ or 4+	Consecutive unselected patients for allergological consultation for conjunctivitis, rhinitis and/or asthma which appeared or deteriorated in late spring and summer	Range 6 - 56 years, (mean not reported)
MIRAGLIA DEL GIUDICE 2002 ¹⁰³	1426 (N=925 asthma)	<ul style="list-style-type: none"> SPT for ≥ 1 aeroallergen [house dust mites, HDM (<i>D. pteronyssinus</i> and <i>D. farina</i>), <i>Parietaria officinalis</i>, 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 	Wheal was at least 3 mm in diameter	Children referred to Paediatric Asthma and Allergy Center because of allergic symptoms: children in whom a diagnosis of asthma, allergic rhinoconjunctivitis, atopic dermatitis or food allergy was confirmed by a pediatric allergologist.	Range 0 - 12 years, (mean not reported)

1

SPT = skin prick test; BPT = bronchial provocation test; IST = intradermal skin test

Table 36: Clinical evidence profile: Skin prick test vs. Physician Dx of asthma

Skin prick test	No of studies	N	Risk of bias	Inconsistency	Indirectness	Imprecision	Median Sensitivity % (range)	Median Specificity % (range) ^e	Area Under Curve (range)	Quality
PHYSICIAN DX WITH OBJECTIVE TEST										
ADULTS										
<i>D. pteronyssinus</i> (Der P) +/- <i>D. farinae</i> (house dust mite).	1	1816	Serious risk of bias ^a	No serious inconsistency ^b	Serious indirectness ^e	N/A ^d	0.39	0.80	-	LOW
<i>Alternaria tenuis</i> (mould).	1	1816	Serious risk of bias ^a	No serious inconsistency ^b	Serious indirectness ^e	N/A ^d	0.07	0.99	-	LOW
≥1 positive from mixed allergens (all studies included mite and grass, plus ≥1 of weed, tree, dust, cat, dog, feathers, mould, egg, milk).	2	2011	Serious risk of bias ^a	No serious inconsistency ^b	Serious indirectness ^e	N/A ^d	Range 0.61 – 0.62	Range 0.63-0.69	-	LOW
Grasses mixed or timothy only.	1	1816	Serious risk of bias ^a	No serious inconsistency ^b	Serious indirectness ^e	N/A ^d	0.32	0.87	-	LOW
<i>Cladosporium</i>	1	1816	Serious risk of bias ^a	No serious inconsistency ^b	Serious indirectness ^e	N/A ^d	0.07	0.97	-	LOW
Cat	1	1816	Serious risk of bias ^a	No serious inconsistency ^b	Serious indirectness ^e	N/A ^d	0.21	0.94	-	LOW
CHILDREN 5-16 years										
<i>D. pteronyssinus</i> (Der P) +/- <i>D. farinae</i> (house dust mite).	1	131	Serious risk of bias ^a	No serious inconsistency ^b	No serious indirectness	N/A ^d	0.83	0.71	-	MODERATE
<i>Phleum pratense</i> (Phl P) timothy grass from Gramineae family.	1	131	Serious risk of bias ^a	No serious inconsistency ^b	No serious indirectness	N/A ^d	0.66	0.50	-	MODERATE
<i>Ambrosia artemisiifoliae</i> (Amb A) common ragweed.	1	131	Serious risk of bias ^a	No serious inconsistency ^b	No serious indirectness	N/A ^d	0.66	0.48	-	MODERATE
≥1 positive from mixed allergens (all studies included mite and grass, plus ≥1 of weed, tree, dust, cat, dog, feathers, mould, egg, milk).	1	131	Serious risk of bias ^a	Serious inconsistency ^b	No serious indirectness	N/A ^d	0.79	0.92	-	MODERATE

Skin prick test	No of studies	N	Risk of bias	Inconsistency	Indirectness	Imprecision	Median Sensitivity % (range)	Median Specificity % (range) ^e	Area Under Curve (range)	Quality
Grasses mixed or timothy only.	1	131	Serious risk of bias ^a	No serious inconsistency ^b	No serious indirectness	N/A ^d	0.66	0.50	-	MODERATE
CHILDREN <5 years										
No evidence identified	0									
PHYSICIAN DX - NO OBJECTIVE TEST										
ADULTS										
<i>Gramineae</i> (grasses) both wild and cultivated.	1	446	Serious risk of bias ^a	No serious inconsistency ^b	Serious indirectness ^c	N/A ^d	0.89	0.11	-	LOW
<i>Artemisia vulgaris</i> (mugwort).	1	446	Serious risk of bias ^a	No serious inconsistency ^b	Serious indirectness ^c	N/A ^d	0.48	0.63	-	LOW
Grasses mixed or timothy only.	1	446	Serious risk of bias ^a	No serious inconsistency ^b	Serious indirectness ^c	N/A ^d	0.89	0.11	-	LOW
CHILDREN 5-16 years										
<i>D. pteronyssinus</i> (Der P) +/- <i>D. farinae</i> (house dust mite).	1	67	Serious risk of bias ^a	No serious inconsistency ^b	Serious indirectness ^c	N/A ^d	0.85	0.35	-	LOW
≥1 positive from mixed allergens (all studies included mite and grass, plus ≥1 of weed, tree, dust, cat, dog, feathers, mould, egg, milk).	1	1426	No risk of bias	No serious inconsistency ^b	Serious indirectness ^c	N/A ^d	0.44	0.56	-	MODERATE
CHILDREN <5 years										
No evidence identified	0									

1 (a) Risk of bias was assessed using the QUADAS-II checklist. Outcomes were downgraded by one if the weighted (by sample size (n)) average number of QUADAS-II domains (patient
2 selection, index test, reference standard and flow and timing) with methodological limitations was one. Outcomes were downgraded by two if the weighted average number of QUADAS-II
3 domains with methodological limitations was more than one.

4 (b) Inconsistency was assessed by inspection of the sensitivity / specificity values in each of the studies in relation to a high (≥75%), moderate (50-74%) or low (<50%) effect estimate.
5 Inconsistency was considered high if the point estimates from individual studies were within two areas, and very high if they were in 3 areas or both high and low areas.

6 (c) None of the studies had objective test as part of the physician's diagnosis of asthma. Population age range spans adult and children population strata with no subgroup analysis.

7 (d) The judgement of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis, where performed.

8 (e) Population is people with symptoms identified from a questionnaire in the general population (not visiting the GP with symptoms).

1 14.4 Economic evidence

2 Published literature

3 No relevant economic evaluations were identified.

4 See also the economic article selection flow chart in Appendix E.

5 Unit costs

6 In the absence of recent UK cost-effectiveness analysis, relevant unit costs were provided to aid
7 consideration of cost-effectiveness. The GDG considered this unit cost alongside the diagnostic
8 pathway evaluated in the economic model.

9 The cost of a skin prick test was identified using the NHS reference costs⁴⁴. Skin prick tests fall under
10 the HRG code JC11Z 'Other Diagnostic Skin Tests', the OPCS code is U27.8. The average 'Total HRG'
11 unit cost is quoted as £195. The GDG agreed that 'outpatient with procedure' was the only setting a
12 skin prick test would be performed in for the consideration on asthma patients. The unit cost quoted
13 for this setting is £173 and it was therefore agreed that this is the most relevant cost to use for skin
14 prick tests.

15 14.5 Evidence statements

16 Clinical

17 *Physician Dx with objective test:*

- 18 • One study with 1816 adults showed that skin prick test (D. pteronyssinus (Der P) +/- D. farina
19 (house dust mite)) has a sensitivity of 0.39 and a corresponding specificity of 0.80 for diagnosing
20 asthma in people presenting with respiratory signs and symptoms. (LOW QUALITY)
- 21 • One study with 1816 adults showed that skin prick test (Alternaria temius (mould)) has a
22 sensitivity of 0.07 and a corresponding specificity of 0.99 for diagnosing asthma in people
23 presenting with respiratory signs and symptoms. (LOW QUALITY)
- 24 • Two studies with 2011 adults showed that skin prick test (≥ 1 positive from mixed allergens (all
25 studies included mite and grass, plus ≥ 1 of weed, tree, dust, cat, dog, feathers, mould, egg, milk))
26 has a sensitivity range of 0.61 to 0.62 and a corresponding specificity range of 0.63 to 0.69 for
27 diagnosing asthma in people presenting with respiratory signs and symptoms. (LOW QUALITY)
- 28 • One study with 1816 adults showed that skin prick test (grasses mixed or timothy only) has a
29 sensitivity of 0.32 and a corresponding specificity range of 0.87 for diagnosing asthma in people
30 presenting with respiratory signs and symptoms. (LOW QUALITY)
- 31 • One study with 1816 adults showed that skin prick test (Cladosporium) has a sensitivity of 0.07
32 and a corresponding specificity of 0.97 for diagnosing asthma in people presenting with
33 respiratory signs and symptoms. (LOW QUALITY)
- 34 • One study with 1816 adults showed that skin prick test (cat) has a sensitivity of 0.21 and a
35 corresponding specificity of 0.94 for diagnosing asthma in people presenting with respiratory
36 signs and symptoms. (LOW QUALITY)
- 37 • One study with 131 children and young people showed that skin prick test (D. pteronyssinus (Der
38 P) +/- D. farina (house dust mite)) has a sensitivity of 0.83 and a corresponding specificity of 0.71
39 for diagnosing asthma in people presenting with respiratory signs and symptoms. (MODERATE
40 QUALITY)
- 41 • One study with 131 children and young people showed that skin prick test (Phleum pratense (Phl
42 P) timothy grass from Gramineae family) has a sensitivity of 0.66 and a corresponding specificity

- 1 of 0.50 for diagnosing asthma in people presenting with respiratory signs and symptoms.
2 (MODERATE QUALITY)
- 3 • One study with 131 children and young people showed that skin prick test (Ambrosia
4 artemisifoliae (Amb A) common ragweed) has a sensitivity of 0.66 and a corresponding specificity
5 of 0.48 for diagnosing asthma in people presenting with respiratory signs and symptoms.
6 (MODERATE QUALITY)
 - 7 • One study with 131 children and young people showed that skin prick test (≥ 1 positive from
8 mixed allergens (all studies included mite and grass, plus ≥ 1 of weed, tree, dust, cat, dog,
9 feathers, mould, egg, milk)) has a sensitivity of 0.79 and a corresponding specificity of 0.92 for
10 diagnosing asthma in people presenting with respiratory signs and symptoms. (MODERATE
11 QUALITY)
 - 12 • One study with 131 children and young people showed that skin prick test (grasses mixed or
13 timothy only) has a sensitivity of 0.66 and a corresponding specificity of 0.50 for diagnosing
14 asthma in people presenting with respiratory signs and symptoms. (MODERATE QUALITY)
 - 15 • No evidence was identified in children <5 years

16 *Physician Dx with no objective test:*

- 17 • One study with 446 adults showed that skin prick test (Gramineae (grasses) both wild and
18 cultivated) has a sensitivity of 0.89 and a corresponding specificity of 0.11 for diagnosing asthma
19 in people presenting with respiratory signs and symptoms. (LOW QUALITY)
- 20 • One study with 446 adults showed that skin prick test (Altemisia vulgaris (mugwort)) has a
21 sensitivity of 0.48 and a corresponding specificity of 0.63 for diagnosing asthma in people
22 presenting with respiratory signs and symptoms. (LOW QUALITY)
- 23 • One study with 446 adults showed that skin prick test (grasses mixed or timothy only) has a
24 sensitivity of 0.89 and a corresponding specificity of 0.11 for diagnosing asthma in people
25 presenting with respiratory signs and symptoms. (LOW QUALITY)
- 26 • One study with 67 children and young people showed that skin prick test (D. pteronyssinus (Der P)
27 +/- D. farina (house dust mite)) has a sensitivity of 0.85 and a corresponding specificity of 0.35 for
28 diagnosing asthma in people presenting with respiratory signs and symptoms. (LOW QUALITY)
- 29 • One study with 1426 children and young people showed that skin prick test (≥ 1 positive from
30 mixed allergens (all studies included mite and grass, plus ≥ 1 of weed, tree, dust, cat, dog,
31 feathers, mould, egg, milk)) has a sensitivity of 0.44 and a corresponding specificity of 0.56 for
32 diagnosing asthma in people presenting with respiratory signs and symptoms. (MODERATE
33 QUALITY)
- 34 • No evidence was identified in children <5 years

35 **Economic**

- 36 • No relevant economic evaluations were identified.

37 **14.6 Recommendations and link to evidence**

38 Please see section 15.6.

15 Diagnosis: Serum IgE measures

15.1 Introduction

Asthma can be divided into extrinsic asthma (atopic or allergic), intrinsic asthma (non-atopic) and occupational asthma. Allergic asthma is the commonest type, is associated with atopy and usually develops in childhood or early adulthood. Atopy is defined as a genetic predisposition to produce immunoglobulin E (IgE) against common environmental aeroallergens such as house dust mites, animal dander, pollens and moulds. Approximately 80% of people with asthma are atopic compared with 30% of the general population.

People with allergic asthma are initially sensitised to allergens and subsequently develop symptoms on re-exposure. Continued exposure may lead to a chronic inflammatory response, which is characterised by persistent symptoms, airways hyper-reactivity and bronchospasm.

Both total IgE and IgE specific for aeroallergens can be measured in the serum of individual patients. As a large proportion of people with asthma are atopic, this raises the question of whether measuring total or specific IgE is a good diagnostic test, in the diagnosis of asthma in people presenting with symptoms.

15.2 Review question: In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of total and specific serum IgE measures?

For full details see review protocol in Appendix C.

Table 37: PICO characteristics of review question

Population	<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"> • Children (1-<5 years old) • Children/young people (5-16 years old) • Adults (>16 years old)
Index test	<p>Serum IgE</p> <ul style="list-style-type: none"> • Total IgE • Specific IgE* (including RAST test) <p>*Report separately 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</p> <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.</p>
Outcomes	<ul style="list-style-type: none"> • Diagnostic accuracy (sensitivity, specificity)

1 15.3 Clinical evidence

2 We searched for cross sectional studies, cohort studies, case series (including both retrospective and
3 prospective analyses) assessing the diagnostic test accuracy of total and specific serum IgE to identify
4 whether the condition is present (as indicated by the reference standard) in people under
5 investigation for asthma.

6 Five studies were included in the review^{2,92,128,157,167}. Evidence from these are summarised in Table 38
7 and the clinical evidence profile below (Table 39). See also the study selection flow chart in Appendix
8 D, forest plots in Appendix J, study evidence tables in Appendix G and exclusion list in Appendix K. All
9 studies were conducted in adults. No evidence was identified for the strata of children aged 5-16
10 years or children <5 years.

11 All of the included studies^{2,92,128,157,167} were cross-sectional studies, and looked at the diagnostic
12 accuracy of IgE in the diagnosis of asthma in a general population, but were included as no evidence
13 was identified in people with suspected asthma. Therefore, the evidence was downgraded for
14 population indirectness. With the exception of one study⁹², the reference standard of asthma
15 diagnosis was established from responses to a questionnaire about previous physician diagnosis, and
16 did not include an objective test. However, due to limited evidence, these studies were included and
17 downgraded in quality. One study⁹² included a skin prick test as an objective test, however this only
18 confirms allergy and is not an objective test for asthma diagnosis.

19 Summary of included studies

20 **Table 38: Summary of studies included in the review: IgE versus reference standard (adults)**

Study	N	Index test/reference standard	Index test cut-off for positivity	Population	Age
ABRAHAM 2007 ²	702 (N=493 asthma)	Specific IgE <ul style="list-style-type: none"> • Dust mite • Grass (timothy) • <i>Alternaria</i> • Cat • Dog 	≥0.35 kU/l	Pregnant women	Adults (21-49 yrs)
LINNEBERG 2006 ⁹²	709 (N=51 asthma)	Specific IgE <ul style="list-style-type: none"> • Pollen • Dust mite 	≥0.35 kU/l	General population sample	Adults (15-69 yrs)
PLASCHKE 1999A ¹²⁸	1572 (N=84 asthma)	Specific IgE <ul style="list-style-type: none"> • Dust mite • Grass • Birch • <i>Cladosporium</i> • Cat 	≥0.70 kU/l	General population sample	Adults (20-44 yrs)
SORIANO 1999 ¹⁵⁷	1816 (N=136 asthma)	Specific IgE or SPT <ul style="list-style-type: none"> • <i>Cladosporium</i> • Dust mite • Grass (timothy) • Cat 	≥0.35 kU/l	General population sample	Adults (20-44 yrs)
TSCHOPP 1998 ¹⁶⁷	8329 (N=153)	Total IgE	≥100 kU/l	General population	Adults

Study	N	Index test/reference standard	Index test cut-off for positivity	Population	Age
	allergic asthma)	Specific IgE <ul style="list-style-type: none">• Pollens• Dust mite• Moulds		sample	(18-60 yrs)

1

Table 39: Clinical evidence profile: IgE vs. Reference Standard

IgE (Threshold)	No of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Median Sensitivity % (range)	Median Specificity % (range) ^e	Area Under Curve (range)	Quality
ADULTS										
DUST MITE Specific IgE										
IgE ≥0.35 kU/L	3	3227	Serious risk of bias ^a	Serious inconsistency ^b	Serious indirectness ^d	N/A ^e	Median 0.39 (range 0.38 to 0.84)	Corresponding 0.80 (range 0.62 to 0.80)	-	VERY LOW
IgE ≥0.70 kU/L	1	1572	Serious risk of bias ^a	No serious inconsistency	Serious indirectness ^d	N/A ^e	0.19	0.94	-	LOW
BIRCH Specific IgE										
IgE ≥0.70 kU/L	1	1572	Serious risk of bias ^a	No serious inconsistency	Serious indirectness ^d	N/A ^e	0.30	0.90	-	LOW
GRASS Specific IgE										
IgE ≥0.35 kU/L	2	2518	Serious risk of bias ^a	Serious inconsistency ^c	Serious indirectness ^d	N/A ^e	Range 0.33 to 0.68	Range 0.81 to 0.87	-	VERY LOW
IgE ≥0.70 kU/L	1	1572	Serious risk of bias ^a	No serious inconsistency	Serious indirectness ^d	N/A ^e	0.36	0.87	-	LOW
ALTERNARIA Specific IgE										
IgE ≥0.35 kU/L	1	702	Serious risk of bias ^a	No serious inconsistency	Serious indirectness ^d	N/A ^e	0.34	0.85	-	LOW
CLADOSPORIUM Specific IgE										
IgE ≥0.35 kU/L	1	1816	Serious risk of bias ^a	No serious inconsistency	Serious indirectness ^d	N/A ^e	0.07	0.97	-	LOW
IgE ≥0.70 kU/L	1	1572	Serious risk of bias ^a	No serious inconsistency	Serious indirectness ^d	N/A ^e	0.04	0.99	-	LOW
POLLEN Specific IgE										

IgE (Threshold)	No of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Median Sensitivity % (range)	Median Specificity % (range) ^e	Area Under Curve (range)	Quality
IgE ≥0.35 kU/L	1	709	No serious risk of bias	No serious inconsistency	Serious indirectness ^d	N/A ^e	0.96	0.64	-	MODERATE
TOTAL IgE										
IgE ≥100 kU/L	1	709	No serious risk of bias	No serious inconsistency	Serious indirectness ^d	N/A ^e	0.57	0.78	-	MODERATE
CAT Specific IgE										
IgE ≥0.35 kU/L	2	2518	Serious risk of bias ^a	No serious inconsistency	Serious indirectness ^d	N/A ^e	Range 0.20 to 0.40	Range 0.88 to 0.94	-	LOW
IgE ≥0.70 kU/L	1	1572	Serious risk of bias ^a	No serious inconsistency	Serious indirectness ^d	N/A ^e	0.40	0.91	-	LOW
DOG Specific IgE										
IgE ≥0.35 kU/L	1	702	Serious risk of bias ^a	No serious inconsistency	Serious indirectness ^d	N/A ^e	0.34	0.88	-	LOW
CHILDREN 5-16 years										
No evidence identified	0									
CHILDREN <5 years										
No evidence identified	0									

1 a) Risk of bias was assessed using the QUADAS-II checklist. Outcomes were downgraded by one if the weighted (by sample size (n)) average number of QUADAS-II domains (patient selection,
2 index test, reference standard and flow and timing) with methodological limitations was one. Outcomes were downgraded by two if the weighted average number of QUADAS-II domains
3 with methodological limitations was more than one.

4 b) Inconsistency was assessed by inspection of the sensitivity / specificity RevMan 5 plots. Linneberg is the outlier, the difference between this study and the others (ie. possible reasons for
5 heterogeneity) may be that the study is conducted in a wider age range which included some children (but was mostly adults).

6 c) Inconsistency was assessed by inspection of the sensitivity / specificity RevMan 5 plots. There was inconsistency for sensitivity but not specificity. The differences between the two studies
7 (ie. possible reasons for heterogeneity) could be that Abraham study was conducted specifically in pregnant women.

8 d) Studies were considered as indirect because they were not conducted in people with 'suspected asthma'

9 e) The judgement of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis, where performed.

1 15.4 Economic evidence

2 Published literature

3 No relevant economic evaluations were identified.

4 See also the economic article selection flow chart in Appendix E.

5 Unit costs

6 In the absence of recent UK cost-effectiveness analysis, relevant unit costs were provided below
7 (Table 40) to aid consideration of cost-effectiveness. The GDG considered these unit costs alongside
8 the diagnostic pathway evaluated in the economic model.

9 **Table 40: Unit costs for total and specific serum IgE tests**

Item	Unit cost	Quantity	Sub total	Source
IgE	£5	1	£5	GDG opinion
RAST	£12 - £20 ^a	1 per allergen	£12-20 per allergen	GDG opinion
Nurse time	£0.75 per minute	5 minutes	£3.75	GDG estimate and PSSRU ^{39,39}
GP time	Average cost of GP appointment (11.7 min) = £36	2 GP appointments (1 for referral and 1 to discuss the results)	£72	PSSRU ^{39,39}
TOTAL			£92.75 - 112.75 ^(b)	

10 (a) The cost for a RAST is dependent on whether it is identifying common allergen, a recombinant allergen, or a mix.

11 (b) This is the cost for one allergen, for additional allergens the cost of additional RASTS would need to be added assuming
12 they are all done at the same time.

13 15.5 Evidence statements

14 Clinical

15 DUST MITE-specific IgE:

- 16 • Three studies with 3227 adults showed that DUST MITE-specific IgE (IgE cut-off ≥ 0.35 Ku/L) has a
17 median sensitivity of 0.39 and a corresponding specificity of 0.80 for diagnosing asthma in the
18 general population. (VERY LOW QUALITY)
- 19 • One study with 1572 adults showed that DUST MITE-specific IgE (IgE cut-off ≥ 0.70 Ku/L) has a
20 sensitivity of 0.19 and a corresponding specificity of 0.94 for diagnosing asthma in the general
21 population. (LOW QUALITY)

22 BIRCH-specific IgE:

- 23 • One study with 1572 adults showed that BIRCH-specific IgE (IgE cut-off ≥ 0.70 Ku/L) has a
24 sensitivity of 0.30 and a corresponding specificity of 0.90 for diagnosing asthma in the general
25 population. (LOW QUALITY)

26 GRASS-specific IgE:

- 27 • Two studies with 2518 adults showed that GRASS-specific IgE (IgE cut-off ≥ 0.35 Ku/L) has a
28 sensitivity range of 0.33 to 0.68 and a corresponding specificity range of 0.81 to 0.87 for
29 diagnosing asthma in the general population. (VERY LOW QUALITY)

- 1 • One study with 1572 adults showed that GRASS-specific IgE (IgE cut-off ≥ 0.70 Ku/L) has a
 2 sensitivity of 0.36 and a corresponding specificity of 0.87 for diagnosing asthma in the general
 3 population. (LOW QUALITY)
- 4 ALTERNARIA-specific IgE:
- 5 • One study with 702 adults showed that ALTERNARIA-specific IgE (IgE cut-off ≥ 0.70 Ku/L) has a
 6 sensitivity of 0.34 and a corresponding specificity of 0.85 for diagnosing asthma in the general
 7 population. (LOW QUALITY)
- 8 CLADOSPORIUM-specific IgE:
- 9 • One study with 1816 adults showed that CLADOSPORIUM-specific IgE (IgE cut-off ≥ 0.35 Ku/L) has
 10 a sensitivity of 0.07 and a corresponding specificity of 0.97 for diagnosing asthma in the general
 11 population. (LOW QUALITY)
- 12 • One study with 1572 adults showed that CLADOSPORIUM-specific IgE (IgE cut-off ≥ 0.70 Ku/L) has
 13 a sensitivity of 0.04 and a corresponding specificity of 0.99 for diagnosing asthma in the general
 14 population. (LOW QUALITY)
- 15 POLLEN-specific IgE:
- 16 • One study with 709 adults showed that POLLEN-specific IgE (IgE cut-off ≥ 0.35 Ku/L) has a
 17 sensitivity of 0.96 and a corresponding specificity of 0.64 for diagnosing asthma in the general
 18 population. (MODERATE QUALITY)
- 19 TOTAL-specific IgE:
- 20 • One study with 709 adults showed that TOTAL-specific IgE (IgE cut-off ≥ 100 Ku/L) has a sensitivity
 21 of 0.57 and a corresponding specificity of 0.78 for diagnosing asthma in the general population.
 22 (MODERATE QUALITY)
- 23 CAT-specific IgE:
- 24 • Two studies with 2518 adults showed that CAT-specific IgE (IgE cut-off ≥ 0.35 Ku/L) has a
 25 sensitivity range of 0.20 to 0.40 and a corresponding specificity of 0.88 to 0.94 for diagnosing
 26 asthma in the general population. (LOW QUALITY)
- 27 • One study with 1572 adults showed that CAT-specific IgE (IgE cut-off ≥ 0.70 Ku/L) has a sensitivity
 28 of 0.40 and a corresponding specificity of 0.91 for diagnosing asthma in the general population.
 29 (LOW QUALITY)
- 30 DOG-specific IgE:
- 31 • One study with 702 adults showed that DOG-specific IgE (IgE cut-off ≥ 0.35 Ku/L) has a sensitivity
 32 of 0.34 and a corresponding specificity of 0.88 for diagnosing asthma in the general population.
 33 (LOW QUALITY)
- 34 • No evidence was identified in children aged 5-16 years.
- 35 • No evidence was identified in children <5 years.
- 36 **Economic**
- 37 • No relevant economic evaluations were identified.

38 15.6 Recommendations and link to evidence

Recommendations	<p>15. Do not offer the following as diagnostic tests for asthma:</p> <ul style="list-style-type: none"> • skin prick tests to aeroallergens • serum total and specific IgE.
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Relative values of different outcomes	<p>The GDG was interested in the diagnostic test accuracy of skin prick tests and of total and specific serum IgE tests in the diagnosis of asthma. One of the concerns that set the scope of this guideline is the over-diagnosis of asthma leading to inappropriate treatment; therefore, the GDG was interested in both the sensitivity and specificity of diagnostic tests and prioritised studies which reported these outcomes.</p> <p>It is important to note that:</p> <ul style="list-style-type: none"> • In the case of serum IgE, the data are extrapolated from population-based data rather than from people with respiratory symptoms. • For skin prick testing, the data reviewed were based on people with suspected asthma, or used people with allergic symptoms as a reference population. <p>The GDG agreed that skin prick test, and specific IgE test plus total IgE, are different modes of testing for a similar phenomenon.</p>
Trade-off between clinical benefits and harms	<p>Total IgE is potentially a useful marker of an allergic state and can be elevated in the absence of positive skin prick or specific IgE titres. A high total IgE has a number of causes and may require further investigation.</p> <p>In adults, the evidence from the studies identified suggests that, for the majority of allergens, total IgE, as well as specific IgE or skin prick tests has poor sensitivity for diagnosing asthma. For the majority of allergens, this poor sensitivity is coupled with a moderate or high specificity. Using these tests in the diagnosis of asthma could help to prevent over-diagnosis of asthma, but would result in a large number of people with asthma being missed. In children aged 5-16 years, evidence suggests that skin prick tests have a moderate sensitivity and specificity for the diagnosis of asthma. Evidence was only available from one study, and no evidence was available for total or specific IgE. In children aged <5 years there was no evidence identified.</p> <p>The GDG debated the risks and benefits and felt that in adults the risks and limitations from conducting blood tests (for serum total IgE and specific IgE) were potentially negligible. In relation to paediatrics, it was noted that children may find blood tests distressing, so they are not often used as a diagnostic test in the paediatric population. However, this short-term distress can be minimised by a variety of mechanisms. The risks of skin prick testing were also thought to be negligible in adults and children. The GDG noted that skin prick tests have the additional benefit that a result will be available within 15 minutes, i.e. within one visit. Whether total or specific IgE or skin prick testing is used is likely to vary depending on the setting. The GDG noted that there would be no additional value in performing both tests (skin prick and specific IgE).</p> <p>Despite the low risk associated with performing these tests, the GDG were concerned about the low sensitivity of the tests and chose not to recommend either test.</p>
Economic considerations	<p>Serum IgE: No relevant economic evaluations were identified for serum total or specific IgE tests. The unit cost for specific and total IgE tests was estimated to be £93 - £113 depending on the allergen identified. An additional £12- £20 would be incurred per extra allergen.</p> <p>Skin prick tests: No relevant economic evaluations were identified for skin prick tests. Skin prick tests are estimated to cost £173.</p> <p>The GDG considered the unit costs of these tests, as well as the downstream implications of correct and incorrect diagnoses. The GDG did not think that serum</p>

	<p>IgE or skin prick tests would be cost-effective as first-line diagnostic tests, as the clinical evidence does not show that they offer sufficient diagnostic accuracy.</p> <p>An original health economic model was built to assess the cost-effectiveness of different diagnostic pathways for asthma in adults. The GDG felt there were no endpoints of the diagnostic pathway where an SPT/IgE test would be of benefit. To be of benefit the test would need to lead to change in the diagnostic decision. The GDG felt that the results from SPT/IgE tests would not be enough to overturn any of the decisions made in the diagnostic pathway and therefore they were not considered a cost-effective use of resources.</p>
Quality of evidence	<p>SKIN PRICK</p> <p>The studies of skin prick testing included populations of patients suspected of having asthma, or having symptoms of asthma and allergic symptoms. The GDG referred back to one of the original papers, Soriano1999¹⁵⁸. This was a large study that dominated the evidence; however, patients were identified from a screening questionnaire as a subset of people with respiratory symptoms (not because they were presenting to the GP). Therefore, the evidence was downgraded for indirectness.</p> <p>The studies included to review the utility of skin prick testing used a cut-off of > 3mm wheal for a positive result, with the exception of one study⁵⁰ which did not mention the cut-off that was used. Three included studies used the ideal reference standard of a physician diagnosis with an objective test, and were reported separately. The GDG focused on the evidence from these studies.</p> <ul style="list-style-type: none"> • In children aged <5 years, there were no included studies using the best reference standard (physician diagnosis with objective test) that addressed the use of skin prick tests in this age group. • In children aged 5-16 years, there was one included study (Drkulec) using the best reference standard (physician diagnosis with objective test) that addressed the use of skin prick tests in this age group. The evidence was of moderate quality. • In adults, there were two included studies (Popovic and Soriano) using the best reference standard (physician diagnosis with objective test) that addressed the use of skin prick tests in this age group. The evidence was of low quality. <p>IgE</p> <p>Due to a lack of evidence in the review population, the studies included in the analysis of serum total IgE and specific IgE testing were in the general population and the GDG had to extrapolate the findings from these. Several studies were found, but were excluded because the reference standard was very similar to the index test (was allergen-specific, e.g. studies comparing specific IgE test to skin prick test or inhaled allergen challenges), and thus do not provide useful information on the utility of the index test in the diagnosis of asthma. The studies relied on questionnaire responses of previous asthma diagnosis, as the reference standard and none of the studies identified had the ideal reference standard of physician diagnosis with an objective test.</p> <ul style="list-style-type: none"> • In children aged <5 years, there were no included studies that addressed the use of total or specific IgE in this age group. • In children aged 5-16 years, there were no included studies that addressed the use of total or specific IgE in this age group. • All five included studies were conducted in adults. For the majority of the tests, evidence was only available from 1 study. Evidence for all except two of the tests was of low and very low quality.

Other considerations	<p>The GDG agreed that there is variation in the access and use of specific IgE testing in primary care for aero- and other allergens. Access to skin prick testing in primary care is generally even more limited.</p> <p>It was noted that there are circumstances in which it is extremely useful to know which allergens a person with asthma is sensitised to. This can be useful therapeutically, for example in terms of avoiding exposure and therefore triggering an attack. However, this benefit applies when the diagnosis of asthma has already been established. The GDG concluded that the evidence was not strong enough to recommend measurement of IgE or skin tests, but made a recommendation which expressed this in terms of using these as diagnostic tests since they did not wish to discourage appropriate use further along the management pathway.</p>
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16 Diagnosis: Fractional exhaled nitric oxide (FeNO)

16.1 Introduction

Asthma can be divided into extrinsic asthma (atopic or allergic), intrinsic asthma (non-atopic) and occupational asthma. Atopy is defined as a genetic predisposition to produce immunoglobulin E (IgE) against common environmental aeroallergens such as house dust mites, animal dander, pollens and moulds. Approximately 80% of people with asthma are atopic compared with 30% of the general population. Atopic asthma is characterised by Th2 lymphocyte driven inflammation within the airways.

Exhaled nitric oxide (NO) mainly originates from the respiratory epithelium and is produced by inducible NO synthase (iNOS). In people with asthma, iNOS expression is upregulated by interleukin-4 and -13, both archetypal Th2 cytokines. Thus exhaled NO primarily signals Th2 lymphocyte driven inflammation in the bronchial mucosa and consequently has potential utility in the diagnosis of asthma. However, as FeNO is a relatively new diagnostic tool the diagnostic test accuracy is currently uncertain.

16.2 Review question: In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of fractional exhaled nitric oxide (FeNO) measures?

For full details see review protocol in Appendix C.

Table 41: Characteristics of review question

Component	Description
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">• Children (1-<5 years old)• Children/young people (5-16 years old)• Adults (>16 years old)
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. 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">• Diagnostic accuracy (Sensitivity and specificity)• FeNO levels

16.3 Clinical evidence

We searched for cross sectional studies, cohort studies, case series (including both retrospective and prospective analyses) assessing the diagnostic test accuracy of FeNO to identify whether the condition is present (as indicated by the reference standard) in people under investigation for asthma.

Seventeen studies were included in the review^{18,26,29,35,36,48,67,85,87,97,140,148,149,179,185,189} (see Table 42, Table 43 and Table 44). Evidence from these are summarised in the clinical evidence profile below

1 (Table 45). See also the study selection flow chart in Appendix D, and sensitivity / specificity forest
2 plots in Appendix J, study evidence tables in Appendix G and exclusion list in Appendix K.

3 Seven of the total included studies were cross-sectional and compared the diagnostic accuracy of
4 FeNO with a physician diagnosis plus objective test for asthma in people with suspected
5 asthma^{36,56,67,87,140,179,185}. Studies using a cut-off threshold for the reference standard objective test
6 that differed from the protocol were not included in this review as there was enough evidence
7 available from studies with the ideal reference standard. A variety of index test cut-off thresholds
8 were used in the included studies, these are summarised in Table 42.

- 9
- Three of these studies were in adults only^{56,87,140}.
 - 10 • Three of these studies were in a mixed population of adults and children/young people (data not
11 separated), and were analysed in the adult strata due to the average age of the population (>16
12 years): CORDEIRO³⁶(age 7 and above), HEFFLER⁶⁷ (age 11 and above), VOUTILAINEN¹⁷⁹ (age 14 and
13 above).
 - 14 • One study was in children/young people alone: WOO¹⁸⁵ (aged 8 to 16 years).

15 One study was a cross-sectional study and compared the diagnostic accuracy of FeNO with a
16 methacholine challenge test reference standard in adults only²⁹.

17 Nine studies were case-control studies and assessed FeNO levels in people with asthma or asthma vs.
18 other respiratory diseases or healthy controls^{18,26,35,48,85,97,148,149,189}. FeNO levels were also included
19 from the cross-sectional studies, comparing those with a final diagnosis of asthma with those with
20 symptoms but without a final diagnosis of asthma. In total seventeen studies were included for FeNO
21 levels and median values are summarised for all, adults alone and children/young people alone in
22 Table 42.

Summary of included studies

Table 42: Summary of studies included in the review: diagnostic accuracy of FeNO test versus physician diagnosis with objective test (could use >1 test)

Study	Presentation	Target condition	Index test	Reference standard	Comments
Cordeiro 2011 ³⁶	New referrals to outpatient allergy clinic N=114 mixed population	Asthma	<ul style="list-style-type: none"> • FeNO: 27ppb • Flow rate 50ml/s • Niox-Flex device 	History of typical respiratory symptoms and FEV1 improvement >12% and >200mL with salbutamol 400µg or PC20 histamine ≤8mg/mL	See below for FeNO levels from same study
Fukuhara 2011 ⁵⁶	Outpatients referred to pulmonary medicine department. At least 1 of the subjective symptoms: recurrent cough, wheezing or dyspnoea (including chest tightness) N=61 Adults	Asthma	<ul style="list-style-type: none"> • FeNO: ≥40ppb • Flow rate 50ml/s • NA623N , Chest MI Japan device 	At least 2 of the following: induced sputum eosinophilia, AHR, reversible airway obstruction. Airway reversibility defined as a change in FEV1 of 200ml or ≥12% after SABA or after 2-4 weeks treatment with ICS or bronchodilator. AHR defined as dose of MCh at which airway resistance began to rise (cut-off <12.5U). And other diseases ruled out using chest radiography, computed tomography and other lab tests.	
Heffler 2006 ⁶⁷	Patients referred to allergy department for diagnostic evaluation of persistent rhinitis and asthma-like lower airways symptoms (cough, dyspnoea, chest tightness and wheezing) for 2 months N=48 mixed population	Asthma	<ul style="list-style-type: none"> • FeNO: 36ppb • Flow rate 50ml/s • Niox device 	Typical symptoms and significant response to bronchodilator (≥12% improvement in FEV1 with salbutamol) or airway hyper-reactivity to methacholine (PD20 FEV1 ≤800µg)	See below for FeNO levels from same study
Kowal 2009 ⁸⁷	Patients with chronic cough (at least 8 weeks) referred to asthma clinic for	Asthma	<ul style="list-style-type: none"> • FeNO: 40ppb flow 	Significant diurnal changes in PEF or significant improvement of FEV1 with 200µg salbutamol	See below for FeNO levels from same

Study	Presentation	Target condition	Index test	Reference standard	Comments
	evaluation N=540 Adults		rate 50ml/s • NOA 280 Sievers device		study
Sato 2008 ¹⁴⁰	Prolonged cough or wheezing >3 weeks attending Department of Pulmonary Medicine N=71 Adults	Asthma	<ul style="list-style-type: none"> • FeNO: 38.8ppb • Flow rate 50ml/s • Device from Kimoto, Japan (no further details given). 	<ul style="list-style-type: none"> • Bronchial asthma: cough + wheeze >3 weeks, sputum eosinophilia + airway hyper-reactivity to methacholine or reversible airflow limitation (improvement in FEV1 of 200mL and ≥12%) with salbutamol or long-acting β2-agonist • Cough variant asthma: cough without wheezing >3 weeks, sputum eosinophilia + airway hyper- reactivity to methacholine or reversible airflow limitation 	Asthma group = bronchial asthma + cough variant asthma; compared with non-asthma group = eosinophilic bronchitis without asthma, post-infectious cough, post-nasal drip, COPD, chronic bronchitis, cough with GERD or sino-bronchial syndrome. See below for FeNO levels from same study
Voutilainen 2013 ¹⁷⁹	Sedentary patients remitted to an allergy and asthma clinic because of respiratory symptoms (cough, dyspnoea or wheeze) N=87 (study also included a group of elite athletes N=87, not included in this review)	Asthma	<ul style="list-style-type: none"> • FeNO: 30ppb • Online single exhalation technique recommended by ATS • NIOX 	<ul style="list-style-type: none"> • 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 	See below for FeNO levels from same study
Woo 2012 ¹⁸⁵	Children presenting with non-specific	Asthma	<ul style="list-style-type: none"> • FeNO: 	History + reversible airflow obstruction (≥12%)	Unclear if treatment

Study	Presentation	Target condition	Index test	Reference standard	Comments
	respiratory symptoms e.g. cough, wheezing, shortness of breath, referred to paediatric outpatients for evaluation of asthma N=245 Children/young people		22ppb <ul style="list-style-type: none"> flow rate 50ml/s NIOX MINO device 	improvement in FEV1 with inhaled β -agonist) and/or airway hyper-reactivity (methacholine PC20 \leq 8mg/mL)	naïve. See below for FeNO levels from same study

Table 43: Summary of studies included in the review : diagnostic accuracy of FeNO test versus individual comparator test

Study	Presentation	Target condition	Index test	Comparator tests	Comments
Chatkin 1999 ²⁹	Chronic cough (>3 weeks) of unknown cause referred for diagnosis N=38 Adults	Asthma	<ul style="list-style-type: none"> FeNO: 30ppb Flow rate 45ml/s Sievers 280 device 	Positive to methacholine challenge (PC20 \leq 8mg/mL)	See below for FeNO levels from same study

Table 44: Summary of studies included in the review : comparison of FeNO levels between people with asthma and non-asthma

Study	Presentation	Target condition	Index test	Non-asthma conditions	Comments
BERLYNE 2000 ¹⁸	Asthma (steroid naïve). Symptoms of wheeze, breathlessness or cough in past year plus MCT PC20 <8 mg/ml if the FEV1/VC >70%; or a post-BD FEV1 >15% if the FEV1/VC was <70%. Not received ICS in	Asthma	<ul style="list-style-type: none"> FeNO; flow rate 45ml/s Sievers 240 device 	<ul style="list-style-type: none"> eosinophilic bronchitis healthy controls - atopic healthy controls – nonatopic 	

Study	Presentation	Target condition	Index test	Non-asthma conditions	Comments
	previous month.				
CARDINALE 2005 ²⁶	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	Asthma	<ul style="list-style-type: none"> • FeNO; flow rate 50ml/s • NOA Tm280 Sievers device 	<ul style="list-style-type: none"> • allergic rhinitis • healthy controls 	
Chatkin 1999* ²⁹	Chronic cough (>3 weeks) of unknown cause referred for diagnosis	Asthma	<ul style="list-style-type: none"> • FeNO; flow rate 45ml/s • Sievers 280 device 	Chronic cough (but methacholine negative)	
CIPRANDI 2013 ³⁵	Allergic asthma. Paediatrician using validated criteria (GINA). Consistent symptoms and signs, lung function impairment and BDR. BDR FEV1>12%. Allergy by SPT for common aeroallergens	Asthma	<ul style="list-style-type: none"> • FeNO; flow rate 50ml/s • Sievers 280 device 	<ul style="list-style-type: none"> • allergic rhinitis 	
Cordeiro 2011* ³⁶	New referrals to outpatient allergy clinic	Asthma	<ul style="list-style-type: none"> • FeNO; flow rate 50ml/s • Niox-Flex 	<ul style="list-style-type: none"> • Allergic rhinitis • Allergic rhinitis, nonallergic rhinitis, eczema, urticarial, other (all together) 	Unclear if treatment naive
Deykin 2002 ⁴⁸	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	Asthma	<ul style="list-style-type: none"> • FeNO; flow rate 50ml/s. • NOA 280 Sievers device 	<ul style="list-style-type: none"> • Healthy controls 	Gives FeNO levels at other flow rates as well as 50ml/s
Fukuhara 2011* ⁵⁶	Outpatients referred to pulmonary medicine department. At least 1 of the subjective symptoms: recurrent cough,	Asthma	<ul style="list-style-type: none"> • FeNO: flow rate 	Did not meet criteria for diagnosis of asthma but final diagnoses not reported	

Study	Presentation	Target condition	Index test	Non-asthma conditions	Comments
	wheezing or dyspnoea (including chest tightness)		50ml/s <ul style="list-style-type: none"> • NA623N , Chest MI Japan device 		
Heffler 2006* ⁶⁷	Patients referred to allergy department for diagnostic evaluation of persistent rhinitis and asthma-like lower airways symptoms (cough, dyspnoea, chest tightness and wheezing) for 2 months	Asthma	<ul style="list-style-type: none"> • FeNO; flow rate 50ml/s. • Niox 	Did not meet criteria for diagnosis of asthma but final diagnoses not reported	
Kostikas 2008*	Subjects with at least one asthma symptom on a screening questionnaire among students	Asthma	<ul style="list-style-type: none"> • FeNO; flow rate 50ml/s. • NIOX MINO device 	<ul style="list-style-type: none"> • Allergic rhinitis • non-specific respiratory symptoms • healthy controls 	Subjects had not presented to healthcare professionals. Only data from non-smokers included in FeNO levels analysis.
Kowal 2009* ⁸⁷	Patients with chronic cough (at least 8 weeks) referred to asthma clinic for evaluation	Asthma	<ul style="list-style-type: none"> • FeNO; flow rate 50ml/s. • NOA 280 Sievers device 	<ul style="list-style-type: none"> • Rhinitis/sinusitis • gastroesophageal reflux • healthy controls 	
Louhelainen 2008A ⁹⁷	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 \geq 15% or improvement in FEV1 \geq 12% after bronchodilator or PD15 of histamine <0.4mg or \geq 20% diurnal variation in PEF values and/or \geq 15% improvement in PEF after bronchodilator at home)	Asthma	<ul style="list-style-type: none"> • FeNO; flow rate 50ml/s. • Niox device 	<ul style="list-style-type: none"> • Healthy controls 	Patients with asthma and healthy controls grouped by age (adult = 16-72 yrs; child = 7-14 yrs); COPD all adult

Study	Presentation	Target condition	Index test	Non-asthma conditions	Comments
Sato 2008* ¹⁴⁰	Prolonged cough or wheezing >3 weeks attending Department of Pulmonary Medicine	Asthma	<ul style="list-style-type: none"> • FeNO; flow rate 50ml/s. • Device from Kimoto, Japan (no further details given). 	<ul style="list-style-type: none"> • Eosinophilic bronchitis without asthma • Post-infectious cough, post-nasal drip, COPD, chronic bronchitis, cough with GERD or sino-bronchial syndrome 	
Shimoda 2013 ¹⁴⁸	Patients referred to asthma clinic with cough variant asthma or bronchial asthma	Asthma	<ul style="list-style-type: none"> • FeNO; flow rate 50ml/s • NOA 280 Sievers device 	Healthy controls.	Each type of asthma compared separately with healthy controls.
Shome 2006 ¹⁴⁹	Patients with newly-diagnosed asthma	Asthma	<ul style="list-style-type: none"> • FeNO; flow rate 50ml/s • CLD 88sp, EcoPhysics device 	Healthy controls	Patients with asthma grouped by mild versus moderate/severe disease
Voutilainen 2013* ¹⁷⁹	Sedentary patients remitted to an allergy and asthma clinic because of respiratory symptoms (cough, dyspnoea or wheeze)	Asthma	<ul style="list-style-type: none"> • FeNO: 30ppb • Online single exhalation technique recommended by ATS 	Non-asthma (not BDR $\geq 12\%$, PEFv $\geq 20\%$, BDR of PEF $\geq 15\%$, exercise challenge test $\geq 15\%$ or BHR MCh PD20 or hist PD15 $\leq 0.4\text{mg}$); final diagnosis not stated	

Study	Presentation	Target condition	Index test	Non-asthma conditions	Comments
			<ul style="list-style-type: none"> NIOX 		
Woo 2012* ¹⁸⁵	Children presenting with non-specific respiratory symptoms e.g. cough, wheezing, shortness of breath, referred to paediatric outpatients for evaluation of asthma	Asthma	<ul style="list-style-type: none"> FeNO; flow rate 50ml/s NIOX MINO device 	Non-asthma (not airway hyper-reactivity (cut off for methacholine PC20 of 8mg/mL) or reversible airflow obstruction (12% improvement in FEV1 with inhaled β-agonist); final diagnoses not stated	Unclear if treatment naïve. Asthma and non-asthma groups also sub-divided by atopic vs. non-atopic
ZIETKOWSKI 2006A ¹⁸⁹	Steroid-naïve patients with mild to moderate asthma (56 allergic and 45 nonallergic). Asthma Dx according to GINA	Asthma	FeNO; flow rate 50ml/s	Healthy controls	

Table 45: Clinical evidence profile: Diagnostic Test Accuracy for FeNO

Index Test (Threshold)	No of studies		Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity % (range/media n 95% CI)	Specificity % (range/media n 95% CI)	Area Under Curve (range)	Quality
	1	n								
FeNO vs. Physician Dx with objective test: Adults										
FeNO >27ppb	1	114	No risk of bias ^(a)	No serious inconsistency	Serious indirectness ^{(c)(d)(e)}	n/a ^(f)	78.6	91.7	-	MODERATE
FeNO >30ppb	1	87	Serious risk of bias ^(a)	No serious inconsistency	Serious indirectness ^(c)	n/a ^(f)	43.0	89.0	0.738	LOW
FeNO >36ppb	1	48	No risk of bias ^(a)	No serious inconsistency	Serious indirectness ^(c)	n/a ^(f)	77.8	60.0	-	MODERATE
FeNO >38.8ppb	1	71	No risk of bias ^(a)	No serious inconsistency	Serious indirectness ^(e)	n/a ^(f)	79.2	91.3	-	MODERATE

Index Test (Threshold)	No of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity % (range/media n 95% CI)	Specificity % (range/media n 95% CI)	Area Under Curve (range)	Quality
FeNO >40ppb	2	601	Very serious risk of bias ^(a)	No serious inconsistency	Serious indirectness ^{(d)(e)}	n/a ^(f)	Range 78.6 - 88.3	Range 82.6 - 89.5	-	VERY LOW
FeNO vs. Physician Dx with objective test: Children/young people										
FeNO >22ppb	1	245	No risk of bias ^(a)	No serious inconsistency	No serious indirectness	n/a ^(f)	56.9	87.2	-	HIGH
FeNO vs. methacholine ≤8mg/mL										
12 FeNO >30ppb	1	38	No risk of bias ^(a)	No serious inconsistency	No serious indirectness	n/a ^(f)	75.0	86.7	-	HIGH

(a) Risk of bias was assessed using the QUADAS-II checklist. Outcomes were downgraded by one if the weighted (by sample size (n)) average number of QUADAS-II domains (patient selection, index test, reference standard and flow and timing) with methodological limitations was one. Outcomes were downgraded by two if the weighted average number of QUADAS-II domains with methodological limitations was more than one.

