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THE MANAGEMENT OF CHILDHOOD ASTHMA

In this manual the writer presents a complete catalog of allergic procedures so that it will be possible for the physician who treats children to give his asthmatic patients specific, positive, and lasting relief.

With an increasing number of physicians becoming interested in the allergic approach to childhood asthma, a need has arisen for a text which would embody the methods essential to the proper establishment of allergic control. It is to meet this need that this manual has been prepared.

ESSENTIAL STEPS IN MANAGEMENT are discussed:

- **Understanding the Nature of Asthma.** This involves a thorough knowledge of how allergy affects not only the bronchial tree but the child as a whole.
- **Correct Diagnosis.** There is no greater mistake than embarking on the allergic management of a disease presumed to be asthma which is not asthma at all—nothing makes the allergist appear more ridiculous.
- **Familiarity with Allergens.** The allergist must be an expert on allergens. He must know what might cause asthma, what commonly causes asthma, the sources of allergens, how they are related, when and where they are likely to appear, and how they react.
- **Accurate Detection of Allergens.** The physician enters one of the most interesting and rewarding areas of medical practice when he assumes the role of allergist-detective, and the skills developed by two generations of allergists are at his disposal to help in the search.
- **Protection of the Patient from Allergens.** Final success is not attained until the patient is properly protected from the allergens peculiar to his case.

The BASIC ALLERGIC PRINCIPLES on which these steps are founded are comparatively simple. SUCCESSFUL RESULTS depend on minute attention to details of allergic diagnosis and treatment.

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by

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THE MANAGEMENT OF CHILDHOOD ASTHMA

PREFACE

What is childhood asthma? Is it a mysterious syndrome for which there is little hope and no specific treatment? Is it a more or less harmless childhood problem which will eventually be outgrown? Is it some sort of neurosis with roots in the mother's emotional life? In spite of the fact that allergic management of asthma has proved uniformly effective, questions like these continue to be asked or implied.

In Burton's *The Anatomy of Melancholy* is found this abbreviated account of a Sixteenth Century consultation, "In Reinerus Solenander's counsels, he and Dr. Brance both agreed that the patient's disease was hypochondriacal melancholy. Dr. Matholdus said it was *asthma* and nothing else." Taking his cue from the forthright dissenting consultant, the allergist of today might add, "And it is an allergic disease and nothing else!"

With an increasing number of physicians becoming interested in the allergic approach to childhood asthma, a need has arisen for a text which would include the methods essential to the proper establishment of allergic control. It is to meet this need that this manual has been prepared. Neither this book nor any other can hope to give all the information that every physician will require in every case, but if with its use the reader can develop a sound basis for an attack against the disease, it will have fulfilled the purpose for which it was written.

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F. S.

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THE MANAGEMENT OF CHILDHOOD ASTHMA

It is one of the wonders of pediatric allergy practice that the mother of the asthmatic child is typically patient, devoted, observant, and wise. To this typical mother this book is dedicated.

She openeth her mouth with wisdom; and in her tongue is the law of kindness.—
—Proverbs XXXI: 26

"The asthma doctor must and dare not forget that his own quiet, deliberate and reassuring manner and his absolute conviction that almost all cases of asthma can be cured, constitute one of the most important prerequisites for success."

—URBACH[87,88]

Chapter 1

THE ASTHMATIC CHILD AND HIS FAMILY

ASTHMA AND THE CHILD

No matter how poor a medical term may be, once it becomes attached to a disease entity it is not likely to be replaced. This is true of malaria and angina pectoris, and it is true of asthma. An attempt to improve the term and differentiate it from cardiac dyspnea has been made by speaking of "bronchial" asthma, but this is of little help as all asthma is bronchial. It might better be called *bronchial allergy* or allergic bronchitis, but these terms have little backing and no official sanction.

Asthma may be defined as an allergic disease of the bronchioles and small bronchi characterized by edema of the mucosa, muscle spasm, and hypersecretion of mucus. The outstanding clinical manifestations are dyspnea, wheezing and cough. These phenomena occur in attacks, separated by intervals of more or less relief. Although spontaneous remission is not unknown in asthma, it is essentially a chronic disease which if untreated usually leads to progressive loss of vital capacity and emphysema. It is a common disease of childhood and is found at all ages.

Asthma seldom if ever occurs as an isolated allergic manifestation. The patient is, allergically speaking, "sick all over," asthma representing only one of many allergic manifestations. For uniformly successful results in this disease the physician must identify *all* allergic manifestations and *all* responsible allergens.