(b) Inconsistency was assessed by inspection of the sensitivity / specificity values in each of the studies in relation to a high (≥75%), moderate (50-74%) or low (<50%) effect estimate. Inconsistency was considered high if the point estimates from individual studies were within two areas, and very high if they were in 3 areas or both high and low areas.

(c) Mixed population of adults and children/young people

(d) Unclear if treated at baseline in one study

(e) Smokers included in the study

(f) The judgement of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis, where performed.

1 16.4 Economic evidence

2 Published literature

3 Three economic evaluations relating to this review question were identified but were excluded due
4 to a combination of limited applicability and methodological limitations.^{17,65,131} These are
5 summarised in Appendix L, with reasons for exclusion given. All these three studies assessed
6 individual tests in isolation, while the GDG was interested in knowing the cost-effectiveness of
7 diagnostic strategies including more than one test.

8 New cost-effectiveness analysis

9 An original health economic model was built for adults to assess the cost-effectiveness of several
10 diagnostic pathways, which included FeNO. Full details of the model can be found in Appendix M. A
11 summary of the model can be found in section 18.4 .

12 Unit costs of performing FeNO on children

13 As an economic model was not feasible for children the GDG considered the unit cost of performing
14 FeNO to evaluate its cost-effectiveness as part of a pathway for diagnosing asthma. This unit cost is
15 presented below (Table 46).

16 **Table 46: Cost of FeNO**

Item	Quantity ^(a)	Unit cost	Total Cost (quantity*unit cost)	Source of unit cost
Time taken to conduct test with GP practice nurse	5-10 minutes	£0.73 per minute	£3.65-£7.30	PSSRU ³⁹
Cost of FeNO equipment per use	1	£6.36 per use	£6.36	Harnan et al ⁶⁵
Total			£10.01-£13.66	

17 (a) Based on GDG opinion.

18 The GDG also acknowledged the annual cost of drugs for the management of asthma in children.
19 Preventing these costs from occurring for children without asthma would be a large benefit derived
20 from a diagnostic strategy with a high specificity. This cost was estimated to be £201 from a study by
21 Main et al.^{98,98}

22 16.5 Evidence statements

23 Clinical

- 24 • One study with 114 adults showed that FeNO (cut-off 27ppb) has a sensitivity of 78.6% and a
25 corresponding specificity of 91.7% for diagnosing asthma in people presenting with respiratory
26 signs and symptoms. (MODERATE QUALITY).
- 27 • One study with 87 adults showed that FeNO (cut-off 30ppb) has a sensitivity of 43.0% and a
28 corresponding specificity of 89.0% for diagnosing asthma in people presenting with respiratory
29 signs and symptoms. (MODERATE QUALITY).

- 1 • One study with 48 adults showed that FeNO (cut-off 36ppb) has a sensitivity of 77.8% and a
2 corresponding specificity of 60.0% for diagnosing asthma in people presenting with respiratory
3 signs and symptoms. (MODERATE QUALITY).
- 4 • One study with 71 adults showed that FeNO (cut-off 38.8ppb) has a sensitivity of 79.2% and a
5 corresponding specificity of 91.3% for diagnosing asthma in people presenting with respiratory
6 signs and symptoms. (MODERATE QUALITY).
- 7 • Two studies with 601 adults showed that FeNO (cut-off 40ppb) has a sensitivity range of 78.6-
8 88.3% and a corresponding specificity range of 82.6-89.5% for diagnosing asthma in people
9 presenting with respiratory signs and symptoms. (VERY LOW QUALITY).
- 10 • One study with 245 children showed that FeNO (cut-off 22ppb) has a sensitivity of 56.9% and a
11 corresponding specificity of 87.2% for diagnosing asthma in people presenting with respiratory
12 signs and symptoms. (HIGH QUALITY)
- 13 • One study with 38 adults showed that FeNO (cut-off 30ppb) has a sensitivity of 75.0% and a
14 corresponding specificity of 86.7% for a positive methacholine challenge test in people presenting
15 with respiratory signs and symptoms. (HIGH QUALITY)

16 Economic

- 17 • No relevant economic evaluations were identified
- 18 • An original health economic model found that FeNO (together with spirometry, BDR and when
19 there are conflicting results PEFv and MCT) was part of the most cost-effective diagnostic
20 pathway used to diagnose asthma in adults aged 16 and over (see diagnostic algorithms in section
21 4.1). This evidence is directly applicable with minor limitations.

22 16.6 Recommendations and link to evidence

Recommendations	<p>16. Offer a FeNO test in 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.</p> <p>17. Offer a FeNO test in children aged 5-16 years if there is diagnostic uncertainty after initial assessment and they have either:</p> <ul style="list-style-type: none"> • normal spirometry or • obstructive spirometry with negative BDR. <p>Regard a FeNO level of 35 ppb or more as a positive test.</p>
Relative values of different diagnostic measures and outcomes	<p>The GDG was interested in the diagnostic test accuracy of fractional exhaled nitric oxide (FeNO) measures using a flow rate of 50ml/s for the FeNO test.</p> <p>One of the concerns that set the scope of this guideline is the over-diagnosis of asthma leading to inappropriate treatment; therefore, the GDG was interested in both the sensitivity and specificity of diagnostic tests and prioritised studies which reported these outcomes. Sensitivity and specificity values will depend on the chosen cut-off point. It was noted that ATS guidelines⁵¹ have classified low FeNO levels as <25ppb in adults and <20ppb in children, these levels indicating normal airways, and high FeNO levels as >50ppb in adults and >35ppb in children indicating eosinophilic inflammation. The ATS guidelines specify that FeNO levels between these ranges should be interpreted with caution.</p> <p>For the diagnosis of asthma with FeNO as the index test, the GDG included studies with a cut-off threshold for diagnosis between 20-50ppb. Studies using a cut-off threshold for the reference standard objective test that differed from the protocol were not included in this review, as there was enough evidence available from</p>

	<p>studies with the ideal reference standard. The GDG noted that the number of people diagnosed with asthma will vary with the cut-off threshold for the reference standard objective test, and therefore only the optimal threshold should be used if evidence is available.</p> <p>The GDG considered evidence from a summary ROC curve when assessing the heterogeneity in the results and any threshold effect. They also viewed evidence from case-control and cross-sectional studies comparing FeNO levels in patients with asthma vs. other respiratory conditions or healthy controls when choosing an appropriate cut-off value for FeNO as a diagnostic test.</p>
Trade-off between clinical benefits and harms	<p>The FeNO test can be performed in around 10 minutes and can be performed within primary care.</p> <p>The sensitivity and specificity of FeNO in adults was high, with the exception of one study with a moderate specificity (cut-off >36ppb⁶⁷) and one study with a low sensitivity (cut-off >30ppb¹⁷⁹). In children/young people, FeNO had a moderate sensitivity and a high specificity.</p> <p>Due to the high sensitivity and specificity of the test at the majority of thresholds, the GDG discussed the use of FeNO as a test in the diagnosis of asthma within a diagnostic algorithm. There is some uncertainty about the best FeNO cut-off threshold to distinguish between asthma and non-asthma. When considering a cut-off threshold, the GDG discussed the sensitivity and specificity data, and evidence for the FeNO levels in patients with asthma, other respiratory conditions and healthy controls. A cut-off of greater than or equal to 40ppb was chosen in adults as this cut-off value has a high sensitivity and specificity and is above the range of FeNO levels observed in a population of mixed respiratory symptoms without a diagnosis of asthma; therefore, a cut-off of 40ppb will limit the number of false positives. FeNO levels were generally lower in children with asthma and healthy controls. The GDG discussed the high prevalence of rhinitis in children and that the cut-off threshold for the diagnosis of asthma should lie above the range of FeNO values in children with rhinitis. A cut-off of greater than or equal to 35ppb was chosen in children. The GDG discussed the limitations of cut-off values lower than these, as more false positives occur.</p>
Economic considerations	<p>No economic evaluations were included which assessed the use of FeNO as part of a diagnostic pathway. Therefore, an original health economic model was built to assess the cost-effectiveness of different diagnostic pathways for asthma. The model assessed the additional costs of tests against cost-savings from unnecessary asthma medication, and the increased health outcomes from providing correct treatment.</p> <p>FeNO had the best diagnostic accuracy out of all the tests that are conducted in primary care. Due to this the GDG agreed that FeNO should appear in every diagnostic pathway as it would be pivotal in making a diagnosis. In the model strategies that gave FeNO to all patients in the pathway dominated the strategies that did not. Therefore FeNO is a highly cost-effective component of the diagnostic algorithm.</p> <p>The most cost-effective strategy involved using spirometry, bronchodilator reversibility (BDR), FeNO, peak expiratory flow variability (PEFv) and a methacholine challenge test (MCT) to diagnose asthma. In this strategy, everybody with symptoms of asthma would undergo a spirometry and FeNO test, those who had an obstructive spirometry would also receive a BDR test. Only those who had non-obstructive spirometry and conflicting FeNO and PEFv test results would receive a MCT. Adopting this strategy dominated all other strategies apart from those which performed challenge tests at more points in the pathway. The ICERs of adopting these further strategies were above £20,000 per QALY gained.</p>

	<p>In children the GDG recognised FeNO as having considerable value in a diagnostic pathway as it can be performed at a low cost and the clinical evidence showed it had a high specificity. Apart from children who produce a positive bronchodilator reversibility result, the GDG felt that FeNO measurements would add value to all other points in the pathway. The GDG noted that as not all children would receive a FeNO test the average unit cost of including FeNO in the proposed diagnostic algorithm would be less.</p>
Quality of evidence	<p>The evidence ranged from very low to high quality. The limitations of the studies included the variable inclusion criteria, making directness to the clinical question variable and the risk of bias as assessed using the QUADAS II checklist.</p> <ul style="list-style-type: none"> • In children aged <5 years, no studies were identified. • In children and young people aged 5-16 years, there was one included study¹⁸⁵ with a cut-off of 22ppb, using the reference standard (physician diagnosis with objective test), FeNO had a moderate sensitivity and high specificity. The evidence was high quality. • In adults, there were five included studies. At cut-off thresholds ranging from 27-40ppb, FeNO had a high sensitivity and a high specificity, with the exception of two studies with a low sensitivity at a cut-off of 30ppb¹⁷⁹ and a moderate specificity at a cut-off of 36ppb⁶⁷. The quality of the evidence was downgraded if there was a mixed population of adults and children/young people with no breakdown of the results, if there was uncertainty about medications at baseline or if the population included smokers. One study (Cordeiro 2011) had an indirect population with general allergic symptoms rather than respiratory symptoms. The quality of the evidence ranged from very low to high quality. Additionally, in adults, one study comparing FeNO with methacholine challenge test as a proxy for asthma showed high sensitivity and high specificity at a cut-off value of 30ppb. <p>The evidence for FeNO levels in asthma, other respiratory conditions and healthy controls is limited by the lack of numbers for some populations.</p> <p>The economic evidence was assessed as directly applicable with minor limitations.</p>
Other considerations	<p>The GDG discussed variables which may affect the FeNO test. A standard flow-rate of 50ml/s should be used and the flow-rate is independent of body size. FeNO levels can be altered by corticosteroids, smoking or previous smoking history and diet. The GDG excluded studies in which more than 50% of the population were taking corticosteroids, or if the smoking history of the population was unclear. FeNO measures are independent of peripheral blood eosinophil levels.</p> <p>The GDG considered the placement of FeNO in a diagnostic pathway, taking into account the diagnostic accuracy of the test and the practicality of performing the test. The GDG noted that FeNO can be performed fairly easily in primary care and is a simple test for the patient to complete. The GDG also noted the high diagnostic accuracy of FeNO relative to all other tests that can be performed in primary care. For these reasons, the GDG felt it would be appropriate to give all patients who had undergone a spirometry and (where relevant) bronchodilator reversibility (BDR) testing, a FeNO test. A FeNO test could easily be performed after a spirometry or BDR test at a low marginal cost. The GDG also considered the additional benefit of identifying patients likely to be steroid responsive.</p> <p>For adults aged over 16 years with obstructive spirometry, reversible airways (positive BDR), no variability in peak flow readings and a very low FeNO count of less than 25 ppb, the decision to either consider an alternative diagnosis or refer for a specialist opinion will differ on a case-by-case basis.</p>

For instance, a 55-year-old with a 30 pack year smoking history, who demonstrates obstructive spirometry with reversibility, but a FeNO of 10ppb and no peak flow variability, is likely to have COPD. On the other hand, a 20-year-old who has never smoked, with obstructive spirometry with reversibility, a FeNO of 24ppb and no peak flow variability, may well need a specialist opinion for further investigation, rather than considering an alternative diagnosis.

1

17 Diagnosis: Peripheral blood eosinophil count

17.1 Introduction

Eosinophils are a form of white blood cells produced by the bone marrow. Their exact role in health has yet to be determined, but it is believed that they play a role in fighting parasitic infections and primarily reside within the lining of the gut.

Biopsies taken from the lungs of people with asthma have frequently demonstrated increased numbers of eosinophils and the number of eosinophils is also often increased in sputum samples taken from people with asthma. Measurement of sputum eosinophil numbers have been used to aid the diagnosis and management of asthma. However, this is a time consuming procedure, which is only performed in a specialist setting. Eosinophils travel from the bone marrow to the lung, it is therefore logical to investigate whether measurement of blood eosinophils is a useful tool for asthma diagnosis.

17.2 Review question: In people under investigation for asthma, what is the diagnostic test accuracy and cost-effectiveness of eosinophil blood count measures?

For full details see review protocol in Appendix C.

Table 47: PICO characteristics of review question

Population	People with suspected asthma (presenting with respiratory symptoms). All ages, stratified into the following 3 different groups: <ul style="list-style-type: none">• Children (1-<5 years old)• Children/young people (5-16 years old)• Adults (>16 years old)
Index test	Peripheral blood eosinophil count (may be part of FBC)
Reference standard	Physician diagnosis of asthma based on symptoms plus an objective test 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">• Diagnostic accuracy (sensitivity, specificity)• Eosinophil levels

17.3 Clinical evidence

We searched for cross sectional studies, cohort studies, case series (including both retrospective and prospective analyses) assessing the diagnostic test accuracy of peripheral blood eosinophil counts to identify whether the condition is present (as indicated by the reference standard) in people under investigation for asthma.

Twenty studies were included in the review^{9,64,70,79,86,88,89,102,109,121,129,138,147,151,152,164,165,168,177,189}. Evidence from these are summarised in Table 48 and the clinical evidence profile below (Table 49). See also the study selection flow chart in Appendix D, forest plots in Appendix J, study evidence tables in Appendix G and exclusion list in Appendix K.

Four of the studies^{86,129,147,164} were cross-sectional studies, and looked at the diagnostic accuracy of peripheral blood eosinophil counts in people with suspected asthma. Three of these studies had a reference standard of physician diagnosis plus and objective test^{86,129,164}. The remaining study¹⁴⁷ had

1 a physician diagnosis of atopic asthma without an objective test, but was included due to limited
 2 evidence with the ideal reference standard. This study was downgraded for indirectness. Two studies
 3 were in adults^{129,164} and the other two studies were in children^{86,147} and evidence was analysed in the
 4 5-16 year strata. No evidence was identified in children <5 years.

5 The remaining sixteen studies^{9,64,70,79,88,89,102,109,121,138,151,152,165,168,177,189} were either case-series (of
 6 asthma only patients, no comparison), or were case-control studies, which compared the levels of
 7 peripheral blood eosinophils counts in people who had already been diagnosed with asthma vs.
 8 healthy controls and/or other respiratory symptoms or conditions. Although one of these studies
 9 (Backer 2002¹⁰) was a cross-sectional study but only reported blood eosinophil counts (and not
 10 sensitivity and specificity). The studies are summarised in Table 48. Evidence from these studies is
 11 summarised in Appendix G. Studies measuring eosinophil count simply stating 'cells/mm³' have not
 12 been included in the pooled summary results.

13 **Table 48: Summary of included studies**

Study	N	Index test*/reference standard	Index test cut-off for positivity	Population	Age
Adults: PBE vs. reference standard					
POPOVIC 2002 ¹²⁹	195 (N=141 asthma)	PBE vs. Physician Dx + objective test (BDR)	Not reported	Suspected asthma (dyspnoea)	Adults (mean 39 yrs)
TILEMANN 2011 ¹⁶⁴	210 (N=86 asthma)	PBE vs. BDR	≥4.15%	Suspected obstructive airways disease.	Adults (mean 49 yrs)
Children 5-16 years: PBE vs. reference standard					
KOTANIEMI 2002 ⁸⁶	82 (N=33 asthma)	PBE vs. Physician Dx + objective test (exercise challenge test)	≥0.45 x 10 ⁹ /l.	Suspected asthma (wheeze)	Children (mean 7.2 yrs)
SHIELDS 1999 ¹⁴⁷	137 (N=60 asthma)	PBE vs. Physician Dx	>4% and >8%	History of wheezing	Children (range 1-15 yrs)
Studies reporting PBE counts					
BACKER 2002 ^{9,10}	624 (N=103 asthma)	PBE counts only	N/A	General population sample	Adults (range 19-29 yrs)
HALVANI 2012 ⁶⁴	98 (N=61 asthma)	PBE counts only	N/A	Asthma and healthy controls	Adults (mean 38 yrs)
HUNTER 2002 ⁷⁰	110 (N=89 asthma)	PBE counts only	N/A	Asthma and healthy controls	Mainly adults (mean 39 yrs)
KHAKZAD 2009 ⁷⁹	62 (N=50 asthma)	PBE counts only	N/A	Asthma and healthy controls	Adults (mean 40 yrs)
KROEGEL 1998 ⁸⁸	56 (N=14)	PBE counts only	N/A	Asthma,	Adults

Study	N	Index test*/reference standard	Index test cut-off for positivity	Population	Age
	asthma)			suspected asthma, COPD and healthy controls	(mean 55 yrs)
LABBE 2001 ⁸⁹	143 (N=88 asthma)	PBE counts only	N/A	Asthma and healthy controls	Children (mean 7 yrs)
METSO 2000 ¹⁰²	190 (N=160 asthma)	PBE counts only	N/A	Asthma and healthy controls	Mainly adults (range 16-60)
NORDLUND 2012 ¹⁰⁹	39	PBE counts only	N/A	Asthma	Children (mean 14 yrs)
PIIPPOSAVOLAINE N 2007 ¹²¹	83	PBE counts only	N/A	Wheezing/ bronchiolitis	Children (<2 yrs, mean not reported)
RYTILA 2000 ¹³⁸	68 (N=25 asthma)	PBE counts only	N/A	Asthma and healthy controls	Mainly adults (mean 38 yrs)
SILVESTRI 2001A ^{150,151}	112	PBE counts only	N/A	Asthma	Children (mean 10.6 yrs)
SILVESTRI 2003 ^{150,152}	92	PBE counts only	N/A	Asthma	Children (mean 10.7 yrs)
TOMASIAKLOZOWS KA 2012 ¹⁶⁵	110 (N=91 asthma)	PBE counts only	N/A	Asthma and healthy controls	Adults (mean 38 yrs)
TUCHINDA 1987 ¹⁶⁸	1000	PBE counts only	N/A	Asthma	Children <13 years (mean not reported)
VILA-INDURAIN 1999 ¹⁷⁷	57 (N=36 asthma)	PBE counts only	N/A	Asthma and healthy controls	Children (8-18 yrs, mean not reported)
ZIETKOWSKI 2006A ¹⁸⁹	140 (N=101 asthma)	PBE counts only	N/A	Asthma and healthy controls	Adults (mean 35 yrs)

1

PBE = peripheral blood eosinophil count

Table 49: Clinical evidence profile: PBE count vs. Physician Dx of asthma:

Blood eosinophil count	No of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Median Sensitivity, or PBE counts (range)	Median Specificity or PBE counts (range) ^e	Area Under Curve (range)	Quality
ADULTS										
≥4.15%	1	210	Serious risk of bias ^a	No serious inconsistency ^b	No serious indirectness	N/A ^c	0.36	0.83	-	MODERATE
cut-off not reported	1	195	Serious risk of bias ^a	No serious inconsistency ^b	Serious indirectness ^e	N/A ^c	0.15	0.39	-	LOW
CHILDREN 5-16 years old										
>4%	1	137	Serious risk of bias ^a	No serious inconsistency ^b	Serious indirectness ^d	N/A ^c	0.62	0.67	-	LOW
>8%	1	137	Serious risk of bias ^a	No serious inconsistency ^b	Serious indirectness ^d	N/A ^c	0.38	0.93	-	LOW
≥0.45 x 10 ⁹ /l	1	82	Serious risk of bias ^a	No serious inconsistency ^b	No serious indirectness	N/A ^c	0.55	0.84	-	MODERATE
CHILDREN 1-<5 years old										
No evidence identified	0									

a) Risk of bias was assessed using the QUADAS-II checklist. Outcomes were downgraded by one if the weighted (by sample size (n)) average number of QUADAS-II domains (patient selection, index test, reference standard and flow and timing) with methodological limitations was one. Outcomes were downgraded by two if the weighted average number of QUADAS-II domains with methodological limitations was more than one.

b) Inconsistency was assessed by inspection of the sensitivity / specificity values in each of the studies in relation to a high (≥75%), moderate (50-74%) or low (<50%) effect estimate. Inconsistency was considered high if the point estimates from individual studies were within two areas, and very high if they were in 3 areas or both high and low areas.

c) The judgement of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis, where performed.

d) Reference standard did not include an objective test.

e) Index test cut-off not reported.

1 17.4 Economic evidence

2 Published literature

3 No relevant economic evaluations were identified. See also the economic article selection flow chart
4 in Appendix E.

5 Unit costs

6 In the absence of recent UK cost-effectiveness analysis, relevant unit costs were provided to aid
7 consideration of cost-effectiveness. The GDG considered this unit cost alongside the diagnostic
8 pathway evaluated in the economic model.

9 **Table 50: Unit costs for eosinophil blood count**

Item	Unit cost	Quantity	Sub total	Source
Lab costs associated with eosinophils	£10.33	1	£10.33	GDG estimate
GP time	Average cost of GP appointment (11.7 min) = £36	2 GP appointments (1 for referral and 1 to discuss the results)	£72	PSSRU ^{39,39}
TOTAL			£82.33	

10

11 17.5 Evidence statements

12 Clinical

- 13 • One study with 210 adults showed that blood eosinophil count (cut-off $\geq 4.15\%$) has a sensitivity
14 of 0.36 and a corresponding specificity of 0.83 for diagnosing asthma in people presenting with
15 respiratory signs and symptoms. (MODERATE QUALITY)
- 16 • One study with 195 adults showed that blood eosinophil count (no cut-off reported) has a
17 sensitivity of 0.15 and a corresponding specificity of 0.39 for diagnosing asthma in people
18 presenting with respiratory signs and symptoms. (LOW QUALITY)
- 19 • One study with 137 children and young people showed that blood eosinophil count (cut-off $>4\%$)
20 has a sensitivity of 0.62 and a corresponding specificity of 0.67 for diagnosing asthma in people
21 presenting with respiratory signs and symptoms. (LOW QUALITY)
- 22 • One study with 137 children and young people showed that blood eosinophil count (cut-off $>8\%$)
23 has a sensitivity of 0.38 and a corresponding specificity of 0.93 for diagnosing asthma in people
24 presenting with respiratory signs and symptoms. (LOW QUALITY)
- 25 • One study with 82 children and young people showed that blood eosinophil count (cut-off $\geq 0.45 \times$
26 $10^9/l$) has a sensitivity of 0.55 and a corresponding specificity of 0.84 for diagnosing asthma in
27 people presenting with respiratory signs and symptoms. (MODERATE QUALITY)
- 28 • No evidence was identified in children <5 years.

29 Economic

- 30 • No relevant economic evaluations were identified.

1 17.6 Recommendations and link to evidence

Recommendations	18. Do not offer a peripheral blood eosinophil count as a diagnostic test for asthma.
Research recommendations	1. What is the acceptability and diagnostic accuracy of objective tests that could be used to comprise a diagnostic pathway for asthma in children aged 5-16 years old (for example, exercise challenge, direct bronchial challenge with histamine or methacholine, indirect bronchial challenge with mannitol and peripheral blood eosinophil count)?
Relative values of different outcomes	<p>The GDG was interested in the diagnostic test accuracy of blood eosinophil counts in the diagnosis of asthma. One of the concerns that set the scope of this guideline is the over-diagnosis of asthma leading to inappropriate treatment; therefore, the GDG was interested in both the sensitivity and specificity of diagnostic tests and prioritised studies which reported these outcomes.</p> <p>Sensitivity and specificity values will depend on the chosen cut-off point, but in most studies (despite often using different cut-offs), the cut-off chosen appeared to give better specificity than sensitivity.</p> <p>Eosinophil levels from population studies including people with asthma and people without asthma were also considered if the studies reported levels separately in those with asthma. These studies show that an asthma diagnosis is more likely with increasing blood eosinophil level, but the overlap between asthma and non-asthma is considerable.</p>
Trade off between clinical benefits and harms	<p>The benefit of measuring eosinophil levels was considered purely in terms of the value as a diagnostic test, and therefore it is dependent on the sensitivity and specificity. In adults, a cut-off threshold of $\geq 4.15\%$ resulted in a low sensitivity but a high specificity. In children, the sensitivity at all thresholds was low or moderate, and the specificity was moderate or high. Measuring blood eosinophils in the diagnosis of asthma could prevent over-diagnosis of asthma, but would result in a large number of people with asthma being missed due to a poor sensitivity of the test.</p> <p>Over-reliance on an eosinophil level as a test of asthma would be a potential harm, but, apart from this, the only disadvantage is that a blood sample has to be provided. In most adults this does not present a problem, although a few people have needle phobia. Obtaining a blood sample poses a greater problem in children, but although the procedure can be distressing the use of anaesthetic patches should ameliorate this.</p> <p>There is a delay between taking blood and obtaining the eosinophil result which constitutes a slight disadvantage in comparison to some other potential tests for asthma, which can provide immediate answers. The GDG also noted that some GP practices do not have a phlebotomy service and their patients would have to make a separate visit to a hospital for the blood sample to be taken.</p>
Economic considerations	<p>No relevant economic evaluations were identified for blood eosinophil count.</p> <p>The GDG considered the unit costs of these tests, as well as the downstream implications of correct and incorrect diagnoses. The GDG did not think that blood eosinophil count would be cost-effective as first-line diagnostic tests, as the clinical evidence does not show that they offer sufficient diagnostic accuracy.</p> <p>An original health economic model was built to assess the cost-effectiveness of different diagnostic pathways for asthma. The GDG felt there were no endpoints of the diagnostic pathway where an eosinophil test would be of benefit. To be of benefit the test would need to lead to change in the diagnostic decision. The GDG felt that the results from eosinophil tests would not be enough to overturn any of</p>

	<p>the decisions made in the diagnostic pathway and therefore they were not considered a cost-effective use of resources.</p>
Quality of evidence	<p>In children aged <5 years there was little evidence. There were no studies giving sensitivity or specificity values in this age group, and only one study (PIIPPOSAVOLAINEN 2007) which provided eosinophil levels in people with asthma.</p> <p>In children aged 5-16 years, two studies assessed the diagnostic accuracy of PBE counts for asthma diagnosis. One study had an ideal reference standard of physician diagnosis plus an objective test. The other study had a physician diagnosis of atopic asthma without an objective test, but was included due to limited evidence with the ideal reference standard. The evidence was of low to moderate quality. Other studies of eosinophil levels in different population groups of similar age ranges (groups with asthma vs. groups without asthma), showed that peripheral blood eosinophil (PBE) counts were generally higher in: asthma vs. non-asthma or healthy controls; allergic asthma vs. non-allergic asthma; asthma with normal FEV₁ vs. those with low FEV₁.</p> <p>In adults, two studies assessed the diagnostic accuracy of PBE counts for asthma diagnosis using the ideal reference standard of physician diagnosis plus an objective test. The evidence was of low to moderate quality. Other studies of eosinophil levels in different population groups (groups with asthma vs. groups without asthma), showed that PBE counts were generally higher in: asthma vs. non-asthma or healthy controls; allergic asthma vs. non-allergic asthma.</p>
Other considerations	<p>The GDG noted that eosinophil counts are known to be elevated in conditions other than asthma (e.g. parasitic infection) and therefore would be unreliable as a diagnostic test for asthma in isolation.</p> <p>The GDG considered the use of eosinophil blood tests in a diagnostic algorithm taking into account practicality of performing the test and diagnostic accuracy. They noted that there were no areas of diagnostic uncertainty in the proposed algorithm where a blood eosinophil count could be of significant benefit, since the results from the test would not be conclusive enough to reverse any diagnostic decisions made on the basis of other tests.</p> <p>The GDG made a high-priority research recommendation to investigate the acceptability and performance characteristics of objective tests, including peripheral blood eosinophil tests, which could be used to comprise a diagnostic pathway for asthma in children aged 5-16 years old. Further details on the high-priority research recommendation made can be found in appendix N, along with the full list of research recommendations made.</p>

18 Diagnosis: Direct bronchial challenge test with histamine and methacholine

18.1 Introduction

Hyper-reactivity of the airways to non-specific stimuli is a key feature of asthma. Bronchial hyper-reactivity (BHR) can be measured in a number of different ways. Inhalation of the bronchoconstrictors histamine and methacholine can be used to measure BHR. In both histamine and methacholine challenge tests, incremental doses of one or the other agent are administered by inhalation until there is a fall in the person's FEV1 of at least 20% from the baseline value. The result is expressed as the PC20 (provocation concentration) or PD20 (provocation dose) of bronchoconstrictor required to produce a 20% fall in FEV1. However, the diagnostic test accuracy of bronchial challenge tests with histamine or methacholine to diagnose asthma is currently uncertain.

18.2 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?

For full details see review protocol in Appendix C.

Table 51: Characteristics of review question

Population	People with suspected asthma (presenting with respiratory symptoms). Ages stratified into the following 2 different groups: <ul style="list-style-type: none"> • Children/young people (5-16 years old) • Adults (>16 years old)
Index test	<ul style="list-style-type: none"> • Histamine PC20 or PD20 • Methacholine PC20 or PD20 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
Statistical measures	<ul style="list-style-type: none"> • Diagnostic accuracy (sensitivity and specificity)
Study design	Cross sectional studies, cohort studies, case series (including both retrospective and prospective analyses)

18.3 Clinical evidence

We searched for cross sectional studies, cohort studies, case series (including both retrospective and prospective analyses) assessing the diagnostic test accuracy of airway hyper-reactivity (non-specific bronchial challenge) with histamine and methacholine to identify whether the condition is present (as indicated by the reference standard) in people under investigation for asthma.

The GDG considered evidence from studies reporting a cut-off value of ≤ 8 mg/ml. The GDG excluded studies with a cut-off value of a fall in FEV1 greater than or equal to 20% (PC20) at a concentration of ≤ 16 mg/ml from the review (with one exception noted below). Values at the higher end of this range are likely to occur in some healthy individuals and the GDG was concerned about a high number of

1 false positives at this cut-off value. Six studies were included in the review^{7,66,84,87,108,129} (see Table 52
2 and Table 53). Evidence from these are summarised in the clinical evidence profile below (Table 54
3 and Table 55). See also clinical article selection in Appendix D, sensitivity and specificity forest plots
4 in Appendix J, clinical evidence tables in Appendix G and excluded clinical studies in Appendix K.

5 Five studies^{7,66,87,108,129} were cross-sectional studies, and looked at the diagnostic accuracy of the
6 methacholine or histamine challenge test in patients with suspected asthma or asthma symptoms.
7 The reference standard was physician's diagnosis of asthma with an objective test. A variety of
8 objective tests were used for the reference standard (see Table 52). Four studies were in adults and
9 one study in children aged 5-16 years. In children aged 5-16 years, no evidence was available using
10 the ideal cut-off of 8mg/ml. Therefore, evidence was included from one study using a cut-off value
11 for a positive test of 16mg/ml⁷. This study also reported data in adults, children and young people
12 combined, however it was not included in the review in adults here, as other studies with the
13 preferred threshold of 8mg/ml were available in the adult population.

14 The remaining study⁸⁴ was a case-series, and looked at the diagnostic accuracy of methacholine or
15 histamine challenge tests vs. other diagnostic tests, in people who had already been diagnosed with
16 asthma. In this case, the index test was taken to be histamine challenge and the other test as the
17 reference standard.

Summary of included studies

Table 52: Summary of studies included in the review: Adults

Study	Population	Index test & cut-off	Reference standard	Comparator test & cut-off
HEDMAN 1998 ⁶⁶	N=230 Adults Referred with symptoms of cough, dyspnoea or wheezing of unknown cause	MCT PD20 6900µg	Physician Dx with objective test - according to guidelines of the American Thoracic Society (documented variation in FEV1 or PEF of ≥15% after medication, or repeatedly a ≥20% spontaneous PEFv during a period of 2 weeks AND a ≥15% decrease in FEV1 after a specific allergen provocation or during an exercise test)	None
KOSKELA 2003 ⁸⁴	N=42 Adults All people with asthma - recent Dx of asthma based on Physician Dx and objective test	HCT PD15 1mg and 0.4mg	n/a – all people with asthma so use comparator test	MANNITOL PD15 <635mg
KOWAL 2009 ⁸⁷	N=540 Adults (18-45 yrs) Referred to asthma clinic with chronic cough	HCT PC20 8mg/ml	Clinical follow-up 6 months (with objective test) (diurnal PEFV or significant improvement of FEV1 on administration of 200µg of salbutamol according to the GINA guidelines)	None
NIEMINEN 1992 ¹⁰⁸	N=791 Adults Referred to pulmonary clinic with dyspnoea, wheezing, prolonged cough or history of asthma	MCT PD20 2,600 µg	Physician Dx with objective test - according to guidelines of the American Thoracic Society (documented variation in FEV1 or PEF of ≥15% after medication, or repeatedly a ≥20% spontaneous PEFv during a period of 2 weeks AND a ≥15% decrease in FEV1 after a specific allergen provocation or during an exercise test)	None

Study	Population	Index test & cut-off	Reference standard	Comparator test & cut-off
POPOVIK 2002 ¹²⁹	N=195 Referred by GP with suspected asthma and symptoms of breathlessness / dyspnoea.	MCT PC20 8 mg/ml	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)	None

Table 53: Summary of studies included in the review: children 5-16 years

Study	Population	Index test & cut-off	Reference standard	Comparator test & cut-off
ANDERSON 2009 ⁷	N=375 Adults and children/young people (6-50 yrs). Sn/sp given for (a) all ages; (b) <18 yrs only Signs and symptoms suggestive of asthma according to NIH questionnaire with an equivocal Dx of asthma or referred for further investigation	MCT PC20 16mg/ml	Physician Dx with objective test (access to exercise challenge test result, history, examination, skin tests and BDR but not methacholine and mannitol challenge tests)	None (no comparator used as population is suspected asthma)

Table 54: Clinical evidence profile: Methacholine Challenge Test/Histamine Challenge Test vs Reference Standard (physician Dx and objective test)

Index Test (Threshold)	No of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity %median (range)	Specificity %median (range)	Area Under Curve (range)	Quality
Methacholine/Histamine Challenge Test:Adults										
PC20 ≤8mg/ml	2	735	Very serious risk of bias ^(a)	No serious inconsistency ^(b)	No serious indirectness	n/a ^(d)	93 - 97	83 - 100	n/a	LOW
PD20 ≤6900µg	1	230	No risk of bias ^(a)	No serious inconsistency ^(b)	No serious indirectness	n/a ^(d)	77	82	n/a	HIGH

Index Test (Threshold)	No of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity %median (range)	Specificity %median (range)	Area Under Curve (range)	Quality
PD20 ≤2600µg	1	791	Serious risk of bias ^(a)	No serious inconsistency ^(b)	No serious indirectness	n/a ^(d)	89	76	n/a	MODERATE
Methacholine Challenge Test: aged<18 years										
PC20 ≤16mg/ml	1	115	Serious risk of bias ^(a)	No serious inconsistency ^(b)	Serious indirectness ^(c)	n/a ^(d)	66	63	n/a	LOW

(a) Risk of bias was assessed using the QUADAS-II checklist. Outcomes were downgraded by one if the weighted (by sample size (n)) average number of QUADAS-II domains (patient selection, index test, reference standard and flow and timing) with methodological limitations was one. Outcomes were downgraded by two if the weighted average number of QUADAS-II domains with methodological limitations was more than one.

(b) Inconsistency was assessed by inspection of the sensitivity / specificity values in each of the studies in relation to a high (≥75%), moderate (50-74%) or low (<50%) effect estimate. Inconsistency was considered high if the point estimates from individual studies were within two areas, and very high if they were in 3 areas or both high and low areas.

(c) Study age range of 6-18 years does not match protocol of 6-15 years. Screening criteria included FEV1 >70% and non-atopic: selected group at screening may be a group with mild disease

(d) The judgement of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis, where performed.

Table 55: Clinical evidence profile: Methacholine Challenge Test/Histamine Challenge Test vs Other Tests

Index Test (Threshold)	No of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity %median (range)	Specificity %median (range)	Area Under Curve (range)	Quality
Histamine Challenge Test vs Mannitol Challenge Test: Adults										
PD15 ≤1mg	1	37	No risk of bias ^(a)	No serious inconsistency ^(b)	Serious indirectness ^(c)	n/a ^(d)	100	39	n/a	MODERATE
PD15 ≤0.4mg	1	37	No risk of bias ^(a)	No serious inconsistency ^(b)	Serious indirectness ^(c)	n/a ^(d)	84	89	n/a	MODERATE

(a) Risk of bias was assessed using the QUADAS-II checklist. Outcomes were downgraded by one if the weighted (by sample size (n)) average number of QUADAS-II domains (patient selection, index test, reference standard and flow and timing) with methodological limitations was one. Outcomes were downgraded by two if the weighted average number of QUADAS-II domains with methodological limitations was more than one.

(b) Inconsistency was assessed by inspection of the sensitivity / specificity values in each of the studies in relation to a high (≥75%), moderate (50-74%) or low (<50%) effect estimate. Inconsistency was considered high if the point estimates from individual studies were within two areas, and very high if they were in 3 areas or both high and low areas.

(c) Comparator test used as reference standard in people with confirmed asthma.

(d) The judgement of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis, where performed.

1 **18.4 Economic evidence**

2 **Published literature**

3 No relevant economic evaluations were identified.

4 See also the economic article selection flow chart in Appendix E.

5 **Health economic modelling**

6 ***Model overview/methods***

7 Six diagnostic strategies were created using combinations of the following tests:

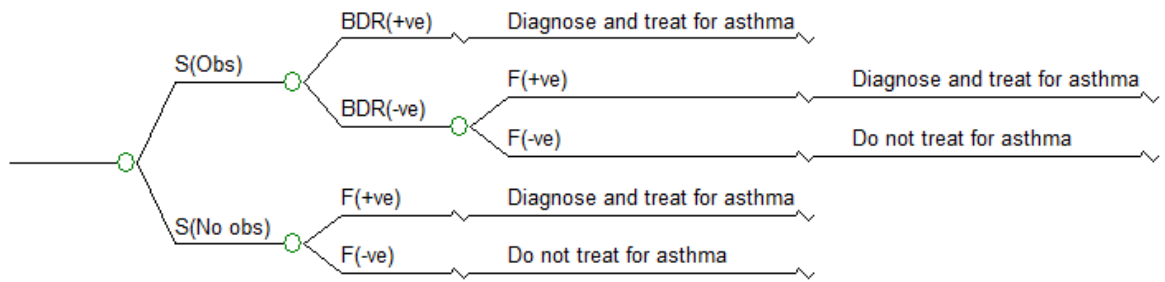
- 8 • spirometry
- 9 • bronchodilator reversibility
- 10 • FeNO
- 11 • peak expiratory flow variability
- 12 • challenge tests.

13 The GDG agreed that only one challenge test would ever be conducted per patient meaning that
14 challenge testing would only appear once in a diagnostic strategy. Therefore once the diagnostic
15 strategies were developed it was proposed to duplicate each strategy which used challenge testing
16 using the diagnostic accuracies and costs of histamine/methacholine, mannitol or exercise challenge
17 test. However once the costs of an exercise challenge test and a methacholine challenge test had
18 been established it was apparent that the exercise challenge test was the more expensive test. The
19 clinical review also found that exercise challenge tests had a lower sensitivity and specificity when
20 compared to a methacholine challenge test. Therefore exercise challenge tests were not modelled as
21 they would always be dominated (more costly and provide lower health outcomes) when compared
22 to methacholine challenge tests. Mannitol was also not modelled as the clinical review found it had a
23 low sensitivity and specificity. Adding mannitol to the diagnostic pathway would in fact decrease the
24 overall diagnostic accuracy of the pathway making it dominated by strategies that did not use
25 challenge tests.

26 All the pathways were constructed using clinical judgement and taking into account the evidence
27 produced in the clinical review.

28 **Strategy 1**

29 Strategy 1 involves the fewest number of tests. The exact point that each test appears in the
30 diagnostic pathway and at which point patients are diagnosed with asthma is shown in Figure 4. For
31 example in Figure 4 spirometry (S) is used as the initial test, followed by bronchodilator reversibility
32 (BDR) if S detects obstruction (Obs) or FeNO (F) if S does not detect obstruction (No obs). If BDR is
33 negative this is followed by F. A diagnosis of asthma is made with either a positive BDR or F, while
34 asthma is excluded only with a negative F.

1 **Figure 4: Strategy 1**

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(-ve): negative; (+ve): positive; BDR: bronchodilator reversibility test; F: FeNO; S: spirometry; (Obs): obstruction

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Strategy 2

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The second strategy involves spirometry, bronchodilator reversibility, FeNO and PEF variability (PEF). The diagnostic pathway is shown in Figure 5. As more tests can be conducted after a FeNO test, if a patient receives a negative FeNO test, the FeNO level that was measured in the patient is also taken into account when deciding what to do next. This test is considered negative when the FeNO level is below 40 parts per billion (ppb), however the confidence in excluding a diagnosis of asthma depends on how close to this cut off the result is. If the FeNO level is below 25 parts per billion (ppb), along with an obstructive spirometry and a negative BDR, asthma is ruled out. If the FeNO level is between 25 – 40ppb then the diagnosis of asthma still cannot be ruled out and further tests are conducted. In strategy 2 below the patient goes on to have a PEFv test.

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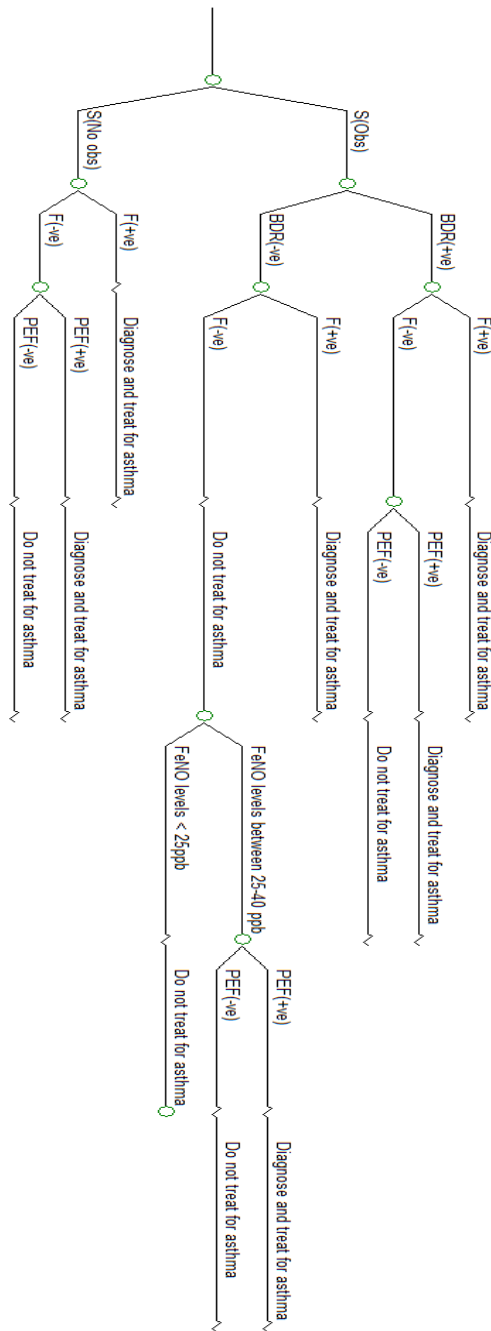
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Figure 5: Strategy 2



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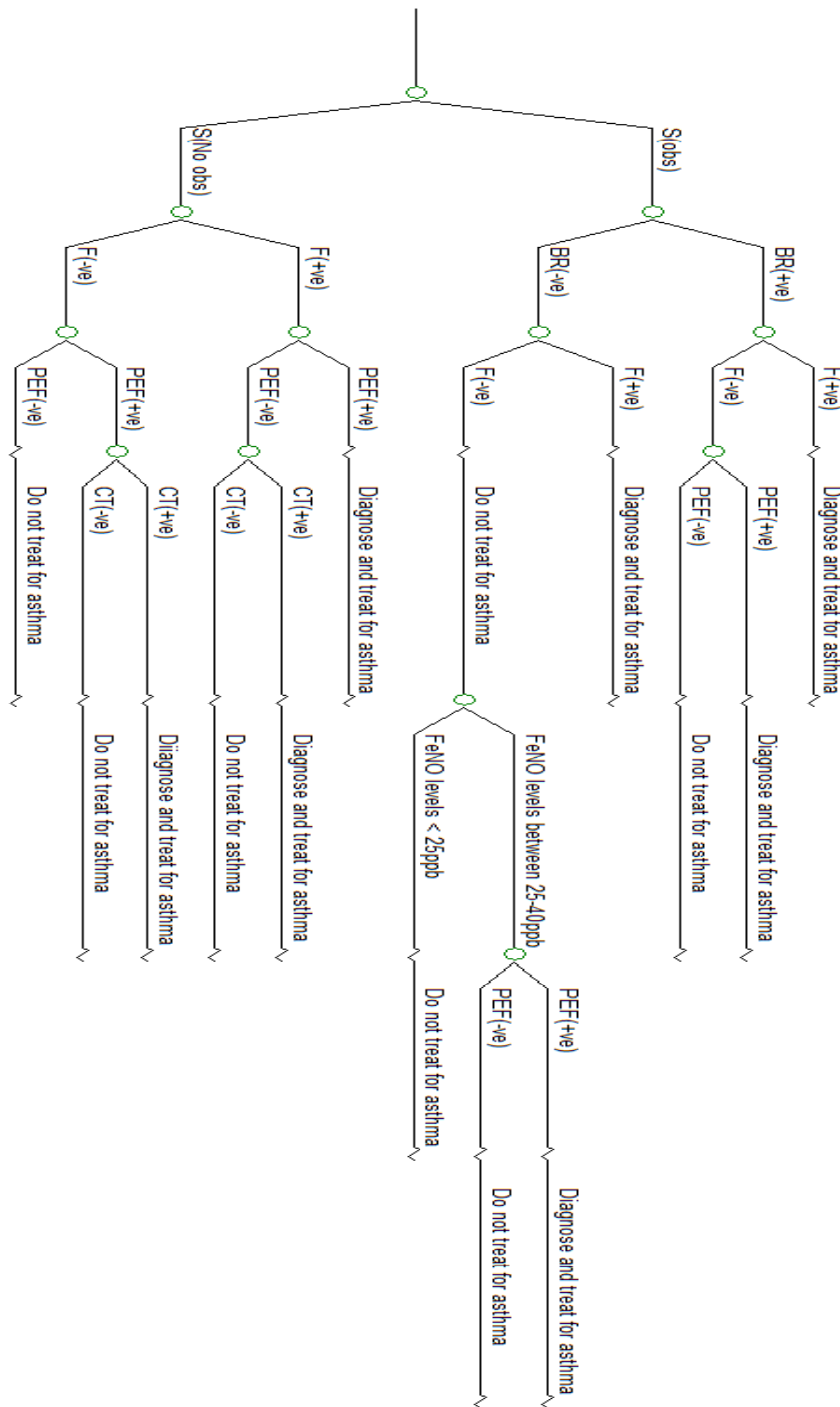
3 (-ve): negative; (+ve): positive; BDR: bronchodilator reversibility test; F: FeNO; S: spirometry; (Obs): obstruction;
 4 PEF: peak expiratory flow variability

5 **Strategy 3**

6 The third strategy uses spirometry, bronchodilator reversibility, FeNO, PEF variability and a
 7 methacholine challenge test (CT). The diagnostic pathway is shown in Figure 6. Note in this pathway
 8 challenge tests are only used on patients who have a non-obstructive spirometry.

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Figure 6: Strategy 3



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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

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Strategy 4

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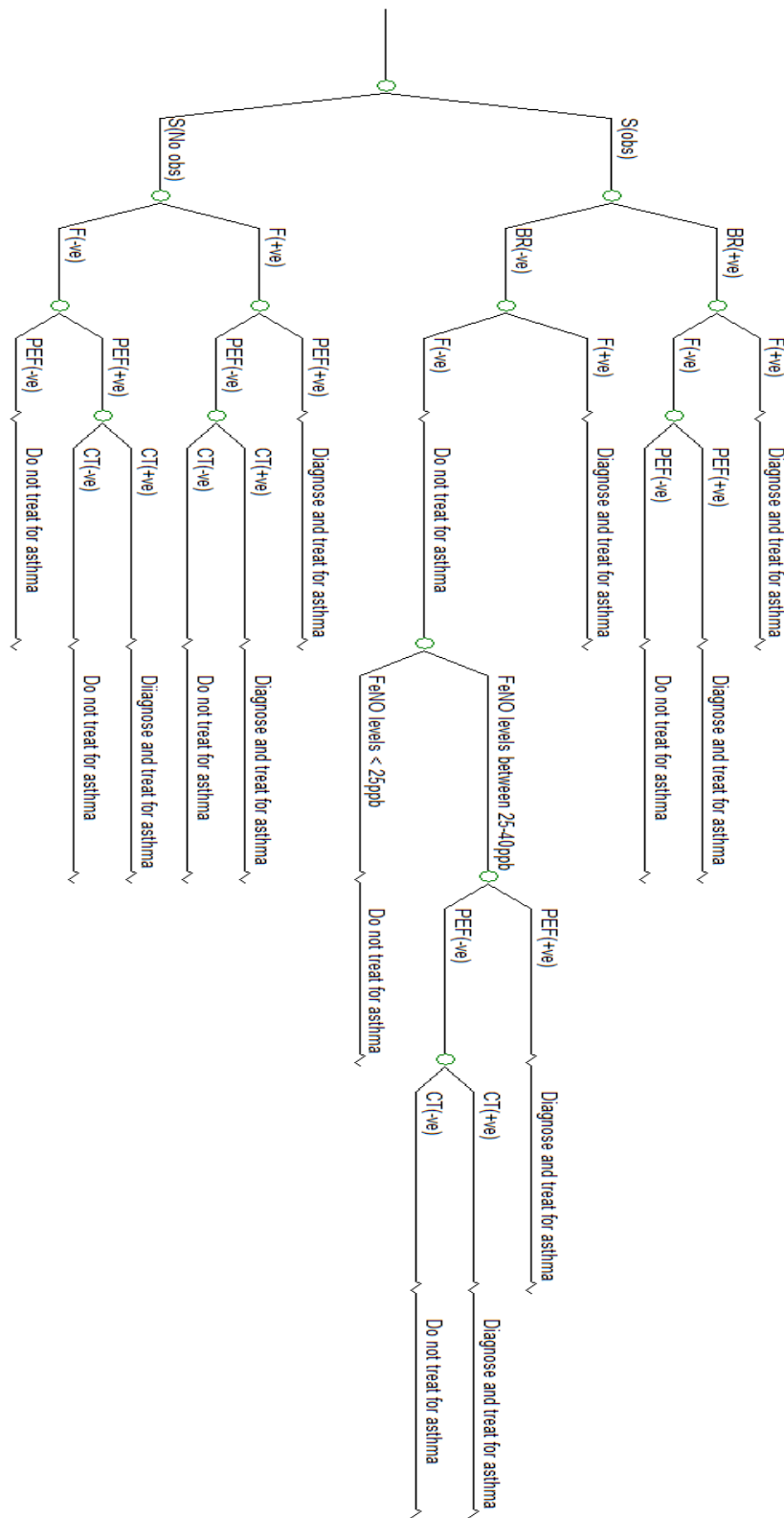
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The fourth strategy shown in Figure 7 expands the use of challenge tests as seen in strategy 3. Now a CT is also conducted on patients with a positive BDR, negative FeNO and a negative PEFv result. The use of FeNO levels is also taken into account, whereby a CT is only conducted in this arm when FeNO levels are between 25-40ppb.

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Figure 7: Strategy 4



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4 (-ve): negative; (+ve): positive; BDR: bronchodilator reversibility test; CT: challenge test; F: FeNO; S: spirometry;

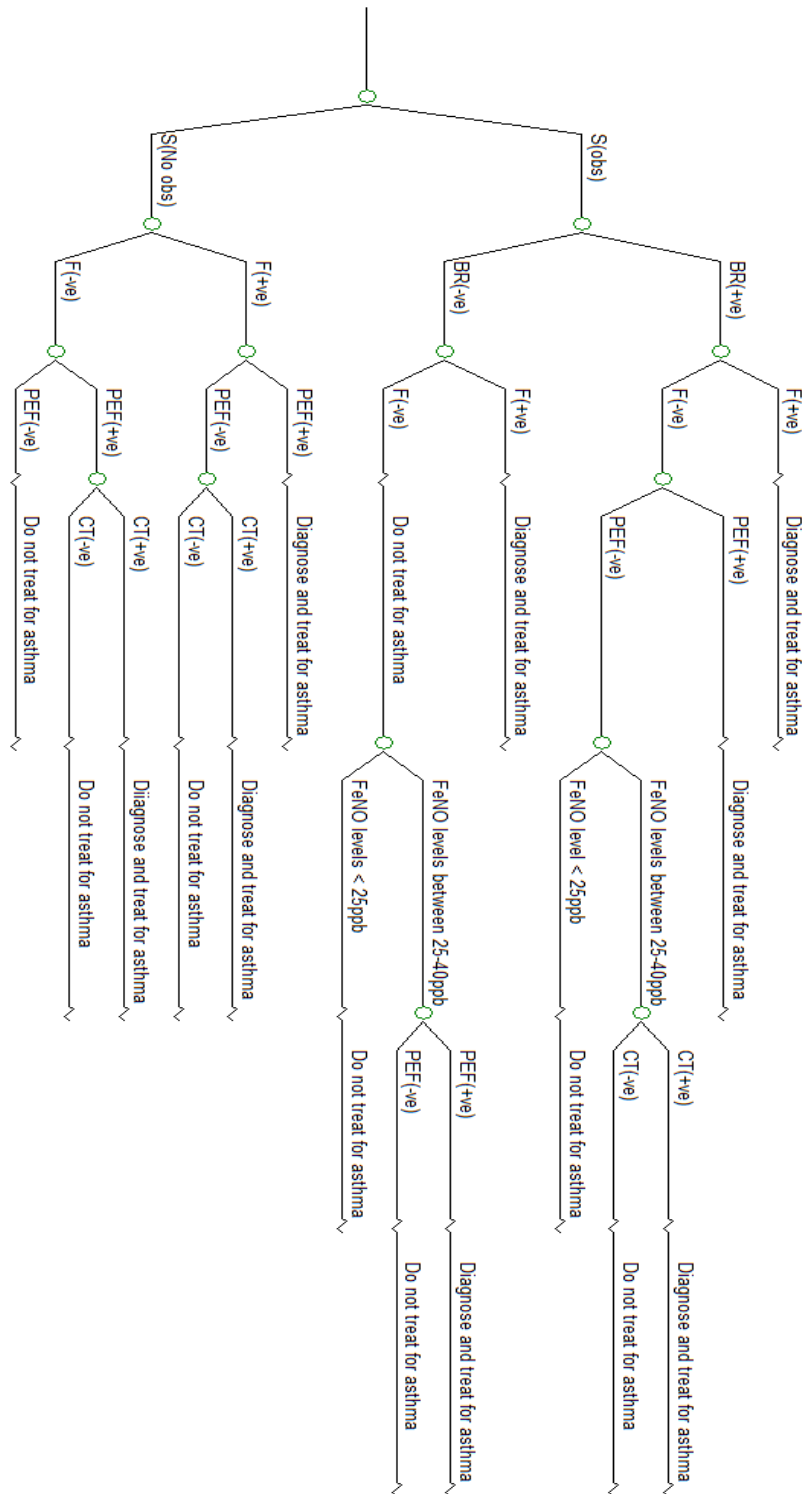
5 (Obs): obstruction; PEF: peak expiratory flow variability

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Strategy 5

The fifth strategy, shown below in Figure 8, also expands the use of challenge tests, as seen in strategy 3, however places the additional CT at a different point in the pathway. Now a CT is also conducted on patients with a negative BDR, negative FeNO (between 25-40ppb) and a negative PEFv test result.

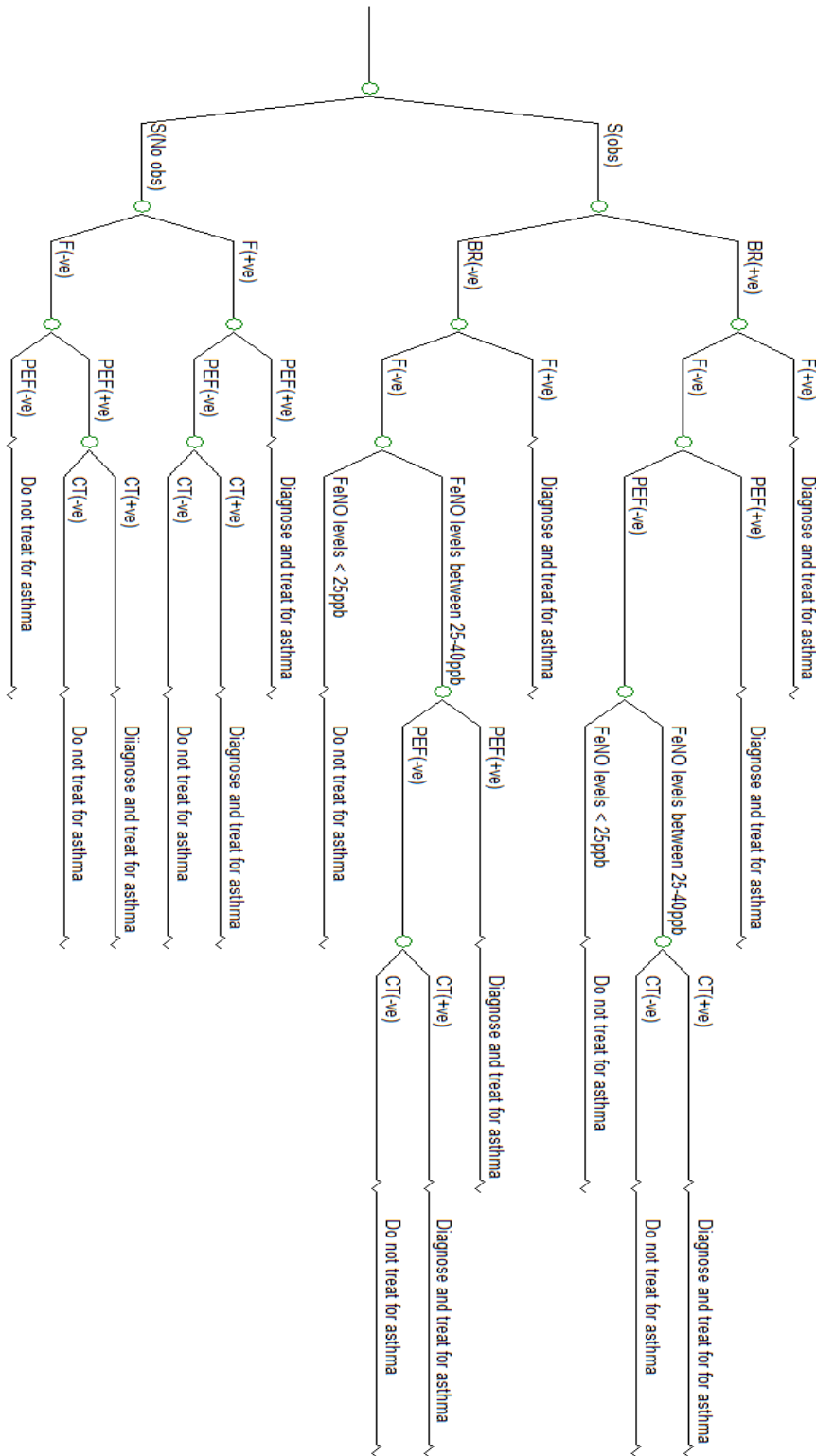
Figure 8: Strategy 5



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- 1 **Strategy 6**
- 2 The sixth strategy, shown below in Figure 9, is the most comprehensive and uses the maximum
- 3 number of challenge tests.

4 **Figure 9: Strategy 6**



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1 Current practice

2 A final strategy considered involves not giving the patient any tests and diagnosing without the use of
3 objective tests. To make this strategy more reflective of current practice it is assumed that some of
4 the non-asthmatics will be correctly diagnosed as not having asthma. One prevailing thought is that
5 one third of people currently diagnosed with asthma are misdiagnosed, ie they do not have asthma
6 (False positive) according to a study by Aaron et al.^{1,1} Therefore, the proportion of false positives
7 calculated in this strategy will be a third of the total number of positive diagnoses made:

$$\frac{\text{False positives}}{\text{False positives} + \text{True positives}} = \frac{1}{3}$$

8 As no tests are conducted the only costs that are incurred in this strategy are those that occur after
9 the diagnosis is made (e.g. the cost of asthma treatment). An assumption was made that all people
10 with asthma are correctly diagnosed giving this strategy a sensitivity of 100%.

11 The economic evaluation was a cost-utility analysis, where lifetime costs and quality-adjusted life-
12 years (QALYs) were considered from a UK NHS and personal social services perspective. The model
13 was based on two parts:

- 14 • **Decision tree** - Using the sensitivity and specificity, combined with data on the prevalence of
15 asthma in the defined population, the model identifies the proportion of patients that receive a
16 true positive (TP), true negative (TN), false positive (FP) or false negative (FN) diagnosis.
- 17 • **Markov model** - Once the diagnosis is made the patient moves on to the second part of the
18 model which involves a Markov model to fully evaluate the patients' health and cost outcomes.
19 This incorporates the time spent misdiagnosed and the associated decrease in quality of life,
20 higher mortality risks and wasted NHS resources.

21 The model makes some assumptions concerning:

- 22 • Conditional dependence
- 23 • The underlying condition the individual will have if they present asthma symptoms but do
24 not have asthma
- 25 • The length of misdiagnosis
- 26 • Quality of life for incorrectly treated individuals (false positives and false negatives)

27 The accuracy of diagnostic tests was taken from the clinical reviews presented in this guideline and
28 altered, where appropriate, in light of conditional dependence. Full details on how these
29 assumptions were implemented can be found in the full model write up in appendix M.

30 Results

31 The results below in Table 56 show that diagnostic strategy 3 has the highest net monetary benefit
32 and is therefore the most cost-effective way of diagnosing asthma. Strategy 6 produces the highest
33 number of QALYs however is not deemed cost-effective at a £20,000 per QALY threshold. Strategy 1
34 produces the least QALYs and the highest cost.

35 **Table 56: 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	Mean per patient		NMB at £20,000 threshold	Rank at £20,000 threshold	Probability of being CE at £20,000 threshold
	QALYs	Cost			
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%

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Table 57 below shows the overall sensitivity and specificity of each diagnostic pathway, that is the percentage of patients with asthma that receive a true positive diagnosis and the percentage of patients without asthma that receive a true negative diagnosis.

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Table 57: 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%

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Table 57 shows a dramatic increase in specificity once FeNO is routinely performed on all individuals (strategy 2). Once challenge tests are added to the diagnostic pathway specificity also increases considerably (strategies 3, 4, 5 and 6). No strategy has a single highest value for sensitivity and specificity though strategy 6 has the highest diagnostic odds ratio. Finally Table 58 below shows the costs associated with objective tests for each strategy.

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Table 58: 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

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Table 58 shows that although the strategies that include challenge tests cost more the increase in cost is far less than the additional cost of a single challenge tests as the majority of individuals will not go on to receive one.

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Overall this analysis showed that strategy 3 is the most cost-effective strategy at a £20,000 per QALY threshold. Further challenge testing on patients with an obstructive spirometry who had either (negative BDR and FeNO results) or (positive BDR, negative FeNO and PEFv results) provided higher health outcomes however were not cost-effective at a £20,000 per QALY threshold.

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A series of sensitivity analyses show that, with regards to the routine use of challenge tests in asthma diagnosis, the model results are highly robust to health and cost outcomes attached to false positives, speed of re-diagnosis and the effects of conditional dependence. These are three key uncertain areas of the model. The sensitivity analyses did show however that there is scope for additional challenge tests (as detailed in strategies 5 and 6) to be cost-effective at a £20,000 per QALY threshold. In the base case the ICER for providing an additional challenge test as detailed in strategy 5 was £20,276 per QALY. The ICER of providing challenge tests at all appropriate points in the pathway, as detailed by strategy 6, was £32,565. However sensitivity analyses showed there were some scenarios where it was cost-effective to do these additional challenge tests such as when the diagnostic accuracy of FeNO changed. The sensitivity analyses also showed that the cost-

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1 effectiveness of performing these additional challenge tests was contingent on a very high specificity
2 of methacholine challenge tests. As the model does not fully capture conditional dependence
3 concerning the accuracy of this test the GDG were cautious to routinely recommend these additional
4 challenge tests.

5 The GDG believe these additional challenge tests would be cost-effective in some situations where
6 other diagnoses could not easily be ruled in. For example if another diagnosis, such as COPD, is
7 considered likely then further challenge testing should not be considered. Therefore these additional
8 challenge tests should not be routinely carried out, unlike those placed in strategy 3 but should still
9 be considered.

10 The main limitations of the model concerned the lack of clinical data informing parameters
11 associated with misdiagnosis as, due to ethical reasons; this evidence will likely never be available.
12 However the model results were robust to all the assumptions imposed arounds these parameters
13 which therefore limits their impact on the model.

14 Full details of the model and results can be found in appendix M.

15 **Unit cost of performing a direct bronchial challenge test on children**

16 As an economic model was not feasible for children, the GDG considered the unit cost of performing
17 a direct bronchial challenge test to evaluate its cost-effectiveness as part of a pathway for diagnosing
18 asthma. The NHS reference cost associated with 'Bronchial reactivity studies' (HRG code: DZ36Z) is
19 £177.⁴⁵ A paediatric respiratory outpatient visit would also need to be considered to interpret the
20 result; this is cost as £197 in the NHS reference costs.

21 **18.5 Evidence statements**

22 **Clinical**

- 23 • Two studies with 735 adults showed that methacholine/histamine challenge test (PC20 cut-off
24 8mg/ml) has a sensitivity range of 93-97% and a corresponding specificity range of 83-100% for
25 diagnosing asthma in people presenting with respiratory signs and symptoms. (LOW QUALITY)
- 26 • One study with 230 adults showed that methacholine/histamine challenge test (PD20 cut-off
27 6900µg) has a sensitivity of 77% and a corresponding specificity of 82% for diagnosing asthma in
28 people presenting with respiratory signs and symptoms. (HIGH QUALITY)
- 29 • One study with 791 adults showed that methacholine/histamine challenge test (PD20 cut-off
30 2600µg) has a sensitivity of 89% and a corresponding specificity of 76% for diagnosing asthma in
31 people presenting with respiratory signs and symptoms. (MODERATE QUALITY)
- 32 • One study with 115 children and young people showed that methacholine/histamine challenge
33 test (PC20 cut-off 16mg/ml) has a sensitivity of 66% and a corresponding specificity of 63% for
34 diagnosing asthma in people presenting with respiratory signs and symptoms. (LOW QUALITY)
- 35 • One study with 37 adults showed that methacholine/histamine challenge test (PD15 cut-off 1mg)
36 has a sensitivity of 100% and a corresponding specificity of 39% for a positive mannitol challenge
37 test in people with asthma. (MODERATE QUALITY)
- 38 • One study with 37 adults showed that methacholine/histamine challenge test (PD15 cut-off 4mg)
39 has a sensitivity of 84% and a corresponding specificity of 89% for a positive mannitol challenge
40 test in people with asthma. (MODERATE QUALITY)

41 **Economic**

- 42 • An original health economic model found that histamine and methacholine challenge test
43 (together with spirometry, BDR, FeNO and PEFv) was part of the most cost-effective diagnostic

- 1 pathway used to diagnose asthma in adults aged 16 and over (see diagnostic algorithms in section
- 2 4.1). This evidence is directly applicable with minor limitations.

1 18.6 Recommendations and link to evidence

<p>Recommendations</p>	<p>19. Offer a direct bronchial challenge test with histamine or methacholine^f in adults and young people older than 16 if there is diagnostic uncertainty after a normal spirometry and either a:</p> <ul style="list-style-type: none"> • FeNO level of 40 ppb or more and no variability in peak flow readings or • FeNO level of 39 ppb or less with variability in peak flow readings. <p>Regard a PC20 value of 8 mg/ml or less as a positive test.</p> <p>20. Consider a direct bronchial challenge test with histamine or methacholine^f in adults and young people older than 16 with:</p> <ul style="list-style-type: none"> • obstructive spirometry and • a FeNO level between 25 and 39 ppb and • no variability in peak flow readings (less than 20% variability over a 2-4 week period). <p>Regard a PC20 value of 8 mg/ml or less as a positive test.</p>
<p>Research recommendations</p>	<p>1. What is the acceptability and diagnostic accuracy of objective tests that could be used to comprise a diagnostic pathway for asthma in children aged 5-16 years old (for example, exercise challenge, direct bronchial challenge with histamine or methacholine, indirect bronchial challenge with mannitol and peripheral blood eosinophil count)?</p>
<p>Relative values of different outcomes</p>	<p>The GDG was interested in the diagnostic test accuracy of airway hyper-reactivity (non-specific bronchial challenge) with histamine or methacholine.</p> <p>One of the concerns that set the scope of this guideline is the over-diagnosis of asthma leading to inappropriate treatment; therefore, the GDG was interested in both the sensitivity and specificity of diagnostic tests and prioritised studies which reported these outcomes. Sensitivity and specificity values will depend on the chosen cut-off point. The GDG considered evidence from studies reporting a cut-off value of ≤ 8 mg/ml. The GDG excluded studies with a cut-off value of a fall in FEV1 greater than or equal to 20% (PC20) at a concentration of ≤ 16 mg/ml from the review. Values at the higher end of this range are likely to occur in some healthy individuals, and the GDG was concerned about a high number of false positives at this cut-off value.</p> <p>Evidence from studies reporting a PD20 cut-off of ≤ 6900 μg or ≤ 2600 μg were also considered, particularly when a ROC curve had been used in the study to identify the diagnostic cut-off. In children, evidence from studies with a cut-off value of ≤ 16 mg/ml was considered due to lack of other evidence.</p>
<p>Trade-off between clinical benefits and harms</p>	<p>The sensitivity and specificity of methacholine and histamine challenge tests was high in adults at all three cut-off thresholds (including the preferred threshold of 8 mg/ml), suggesting it is both a good rule-in and rule-out test at this threshold. In children aged 5-16 years, there was no evidence at the preferred cut-off threshold of 8 mg/ml, so evidence was included at a cut-off of 16 mg/ml. The sensitivity and specificity of the test in children aged 5-16 years was moderate.</p>

^f At the time of consultation (January 2015), methacholine did not have a 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.

	<p>As with all functional tests, it relies on the ability to perform spirometry according to standard spirometry techniques. Bronchial hyper-reactivity varies over time so a negative test does not completely exclude asthma (the test cannot be used to rule-out asthma on its own).</p> <p>The methacholine or histamine challenge test is time-consuming and needs to be performed in secondary care. Patients who have been started on empirical anti-asthma treatment will have to stop treatment prior to the test, which may put them at risk, although this risk is low in people in whom there is genuine diagnostic doubt. Furthermore, methacholine and histamine challenge tests are very well tolerated in the vast majority of patients, but there is a rare risk of a severe bronchospasm response to methacholine and histamine and therefore resuscitation facilities are required wherever the test is to be performed.</p> <p>Histamine can cause throat irritation and methacholine is likely to be better tolerated.</p>
Economic considerations	<p>No economic evaluations were found which assessed the use of direct bronchial challenge tests as part of a diagnostic pathway. Therefore, an original health economic model was built to assess the cost-effectiveness of different diagnostic pathways for asthma. The model assessed the additional costs of tests against cost-savings from unnecessary asthma medication, and the increased health outcomes from providing correct treatment.</p> <p>The most cost-effective strategy involved using spirometry, bronchodilator reversibility (BDR), FeNO, peak expiratory flow variability (PEFv) and a methacholine challenge test (MCT) to diagnose asthma. In this strategy everybody with symptoms of asthma would undergo a spirometry and FeNO measurement, those who had an obstructive spirometry would also receive a BDR test. Only those who had non-obstructive spirometry and conflicting FeNO and PEFv test results would receive a MCT. Adopting this strategy dominated all other strategies apart from those which performed challenge tests at additional points in the pathway. The ICERs of adopting these further strategies were above £20,000 per QALY gained.</p> <p>The model result of using challenge tests in a diagnostic pathway as opposed to no challenge tests was robust to changes in all key assumptions apart from significant changes in health benefits derived from correctly diagnosing people who do not have asthma. The GDG noted that the model did not consider mortality impacts; severe misdiagnoses such as tuberculosis or lung cancer; or the adverse effects of asthma treatment. Including these aspects would increase the cost-effectiveness of strategies that include challenge testing as they have a higher specificity. This shows there is considerable value in using highly accurate challenge tests outside of primary care to diagnose asthma.</p> <p>The sensitivity analysis did pick up on an element of uncertainty in the model with regards to how many MCTs should be conducted. This uncertainty has been captured in the strength of recommendations around the use of challenge tests in certain points of the pathway.</p> <p>Where challenge tests are offered in the algorithm of recommendation there is strong evidence to suggest that doing so is cost-effective at a £20,000 per QALY threshold, therefore they should be routinely performed on all patients at these points. In the base case performing challenge tests at these points was a dominant strategy, producing better health outcomes at a lower cost, than not performing challenge tests. This result was robust to a variety of sensitivity analyses which supports their strong recommendation.</p>

	<p>Where challenge tests are ‘considered’ in the algorithm of recommendations there is evidence to suggest they could be cost-effective at a £20,000 per QALY threshold, however this evidence is much more uncertain. At these points in the pathway MCTs should be considered on a case by case basis where the clinician will decide if they have enough evidence to exclude asthma. If the clinician believes the individual has strong signs of asthma or their symptoms are unlikely to be caused by something else then referring them for a challenge test and confirming this result will be a cost-effective use of resources. For example COPD can be ruled-out for an individual who is 30 years old and never smoked. By reserving challenge tests for these patients it can be ensured that only those with the highest diagnostic uncertainty receive the tests at this point making them cost-effective for these patients.</p> <p>For children, as the clinical evidence informing the diagnostic accuracy of these tests was poor and the cost of using these tests is very high, the GDG felt they could not make a recommendation concerning their use in a diagnostic pathway from consensus alone. Therefore an appropriate research recommendation was devised.</p>
Quality of evidence	<p>The quality of the evidence ranged from low to high. The GDG noted that in included studies there were very few false positives, which increases the specificity of the test. It is possible that the test will perform less well outside trial conditions.</p> <ul style="list-style-type: none"> • In children aged <5 years, we did not search for studies as spirometry is not routinely performed in this age group. • In children aged 5-16 years, there was one included study⁷ using the reference standard (physician diagnosis with objective test) that addressed the use of methacholine in this age group. Methacholine challenge tests had a moderate sensitivity and moderate specificity. Evidence with a cut-off value of $\leq 16\text{mg/ml}$ was considered due to lack of evidence in children and young people. The GDG was concerned that the inclusion criteria for the study ($\text{FEV}_1 > 70\%$ and non-atopic) may pre-select a population with mild disease, and therefore the evidence was downgraded for indirectness. Overall, this evidence was of low quality. • In adults, there were four included studies^{66,87,108,129} using the best reference standard (physician diagnosis with objective test) that addressed the use of methacholine or histamine challenge test. Two studies used a cut-off threshold for a positive test of 8mg/ml. The evidence at this threshold was of low quality. Additionally, in adults there was one study comparing methacholine or histamine challenge testing with mannitol challenge testing as a proxy for asthma; this study showed high sensitivity but low specificity at a cut-off value of $\text{PC}_{15} \leq 1\text{mg}$ and a high sensitivity and high specificity at a cut-off value of $\text{PC}_{15} \leq 0.4\text{mg}$. <p>The economic evidence was assessed as directly applicable with minor limitations.</p>
Other considerations	<p>The GDG recommendation is based on review of the evidence in adults and consensus opinion of the GDG for a research recommendation in children. The GDG made a high-priority research recommendation to investigate the acceptability and performance characteristics of objective tests, including histamine and methacholine challenge tests, which could be used to comprise a diagnostic pathway for asthma in children aged 5-16 years old. Further details on the high-priority research recommendation made can be found in appendix N, along with the full list of research recommendations.</p> <p>Based on the best available evidence, the bronchial challenge is currently the best test available for adults; however its use is limited by familiarity and ability to perform the test. It is limited to secondary care and, particularly in a paediatric population, there is a lack of experience using the test. As with all functional tests, it relies on the ability to perform spirometry according to standard spirometry techniques. Bronchial hyper-reactivity varies over time so a negative test does not</p>

exclude asthma, therefore the test cannot be used to rule-out asthma on its own.

The available evidence suggested that the best combination of sensitivity/specificity is at the cut-off point of 8mg/ml for PC20. This was included in the recommendation. The GDG accepted that calculating a PD20 rather than a PC20 is entirely valid, but PD20 will vary more with the dosimeter used in the test, and therefore a recommended cut-off value for PD20 is not given.

When considering the use of a histamine/methacholine challenge test (MCT) in a diagnostic pathway the GDG considered the diagnostic accuracy of the test and the practicality of implementing the test. Unlike most tests that are used to diagnose asthma the MCT, currently, can only be performed in secondary care. The GDG felt this test should only be performed on individuals who have considerable diagnostic uncertainty after performing other tests. Regarding the MCTs exact placement in a pathway the GDG noted certain combination of test results they felt would result in a definitive diagnosis. Therefore the MCT is used after conflicting test results where diagnostic uncertainty is highest.

The GDG felt this may be an important and useful test in the diagnosis of asthma in children but there is currently inadequate evidence available to assess either its efficacy or acceptability and tolerability for children and their care givers.

19 Diagnosis: Indirect bronchial challenge test with mannitol

19.1 Introduction

Hyper-reactivity of the airways is a key feature of asthma. Inhaled dry powder mannitol increases the osmolarity of the mucosal lining of the respiratory epithelium and leads to bronchoconstriction by inducing the release of inflammatory mediators. This is an indirect bronchial provocation test similar to exercise testing and to eucapnoic voluntary hyperpnea. The test is performed by inhaling increasing doses of mannitol until lung function testing demonstrates a 15% reduction in FEV1 from baseline. It is said to mimic the mechanism of bronchoconstriction in exercise induced asthma. As this test is easy to perform, easy to standardise and carries a low risk of severe bronchoconstriction, its utility and accuracy in the diagnosis of asthma in people with asthma symptoms is of interest.

19.2 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?

For full details see review protocol in Appendix C.

Table 59: Characteristics of review question

Population	People with suspected asthma (presenting with respiratory symptoms). Ages stratified into the following 2 different groups: <ul style="list-style-type: none">• Children/young people (5-16 years old)• Adults (>16 years old)
Index test	Mannitol
Reference standard	Physician diagnosis of asthma based on symptoms plus an objective test
Statistical measures	Diagnostic accuracy (sensitivity, specificity)

19.3 Clinical evidence

We searched for cross sectional studies, cohort studies, case series (including both retrospective and prospective analyses) assessing the diagnostic test accuracy of airway hyper-reactivity (non-specific bronchial challenge) with mannitol to identify whether the condition is present (as indicated by the reference standard) in people under investigation for asthma.

One study was included in the review⁷. Evidence from this study is summarised in Table 60 and in the clinical evidence profile below (Table 61).

Evidence was available from adults and children/young people pooled together (6-50 years) and from children and young people alone (6-18 years). Data for forest plots have been separated into these two strata; however these groups are indirect to the protocol. See also Appendix D: Clinical article selection, Appendix J: Coupled sensitivity / specificity forest plots, Appendix G: Clinical evidence tables and Appendix K: Excluded clinical studies.

- 1 The included study⁷ was a cross-sectional study, and looked at the diagnostic accuracy of the
- 2 mannitol challenge test in patients with suspected asthma or asthma symptoms. The reference
- 3 standard was physician's diagnosis of asthma with an objective test.

Summary of included studies

Table 60: Summary of studies included in the review

Study	Population	Index test & cut-off	Reference standard	Comparator test & cut-off
ANDERSON 2009 ⁷	N=375 Adults and children/young people (6-50 yrs). Sn/sp given for: <ul style="list-style-type: none"> • all ages • <18 yrs only Signs and symptoms suggestive of asthma according to NIH questionnaire with an equivocal Dx of asthma or referred for further investigation	Mannitol ≥15% fall in FEV1 ≤635mg or 10% fall between consecutive doses.	Physician Dx with objective test (access to exercise challenge test result, history, examination, skin tests and BDR but not methacholine and mannitol challenge tests)	No comparator as population is suspected asthma not confirmed asthma

Table 61: Clinical evidence profile: Mannitol Challenge Test vs Reference Standard (physician Dx and objective test)

Index Test (Threshold)	No of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity % (range)	Specificity % (range)	Area Under Curve (range)	Quality
Mannitol Challenge Test – all age groups										
≥15% fall in FEV1 ≤635mg or 10% fall between consecutive doses	1	375	Serious risk of bias ^(a)	No serious inconsistency ^(b)	Serious indirectness ^(c)	n/a ^(e)	56	75	n/a	LOW
Mannitol Challenge Test <18 yrs										
≥15% fall in FEV1 ≤635mg or 10% fall between consecutive doses	1	115	Serious risk of bias ^(a)	No serious inconsistency ^(b)	Serious indirectness ^(d)	n/a ^(e)	63	81	n/a	LOW

(a) Risk of bias was assessed using the QUADAS-II checklist. Outcomes were downgraded by one if the weighted (by sample size (n)) average number of QUADAS-II domains (patient selection, index test, reference standard and flow and timing) with methodological limitations was one. Outcomes were downgraded by two if the weighted average number of QUADAS-II domains with methodological limitations was more than one.

(b) Inconsistency was assessed by inspection of the sensitivity / specificity values in each of the studies in relation to a high (≥75%), moderate (50-74%) or low (<50%) effect estimate. Inconsistency was considered high if the point estimates from individual studies were within two areas, and very high if they were in 3 areas or both high and low areas.

(c) Inclusion of one study with mixed population of adults and children/young people. Screening criteria included FEV1 >70% and non-atopic: selected group at screening may be a group with mild disease.

(d) Study age range of 6-18 yrs does not match protocol of 5-16 years. Screening criteria included FEV1 >70% and non-atopic: selected group at screening may be a group with mild disease.

(e) The judgement of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis, where performed.

1 19.4 Economic evidence

2 Published literature

3 No relevant economic evaluations were identified.

4 See also the economic article selection flow chart in Appendix E.

5 New cost-effectiveness analysis

6 An original health economic model was built for adults to assess the cost-effectiveness of several
7 diagnostic pathways. Non-specific bronchial challenge test with mannitol was considered as part of
8 the diagnostic strategy, however due to its low diagnostic accuracy, found in the clinical review,
9 adding mannitol to the diagnostic pathway reduced the overall sensitivity and specificity. This meant
10 the strategy would cost more and produce poorer health outcomes making it a dominated strategy.
11 Full details of the model can be found in Appendix M. A summary of the model can be found in
12 section 18.4.

13 Unit cost of performing a bronchial challenge test with mannitol on children

14 As an economic model was not feasible for children, the GDG considered the unit cost of performing
15 a direct bronchial challenge test to evaluate its cost-effectiveness as part of a pathway for diagnosing
16 asthma. The NHS reference cost associated with 'Bronchial reactivity studies' (HRG code: DZ36Z) is
17 £177.⁴⁵ A paediatric respiratory outpatient visit would also need to be considered to interpret the
18 result; this is cost as £197 in the NHS reference costs.

19 19.5 Evidence statements

20 Clinical

- 21 • One study with 375 adults, children and young people showed that mannitol challenge test has a
22 sensitivity of 56% and a corresponding specificity of 75% for diagnosing asthma in people
23 presenting with respiratory signs and symptoms. (LOW QUALITY)
- 24 • One study with 115 children and young people showed that mannitol challenge test has a
25 sensitivity of 63% and a corresponding specificity of 81% for diagnosing asthma in people
26 presenting with respiratory signs and symptoms. (LOW QUALITY)

27 Economic

- 28 • No relevant economic evaluations were identified.

29 19.6 Recommendations and link to evidence

Recommendations	No clinical recommendation.
Research recommendations	<p>1. What is the acceptability and diagnostic accuracy of objective tests that could be used to comprise a diagnostic pathway for asthma in children aged 5-16 years old (for example, exercise challenge, direct bronchial challenge with histamine or methacholine, indirect bronchial challenge with mannitol and peripheral blood eosinophil count)?</p> <p>2. What is the clinical and cost effectiveness of using an indirect bronchial</p>

	challenge test with mannitol to diagnose asthma in adults and young people older than 16?
Relative values of different outcomes	<p>The GDG was interested in the diagnostic test accuracy of airway hyper-reactivity (non-specific bronchial challenge) with mannitol.</p> <p>One of the concerns that set the scope of this guideline is the over-diagnosis of asthma leading to inappropriate treatment; therefore, the GDG was interested in both the sensitivity and specificity of diagnostic tests and prioritised studies which reported these outcomes. Sensitivity and specificity values will depend on the chosen cut-off point. The cut-off point of a fall in FEV1 greater than or equal to 15% at a cumulative dose ≤ 635mg of mannitol was taken as the standard cut-off currently used in clinical practice.</p>
Trade-off between clinical benefits and harms	<p>Data were considered from adults, children and young people pooled together, and from children <18 years alone. In both groups, the mannitol challenge test had a moderate sensitivity and a high specificity. This suggests mannitol challenge tests have more utility as a rule-in test, meaning that a positive test would identify asthma, whereas a negative test may not rule-out the condition.</p> <p>The mannitol challenge test is relatively less time-consuming compared to other BHR tests (but more time-consuming than some objective tests). It is currently only licensed to be performed in secondary care. There is a risk of a severe bronchospasm response to mannitol and therefore resuscitation facilities are required wherever the test is to be performed.</p>
Economic considerations	<p>No economic evaluations were found which assessed the use of bronchial challenge test with mannitol as part of a diagnostic pathway. An original health-economic model was built to assess the cost-effectiveness of different diagnostic pathways for asthma. The model assessed the additional costs of tests against cost savings from unnecessary asthma medication and increased health outcomes from providing correct treatment.</p> <p>A strategy was considered that gave patients mannitol rather than a histamine/methacholine challenge test. Only one clinical study was found for mannitol which showed it had moderate sensitivity and a moderate/high specificity. However due to its low diagnostic accuracy relative to tests that precede it, such as FeNO, using it in a diagnostic pathway would actually reduce the overall diagnostic accuracy of the strategy thus making mannitol a dominated option. The GDG felt that the body of evidence found for mannitol was not of high quality and not strong enough to make a recommendation.</p> <p>The GDG also noted that in the future there is scope to perform mannitol in primary care which would significantly lower its cost, as there would be no requirement for referral to secondary care. For this to occur, further research will be required to demonstrate that the mannitol challenge test is safe in primary care allowing for a change to its licensed indication.</p> <p>For children, as the clinical evidence informing the diagnostic accuracy of these tests was poor and the cost of using these tests is very high, the GDG felt they could not make a recommendation concerning their use in a diagnostic pathway from consensus alone. Therefore an appropriate research recommendation was devised.</p>
Quality of evidence	<p>Evidence from one study was included in the review.</p> <ul style="list-style-type: none"> • In children aged <5 years, we did not search for studies, as spirometry is not routinely performed in this age-group and the mannitol test requires a spirometry test to be performed as it is based on induced change in FEV1. • In children aged 5-16 years, there was one included study⁷ using the reference standard (physician diagnosis with objective test) that addressed the use of

	<p>mannitol in this age group. Mannitol challenge test had a moderate sensitivity and higher specificity. The GDG was concerned that the inclusion criteria for the study (FEV1 >70% and non-atopic) may pre-select a population with mild disease, and therefore the evidence was downgraded for indirectness. Overall, the evidence was of low quality.</p> <ul style="list-style-type: none"> • In adults, no studies were identified using the best reference standard (physician diagnosis with objective test) that addressed the use of mannitol in adults-alone group. The one included study⁷ looked at a mixed population of adults and children aged 5-16 years using the reference standard (physician diagnosis with objective test). The GDG considered this evidence for the adult population. Mannitol challenge test had a moderate sensitivity and higher specificity. The quality of the evidence was downgraded, as the included study had a mixed population of adults, children and young people, and was indirect to the protocol. The GDG was concerned that the inclusion criteria for the study (FEV1 >70% and non-atopic) may pre-select a population with mild disease, and therefore the evidence was downgraded for indirectness. Overall, the evidence was of low quality.
Other considerations	<p>The GDG was interested in the position of indirect challenge tests within an algorithm of diagnostic tests. However, the GDG felt there was not enough evidence of sufficient quality to make a recommendation regarding the use of mannitol as an indirect bronchial challenge test to diagnose asthma. The GDG made a high-priority research recommendation to investigate the clinical and cost-effectiveness of mannitol challenge tests in adults aged over 16 years. Further details on the research recommendation made can be found in appendix N.</p> <p>Mannitol testing requires a spirometry to be performed as part of the test. The GDG noted that the spirometry should be performed in accordance with standard technical guidelines.</p> <p>Indirect bronchial challenge testing with mannitol is done in secondary care only, as this test is currently not licensed in primary care.</p> <p>The GDG made a high-priority research recommendation to investigate the acceptability and performance characteristics of objective tests, including mannitol challenge tests, which could be used to comprise a diagnostic pathway for asthma in children aged 5-16 years old. Further details on the high-priority research recommendation made can be found in appendix N.</p>

20 Diagnosis: Indirect bronchial challenge test with exercise

20.1 Introduction

In cases where a diagnosis of asthma remains in doubt and objective evidence is lacking, a bronchial challenge test can be used, and this could be either a direct or indirect challenge test. Direct bronchial challenge testing with increasing doses of inhaled methacholine is covered in chapter 18 of this guideline; currently it is rarely performed in the UK, and particularly not in children. Instead, indirect bronchial provocation testing is done in children in the form of an exercise test. Exercise testing is an 'indirect' measure of BHR whereby, in susceptible individuals, it triggers the endogenous release of inflammatory mediators, primarily eicosanoids, prostaglandins and histamine, which cause bronchoconstriction^{6,116}. This is due to thermal and osmotic changes at the airway surface as a consequence of increased aerobic demand.

The European Respiratory Society (ERS) and American Thoracic Society (ATS) recommend its use in patients with an intermediate probability of asthma and no evidence of reversible airway obstruction as well as for patients with severe symptoms or a poor response to pharmacotherapy^{115,116}. However, currently there is uncertainty around the diagnostic accuracy of exercise challenge tests.

20.2 Review question: In people under investigation for asthma, what is the diagnostic accuracy of bronchoconstriction in response to an exercise challenge?

For full details see review protocol in Appendix C.

Table 62: PICO characteristics of review question

Component	Description
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">• Children/young people (5-16 years old)• Adults (>16 years old)
Index test	Exercise challenge test (>10% FEV1 bronchoconstriction in response to exercise – within 15 mins) <ol style="list-style-type: none">1. Change in FEV1 \geq10% post-exercise2. If the study has used a cut-off based on performing a ROC NOTE: usually this is a 6 minute exercise challenge test.
Reference standard	Physician diagnosis of asthma based on symptoms plus an objective test
Outcomes	Diagnostic accuracy (sensitivity and specificity)

20.3 Clinical evidence

We searched for cross-sectional studies, cohort studies, case series (including both retrospective and prospective analyses) assessing the diagnostic test accuracy of exercise challenge test to identify whether the condition is present (as indicated by the reference standard) in people under investigation for asthma.

Five studies were included in the review^{8,52,78,82,91} (see Table 63). Evidence from these studies is summarised in the clinical evidence profile below (Table 64). See also the study selection flow chart in Appendix D, sensitivity/specificity forest plots in Appendix J, study evidence tables in Appendix G and exclusion list in Appendix K.

One of the studies⁸² was a cross-sectional study, and looked at the diagnostic accuracy of exercise test versus the reference standard in adults. This study included a population with asthma and allergic rhinitis, but was included due to the lack of evidence in people with suspected asthma. The remaining four studies^{8,52,78,91} were case-series, and looked at the diagnostic accuracy of exercise test response vs. other diagnostic tests, in people who had already been diagnosed with asthma. In this case, the index test was taken to be the exercise test and the other test as the reference standard. These studies were included due to the lack of available evidence and were downgraded for indirectness. Two studies were in adults and two studies in children. These have been reported separately in the different strata.

Summary of included studies

Table 63: Summary of studies included in the review

Study	N	Index test/reference standard	Index test cut-off for positivity	Population	Age
Exercise test vs. reference standard (physician diagnosis)					
Klepac 2004 ⁸²	35	Exercise test (6 minute treadmill) GINA definition of asthma; symptoms of asthma 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 inhaled allergen. Allergic rhinitis patients met EAACI definition; negative to histamine; positive skin prick tests to at least 1 inhaled allergen	$\Delta FEV1 \geq 10\%$	Asthma or allergic rhinitis	Asthma: range 15 to 48 years; allergic rhinitis: range 15 to 45 years
Exercise test vs. other tests					
Avital 2000 ⁸	135	Exercise test 6 minutes treadmill Methacholine PC20 <8mg	$\Delta FEV1\%_{init} > 8.2\%$	Children and young adults with asthma	Mean 12.4 (3.9) years
Eggleston 1979 ⁵²	45	Exercise test 5 minutes treadmill Methacholine	$\Delta FEV1 \geq 18\%$ (cut off for 2SD from mean normal response)	Young adults with asthma	Range 16 to 30 years
Kersten 2009 ⁷⁸	25	Exercise challenge running with nose clip on treadmill in cold air at ice rink (temperature 1°C) for 6 minutes Mannitol challenge up to cumulative dose 6.35mg	$\Delta FEV1\%_{init} > 15\%$ for both tests	Children with a history of allergic asthma and exercise induced bronchoconstriction recruited from outpatient clinic; clinically stable, otherwise	Mean 12.4 (2.0) years

Study	N	Index test/reference standard	Index test cut-off for positivity	Population	Age
				healthy; FEV1 at least 70% predicted normal value; able to run on treadmill and perform reproducible spirometry	
Lin 1991 ⁹¹	22	Exercise test (10 minute treadmill) Methacholine challenge	Δ FEV1%init >20%	Stable unmedicated asthma; FEV1 >75% normal	Range 20 to 40 years

Table 64: Clinical evidence profile: Exercise test vs. Physician Dx of asthma

PEF variability (Threshold)	No of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Median Sensitivity % (range)	Median Specificity % (range) ^e	Area Under Curve (range)	Quality
ADULTS: Exercise test versus physician diagnosis										
ΔFEV1 ≥10%	1	35	Serious risk of bias ^a	No serious inconsistency ^b	Serious indirectness ^d	N/A ^c	26	100	-	LOW
ADULTS: Exercise test versus other tests										
Exercise test ΔFEV1 ≥18% vs. methacholine	1	45	Serious risk of bias ^a	No serious inconsistency ^b	Serious indirectness ^e	N/A	80	Not estimable	-	LOW
Exercise test ΔFEV1 ≥20% vs. methacholine	1	22	Serious risk of bias ^a	No serious inconsistency ^b	Serious indirectness ^e	N/A	43	100	-	LOW
CHILDREN 5-16 years: Exercise test versus other tests										
Cold air exercise test ΔFEV1 % init >15% vs. mannitol ΔFEV1 % init >15%	1	25	Serious risk of bias ^a	No serious inconsistency ^b	Serious indirectness ^e	N/A	69	92	-	LOW
Exercise ΔFEV1 ≥8.2% vs. methacholine PC20 ≤8mg/mL	1	135	Serious risk of bias ^a	No serious inconsistency ^b	Serious indirectness ^e	N/A	72	67	-	LOW

(a) Risk of bias was assessed using the QUADAS-II checklist. Outcomes were downgraded by one if the weighted (by sample size (n)) average number of QUADAS-II domains (patient selection, index test, reference standard and flow and timing) with methodological limitations was one. Outcomes were downgraded by two if the weighted average number of QUADAS-II domains with methodological limitations was more than one.

(b) Inconsistency was assessed by inspection of the sensitivity / specificity values in each of the studies in relation to a high (≥75%), moderate (50-74%) or low (<50%) effect estimate. Inconsistency was considered high if the point estimates from individual studies were within two areas, and very high if they were in 3 areas or both high and low areas.

(c) The judgement of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis, where performed.

(d) Population is asthma or allergic rhinitis, not suspected asthma.

(e) Population with asthma and accuracy of exercise challenge test for other tests.

1 20.4 Economic evidence

2 Published literature

3 No relevant economic evaluations were identified.

4 See also the economic article selection flow chart in Appendix E.

5 New cost-effectiveness analysis

6 An original health economic model was built to assess the cost-effectiveness several diagnostic
7 pathways. Bronchial challenge test with exercise was considered as part of the diagnostic strategy,
8 however this tests has lower accuracy and higher costs compared to direct bronchial challenge test
9 with histamine or methacholine, therefore it was excluded from the formal analysis. Full details of
10 the model can be found in Appendix M. A summary of the model can be found in section 18.4.

11 Unit cost of performing a direct bronchial challenge test with exercise on children

12 As an economic model was not feasible for children, the GDG considered the unit cost of performing
13 a direct bronchial challenge test to evaluate its cost-effectiveness as part of a pathway for diagnosing
14 asthma. The NHS reference cost associated with 'Complex lung function exercise testing' (HRG code:
15 DZ31Z) is £180.⁴⁵ A paediatric respiratory outpatient visit would also need to be considered to
16 interpret the result; this is cost as £197 in the NHS reference costs.

17

18 20.5 Evidence statements

19 Clinical

- 20 • One study with 35 adults showed that exercise test ($\Delta FEV1 \geq 10\%$) versus physician diagnosis has a
21 sensitivity of 0.26 and a corresponding specificity of 1.00 for diagnosing asthma in people
22 presenting with respiratory signs and symptoms. (LOW QUALITY)
- 23 • One study with 45 adults showed that exercise test ($\Delta FEV1 \geq 18\%$) has a sensitivity of 0.80 [it was
24 not possible to calculate corresponding specificity] for predicting a positive methacholine test in
25 people with asthma. (LOW QUALITY)
- 26 • One study with 22 adults showed that exercise test ($\Delta FEV1 \geq 20\%$) has a sensitivity of 0.43 and a
27 corresponding specificity of 1.00 for predicting a positive methacholine test in people with
28 asthma. (LOW QUALITY)
- 29 • One study with 25 children and young people showed that exercise test versus physician diagnosis
30 (cold air exercise test $\Delta FEV1$ % init $>15\%$ vs. mannitol $\Delta FEV1$ % init $>15\%$) has a sensitivity of 0.69
31 and a corresponding specificity of 0.92 for diagnosing asthma in people presenting with
32 respiratory signs and symptoms. (LOW QUALITY)
- 33 • One study with 135 children and young people showed that exercise test ($\Delta FEV1 \geq 8.2\%$) has a
34 sensitivity of 0.72 and a corresponding specificity of 0.67 for predicting a positive methacholine
35 challenge test ($PC20 \leq 8\text{mg/mL}$) in people with asthma. (LOW QUALITY)

36 Economic

- 37 • No relevant economic evaluations were identified.