The young child does not seem unduly disturbed by his asthma. He is aware of his heaving chest and can hear his wheezing, but it does not seem to occur to him that everyone is not affected in the same way. As he grows older he begins to see that he is different, that he is under certain restrictions, and receives special consideration from others. With this new awareness comes the urge to get well. It is a source of continual surprise to allergists to note how early in life their little patients accept the restrictions and discomfort of allergic management. In watching their diets they are often more alert than their mothers, and where hyposensitization is given, they accept their "shots" with remarkable cheerfulness and fortitude.

THE FAMILY

A surgeon repairing a hernia does not invite the family in to assist him. A physician dealing with an asthmatic child, however, must do just that, and his success depends very much on his ability to gain the confidence of the parents and enlist their cooperation. To gain their confidence he must understand how they feel about their child, and to enlist their cooperation he must educate them in the fundamentals of allergy and asthma.

The Parents' Feelings

The most significant reaction of parents on becoming aware that their child has asthma is fear. They have probably known of asthma among their acquaintances, and they think at once of the most serious case in their experience. The "asthma" they have known may well have been any one of a number of other chest diseases, but the word still strikes fear to the heart and often leads to dismay and panic. With the passage of time the attacks are inclined to become increasingly severe, and the desire to escape from so frightening a situation is often overpowering, leading to the urge to flee to some supposedly ideal climate. Such flight not infrequently takes place, often at the price of family disruption and financial ruin.

The child, then, is often the center of a taut emotional situation, and no matter how calm the surface, it is well to proceed on the assumption that all is not well within. The mother is certain to have had extensive and gratuitous advice from all sorts and conditions of people, and has almost certainly been assured by someone that the whole problem stems from the fact that her child is unwanted and rejected. In her unhappy and bewildered condition she may half way accept this cruel judgment, and with her original problem complicated by guilt and frustration, her misery may have been heightened to an almost unbearable extent.

If the physician sees that he is dealing with a family whose integrity is threatened by the emotional by-products of asthma, he has an opportunity to do much to restore it. When the parents learn that he is fully aware of their feelings and looks upon them with sympathy and understanding, the way is clear for their self confidence and poise to return. If he then proceeds to embark on a tireless campaign against the child's disease, even though progress be slow and uneven, he can look for patience and trust in his relations with the family.

Parent Education

The allergist works mainly with the mother of the asthmatic child, and he should teach her all she is capable of learning about allergy and asthma, withholding nothing that will make for better management of the disease.

She should know something of:

(1) The theory of allergy.

(2) The nature of asthma.

(3) The common causes of asthma.

(4) How the causes are detected.

(5) The limitations of skin testing.

(6) What to do in case of an attack.

(7) How long it will probably take to achieve control.

(8) Special factors applicable to her child.

Much of this information she can pass on to her husband, and all of it to her growing child. No fear need be felt that the mother will "go off on her own" in treatment. Some women do this anyway, and the better she understands allergy and asthma, the less tempted she will be to experiment with irrational methods.

An excellent booklet for family education, *Allergy in Children,* is now available through the American Foundation for Allergic Diseases, Inc., 274 Madison Avenue, New York 16, New York.

Chapter 2

THE DIAGNOSIS OF ASTHMA

It is impossible to exaggerate the importance of careful diagnosis in the child with dyspnea, wheezing, or cough. It is the responsibility of the allergist to determine if each case is *really* asthma and *only* asthma. The three essentials in diagnosis are:

(1) The presence of the typical clinical picture.
(2) The presence of associated allergic traits.
(3) Differential diagnosis.

THE CLINICAL PICTURE

An attack of asthma characteristically begins with sneezing, nasal discharge, and a dry cough. As the attack develops the cough becomes steadily more severe and frequent, and wheezing and dyspnea rapidly set in. It is soon apparent that the distress of the child is great. This is reflected in his anxious expression, labored breathing, and pale, clammy skin. In severe attacks the lips may be cyanotic, especially in young children, and further evidence of oxygen-want may include restlessness, irritability, and even delirium. The patient's efforts are soon concentrated on breathing, and this, with his frequent inability to take fluids, leads to progressive weakness and dehydration. Vomiting is common and may, as Ratner[66] has pointed out, bring a measure of relief. If it is prolonged, however, it further interferes with respiration and greatly aggravates dehydration and fatigue.