1 20.6 Recommendations and link to evidence

Recommendations	21. Do not offer adults and young people older than 16 an exercise challenge test as a diagnostic test for asthma.
Research recommendations	1. What is the acceptability and diagnostic accuracy of objective tests that could be used to comprise a diagnostic pathway for asthma in children aged 5-16 years old (for example, exercise challenge, direct bronchial challenge with histamine or methacholine, indirect bronchial challenge with mannitol and peripheral blood eosinophil count)?
Relative values of different outcomes	<p>The GDG was interested in the diagnostic test accuracy of airway hyper-reactivity (non-specific bronchial challenge) with exercise.</p> <p>One of the concerns that set the scope of this guideline is the over-diagnosis of asthma leading to inappropriate treatment; therefore, the GDG was interested in both the sensitivity and specificity of diagnostic tests and prioritised studies which reported these outcomes. Sensitivity and specificity values will depend on the chosen cut-off point.</p>
Trade-off between clinical benefits and harms	<p>In adults, evidence was only available from one study for the accuracy of exercise challenge test in the diagnosis of asthma using the ideal reference standard. Exercise challenge test had a low sensitivity and a high specificity. In adults there are more effective indirect challenge tests that can be performed more easily and are more readily available than exercise; therefore, the GDG agreed that exercise challenges have no place in the diagnosis of adult asthma. For an adult exercise test, 2 members of staff, a treadmill and monitoring facilities are required.</p> <p>In children, no evidence was available using the ideal population (suspected asthma, presenting with symptoms) or the ideal reference standard (physician diagnosis with an objective test). The available data suggest an exercise test has a moderate sensitivity and a moderate-to-high specificity in predicting a positive response to a mannitol or methacholine challenge test. An exercise test in a child who is able to run poses no significant harm to the child, but the acceptability of the test to a child or care giver has not been reviewed here.</p>
Economic considerations	<p>No economic evaluations were found which assessed the use of bronchial challenge test with exercise as part of a diagnostic pathway. An original health economic model was built to assess the cost-effectiveness of different diagnostic pathways for asthma. The model assessed the additional costs of tests against cost savings from unnecessary asthma medication and increased health outcomes from providing correct treatment.</p> <p>A strategy was considered that gave patients an exercise challenge test rather than a histamine/methacholine challenge test. The cost of using exercise challenge tests as opposed to other challenge tests is higher as detailed in the NHS reference costs. As the sensitivity and specificity of exercise challenge tests were lower than direct bronchial challenge tests exercise challenge tests were a dominated option.</p> <p>The GDG noted that the costs presented would likely be lower for children and currently they are the only challenge tests available for children. However as the costs are still considerably high the clinical evidence was not strong enough to allow a recommendation to be made. Therefore a future research recommendation was made for children as the body of available evidence was not strong enough to dismiss them. No model was built for children and the results from the adult model could not be extrapolated.</p>
Quality of evidence	The studies in both adults and children where exercise has been tested to make a

	<p>diagnosis of asthma are very small. Larger population based studies exist in children, but these were excluded by the GDG as they represented the use of exercise as a screening tool for the general population and thus the results could not be extrapolated to give a sensitivity or specificity in a population suspected of asthma. The studies in children in particular were also limited by the lack of comparator test (with appropriate diagnostic criteria) other than physician diagnosis and studies were excluded in this regard.</p> <ul style="list-style-type: none"> • In children aged <5 years, we did not search for studies, as an exercise test is not able to be performed very well in this age-group. • In children aged 5-16 years, there were no included studies using the best reference standard (physician diagnosis with objective test) that addressed the use of exercise testing in this age group. • In adults, there was one included study (Klepac) using the best reference standard (physician diagnosis with objective test) that addressed the use of exercise testing in this age group. This study included a population with asthma and allergic rhinitis, but was included due to the lack of evidence in people with suspected asthma. It was downgraded for indirectness. The evidence was of low quality. • All other included studies assessed exercise testing vs. other tests (rather than vs. the reference standard of physician diagnosis with objective test). The evidence was of low quality.
Other considerations	<p>There is very limited evidence concerning the use of exercise tests in those in whom there is clinical suspicion of asthma.</p> <p>Exercise challenge testing requires spirometry to be performed as part of the test. The GDG noted that the spirometry should be performed in accordance with standard technical guidelines.</p> <p>Exercise testing is currently the most commonly used test in children, more commonly performed in secondary care. The GDG was interested in the position of indirect challenge tests within an algorithm of diagnostic tests. However, the true efficacy, acceptability and tolerability of the test for patients under 16 years of age is not known. The GDG felt strongly that further research is urgently needed to identify the efficacy and acceptability in the paediatric population. The GDG made a high-priority research recommendation to investigate the acceptability and performance characteristics of objective tests, including exercise challenge tests, which could be used to comprise a diagnostic pathway for asthma in children aged 5-16 years old. Further details on the high-priority research recommendation made can be found in appendix N.</p>

21 Diagnostic summaries

This chapter discusses the diagnostic pathway for asthma. Table 65 below summarises the cut-off thresholds for the objective tests used in the diagnostic pathway.

Table 65: Thresholds of diagnostic tests

Objective test	Diagnostic cut-off for a positive test
Spirometry	FEV1/FVC ratio <70%
Bronchodilator response	Improvement in FEV1 \geq 12% and increase in volume \geq 200 mls
Peak expiratory flow variability	>20% variability over 2-4 weeks
FeNO	Adults over 16 years: \geq 40 ppb Children 5-16 years: \geq 35 ppb
Methacholine	\leq 8 mg/ml (PC20)
Histamine	\leq 8 mg/ml (PC20)

21.1 Diagnostic algorithms

Please see section 4.1 on page 39 to 42.

21.2 Recommendations and link to evidence

	<p>Children younger than 5 years (algorithm A)</p> <p>22.Treat symptoms based on observation and clinical judgement in children younger than 5 years. If asthma is still suspected when the child is old enough to take part in objective tests (usually around the age of 5), perform these and review the diagnosis.</p>
	<p>Adults and children aged 5 years and over (algorithm A)</p> <p>23.Do not diagnose asthma based on any single diagnostic test alone in adults and children aged 5 years and over.</p>
	<p>Adults and young people older than 16 with obstructive spirometry (algorithm B1)</p> <p>24.Diagnose asthma in adults and young people older than 16 if they have obstructive spirometry and:</p> <ul style="list-style-type: none"> • 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
Recommendations	

challenge test.

25. 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.

26. 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 are a smoker, age, weight, how fit they are) together with their objective test results.

27. 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)

28. 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.

29. 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.

	<p>Children aged 5–16 (algorithm C)</p> <p>30. Diagnose asthma in children aged 5–16 if they have:</p> <ul style="list-style-type: none"> • 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. <p>31. 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.</p> <p>32. Suspect asthma in children aged 5–16 if they have:</p> <ul style="list-style-type: none"> • 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 confirmed by a retest after 6 weeks. <p>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.</p> <p>33. Consider alternative diagnoses in children aged 5–16 if they have normal spirometry, a FeNO level of 34 ppb or less and:</p> <ul style="list-style-type: none"> • negative peak flow variability or • positive peak flow variability that is negative on retest after 6 weeks.
Relative values of different outcomes	See sections 11.6, 12.6, 13.6, 16.6 and 18.6.
Trade-off between clinical benefits and harms	See sections 11.6, 12.6, 13.6, 16.6 and 18.6.
Economic considerations	See sections 11.6, 12.6, 13.6, 16.6 and 18.6.
Quality of evidence	See sections 11.6, 12.6, 13.6, 16.6 and 18.6.
Other considerations	<p>The diagnostic algorithms assume that the objective tests have been performed correctly.</p> <p><u>Children younger than 5 years old:</u></p> <p>A certain diagnosis of asthma cannot be made in this age group as no objective tests could be conducted. The GDG agreed that the only viable option would be to treat the child's symptoms accordingly; however, a diagnosis of asthma could not be confirmed until the child was old enough to perform objective tests.</p> <p><u>Children 5-16 years old and adults and young people older than 16 years old:</u></p> <p>For adults and children aged 5 years and older a diagnostic algorithm was built whereby the individual could arrive at different endpoints based on their test results.</p>

The following points detail what happens at each endpoint.

- **Diagnose with asthma**

At these points in the pathway the evidence captured from the test results was conclusive enough to make a firm diagnosis of asthma. Although at these points in the pathway there is a very small probability that the individual may not have asthma the likelihood is so low that delaying treatment any longer for the majority of patients would lead to much worse health outcomes.

- **Suspect asthma but do not rule out other diagnoses if symptom control continues to remain poor after treatment and review the diagnosis after 6 weeks by repeating any abnormal tests and reviewing symptoms**

At these points in the pathway the evidence gathered from the objective tests suggests asthma as the most likely diagnosis but is not unequivocal; there is a small probability that the symptoms may be derived from another cause. Therefore fixing a diagnosis of asthma could lead to a few cases of lifelong misdiagnosis. The GDG agreed that it would be best to commence anti-asthma treatment but to not regard the diagnosis as fixed, to monitor the response carefully, and to have a low threshold for investigating for other conditions. Doing so will help further minimise the number of false positives produced by the algorithm.

The GDG agreed that inhaled corticosteroids was the appropriate anti-asthma treatment to commence in these circumstances, and that review after 6 weeks was an appropriate interval to allow this treatment to take effect before re-assessing.

- **Consider alternative diagnoses**

At these points in the pathway there is significant evidence to rule-out the diagnosis of asthma. Ruling out the diagnosis of asthma will allow investigation to establish an alternative cause of the presenting symptoms. Although at these points in the pathway there is a very small probability that the individual may have asthma the likelihood is so low that delaying investigative procedures for other conditions for the majority of patients would lead to much worse health outcomes.

- **Re-test the individual after 6 weeks (children 5-16 only)**

At this point in the algorithm all tests point towards an alternative diagnosis however the PEFv test indicates asthma. The GDG noted that there are time-dependent reasons that can cause this test to produce false positives as well as the fact it is contingent on the patient performing the test correctly. Therefore the GDG felt by waiting and repeating this test then if the test remains positive then this could lead the clinician to suspect asthma and act accordingly.

- **Refer for specialist opinion (children 5-16 only)**

At this singular point in the algorithm the child would have an obstructive spirometry but a negative bronchodilator reversibility test and a negative FeNO. This would indicate that the child has a very unique form of asthma or another, potentially serious, condition. The GDG therefore felt in this circumstance that a specialist opinion would be needed to ensure the child's condition was effectively diagnosed and managed.

- **Consider alternative diagnosis or refer to specialist (adults and young people older than 16 years old only)**

At this singular point in the pathway the individual is unlikely to have asthma, but they have reversible airways. A possible diagnosis for this individual could be COPD as people with this condition can produce positive results from a bronchodilator

reversibility test. However if the clinician cannot rule-in an alternative diagnosis then specialist referral may be the best option to ensure the individual receives the best management.

1

1 **22 Monitoring asthma control**

2 Chapters 23 to 30 review the clinical and cost-effectiveness of interventions used to monitor asthma
3 control.

23 Monitoring: Symptom scores and questionnaires

23.1 Introduction

Published evidence suggests that both patients and clinicians tend to underestimate asthma severity and overestimate asthma control when simply asking a patient ‘How is your asthma?’ As a result of this, multiple different asthma questionnaires have been developed both to assess asthma-related quality of life and asthma control. These questionnaires have primarily been validated in patients with mild to moderate asthma. Questionnaires have the potential to be used to aid the monitoring of asthma as minimally clinically important differences have been established for the majority of the questionnaires.

23.2 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?

For full details see review protocol in Appendix C.

Table 66: PICO characteristics of review question

Population	<p>People with asthma (defined as physician Dx with objective test or recurrent persistent wheeze in <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.</p> <p>All ages, stratified into the following 3 different groups:</p> <ul style="list-style-type: none"> • Children (1-<5 years old) • Children/young people (5-16 years old) • Adults (>16 years old)
Intervention(s)	<p>Monitoring the following, and using the outcomes of scores/questionnaires to adjust management/therapy according to physician decision or personalised treatment plan:</p> <ul style="list-style-type: none"> • Symptom scores or diaries • Symptom/control questionnaires • Quality of life questionnaires (asthma specific)
Comparison(s)	<p>Comparison of adjustment of asthma therapy based on symptom scores or questionnaires to:</p> <ul style="list-style-type: none"> • Usual care: e.g. clinical symptoms (with/without spirometry/PEF) according to guidelines (including BTS/SIGN, GINA) <p>Comparison of adjustment of asthma therapy based on:</p> <ul style="list-style-type: none"> • Symptom scores or diaries vs. questionnaires • Control questionnaire vs. other control questionnaire • QOL questionnaire vs. control questionnaire
Outcomes	<p>Critical outcomes</p> <ul style="list-style-type: none"> • Mortality • Unscheduled healthcare utilisation (ED/A&E visit; hospital admissions; GP out of hours or walk-in centre) • Exacerbations (defined as need for course of oral steroids)

	<ul style="list-style-type: none"> • Asthma control questionnaires (ACT; CACT; ACQ; PACQ; RCP-3) • QoL (AQLQ; pAQLQ; St George's respiratory questionnaire) <p>Important outcomes</p> <ul style="list-style-type: none"> • Lung function (FEV1, PEF) • Symptoms (annual symptom free days) • Dose of regular asthma therapy / preventer medication (ICS dose) • Rescue medication (SABA use) • Time off school or work
Study design	RCTs

1 23.3 Clinical evidence

2 We searched for randomised trials comparing the effectiveness of monitoring using asthma control
3 questionnaires, QoL questionnaires or symptom diaries vs monitoring according to usual care to
4 guide asthma treatment and management. The asthma control questionnaires and QoL
5 questionnaires considered in the review are summarised in Table 67.

6 Three studies (four papers) were included in the review^{101,134,173} these are summarised in Table 68
7 below. See also the study selection flow chart in Appendix D, study evidence tables in Appendix G,
8 forest plots in Appendix J, GRADE tables in Appendix I and excluded studies list in Appendix K. All
9 relevant clinical studies used monitoring with asthma control questionnaires to guide management
10 or treatment. No relevant clinical studies were identified using monitoring with asthma-specific QoL
11 questionnaires to guide management or treatment. No relevant clinical studies were identified using
12 monitoring with symptom scores or diaries vs. usual care. Studies comparing monitoring with
13 symptoms scores or diaries with monitoring using PEF or FeNO are reported in the respective
14 reviews.

15 In children age 5-16 years, evidence comparing monitoring with questionnaires vs. usual care to
16 guide ongoing management was available from one study¹³⁴ summarised in the clinical evidence
17 summary (Table 69). This study was in children with uncontrolled asthma and used the Asthma
18 Control Questionnaire (ACQ) to guide treatment according to a treatment algorithm. Outcomes are
19 reported at both <6months and ≥6 months.

20 In adults age >16 years, evidence comparing monitoring with questionnaires vs. usual care to guide
21 ongoing management was available from two studies^{101,173} summarised in the clinical evidence
22 summary (Table 70). One study used the ACQ to guide treatment according to a treatment algorithm,
23 the other study used the Asthma Control Test (ACT) to guide pharmacist care.

24 No relevant clinical studies comparing monitoring with questionnaires vs. usual care to guide ongoing
25 management were available in children age 1-5 years old.

26 Table 68 also summarises additional education interventions received by the intervention or
27 comparator groups. In studies where both the intervention and comparator groups receive
28 education, the monitoring intervention may show reduced effectiveness as the control group might
29 also be expected to show improvement due to the education (saturation effects).

Table 67: Summary of questionnaires

Questionnaire	Reference	Number of items and Scale	Recall period	Established MID	Population for intended use
Asthma control questionnaires					
Asthma Control Test (ACT)	Developed by QualityMetric Inc. and GSK Nathan et al. Development of the asthma control test: a survey for assessing asthma control. <i>J Allergy Clin Immunol.</i> 2004 Jan;113(1):59-65 ¹⁰⁴ .	5-items (activity limitations, shortness of breath, nocturnal symptoms, rescue medication, overall control in past 4 weeks) Each scored from 1 (worst) to 5 (best) Range 5-25 (better indicated by higher values)	Past 4 weeks	3.0	Adolescents and adults (12+ years)
Paediatric ACT (CACT)	Developed by QualityMetric Inc. and GSK Liu et al. Development and cross-sectional validation of the Childhood Asthma Control Test. <i>J Allergy Clin Immunol.</i> 2007; 119, 817-825 ⁹⁴ .	7-item scale (4 child-reported and 3 caregiver reported) The child-completed items use a 4-point response scale and the caregiver-completed items use a 6-point response scale) Range 0-27 (better indicated by higher values)	Past 4 weeks	None established	Children 4-11 years
Asthma Control Questionnaire (ACQ)	Juniper et al. Development and validation of a questionnaire to measure asthma control. <i>Eur Respir J</i> 1999; 14: 902-907 ⁷⁶	7 items (specific symptoms, timing of symptoms, activity limitation, rescue medications, lung function) Each scored from 0 (best) to 6 (worst) Range 0-6 (better indicated by lower values)	Past week	0.5 (score of 1.5 best discriminator between controlled and uncontrolled)	Children and adults (6+ years)
RCP 3 questions	Pearson MB (ed). Measuring clinical outcomes in asthma: a patient-focused approach. London: Royal College of	3 items Each item scored 0 (no) or 1 (yes) (better indicated by lower values)	Past week (or month)	None established	

Questionnaire	Reference	Number of items and Scale	Recall period	Established MID	Population for intended use
	Physicians; 1999.				
Asthma QOL questionnaires					
Asthma Quality of Life Questionnaire (AQLQ)	Juniper et al. Measuring quality of life in asthma. Am Rev Respir Dis 1993; 147: 832-838 ⁷⁴	32 items 7 point scale, 1-7 (better indicated by higher values)	Past 2 weeks	0.5	Adults
Mini AQLQ	Juniper et al. Eur Respir J 1999; 14: 32-38 ⁷²	15 items 7 point scale, 1-7 (better indicated by higher values)	Past 2 weeks	0.5	Adults
Paediatric AQLQ (child)	Juniper et al. Measuring quality of life in children with asthma. Quality of Life Research 1996; 5: 35-46 ⁷³	23 items 7 point scale, 1-7 (better indicated by higher values)	Past week	0.5	Paediatrics
Paediatric AQLQ (carer PACQLQ)	Juniper et al. Measuring quality of life in the parents of children with asthma. Quality of Life Research 1996; 5: 27-34	13 items 7 point scale, 1-7 (better indicated by higher values)	Past week	0.5	Caregivers

Table 68: Summary of studies included in the review

Study	Intervention	Comparison	Population	Outcomes	
MEER 2009 ¹⁷³ RCT	Internet based self-management (treatment plan, online education and communication with nurse). Treatment algorithm tells patients how to adjust their treatment according to weekly ACQ score: - Four consecutive scores ≤0.5 : decrease treatment according to plan - Two scores >0.5 but <1: increase treatment	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.	ADULTS. Phys Dx asthma and ICS for at least 3 months in the previous year.	<ul style="list-style-type: none"> • QOL • Exacerbations • Asthma control • Lung function • Symptoms • ICS use 	Both groups received a prior basic education session (but intervention group received additional web-

Study	Intervention	Comparison	Population	Outcomes	
	according to plan - One score ≥ 1 but < 1.5 : immediately increase according to plan - One score > 1.5 : immediately increase treatment and contact nurse.				based and face-to-face education
MEHUYS 2008 ¹⁰¹ RCT	Pharmacist advice based on ACT score at 0, 1 and 3 month: -ACT < 15 : immediate referral to GP or specialist -ACT 15-19: review inhaler technique and check controller adherence -ACT > 19 : no advice, inform patient asthma is well-controlled	Usual pharmacist care	ADULTS with a prescription for asthma medication and treated for asthma > 12 months, using controller meds	<ul style="list-style-type: none"> • QOL • Exacerbations • UHU • Asthma control • Rescue medication 	ONLY INTERVENTION GROUP - additional personal education from the pharmacist at the start
RIKKERS 2012 ¹³⁴ RCT	Same as VAN DER MEER 2009	Same as VAN DER MEER 2009	CHILDREN 12-18 years, asthma not well controlled asthma as assessed by ACQ > 0.75 and/or ATAQ < 1.0	<ul style="list-style-type: none"> • QOL • Exacerbations • Asthma control • Lung function • Symptoms • ICS use 	Same as VAN DER MEER 2009

Table 69: Clinical evidence summary: Children (5-16 years) with uncontrolled asthma: Monitoring questionnaires + treatment vs UC + treatment.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with UC + treatment	Risk difference with Children with uncontrolled asthma: Monitoring control + treatment (95% CI)
QOL (< 6months) PAQLQ. Scale from: 1 to 7.	90 (1 study) 3 months	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		The mean QOL in the control groups was 5.68	The mean QOL in the intervention groups was 0.4 higher (0.17 to 0.63 higher)
QOL (≥ 6months) PAQLQ. Scale from: 1 to 7.	90 (1 study) 12 months	⊕⊕⊕⊖ LOW ¹ due to risk of bias		The mean QOL in the control groups was 6.05	The mean QOL in the intervention groups was 0.05 lower (0.5 lower to 0.4 higher)
Exacerbations (≥ 6months) Course of OCS	75 (1 study) 12 months	⊕⊕⊕⊖ VERY LOW ^{1,3} due to risk of bias, imprecision	RR 1.14 (0.41 to 3.22)	Moderate 150 per 1000	21 more per 1000 (from 89 fewer to 333 more)

Outcomes	No of	Quality of the	Relative	Anticipated absolute effects	
Asthma control (< 6months) ACQ. Scale from: 0 to 6.	90 (1 study) 3 months	⊕⊕⊕⊖ LOW ¹ due to risk of bias		The mean asthma control in the control groups was 1.19	The mean asthma control in the intervention groups was 0.32 lower (0.56 to 0.08 lower)
Asthma control (≥ 6months) ACQ. Scale from: 0 to 6.	90 (1 study) 12 months	⊕⊕⊕⊖ LOW ¹ due to risk of bias		The mean asthma control in the control groups was 0.79	The mean asthma control in the intervention groups was 0.05 lower (0.35 lower to 0.25 higher)
Lung function (< 6months) FEV1 L	90 (1 study) 3 months	⊕⊖⊖⊖ VERY LOW ^{1,2} due to risk of bias, imprecision		The mean lung function in the control groups was 2.9 L	The mean lung function in the intervention groups was 0.23 higher (0.08 to 0.38 higher)
Lung function (≥ 6months) FEV1 L	90 (1 study) 12 months	⊕⊖⊖⊖ VERY LOW ^{1,2} due to risk of bias, imprecision		The mean lung function in the control groups was 3.12 L	The mean lung function in the intervention groups was 0.1 higher (0.11 lower to 0.31 higher)
Symptom free days (< 6months) % over 2 weeks . Scale from: 0 to 100.	90 (1 study) 3 months	⊕⊖⊖⊖ VERY LOW ^{1,4} due to risk of bias, imprecision		The mean symptom free days in the control groups was 76 %	The mean symptom free days in the intervention groups was 1.5 lower (14.5 lower to 11.5 higher)
Symptom free days (≥ 6months) % over 2 weeks.	90 (1 study) 12 months	⊕⊖⊖⊖ VERY LOW ^{1,4} due to risk of bias, imprecision		The mean symptom free days in the control groups was 80 %	The mean symptom free days in the intervention groups was 4 higher (9.7 lower to 17.7 higher)
ICS use (< 6months) mean daily dose ug	90 (1 study) 3 months	⊕⊖⊖⊖ VERY LOW ^{1,4} due to risk of bias, imprecision		The mean ICS use in the control groups was 334 ug	The mean ICS use in the intervention groups was 14 higher (79 lower to 107 higher)
ICS use (≥ 6months) mean daily dose ug	90 (1 study) 12 months	⊕⊖⊖⊖ VERY LOW ^{1,4} due to risk of bias, imprecision		The mean ICS use in the control groups was 265 ug	The mean ICS use in the intervention groups was 14 higher (75 lower to 103 higher)

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

1

Table 70: Clinical evidence summary: Adults and young people (>16 years) overall: Monitoring questionnaires + treatment vs UC + treatment.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with UC + treatment	Risk difference with Adults overall: Monitoring control + treatment (95% CI)
QOL (≥ 6months)	333	⊕⊕⊕⊖		The mean QOL in the control groups	The mean QOL in the intervention groups

Outcomes	No of	Quality of the evidence	Relative	Anticipated absolute effects	
AQLQ. Scale from: 1 to 7.	(2 studies) 6-12 months	MODERATE ¹ due to risk of bias		was 5.89	was 0.32 higher (0.17 to 0.47 higher)
Exacerbations (≥ 6months) course of OCS	183 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	HR 1.18 (0.51 to 2.73)	Moderate 109 per 1000	18 more per 1000 (from 52 fewer to 161 more)
Exacerbations (≥ 6months) ER, hospitalisation or OCS	333 (2 studies) 6-12 months	⊕⊕⊕⊕ VERY LOW ^{1,3,4} due to risk of bias, indirectness, imprecision	RR 1.1 (0.61 to 1.99)	Moderate 112 per 1000	11 more per 1000 (from 44 fewer to 111 more)
UHU (≥ 6months) ER or hospitalisation	150 (1 study) 6 months	⊕⊕⊕⊕ VERY LOW ^{4,5} due to risk of bias, imprecision	RR 0.17 (0.02 to 1.46)	Moderate 71 per 1000	59 fewer per 1000 (from 70 fewer to 33 more)
Asthma control (< 6months) ACT. Scale from: 5 to 25.	183 (1 study) 3 months	⊕⊕⊕⊕ LOW ⁵ due to risk of bias		The mean asthma control in the control groups was 20.0	The mean asthma control in the intervention groups was 0.3 higher (0.73 lower to 1.33 higher)
Asthma control (≥ 6months) ACQ . Scale from: 0 to 6.	183 (1 study) 12 months	⊕⊕⊕⊕ LOW ^{1,6} due to risk of bias, imprecision		The mean asthma control in the control groups was 1.04	The mean asthma control in the intervention groups was 0.47 lower (0.64 to 0.3 lower)
Asthma control (≥ 6months) ACT. Scale from: 5 to 25.	150 (1 study) 6 months	⊕⊕⊕⊕ LOW ⁵ due to risk of bias		The mean asthma control in the control groups was 19.7	The mean asthma control in the intervention groups was 0.5 higher (0.86 lower to 1.86 higher)
Lung function (≥ 6months) FEV1 L	183 (1 study) 12 months	⊕⊕⊕⊕ LOW ^{1,6} due to risk of bias, imprecision		The mean lung function in the control groups was 3.12 L	The mean lung function in the intervention groups was 0.25 higher (0.03 to 0.47 higher)
Symptom free days (≥ 6months) % over 2 weeks. Scale from: 0 to 100.	183 (1 study) 12 months	⊕⊕⊕⊕ LOW ^{1,6} due to risk of bias, imprecision		The mean symptom free days in the control groups was 51.8 %	The mean symptom free days in the intervention groups was 10.9 higher (0.05 to 21.75 higher)
ICS use (≥ 6months) mean daily dose ug	183 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		The mean ICS use in the control groups was 470 ug	The mean ICS use in the intervention groups was 57 higher (38 lower to 152 higher)
Rescue medication (< 6months) puffs/day	183 (1 study) 3 months	⊕⊕⊕⊕ LOW ^{1,6} due to risk of bias, imprecision		The mean rescue medication in the control groups was 1.3 puffs/day	The mean rescue medication in the intervention groups was 0.62 lower (1.21 to 0.03 lower)
Rescue medication (≥ 6months) puffs/day	150 (1 study) 6 months	⊕⊕⊕⊕ MODERATE ¹ due to risk of bias		The mean rescue medication in the control groups was 0.9 puffs/day	The mean rescue medication in the intervention groups was 0.23 lower (0.66 lower to 0.2 higher)

Outcomes	No of	Quality of the evidence	Relative	Anticipated absolute effects
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				

1 23.4 Economic evidence

2 Published literature

3 No relevant economic evaluations were identified.

4 See also the economic article selection flow chart in Appendix E.

5 23.5 Evidence statements

6 Clinical

7 CHILDREN (5-16 years)

- 8 • No evidence was identified on mortality and unscheduled healthcare utilisation outcomes.
- 9 • Monitoring asthma control questionnaires vs usual monitoring was considered a clinically
10 important benefit for QOL, asthma control questionnaire score and lung function (FEV1) at <6
11 months (evidence for all outcomes from 1 study, N=90, low and very low quality)
- 12 • Monitoring asthma control questionnaires vs usual monitoring resulted in no clinically important
13 difference for QOL, asthma control questionnaire score, and lung function (FEV1), all at ≥6
14 months, and for symptom free days and ICS use, both at <6 months and ≥6 months (all evidence
15 from 1 study, N=90, low and very low quality).
- 16 • Monitoring asthma control questionnaires vs usual monitoring resulted in a borderline clinically
17 important difference for exacerbations at ≥ 6 months (1 study, N=75, very low quality)

18 ADULTS (>16 years)

- 19 • No evidence was identified for mortality.
- 20 • Monitoring asthma control questionnaires vs usual monitoring was considered a clinically
21 important benefit for QOL (2 studies, N=333, moderate quality), UHU (1 study, N=150, very low
22 quality), asthma control questionnaire score measured on the ACQ (1 study, N=183, low quality),
23 lung function and symptom-free days (both from 1 study, N=183, low quality), all at ≥6 months
24 and for use of rescue medication and <6 months and ≥6 months (low and moderate quality).
- 25 • Monitoring asthma control questionnaires vs usual monitoring resulted in no clinically important
26 difference for Asthma control questionnaire score at < 6 months and ≥ 6 months measured on the
27 ACT (1 study, low quality) and for ICS use at ≥6 months (1 study, N=183, very low quality).
- 28 • Monitoring asthma control questionnaires vs usual monitoring resulted in a borderline clinically
29 important difference for exacerbations (assessed with course of OCS) (2 studies, N=333, very low
30 quality) and exacerbations (assessed with ER, hospitalisation or course of OCS) (2 studies, N=333,
31 very low quality), both at ≥ 6 months.

32 Economic

- 33 • No relevant economic evaluations were identified.

34 23.6 Recommendations and link to evidence

Recommendations	<p>34. Monitor asthma control at every review.</p> <p>35. Consider using a validated questionnaire (the Asthma Control Questionnaire or Asthma Control Test) to monitor asthma control in</p>
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	adults and young people older than 16.
Research recommendations	<p>1. 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 aged over 16 years?</p> <p>2. 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?</p>
Relative values of different outcomes	<p>The GDG considered the following outcomes as critical for this review: mortality, quality of life, exacerbations, asthma control measured by questionnaires and unscheduled healthcare utilisation.</p> <p>The GDG noted that exacerbations of asthma can lead to both unscheduled healthcare utilisation (ED visits, out-of-hours GP surgery visits or hospitalisation) and the need for a course of OCS. Therefore, the GDG considered exacerbations requiring OCS treatment and exacerbations requiring unscheduled healthcare utilisation separately.</p> <p>The GDG also considered the following important outcomes: lung function (FEV1), symptoms (symptom free days), dose of regular asthma therapy (ICS dose), rescue medication (SABA dose) and time off school or work. These outcomes were considered as important measures of asthma control for the patient. The GDG acknowledged that regular asthma preventer therapy (ICS) is often under prescribed / used, and rescue medications (SABA) may be overprescribed / used¹³⁵.</p>
Trade-off between clinical benefits and harms	<p>No RCT evidence was identified using asthma-specific QOL questionnaires or symptom diaries to monitor and guide asthma management, compared to each other or to usual care. For asthma control questionnaires, RCT evidence was identified for the ACQ and the ACT, but not the RCP 3 questions.</p> <p><u>In adults</u>, monitoring asthma control questionnaires vs usual monitoring was considered a clinically important benefit for QOL, UHU and asthma control questionnaire score measured using the ACQ at >6 months. Evidence showed that there may be no clinically important difference between monitoring asthma control questionnaires vs usual monitoring in the asthma control questionnaire score measured using the ACT. There was evidence of an increase in the rate of exacerbations in the monitoring group; however, it was unclear if this represented a clinically important harm. The GDG acknowledged that on some occasions OCS may be of benefit by preventing a more severe asthma attack requiring UHU.</p> <p>Evidence from one study showed that monitoring questionnaire scores resulted in a clinically important benefit in lung function, use of rescue medication and symptom-free days. These outcomes were particularly important to the GDG and patient. The evidence suggested there may be no clinically important benefit in ICS use. The GDG opinion was that asthma control is better captured using a questionnaire and the evidence suggests some longer-term benefit.</p> <p><u>In children</u>, monitoring asthma control questionnaires vs usual monitoring was considered a clinically important benefit for QOL and asthma control questionnaire score at <6 months, but not at > 6 months. There was evidence of an increase in the rate of exacerbations in the monitoring group; however, it was unclear if this represented a clinically important harm. The GDG acknowledged that on some occasions OCS may be of benefit by preventing a more severe asthma attack requiring UHU.</p> <p>Evidence from one study showed that monitoring questionnaire scores resulted in a clinically important benefit in lung function at < 6 months but not at >6 months. The</p>

	<p>GDG did not think the difference in symptom-free days and ICS use represented a clinically important difference.</p> <p>The evidence was suggestive of a benefit at <6 months follow-up, but not at >6 months follow-up. The GDG acknowledged that good asthma control scores are associated with better outcomes. Due to the uncertainty of a longer term benefit, the GDG recommended a future research recommendation in children on the effectiveness of monitoring asthma control using validated questionnaires.</p> <p>No evidence was identified in children aged 1-<5 years old.</p>
Economic considerations	<p>No economic evidence was found on symptoms scores.</p> <p>As the individual will be attending an annual asthma review anyway, the additional cost of monitoring asthma control with a validated questionnaire within this review will be negligible. However there may be additional costs to consider from using these questionnaires to increase or decrease medication usage. The GDG's decision to recommend these questionnaires was based on clinical evidence showing that they were clinically effective and therefore changes in medication were providing benefit. Uncertainty in this evidence and the cost-effectiveness led the GDG to make a 'consider' rather than 'offer' recommendation.</p>
Quality of evidence	<p>In adults, the evidence for the important and critical outcomes was of low and very low quality with the exception of the QOL outcome of moderate quality. Only one study contributed to the evidence for the majority of outcomes, and all studies were of small sample size. The GDG felt that the treatment algorithm in the Meer 2009 study was quite intensive. The GDG did not think an ACQ score between 0.5-1.0 would always warrant an increase in treatment. The strength of the recommendation was based on the GDG opinion (not the evidence alone) that a questionnaire should be used to capture symptom and control information.</p> <p>In children, all evidence was of very low and low quality. One study contributed to the evidence for each outcome and the majority of studies were of small sample size. Again, the GDG felt that the treatment algorithm in the Rijkers 2012 study was quite intensive. The GDG did not think an ACQ score between 0.5-1.0 would always warrant an increase in treatment. The GDG noted that at 12 months there was an increase in asthma control in the comparator group, perhaps due to additional education or participation in a research study. This may have masked a benefit in the intervention group.</p> <p>The GDG noted the different populations within the studies. In children, the participants were uncontrolled at the start of the study, whereas in adults, the participants were controlled at the start of the study.</p> <p>No evidence was identified in children aged 1-<5 years old.</p>
Other considerations	<p>The monitoring interventions reported in the studies were complex interventions involving different treatment algorithms, not only monitoring control questionnaires in isolation. The GDG noted that it was hard to look at the monitoring intervention outside of the clinical care provided. It was noted that some studies included additional educational components, and that the effect of monitoring control questionnaires may be saturated due to improved outcomes in the control group. The GDG noted that the studies looked at the use of questionnaires within a particular context (for example, a pharmacist monitoring programme or treatment algorithm).</p> <p>Whilst the GDG did not look at the individual evidence from prognostic studies of asthma control questionnaire scores as a risk factor for future outcomes, the GDG was aware of and discussed the existence of prognostic evidence within the broader literature base showing that poor asthma control scores predict future risk.</p>

The GDG consensus was that not enough information is gathered from just asking, 'how is your asthma today', and that asthma control questionnaires should be used at every asthma review. The GDG discussed the NICE quality standards which recommend an asthma review annually.

The GDG was aware of validation studies for the QOL questionnaires and for the RCP 3 questionnaires, but not of any RCT studies of monitoring using these questionnaires to guide treatment. The GDG made a future research recommendation for the use of QOL questionnaires and the RCP 3 questions for monitoring asthma control. The GDG also made a future research recommendation to investigate the clinical and cost-effectiveness of using validated paediatric questionnaires to monitor asthma control in children aged 5-16 years old (please see appendix N for the full list of research recommendations made).

24 Monitoring: Lung function tests

24.1 Introduction

The aim of the review was to assess the clinical and cost-effectiveness of lung function measurements in the monitoring of asthma.

Airflow obstruction is a recognised characteristic abnormality in asthma. Guidelines for the management of asthma in children and adults emphasise the importance of objective assessment of lung function, in particular airflow obstruction.

Lung function does not correlate strongly with asthma symptoms in adults or children and many people with asthma are poor perceivers of changes in airway calibre. Evidence of airways obstruction is a poor prognostic factor for the outcome of asthma and a low FEV1 identifies patients at risk of asthma exacerbations, independent of symptom levels, especially if FEV1 is <60% predicted.

FEV1 is considered to be the “gold standard” measurement of airways obstruction due to its accurate, well standardised measurements, repeatability and reliable reference values.

PEF may provide some useful information however a normal PEF does not rule out significant airways obstruction and the variation in normal values, particularly in healthy children, is large, making comparison to reference values less helpful.

While the role of spirometry in the diagnosis and initial assessment of asthma is well established, its optimal role in the ongoing monitoring of asthma is still an area of uncertainty.

24.2 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?

For full details see review protocol in Appendix C.

Table 71: PICO characteristics of review question

Population	<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"> • Children/young people (5-16 years old) • Adults (>16 years old)
Intervention(s)	<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"> • Spirometry (FEV1; FEV1/FVC; Flow loop measures) • PEF
Comparison(s)	<p>Comparison of adjustment of asthma therapy based on lung function tests to:</p> <ul style="list-style-type: none"> • Usual care: eg clinical symptoms according to guidelines (including BTS/SIGN, GINA) • Asthma control or QOL questionnaires

	Comparison of adjustment of asthma therapy based on: <ul style="list-style-type: none"> • Spirometry versus PEF
Outcomes	<p>Critical outcomes:</p> <ul style="list-style-type: none"> • Mortality • Unscheduled healthcare utilisation (ED/A&E visit; hospital admissions; GP out of hours or walk-in centre) • Exacerbations (defined as need for course of oral steroids) • Asthma control questionnaires (ACT; CACT; ACQ; PACQ; RCP-3) • QoL (AQLQ; pAQLQ; St George's respiratory questionnaire) <p>Important outcomes:</p> <ul style="list-style-type: none"> • Lung function (FEV1, PEF) • Symptoms (annual symptom free days) • Dose of regular asthma therapy / preventer medication (ICS dose) • Rescue medication (SABA use) • Time off school or work
Study design	RCT

1 24.3 Clinical evidence

2 We searched for randomised trials comparing the effectiveness of monitoring lung function using
3 spirometry or peak expiratory flow measures versus monitoring according to usual care (for example
4 clinical symptoms) to guide asthma treatment and management.

5 Eleven studies were included in the review^{3,23,28,37,38,77,90,96,169,180,187}, summarised in Table 72 and Table
6 73. See also the study selection flow chart in Appendix D, study evidence tables in Appendix G, forest
7 plots in Appendix J, GRADE tables in Appendix I and excluded studies list in Appendix K. Evidence in
8 adults was available from eight studies^{96,3,23,28,37,38,77,169}. Evidence in children and young people was
9 available from four studies^{28,90,180,187}.

10 All studies were of self-management, with the action plans based on PEF readings versus action plans
11 based on symptoms. Studies investigating the effectiveness of self-management plans based on PEF
12 versus no self-management (the effectiveness of self-management plans) were excluded. No studies
13 were identified monitoring spirometry. In three studies, the action plan in the intervention group
14 was based on PEF and symptoms^{96,180,187}. In the remaining studies, the action plan in the intervention
15 group was based on PEF alone. One study also incorporated adjustment by the GP in addition to self-
16 management⁹⁶.

17 A Cochrane systematic review was identified and included¹⁹. Studies included in this review were
18 included and data extracted separately to incorporate additional studies and outcomes from the
19 protocol.

Table 72: Summary of studies included in the review: Adults

Study	Intervention/comparison	Population	Outcomes	Follow up
Adams 2001 ³	Self-management action plan based on PEF / Self-management action plan based on symptoms	Adults 17-70 years Physician's diagnosis of asthma defined by ATS	Hospitalisation (mean days); ED visits (mean days); FEV1; (time off work) mean days	12 months
Buist 2006 ²³	Self-management action plan based on PEF / Self-management action plan based on symptoms	50-92 years, moderate to severe asthma Physician-diagnosed asthma and had medication use suggestive of moderate-to-severe asthma; bronchodilator reversibility (> 8% of baseline FEV1)	QOL (AQLQ dichotomised); total asthma-related health care utilisation	2 years
Charlton 1990 ²⁸	Self-management action plan based on PEF / Self-management action plan based on symptoms	Adults and children stratum separately Patients on the repeat prescribing register who were receiving prophylactic treatment for asthma	Exacerbations (OCS); rescue medications	12 months
Cote 1997 ³⁷	Self-management action plan based on PEF / Self-management action plan based on symptoms	16 years and over, moderate to severe asthma The diagnosis had to be confirmed by either a documented reversibility greater than 15% in FEV1 or a methacholine PC20<8mg/ml	Exacerbations (OCS); Hospitalisation (mean events); ED visits (mean events); time off work (mean days)	12 months
Cowie 1997 ³⁸	Self-management action plan based on PEF / Self-management action plan based on symptoms	Adults and adolescents Adult and adolescent patients who had received urgent treatment for their asthma in the preceding 12 months and used asthma medication	Visits for urgent treatment; hospital admissions	6 months
Kaya 2009 ⁷⁷	Self-management action plan based on PEF / Self-management action plan based on symptoms	Adults Patients with persistent asthma receiving care for at least one year in asthma clinic	FEV1; PEF	12 months
Lopez-	Self-management action plan based on PEF,	17-65 years	Hospitalisation; ED visits;	12

Study	Intervention/comparison	Population	Outcomes	Follow up
Vina 2000 ⁹⁶	symptoms & medications (and additional GP visits with adjustment based on spirometry, PEF and symptoms) / Self-management action plan based on symptoms (and additional GP visits with adjustment based on spirometry and symptoms)	ATS definition of asthma, with symptoms of episodic wheezing, cough and shortness of breath responding to bronchodilators, and documented BDR (>20% increase in FEV1 or PEF) or BHR (in patients with normal spirometry).	FEV1; time off work	months
Turner 1998 ¹⁶⁹	Self-management action plan based on PEF / Self-management action plan based on symptoms	18-55 years Moderate to moderately severe asthma. BHR (methacholine <8mg/ml) and daily ICS.	QOL (SD not reported); Exacerbations (OCS); Hospitalisation; ED visits; unscheduled doctor visits; FEV1; PEF; time off work	6 months

Table 73: Summary of studies included in the review: Children

Study	Intervention/comparison	Population	Outcomes	Follow up
Charlton 1990 ²⁸	Self-management action plan based on PEF / Self-management action plan based on symptoms	Adults and children stratum separately Patients on the repeat prescribing register who were receiving prophylactic treatment for asthma	Exacerbations (OCS); rescue medications	12 months
Letz 2004 ⁹⁰	Self-management action plan based on PEF / Self-management action plan based on symptoms	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). Diagnosis made on the basis of history, examination and pre/post-BD lung function testing.	Exacerbations (OCS)	3 months
Wensley 2004 ¹⁸⁰	Self-management action plan based on PEF and symptoms / Self-management action plan based on symptoms	Children 7-14 years Physician diagnosis asthma and at least step 2 of BTS treatment guidelines.	Hospitalisation; ED visits; unscheduled doctor visits; FEV1; PEF; symptom free days; time off work	12 weeks
Yoos 2002 ¹⁸⁷	Self-management action plan based on PEF and symptoms / Self-management	Children 6-19 years	FEV1	3 months

Study	Intervention/comparison	Population	Outcomes	Follow up
	action plan based on symptoms	Diagnosis of asthma and more than 3 asthma-related healthcare visits in the past 12 months		hs

Table 74: Clinical evidence summary: Adults: Monitoring PEF versus symptom monitoring

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with PEF versus symptoms monitoring: adults (95% CI)
QOL ≥6 months AQLQ increase >0.5 points	262 (1 study) 2 years	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 0.99 (0.73 to 1.35)	Moderate 391 per 1000	4 fewer per 1000 (from 106 fewer to 137 more)
QOL ≥6 months AQLQ decrease >0.5 points	262 (1 study) 2 years	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision	RR 1.39 (0.67 to 2.88)	Moderate 86 per 1000	34 more per 1000 (from 28 fewer to 162 more)
Exacerbation ≥6 months need for OCS	152 (2 studies) 6-12 months	⊕⊕⊕⊕ VERY LOW ^{1,3,4} due to risk of bias, inconsistency, imprecision	RR 1.28 (0.29 to 5.57)	Moderate 169 per 1000	47 more per 1000 (from 120 fewer to 772 more)
Exacerbations ≥6 months number of OCS courses	95 (1 study) 12 months	⊕⊕⊕⊕ LOW ¹ due to risk of bias		The mean exacerbations ≥6 months in the control groups was 0.9 courses of OCS	The mean exacerbations ≥6 months in the intervention groups was 0.20 lower (0.74 lower to 0.34 higher)
UHU ≥6 months Total asthma-related health care utilisation	294 (1 study) 2 years	⊕⊕⊕⊕ MODERATE ⁵ due to risk of bias		The mean uhu ≥6 months in the control groups was 1.5	The mean uhu ≥6 months in the intervention groups was 0.11 lower (0.59 lower to 0.37 higher)
UHU ≥6 months Hospitalisation	283 (3 studies) 6-12 months	⊕⊕⊕⊕ VERY LOW ^{3,5} due to risk of bias, imprecision	RR 1.17 (0.31 to 4.43)	Moderate 22 per 1000	4 more per 1000 (from 15 fewer to 75 more)
UHU ≥6 months Number of hospital admissions	95 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		The mean uhu ≥6 months in the control groups was 0.09	The mean uhu ≥6 months in the intervention groups was 0.05 lower (0.16 lower to 0.06 higher)
UHU ≥6 months days hospitalisation	88 (1 study) 12 months	⊕⊕⊕⊕ MODERATE ⁵ due to risk of bias		The mean uhu ≥6 months in the control groups was 0.1	The mean uhu ≥6 months in the intervention groups was 0.03 lower (0.21 lower to 0.15 higher)
UHU ≥6 months ED visits	192 (2 studies) 6-12 months	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 3.78 (0.96 to 14.93)	22 per 1000	60 more per 1000 (from 1 fewer to 303 more)
UHU ≥6 months Mean number of ED visits	183 (2 studies)	⊕⊕⊕⊕ MODERATE ⁵		The mean uhu ≥6 months in the control groups was	The mean uhu ≥6 months in the intervention groups was 0.04 lower

Outcomes	No of	Quality of the evidence	Relative	Anticipated absolute effects	
	12 months	due to risk of bias		0.11	(0.2 lower to 0.12 higher)
UHU ≥6 months Unscheduled doctors visit	183 (2 studies) 6 months	⊕⊕⊕⊕ VERY LOW ^{3,5,6} due to risk of bias, inconsistency, imprecision	RR 0.77 (0.18 to 3.34)	Moderate 281 per 1000	65 fewer per 1000 (from 230 fewer to 658 more)
Rescue medication ≥6months requiring nebulised salbutamol	65 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, imprecision	RR 1.98 (0.35 to 11.08)	Moderate 54 per 1000	53 more per 1000 (from 35 fewer to 544 more)
FEV1 L ≥6 months	88 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		The mean fev1 l ≥6 months in the control groups was 2.71	The mean fev1 l ≥6 months in the intervention groups was 0.26 lower (0.61 lower to 0.09 higher)
FEV1 % ≥6 months Scale from: 0 to 100.	163 (2 studies) 6-12 months	⊕⊕⊕⊕ LOW ¹ due to risk of bias		The mean fev1 % ≥6 months in the control groups was 84.1 %	The mean fev1 % ≥6 months in the intervention groups was 0.10 higher (0.92 lower to 1.12 higher)
PEF % best ≥6 months Scale from: 0 to 100.	63 (1 study) 6 months	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		The mean pef % best ≥6 months in the control groups was 79.62 %	The mean pef % best ≥6 months in the intervention groups was 5.31 higher (1.91 lower to 12.53 higher)
Time off work ≥6 months	192 (2 studies) 6-12 months	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, imprecision	RR 1.41 (0.62 to 3.21)	Moderate 83 per 1000	34 more per 1000 (from 32 fewer to 183 more)
Mean days off work ≥6 months	183 (2 studies) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		The mean days off work ≥6 months in the control groups was 2.6 days	The mean days off work ≥6 months in the intervention groups was 2.5 higher (1.27 to 3.74 higher)

¹ The majority of the evidence was from studies at very high risk of bias

² 95% CI crosses one MID

³ 95% CI crosses two MIDs

⁴ Heterogeneity in the point estimates, I²=52%

⁵ The majority of the evidence was from studies at high risk of bias

⁶ Heterogeneity in the point estimates, I²=86%

Table 75: Clinical evidence summary: Children: Monitoring PEF versus symptom monitoring

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with PEF versus symptoms monitoring: children (95% CI)
Exacerbations <6months OCS	24 (1 study) 3 months	⊕⊕⊕⊕ VERY LOW ^{2,3} due to risk of bias,	RR 1.00 (0.07 to 14.21)	83 per 1000	Moderate 0 fewer per 1000 (from 77 fewer to 1000 more) ¹

Outcomes	No of	Quality of the evidence	Relative	Anticipated absolute effects	
		imprecision			
Exacerbations ≥6months OCS	46 (1 study) 12 months	⊕⊕⊕⊖ LOW ² due to risk of bias	OR 16.34 (3.25 to 82.24)	0 per 1000	Moderate 370 more per 1000 (from 150 more to 590 more) ¹
UHU <6 months Hospitalisation	89 (1 study) 12 weeks	⊕⊖⊖⊖ VERY LOW ^{3,4} due to risk of bias, imprecision	OR 7.56 (0.15 to 381.04)	0 per 1000	Moderate 20 more per 1000 (from 40 fewer to 80 more) ¹
UHU <6 months Attendance at A&E	89 (1 study) 12 weeks	⊕⊖⊖⊖ VERY LOW ^{3,4} due to risk of bias, imprecision	OR 7.56 (0.15 to 381.04)	0 per 1000	Moderate 20 more per 1000 (from 40 fewer to 80 more) ¹
UHU(<6 months) Emergency GP visits	89 (1 study) 12 weeks	⊕⊖⊖⊖ VERY LOW ^{3,4} due to risk of bias, imprecision	RR 0.93 (0.44 to 1.97)	244 per 1000	Moderate 17 fewer per 1000 (from 137 fewer to 237 more)
Rescue meds ≥6 months requiring salbutamol	44 (1 study) 12 months	⊕⊖⊖⊖ VERY LOW ^{2,5} due to risk of bias, imprecision	OR 14.15 (0.79 to 252.1)	0 per 1000	Moderate 120 more per 1000 (from 50 fewer to 280 more) ¹
FEV1 % best (<6 months)	202 (2 studies) 12 weeks	⊕⊕⊕⊖ LOW ² due to risk of bias		The mean fev1 % best (<6 months) in the control groups was 88.5 %	The mean fev1 % best (<6 months) in the intervention groups was 0.39 higher (0.21 lower to 0.98 higher)
PEF % best (<6 months)	89 (1 study) 12 weeks	⊕⊖⊖⊖ VERY LOW ^{2,3} due to risk of bias, imprecision		The mean pef % best (<6 months) in the control groups was 80.6 %	The mean pef % best (<6 months) in the intervention groups was 2.8 higher (2.15 to 3.45 higher)
Time off school (<6 months)	89 (1 study) 12 weeks	⊕⊖⊖⊖ VERY LOW ^{2,3} due to risk of bias, imprecision	RR 1.18 (0.64 to 2.18)	289 per 1000	Moderate 52 more per 1000 (from 104 fewer to 341 more)

¹ Manual risk difference calculation due to no events in one group
² The majority of the evidence was from studies at very high risk of bias
³ 95% CI crosses 2 MIDs
⁴ The majority of the evidence was from studies at high risk of bias
⁵ 95% CI crosses one MID

1 24.4 Economic evidence

2 Published literature

3 No relevant economic evaluations were identified.

4 See also the economic article selection flow chart in Appendix E.

5 24.5 Evidence statements

6 Clinical

7 ADULTS (>16 years): monitoring PEF vs conventional monitoring

- 8 • No evidence was identified for mortality, asthma control questionnaires or QOL (as a continuous
9 outcome).
- 10 • Monitoring PEF vs conventional monitoring was considered a clinically important harm for asthma
11 exacerbations (2 studies, N=152, very low quality), UHU ED visits,(2 studies, N=192, very low
12 quality) and number of people requiring nebulised salbutamol (1 study, N=65, very low quality),
13 all at ≥6 months and for lung function (FEV1) at ≥6 months when measured in litres (1 study,
14 N=88, very low quality). However, this benefit was not seen when lung function was measured as
15 %pred, there was no difference between the two groups (2 studies, N=163, very low quality).
- 16 • Monitoring PEF vs conventional monitoring was considered a clinically important benefit for UHU
17 GP visits (2 studies, N=183, very low quality) and lung function when measured as PEF %best (1
18 study, N=63, very low quality), both at ≥6 months.
- 19 • Monitoring PEF vs conventional monitoring resulted in no clinically important difference for UHU
20 hospitalisation (3 studies, N=283, very low quality) and time off work (2 studies, N=192, very low
21 quality), both at ≥6 months.
- 22 • Evidence was also available for asthma exacerbations (mean number of OCS courses per person)
23 and for UHU (mean number of total asthma related visits, mean number of hospitalisations, mean
24 number of days in hospital and mean number of ED visits) as continuous outcomes. However, for
25 all these outcomes, it is unclear whether the lower absolute values in the PEF monitoring group
26 represent a clinical benefit when reported on a continuous scale.

27 CHILDREN (>16 years): monitoring PEF vs conventional monitoring

- 28 • No evidence was identified for mortality, asthma control questionnaires or QOL.
- 29 • Monitoring PEF vs conventional monitoring resulted in no clinically important difference for
30 asthma exacerbations (1 study, N=24, very low quality) and lung function measured as both FEV1
31 %best (2 studies, N=202, low quality) and PEF %best (1 study, N=89, very low quality), all at <6
32 months.
- 33 • Monitoring PEF vs conventional monitoring was considered a clinically important harm for asthma
34 exacerbations (1 study, N=46, low quality) and time off school (1 study, N=89, very low quality),
35 both at <6 months, and for use of rescue medications (1 study, N=44, very low quality) at ≥6
36 months.
- 37 • Monitoring PEF vs conventional monitoring resulted in an borderline clinically important
38 difference for UHU hospitalisations, ED visits and GP visits (1 study, N=89, very low quality), all at
39 <6 months.

40 Economic

- 41 • No relevant economic evaluations were identified.

1 24.6 Recommendations and link to evidence

Recommendations	36. Monitor asthma control at each review in adults and children aged 5 years and over using either spirometry (FEV₁) or peak flow variability.
Relative values of different outcomes	<p>The GDG considered the following outcomes as critical for this review: mortality, quality of life, exacerbations, asthma control measured by questionnaires and unscheduled healthcare utilisation.</p> <p>The GDG noted that exacerbations of asthma can lead to both unscheduled healthcare utilisation (ED visits, out-of-hours GP surgery visits or hospitalisation) and the need for a course of OCS. Therefore, the GDG considered exacerbations requiring OCS treatment and exacerbations requiring unscheduled healthcare utilisation separately.</p> <p>The GDG also considered the following important outcomes: lung function (FEV₁), symptoms (symptom scores and symptom-free days), dose of regular asthma therapy (ICS dose), rescue medication requirement (SABA dose) and time off school or work. These outcomes were considered as important measures of asthma control for the patient. The GDG acknowledged that regular asthma preventer therapy (ICS) is often under prescribed / used, and rescue medications (SABA) may be overprescribed / used¹³⁵.</p>
Trade-off between clinical benefits and harms	<p>In adults, monitoring including PEF vs. monitoring without PEF was associated with a clinically important benefit for UHU (unscheduled GP visits) and a clinically important harm for ED visits and asthma exacerbations (OCS use). The GDG acknowledged that on some occasions OCS may be of benefit by preventing a more severe asthma attack requiring UHU. There was no clinically important difference in hospitalisations. For the majority of the outcomes, evidence was only available from two studies, and no evidence was available for mortality, asthma control questionnaires or QOL.</p> <p>In children, monitoring including PEF vs monitoring without PEF was associated with no clinically important benefit in asthma exacerbations at less than 6 months and a clinically important harm for asthma exacerbations at more than 6 months. There was a trend towards more hospitalisations and ED visits in the PEF monitoring group and fewer GP visits, but the GDG considered the clinical harms and benefits to be unclear. For the majority of the outcomes, evidence was only available from one study, and no evidence was available for mortality, asthma control questionnaires or QOL.</p> <p>The GDG noted that all of the studies compared self-management using PEF monitoring with self-management using symptom monitoring. No studies were identified comparing monitoring of PEF vs monitoring of symptoms by a GP. Also, no studies were identified monitoring spirometry. According to the GDG, some outcomes favoured PEF monitoring, whereas others favoured symptom monitoring. The GDG agreed that all people with asthma should have a self-management action plan, but there is no evidence to show PEF-monitoring plans are better than symptom-monitoring plans. The GDG also discussed the small increase in hospitalisations and the need for nebulised salbutamol. This may be an appropriate increase in outcomes in some people and may reflect the PEF self-management monitoring intervention recognising poor control at an earlier stage.</p> <p>No evidence was available to assess the utility of monitoring spirometry to measure asthma control. The GDG debated the importance of monitoring spirometry and the additional information that it provided over and above PEF. Given the relative ease of monitoring spirometry and the additional information that it provides, the GDG</p>

	<p>felt that spirometry should be measured at every review. Spirometry provides additional information on the level of airways obstruction and can be compared to the previous best measurement or predicted measurement based on age and height of the individual.</p> <p>As no evidence was identified comparing PEF or spirometry monitoring by a GP at each asthma review, the GDG made a consensus recommendation on the basis of current best practice that either spirometry (FEV1) or PEF should be used at every asthma review to monitor asthma control in children aged over 5 years. Children under 5 years are unable to perform these tests.</p>
Economic considerations	<p>No relevant economic evaluations were identified.</p> <p>The cost of providing the equipment, such as peak-flow meters, to monitor asthma is likely to be negligible. The main cost-consequence of monitoring using lung function tests is the impact it has on medication usage. If monitoring using lung function tests produces false results which increase medication usage then this will stand as an inefficient use of NHS resources as costs will increase with no added health benefits. On the other hand, if accurate, monitoring using lung function tests could reduce medication usage and provide cost savings.</p> <p>The clinical evidence showed a reduction in unscheduled healthcare utilisation. Although oral corticosteroid usage was higher in the lung function test group compared to the no lung function test group, the GDG felt that this may be due to the poor control being identified early and thus preventing expensive hospitalised exacerbations. The GDG considered it likely that using lung functions tests to monitor asthma control is cost-effective at a £20,000 per QALY threshold.</p>
Quality of evidence	<p>In adults, for the comparison of monitoring PEF vs conventional monitoring, evidence ranged from very low to moderate quality. For the majority of the outcomes, evidence was only available from one or two studies.</p> <p>In children, all the evidence was of very low and low quality. For the majority of the outcomes, evidence was only available from one study and the studies were of small sample size.</p> <p>The GDG noted that the majority of the evidence was from older studies.</p>
Other considerations	None.

25 Monitoring: Fractional exhaled nitric oxide (FeNO)

25.1 Introduction

Asthma can be divided into extrinsic asthma (atopic or allergic), intrinsic asthma (non-atopic) and occupational asthma. Atopy is defined as a genetic predisposition to produce immunoglobulin E (IgE) against common environmental aeroallergens such as house dust mites, animal dander, pollens and moulds. Approximately 80% of people with asthma are atopic compared with 30% of the general population. Atopic asthma is characterised by Th2 lymphocyte driven inflammation within the airways.

Exhaled nitric oxide (NO) mainly originates from the respiratory epithelium and is produced by inducible NO synthase (iNOS). In patients with asthma, iNOS expression is upregulated by interleukin-4 and -13, both archetypal Th2 cytokines. Thus exhaled NO primarily signals Th2 lymphocyte driven inflammation in the bronchial mucosa and consequently has potential utility in the monitoring of airways inflammation in asthma.

25.2 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?

For full details see review protocol in Appendix C.

Table 76: PICO characteristics of review question

Population	<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"> • Children/young people (5-16 years old) • Adults (>16 years old)
Intervention(s)	<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(s)	<p>Comparison of adjustment of asthma therapy based on FeNO to:</p> <ul style="list-style-type: none"> • Usual care: eg clinical symptoms (with or without PEF) according to guidelines (including BTS/SIGN, GINA) • Asthma control questionnaires or QOL questionnaires • Lung function tests (spirometry or PEFv) • Blood eosinophils • Challenge tests <p>Comparison of different frequencies of monitoring using FeNO.</p>
Outcomes	<p>Critical outcomes:</p> <ul style="list-style-type: none"> • Mortality

- Unscheduled healthcare utilisation (ED/A&E visit; hospital admissions; GP out of hours or walk-in centre)
 - Exacerbations (defined as need for course of oral steroids)
 - Asthma control questionnaires (ACT; CACT; ACQ; PACQ; RCP-3)
 - QoL (AQLQ; pAQLQ; St George's respiratory questionnaire)
- Important outcomes:
- Lung function (FEV₁, PEF)
 - Symptoms (annual symptom free days)
 - Dose of regular asthma therapy / preventer medication (ICS dose)
 - Rescue medication (SABA use)
 - Time off school or work

1 25.3 Clinical evidence

2 We searched for randomised trials comparing FeNO monitoring versus conventional monitoring, in
 3 patients with asthma. A Cochrane systematic review was identified¹²⁰. Studies included in this
 4 Cochrane review were included individually and data extracted separately in order to incorporate
 5 additional outcomes from the protocol and additional, more recently published studies.

6 Fourteen studies (13 RCTs and the Cochrane review) were included in the
 7 review^{25,41,55,117,117,120,122,123,146,154,161,162,176}, all compared FeNO monitoring versus conventional
 8 monitoring. These studies are summarised in Table 77 and Table 78 below. See also the study
 9 selection flow chart in Appendix D, study evidence tables in Appendix G, forest plots in Appendix J,
 10 GRADE tables in Appendix I and excluded studies list in Appendix K.

11 Evidence in adults was available from five studies^{25,146,154,161} and evidence in children from eight
 12 studies^{40,55,117,122,123,162,176}. For the conventional monitoring group, some studies monitored symptoms
 13 alone and other studies used algorithms for treatment adjustment based on symptoms, lung function
 14 and bronchodilator (BD) use. For the FeNO monitoring group, studies monitored FeNO alone; FeNO
 15 and symptoms; or FeNO, symptoms, lung function and BD use. Two studies included patients with
 16 severe asthma: Peirsman¹¹⁷ included 6% (N= 3) patients with severe asthma in the control group and
 17 4% (N=2) severe asthma in the intervention group; Pike¹²³ recruited patients with moderate to severe
 18 asthma.

Table 77: Summary of studies included in the review: ADULTS

Study	Intervention/comparison (frequency of adjustment)	Population	Outcomes	Follow-up and frequency of adjustment
Calhoun 2012 ²⁵	Monitoring FeNO / monitoring symptoms and lung function (every 6 weeks) FeNO cut-off: <22ppb step-down; 22-35ppb maintain; >35 step up	Adults Physician diagnosis with BDR or AHR	QOL; exacerbations; asthma control questionnaires; SABA use; ICS use; lung function; time off work	6, 12 and 36 weeks
Honkoop 2014	Monitoring FeNO and symptoms (ACQ score) / monitoring symptom control questionnaire and treatment (every 3 months) FeNO cut-off: <25ppb; 22-35ppb; >50 step up	Adults Physician diagnosis according to the Dutch national guidelines	Exacerbation; ACQ; UHU (ED visit & hospitalisation); lung function	12 months
Shaw 2007 ¹⁴⁶	Monitoring FeNO and symptoms (ACQ score) / monitoring symptoms (ACQ score) (monthly to 4 months then every 2 months) FeNO cut-off: <16ppb (or <26ppb twice) step-down; >26 ppb step up	Adults GP diagnosis of asthma.	Exacerbations; ICS use	12 months
Smith 2005 ¹⁵⁴	Monitoring FeNO (additional safety buffer if asthma deteriorated in absence of FeNO rise) / monitoring symptoms, BD use and lung function (every 2 months) FeNO cut-off: 35ppb (safety buffer to step-up if deteriorating asthma in the absence of a rise in FeNO)	12 – 75 years Chronic asthma	Exacerbations; SABA use; ICS use; lung function; symptom free days	12 months
Syk 2013 ¹⁶¹	Monitoring FeNO and symptoms / monitoring symptoms, beta agonist use, lung function (at 1, 2, 4 and 8 months) Men - FeNO step-down: <21 ppb; no change 21-25 ppb; step-up; ≥26 ppb / Women – FeNo step-down: <19; no change 19-23; step-up ≥24	18-64 years Physician diagnosis of asthma and atopic	Exacerbation; ACQ; SABA use; ICS use; lung function	12 months

Table 78: Summary of studies included in the review: CHILDREN

Study	Intervention/comparison (frequency of adjustment)	Population	Outcomes	Follow-up and frequency of adjustment
De jongste 2009 ⁴¹	Monitoring FeNO and symptoms / monitoring symptoms (measured daily and adjusted based on 3 week mean) FeNO step-down: symptom score low, FeNO low; maintain: symptom score high, FeNO low; step-up performed in every other case. Cut-off: 20 ppb for children aged 6-10 years and 25 ppb for older children	Children 6-18 years Diagnosed according to GINA	QOL; exacerbation; UHU; SABA use; ICS use; lung function; symptom free days	30 weeks
Fritsch 2006 ⁵⁵	Monitoring symptoms, beta agonist use, lung function, and FeNO / monitoring symptoms, beta agonist use and lung function (every 6 weeks) Step-down: FEV1% predicted: ≥80%, no or mild symptoms, and beta agonist use <6 puffs over last 14 days; step-up performed in every other case. Further adjustment based on FeNO cut-off >20 ppb	Children 6-18 years Diagnosed according to ATS	Exacerbation; ICS use	6 months
Peirsman 2013 ¹¹⁷	Monitoring FeNO and symptoms / monitoring symptoms, beta agonist use, lung function (every 3 months) FeNO cut-off: 20 ppb	Children Mild to severe allergic asthma according to GINA guidelines	Exacerbation; UHU; ICS use; lung function; symptom free days; time off school	12 months
Petsky 2014 ¹¹⁹	Monitoring FeNO and atopic status / monitoring symptoms (monthly to 4 months then every 2 months) FeNO cut-off: ≥10 ppb in children with no positive skin prick test (SPT), ≥12 ppb in children with one	Children aged >4 years with persistent asthma	Exacerbation; QOL; UHU; ICS use; lung function	12 months

Study	Intervention/comparison (frequency of adjustment)	Population	Outcomes	Follow-up and frequency of adjustment
	positive SPT, and ≥ 20 ppb in children with ≥ 2 positive SPT			
Pijnenburg 2005 ¹²²	Monitoring FeNO and symptoms / monitoring symptoms (every 3 months) FeNO step-down: ≤ 30 ppb and symptom score ≤ 14 ; maintain: ≤ 30 ppb and symptom > 14 ; step-up: > 30 ppb, regardless of symptoms.	Children Atopic asthma, and fulfilled ATS criteria for asthma.	Exacerbation; ICS use; lung function	12 months
Pike 2012 ¹²³	Monitoring FeNO and symptoms / monitoring symptoms, BD use and lung function (every 2 months) FeNO cut-off: step-up: ≥ 25 ppb or FeNO more than twice baseline; maintain: > 15 ppb to ≤ 25 ppb; step-down: ≤ 15 ppb.	6-17 years Clinical diagnosis of asthma with BDR or PEFv	UHU; ICS use	12 months
Szeffler 2008 ¹⁶²	Monitoring FeNO, symptoms, BD use and lung function / monitoring symptoms, BD use and lung function (every 6-8 weeks) Control level determined based on all the above. FeNO control level one: 0-20ppb; two: 20.1-30ppb; three: 30.1-40ppb; four: > 40 ppb.	12 to 20 years Asthma	Exacerbation; UHU; ACQ; ICS use; lung function; symptoms free days; time off school	46 weeks
Verini 2010 ¹⁷⁶	Monitoring FeNO, symptoms, BD use and lung function / monitoring symptoms, BD use and lung function (every 6 months) FeNO cut-off: ≥ 12 ppb	6-17 years Diagnosis made according to ATS-ERS criteria	ICS use; SABA use	12 months

Table 79: Clinical evidence summary: [FeNO versus Conventional Monitoring] Adults

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with FeNO versus conventional monitoring ADULTS (95% CI)
UHU (ED visit) ≥6 months	415 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	OR 0.68 (0.12 to 3.98)	Moderate 14 per 1000	4 fewer per 1000 (from 12 fewer to 39 more)
UHU (hospitalisation) ≥6 months	415 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	OR 0.52 (0.05 to 5.07)	Moderate 10 per 1000	5 fewer per 1000 (from 9 fewer to 39 more)
Exacerbation (OCS) ≥6 months	393 (3 studies) 52 weeks	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 0.84 (0.56 to 1.26)	Moderate 313 per 1000	50 fewer per 1000 (from 138 fewer to 81 more)
Exacerbation (OCS) ≥6 months	342 (1 study) 9 months	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	HR 0.91 (0.39 to 2.11)	Moderate	- ³
Exacerbation (OCS) ≥6 months	415 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	OR 0.64 (0.27 to 1.56)	Moderate	- ³
AQLQ (≥ 6months) Asthma Quality of Life Questionnaire. Scale from: 1 to 7.	227 (1 study) 6 weeks	⊕⊕⊕⊕ LOW ¹ due to risk of bias		The mean aqlq (≥ 6months) in the control groups was 0.02 change score	The mean aqlq (≥ 6months) in the intervention groups was 0 higher (0.22 lower to 22 higher) ⁵
ACQ ≥6 months Asthma Control Questionnaire. Scale from: 0 to 6.	644 (2 studies) 9-12 months	⊕⊕⊕⊕ MODERATE ¹ due to risk of bias		The mean acq ≥6 months in the control groups was 0.03 change score	The mean acq ≥6 months in the intervention groups was 0.05 lower (0.13 lower to 0.04 higher)
ACQ (clinically important improvement, ≥0.5) ≥6 months Asthma Control Questionnaire	155 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 1.39 (0.86 to 2.26)	Moderate 257 per 1000	100 more per 1000 (from 36 fewer to 324 more)
FEV1 %pred Scale from: 0 to 100.	736 (3 studies) 9-12 months	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		The mean fev1 %pred in the control groups was 82.3 %	The mean fev1 %pred in the intervention groups was 0.45 higher (0.69 lower to 1.59 higher)
FEV1, litres ≥6 months	166 (1 study) 12 months	⊕⊕⊕⊕ LOW ¹ due to risk of bias		The mean fev1, litres ≥6 months in the control groups was -0.006 litres change score	The mean fev1, litres ≥6 months in the intervention groups was 0.03 lower (0.11 lower to 0.06 higher)
PEF am (L/min) ≥6 months	321 (2 studies)	⊕⊕⊕⊕ LOW ¹		The mean pef am (l/min) ≥6 months in the control groups was	The mean pef am (l/min) ≥6 months in the intervention groups was

Outcomes	No of	Quality of the evidence	Relative	Anticipated absolute effects	
	9-12 months	due to risk of bias		403 L/min	2 higher (10.39 lower to 14.39 higher)
PEF pm (L/min) ≥6 months	227 (1 study) 9 months	⊕⊕⊕⊖ LOW ¹ due to risk of bias		The mean pef pm (l/min) ≥6 months in the control groups was -13.3 L/min change score	The mean pef pm (l/min) ≥6 months in the intervention groups was 3.8 higher (10 lower to 17.6 higher)
ICS use ≥6 months fluticasone or BDP equivalent	212 (2 studies) 12 months	⊕⊖⊖⊖ VERY LOW ^{1,2,6} due to risk of bias, indirectness, imprecision		The mean ics use ≥6 months in the control groups was 768 mcg	The mean ics use ≥6 months in the intervention groups was 0.53 standard deviations lower (0.8 to 0.25 lower)
Rescue medication (puffs/day) ≥6 months	321 (2 studies) 9-12 months	⊕⊖⊖⊖ VERY LOW ^{1,6} due to risk of bias, indirectness		The mean rescue medication (puffs/day) ≥6 months in the control groups was 0.4	The mean rescue medication (puffs/day) ≥6 months in the intervention groups was 0.06 lower (0.12 lower to 0 higher)
% symptom free days ≥6 months Scale from: 0 to 100.	94 (1 study) 12 months	⊕⊖⊖⊖ VERY LOW ^{1,2} due to risk of bias, imprecision		The mean % symptom free days ≥6 months in the control groups was 63.7 %	The mean % symptom free days ≥6 months in the intervention groups was 5.6 higher (8.51 lower to 19.71 higher)
Time of work (number of people) ≥6 months	229 (1 study) 9 months	⊕⊖⊖⊖ VERY LOW ^{1,2} due to risk of bias, imprecision	OR 2 (1.17 to 3.41)	Moderate	³

¹ 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

² Downgraded by one increment if the confidence interval crossed one MID or by two increments if the confidence interval crossed both MIDs

³ Control group event rate not reported

⁴ Control group event rate not reported

⁵ 97.5% CI reported and extracted

⁶ Downgraded by one/two increments because: the majority of the evidence had indirect outcomes

Table 80: Clinical evidence summary: [FeNO versus Conventional Monitoring] Children

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with FeNO versus conventional monitoring CHILD (95% CI)
UHU (unscheduled visits) ≥6 months	581 (2 studies) 46-52 weeks	⊕⊖⊖⊖ VERY LOW ^{1,2} due to inconsistency, imprecision	RR 0.67 (0.29 to 1.55)	Moderate 299 per 1000	99 fewer per 1000 (from 212 fewer to 164 more)
UHU (hospitalisation) ≥6 months	725	⊕⊖⊖⊖	RR 0.97	Moderate	

Outcomes	No of	Quality of the	Relative	Anticipated absolute effects	
	(4 studies) 46-52 weeks	VERY LOW ^{2,3} due to risk of bias, imprecision	(0.48 to 1.95)	34 per 1000	1 fewer per 1000 (from 18 fewer to 32 more)
UHU (number of children ≥1 emergency room admin) ≥6 months	91 (1 study) 52 weeks	⊕⊖⊖⊖ VERY LOW ^{2,3} due to risk of bias, imprecision	RR 0.51 (0.1 to 2.65)	Moderate 87 per 1000	43 fewer per 1000 (from 78 fewer to 144 more)
Exacerbation (OCS) ≥6 months	927 (6 studies) 43 weeks	⊕⊕⊕⊖ MODERATE ² due to imprecision	RR 0.74 (0.61 to 0.9)	Moderate 192 per 1000	50 fewer per 1000 (from 19 fewer to 75 fewer)
Asthma control (ACT score) ≥6 months ACT. Scale from: 5 to 25.	494 (1 study) 46 weeks	⊕⊕⊕⊕ HIGH		The mean asthma control (act score) ≥6 months in the control groups was 21.83	The mean asthma control (act score) ≥6 months in the intervention groups was 0.06 higher (0.27 lower to 0.39 higher)
PACQLQ (Pediatric Asthma Caregiver) ≥6 months Pediatric Asthma Care Quality of Life Questionnaire. Scale from: 1 to 7.	147 (1 study) 30 weeks	⊕⊕⊖⊖ LOW ³ due to risk of bias		The mean pacqlq (pediatric asthma caregiver) ≥6 months in the control groups was 6.2	The mean pacqlq (pediatric asthma caregiver) ≥6 months in the intervention groups was 0 higher (0.24 lower to 0.24 higher)
FEV1 % pred ≥6 months Scale from: 0 to 100.	579 (2 studies) 46-52 weeks	⊕⊕⊕⊖ MODERATE ² due to imprecision		The mean fev1 % pred in the control groups was 95.5 %	The mean fev1 % pred in the intervention groups was 0.94 higher (0.31 lower to 2.19 higher)
ICS dose ≥6 months fluticasone	494 (1 study) 46 weeks	⊕⊕⊕⊖ MODERATE ⁴ due to indirectness		The mean ics dose in the control groups was 570 mcg (estimated from graph)	The mean ics dose in the intervention groups was 118.9 higher (48.5 to 189.3 higher)
% symptom free days ≥6 months Scale from: 0 to 100.	147 (1 study) 30 weeks	⊕⊖⊖⊖ VERY LOW ^{2,3} due to risk of bias, imprecision			The mean % symptom free days in the intervention groups was 0.3 higher (10 lower to 10.6 higher)
Number of symptom days in last 2 weeks; ≥6 months	494 (2 studies) 46 weeks	⊕⊕⊕⊕ HIGH		The mean number of symptom days in last 2 weeks; ≥6 months in the control groups was 1.89	The mean number of symptom days in last 2 weeks; ≥6 months in the intervention groups was 0.04 higher (0.21 lower to 0.29 higher)
Number of patients not using inhaled corticosteroids or anti-leukotrienes ≥6 months	64 (1 study) 12 months	⊕⊖⊖⊖ VERY LOW ^{2,3} due to risk of bias, imprecision	RR 0.33 (0.07 to 1.53)	Moderate 188 per 1000	126 fewer per 1000 (from 175 fewer to 100 more)

Outcomes	No of	Quality of the	Relative	Anticipated absolute effects	
Rescue medication (no. of patients needed beta-agonist due to symptoms) ≥6 months	64 (1 study) 12 months	⊕⊖⊖⊖ VERY LOW ^{2,3} due to risk of bias, imprecision	RR 0.62 (0.42 to 0.9)	Moderate 813 per 1000	309 fewer per 1000 (from 81 fewer to 472 fewer)
Number of school days missed in last 2 weeks; ≥6 months	494 (1 study) 46 weeks	⊕⊕⊕⊕ HIGH		The mean number of school days missed in last 2 weeks; ≥6 months in the control groups was 0.23 days	The mean number of school days missed in last 2 weeks; ≥6 months in the intervention groups was 0.04 lower (0.12 lower to 0.04 higher)
Time off (school - number of children missed school) ≥6 months	92 (1 study) 12 months	⊕⊖⊖⊖ VERY LOW ^{2,3} due to risk of bias, imprecision	RR 0.83 (0.4 to 1.73)	Moderate 261 per 1000	44 fewer per 1000 (from 157 fewer to 191 more)

¹ Downgraded by one/two increments because: heterogeneity, I²=50%, p=0.04

² Downgraded by one increment if the confidence interval crossed one MID or by two increments if the confidence interval crossed both MIDs

³ 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

⁴ Downgraded by one/two increments because: the majority of the evidence had indirect outcomes

Table 81: Clinical evidence summary: [FeNO versus Conventional Monitoring] Adults – outcomes reported with median values

ICS: ADULTS	
Dose of regular therapy	
Calhoun (9 mo) ≥6mo = ICS, expressed as equivalent dose to BDP	As means (without variance – cannot calculate effect estimates)
Shaw (12 mo) ≥6mo = ICS, expressed as equivalent dose to BDP	As means
Smith (12 mo) ≥ 6mo = fluticasone equivalent dose	As means
Syk (12 mo) ≥ 6mo = Budesonide equivalent dose	FeNO group: 0 (-400 - 400), N= 86. Control group: 0 (-200 - 200), N= 78. [p=.945]

Table 82: Clinical evidence summary: [FeNO versus Conventional Monitoring] Children – outcomes reported with median values

ICS: CHILDREN	
Dose of regular therapy	
De Jongste (30 wk) ≥6mo = budesonide	Medians. FeNO group: 200 mcg/day (0-500). Control group: 200 mcg/day (100-500). P=<0.0001.
Fritsch (6 mo) ≥6mo = Fluticasone and budesonide permitted (unclear)	Medians. FeNO group: 316 mcg (200-500 mcg). Control group: 241 mcg (26-607 mcg).
Perisman (12 mo) ≥6mo = Budesonide or equivalent	Medians. FeNO group: +100 mcg (0, +400). Control group: 0 mcg (-200, +80). P=0.016

ICS: CHILDREN	
Petsky (12 mo) ≥6mo = fluticasone	Medians. FeNO group: 400, (250-600). Control group: 200, (100-400).
Pijnenburg (3 mo) <6mo = budesonide	As means (cannot calculate effect estimate). Mean daily ICS dose increased between visits 1 (0 months) and 2 (3 months) by 169 mcg (95% CI, 80-259; p<0.001) in the FeNO group and 172 mcg (95% CI, 92-251; p<0.001) in the symptom group.
Pike (12 mo) ≥6mo = Beclometasone, fluticasone and budesonide permitted (unclear)	Medians. FeNO group: 800 (400-1000), N=34. Control group: 500 (400-1000), N=43. P=0.0543.
Szefler (46 we) ≥6mo = fluticasone	As means
Verini (12 mo) ≥6mo = ICS unclear	Only reported as number not using ICS or anti-LTs

[Median range - Budesonide, FeNO: 100-800 mcg. Control: 0-500 mcg; Fluticasone, FeNO: 316-800 mcg, Control: 200-500 mcg]

GENERAL: other outcomes reported as medians

Rescue Meds	
Syk (12 mo) ≥6mo = SABA use per week, at 8-12 months	Medians. FeNO group: 1.56 (0.06-5.18). Control group: 0.94 (0.03-2.81)

GENERAL: other outcomes reported as medians

% Symptom free	
-----------------------	--

GENERAL: other outcomes reported as medians	
Perisman (12 mo) ≥6mo	Medians. FeNO group: 83.7 (27.1-91.9). Control group: 79.6 (51.7-94.0).
Rescue Meds	
De Jongste (30 wk) ≥6mo = beta agonist puffs per 3 weeks	The median number of rescue beta-agonist puffs per 3 weeks was similar at baseline [2 (0-19) in the FeNO group and 2 (0-21) in the control group] and decreased to 0 (0-19) and 1 (0-19), respectively.

1 **25.4 Economic evidence**

2 **Published literature**

3 One economic evaluation was identified with the relevant comparison and has been included in this
4 review.⁶⁵ This is summarised in the economic evidence profile below (Table 83) and the economic
5 evidence table in Appendix H.

6 Three economic evaluations relating to this review question were identified but were excluded due
7 to methodological limitations and the availability of more applicable evidence.^{17,68,131} These are listed
8 in Appendix L, with reasons for exclusion given.

9 See also the economic article selection flow chart in Appendix E.

Table 83: Economic evidence profile: FeNO monitoring versus standard care

Study	Applicability	Limitations	Other comments	Incremental cost	Incremental effects	Cost-effectiveness	Uncertainty
Harnan et al. 2013 (UK) ⁶⁵	Directly applicable ^(a)	Potentially serious limitations ^(b)	The economic evaluation was conducted using a Markov model with a lifetime horizon. The evaluation compared monitoring using 4 FeNO measurements per year plus annual clinical review to annual clinical review only (standard care) each year of the patient's life. Separate analyses were run for children and for adults.	Children: £2288 ^(c) Adults: £81	Children: 0.0560 QALYs Adults: 0.0379 QALYs	Children: £45,213 per QALY gained Adults: £2,146 per QALY gained	<p>Probabilistic sensitivity analysis (PSA) showed that FeNO monitoring on adults had an 82% chance of being cost-effective at a £20,000 per QALY threshold.</p> <p>A variety of one-way sensitivity analyses were conducted on the adult analysis. The result was most sensitive to how long the impact of FeNO monitoring lasted. If the impacts on exacerbation rates and change in inhaled-corticosteroids (ICS) dosage lasted less than 30 years (as opposed to lifetime in the base case) then FeNO monitoring was no longer cost-effective with an ICER of £29,707 per QALY gained.</p> <p>PSA on the result for children showed that FeNO monitoring had a 1% chance of being cost-effective at a £20,000 per QALY threshold.</p> <p>The same one-way sensitivity analyses were conducted for children. The result was most sensitive to how long the impact of FeNO monitoring on exacerbation rates and ICS dosage lasted. If it lasted less than 5 years then FeNO monitoring was considered cost-effective with an ICER of £7598 per QALY gained. This is because ICS dosage was increased following monitoring and that increased costs.</p>

(a) Cost-utility analysis conducted using an NHS perspective

(b) Both analyses for children and adults are based on single RCT trials. Only quality of life improvements from reduced exacerbations are considered and impacts on mortality are not considered, however these limitations are due to a lack of clinical evidence rather than methodological choices. Strong assumptions imposed regarding extrapolating treatment effects over a lifetime horizon. Model results are very sensitive to changes in core parameters.

(c) The significant difference in cost between adults and children is due to FeNO monitoring reducing medication costs for adults but increasing medication costs for children.

1 **Unit costs**

2 Although UK economic evidence was available, the unit cost of FeNO monitoring was presented to
3 the GDG for considerations. This is reported in Table 85 below.

4 **Table 84: Annual cost of FeNO monitoring**

Item	Unit cost	Quantity per year	Annual cost	Source
20 minute practice nurse visit	£14.66	4	£58.64	PSSRU 2013 ³⁹
Marginal cost of using FeNO equipment ^(a)	£4.82–£7.07	4	£19.28–£28.28	Harnan et al. 2013 ⁶⁵
		Annual total	£77.92–£86.92	

5 (a) The cost varies depending on whether NIOX VERO, NIOX MINO or No breath equipment is used
6

7 **Economic considerations**

8 One study by Honkoop et al^{68,69} was excluded from the economic review as the uncertainty
9 surrounding the health benefits derived from the monitoring strategies was too uncertain to produce
10 a reliable ICER. The reason being QALYs were likely rounded, but also quality of life was valued using
11 a Dutch EQ-5D tariff. However this study was a within-trial analysis that provided useful data on the
12 potential cost impact of FeNO monitoring, therefore these costs were presented to the GDG for
13 consideration and are shown below in Table 85. Note the societal costs from the paper have been
14 excluded as the NICE reference case only uses costs that are incurred by the NHS. These costs had a
15 strong influence over the cost-effectiveness of FeNO in the study. Non-asthma related costs have
16 also been excluded as there was no reason to believe why these costs would be influenced by FeNO
17 monitoring and they are likely to drastically fluctuate year on year. This was shown by the large
18 confidence intervals surrounding these costs.

19 **Table 85: Incremental costs of FeNO monitoring compared to monitoring using Asthma Control
20 Questionnaire**

Item	Incremental cost
Asthma medication costs	-£78
Marginal cost of using FeNO equipment	£73
Asthma related healthcare visits	-£40
Annual total	-£45

21
22 Table 85 above shows that FeNO monitoring resulted in costs that were £45 lower from FeNO
23 monitoring. However as the study was not conducted in a UK setting it is difficult to say whether the
24 asthma related healthcare visit costs would remain the same in a UK setting, no information was
25 given on resource use. These costs are only gathered from one year of follow-up. Medication useage
26 fluctuated significantly in the study and there was no indication that medication useage would
27 remain the same after one year of follow-up.

1 25.5 Evidence statements

2 Clinical

3 Children

- 4 • No evidence was identified for mortality.
- 5 • Monitoring FeNO vs conventional monitoring was considered a clinical benefit for asthma
6 exacerbations (OCS use; 6 studies, N=927, moderate quality), UHU all unscheduled visits (2
7 studies, N=581, very low quality) and use of rescue medication (1 study, N=64, very low quality),
8 all at ≥6 months.
- 9 • Monitoring FeNO vs conventional monitoring resulted in a borderline clinically important
10 difference for UHU emergency room admissions (1 study, N=91, very low quality) and time off
11 school (1 study, N=92, very low quality), both at ≥6 months.
- 12 • Monitoring FeNO vs conventional monitoring resulted in no clinically important difference for
13 UHU hospitalisations (4 studies, N=725, very low quality), asthma control questionnaire score (1
14 study, N=494, high quality), QOL (1 study, N=147, low quality), lung function measured as FEV1
15 %pred (2 studies, N=579, moderate quality), symptom free days reported as both the % of days
16 and number of days (very low and high quality, respectively) and days off school when reported
17 as the mean number of days (1 study, N=494, high quality), all at ≥6 months.
- 18 • Although evidence from one study showed fewer patients in the FeNO group required inhaled
19 corticosteroids or anti-leukotrienes, in general, there was no clinically important difference in the
20 mean or median dose of ICS between groups.

21 Adults

- 22 • No evidence was identified for mortality.
- 23 • Monitoring FeNO vs conventional monitoring resulted in a clinically important benefit for asthma
24 exacerbations at ≥6 months (3 studies, N=393, very low quality). More people in the FeNO
25 monitoring group had a clinically important improvement in ACQ score (1 study, N=155, very low
26 quality), however, there was no clinically important difference in the mean ACQ score.
- 27 • Monitoring FeNO vs conventional monitoring resulted in no clinically important difference for
28 UHU ED visits or hospitalisations (1 study, N=415, very low quality), QOL (1 study, N=227, low
29 quality), asthma control questionnaire score (2 studies, N=644, moderate quality), lung function
30 when measured as FEV1 litres, FEV1 %pred or PEF L/min (low to very low quality), use of rescue
31 medications (2 studies, N=321, very low quality) and symptom free days (1 study, N=94, very low
32 quality), all at ≥6 months.

33 Economic

- 34 • One cost–utility analysis found that for monitoring asthma
 - 35 ○ FeNO was cost-effective in adults compared to standard care (ICER: £2146 per QALY gained).
 - 36 ○ FeNO was not cost-effective in children compared to standard care (ICER: £45,213 per QALY
37 gained).
- 38 This analysis was assessed as directly applicable with potentially serious limitations.

39 25.6 Recommendations and link to evidence

	37. Do not routinely use FeNO to monitor asthma control.
Recommendations	38. Consider FeNO measurement as an option to support asthma

	management in people who are symptomatic despite using inhaled corticosteroids [This recommendation is from Measuring fractional exhaled nitric oxide concentration in asthma (DG12) [2014].
Research recommendations	<p>1. Which patient groups are likely to benefit from FeNO monitoring to guide asthma management, for example, individuals with atopy, frequent asthma attacks, poor adherence?</p> <p>2. What is the clinical and cost effectiveness of FeNO-guided monitoring of asthma in real-world settings?</p>
Relative values of different outcomes	<p>The GDG considered the following outcomes as critical for this review: mortality, quality of life, exacerbations, asthma control measured by questionnaires and unscheduled healthcare utilisation.</p> <p>The GDG noted that exacerbations of asthma can lead to both unscheduled healthcare utilisation (ED visits, out-of-hours GP surgery visits or hospitalisation) and the need for a course of OCS. Therefore, the GDG considered exacerbations requiring OCS treatment and exacerbations requiring unscheduled healthcare utilisation separately.</p> <p>The GDG also considered the following important outcomes: lung function (FEV₁), symptoms (symptom-free days), dose of regular asthma therapy (ICS dose), rescue medication (SABA dose) and time off school or work. These outcomes were considered as important measures of asthma control for the patient. The GDG acknowledged that regular asthma preventer therapy (ICS) is often under-prescribed/used, and rescue medications (SABA) may be over-prescribed/used¹³⁵.</p>
Trade-off between clinical benefits and harms	<p><u>In children</u>, monitoring FeNO vs conventional monitoring was considered to confer a clinically important benefit in reduction in exacerbations (defined as the need for course of oral corticosteroids). Evidence from six studies suggested fewer children required a course of OCS in the FeNO monitoring group. There was also a clinical benefit in UHU when reported as all unscheduled visits, and rescue medication use in the FeNO monitoring group. However, there was no clinically important difference in UHU hospitalisations, asthma control questionnaire score, quality of life, dose of regular therapy (inhaled corticosteroid dose), lung function and symptom-free days. Whilst there were reports of fewer UHU emergency room visits and less time off from school the differences in these parameters between the FeNO group and the control group were small and insufficient for the GDG to justify a recommendation in favour of FeNO. For the majority of the outcomes, evidence was only available from one study, and no evidence was available for mortality.</p> <p>It is the view of the GDG that whilst evidence exists (some of which is of high quality, with one study indicating a positive result), overall it is insufficient to support the use of FeNO in children. The evidence for paediatrics is dominated by two studies (de Jongste 2009 and Szeffler 2008). Analysis suggests that there is evidence of a trend towards clinical benefit in exacerbations (i.e. fewer children requiring a course of OCS in the FeNO monitoring group); however, there is essentially no difference in clinically meaningful outcomes between the FeNO and the control-group patients. The GDG noted a different method of administering OCS in the US study (Szeffler 2008) from that normally found in the UK. This study involved parent-initiated use of OCS rather than doctor-initiated, and may represent a different population to the UK and influence the magnitude of effect seen in this outcome. Furthermore, it was noted that the cumulative steroid burden (OCS and ICS) is still higher in people who had FeNO monitoring, and those in the FeNO group received higher doses of ICS. The GDG also acknowledged that, on some occasions, OCS may be of benefit by preventing a more severe asthma attack requiring UHU.</p>

	<p>The GDG concluded that there is insufficient evidence to support routine FeNO for monitoring in children, and targeted research in this area is required to identify whether FeNO monitoring is beneficial in certain subgroups, for example, in those with severe asthma. Severe asthma is, however, outside the scope of this review. Monitoring FeNO may also benefit those patients with symptoms despite taking ICS, for example, with relative steroid-resistant Th2 high disease, but there is no evidence to support this currently; further research is required. Research in these areas would require very large participant numbers in order to subgroup patients.</p> <p><u>In adults</u>, monitoring FeNO vs conventional monitoring was considered to confer a clinically important benefit for asthma exacerbations due to fewer people requiring a course of OCS in the FeNO monitoring group. The GDG acknowledged that on some occasions OCS may be of benefit by preventing a more severe asthma attack requiring UHU. There was no clinically important difference in quality of life, mean asthma control questionnaire score, UHU (ED visits and hospitalisations), lung function measured by FEV1 or PEF, symptom free days and dose of regular therapy (inhaled corticosteroids). For the majority of the outcomes, evidence was only available from one study, and no evidence was available for mortality.</p> <p>As with children, the GDG concluded that there is little evidence to support FeNO for routine monitoring in adults. There was some evidence to suggest a small clinical benefit of FeNO monitoring on the outcome of exacerbations. The GDG discussed the definition for the exacerbation outcome – as stated in the protocol, as usual with a dichotomous outcome, the review considered the number of patients requiring a course of oral corticosteroids. However, it was noted that the number of oral corticosteroids courses prescribed may provide different and valuable information, and would perhaps be a more responsive measure.</p>
Economic considerations	<p>One health economic study was presented to the GDG. This study reported different results for children and adults and separately.</p> <p>The study concluded that for adults FeNO monitoring could be cost-effective with an ICER of £2,146 per QALY gained. However this result is contingent on various strong assumptions that the GDG debated. The main assumption underpinning the result is that the benefits derived from FeNO monitoring in terms of exacerbation and ICS dosage will be life-long. The GDG agreed that this assumption is unlikely to hold in reality as any potential benefits would be seen early on and as time passes the benefits would decrease as there would be less need for medicine titration once experience had shown the optimum dose in each individual person. The result was also contingent on the idea that inhaled-corticosteroid usage would be lower for the remainder of the individual's life. As the health benefit from FeNO monitoring is small this benefit has a significant impact on the cost-effectiveness of FeNO monitoring. The GDG agreed that lower ICS usage is unlikely to hold for the remainder of the individual's life especially since this result was extrapolated from one RCT with a two-year follow up time. In the sensitivity analysis the economic study showed that slight changes to these assumptions, such as making FeNO benefit only last for 30 years or less, was enough to drive the ICER above £20,000 per QALY. Due to considerable uncertainty in the result and contention over the assumptions used, the GDG agreed that this evidence was not certain enough to recommend FeNO monitoring for adults given its proven low health benefit in the general asthma community, as shown in our clinical review.</p> <p>The study concluded for children that FeNO monitoring was not cost-effective with an ICER of £45,213 per QALY gained. This result was based on the same strong assumptions as in the adult model. As this study was based on one non-UK RCT and the assumptions were unlikely to hold in reality, the GDG was cautious about the</p>

	<p>validity of this evidence. However the clinical evidence in our review showed little to no benefit of FeNO monitoring in children and changing the assumptions on the duration of effectiveness would increase the ICER even more, so the GDG had no reason to believe the conclusions of the study were wrong and concluded that FeNO monitoring is not cost-effective in children with asthma.</p> <p>The GDG also considered the cost implications derived from the study by Honkoop. The GDG noted that the only reliable information was the cost derived from the difference in medication usage between the monitoring strategies. This cost was calculated in the study as being £78. This is £5 greater than the cost of the FeNO monitoring used in the study. This suggests that FeNO is the slightly cheaper alternative. The study also showed FeNO produced further cost savings from reduced healthcare visits which resulted in a further £40 cost-saving. However the study used a Dutch healthcare perspective and gave no information on resource use, making it difficult to extrapolate this value to a UK setting. The GDG's main concern was that these data were extracted over a 12 month time frame; as asthma is a variable disease, a longer time-frame would be needed to show if over time these costs remained consistently different.</p> <p>FeNO monitoring costs £77 - £87 per patient per year. It can also have a large impact on resource utilisation by increasing or reducing ICS usage. Given there was no strong clinical evidence that showed significant health benefits the GDG noted that FeNO monitoring was unlikely to be cost-effective as a routine management strategy for all people with asthma. However the GDG noted that in a specific severe subgroup of patients the health benefits could be much higher. Therefore in these people FeNO monitoring could be a cost-effective management strategy and therefore identifying this subgroup through research was the GDGs top priority.</p>
Quality of evidence	<p>In children, for the comparison of monitoring FeNO tests vs conventional monitoring, evidence for four of the critical outcomes ranged from very low to high quality (specifically: unscheduled healthcare utilisation, very low; quality of life, low; exacerbation, moderate; asthma control questionnaire, high). Evidence for all other outcomes was of very low quality (symptom-free days, rescue medication, and time off school), moderate quality (dose of regular therapy (ICS), lung function), and high quality (number of symptom-free days in last 2 weeks, number of school days missed). For the majority of the outcomes, evidence was only available from one study with a follow-up of 30-52 weeks.</p> <p>In adults, for the comparison of monitoring FeNO vs conventional monitoring, evidence for all outcomes was of low and very low quality. For the majority of the outcomes, evidence was only available from one study with a follow-up of 36-52 weeks.</p> <p>The economic evidence was assessed as directly applicable with potentially serious limitations.</p>
Other considerations	<p>It is the view of the GDG that there is very little additional benefit for monitoring FeNO compared with conventional monitoring. The GDG was aware that the NICE DAP recommended FeNO monitoring "<i>as an option to support asthma management (in conjunction with the British guideline on the management of asthma) in people who are symptomatic despite using inhaled corticosteroids</i>". It is important to note that the current review has included three additional studies in children and one additional study in adults. It should also be noted that the NICE DAP considered the definition of exacerbation as that stated in the study. In this review, however, the definition of exacerbation was defined and agreed by the GDG a priori as the number of people requiring a course of OCS. Even taking the study definition of exacerbations into account, there was only a trend towards benefit from FeNO monitoring (in adults) in the NICE DAP. No meta-analysis was performed in children</p>

in the NICE DAP.

Although evidence from published studies does not suggest a significant benefit for monitoring FeNO compared with conventional monitoring, the GDG noted its potential importance in identifying adherence. FeNO levels are very much predicated on whether or not patients are adhering to treatment, and FeNO may be potentially useful in monitoring whether or not they are taking inhaled steroids as prescribed.

The GDG noted the heterogeneity between studies with regards to the algorithms used for treatment adjustment in the intervention and control arms. The change in outcomes would be dependent on the algorithm and cut-off values used, which complicates the assessment of the effectiveness of FeNO as a monitoring strategy. In the conventional monitoring group, some studies monitored symptoms alone and other studies used algorithms for treatment adjustment based on symptoms, lung function and bronchodilator (BD) use. For the FeNO monitoring group, studies monitored FeNO alone; FeNO and symptoms; or FeNO, symptoms, lung function and BD use. Similarly, different FeNO cut-off levels were employed across the studies (<20ppb, <25ppb, <35ppb, etc.). Furthermore, there was heterogeneity in the definition of the 'severe asthma exacerbations' outcome between individual studies. For this review, severe asthma exacerbations were considered as requiring a course of OCS. Other study definitions (for example, asthma exacerbations resulting in hospitalisation or increased use of SABA) were reported in the review under the relevant protocol outcomes.

The GDG noted that in the studies included, the frequency of visits (around 4 times per year) was the same in the intervention and control groups. The GDG also discussed that FeNO monitoring may be of benefit in patients in specialist centres. The GDG therefore made future research recommendations to investigate which subgroups of patients are likely to benefit from FeNO monitoring to guide asthma management, e.g. individuals with atopy, frequent asthma attacks and/or those with poor adherence, and the clinical and health economic benefit of FeNO-guided monitoring of asthma in real-world settings (please see appendix N for the full list of research recommendations made).

26 Monitoring: Peripheral blood eosinophil count

26.1 Introduction

Eosinophils are a form of white blood cells produced by the bone marrow. Their exact role in health has yet to be determined, but it is believed that they play a role in fighting parasitic infections and primarily reside within the lining of the gut.

Biopsies taken from the lungs of people with asthma have frequently demonstrated increased numbers of eosinophils and the number of eosinophils is also often increased in sputum samples taken from asthma sufferers. Measurement of sputum eosinophil numbers have been used to aid the diagnosis and management of asthma. However, this is a time consuming procedure, which is only performed in a specialist setting. Eosinophils travel in the blood stream from the bone marrow to the lung, it is therefore logical to investigate whether measurement of blood eosinophils is a useful tool for monitoring asthma control.

26.2 Review question: In people with asthma, what is the clinical and cost-effectiveness of using the peripheral blood eosinophil count for monitoring asthma control?

For full details see review protocol in Appendix C.

Table 86: PICO characteristics of review question

Population	<p>People with asthma (defined as physician Dx with objective test or recurrent persistent wheeze in <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"> • Children (1-<5 years old) • Children/young people (5-16 years old) • Adults (>16 years old)
Intervention(s)	<p>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)</p>
Comparison(s)	<p>Comparison of adjustment of asthma therapy based on peripheral blood eosinophil count to:</p> <ul style="list-style-type: none"> • Usual care: eg clinical symptoms (with or without PEF) according to guidelines (including BTS/SIGN, GINA) • Asthma control questionnaires or QOL questionnaires • Lung function tests (spirometry or PEFv) • Challenge tests <p>Comparison of different frequencies of monitoring using blood eosinophil count.</p>
Outcomes	<p>Critical outcomes:</p> <ul style="list-style-type: none"> • Mortality • Unscheduled healthcare utilisation (ED/A&E visit; hospital admissions; GP out of hours or walk-in centre) • Exacerbations (defined as need for course of oral steroids)

	<ul style="list-style-type: none"> • Asthma control questionnaires (ACT; CACT; ACQ; PACQ; RCP-3) • QoL (AQLQ; pAQLQ; St George’s respiratory questionnaire) <p>Important outcomes:</p> <ul style="list-style-type: none"> • Lung function (FEV1, PEF) • Symptoms (annual symptom free days) • Dose of regular asthma therapy / preventer medication (ICS dose) • Rescue medication (SABA use) • Time off school or work
Study design	RCTs

1 **26.3 Clinical evidence**

2 No relevant clinical evidence was identified from RCTs (from full papers or conference abstracts)
 3 looking at the effectiveness of using the peripheral blood eosinophil count for monitoring asthma
 4 control.

5 **26.4 Economic evidence**

6 **Published literature**

7 No relevant economic evaluations were identified.
 8 See also the economic article selection flow chart in Appendix E.

9 **26.5 Evidence statements**

10 **Clinical**

11 • No relevant clinical studies were identified.

12 **Economic**

13 • No relevant economic evaluations were identified.

14 **26.6 Recommendations and link to evidence**

Recommendations	No clinical recommendation.
Research recommendations	3. What is the clinical and cost effectiveness of using blood eosinophils as a tool to monitor asthma control?
Relative values of different outcomes	<p>The GDG considered the following outcomes as critical for this review: mortality, quality of life, exacerbations, asthma control measured by questionnaires and unscheduled healthcare utilisation.</p> <p>The GDG noted that exacerbations of asthma can lead to both unscheduled healthcare utilisation (ED visits, out-of-hours GP surgery visits or hospitalisation) and the need for a course of OCS. Therefore, the GDG considered exacerbations requiring OCS treatment and exacerbations requiring unscheduled healthcare utilisation separately.</p> <p>The GDG also considered the following important outcomes: lung function (FEV1),</p>

	symptoms (symptom-free days), dose of regular asthma therapy (ICS dose), rescue medication (SABA dose) and time off school or work. These outcomes were considered as important measures of asthma control for the patient. The GDG acknowledged that regular asthma preventer therapy (ICS) is often underprescribed / used, and rescue medications (SABA) may be overprescribed / used (NRAD ¹³⁵).
Trade-off between clinical benefits and harms	No RCT evidence was identified.
Economic considerations	As no clinical evidence was found, there was no way to determine the cost-effectiveness of using blood eosinophils for monitoring asthma.
Quality of evidence	No RCT evidence was identified.
Other considerations	The GDG was aware of and discussed the existence of prognostic studies within the broader literature base showing the association between peripheral blood eosinophils and future outcomes. However, these studies do not show that interventions based on the peripheral blood eosinophil level improve patient outcomes. There is some evidence for monitoring sputum eosinophil levels in asthma ⁵⁹ , but the practical difficulties of doing this have prevented translation into routine practice. Blood eosinophil measurement is relatively quick and easy to perform, correlates loosely with sputum eosinophilia, and there are prognostic studies within the literature suggesting that the blood eosinophil count may be predictive of future outcomes. The GDG was therefore keen to make a future research recommendation to explore whether improved patient outcomes might result when the blood eosinophil count is used to monitor asthma control and guide treatment (please see appendix N for the full list of research recommendations made).

1 27 Monitoring: Challenge tests

2 27.1 Introduction

3 Asthma is characterised by excessive constriction of the smooth muscle in the airways in response to
 4 a variety of stimuli, including inhaled allergens, viral infections, cold air, smoke and other irritants.
 5 The degree of bronchoconstriction induced by an appropriate exposure is considerably greater in
 6 people with asthma than in those without, although bronchoconstriction can be induced in healthy
 7 people if high enough stimuli are provided. The ‘twitchiness’ of the airways can be assessed by
 8 ‘bronchial challenge tests’, in which the individual is exposed to progressively higher levels of
 9 constriction-inducing stimuli and the level of bronchoconstriction (usually assessed as FEV1) is
 10 assessed. Exposure usually occurs through incrementally greater exposure to an inhaled constrictor,
 11 usually as a ‘direct’ challenge (e.g. with a nebulized bronchconstrictor molecule, such as
 12 methacholine or histamine) or as an ‘indirect’ challenge (e.g. hypertonic saline, mannitol inhalation,
 13 eucapnic hyperventilation or exercise), measuring the level of exposure required to produce a 10 or
 14 20% fall in FEV1. The result is usually expressed as the concentration or cumulative dose of an
 15 exposure resulting in a specified fall in FEV1.

16 The test needs to be done in a controlled pulmonary function laboratory setting by a qualified
 17 technician with appropriate equipment and protocols and resuscitation facilities, as there is a small
 18 risk of severe bronchoconstriction. The test will usually take approximately 30 minutes, and is usually
 19 mildly unpleasant to the patient, in that it involves induced bronchoconstriction (which is relieved by
 20 inhaled bronchodilator at the end of the test). The test is unsuitable for younger children. Varieties of
 21 this test are available in most hospital lung departments, but are rarely available to GPs currently.
 22 However, the clinical and cost-effectiveness of using indirect challenge tests to monitor asthma
 23 control is currently uncertain.

24 27.2 Review question: In people with asthma, what is the clinical and 25 cost-effectiveness of using indirect challenge tests with mannitol or 26 direct challenge tests with histamine or methacholine for 27 monitoring asthma control?

28 For full details see review protocol in Appendix A.

29 **Table 87: PICO characteristics of review question**

Population	<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"> • Children/young people (5-16 years old) • Adults (>16 years old)
Intervention(s)	<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"> • Indirect challenge test with mannitol • Direct challenge test with methacholine or histamine
Comparison(s)	<p>Comparison of adjustment of asthma therapy based on indirect or direct challenge tests</p>

	<p>to:</p> <ul style="list-style-type: none"> • Usual care: eg clinical symptoms according to guidelines (including BTS/SIGN, GINA) • Asthma control questionnaires or QOL questionnaires • Lung function tests (spirometry or PEFv) <p>Comparison of adjustment of asthma therapy based on:</p> <ul style="list-style-type: none"> • Indirect vs direct challenge tests • Comparison of different frequencies of monitoring using challenge tests
Outcomes	<p>Critical outcomes:</p> <ul style="list-style-type: none"> • Mortality • Unscheduled healthcare utilisation (ED/A&E visit; hospital admissions; GP out of hours or walk-in centre) • Exacerbations (defined as need for course of oral steroids) • Asthma control questionnaires (ACT; CACT; ACQ; PACQ; RCP-3) • QoL (AQLQ; pAQLQ; St George's respiratory questionnaire) <p>Important outcomes:</p> <ul style="list-style-type: none"> • Lung function (FEV1, PEF) • Symptoms (annual symptom free days) • Dose of regular asthma therapy / preventer medication (ICS dose) • Rescue medication (SABA use) • Time off school or work
Study design	<ul style="list-style-type: none"> • RCTs • Exclude observational cohort studies and NRS unless limited evidence from RCTs

1 27.3 Clinical evidence

2 We searched for randomised trials comparing the effectiveness of monitoring using indirect or direct
3 challenge tests vs. monitoring according to usual care to guide asthma treatment and management.
4 Four studies were included in the review^{83,93,110,156} these are summarised in Table 88 below. See also
5 the study selection flow chart in Appendix D, clinical evidence tables in Appendix G, forest plots in
6 Appendix J, GRADE tables in Appendix I and excluded studies list in Appendix K.

7 Three involved adults^{83,93,156} and one involved children¹¹⁰; all compared challenge tests versus no
8 challenge tests for monitoring. For the monitoring intervention, three studies used methacholine
9 challenge test^{83,110,156}, including the study in children, and one study used mannitol challenge test⁹³.
10 No evidence was found for monitoring mannitol challenge tests in children. For the comparator
11 group, some studies monitored symptoms alone and other studies used algorithms for treatment
12 adjustment based on more than one clinical parameter (for example, symptoms, BD use and lung
13 function). Evidence from these studies is summarised in the clinical evidence summary below in
14 Table 89, Table 90 and Table 91.

Table 88: Summary of studies included in the review

Study	Intervention/comparison	Population	Outcomes	Comments
Koenig 2008 ⁸³	BHR (methacholine PC20)/ 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).	12 years of age and older 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 salbutamol.	Mortality, exacerbations (not defined), ICS dose, lung function (FEV1 and PEF), % symptom-free days	
Lipworth 2012 ⁹³	Treatment adjusted based on mannitol AHR only, every 2 months for 12 months/ Treatment adjusted according to BTS guidelines	18 to 65 years old History of mild to moderate persistent asthma	AQLQ, exacerbations (OCS), lung function (FEV1 and PEF)	Step down of treatment before study
Nuijsink 2007 ¹¹⁰	Treatment adjusted on the basis of methacholine AHR and symptom score/ Treatment adjusted on the basis of symptom score only	Children aged 6–16 years Documented clinical history of moderate persistent asthma, according to GINA guidelines.	Exacerbations (OCS), daily ICS dose, lung function (FEV1), % symptom-free days	
Sont 1999 ¹⁵⁶	Treatment adjusted at each 3 month visit based on severity class or methacholine AHR/ Treatment adjusted at each 3 month visit based on severity class only	18 to 50 years old History of episodic chest tightness and wheezing in the previous year and visiting a chest physician for their asthma.	Lung function (FEV1)	Did not report severe exacerbations due to infrequent events, only mild exacerbations reported

Table 89: Clinical evidence summary: ADULTS Methacholine challenge test versus no challenge test for asthma monitoring

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with ADULTS Methacholine challenge test versus no challenge test (95% CI)
Mortality (≥6 months)	212 (1 study) 40 weeks	⊕⊕⊕⊕ VERY LOW ^{2,3} due to risk of bias, imprecision	OR 7.53 (0.15 to 379.61)	Moderate 0 per 1000	10 more per 1000 (from 20 fewer to 40 more) ¹
Asthma exacerbations (≥6 months)	212 (1 study) 40 weeks	⊕⊕⊕⊕ VERY LOW ^{2,3,4} due to risk of bias, indirectness, imprecision	RR 0.86 (0.52 to 1.42)	Moderate 243 per 1000	34 fewer per 1000 (from 117 fewer to 102 more)
Rescue medications (≥6 months) Salbutamol puffs/day	212 (1 study) 40 weeks	⊕⊕⊕⊕ MODERATE ⁵ due to risk of bias		The mean rescue medications (≥6 months) in the control groups was -0.7 puffs/day (change score)	The mean rescue medications (≥6 months) in the intervention groups was 0.1 lower (0.58 lower to 0.38 higher)
ICS use >6months mean daily dose (mcg; fluticasone propionate)	212 (1 study) 40 weeks	⊕⊕⊕⊕ MODERATE ⁵ due to risk of bias		The mean ics use >6months in the control groups was 254 mcg	The mean ics use >6months in the intervention groups was 131.2 higher (83.57 to 178.83 higher)
FEV1 (≥6 months) L	279 (2 studies) 40-104 weeks	⊕⊕⊕⊕ LOW ^{5,6} due to risk of bias, inconsistency		The mean fev1 (≥6 months) in the control groups was 0.05 L change score	The mean fev1 (≥6 months) in the intervention groups was 0.04 lower (0.09 lower to 0.16 higher)
% symptom free days (≥6 months) Scale from: 0 to 100.	212 (1 study) 40 weeks	⊕⊕⊕⊕ MODERATE ⁵ due to risk of bias		The mean % symptom free days (≥6 months) in the control groups was 18.1 % change score	The mean % symptom free days (≥6 months) in the intervention groups was 5.1 lower (20.06 lower to 9.86 higher)
PEF am (≥6 months) L/min	212 (1 study) 40 weeks	⊕⊕⊕⊕ MODERATE ⁵ due to risk of bias		The mean pef am (≥6 months) in the control groups was 407 L/min	The mean pef am (≥6 months) in the intervention groups was 8.6 lower (17.20 lower to 0 higher)
PEF pm (≥6 months) L/min	212 (1 study) 40 weeks	⊕⊕⊕⊕ LOW ^{5,7} due to risk of bias, imprecision		The mean pef pm (≥6 months) in the control groups was 22.4 L/min change score	The mean pef pm (≥6 months) in the intervention groups was 6 lower (29.96 lower to 17.96 higher)

¹ Manual calculation of absolute effect as zero events in the control group

² The majority of the evidence was from studies at very high risk of bias due to allocation concealment and missing data

³ 95% CI crosses 2 MIDs

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 I²=72% P<0.06. Only 2 studies so random effects model used.

⁷ 95% CI crosses one MID

Table 90: Clinical evidence summary: ADULTS Mannitol challenge test versus no challenge test for asthma monitoring

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with ADULTS Mannitol challenge test versus no challenge test (95% CI)
AQLQ (≥6 months) mini AQLQ. Scale from: 1 to 7.	119 (1 study) 52 weeks	⊕⊕⊖⊖ LOW ^{1,2} due to risk of bias, indirectness		The mean aqlq (≥6 months) in the control groups was 5.9	The mean aqlq (≥6 months) in the intervention groups was 0.06 higher (0.3 lower to 0.42 higher)
Asthma exacerbations (≥6 months)	119 (1 study) 52 weeks	⊕⊖⊖⊖ VERY LOW ^{2,3,4} due to risk of bias, indirectness, imprecision	RR 0.88 (0.44 to 1.76)	Moderate 224 per 1000	27 fewer per 1000 (from 125 fewer to 170 more)
Rescue medications (≥6 months) Salbutamol puffs/day	119 (1 study) 52 weeks	⊕⊖⊖⊖ VERY LOW ^{1,2,5} due to risk of bias, indirectness, imprecision		The mean rescue medications (≥6 months) in the control groups was 0.67 puffs/day	The mean rescue medications (≥6 months) in the intervention groups was 0.31 lower (0.73 lower to 0.11 higher)
ICS use >6months mean daily dose (mcg; ciclesonide)	119 (1 study) 52 weeks	⊕⊕⊖⊖ LOW ^{1,2} due to risk of bias, indirectness		The mean ics use >6months in the control groups was 208 mcg	The mean ics use >6months in the intervention groups was 306 higher (241.71 to 370.29 higher)
FEV1% (≥6 months)	119 (1 study) 52 weeks	⊕⊕⊖⊖ LOW ^{1,2,6} due to risk of bias, indirectness		The mean fev1% (≥6 months) in the control groups was 88 %	The mean fev1% (≥6 months) in the intervention groups was 0.3 higher (8.21 lower to 8.81 higher)
PEF% (≥6 months) Scale from: 0 to 100.	119 (1 study) 52 weeks	⊕⊕⊖⊖ LOW ^{1,2} due to risk of bias, indirectness		The mean pef% (≥6 months) in the control groups was 94.3 %	The mean pef% (≥6 months) in the intervention groups was 2.7 lower (13.17 lower to 7.77 higher)
PEF am (≥6 months) L/min	119 (1 study) 52 weeks	⊕⊖⊖⊖ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		The mean pef am (≥6 months) in the control groups was 411.1 L/min	The mean pef am (≥6 months) in the intervention groups was 1.5 higher (34.7 lower to 37.7 higher)

¹ The majority of the evidence was from studies at high risk of bias due to blinding

² 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).

³ The majority of the evidence was from studies at high risk of bias due to missing data

⁴ 95% CI crosses 2 MIDs

⁵ 95% CI crosses one MID

⁶ The majority of the evidence was from studies at high risk of bias due to baseline differences

Table 91: Clinical evidence summary: CHILDREN Challenge test versus no challenge test for asthma monitoring

Outcomes	No of Participants	Quality of the evidence (GRADE)	Relative effect	Anticipated absolute effects	
				Risk with Control	Risk difference with CHILDREN Challenge test

	(studies) Follow up		(95% CI)		versus no challenge test (95% CI)
Asthma exacerbations (≥6 months) OCS course	206 (1 study) 2 years	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision	RR 0.96 (0.51 to 1.79)	Moderate 164 per 1000	7 fewer per 1000 (from 80 fewer to 130 more)
ICS dose Mean daily dose for treatment period	175 (1 study) 2 years	⊕⊕⊕⊕ VERY LOW ^{2,4,5} due to risk of bias, indirectness, imprecision		The mean ics dose in the control groups was 478 mcg	The mean ics dose in the intervention groups was 84 higher (10.66 to 157.34 higher)
FEV1% (≥6 months) Scale from: 0 to 100.	185 (1 study) 2 years	⊕⊕⊕⊕ LOW ^{2,4} due to risk of bias, indirectness		The mean fev1% (≥6 months) in the control groups was 93 %	The mean fev1% (≥6 months) in the intervention groups was 6 higher (1.2 lower to 10.8 higher)
% symptom free days (≥6 months) in last 3 months of treatment. Scale from: 0 to 100.	175 (1 study) 2 years	⊕⊕⊕⊕ VERY LOW ^{2,3,4} due to risk of bias, indirectness, imprecision		The mean % symptom free days (≥6 months) in the control groups was 71 %	The mean % symptom free days (≥6 months) in the intervention groups was 1.1 lower (10.1 lower to 7.9 higher)

¹ No explanation was provided

² Patients initially underwent step-down of their existing treatment.

³ 95% CI crosses both MIDs

⁴ The majority of the evidence was at high risk of bias due to allocation concealment and baseline differences

⁵ 95% CI crosses one MID

1 27.4 Economic evidence

2 Published literature

3 No relevant economic evaluations were identified.

4 See also the economic article selection flow chart in Appendix E.

5 Unit costs

6 In the absence of recent UK cost-effectiveness analysis, relevant unit costs are provided below to aid
7 consideration of cost-effectiveness.

8 **Table 92: Unit costs of monitoring with challenge tests**

Item	Quantity ^(a)	Unit cost	Cost (per year)	Source of unit cost
Secondary care respiratory medicine outpatient visit	3	£150	£450	NHS reference costs ⁴⁵
Bronchial reactivity studies - Lab costs	3	£177	£531	NHS reference costs ⁴⁵
Total			£981	

9 (a) Based on GDG opinion.

10 Economic considerations

11 Using the incremental cost of monitoring using challenge tests, the QALY increase which would be
12 required for challenge tests to be considered cost-effective at a £20,000 per QALY threshold can be
13 calculated as:

$$\text{Change in QALYs} = \frac{\text{Change in cost}}{\text{£20,000}}$$

14 Therefore, if it costs £981 to monitor using challenge tests each year, then this strategy would need
15 to generate 0.04905 extra QALYs for each year monitoring occurs. This could be achieved by
16 improving quality of life by 0.04905 per year or producing less quality of life per year but improving
17 life expectancy.

$$\frac{\text{£981}}{\text{£20,000}} = 0.04905$$

18 To help put this figure into context we can consider the disutility and costs associated with an
19 exacerbation.

20 **Table 93: Disutility a patient experiences with an exacerbation**

Severity of exacerbation	Quality of life decrease during exacerbation	Duration of exacerbation (years)	Disutility (QALYs)	Cost of exacerbation
Severe	0.56	0.08	0.0448	£873.75
Non-severe	0.32	0.01	0.0032	£38.33

21 Source: Harnan et al⁶⁵, NHS reference costs⁴⁵

1 Based on these figures, monitoring using challenge tests would have to greatly decrease the number
2 of exacerbations per year for it to be cost-effective.

3 **27.5 Evidence statements**

4 **Clinical**

5 ADULTS (>16 years): monitoring methacholine challenge tests vs conventional monitoring

- 6 • No evidence was identified for UHU, QOL or asthma control questionnaires.
- 7 • Monitoring methacholine challenge tests vs conventional monitoring resulted in a borderline
8 clinically important difference for mortality at ≥ 6 months (1 study, N=212, very low quality)
- 9 • Monitoring methacholine challenge tests vs conventional monitoring was considered a clinically
10 important benefit for asthma exacerbations at ≥ 6 months (1 study, N=212, very low quality)
- 11 • Monitoring methacholine challenge tests vs conventional monitoring resulted in no clinically
12 important difference for use of rescue medications (1 study, N=212, moderate quality), lung
13 function measured as FEV1 litres or PEF (low to moderate quality) and symptom free days (1
14 study, N=212, moderate quality), all at ≥ 6 months. Evidence of moderate quality was available
15 from 1 study demonstrating a higher mean ICS dose in the methacholine challenge test
16 monitoring group.

17 ADULTS (>16 years): monitoring mannitol challenge tests vs conventional monitoring

- 18 • No evidence was identified for mortality, UHU or asthma control questionnaires.
- 19 • Monitoring mannitol challenge tests vs conventional monitoring was considered a clinically
20 important benefit for asthma exacerbations (1 study, N=119, very low quality) and use of rescue
21 medications (1 study, N=119, very low quality), both at ≥ 6 months.
- 22 • Monitoring mannitol challenge tests vs conventional monitoring resulted in no clinically important
23 difference for QOL at (1 study, N=119, low quality) and lung function measured using FEV1 or PEF
24 (low to very low quality), all at ≥ 6 months.
- 25 • Evidence of low quality was available from 1 study demonstrating a higher mean ICS dose in the
26 mannitol challenge test monitoring group.

27 CHILDREN (5-16 years): monitoring methacholine challenge tests vs conventional monitoring

- 28 • No evidence was identified for mortality, UHU, QOL or asthma control questionnaires.
- 29 • Monitoring methacholine challenge tests vs conventional monitoring resulted in no clinically
30 important difference for asthma exacerbations (1 study, N=206, very low quality), lung function
31 measured using FEV1 (1 study, N=185, low quality) and symptom free days (1 study, N=185, very
32 low quality), all at ≥ 6 months.
- 33 • Evidence of very low quality was available from 1 study demonstrating a higher mean ICS dose in
34 the methacholine challenge test monitoring group.

35 **Economic**

- 36 • No relevant economic evaluations were identified.

37 **27.6 Recommendations and link to evidence**

Recommendations	39. Do not use challenge testing to monitor asthma control.
Relative values of different outcomes	The GDG considered the following outcomes as critical for this review: mortality, quality of life, exacerbations, asthma control measured by questionnaires and unscheduled healthcare utilisation.

	<p>The GDG noted that exacerbations of asthma can lead to both unscheduled healthcare utilisation (ED visits, out-of-hours GP surgery visits or hospitalisation) and the need for a course of OCS. Therefore, the GDG considered exacerbations requiring OCS treatment and exacerbations requiring unscheduled healthcare utilisation separately.</p> <p>The GDG also considered the following important outcomes: lung function (FEV1), symptoms (symptom-free days), dose of regular asthma therapy (ICS dose), rescue medication (SABA dose) and time off school or work. These outcomes were considered as important measures of asthma control for the patient. The GDG acknowledged that regular asthma preventer therapy (ICS) is often underprescribed / used, and rescue medications (SABA) may be overprescribed / used.¹³⁵</p>
Trade-off between clinical benefits and harms	<p>Evidence was available on mortality in adults from a single study of methacholine challenge testing, reporting one death in the monitoring group (reported as unrelated to asthma). Monitoring methacholine challenge tests demonstrated a clinically important benefit for asthma exacerbations. For the majority of the outcomes, evidence was only available from one study, and no evidence was available for UHU, QOL or asthma control questionnaire scores. There was no clinically important difference in SABA use, FEV1, the % symptom-free days or PEF. The mean dose of fluticasone propionate was 131.2mcg higher in the challenge test monitoring group at 40 weeks.</p> <p>In children, monitoring methacholine challenge tests vs conventional monitoring resulted in no clinically important difference for asthma exacerbations at ≥ 6 months. Evidence was only available from one study, and no evidence was available for mortality, UHU, QOL or asthma control questionnaire scores. There was no clinically important difference in FEV1 or % symptom-free days. The mean ICS dose was 84mcg higher in the challenge test monitoring group at 2 years.</p> <p>In adults, monitoring mannitol challenge tests vs conventional monitoring was considered to confer a clinically important benefit for asthma exacerbations and SABA use at 1 year, but there was no clinically important difference in the QOL, FEV1 or PEF between monitoring groups. Evidence was only available from one study, and no evidence was available for mortality, UHU or asthma control questionnaire scores. The mean ICS dose (using ciclesonide) was 306mcg higher in the challenge test monitoring group at 1 year.</p> <p>No evidence was found for monitoring mannitol challenge tests in children.</p> <p>The GDG considered there to be a small benefit in asthma exacerbations in adults when monitoring methacholine or mannitol challenge tests; however, this was at the expense of a higher steroid load. The GDG acknowledged that on some occasions OCS may be of benefit by preventing a more severe asthma attack requiring UHU. The evidence was limited and the majority of the evidence was of low quality. The GDG agreed that the evidence was not strong enough to recommend challenge testing for monitoring of asthma.</p>
Economic considerations	<p>The cost of challenge test monitoring was estimated to be £981 per year. This includes the cost of three respiratory outpatient visits and the cost of conducting the challenge test each review. At this cost, the intervention would need to provide an additional 0.04905 QALYs per year of monitoring to be considered cost-effective. The GDG was presented with severe and non-severe exacerbation disutilities to aid in their consideration of cost-effectiveness. It was noted that challenge tests would need to reduce severe exacerbations by at least one every year to be considered cost-effective at a £20,000 per QALY threshold. This level of benefit was not shown</p>

	<p>in the clinical review. The clinical evidence did not suggest that these benefits were achievable and therefore the GDG felt that challenge tests would not be cost-effective in routine care.</p>
Quality of evidence	<p>In adults, for the comparison of monitoring methacholine challenge tests vs conventional monitoring, evidence for both of the critical outcomes was of very low quality. In particular, there was little evidence on mortality and the single study which reported this did not have the power to show a significant difference. Evidence for all other outcomes was of low or moderate quality. For the majority of the outcomes, evidence was only available from one study with a long follow-up of 40-104 weeks.</p> <p>In children, for the comparison of monitoring methacholine challenge tests vs conventional monitoring, evidence for all outcomes was of low and very low quality. Evidence was only available from one study with a long follow-up of 2 years.</p> <p>In adults, for the comparison of monitoring mannitol challenge tests vs conventional monitoring, evidence for all outcomes was of low and very low quality. Evidence was only available from one study with a long follow-up of 1 year.</p>
Other considerations	<p>The GDG noted the heterogeneity between studies with regards to the algorithms used for treatment adjustment based on the challenge tests. The change in ICS dose and outcomes would be dependent on the algorithm and cut-off values used, so it is difficult to assess the effectiveness of challenge tests as a treatment strategy. This would also be dependent on the baseline severity of asthma and current ICS treatment level. The GDG acknowledged that in certain high-risk people challenge testing may have a benefit but not at a population level.</p>

28 Monitoring adherence to treatment

28.1 Introduction

The regular (daily) use of inhaled corticosteroids (ICS) is advised for all patients other than those with mild, infrequent symptoms and low risk of exacerbation, with additional regular maintenance therapy added for those failing to achieve control with standard doses of ICS alone. There is strong evidence of a favourable risk-benefit ratio for regular ICS in reducing symptoms, improving quality of life and reducing risks of asthma attacks, hospitalisations and death. However, despite these proven benefits, non-adherence to treatment is common. On average patients prescribed regular ICS receive prescriptions for less than half the number of inhalers they need for regular treatment each year. Non-adherence is associated with poor outcomes and increased risk in patients of all levels of asthma severity, including those with the most difficult to control asthma.

Non-adherence occurs for a variety of reasons, some intentional and some non-intentional, often relating to patient beliefs, health literacy and to clinician-patient communication. When recognised, poor adherence can be improved through various communication and management strategies, including shared decision-making and personal asthma action plans. GP computerised repeat prescribing systems allow an objective record of refill prescriptions for ICS and other medication to be accessed by clinicians, and can be assessed as part of a structured asthma review. This review investigates the best method of monitoring adherence to treatment.

28.2 Review question: In people with asthma, what is the clinical and cost-effectiveness of monitoring adherence to treatment?

For full details see review protocol in Appendix A.

Table 94: PICO characteristics of review question

Population / Target Condition	<p>People with asthma (defined as physician Dx with objective test or recurrent persistent wheeze in <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.</p> <p>All ages, stratified into the following 3 different groups:</p> <ul style="list-style-type: none"> • Children (1-<5 years old) • Children/young people (5-16 years old) • Adults (>16 years old)
Intervention(s)	<p>Monitoring adherence/compliance/concordance using the following methods and provide patient feedback or intervention to improve:</p> <ul style="list-style-type: none"> • Adherence with repeat therapy (using prescription and refill data) • Electronic monitoring inhalers (to monitor inhaler use) • Prednisolone levels (serum and urine – when on prednisolone) • MARS questionnaire (medication adherence rating scale) • FeNO levels (comes down if patients are taking their inhalers) • Theophylline levels (when on theophylline)
Comparison(s)	<ul style="list-style-type: none"> • No monitoring of adherence • Usual care • Comparison of different frequencies of monitoring adherence
Outcomes	<p>Critical outcomes:</p> <ul style="list-style-type: none"> • Mortality

Study design	<ul style="list-style-type: none"> • Unscheduled healthcare utilisation (ED/A&E visit; hospital admissions; GP out of hours or walk-in centre) • Exacerbations (defined as need for course of oral steroids) • Asthma control questionnaires (ACT; CACT; ACQ; PACQ; RCP-3) • QoL (AQLQ; pAQLQ; St George's respiratory questionnaire) • Adherence <p>Important outcomes:</p> <ul style="list-style-type: none"> • Lung function (FEV1, PEF) • Symptoms (annual symptom free days) • Dose of regular asthma therapy / preventer medication (ICS dose) • Rescue medication (SABA use) • Time off school or work
	RCTs

1 28.3 Clinical evidence

2 We searched for randomised trials comparing the effectiveness of monitoring adherence with
3 feedback vs. no monitoring of adherence/usual care to guide asthma treatment and management.

4 Four studies were included in the review^{24,111,114,184}, these are summarised in Table 95 below. See also
5 the study selection flow chart in Appendix D, study evidence tables in Appendix G, forest plots in
6 Appendix J, GRADE tables in Appendix I and excluded studies list in Appendix K. Three studies used
7 an electronic monitoring device in the inhaler to monitor adherence to treatment plus feedback from
8 the physician. One study used prescription refill data to monitor adherence, with physician access to
9 this data during review. No relevant RCTs were identified that monitored adherence using
10 prednisolone levels, MARS questionnaires, FeNO levels or theophylline levels compared to no
11 monitoring.

12 In children age 5-16 years, evidence comparing monitoring adherence plus feedback vs. no
13 monitoring to guide ongoing management was available from two studies^{24,114} summarised in the
14 clinical evidence summary (Table 96). These studies were in children with uncontrolled asthma and
15 evidence was available for outcomes reported at both <6months and ≥6 months.

16 In adults age >16 years, evidence comparing monitoring adherence plus feedback vs. no monitoring
17 to guide ongoing management was available from two studies^{111,184} summarised in the clinical
18 evidence summary (Table 97). These studies were in adults with mixed level of asthma control and
19 evidence was available for outcomes reported at both <6months and ≥6 months.

20 In children age 1-<5 years, no relevant clinical studies comparing monitoring adherence plus
21 feedback vs no monitoring were identified.

22 Table 95 also summarises additional education interventions received by the intervention or
23 comparator groups. In studies where both the intervention and comparator groups receive
24 education, the monitoring intervention may show reduced effectiveness as the control group might
25 also be expected to show improvement due to the education (saturation effects).

26 One study¹¹¹ was downgraded due to including an atypically high number of patients with severe
27 asthma. Other limitations of the studies included a small sample size and short follow-up period in
28 some studies. Adherence monitoring using the two methods reported (electronic recording of
29 actuations or refill prescriptions) are indirect measures of adherence and do not necessarily ensure
30 that the patient is taking the prescribed dose. A further limitation of Williams 2010 is that not all the
31 patients in the intervention group had their adherence data viewed by their physician.

Table 95: Summary of studies included in the review

Study	Intervention	Comparison	Population	Outcomes	
BURGESS 2010 ²⁴ RCT	Electronic monitoring device. Adherence shared with child and carer and incorporated into the management plan (direct feedback from physician)	Usual care (no adherence feedback)	CHILDREN (6-14 years). Unstable asthma (not well controlled despite preventative medication)	<ul style="list-style-type: none"> • Adherence • Exacerbation • Rescue medication 	In both groups: personalised asthma education and generic written information. Personalised asthma management plan devised, assessment of inhaler technique.
ONYIRIMBA 2003 ¹¹¹ RCT	Electronic monitoring device. Received direct feedback on ICS use from the clinician investigator and discussion of techniques to improve adherence (in addition to standard asthma care)	Usual care (no adherence feedback)	ADULTS. Moderate to severe asthma with regular ICS and low socioeconomic status	<ul style="list-style-type: none"> • QOL • Lung function 	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. Physician input, therapy adjustment and implementation of a management plan based on PEF or symptoms at these sessions.
OTSUKI 2009 ¹¹⁴ RCT	Electronic monitoring device. Feedback of adherence, goal-setting and reinforcement of adherence goals and strategies for self-monitoring of medication use	Usual care (no adherence feedback)	CHILDREN (2-12 years). Phys Dx asthma and 2 ED visits or 1 hospitalisation in last year	<ul style="list-style-type: none"> • Adherence (self-reported) • Adherence (refill) • Exacerbation • UHU 	In both groups: Home-based asthma education programme (five 30min home visits by trained asthma educators; review of asthma regime; training in inhaler technique; development of asthma action plan and other education materials).
WILLIAMS 2010 ¹⁸⁴ Cluster RCT	Prescription refill adherence. Physicians provided with adherence information when reviewing and writing prescriptions.	Usual care (no adherence feedback)	ADULTS and CHILDREN (5-56 years). At least one asthma Dx and on ICS.	<ul style="list-style-type: none"> • Adherence • Exacerbation • UHU 	In both groups: GP practices in both groups received information on the most recent asthma guidelines, and methods for discussing nonadherence with their patients.

Table 96: Clinical evidence summary: Children (5-16 years) with uncontrolled asthma: Monitoring adherence + feedback vs no monitoring.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with UC + treatment	Risk difference with Children with uncontrolled asthma: Monitoring adherence + treatment (95% CI)
Adherence <6months % of prescribed doses measured by	26 (1 study)	⊕⊖⊖⊖ VERY LOW ^{1,2}		The mean adherence <6months in the control groups was	The mean adherence <6months in the intervention groups was

Outcomes	No of	Quality of the	Relative	Anticipated absolute effects	
the electronic inhaler	4 months	due to risk of bias, imprecision		55.3 %	28.9 higher (8.62 to 49.18 higher)
Adherence ≥6months Number of canister refills (100% adherence = 3.0). Scale from: 0 to 3.	157 (1 study) 18 months	⊕⊕⊕⊖ LOW ¹ due to risk of bias		The mean adherence ≥6months in the control groups was 0.6 canister refills	The mean adherence ≥6months in the intervention groups was 0.02 lower (0.29 lower to 0.25 higher)
Adherence (self-reported) ≥6months % self-reported adherence in previous 6 months. Scale from: 0 to 100.	157 (1 study) 18 months	⊕⊕⊕⊖ LOW ¹ due to risk of bias		The mean adherence (self-reported) ≥6months in the control groups was 85.4 %	The mean adherence (self-reported) ≥6months in the intervention groups was 1.95 higher (5.87 lower to 9.77 higher)
Exacerbation < 6months need for OCS	26 (1 study) 4 months	⊕⊕⊕⊖ VERY LOW ^{1,3} due to risk of bias, imprecision	RR 2.57 (0.31 to 21.59)	Moderate 83 per 1000	130 more per 1000 (from 57 fewer to 1000 more)
Exacerbation ≥6 months no. of OCS courses in 6 months	157 (1 study) 18 months	⊕⊕⊕⊖ MODERATE ⁴ due to risk of bias		The mean exacerbation ≥6 months in the control groups was 0.74 courses of OCS	The mean exacerbation ≥6 months in the intervention groups was 0.22 higher (0.19 lower to 0.63 higher)
UHU ≥6 months Hospitalisations in previous 6 months	157 (1 study) 18 months	⊕⊕⊕⊖ MODERATE ⁴ due to risk of bias		The mean uhu ≥6 months in the control groups was 12	The mean uhu ≥6 months in the intervention groups was 0 higher (4.8 lower to 4.8 higher)
Rescue medication < 6months Reliever medication 3 or more times a week	26 (1 study) 4 months	⊕⊕⊕⊖ VERY LOW ^{1,3} due to risk of bias, imprecision	OR 6.92 (0.41 to 118.14)	Moderate 0 per 1000	140 more per 1000 (from 7 more to 360 more) ⁵

¹ The majority of the evidence was from studies at very high risk of bias

² 95% CI crosses one MID

³ 95% CI crosses both MID

⁴ The majority of the evidence was from studies at high risk of bias

⁵ Manual calculation of absolute risk difference as no events in the control group

Table 97: Clinical evidence summary: Adults (>16 years) overall: Monitoring adherence + feedback vs no monitoring.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with UC + treatment	Risk difference with Adults overall: Monitoring adherence + treatment (95% CI)
Adherence ≥6months % adherence to prescription refills in previous 3 months. Scale from: 0 to 100.	0 (1 study) 12 months	⊕⊕⊕⊖ VERY LOW ^{1,2} due to risk of bias, imprecision		The mean adherence in the control groups was 23.3 %	The mean adherence in the intervention groups was 2 lower (8.61 lower to 4.61 higher)
QOL <6months AQLQ. Scale from: 1 to 7.	19 (1 study) 10 weeks	⊕⊕⊕⊖ VERY LOW ^{3,4,5} due to risk of bias,		The mean QOL in the control groups was 4.51	The mean QOL in the intervention groups was 0.37 higher

Outcomes	No of	Quality of the evidence	Relative	Anticipated absolute effects	
		indirectness, imprecision			(0.08 to 0.66 higher)
Exacerbation ≥6months course of OCS	2698 (1 study) 12 months	⊕⊕⊕⊖ LOW ¹ due to risk of bias	HR 1.07 (0.89 to 1.29)	Moderate 220 per 1000	13 more per 1000 (from 22 fewer to 54 more)
UHU (hospitalisation) ≥6months	2698 (1 study) 12 months	⊕⊖⊖⊖ VERY LOW ^{1,6} due to risk of bias, imprecision	HR 0.86 (0.32 to 2.31)	Moderate 8 per 1000	1 fewer per 1000 (from 6 fewer to 11 more)
UHU (ED visit) ≥6months	2698 (1 study) 12 months	⊕⊖⊖⊖ VERY LOW ^{1,5} due to risk of bias, imprecision	HR 1.22 (0.83 to 1.79)	Moderate 81 per 1000	17 more per 1000 (from 13 fewer to 59 more)
Lung function <6months FEV1 L	19 (1 study) 10 weeks	⊕⊖⊖⊖ VERY LOW ^{2,3,4} due to risk of bias, indirectness, imprecision		The mean lung function in the control groups was 0.16 L	The mean lung function in the intervention groups was 0.12 lower (7.31 lower to 7.07 higher)

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

1 28.4 Economic evidence

2 Published literature

3 No relevant economic evaluations were identified.

4 See also the economic article selection flow chart in Appendix E.

5 28.5 Evidence statements

6 Clinical

7 CHILDREN (5-16 years)

- 8 • No evidence was identified on mortality, quality of life or asthma control questionnaire outcomes.
- 9 • Monitoring adherence vs no monitoring was considered a clinically important benefit for
10 adherence measured by the percentage of doses registered by the inhaler (1 study, N=26, very
11 low quality), at <6 months
- 12 • Monitoring adherence vs no monitoring was considered a clinically important harm for asthma
13 exacerbations (number of patients requiring OCS, 1 study, N=26, very low quality) and use of
14 rescue medications (1 study, N=26, very low quality), both at <6 months.
- 15 • Monitoring adherence vs no monitoring resulted in no clinically important difference for
16 adherence measured by the number of canister refills (1 study, N=157, low quality), adherence
17 measured by percentage self-reported adherence (1 study, N=157, low quality) and UHU
18 hospitalisations (1 study, N=157, moderate quality), all at ≥6 months.
- 19 • Monitoring adherence vs no monitoring resulted in a borderline clinically important difference for
20 asthma exacerbations at ≥6 months (mean number of OCS courses in 6 months, 1 study, N=157,
21 moderate quality).

22 ADULTS (>16 years)

- 23 • No evidence was identified for mortality or asthma control questionnaire outcomes.
- 24 • Monitoring adherence vs no monitoring resulted in no clinically important difference for
25 adherence measured percentage of prescription refills (1 study, N=2698, very low quality) and
26 UHU hospitalisations (1 study N=2698, very low quality), both and ≥6 months and for lung
27 function measured using FEV1 (1 study, N=19, very low quality), at <6 months.
- 28 • Monitoring adherence vs no monitoring resulted in a borderline clinically important difference for
29 asthma exacerbations (number of patients requiring OCS, 1 study N=2698, low quality) and UHU
30 ED visits (1 study N=2698, very low quality), both at ≥6 months and for QOL (1 study, N=19, very
31 low quality) at <6 months.

32 Economic

- 33 • No relevant economic evaluations were identified.

34 28.6 Recommendations and link to evidence

Recommendations	No clinical recommendation.
Research recommendations	4. What is the clinical and cost effectiveness of using electronic alert systems designed to monitor and improve adherence with regular

	inhaled maintenance therapy in people with asthma?
Relative values of different outcomes	<p>The GDG considered the following outcomes as critical for this review: adherence to regular ICS treatment, mortality, quality of life, exacerbations, asthma control measured by questionnaires and unscheduled healthcare utilisation.</p> <p>The GDG acknowledged that the aim of studies monitoring adherence to regular ICS treatment is often to improve adherence itself. Therefore, the outcome of adherence to treatment itself was considered to be an important outcome for this question. Whilst this does not directly provide evidence of asthma control, poor adherence to treatment is associated with poor outcomes.</p> <p>The GDG noted that exacerbations of asthma can lead to both unscheduled healthcare utilisation (ED visits, out-of-hours GP surgery visits or hospitalisation) and the need for a course of OCS. Therefore, exacerbations requiring OCS treatment and exacerbations requiring unscheduled healthcare utilisation were considered separately.</p> <p>The following important outcomes were considered: lung function (FEV1), symptoms (symptom-free days), dose of regular asthma therapy (ICS dose), rescue medication (SABA dose) and time off school or work. These outcomes were considered as important measures of asthma control for the patient. The GDG acknowledged that regular asthma preventer therapy (ICS) is often underprescribed / used, and rescue medications (SABA) may be overprescribed / used¹³⁵.</p>
Trade-off between clinical benefits and harms	<p>In adults, whilst the effect estimate did not reach the established MID, the GDG agreed that an AQLQ QOL score of 0.37 higher may represent a clinically important benefit, although evidence was from one small study. Evidence showed no convincing difference between monitoring and no monitoring in the adherence to treatment and rate of hospitalisation. There was evidence of an increase in the rate of exacerbations and ED visits in the monitoring group; however, it was unclear if this represented a clinically important harm. The GDG acknowledged that on some occasions OCS may be of benefit by preventing a more severe asthma attack requiring UHU. Evidence from one small study with N=19 showed that monitoring adherence resulted in no clinically important difference in lung function. No evidence was available on mortality and asthma control using validated questionnaires.</p> <p>In children, evidence from one study showed that monitoring adherence resulted in a clinically important benefit in adherence measured by the number of prescribed doses administered by the electronic inhaler.. There was evidence from one small study of an increase in the rate of exacerbations in the monitoring group, which may represent a clinically important harm. Evidence showed no convincing difference between monitoring and no monitoring in the rate of unscheduled healthcare utilisation, and adherence to treatment (measured by self-report or the percentage of refills taken). No evidence was identified on mortality, quality of life or asthma control questionnaire outcomes.</p> <p>No evidence was identified in children aged 1-<5 years old.</p> <p>Overall, the GDG felt that there was not enough available evidence to weigh up the benefits and harms and make a recommendation to monitor adherence to treatment. Monitoring adherence and providing feedback to the patient does not have any direct safety implications to the patient. The GDG acknowledged that good adherence to treatment is associated with better outcomes and future research is needed to establish the clinical effectiveness of systems that alert healthcare professionals to poor patient adherence.</p>

Economic considerations	<p>No economic evaluations were identified.</p> <p>Prescribing all individuals with electronic monitoring devices would increase NHS costs. The GDG felt, however, that the evidence on the use of these devices was weak and gave no true indication of how effective and therefore cost-effective these devices were.</p> <p>Although in some reviews monitoring adherence showed that the use of oral steroids increased, the GDG felt that this occurred because an individual's poor asthma control was identified early and treated accordingly. Therefore, although it may appear that monitoring adherence increases NHS costs, in fact, it may reduce costs in the long run and improve health outcomes.</p> <p>Overall, the clinical evidence gave no strong indication of how cost-effective monitoring adherence could be or how it should be conducted and therefore the GDG felt that this area would benefit greatly from a future research recommendation.</p>
Quality of evidence	<p>Evidence for each outcome was only available from one study and the majority of the evidence was of low and very low quality.</p> <p>In adults, all evidence was of low and very low quality. Lung function and QOL outcomes were only available from one study with a small sample size. The other outcomes were also only available from one study: a large study with a cluster randomised design. In this study, it was noted that only a proportion of physicians accessed the adherence data during the patient review. The GDG noted that one study (Onyrimba 2003) stated that patients could be switched to a twice-daily ICS regimen if necessary, suggesting some patients started on a once-daily regimen. The GDG questioned the applicability and directness of this study as only certain ICS drugs can be used once daily.</p> <p>In children, the evidence was of low and very low quality with the exception of the outcomes for UHU and exacerbations. However, the exacerbations outcome was reported as the mean number of OCS courses in 6 months and the GDG was uncertain about how to interpret the evidence for exacerbations as a continuous outcome. Only one study contributed to the evidence for each outcome and the studies were of small sample size.</p> <p>No evidence was identified in children aged 1-<5 years old.</p> <p>The GDG believed the uncertainty in the available evidence for all outcomes was sufficient to justify delaying a recommendation to await further research.</p>
Other considerations	<p>The monitoring interventions reported in the studies were complex interventions which did not just monitor adherence in isolation. The GDG noted that it was hard to look at monitoring adherence in isolation outside of the clinical care provided. It was noted that some studies included an educational component in the control group, and that the effect of monitoring adherence may be saturated due to improved outcomes in the control group.</p> <p>Whilst the GDG did not look at the individual evidence from prognostic studies of adherence as a risk factor for future outcomes, the GDG was aware of and discussed key prognostic studies showing that poor adherence predicts future risk^{53,136,159,160}. The GDG also considered the NRAD audit¹³⁵, which reported poor adherence in a large majority of the patients, and an association between non-adherence to preventer inhaled corticosteroids and increased risk of poor asthma control.</p>

The GDG considered that adherence to preventer treatment is an important area of asthma care and should be regularly monitored in all patients. The GDG decided to make a high-priority research recommendation to investigate the clinical and cost-effectiveness of using electronic alert systems designed to monitor and improve adherence with regular inhaled maintenance therapy in people with asthma, and discussed the alignment of the research recommendation with the recommendations from the NRAD report. The NRAD recommends that electronic surveillance of prescribing in primary care should be introduced as a matter of urgency to alert clinicians to patients being prescribed excessive quantities of short-acting reliever inhalers, or too few preventer inhalers. Further details on the high-priority research recommendation made can be found in appendix N, along with the full list of research recommendations made.

1

29 Monitoring inhaler technique

29.1 Introduction

The selection of an appropriate inhaler device is an important part of pharmacotherapy for asthma management. With all inhalers, correct technique is essential for ensuring appropriate (or proper) delivery of treatment. There should be proper understanding of, and training in, inhaler technique for patients, parents and/or carers. It is essential for healthcare professionals such as GPs, practice nurses, asthma nurse specialists, health visitors, school nurses, hospital doctors and nurses dealing with people with asthma-related medical problems to have an equally good understanding, so that they can provide education and support.

This review investigates the best method of monitoring inhaler technique, and the frequency with which this should be applied.

29.2 Review question: In people with asthma, what is the optimal frequency and method for monitoring inhaler technique?

For full details see review protocol in Appendix C.

Table 98: PICO characteristics of review question

Population	<p>People with asthma (defined as physician Dx with objective test or recurrent persistent wheeze in <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"> • Children (1-<5 years old) • Children/young people (5-16 years old) • Adults (>16 years old)
Intervention(s)	<p>Monitoring inhaler technique using the following methods and provide patient feedback or intervention to improve inhaler technique:</p> <ul style="list-style-type: none"> • Electronic devices to monitor inhaler technique • Visual monitoring by doctor, nurse or pharmacist
Comparison(s)	<ul style="list-style-type: none"> • No monitoring of inhaler technique • Comparison of different frequencies of monitoring inhaler technique • Monitoring using electronic devices vs monitoring by visual inspection
Outcomes	<p>Critical outcomes:</p> <ul style="list-style-type: none"> • Mortality • Unscheduled healthcare utilisation (ED/A&E visit; hospital admissions; GP out of hours or walk-in centre) • Exacerbations (defined as need for course of oral steroids) • Asthma control questionnaires (ACT; CACT; ACQ; PACQ; RCP-3) • QoL (AQLQ; pAQLQ; St George's respiratory questionnaire) <p>Important outcomes:</p> <ul style="list-style-type: none"> • Lung function (FEV1, PEF) • Symptoms (annual symptom free days) • Dose of regular asthma therapy / preventer medication (ICS dose) • Rescue medication (SABA use) • Time off school or work

1 29.3 Clinical evidence

2 We searched for randomised trials comparing the effectiveness of monitoring inhaler technique with
3 feedback vs. no monitoring of inhaler technique. We also searched for randomised trials comparing
4 the effectiveness of monitoring inhaler technique using different methods (visual inspection by a
5 healthcare professional with verbal feedback or monitoring inhaler technique using electronic
6 devices with feedback).

7 Four studies were included in the review^{4,5,13,14}, these are summarised in Table 99 below. See also the
8 study selection flow chart in Appendix D, study evidence tables in Appendix G, forest plots in
9 Appendix J, GRADE tables in Appendix I and excluded studies list in Appendix K.

10 Evidence was identified for the following strata and comparisons:

11 In adults:

- 12 • Comparison 1: visual monitoring of inhaler technique with verbal feedback plus use of electronic
13 training device vs. visual monitoring of inhaler technique with verbal feedback alone (2 studies,
14 one in primary care⁵ and one in secondary care⁴).
- 15 • Comparison 2: visual monitoring of inhaler technique (and PEF meter technique) by pharmacist
16 plus feedback vs. monitoring of PEF meter technique only (1 study^{13,14}).

17 In children:

- 18 • Comparison 1: visual monitoring of inhaler technique with verbal feedback plus use of electronic
19 training device vs. visual monitoring of inhaler technique with verbal feedback alone (1 study⁵).

20 For comparison 1 in both adults and children, the aim of monitoring in both studies was to slow
21 down the inhalation rate in people with poor inhaler technique due to fast inhalation flow rate (IFR).
22 For the study which provided evidence for both adults and children⁵, the population included those
23 with poor inhaler technique (defined as poor hand-lung coordination and an IFR ≥ 90 l/min). The
24 other study in adults⁴ was in a population with good coordination but poor inhaler technique defined
25 as a fast IFR ≥ 90 l/min.

Table 99: Summary of studies included in the review

Study	Intervention/comparison	Population	Outcomes	Comments
Al-showair 2007⁴	Verbal training + 2Tone Trainer (2TT) vs verbal training alone. Verbal training on the most desirable inhalation technique + 2Tone Trainer every morning and night to obtain the one-tone sound and to use the same inhalation procedure when using their MDI.	Adults - Secondary care Identified with poor inhaler technique (good coordination but inhaled too fast IFR ≥ 90 l/min).	QOL Lung function	1 visit, 6 weeks follow-up (intervention group encouraged to practice with 2TT twice daily before taking their MDI).
Ammari 2013⁵	Verbal training + 2TT vs verbal training alone. Verbal training on the most desirable inhalation technique + 2Tone Trainer every morning and night to obtain the one-tone sound and to use the same inhalation procedure when using their MDI.	Adults - Primary care Identified with poor inhaler technique (defined as poor hand-lung coordination and an IFR ≥ 90 l/min).	QOL Lung function	1 visit, 6 weeks follow-up (intervention group encouraged to practice with 2TT twice daily before taking their MDI).
		Children - Primary care Identified with poor inhaler technique (defined as poor hand-lung coordination and an IFR ≥ 90 l/min).	QOL Lung function	
Basheti 2007^{13,14}	Monitoring PEF meter and inhaler technique + feedback vs monitoring PEF meter technique only Pharmacy trained to deliver education on PEF 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.	Adults – Community pharmacy Doctor diagnosed asthma; use of ICS with Turbuhaler or Diskus with or without LABA.	<6 months QOL Lung function ≥ 6 months QOL Lung function	Training at 0, 1, 2, 3 and 6 months. Follow-up 6 months.

Table 100: ADULTS: Monitoring inhaler technique compared to no monitoring for asthma

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with No monitoring	Risk difference with ADULTS: Monitoring inhaler technique (95% CI)

Outcomes	No of	Quality of the	Relative	Anticipated absolute effects	
Lung function <6 months PEF Min%Max (higher is less variability). Scale from: 0 to 100.	97 (1 study) 3 months	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		The mean lung function <6 months in the control groups was 77.6 %	The mean lung function <6 months in the intervention groups was 6.2 higher (2.68 to 9.72 higher)
Lung function ≥6 months PEF Min%Max (higher is less variability). Scale from: 0 to 100.	97 (1 study) 6 months	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		The mean lung function ≥6 months in the control groups was 74.4 %	The mean lung function ≥6 months in the intervention groups was 4.5 higher (0.79 to 8.21 higher)
QOL <6 months Marks AQLQ. Scale from: 0 to 10.	97 (1 study) 3 months	⊕⊕⊕⊕ LOW ¹ due to risk of bias		The mean qol <6 months in the control groups was 1.35	The mean qol <6 months in the intervention groups was 0.55 lower (0.77 to 0.33 lower)
QOL ≥6 months Marks AQLQ. Scale from: 0 to 10.	97 (1 study) 6 months	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		The mean qol ≥6 months in the control groups was 1.3	The mean qol ≥6 months in the intervention groups was 0.5 lower (0.74 to 0.26 lower)

¹ The evidence was from one study at very high risk of bias for this outcome

² 95% CI crosses one MID

Table 101: ADULTS: Monitoring (verbal and electronic) compared to verbal monitoring only for asthma

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Verbal monitoring only	Risk difference with ADULTS: Monitoring (verbal and electronic) (95% CI)
QOL <6 months mini AQLQ. Scale from: 1 to 7.	105 (2 studies) 6 weeks	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		The mean qol <6 months in the control groups was 4.2	The mean qol <6 months in the intervention groups was 0.38 higher (0.02 lower to 0.79 higher)
Lung function <6 months FEV1 L	71 (1 study) 6 weeks	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		The mean lung function <6 months in the control groups was 2.16 L	The mean lung function <6 months in the intervention groups was 0.23 lower (0.55 lower to 0.09 higher)
Lung function <6 months FEV1 % pred. Scale from: 0 to 100.	34 (1 study) 6 weeks	⊕⊕⊕⊕ LOW ^{2,3} due to risk of bias, imprecision		The mean lung function <6 months in the control groups was 87.2 %	The mean lung function <6 months in the intervention groups was 9.1 higher (3.71 lower to 21.91 higher)

¹ The majority of the evidence was from studies at very high risk of bias for this outcome

² 95% CI crosses one MID

³ The majority of the evidence was from studies at high risk of bias for this outcome

Table 102: CHILDREN: Monitoring (verbal and electronic) compared to verbal monitoring only for asthma

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Verbal monitoring only	Risk difference with CHILDREN: Monitoring (verbal and electronic) (95% CI)
Lung function <6 months FEV1 % pred. Scale from: 0 to 100.	12 (1 study) 6 weeks	⊕⊖⊖⊖ VERY LOW ^{1,2} due to risk of bias, imprecision		The mean lung function <6 months in the control groups was 94.1 %	The mean lung function <6 months in the intervention groups was 3.2 lower (15.27 lower to 8.87 higher)
QOL <6 months PAQLQ. Scale from: 1 to 7.	12 (1 study) 6 weeks	⊕⊖⊖⊖ VERY LOW ^{2,3} due to risk of bias, imprecision		The mean qol <6 months in the control groups was -0.391 change score	The mean qol <6 months in the intervention groups was 0.03 higher (0.66 lower to 0.72 higher)

¹ The evidence was from one study at high risk of bias for this outcome

² 95% CI crosses both MIDs

³ No explanation was provided

1 29.4 Economic evidence

2 Published literature

3 No relevant economic evaluations were identified.

4 See also the economic article selection flow chart in Appendix E.

5 29.5 Evidence statements

6 Clinical

7 ADULTS (>16 years): monitoring inhaler technique compared to no monitoring

- 8 • No evidence was identified for mortality, UHU, exacerbations or asthma control questionnaires.
- 9 • Monitoring inhaler technique vs. no monitoring resulted in a borderline clinically important
10 difference for QOL at <6 months and ≥6 months (1 study, N=97, low to very low quality) and PEF
11 variability at <6 months and ≥6 months (1 study, N=97, very low quality)

12 ADULTS (>16 years): monitoring inhaler technique (verbal and electronic trainer device) compared to 13 verbal monitoring only

- 14 • No evidence was identified for mortality, UHU, exacerbations or asthma control questionnaires.
- 15 • Monitoring inhaler technique (verbal and electronic trainer device) vs. verbal monitoring only was
16 considered a clinically important benefit for QOL at (2 studies, N=105, very low quality) and lung
17 function measured using FEV1 %pred (1 study, N=34, low quality), but not when measured using
18 FEV1 litres where a clinical harm was observed (1 study, N=71, very low quality), all at <6 months.

20 CHILDREN (5-16 years): monitoring inhaler technique (verbal and electronic trainer device) compared 21 to verbal monitoring only

- 22 • No evidence was identified for mortality, UHU, exacerbations or asthma control questionnaires.
- 23 • Monitoring asthma control questionnaires vs. usual monitoring resulted in no clinically important
24 difference for QOL and lung function measured using FEV1 (both 1 study, N=12, very low quality),
25 both at <6 months.

26 Economic

- 27 • No relevant economic evaluations were identified.

28 29.6 Recommendations and link to evidence

Recommendations	40. Monitor the inhaler technique of people with asthma (in line with the NICE Quality Standard on asthma): <ul style="list-style-type: none">• after every asthma attack• when the device is changed• at every annual review.
Research recommendations	5. What is the current frequency and the current method being used to check the inhaler technique of people with asthma? What is the optimal frequency and the best method of checking inhaler technique to

	improve clinical outcomes for people with asthma?
Relative values of different outcomes	<p>The GDG considered the following outcomes as critical for this review: mortality, quality of life, exacerbations, asthma control measured by questionnaires and unscheduled healthcare utilisation.</p> <p>The GDG noted that exacerbations of asthma can lead to both unscheduled healthcare utilisation (ED visits, out-of-hours GP surgery visits or hospitalisation) and the need for a course of OCS. Therefore, exacerbations requiring OCS treatment and exacerbations requiring unscheduled healthcare utilisation were considered separately.</p> <p>The GDG also considered the following important outcomes: lung function (FEV1), symptoms (symptom-free days), dose of regular asthma therapy (ICS dose), rescue medication (SABA dose) and time off school or work. These outcomes were considered as important measures of asthma control for the patient. The GDG acknowledged that regular asthma preventer therapy (ICS) is often under-prescribed / used, and rescue medications (SABA) may be overprescribed / used¹³⁵.</p>
Trade-off between clinical benefits and harms	<p><u>Monitoring inhaler technique</u></p> <p>RCT evidence was only identified from one study in adults for the comparison of monitoring inhaler technique vs. no monitoring. There was a difference in QOL at both 3 months and 6 months. QOL scores on the Marks AQLQ scale were lower in the monitoring group, indicating better QOL; however, there is no established MID for this scale and the GDG was unsure of the clinical importance. There was less PEF variability in the monitoring group at both 3 and 6 months, which may represent a clinically important benefit. No evidence was available for mortality, UHU, exacerbations or asthma control questionnaire scores.</p> <p><u>Monitoring inhaler technique plus the use of an electronic training device</u></p> <p>RCT evidence was also identified comparing monitoring of inhaler technique plus the use of an electronic training device vs monitoring inhaler technique alone in both adults and children. The aim of monitoring in these studies was to decrease the inhalation rate in people with poor inhaler technique due to fast inhalation flow rate. For the study which provided evidence for both adults and children, the population included those with poor inhaler technique (defined as poor hand-lung coordination and an IFR ≥ 90 l/min). The other study in adults was in a population with good coordination but poor inhaler technique defined as a fast IFR ≥ 90 l/min.</p> <p>In adults, monitoring inhaler technique (verbal and electronic trainer device) compared to verbal monitoring resulted in a clinically important benefit in QOL at 6 weeks. Evidence was available from two studies. For the additional use of the electronic training device, one study showed a clinically important harm in the secondary outcome of FEV1 at 6 weeks and the other study showed a clinically important benefit in FEV1 at 6 weeks. No evidence was available for mortality, UHU, exacerbations or asthma control questionnaire scores.</p> <p>In children and young people, monitoring inhaler technique (verbal and electronic trainer device) compared to verbal monitoring resulted in no clinically important difference in QOL at 6 weeks. Monitoring using the electronic training device resulted in a lower FEV1 at 6 weeks, but this difference was not of clinical benefit.</p>
Economic considerations	<p>No economic evidence was found on monitoring inhaler technique.</p> <p>The cost of monitoring inhaler technique is negligible as this could be carried out as part of routine visits.</p> <p>The clinical review showed that in adults monitoring inhaler technique (verbal and electronic trainer device) compared to verbal monitoring resulted in a clinically important benefit in QOL at 6 weeks. Therefore the GDG considered monitoring</p>

	inhaler technique likely to be cost-effective.
Quality of evidence	<p>In adults, for monitoring inhaler technique vs no monitoring, evidence for the important and critical outcomes was of low and very low quality. Only one study contributed to the evidence for all outcomes, and this study was of small sample size.</p> <p>In adults, for monitoring inhaler technique (verbal and electronic trainer device) compared to verbal monitoring only, evidence for the important and critical outcomes was of low and very low quality. Evidence was available from two small studies with a short follow-up time of 6 weeks.</p> <p>In children and young people, for monitoring inhaler technique (verbal and electronic trainer device) compared to verbal monitoring only, evidence for the important and critical outcomes was of very low quality. Only one very small study contributed to the evidence for all outcomes with a short follow-up time of 6 weeks.</p>
Other considerations	<p>The GDG discussed the importance of good inhaler technique. Whilst the GDG did not look at the evidence from prognostic studies of poor inhaler technique as a risk factor for future outcomes, the GDG was aware of and discussed the existence of prognostic studies within the broader literature base showing that poor inhaler technique predicts future risk. The GDG was in agreement with the NICE Quality Standard for asthma that inhaler technique should be assessed after every attack, with every change of inhaler device and at every annual asthma review. They made a recommendation based on consensus agreement (not the evidence alone). The GDG felt it was unethical to make a future research recommendation to compare monitoring inhaler technique vs. no monitoring of inhaler technique and hence made a recommendation on appropriate timing for checking inhaler technique.</p> <p>The GDG agreed that healthcare professionals need to be regularly trained in inhaler technique in order to monitor inhaler technique effectively.</p> <p>The GDG was interested in the best method of monitoring inhaler technique. Due to the absence of evidence, the GDG made a high-priority future research recommendation to assess the best method for monitoring inhaler technique. Further details on the high-priority research recommendation made can be found in appendix N. The GDG was aware of additional observational studies using different methods of monitoring inhaler technique, and the effect on the outcome of inhaler technique score itself. However, studies of this sort were excluded as they do not report the relevant efficacy outcome and were short-term observational studies. The GDG felt that RCT evidence was needed to assess the long-term benefit of different methods of monitoring inhaler technique.</p>

1 30 Monitoring: Tele-healthcare

2 30.1 Introduction

3 Tele-healthcare is the utilisation of information and communication technologies by patients and
4 healthcare professionals to deliver clinical care, health promotion or to carry out research where the
5 participants are not in the same location. The information shared between participants may be
6 stored and used later or may be used interactively to make a diagnosis, to monitor a condition or to
7 enable the patient to adjust a clinical management plan. Tele-healthcare has the potential to
8 improve monitoring of asthma by increasing accessibility of care for patients and supporting effective
9 self-management, reducing cost and detecting exacerbations or loss of asthma control sooner.
10 However, there are also risks involved with the use of tele-healthcare for monitoring asthma, and the
11 benefits and harms need to be considered.

12 30.2 Review question: In people with asthma, what is the clinical and 13 cost-effectiveness of tele-healthcare to monitor asthma control?

14 For full details see review protocol in Appendix C.

15 **Table 103: PICO characteristics of review question**

Population	Children and adults with clinician-diagnosed asthma
Intervention(s)	Tele-healthcare interventions (review divided into two sections): <ul style="list-style-type: none"> • Tele-healthcare with healthcare professional involvement • Tele-healthcare with no involvement from a healthcare provider
Comparison(s)	Usual care or any other control intervention
Outcomes	Critical outcomes: <ul style="list-style-type: none"> • Mortality • Exacerbations requiring hospitalisation • Exacerbations (defined as need for course of oral steroids) • Unscheduled healthcare visits • QoL (AQLQ; pAQLQ; St George’s respiratory questionnaire) • Asthma control questionnaires (ACT; CACT; ACQ; PACQ; RCP-3) Important outcomes: <ul style="list-style-type: none"> • Lung function (FEV1, PEF) • Symptoms (annual symptom free days)
Study design	Full reports of parallel randomised controlled trials

16 Tele-health interventions with healthcare professional involvement and interventions with no
17 involvement from a healthcare provider were dealt with separately (see section 30.3.2). The cost-
18 effectiveness of fully automated interventions is likely to be very different to those which include
19 personalised feedback from a health professional. Both reviews had the same study inclusion criteria
20 with respect to population, comparison, outcomes and study design.

1 30.3 Clinical evidence

2 30.3.1 Tele-healthcare with healthcare professional involvement

3 We searched for randomised controlled trials comparing tele-healthcare interventions delivered with
4 input from a healthcare provider with usual care or a control intervention.

5 Twenty-five studies met the review eligibility criteria;<sup>11,12,27,30,47,49,60-
6 63,71,80,95,113,124,125,130,133,137,145,173,178,182,186,188</sup> these are summarised in Table 104 below. See also the
7 study selection flow chart in Appendix D, study evidence tables in Appendix G, forest plots in
8 Appendix J, GRADE tables in Appendix I and excluded studies list in Appendix K.

9 Thirteen of the 16 adult studies and eight of the 10 children studies reported data that could be
10 included in meta-analysis for one or more of the clinical outcomes.

11 Studies were analysed in three separate comparisons which were identified as addressing three
12 questions relating to the use of tele-healthcare. These comparisons were not pre-specified in the
13 review protocol, but were necessary in order to make the analyses clinically meaningful and were
14 constructed prior to extraction and pooling of outcome data.

15 1. How do consultations conducted with tele-healthcare compare to face-to-face reviews?

16 Studies assessed the feasibility of replacing face-to-face monitoring in clinics with tele-healthcare
17 reviews.

18 2. Is tele-healthcare monitoring better than paper-based self-monitoring?

19 These studies isolated the effect of using tele-healthcare systems (e.g. an electronic diary or
20 program) by controlling for the non-specific effects of self-monitoring.

21 3. Do broad tele-healthcare packages improve health outcomes?

22 The aim of these studies was to test a complete monitoring package delivered solely or
23 predominantly with tele-healthcare. The studies did not isolate the effect of tele-health
24 components from non-specific effects of increased contact with healthcare services.

25 Tele-health interventions within each of the comparisons varied with respect to the length and type
26 of tele-health intervention, qualifications of the health provider involved and the extent of their
27 input, and participant inclusion and exclusion criteria. There were not enough studies to reliably
28 explore the effect of these moderators within each comparison, so important differences have been
29 summarised narratively.

30 In adults aged > 16 years, evidence for comparison one was available in four studies^{60,124,125,133}. Three
31 studies compared telephone consultations with face-to-face equivalents, either with an asthma
32 nurse or a doctor for either six or 12 months. One study compared a six-month PEF monitoring and
33 email advice intervention with a clinic-based equivalent. Evidence for comparison 2 was available
34 from four studies with four to 12 months' follow-up^{95,113,137,173}. Comparison 2 studies used primarily
35 mobile phone-based interventions (SMS or smart-phone software) aimed at symptom monitoring by
36 an asthma nurse or clinician compared with paper symptom diaries. Two studies included in
37 comparison 1^{124,133} also compared their tele-health interventions with a usual care control group
38 which were included in comparison 3 with five other studies ranging from three months to a
39 year^{11,49,130,178,182}. Comparison 3 studies were the most varied; all used usual care or similarly minimal
40 control groups, but interventions included monitoring and advice programs *via* telephone, internet
41 or SMS, and hospital discharge telephone monitoring.

42 In children aged 5 to 16 years, evidence for comparison one was available from one study²⁷
43 comparing internet-based case management and education from a paediatrician with face-to-face
44 sessions for one year. One child study⁷¹ provided evidence for comparison two, comparing a three-

1 month internet monitoring program, PEF diary and physician feedback with a PEF diary alone.
 2 Evidence for comparison three was available from six child studies with follow-ups ranging from
 3 three months to a year^{47,62,186}, comparing a range of tele-healthcare packages to usual care.
 4 No relevant studies were found comparing tele-health interventions with usual care or a control
 5 intervention for children aged less than five.

6 **Table 104: Summary of studies included in the review**

Study	Intervention/comparison	Population	Outcomes	Follow-up
Baptist 2013 ¹¹	Asthma calls plus face to face sessions with a health educator vs. non-asthma calls	<ul style="list-style-type: none"> Older adults N=70 65+ years Daily controller meds 83% predicted FEV1 	<ul style="list-style-type: none"> Dichot. ACQ Hospitalisation GP visits FEV1 	6 and 12 months
Barbanel 2003 ¹²	Training course and follow-up pharmacist calls vs. routine care	<ul style="list-style-type: none"> Adults N=24 18-65 years All taking ICS 	<ul style="list-style-type: none"> Withdrawal 	6 months
Chan 2007 ²⁷	Internet-based case management and education from a paediatrician vs. face-to-face sessions	<ul style="list-style-type: none"> Children/adolescents N=120 6-17 years Persistent asthma 	<ul style="list-style-type: none"> Hospitalisations ED visits PAQLQ FEV1 % predicted 	12 months
Chatkin 2006 ³⁰	Calls from physician to improve adherence vs. routine care	<ul style="list-style-type: none"> Adults/adolescents N=271 12+ years Mod./severe asthma 	<ul style="list-style-type: none"> Adherence measures 	Unknown follow-up
Deschildre 2012 ⁴⁷	Daily FEV1 transmission via internet with physician feedback vs. routine care	<ul style="list-style-type: none"> Children/adolescents N=50 6-16 years Severe allergic asthma, frequent exacerbations 	<ul style="list-style-type: none"> Hospitalisations Oral steroid use 	12 months
Donald 2008 ⁴⁹	Post hospital discharge telephone PEF and symptom monitoring by nurse vs. routine care	<ul style="list-style-type: none"> Adults N=71 18-55 years Previous asthma admission 	<ul style="list-style-type: none"> Hospitalisations ED visits GP visits Oral steroid use Absence 	12 months
Gruffydd-Jones 2005 ⁶⁰	6-monthly telephone monitoring by asthma nurse vs. usual 6-monthly clinic consultations	<ul style="list-style-type: none"> Adults N=194 17-70 years 	<ul style="list-style-type: none"> AQLQ ACQ Costs 	6 and 12 months
Guendelman 2002 ⁶¹	Internet management and education program with asthma nurse vs. paper symptom diary	<ul style="list-style-type: none"> Children/adolescents N=134 8-16 years Persistent asthma 	<ul style="list-style-type: none"> Hospitalisations ED visits 	3 months

Study	Intervention/comparison	Population	Outcomes	Follow-up
Gustafson 2012 ⁶²	Automated management software with monthly calls from nurse vs. routine care	<ul style="list-style-type: none"> • Children • N=301 • 4-12 years • Controller meds and poor adherence 	<ul style="list-style-type: none"> • ACQ 	12 months
Halterman 2012 ⁶³	Internet communication, prescription, and symptom monitoring by asthma nurse vs. routine care	<ul style="list-style-type: none"> • Children • N=100 • 3-10 years • Persistent symptoms 	<ul style="list-style-type: none"> • Hospitalisations • ED visits • GP visits • AQLQ • School absence 	8 months
Jan 2007 ⁷¹	Internet monitoring program and PEF diary with physician email or phone feedback vs. PEF diary and routine care	<ul style="list-style-type: none"> • Children • N=164 • 6-12 years 	<ul style="list-style-type: none"> • PEF 	3 months
Khan 2004 ⁸⁰	Post-discharge telephone follow-up from nurse vs. written materials	<ul style="list-style-type: none"> • Children • N=310 • 1-15 years • Recent ED discharge 	<ul style="list-style-type: none"> • Hospitalisation • ED visits • Parent QoL 	6 months
Liu 2011 ⁹⁵	Mobile phone software with electronic diary reviewed by staff daily vs. written asthma diary	<ul style="list-style-type: none"> • Adults • N=89 • Mean 52 years • Mod./severe asthma 	<ul style="list-style-type: none"> • Mortality • Hospitalisations • ED visits • FEV1 and PEF • SF12 	6 months
Ostojic 2005 ¹¹³	Written asthma diary and PEF send via text daily with weekly instructions from a specialist vs. diary only	<ul style="list-style-type: none"> • Adults • N=16 • Mean 25 years • Moderate asthma • All using LABA/ICS 	<ul style="list-style-type: none"> • Hospitalisations • FEV1 	4 months
Pinnock 2003 ¹²⁵	Telephone review vs. face-to-face review, both with the asthma nurse	<ul style="list-style-type: none"> • Adults • N=278 • 18+ years • Asthma for 1 year + 	<ul style="list-style-type: none"> • Hospitalisation • ED visits • Oral steroid use • GP visits • AQLQ 	Variable follow-up, pragmatic design
Pinnock 2007 ¹²⁴	Pre-arranged phone or face-to-face review vs. face-to-face only vs. usual care (no review)	<ul style="list-style-type: none"> • Adults • N=1728 • 12+ years (mean 44) 	<ul style="list-style-type: none"> • AQLQ • ACQ • Costs 	12 months
Prabhakaran 2009 ¹³⁰	SMS monitoring and education with the asthma nurse vs. education with no SMS monitoring	<ul style="list-style-type: none"> • Adults • N=120 • 21+ years • Previous asthma admission 	<ul style="list-style-type: none"> • Hospitalisation • ED visits • Dichot. ACT 	3 months

Study	Intervention/comparison	Population	Outcomes	Follow-up
Rasmussen 2005 ¹³³	Electronic PEF diary and advice via email vs. face-to-face specialist instruction with PEF vs. usual GP contact	<ul style="list-style-type: none"> • Adults • N=300 • 18-45 years 	<ul style="list-style-type: none"> • Hospitalisation • ED visits • GP visits • FEV1 	12 months
Ryan 2012 ¹³⁷	Twice daily mobile phone symptom, drug, and PEF transmission with immediate feedback vs. paper monitoring	<ul style="list-style-type: none"> • Adults • N=288 • 12+ years (mean 49) • Poorly controlled asthma 	<ul style="list-style-type: none"> • Hospitalisation • ED visits • GP visits • Oral steroid use • AQLQ • ACQ 	6 months
Seid 2012 ¹⁴⁵	Tailored SMS plus in-person motivational interviewing vs. education without tailored SMS	<ul style="list-style-type: none"> • Adolescents • N=26 • 12-18 years • Mod./severe asthma 	<ul style="list-style-type: none"> • PedsQL 	1 and 3 months
Van der Meer 2009 ¹⁷³	Daily symptom and FEV1 reporting via internet or SMS plus communication with an asthma nurse vs. diary only	<ul style="list-style-type: none"> • Adults • N=200 • 18-50 years • ICS for > 3 months in the past year • No OCS therapy 	<ul style="list-style-type: none"> • AQLQ 	12 months
Vollmer 2006 ¹⁷⁸	Three phone calls with tailored advice vs. routine care	<ul style="list-style-type: none"> • Adults • N=6948 • 18+ years 	<ul style="list-style-type: none"> • AQLQ 	10 months
Willems 2007 ¹⁸²	Internet daily PEF monitoring with feedback from asthma nurse vs. routine care	<ul style="list-style-type: none"> • Adults and children • N=109 • 7+ years (mean=28) 	<ul style="list-style-type: none"> • AQLQ • ED visits 	12 months
Xu 2010 ¹⁸⁶	Symptom monitoring and advice in fortnightly follow-up calls from nurse specialist vs. routine care	<ul style="list-style-type: none"> • Children/adolescents • N=121 • 3-16 years • Recent exacerbation 	<ul style="list-style-type: none"> • Hospitalisations • ED visits • Oral steroids • School absence 	6 months
Young 2012 ¹⁸⁸	Telephone pharmacist consultations vs. routine care	<ul style="list-style-type: none"> • Adults • N=98 • 19+ years 	<ul style="list-style-type: none"> • Withdrawal 	Unknown follow-up

Table 105: Adult comparison 1: Tele-health services versus face-to-face equivalents for adults with asthma

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with face-to-face equivalents	Risk difference with Tele-health services (95% CI)
Quality of life Asthma Quality of Life Questionnaire. Scale from: 1 to 7.	960 (3 studies) 12 months	⊕⊕⊕⊖ MODERATE ² due to risk of bias		The mean quality of life in the control groups was 5.35 units ¹	The mean quality of life in the intervention groups was 0.01 lower (0.17 lower to 0.14 higher)
UHU hospitalisation	451 (2 studies) 6 months ⁴	⊕⊖⊖⊖ VERY LOW ^{2,5,6} due to risk of bias, imprecision	OR 0.14 (0 to 7.06) ³	Moderate 6 per 1000	5 fewer per 1000 (from 6 fewer to 35 more)
UHU ED visit	451 (2 studies) 6 months ⁴	⊕⊖⊖⊖ VERY LOW ^{2,5,6} due to risk of bias, imprecision	OR 7.75 (0.48 to 124.9) ³	Moderate 0 per 1000	-
Exacerbations requiring oral steroids	278 (1 study)	⊕⊖⊖⊖ VERY LOW ^{2,6} due to risk of bias, imprecision	RR 1.72 (0.42 to 7.04)	Moderate 21 per 1000	15 more per 1000 (from 12 fewer to 127 more)
Asthma control Asthma Control Questionnaire. Scale from: 0 to 6.	682 (2 studies) 12 months	⊕⊕⊕⊖ MODERATE ² due to risk of bias		The mean asthma control in the control groups was 1.33 units ⁷	The mean asthma control in the intervention groups was 0.11 lower (0.27 lower to 0.04 higher)
UHU GP visits	451 (2 studies) 6 months ⁴	⊕⊕⊖⊖ LOW ^{2,6,8} due to risk of bias, imprecision	RR 0.86 (0.56 to 1.32)	Moderate 132 per 1000	18 fewer per 1000 (from 58 fewer to 42 more)
Change in FEV1 (mL)	173 (1 study) 6 months	⊕⊖⊖⊖ VERY LOW ^{2,5,9} due to risk of bias, imprecision		The mean change in fev1 (ml) in the control groups was 35 mL	The mean change in fev1 (ml) in the intervention groups was 152 higher (54 to 250 higher)
Withdrawal	672 (3 studies) 6-12 months	⊕⊖⊖⊖ VERY LOW ^{6,10} due to inconsistency, imprecision	RR 0.78 (0.32 to 1.9)	Moderate 120 per 1000	26 fewer per 1000 (from 82 fewer to 108 more)

¹ Weighted endpoint mean of the control groups

² Studies could not use blinding to control for performance or detection bias

³ Very rare events - Peto odds ratio used

⁴ Pinnock 2003 was a pragmatic trial of variable intervention duration, but did not contribute any events to the analysis

⁵ Evidence of sub-optimal randomisation procedures and imputation of missing values, and selective reporting

⁶ 95% CI crosses both the MIDs

⁷ Endpoint mean in the control group of Pinnock 2007, the larger of the two included trials (Gruffydd-Jones reported mean change)

Outcomes	No of	Quality of the evidence	Relative	Anticipated absolute effects
⁸ While there were several issues with one of the studies in the analysis, it only accounted for 6.6% of the analysis weight.				
⁹ 95% CI crossed an MID				
¹⁰ Heterogeneity was high (I ² = 79%)				

Table 106: Adult comparison 2: Tele-monitoring versus paper-based monitoring for adults with asthma

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Paper-based monitoring	Risk difference with Tele-monitoring (95% CI)
Quality of life Asthma Quality of Life Questionnaire. Scale from: 1 to 7.	384 (2 studies) 6-12 months	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, inconsistency, imprecision		The mean quality of life in the control groups was 5.45 units	The mean quality of life in the intervention groups was 0.21 higher (0.09 lower to 0.5 higher)
UHU hospitalisation	386 (3 studies) 4-6 months	⊕⊕⊕⊕ VERY LOW ^{4,5,6} due to risk of bias, inconsistency, imprecision	RR 0.60 (0.13 to 2.86)	Moderate 22 per 1000	9 fewer per 1000 (from 19 fewer to 41 more)
UHU ED visit	370 (2 studies) 6 months	⊕⊕⊕⊕ VERY LOW ^{6,7,8} due to risk of bias, inconsistency, imprecision	RR 0.89 (0.02 to 33.53)	Moderate 130 per 1000	14 fewer per 1000 (from 127 fewer to 1000 more)
Exacerbations requiring oral steroids	281 (1 study) 6 months	⊕⊕⊕⊖ LOW ⁶ due to imprecision	RR 0.94 (0.59 to 1.49)	Moderate 213 per 1000	13 fewer per 1000 (from 87 fewer to 104 more)
Asthma control Asthma Control Questionnaire. Scale from: 0 to 6.	478 (2 studies) 6-12 months	⊕⊕⊕⊕ VERY LOW ^{1,3,9} due to risk of bias, inconsistency, imprecision		The mean asthma control in the control groups was 1.56 units	The mean asthma control in the intervention groups was 0.24 lower (0.72 lower to 0.24 higher)
UHU GP visits	281 (1 study) 6 months	⊕⊕⊕⊕ MODERATE ³ due to imprecision	RR 1.25 (0.89 to 1.76)	Moderate 291 per 1000	73 more per 1000 (from 32 fewer to 221 more)
Change in FEV1 (mL)	200 (1 study) 12 months	⊕⊕⊕⊖ LOW ^{3,10} due to risk of bias, imprecision		The mean change in fev1 (ml) in the control groups was -10 mL	The mean change in fev1 (ml) in the intervention groups was 250 higher (33.36 to 466.64 higher)
PEF (L/min)	89 (1 study) 6 months	⊕⊕⊕⊖ LOW ^{3,7} due to risk of bias, imprecision		The mean pef (l/min) in the control groups was 343.5 Litres per minute	The mean pef (l/min) in the intervention groups was 39.2 higher (16.58 to 61.82 higher)
Withdrawal	624 (4 studies) 4-12 months	⊕⊕⊕⊖ LOW ⁵ due to imprecision	RR 1.01 (0.73 to 1.39)	Moderate 152 per 1000	2 more per 1000 (from 41 fewer to 59 more)

Outcomes	No of	Quality of the evidence	Relative	Anticipated absolute effects
¹ One study analysed complete cases and did not blind participants, investigators or outcome assessors, which carried the majority of the analysis weight. ² Heterogeneity was high (I ² = 53%) ³ 95% CI crosses one of the MIDs ⁴ Only one study used any blinding procedures (outcome assessors), and there were uncertainties regarding allocation concealment ⁵ Heterogeneity was not statistically significant (I ² = 42%), but point estimates are very different ⁶ 95% CIs cross both MIDs ⁷ Study carrying the most weight did not blind outcome assessors (and could not blind participants and investigators), and dropout was high in both groups ⁸ Heterogeneity was high (I ² = 80%) ⁹ Heterogeneity was very high (I squared = 91%) ¹⁰ No blinding of outcome assessors (and unable to blind participants and investigators). Only complete cases were analysed.				

Table 107: Adult comparison 3: Tele-health packages versus nothing (usual care) for adults with asthma

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Nothing (usual care)	Risk difference with Tele-health packages (95% CI)
Quality of life Asthma Quality of Life Questionnaire. Scale from: 1 to 7.	1633 (3 studies) 10-12 months	⊕⊕⊕⊖ MODERATE ¹ due to risk of bias		The mean quality of life in the control groups was 5.18 units	The mean quality of life in the intervention groups was 0.08 higher (0.03 lower to 0.20 higher)
UHU hospitalisation	404 (4 studies) 6-12 months	⊕⊕⊕⊖ MODERATE ^{1,3} due to risk of bias	OR 0.16 (0.05 to 0.56) ²	Moderate 56 per 1000	47 fewer per 1000 (from 24 fewer to 53 fewer)
UHU ED visit	415 (4 studies) 6-12 months	⊕⊖⊖⊖ VERY LOW ^{1,4,5} due to risk of bias, imprecision	RR 0.82 (0.38 to 1.8)	Moderate 65 per 1000	12 fewer per 1000 (from 40 fewer to 52 more)
Exacerbations requiring oral steroids	60 (1 study) 12 months	⊕⊖⊖⊖ VERY LOW ^{1,5} due to risk of bias, imprecision	RR 0.94 (0.67 to 1.3)	Moderate 724 per 1000	43 fewer per 1000 (from 239 fewer to 217 more)
Asthma control Asthma Control Questionnaire. Scale from: 0 to 6.	556 (1 study) 12 months	⊕⊕⊕⊕ HIGH		The mean asthma control in the control groups was 1.24 units	The mean asthma control in the intervention groups was 0.04 lower (0.2 lower to 0.12 higher)
UHU GP visits	295 (3 studies) 6-12 months	⊕⊖⊖⊖ VERY LOW ^{1,5,6,7} due to risk of bias, inconsistency, imprecision	RR 0.96 (0.39 to 2.37)	Moderate 389 per 1000	16 fewer per 1000 (from 237 fewer to 533 more)
Change in FEV1 (mL)	165 (1 study) 6 months	⊕⊕⊖⊖ LOW ^{1,8} due to risk of bias, imprecision		The mean change in fev1 (ml) in the control groups was 4 mL	The mean change in fev1 (ml) in the intervention groups was 183 higher (85 to 281 higher)

Outcomes	No of	Quality of the evidence	Relative	Anticipated absolute effects	
Symptom days per month Scale from: 0 to 30.	608 (1 study)	⊕⊕⊕⊖ MODERATE ⁸ due to imprecision		The mean symptom days per month in the control groups was 7.3 days	The mean symptom days per month in the intervention groups was 0.6 higher (0.82 lower to 2.02 higher)
Symptom nights per month Scale from: 0 to 30.	608 (1 study)	⊕⊕⊕⊖ MODERATE ⁸ due to imprecision		The mean symptom nights per month in the control groups was 3.8 nights	The mean symptom nights per month in the intervention groups was 0.1 lower (1.21 lower to 1.01 higher)
Withdrawal	512 (5 studies) 6-12 months	⊕⊖⊖⊖ VERY LOW ^{1,5} due to risk of bias, imprecision	RR 0.81 (0.51 to 1.29)	Moderate 111 per 1000	21 fewer per 1000 (from 54 fewer to 32 more)

¹ Issues across studies with blinding, completeness of outcome data, and allocation concealment
² Very rare events - Peto odds ratio used
³ Confidence intervals were wide but did not cross an MID
⁴ Point estimates were varied but statistical heterogeneity was low - random effects sensitivity did not change imprecision
⁵ 95% CI crossed both MIDs
⁶ Heterogeneity was high (I² = 66%)
⁷ One study was only recruited older adults (53% of analysis weight)
⁸ 95% CIs crossed an MID

Table 108: Child comparison 1: Tele-health services versus face-to-face equivalents for children with asthma

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with face-to-face equivalents	Risk difference with Tele-health services (95% CI)
Quality of life - child Paediatric Asthma Quality of Life Questionnaire. Scale from: 1 to 7.	120 (1 study) 12 months	⊕⊕⊖⊖ LOW ^{1,2} due to risk of bias, imprecision		The mean quality of life - child in the control groups was 5.8 units	The mean quality of life - child in the intervention groups was 0.3 higher (0.11 lower to 0.71 higher)
Quality of life - caregiver Paediatric Asthma Quality of Life Questionnaire. Scale from: 1 to 7.	120 (1 study) 12 months	⊕⊕⊖⊖ LOW ^{1,2} due to risk of bias, imprecision		The mean quality of life - caregiver in the control groups was 6.2 units	The mean quality of life - caregiver in the intervention groups was 0.2 higher (0.12 lower to 0.52 higher)
UHU hospitalisation	120 (1 study) 12 months	⊕⊖⊖⊖ VERY LOW ^{1,3} due to risk of bias, imprecision	RR 1 (0.06 to 15.62)	Moderate 17 per 1000	0 fewer per 1000 (from 16 fewer to 249 more)
UHU ED visit	120 (1 study) 12 months	⊕⊖⊖⊖ VERY LOW ^{1,3} due to risk of bias, imprecision	RR 2 (0.38 to 10.51)	Moderate 33 per 1000	33 more per 1000 (from 20 fewer to 314 more)

Outcomes	No of	Quality of the	Relative	Anticipated absolute effects
FEV1 % predicted	120 (1 study) 12 months	⊕⊕⊖⊖ LOW ^{1,2} due to risk of bias, imprecision		The mean fev1 % predicted in the control groups was 92.2 % The mean fev1 % predicted in the intervention groups was 5.2 higher (1.48 lower to 11.88 higher)

¹ No blinding and unbalanced attrition
² 95% CI crosses an MID
³ 95% CI crosses both MIDs

Table 109: Child comparison 2: Tele-monitoring versus paper-based monitoring for children with asthma

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Paper-based monitoring	Risk difference with Tele-monitoring (95% CI)
Change in morning PEF (L/min)	153 (1 study) 3 months	⊕⊕⊖⊖ LOW ^{1,2} due to risk of bias, imprecision		The mean change in morning pef (l/min) in the control groups was 10.9 Litres per minute	The mean change in morning pef (l/min) in the intervention groups was 7.80 higher (6.37 lower to 21.97 higher)
Change in evening PEF (L/min)	153 (1 study) 3 months	⊕⊕⊖⊖ LOW ^{1,2} due to risk of bias, imprecision		The mean change in evening pef (l/min) in the control groups was 11.1 Litres per minute	The mean change in evening pef (l/min) in the intervention groups was 12 higher (3.59 lower to 27.59 higher)
Withdrawal	164 (1 study) 3 months	⊕⊖⊖⊖ VERY LOW ^{1,3} due to risk of bias, imprecision	RR 1.04 (0.33 to 3.26)	Moderate 66 per 1000	3 more per 1000 (from 44 fewer to 149 more)

¹ Participants and investigators could not be blind (outcome assessors were blinded)
² 95% CI crosses an MID
³ 95% CI crosses both MIDs

Table 110: Child comparison 3: Tele-health packages versus nothing (usual care) for children with asthma

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Nothing (usual care)	Risk difference with Tele-health packages (95% CI)
Change in quality of life - child Paediatric Asthma Quality of Life Questionnaire. Scale from: 1 to 7.	82 (1 study) 6 months	⊕⊕⊖⊖ LOW ^{1,3} due to risk of bias, imprecision		The mean change in quality of life - child in the control groups was 0.5 units	The mean change in quality of life - child in the intervention groups was 0.70 higher (0.29 to 1.11 higher)
Quality of life - caregiver Paediatric Asthma Quality of Life Questionnaire. Scale from: 1 to 7.	181 (2 studies) 6-12 months	⊕⊕⊕⊖ MODERATE ^{1,2} due to risk of bias		The mean quality of life - caregiver in the control groups was 6.31 units ⁴	The mean quality of life - caregiver in the intervention groups was 0.18 higher (0.10 lower to 0.46 higher)

Outcomes	No of	Quality of the evidence	Relative	Anticipated absolute effects	
UHU hospitalisation	609 (5 studies) 3-12 months	⊕⊕⊕⊕ VERY LOW ^{5,6,7} due to risk of bias, imprecision	RR 1.43 (0.59 to 3.46)	Moderate 20 per 1000	9 more per 1000 (from 8 fewer to 49 more)
UHU ED visit	566 (4 studies) 3-12 months	⊕⊕⊕⊕ VERY LOW ^{5,6,7} due to risk of bias, imprecision	RR 1 (0.56 to 1.8)	Moderate 92 per 1000	0 fewer per 1000 (from 40 fewer to 74 more)
Exacerbations requiring oral steroids	125 (2 studies) 6-12 months	⊕⊕⊕⊕ VERY LOW ^{5,7} due to risk of bias, imprecision	RR 1.01 (0.8 to 1.27)	Moderate 719 per 1000	7 more per 1000 (from 144 fewer to 194 more)
Asthma control Asthma Control Questionnaire. Scale from: 0 to 6.	301 (1 study) 12 months	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		The mean asthma control in the control groups was 2.21 units ⁸	The mean asthma control in the intervention groups was 0.31 lower (0.56 to 0.06 lower)
UHU GP visits	99 (1 study) 8 months	⊕⊕⊕⊕ LOW ⁷ due to imprecision	OR 0.80 (0.30 to 2.13)	Moderate 157 per 1000	31 fewer per 1000 (from 110 fewer to 177 more)
Withdrawal	823 (5 studies) 3-12 months	⊕⊕⊕⊕ VERY LOW ^{5,7,9} due to risk of bias, inconsistency, imprecision	RR 0.86 (0.53 to 1.41)	Moderate 161 per 1000	23 fewer per 1000 (from 76 fewer to 66 more)

¹ One or more study did not blind outcome assessors

² MID is close to, but does not cross the 0.5 MID

³ 95% CI crosses one MID

⁴ Control score in Halterman 2012. Xu 2010 reported change.

⁵ Issues across studies with blinding, completeness of outcome data, and allocation concealment

⁶ Point estimates were varied but statistical heterogeneity was low - random effects sensitivity did not change imprecision

⁷ 95% CI crosses both MIDs

⁸ Control group end score obtained from baseline mean (2.32) minus the reported improvement (0.11)

⁹ Some inconsistency ($I^2 = 38\%$), random effects used

1 **30.3.2 Tele-healthcare with no involvement from a healthcare provider**

2 Three studies were included in the review^{16,33,186} these are summarised in Table 111 below. See also
3 the study selection flow chart in Appendix D, study evidence tables in Appendix G, forest plots in
4 Appendix J, GRADE tables in Appendix I and excluded studies list in Appendix K.

5 In adults age >16 years, evidence comparing tele-healthcare without healthcare professional
6 involvement vs. usual care was available from one study¹⁶ summarised in the clinical evidence
7 summary (Table 112). This study used interactive voice response telephone calls and reported
8 outcomes on QOL and asthma control.

9 In children age 5-16 years, evidence comparing tele-healthcare without healthcare professional
10 involvement vs usual care was available from two studies^{33,186} summarised in the clinical evidence
11 summary (Table 113). One study³³ used a web-based intervention to provide feedback to parents on
12 child's asthma (recommendations regarding controller use and other aspects of asthma care) and
13 reported the outcome use of controller medications. The other study¹⁸⁶ used interaction voice
14 response calls and reported outcomes on exacerbation, UHU, school days lost, parent work days lost
15 and QOL (child and carer). Both studies reported outcomes at ≥6 months.

Table 111: Summary of studies included in the review

Study	Intervention	Comparison	Population	Outcomes
BENDER 2010 ¹⁶	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 included content designed to inquire about asthma symptoms, deliver core educational messages, encourage refilling of ICS prescriptions, and increase communication with providers.	No telephone calls	ADULTS 18 to 65 years; physician-diagnosed asthma for which they were prescribed daily ICS treatment	<ul style="list-style-type: none"> • QOL • Asthma control questionnaire
CHRISTAKI S2012 ³³	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 self-efficacy), feedback on child's asthma (recommendations regarding controller use and other aspects of asthma care).	Control parents had similar intervention around reducing media usage among their children.	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 bronchodilators in the last year).	<ul style="list-style-type: none"> • Controller medication use
XU2010 ¹⁸⁶	Intervention 1: Interactive Voice Response Intervention 2: Specialist nurse support (see section 30.3.1)	Usual care	CHILDREN 3 to 16 years; asthma; admission to hospital in previous 12 months or presented at least once to emergency department or GP or specialist with acute asthma requiring oral steroid rescue in previous 12 months.	<ul style="list-style-type: none"> • Exacerbation • UHU • School days lost • Parent work days lost • QOL (child and carer)

Table 112: Adult comparison 4: Telehealthcare without healthcare professional involvement vs usual care

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with no calls	Risk difference with Interactive voice response telephone calls (95% CI)
QOL <6 months AQLQ. Scale from: 0 to 7.	50 (1 study) 10 weeks	⊕⊕⊖⊖ LOW ^{1,2} due to risk of bias, imprecision		The mean qol <6 months in the control groups was -0.38	The mean qol <6 months in the intervention groups was 0.23 higher (0.32 lower to 0.78 higher)
Asthma Control Questionnaire <6 months ACT. Scale from: 5 to 25.	50 (1 study) 10 weeks	⊕⊖⊖⊖ VERY LOW ^{1,3} due to risk of bias, imprecision		The mean asthma control questionnaire <6 months in the control groups was -1.84	The mean asthma control questionnaire <6 months in the intervention groups was 0.72 higher (1.51 lower to 2.95 higher)

¹ Method of randomisation and allocation concealment unclear
² Crosses one MID
³ Crosses two MIDs

Table 113: Child comparison 4: Telehealthcare without healthcare professional involvement vs usual care

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with No calls	Risk difference with Telephone calls (95% CI)
Exacerbations ≥6 months Self report OCS (assumed to be for exacerbation)	79 (1 study) 6 months	⊕⊖⊖⊖ VERY LOW ^{1,2,3,4} due to risk of bias, imprecision	RR 0.78 (0.48 to 1.26)	Moderate 525 per 1000	116 fewer per 1000 (from 273 fewer to 136 more)
QOL ≥6 months Pediatric Asthma Quality of Life Questionnaire (carer). Scale from: 0 to 7.	80 (1 study) 6 months	⊕⊖⊖⊖ VERY LOW ^{1,2,3,4} due to risk of bias, imprecision		The mean qol ≥6 months in the control groups was 1.0	The mean qol ≥6 months in the intervention groups was 0.2 higher (0.48 lower to 0.88 higher)
QOL ≥6 months Pediatric Asthma Quality of Life Questionnaire (child). Scale from: 0 to 7.	80 (1 study) 6 months	⊕⊕⊖⊖ LOW ^{1,2,3} due to risk of bias		The mean qol ≥6 months in the control groups was 0.5	The mean qol ≥6 months in the intervention groups was 0.6 higher (0.16 to 1.04 higher)
UHU ≥6 months ED visit self report	79 (1 study) 6 months	⊕⊖⊖⊖ VERY LOW ^{1,2,3,5} due to risk of bias, imprecision	RR 1.23 (0.41 to 3.7)	Moderate 125 per 1000	29 more per 1000 (from 74 fewer to 338 more)
UHU hospitalisation ≥6 months Hospital admission self report	79 (1 study) 6 months	⊕⊖⊖⊖ VERY LOW ^{1,2,3,5} due to risk of bias,	RR 1.03 (0.28 to 3.82)	Moderate 100 per 1000	3 more per 1000 (from 72 fewer to 282 more)

Outcomes	No of	Quality of the	Relative	Anticipated absolute effects	
School days lost ≥6 months Self report (yes/no to any time off school)	77 (1 study) 6 months	⊕⊖⊖⊖ VERY LOW ^{1,2,3,5} due to risk of bias, imprecision	RR 0.93 (0.62 to 1.4)	Moderate 564 per 1000	39 fewer per 1000 (from 214 fewer to 226 more)
Parents' work days lost ≥6 months Self report (yes/no to any work days lost)	78 (1 study) 6 months	⊕⊖⊖⊖ VERY LOW ^{1,2,3,5} due to risk of bias, imprecision	RR 1 (0.53 to 1.87)	Moderate 333 per 1000	0 fewer per 1000 (from 157 fewer to 290 more)
Controller medication use in patients who should have been on controller medications at baseline ≥6 months i.e. persistent asthma	49 (1 study) 12 months	⊕⊕⊕⊖ MODERATE ⁴ due to imprecision	RR 2.21 (0.82 to 5.97)	Moderate 167 per 1000	202 more per 1000 (from 30 fewer to 830 more)
Persistent asthma on controllers at baseline but discontinued at 6 months	100 (1 study) 12 months	⊕⊕⊖⊖ LOW ³ due to imprecision	RR 2.76 (0.73 to 10.42)	Moderate 52 per 1000	92 more per 1000 (from 14 fewer to 490 more)
Of those who met severity criteria for controllers at baseline, number on them at 12 months	135 (1 study) 12 months	⊕⊕⊕⊖ MODERATE ⁴ due to imprecision	RR 1.05 (0.81 to 1.37)	Moderate 610 per 1000	30 more per 1000 (from 116 fewer to 226 more)
¹ Method of randomisation and allocation concealment unclear ² Groups not comparable at baseline ³ Underpowered ⁴ Crosses one MID ⁵ Crosses two MIDs					

1 **30.4 Economic evidence**

2 **Published literature**

3 Three economic evaluations were identified with the relevant comparison and have been included in
4 this review.^{60,137,183} These are summarised in the economic evidence profiles below (Table 114, Table
5 115 and Table 116) and the economic evidence tables in Appendix H.

6 Two economic evaluations relating to this review question were identified but were excluded due to
7 a combination of limited applicability and methodological limitations.^{124,126} These are listed in
8 Appendix L, with reasons for exclusion given.

9 See also the economic article selection flow diagram in Appendix E.

Table 114: Economic evidence profile: tele-healthcare consultations versus face-to-face reviews

Study	Applicability	Limitations	Other comments	Incremental cost	Incremental effects	Cost-effectiveness	Uncertainty
Gruffydd-Jones 2005 ⁶⁰ (UK)	Partially applicable ^(a)	Potentially serious limitations ^(b)	The economic evaluation is a within trial analysis of a 12 month RCT. In the intervention a 6 month face to face asthma review was replaced with telephone calls which screened individuals who would need to come in for further assessment. An individualised asthma plan was also formulated and relayed to the patient. This advised them on what to do if their asthma worsened. In the control arm patients received the usual care option of a face to face to review after 6 months.	Bootstrapped cost difference: -£122.35	Higher health outcomes ^(c) were reported in the intervention arm; however these were not clinically significant.	No formal cost-effectiveness was evaluated however it would appear that t tele-healthcare is the dominant strategy (higher or same health with lower costs)	No uncertainty analysis was conducted

(a) Quality of life not assessed using QALYs which may produce different health outcomes.

(b) Short time horizon of 12 months may not reflect long term health and cost outcomes, adverse events are unlikely to be captured in this time, especially with the small cohort of patients monitored. Only quality, not quantity, of life was assessed and 2 individuals died or their condition was exacerbated in the intervention arm. No discussion was made regarding whether this was due to non-asthma causes or sampling error and whether the intervention was responsible.

(c) Health outcomes measured using the ACQ questionnaire

Table 115: Economic evidence profile: tele-healthcare monitoring versus paper-based self-monitoring

Study	Applicability	Limitations	Other comments	Incremental cost	Incremental effects	Cost-effectiveness	Uncertainty
Ryan 2012 ¹³⁷ (UK)	Partially applicable ^(a)	Potentially serious limitations ^(a)	Economic evaluation based on a one year multicentre RCT conducted in the UK. In the intervention arm tele-healthcare	£70	There was no significant change in	No formal cost-effectiveness evaluated	No sensitivity analysis was conducted

Study	Applicability	Limitations	Other comments	Incremental cost	Incremental effects	Cost-effectiveness	Uncertainty
			was implemented through mobile phone monitoring whereby the patient would enter data (symptoms, drug use and peak flow readings) twice daily using a mobile phone application. The patient receives immediate feedback which prompts action based on a pre-arranged plan. Patients in the control arm were asked to collect the same data on paper.		asthma control or self-efficacy between the 2 interventions.	however given there were no changes in health outcomes but a positive cost the tele-healthcare intervention can be seen as dominated.	

(a) Health was not measured using QALYs

(b) Short time horizon of 12 months may not capture long term health and cost outcomes. Also no sensitivity analysis was conducted meaning the results may not be robust to slight changes in certain outcomes intervention costs.

Table 116: Economic evidence profile: tele-healthcare packages versus nothing (usual care)

Study	Applicability	Limitations	Other comments	Incremental cost	Incremental effects	Cost-effectiveness	Uncertainty
Willems 2007 ¹⁸³ (Netherlands)	Partially applicable ^(a)	Potentially serious limitations ^(a)	The economic evaluation based on a 12 month RCT conducted in the Netherlands. In the intervention arm tele-healthcare was implemented using a monitoring device which digitally transferred data to a nurse practitioner who would analyse the data and change asthma medication accordingly.	£421 for children ^(b) £353 for adults ^(c)	0.01 QALYs for children 0.03 for adults	£40,865 per QALY gained for children £10,693 per QALY gained for adults	One sensitivity analysis was conducted by removing monitor costs from the intervention arm, based on the assumption that the price of these devices will fall drastically in the future. This reduced the ICER for adults to £1224 per QALY and for children £10,502 per QALY, therefore making the intervention cost-effective for children by bringing the ICER below the £20,000 threshold.

(a) Study undertaken in the Netherlands therefore costs will be less generalizable to a UK setting.

- 1 (b) *Short time horizon of 12 months may not capture long term health and cost outcomes.*
- 2 (c) *Children defined as individuals aged 7 to 18 years old*
- 3 (d) *Adults defined as individuals over 18 years old*
- 4

1 30.5 Evidence statements

2 Clinical

3 **ADULTS: Tele-health services versus face-to-face equivalents for adults with asthma**

- 4 • No evidence was identified for mortality.
- 5 • There was a borderline clinically important difference for asthma exacerbations requiring OCS (1
6 study, N=278, very low quality), UHU hospitalisations (2 studies, N=451, very low quality) and
7 UHU GP visits (2 studies, N=451, low quality).
- 8 • There was no clinically important difference for QOL (3 studies, N=960, moderate quality), asthma
9 control questionnaire score (2 studies, N=682, moderate quality) and lung function measured
10 using FEV1 (1 study, N=173, very low quality).

11 **ADULTS: Tele-monitoring versus paper-based monitoring for adults with asthma**

- 12 • No evidence was identified for mortality.
- 13 • There was a borderline clinically important difference for asthma exacerbations requiring OCS (1
14 study, N=281, low quality), UHU hospitalisations (3 studies, N=386, very low quality) and UHU ED
15 visits (2 studies, N=370, very low quality).
- 16 • There was no clinically important difference for QOL (2 studies, N=384, very low quality) and
17 asthma control questionnaire score (2 studies, N=478, very low quality).
- 18 • There was a clinically important harm for UHU GP visits (1 study, N=281, moderate quality).
- 19 • There was a clinically important benefit for lung function measured using FEV1 or PEF (low
20 quality)

21 **ADULTS: Tele-health packages versus nothing (usual care) for adults with asthma**

- 22 • No evidence was identified for mortality.
- 23 • There was a clinically important benefit for asthma exacerbations requiring OCS (1 study, N=60,
24 very low quality) and UHU hospitalisations (4 studies, N=404, moderate quality).
- 25 • There was a borderline clinically important benefit for UHU ED visits (4 studies, N=415, very low
26 quality), UHU GP visits (3 studies, N=295, very low quality) and lung function measured using FEV1
27 (1 study, N=165, low quality)
- 28 • There was no clinically important difference for QOL (3 studies, N=1633, moderate quality),
29 asthma control questionnaire score (1 study, N=556, high quality) and symptom free days and
30 nights (1 study, N=608, moderate quality).

31 **ADULTS: Telehealthcare without healthcare professional involvement vs usual care**

- 32 • No evidence was identified for mortality, asthma exacerbations or UHU
- 33 • There was no clinically important difference for QOL (1 study, N=50, low quality) and asthma
34 control questionnaire score (1 study, N=50, very low quality).

35 **CHILDREN: Tele-health services versus face-to-face equivalents for children with asthma**

- 36 • No evidence was identified for mortality, asthma exacerbations or asthma control questionnaires.
- 37 • There was no clinically important difference for QOL carer and QOL child (1 study, N=120, low
38 quality) and UHU hospitalisation (1 study, N=120, very low quality)
- 39 • There was a borderline clinically important difference for ED visits (1 study, N=120, very low
40 quality) and lung function measured using FEV1 (1 study, N=120, low quality).

41 **CHILDREN: Tele-monitoring versus paper-based monitoring for children with asthma**

- 1 • No evidence was identified for any of the 5 priority outcomes.
2 • There was no clinically important difference for lung function measured using PEF (1 study,
3 N=153, very low quality).

4 **CHILDREN: Tele-health packages versus nothing (usual care) for children with asthma**

- 5 • No evidence was identified for mortality.
6 • There was a clinically important benefit for QOL child (1 study, N=82, low quality).
7 • There was no clinically important difference for QOL parent (2 studies, N=181, moderate quality),
8 UHU hospitalisations (5 studies, N=609, very low quality), UHU ED visits (4 studies, N=566, very
9 low quality), asthma exacerbations requiring OCS (2 studies, N=125, very low quality) and Asthma
10 control questionnaire score (1 study, N=301, low quality).
11 • There was a borderline clinically important difference for GP visits (1 study, N=99, low quality).

12 **CHILDREN: Telehealthcare without healthcare professional involvement vs usual care**

- 13 • No evidence was identified for mortality, asthma control questionnaires
14 • There was a clinically important benefit for asthma exacerbations requiring OCS (1 study, N=79,
15 very low quality) and QOL child (1 study, N=80, low quality).
16 • There was no clinically important difference for QOL parent (1 study, N=80, very low quality), UHU
17 (hospitalisation) (1 study, N=79, very low quality) and parent work days lost (1 study, N=78, very
18 low quality).
19 • There was a borderline clinically important difference for UHU ED visits (1 study, N=79, very low
20 quality) and child school days lost (1 study, N=77, very low quality).
21 • Evidence suggested that there was a clinical benefit in the number of people taking ICS
22 medication at 12 months, who should have been on medication at baseline.

23 **Economic**

- 24 • One within trial cost analysis found that tele-healthcare consultations was dominant (produced
25 lower costs and non significant increases in health outcomes) when compared to face-to-face
26 reviews. This analysis was assessed as partially applicable with potentially serious limitations.
27 • One within trial analysis found that tele-healthcare monitoring was dominated (produced higher
28 costs and no increase in health outcomes) when compared to paper based monitoring. This
29 analysis was assessed as partially applicable with potentially serious limitations.
30 • One within trial analysis found that tele-healthcare was cost-effective in adults when compared to
31 nothing (ICER: £10,693). However the same analysis found that tele-healthcare versus nothing
32 was not cost-effective in children (ICER: £40,865).

33 **30.6 Recommendations and link to evidence**

Recommendations	No clinical recommendation.
Research recommendations	6. What is the long-term (more than 12 months) clinical and cost effectiveness of using tele-healthcare as a means to monitor asthma control in children, young people and adults? Modalities of tele-healthcare can include telephone interview (healthcare professional involvement) and internet or smartphone-based monitoring support (no healthcare professional involvement).
Relative values of different outcomes	Due to large heterogeneity between telehealthcare interventions for monitoring asthma in the literature, studies were analysed in four separate groups. These comparisons were not pre-specified in the review protocol, but were necessary in

	<p>order to make the analyses clinically meaningful and were constructed prior to extraction and pooling of outcome data.</p> <p>The GDG considered the following outcomes as critical for this review: mortality, quality of life, exacerbations, asthma control measured by questionnaires and unscheduled healthcare utilisation.</p> <p>Asthma attacks can lead to both unscheduled healthcare utilisation (emergency department (ED) visits, out-of-hours GP surgery visits or hospitalisation) and the need for a course of oral corticosteroids (OCS). Therefore, the GDG considered exacerbations requiring OCS treatment and exacerbations requiring unscheduled healthcare utilisation as separate outcomes.</p> <p>The GDG also considered the following important outcomes: lung function (FEV1), symptoms (symptom-free days), dose of regular asthma therapy (ICS dose), rescue medication (SABA dose) and time off school or work. These outcomes were considered as important measures of asthma control for the patient. The GDG acknowledged that regular asthma preventer therapy, inhaled corticosteroid (ICS), is often underprescribed / used, and rescue medications (for example short acting beta agonists (SABA)) may be overprescribed / used (for further reference see NRAD¹³⁵). Therefore, the GDG reviewed the evidence on these outcomes.</p>
<p>Trade-off between clinical benefits and harms</p>	<p>Four comparisons were considered for both adults and children:</p> <ol style="list-style-type: none"> 1) Tele-health services versus face-to-face equivalents; 2) Tele-monitoring versus paper-based monitoring; 3) Tele-health packages versus standard or usual care and 4) Telehealthcare without healthcare professional involvement vs standard or usual care. <p><u>ADULTS</u></p> <p><u>The GDG noted the following results:</u></p> <p>For tele-health services versus face-to-face equivalents there was</p> <ul style="list-style-type: none"> • borderline clinically important differences for: <ul style="list-style-type: none"> ○ asthma exacerbations requiring OCS ○ hospitalisation ○ GP visits • no clinically important differences for: <ul style="list-style-type: none"> ○ QOL ○ asthma control questionnaire score ○ lung function (FEV1) <p>For tele-monitoring versus paper-based monitoring there was:</p> <ul style="list-style-type: none"> • borderline clinically important differences for: <ul style="list-style-type: none"> ○ asthma exacerbations requiring OCS ○ hospitalisation ○ ED visits • no clinically important differences for: <ul style="list-style-type: none"> ○ QOL ○ asthma control questionnaire score • clinically important benefits for: <ul style="list-style-type: none"> ○ lung function measured using FEV1 or PEF • a clinically important harm for: <ul style="list-style-type: none"> ○ GP visits

For tele-health packages versus usual care there was:

- clinically important benefits for:
 - asthma exacerbations requiring OCS
 - hospitalisation
- borderline clinically important benefits for:
 - ED visits
 - GP visits
 - Lung function measured using FEV1
- no clinically important differences for:
 - QOL
 - asthma control questionnaire score
 - symptom free days and nights

For telehealthcare without healthcare professional involvement vs usual care there was:

- no clinically important difference for:
 - asthma control questionnaire score
 - QOL

In adults, only telehealthcare packages (compared to standard care) appeared to improve outcomes. However, this intervention cannot be considered as assessing the effect of telehealthcare alone, as people received additional care (telehealthcare was not the only difference between the groups).

The GDG acknowledged that monitoring asthma is essential and the consensus of GDG opinion was that this should theoretically result in better outcomes. Without further research the additional benefit of telehealthcare is currently unclear.

The GDG also noted that the secondary outcomes of importance, FEV1 (in the first three comparisons quoted above) showed a benefit in adults; however, this benefit was not reflected in other outcomes, such as the QOL.

For tele-health services versus face-to-face equivalents the GDG noted that there was no difference between the groups. The GDG considered this an important finding given that this comparison potentially replaces face-to-face visits with a telehealthcare interaction. The GDG also noted the heterogeneity between interventions in this comparison, with some studies involving email and others involving telephone calls. An improvement might be expected using telephone calls but not email, as a telephone intervention could be more interactive and reach people who are already considered to be poor compliers. However, evidence was not available from enough studies to subgroup on the basis of 'type of device' as pre-specified in the protocol.

CHILDREN AND YOUNG PEOPLE

For tele-health services versus face-to-face equivalents there was:

- no clinically important differences for:
 - QOL carer and QOL child
 - hospitalisation
- borderline clinically important benefits for:
 - ED visits
 - lung function measured using FEV1

	<p>For tele-monitoring versus paper-based monitoring no evidence was identified for any of the 5 priority outcomes. There was:</p> <ul style="list-style-type: none"> • no clinically important differences for: <ul style="list-style-type: none"> ○ lung function measured using PEF <p>For tele-health packages versus usual care there was:</p> <ul style="list-style-type: none"> • clinically important benefit for: • QOL child no clinically important differences for: <ul style="list-style-type: none"> ○ QOL parent ○ hospitalisation ○ asthma exacerbations requiring OCS ○ asthma control questionnaire score ○ ED visits • borderline clinically important benefits for: <ul style="list-style-type: none"> ○ GP visits <p>For telehealthcare without healthcare professional involvement vs usual care there was:</p> <ul style="list-style-type: none"> • clinically important benefits for: <ul style="list-style-type: none"> ○ asthma exacerbations requiring OCS ○ QOL child • no clinically important differences for: <ul style="list-style-type: none"> ○ QOL parent ○ hospitalisation ○ parent work days lost • borderline clinically important difference for: <ul style="list-style-type: none"> ○ ED visits ○ child school days lost <p><u>CHILDREN < 5 YEARS</u></p> <p>In children <5 years, no evidence was identified.</p> <p>Overall, the GDG concluded that there was a paucity of telehealthcare evidence for the outcomes of interest to the GDG (with no consistency of findings) and the interventions were of limited quality and too heterogeneous to make a recommendation in adults, young people or children for the use of telehealthcare in monitoring asthma. In light of this, the GDG agreed to make a future research recommendation.</p>
<p>Economic considerations</p>	<p>Three health economic papers were presented to the GDG. All three papers were within-trial analyses that appeared in the clinical review.</p> <p>A study by Gruffydd-Jones 2005 looked at tele-healthcare (THC) which replaced face-to-face reviews with a telephone review and found THC to be cheaper and no less effective. However, the GDG noted the considerable heterogeneity that existed over the clinical evidence. Therefore, if the same cost analysis was conducted in another study the results could be very different. The GDG also noted the short 12-month time horizon as a serious limitation to the study's results. Therefore, due to considerable uncertainty, the GDG did not feel they could make a recommendation concerning the replacement of face-to-face reviews with THC.</p>

	<p>A study by Ryan 2012 compared THC monitoring with paper-based monitoring. The study found that THC monitoring resulted in higher costs for the NHS but no significant differences in patient's quality of life. However, again due to considerable heterogeneity in the clinical review and noting the study's short time horizon the GDG did not feel that enough evidence was available to form a recommendation regarding the replacement of paper-based monitoring with THC.</p> <p>Finally, a study by Willems 2007 looked at comparing a THC monitoring intervention to usual care. A formal cost-effectiveness analysis found that THC was cost-effective compared to usual care with an ICER of £10,693 per QALY for adults, but was not cost-effective for children with an ICER of £40,865. The main concern was the study's short time horizon of 12 months; the GDG felt that during this period the benefits of the intervention would be highest and, as time went on, the benefits would decrease.</p> <p>The GDG considered the economic evidence not enough to make a recommendation on this intervention. The GDG also noted that the intervention was very specific and that not enough clinical evidence existed to back up the results to make such a specific recommendation.</p>
Quality of evidence	<p>In adults, the majority of the evidence was of low and very low quality for the critical outcomes. In children (with the exception of the carer QOL outcome in comparison 3 at moderate quality), evidence for all the critical outcomes was of low and very low quality. The evidence was downgraded due to risk of bias, imprecision and inconsistency.</p>
Other considerations	<p>The GDG concluded that there was too little evidence and too much heterogeneity between interventions to support or refute the use of telehealthcare for monitoring asthma. There was also heterogeneity in the severity of asthma within the study populations. Severe asthma is excluded from the scope of this guideline. Five studies were noted to potentially include people with severe asthma; however, the GDG did not exclude these studies because of lack of clarity (it was unclear whether the population within these studies met ERS/ATS guideline operational definition for severe asthma).</p> <p>The GDG agreed that future research in this area is needed, in particular in order to identify the modality of telehealthcare that will be most beneficial. There are some positive indications for telehealthcare, with little evidence of causing clinical harm. However, there was not enough evidence to show a clear clinical benefit and it is important that NHS financial resources are not invested in implementing telehealthcare for monitoring until further evidence is available. Therefore, the GDG recommended the use of telehealthcare in a research setting only and made a high-priority research recommendation to investigate the long-term (more than 12 months) clinical and cost-effectiveness of using tele-healthcare as a means to monitor asthma control. Further details on the high-priority research recommendation made can be found in appendix N.</p> <p>The GDG also discussed whether a 12-month time horizon may be too short to answer this question and that studies with a longer follow-up than 12 months are essential to observe any long-term benefits or harms of telehealthcare for monitoring asthma.</p>

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- 10
- 11

1 32 Acronyms and abbreviations

<	Less than
>	More than
≤	Less than or equal to
≥	More than or equal to
A&E	Accident and emergency
ACQ	Asthma Control Questionnaire
ACT	Asthma Control Test
AHR	Airway hyper-reactivity
AQLQ	Asthma Quality of Life Questionnaire
ATS	American Thoracic Society
BCT	Bronchial challenge test
BDR	Bronchodilator reversibility
BHR	Bronchial hyper-reactivity
BTS	British Thoracic Society
CACT	Children's Asthma Control Test
CS	Corticosteroid
Dx	Diagnosis
ED	Emergency department
ERS	European Respiratory Society
FeNO	Fractional exhaled nitric oxide
FEV ₁	Forced expiratory volume in one second
FVC	Forced vital capacity
GDG	Guideline development group
GINA	Global Initiative for Asthma
ICS	Inhaled corticosteroids
IgE	Immunoglobulin E
LABA	Long-acting beta agonist
MCT	Methacholine challenge test
N/A	Not applicable
NAEPP	National asthma education and prevention program
NCGC	National Clinical Guideline Centre
NICE	National Institute for Health and Care Excellence
NIH	National Institutes of Health
OAD	Obstructive airways disease
OCS	Oral corticosteroids
pAQLQ	Paediatric Asthma Quality of Life Questionnaire
PACQ	Paediatric Asthma Control Questionnaire
PBE	Peripheral blood eosinophils
PEF	Peak expiratory flow
PEFv	Peak expiratory flow variability
ppb	Parts per billion
RCP 3 Questions	Royal College of Physicians 3 Questions

RCP NRAD	Royal College of Physicians National Review of Asthma Deaths
SABA	Short-acting beta agonist
SIGN	Scottish Intercollegiate Guidelines Network
sn	Sensitivity
sp	Specificity
SIC	Specific inhalation challenge
SPT	Skin prick test
THC	Tele-healthcare
Tx	Treatment
UC	Usual care
UHU	Unscheduled healthcare utilisation

1 33 Glossary

2 33.1 Guideline-specific terms

Adherence (to treatment)	The extent to which a patient's action matches the agreed recommendations.
Airway hyper-reactivity	See 'bronchial hyper-reactivity'.
Asthma	A common long-term incurable condition of unknown cause that affects people of all ages whereby the small tubes in the lungs (bronchi) become inflamed when the person encounters something that irritates their lungs (asthma triggers) causing the airways to become narrower making it difficult to breathe and can induce coughing, wheezing and tightness in the chest. Asthma is usually associated with an expiratory polyphonic wheeze. Severity of symptoms varies from person to person; and even in the same person at different times of the day or year. Worsening of symptoms can occur gradually or suddenly (known as an 'asthma attack' or 'asthma exacerbation').
Asthma attack	A worsening of asthma symptoms requiring the use of systemic corticosteroids to prevent a serious outcome.
Asthma exacerbation	See 'asthma attack'.
Atopic disorders	Allergic conditions including allergic rhinitis (hay fever), atopic dermatitis (eczema), allergic asthma and other specific and non-specific allergic conditions such as food allergies.
Bronchial challenge test	A test to measure airway reactivity after inhalation of a non-specific drug.
Bronchial hyper-reactivity	A measure of how easily bronchospasm can be induced in the airways.
Bronchodilator	A drug that widens the airways making it easier to breathe.
Bronchodilator response	See 'bronchodilator reversibility'.
Bronchodilator reversibility	A measure of the ability to reverse an obstruction in the airways using drugs that widen the airways (bronchodilators).
Emergency department	Hospital department that assesses and treats patients with serious or life-threatening injuries or illnesses.
Eosinophilia	A higher than normal number of the type of white blood cell eosinophils circulating in the blood.
Exercise	Any physical activity requiring effort or exertion of the body at a greater intensity than that of a normal resting state.
FeNO test	A test that measures the amount of nitric oxide (NO) present upon exhalation, generally expressed in parts per billion.
FEV ₁	The amount of air you can blow out in one second (forced expiratory volume in one second).
Forced vital capacity	The amount of air which can be forcibly exhaled from the lungs after taking the deepest breath possible.
Histamine	An organic chemical compound which is released by cells in the body as part of a local immune response to certain allergic stimuli causing an inflammatory response and the constriction of smooth muscle.
IgE test	A blood test that measures the amount of IgE antibody circulating in the blood.
Inhaler	A portable device for administering an inhaled drug.
Mannitol	An osmotic diuretic which leads to constriction of the airways.
Methacholine	A synthetic compound that causes constriction of the airways.
Objective test	A test designed to exclude as far as possible the subjective element on the

	part of the person taking, the person administering and the person assessing, the test.
Occupational asthma	Work-related asthma attributable to a particular exposure in the workplace and not due to stimuli encountered outside the workplace.
Peak expiratory flow rate	A measure of the maximum speed of expiration, generally expressed in litres per minute.
Peak expiratory flow variability	A measure of how much the maximum speed of expiration varies in a person over time.
Peripheral blood eosinophil count	A blood test that measures the number of the type of white blood cell eosinophils circulating in the blood.
Questionnaire	A written set of questions on a particular topic designed for the purpose of gathering specific information from a respondent.
Sensitivity (degree of)	<ul style="list-style-type: none"> • Low: 0-50% • Moderate: 50-75% • High: 75-100% See also 'Sensitivity' in the list of general terms below.
Skin prick test	A test that measures the allergic response of an individual to certain specific allergens when a very small amount of the specific allergen is introduced into the skin (usually the inner forearm).
Specificity (degree of)	<ul style="list-style-type: none"> • Low: 0-50% • Moderate: 50-75% • High: 75-100% See also 'Specificity' in the list of general terms below.
Spirometry	A test that measures how a person exhales volumes of air as a function of time.
Tele-healthcare	Information and communication technologies used by patients and healthcare professionals to deliver healthcare, health promotion or to carry out research where the participants are not in the same place. Examples include telephone interviews with a healthcare professional, internet and smartphone-based monitoring support.
Wheeze	A continuous, coarse, whistling sound produced in the airways during breathing (inspiration or expiration) due to a narrowing or obstruction in a part of the respiratory tree. Can be polyphonic (multiple pitches and tones heard over a variable area of the lung) or monophonic (a single pitch and tonal quality heard over an isolated area of the lung).

1 33.2 General terms

Abstract	Summary of a study, which may be published alone or as an introduction to a full scientific paper.
Algorithm (in guidelines)	A flow chart of the clinical decision pathway described in the guideline, where decision points are represented with boxes, linked with arrows.
Allocation concealment	The process used to prevent advance knowledge of group assignment in an RCT. The allocation process should be impervious to any influence by the individual making the allocation, by being administered by someone who is not responsible for recruiting participants.
Applicability	How well the results of a study or NICE evidence review can answer a clinical question or be applied to the population being considered.
Arm (of a clinical study)	Subsection of individuals within a study who receive one particular intervention, for example placebo arm.
Association	Statistical relationship between 2 or more events, characteristics or other

	variables. The relationship may or may not be causal.
Baseline	The initial set of measurements at the beginning of a study (after run-in period where applicable), with which subsequent results are compared.
Bias	Influences on a study that can make the results look better or worse than they really are. (Bias can even make it look as if a treatment works when it does not.) Bias can occur by chance, deliberately or as a result of systematic errors in the design and execution of a study. It can also occur at different stages in the research process, for example, during the collection, analysis, interpretation, publication or review of research data. For examples see selection bias, performance bias, information bias, confounding factor, and publication bias.
Blinding	A way to prevent researchers, doctors and patients in a clinical trial from knowing which study group each patient is in so they cannot influence the results. The best way to do this is by sorting patients into study groups randomly. The purpose of 'blinding' or 'masking' is to protect against bias. A single-blinded study is one in which patients do not know which study group they are in (for example whether they are taking the experimental drug or a placebo). A double-blinded study is one in which neither patients nor the researchers/doctors know which study group the patients are in. A triple blind study is one in which neither the patients, clinicians or the people carrying out the statistical analysis know which treatment patients received.
Carer (caregiver)	Someone who looks after family, partners or friends in need of help because they are ill, frail or have a disability.
Case–control study	A study to find out the cause(s) of a disease or condition. This is done by comparing a group of patients who have the disease or condition (cases) with a group of people who do not have it (controls) but who are otherwise as similar as possible (in characteristics thought to be unrelated to the causes of the disease or condition). This means the researcher can look for aspects of their lives that differ to see if they may cause the condition. For example, a group of people with lung cancer might be compared with a group of people the same age that do not have lung cancer. The researcher could compare how long both groups had been exposed to tobacco smoke. Such studies are retrospective because they look back in time from the outcome to the possible causes of a disease or condition.
Case series	Report of a number of cases of a given disease, usually covering the course of the disease and the response to treatment. There is no comparison (control) group of patients.
Clinical efficacy	The extent to which an intervention is active when studied under controlled research conditions.
Clinical effectiveness	How well a specific test or treatment works when used in the 'real world' (for example, when used by a doctor with a patient at home), rather than in a carefully controlled clinical trial. Trials that assess clinical effectiveness are sometimes called management trials. Clinical effectiveness is not the same as efficacy.
Clinician	A healthcare professional who provides patient care. For example, a doctor, nurse or physiotherapist.
Cochrane Review	The Cochrane Library consists of a regularly updated collection of evidence-based medicine databases including the Cochrane Database of Systematic Reviews (reviews of randomised controlled trials prepared by the Cochrane Collaboration).
Cohort study	A study with 2 or more groups of people – cohorts – with similar characteristics. One group receives a treatment, is exposed to a risk factor or has a particular symptom and the other group does not. The study

	follows their progress over time and records what happens. See also observational study.
Comorbidity	A disease or condition that someone has in addition to the health problem being studied or treated.
Comparability	Similarity of the groups in characteristics likely to affect the study results (such as health status or age).
Confidence interval (CI)	<p>There is always some uncertainty in research. This is because a small group of patients is studied to predict the effects of a treatment on the wider population. The confidence interval is a way of expressing how certain we are about the findings from a study, using statistics. It gives a range of results that is likely to include the 'true' value for the population.</p> <p>The CI is usually stated as '95% CI', which means that the range of values has a 95 in a 100 chance of including the 'true' value. For example, a study may state that 'based on our sample findings, we are 95% certain that the 'true' population blood pressure is not higher than 150 and not lower than 110'. In such a case the 95% CI would be 110 to 150.</p> <p>A wide confidence interval indicates a lack of certainty about the true effect of the test or treatment - often because a small group of patients has been studied. A narrow confidence interval indicates a more precise estimate (for example, if a large number of patients have been studied).</p>
Confounding factor	<p>Something that influences a study and can result in misleading findings if it is not understood or appropriately dealt with.</p> <p>For example, a study of heart disease may look at a group of people that exercises regularly and a group that does not exercise. If the ages of the people in the 2 groups are different, then any difference in heart disease rates between the 2 groups could be because of age rather than exercise. Therefore age is a confounding factor.</p>
Consensus methods	Techniques used to reach agreement on a particular issue. Consensus methods may be used to develop NICE guidance if there is not enough good quality research evidence to give a clear answer to a question. Formal consensus methods include Delphi and nominal group techniques.
Control group	<p>A group of people in a study who do not receive the treatment or test being studied. Instead, they may receive the standard treatment (sometimes called 'usual care') or a dummy treatment (placebo). The results for the control group are compared with those for a group receiving the treatment being tested. The aim is to check for any differences.</p> <p>Ideally, the people in the control group should be as similar as possible to those in the treatment group, to make it as easy as possible to detect any effects due to the treatment.</p>
Cost–benefit analysis (CBA)	Cost-benefit analysis is one of the tools used to carry out an economic evaluation. The costs and benefits are measured using the same monetary units (for example, pounds sterling) to see whether the benefits exceed the costs.
Cost–consequences analysis (CCA)	Cost-consequence analysis is one of the tools used to carry out an economic evaluation. This compares the costs (such as treatment and hospital care) and the consequences (such as health outcomes) of a test or treatment with a suitable alternative. Unlike cost-benefit analysis or cost-effectiveness analysis, it does not attempt to summarise outcomes in a single measure (like the quality-adjusted life year) or in financial terms. Instead, outcomes are shown in their natural units (some of which may be monetary) and it is left to decision-makers to determine whether, overall, the treatment is worth carrying out.
Cost-effectiveness analysis (CEA)	Cost-effectiveness analysis is one of the tools used to carry out an economic evaluation. The benefits are expressed in non-monetary terms related to

	health, such as symptom-free days, heart attacks avoided, deaths avoided or life years gained (that is, the number of years by which life is extended as a result of the intervention).
Cost-effectiveness model	An explicit mathematical framework, which is used to represent clinical decision problems and incorporate evidence from a variety of sources in order to estimate the costs and health outcomes.
Cost–utility analysis (CUA)	Cost-utility analysis is one of the tools used to carry out an economic evaluation. The benefits are assessed in terms of both quality and duration of life, and expressed as quality-adjusted life years (QALYs). See also utility.
Decision analysis	An explicit quantitative approach to decision-making under uncertainty, based on evidence from research. This evidence is translated into probabilities, and then into diagrams or decision trees which direct the clinician through a succession of possible scenarios, actions and outcomes.
Discounting	Costs and perhaps benefits incurred today have a higher value than costs and benefits occurring in the future. Discounting health benefits reflects individual preference for benefits to be experienced in the present rather than the future. Discounting costs reflects individual preference for costs to be experienced in the future rather than the present.
Dominance	A health economics term. When comparing tests or treatments, an option that is both less effective and costs more is said to be 'dominated' by the alternative.
Drop-out	A participant who withdraws from a trial before the end.
Economic evaluation	<p>An economic evaluation is used to assess the cost-effectiveness of healthcare interventions (that is, to compare the costs and benefits of a healthcare intervention to assess whether it is worth doing). The aim of an economic evaluation is to maximise the level of benefits - health effects - relative to the resources available. It should be used to inform and support the decision-making process; it is not supposed to replace the judgement of healthcare professionals.</p> <p>There are several types of economic evaluation: cost-benefit analysis, cost-consequence analysis, cost-effectiveness analysis, cost-minimisation analysis and cost-utility analysis. They use similar methods to define and evaluate costs, but differ in the way they estimate the benefits of a particular drug, programme or intervention.</p>
Effect (as in effect measure, treatment effect, estimate of effect, effect size)	<p>A measure that shows the magnitude of the outcome in one group compared with that in a control group.</p> <p>For example, if the absolute risk reduction is shown to be 5% and it is the outcome of interest, the effect size is 5%.</p> <p>The effect size is usually tested, using statistics, to find out how likely it is that the effect is a result of the treatment and has not just happened by chance (that is, to see if it is statistically significant).</p>
Effectiveness	How beneficial a test or treatment is under usual or everyday conditions, compared with doing nothing or opting for another type of care.
Efficacy	How beneficial a test, treatment or public health intervention is under ideal conditions (for example, in a laboratory), compared with doing nothing or opting for another type of care.
Epidemiological study	The study of a disease within a population, defining its incidence and prevalence and examining the roles of external influences (for example, infection, diet) and interventions.
EQ-5D (EuroQol 5 dimensions)	A standardised instrument used to measure health-related quality of life. It provides a single index value for health status.
Evidence	Information on which a decision or guidance is based. Evidence is obtained from a range of sources including randomised controlled trials,

	observational studies, expert opinion (of clinical professionals or patients).
Exclusion criteria (literature review)	Explicit standards used to decide which studies should be excluded from consideration as potential sources of evidence.
Exclusion criteria (clinical study)	Criteria that define who is not eligible to participate in a clinical study.
Extended dominance	If Option A is both more clinically effective than Option B and has a lower cost per unit of effect, when both are compared with a do-nothing alternative then Option A is said to have extended dominance over Option B. Option A is therefore more cost-effective and should be preferred, other things remaining equal.
Extrapolation	An assumption that the results of studies of a specific population will also hold true for another population with similar characteristics.
Follow-up	Observation over a period of time of an individual, group or initially defined population whose appropriate characteristics have been assessed in order to observe changes in health status or health-related variables.
Generalisability	The extent to which the results of a study hold true for groups that did not participate in the research. See also external validity.
Gold standard	A method, procedure or measurement that is widely accepted as being the best available to test for or treat a disease.
GRADE, GRADE profile	A system developed by the GRADE Working Group to address the shortcomings of present grading systems in healthcare. The GRADE system uses a common, sensible and transparent approach to grading the quality of evidence. The results of applying the GRADE system to clinical trial data are displayed in a table known as a GRADE profile.
Harms	Adverse effects of an intervention.
Health economics	Study or analysis of the cost of using and distributing healthcare resources.
Health-related quality of life (HRQoL)	A measure of the effects of an illness to see how it affects someone's day-to-day life.
Heterogeneity or Lack of homogeneity	The term is used in meta-analyses and systematic reviews to describe when the results of a test or treatment (or estimates of its effect) differ significantly in different studies. Such differences may occur as a result of differences in the populations studied, the outcome measures used or because of different definitions of the variables involved. It is the opposite of homogeneity.
Imprecision	Results are imprecise when studies include relatively few patients and few events and thus have wide confidence intervals around the estimate of effect.
Inclusion criteria (literature review)	Explicit criteria used to decide which studies should be considered as potential sources of evidence.
Incremental analysis	The analysis of additional costs and additional clinical outcomes with different interventions.
Incremental cost	The extra cost linked to using one test or treatment rather than another. Or the additional cost of doing a test or providing a treatment more frequently.
Incremental cost-effectiveness ratio (ICER)	The difference in the mean costs in the population of interest divided by the differences in the mean outcomes in the population of interest for one treatment compared with another.
Incremental net benefit (INB)	The value (usually in monetary terms) of an intervention net of its cost compared with a comparator intervention. The INB can be calculated for a given cost-effectiveness (willingness to pay) threshold. If the threshold is £20,000 per QALY gained then the INB is calculated as: (£20,000 x QALYs gained) – Incremental cost.
Indirectness	The available evidence is different to the review question being addressed,

	in terms of PICO (population, intervention, comparison and outcome).
Intention-to-treat analysis (ITT)	An assessment of the people taking part in a clinical trial, based on the group they were initially (and randomly) allocated to. This is regardless of whether or not they dropped out, fully complied with the treatment or switched to an alternative treatment. Intention-to-treat analyses are often used to assess clinical effectiveness because they mirror actual practice: that is, not everyone complies with treatment and the treatment people receive may be changed according to how they respond to it.
Intervention	In medical terms this could be a drug treatment, surgical procedure, diagnostic or psychological therapy. Examples of public health interventions could include action to help someone to be physically active or to eat a more healthy diet.
Length of stay	The total number of days a participant stays in hospital.
Licence	See 'Product licence'.
Life years gained	Mean average years of life gained per person as a result of the intervention compared with an alternative intervention.
Likelihood ratio	The likelihood ratio combines information about the sensitivity and specificity. It tells you how much a positive or negative result changes the likelihood that a patient would have the disease. The likelihood ratio of a positive test result (LR+) is sensitivity divided by (1 minus specificity).
Long-term care	Residential care in a home that may include skilled nursing care and help with everyday activities. This includes nursing homes and residential homes.
Markov model	A method for estimating long-term costs and effects for recurrent or chronic conditions, based on health states and the probability of transition between them within a given time period (cycle).
Meta-analysis	A method often used in systematic reviews. Results from several studies of the same test or treatment are combined to estimate the overall effect of the treatment.
Negative predictive value (NPV)	In screening or diagnostic tests: A measure of the usefulness of a screening or diagnostic test. It is the proportion of those with a negative test result who do not have the disease, and can be interpreted as the probability that a negative test result is correct. It is calculated as follows: $NPV = TN / (TN + FN)$
Observational study	Individuals or groups are observed or certain factors are measured. No attempt is made to affect the outcome. For example, an observational study of a disease or treatment would allow 'nature' or usual medical care to take its course. Changes or differences in one characteristic (for example, whether or not people received a specific treatment or intervention) are studied without intervening. There is a greater risk of selection bias than in experimental studies.
Odds ratio	Odds are a way to represent how likely it is that something will happen (the probability). An odds ratio compares the probability of something in one group with the probability of the same thing in another. An odds ratio of 1 between 2 groups would show that the probability of the event (for example a person developing a disease, or a treatment working) is the same for both. An odds ratio greater than 1 means the event is more likely in the first group. An odds ratio less than 1 means that the event is less likely in the first group. Sometimes probability can be compared across more than 2 groups - in this case, one of the groups is chosen as the 'reference category', and the odds ratio is calculated for each group compared with the reference category. For example, to compare the risk of dying from lung cancer for non-smokers, occasional smokers and regular smokers, non-smokers could be used as the reference category. Odds ratios would be worked out for occasional

	smokers compared with non-smokers and for regular smokers compared with non-smokers. See also confidence interval, relative risk, risk ratio.
Opportunity cost	The loss of other health care programmes displaced by investment in or introduction of another intervention. This may be best measured by the health benefits that could have been achieved had the money been spent on the next best alternative healthcare intervention.
Outcome	The impact that a test, treatment, policy, programme or other intervention has on a person, group or population. Outcomes from interventions to improve the public's health could include changes in knowledge and behaviour related to health, societal changes (for example, a reduction in crime rates) and a change in people's health and wellbeing or health status. In clinical terms, outcomes could include the number of patients who fully recover from an illness or the number of hospital admissions, and an improvement or deterioration in someone's health, functional ability, symptoms or situation. Researchers should decide what outcomes to measure before a study begins.
P value	<p>The p value is a statistical measure that indicates whether or not an effect is statistically significant.</p> <p>For example, if a study comparing 2 treatments found that one seems more effective than the other, the p value is the probability of obtaining these results by chance. By convention, if the p value is below 0.05 (that is, there is less than a 5% probability that the results occurred by chance) it is considered that there probably is a real difference between treatments. If the p value is 0.001 or less (less than a 1% probability that the results occurred by chance), the result is seen as highly significant.</p> <p>If the p value shows that there is likely to be a difference between treatments, the confidence interval describes how big the difference in effect might be.</p>
Placebo	A fake (or dummy) treatment given to participants in the control group of a clinical trial. It is indistinguishable from the actual treatment (which is given to participants in the experimental group). The aim is to determine what effect the experimental treatment has had - over and above any placebo effect caused because someone has received (or thinks they have received) care or attention.
Polypharmacy	The use or prescription of multiple medications.
Positive predictive value (PPV)	In screening or diagnostic tests: A measure of the usefulness of a screening or diagnostic test. It is the proportion of those with a positive test result who have the disease, and can be interpreted as the probability that a positive test result is correct. It is calculated as follows: $PPV = TP / (TP + FP)$
Power (statistical)	The ability to demonstrate an association when one exists. Power is related to sample size; the larger the sample size, the greater the power and the lower the risk that a possible association could be missed.
Preoperative	The period before surgery commences.
Primary care	Healthcare delivered outside hospitals. It includes a range of services provided by GPs, nurses, health visitors, midwives and other healthcare professionals and allied health professionals such as dentists, pharmacists and opticians.
Primary outcome	The outcome of greatest importance, usually the one in a study that the power calculation is based on.
Product licence	An authorisation from the MHRA to market a medicinal product.
Prognosis	A probable course or outcome of a disease. Prognostic factors are patient or disease characteristics that influence the course. Good prognosis is associated with low rate of undesirable outcomes; poor prognosis is associated with a high rate of undesirable outcomes.

Prospective study	A research study in which the health or other characteristic of participants is monitored (or 'followed up') for a period of time, with events recorded as they happen. This contrasts with retrospective studies.
Publication bias	Publication bias occurs when researchers publish the results of studies showing that a treatment works well and don't publish those showing it did not have any effect. If this happens, analysis of the published results will not give an accurate idea of how well the treatment works. This type of bias can be assessed by a funnel plot.
Quality of life	See 'Health-related quality of life'.
Quality-adjusted life year (QALY)	A measure of the state of health of a person or group in which the benefits, in terms of length of life, are adjusted to reflect the quality of life. One QALY is equal to 1 year of life in perfect health. QALYS are calculated by estimating the years of life remaining for a patient following a particular treatment or intervention and weighting each year with a quality of life score (on a scale of 0 to 1). It is often measured in terms of the person's ability to perform the activities of daily life, freedom from pain and mental disturbance.
Randomisation	Assigning participants in a research study to different groups without taking any similarities or differences between them into account. For example, it could involve using a random numbers table or a computer-generated random sequence. It means that each individual (or each group in the case of cluster randomisation) has the same chance of receiving each intervention.
Randomised controlled trial (RCT)	A study in which a number of similar people are randomly assigned to 2 (or more) groups to test a specific drug or treatment. One group (the experimental group) receives the treatment being tested, the other (the comparison or control group) receives an alternative treatment, a dummy treatment (placebo) or no treatment at all. The groups are followed up to see how effective the experimental treatment was. Outcomes are measured at specific times and any difference in response between the groups is assessed statistically. This method is also used to reduce bias.
RCT	See 'Randomised controlled trial'.
Receiver operated characteristic (ROC) curve	A graphical method of assessing the accuracy of a diagnostic test. Sensitivity is plotted against 1 minus specificity. A perfect test will have a positive, vertical linear slope starting at the origin. A good test will be somewhere close to this ideal.
Reference standard	The test that is considered to be the best available method to establish the presence or absence of the outcome – this may not be the one that is routinely used in practice.
Relative risk (RR)	The ratio of the risk of disease or death among those exposed to certain conditions compared with the risk for those who are not exposed to the same conditions (for example, the risk of people who smoke getting lung cancer compared with the risk for people who do not smoke). If both groups face the same level of risk, the relative risk is 1. If the first group had a relative risk of 2, subjects in that group would be twice as likely to have the event happen. A relative risk of less than one means the outcome is less likely in the first group. Relative risk is sometimes referred to as risk ratio.
Resource implication	The likely impact in terms of finance, workforce or other NHS resources.
Retrospective study	A research study that focuses on the past and present. The study examines past exposure to suspected risk factors for the disease or condition. Unlike prospective studies, it does not cover events that occur after the study group is selected.
Review question	In guideline development, this term refers to the questions about treatment

	and care that are formulated to guide the development of evidence-based recommendations.
Secondary outcome	An outcome used to evaluate additional effects of the intervention deemed a priori as being less important than the primary outcomes.
Selection bias	Selection bias occurs if: a) The characteristics of the people selected for a study differ from the wider population from which they have been drawn, or b) There are differences between groups of participants in a study in terms of how likely they are to get better.
Sensitivity	How well a test detects the thing it is testing for. If a diagnostic test for a disease has high sensitivity, it is likely to pick up all cases of the disease in people who have it (that is, give a 'true positive' result). But if a test is too sensitive it will sometimes also give a positive result in people who don't have the disease (that is, give a 'false positive'). For example, if a test were developed to detect if a woman is 6 months pregnant, a very sensitive test would detect everyone who was 6 months pregnant, but would probably also include those who are 5 and 7 months pregnant. If the same test were more specific (sometimes referred to as having higher specificity), it would detect only those who are 6 months pregnant, and someone who was 5 months pregnant would get a negative result (a 'true negative'). But it would probably also miss some people who were 6 months pregnant (that is, give a 'false negative'). Breast screening is a 'real-life' example. The number of women who are recalled for a second breast screening test is relatively high because the test is very sensitive. If it were made more specific, people who don't have the disease would be less likely to be called back for a second test but more women who have the disease would be missed.
Sensitivity analysis	A means of representing uncertainty in the results of economic evaluations. Uncertainty may arise from missing data, imprecise estimates or methodological controversy. Sensitivity analysis also allows for exploring the generalisability of results to other settings. The analysis is repeated using different assumptions to examine the effect on the results. One-way simple sensitivity analysis (univariate analysis): each parameter is varied individually in order to isolate the consequences of each parameter on the results of the study. Multi-way simple sensitivity analysis (scenario analysis): 2 or more parameters are varied at the same time and the overall effect on the results is evaluated. Threshold sensitivity analysis: the critical value of parameters above or below which the conclusions of the study will change are identified. Probabilistic sensitivity analysis: probability distributions are assigned to the uncertain parameters and are incorporated into evaluation models based on decision analytical techniques (for example, Monte Carlo simulation).
Significance (statistical)	A result is deemed statistically significant if the probability of the result occurring by chance is less than 1 in 20 ($p < 0.05$).
Specificity	The proportion of true negatives that are correctly identified as such. For example in diagnostic testing the specificity is the proportion of non-cases correctly diagnosed as non-cases. See related term 'Sensitivity'. In terms of literature searching a highly specific search is generally narrow and aimed at picking up the key papers in a field and avoiding a wide range of papers.
Stakeholder	An organisation with an interest in a topic that NICE is developing a clinical

	<p>guideline or piece of public health guidance on. Organisations that register as stakeholders can comment on the draft scope and the draft guidance. Stakeholders may be:</p> <ul style="list-style-type: none"> • manufacturers of drugs or equipment • national patient and carer organisations • NHS organisations • organisations representing healthcare professionals.
Systematic review	A review in which evidence from scientific studies has been identified, appraised and synthesised in a methodical way according to predetermined criteria. It may include a meta-analysis.
Time horizon	The time span over which costs and health outcomes are considered in a decision analysis or economic evaluation.
Treatment allocation	Assigning a participant to a particular arm of a trial.
Univariate	Analysis which separately explores each variable in a data set.
Utility	In health economics, a 'utility' is the measure of the preference or value that an individual or society places upon a particular health state. It is generally a number between 0 (representing death) and 1 (perfect health). The most widely used measure of benefit in cost-utility analysis is the quality-adjusted life year, but other measures include disability-adjusted life years (DALYs) and healthy year equivalents (HYES).

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NB The NICE abbreviations and glossary can be found on the NICE website.

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