



# The Official Position Statement from the Saudi Pediatric Pulmonology Association on How to Treat Paediatric Asthma in the COVID-19 Period (SPPA)

Smith CA\*

Department of Psychiatry and Behavioural Sciences, Oklahoma State University Center for Health Sciences, USA

## Abstract

Coronaviruses are a large family of contagions that infect humans, which may affect in mild symptoms analogous to those of the common cold wave. COVID- 19 is most recent subtype analogous or indeed worse than the two former epidemic strains which were the severe acute respiratory pattern coronavirus (SARS- cov) and the Middle East respiratory pattern coronavirus (MERS- cov). The first cases of COVID- 19 surfaced in December 2019. Since also, the contagion causing the complaint has infected further than four million people around the globe and led to hundreds of thousands deaths. We suppose addressing the operation of asthma in the period of this epidemic is important for several reasons high frequency of asthma in Saudi Arabia, further, majorities were unbridled complaint. The statement will give special instructions and answers to common questions of croakers dealing with asthmatic children during this epidemic.

**Keywords:** Asthma; COVID- 19; Saudi pediatric pulmonology association (SPPA)

## Introduction

Coronaviruses are a large family of contagions that infect humans as well as other mammals. There are seven strains that infect humans. The common and fortunately less serious strains are hcov- OC43, hcov- HKU1, hcov- 229E and hcov- NL63. Infections with these contagions generally affect in mild symptoms analogous to those of the common cold wave. Still, infections with the other three strains lead to more severe conditions; they're MERS- cov, SARS- cov and the lately discovered SARS- cov- 2, which is substantially known by the complaint it causes, COVID- 19 [1]. The first cases of COVID- 19 surfaced in December 2019. Since also, the contagion causing the complaint has infected millions around the globe and led to death of hundreds of thousands of people. In Saudi Arabia, the first case of COVID- 19 was verified on March 2, 2020. Since also, the complaint has been checked (with strict intervention), and the cases aren't inviting healthcare installations. For unknown reasons therefore far, COVID- 19 is substantially affecting grown-ups further than children. In a composition from China, it was reported that 2.1 of all verified cases were children lower than 19 times of age. Also in Italy, the prevalence was roughly 1.4. While no children youngish than 19 failed in Italy, one child failed in China. The ideal of this statement is to give special instructions and answers to common questions of croakers dealing with asthmatic children during this epidemic.

## Material and Methods

We searched pubmed up to May 2020 using the following words in different combinations asthma, exacerbation, COVID- 19, inhalation, nebulizer, and steroid. Search sludge include publications in the last 2 times, mortal species, and age lower than 18 times. With these quests, 30 were linked. All were included. Many Guidelines were published for this was intensely reviewed. We understood common the Epidemic COVID- 19 and does it affect modalities of treatment of asthma or asthma exacerbation. The substantiation was inspired from the recommendations in the center of substantiation- grounded drug [2].

## Concern during the epidemic

There are numerous enterprises raised by both parents and

health care providers in how to treat asthma during the epidemic, the following are the main enterprises

Do children with asthma have an advanced threat to be infected with COVID- 19?

The answer so far is no. In a series of severe COVID- 19 adult cases in Wuhan, 0.9 had asthma, while the population frequency of asthma was 6.4. In another civil study in China, they set up that 25 of 1590 admitted cases had comorbidities, and none of them had asthma.

## What are the objects of managing asthma cases during the COVID- 19 epidemic?

There are no substantial differences from the usual guidelines. The hallmark of "control" remains the same, with the ideal of treating with minimum drug, exercising a step up, step down approach. Still, the current COVID- 19 epidemic made access to care more grueling. We advise that cases be kept on the minimum quantum of regulator remedy and to avoid withholding the regulator remedy. It's imperative to reiterate that the situation is evolving and that further data will crop overtime. Likewise, families should be educated about the habitual nature of asthma and the significance of adherence. The ways of the recommended device (s) should be reviewed. Families should also be advised to check their drug force [3].

A Written Action Plan (WAP) is a tradition that helps cases and their caregivers to use the specifics grounded on cases' symptoms. Such

**\*Corresponding author:** Smith CA, Department of Psychiatry and Behavioural Sciences, Oklahoma State University Center for Health Sciences, USA, E-mail: Smith\_C.A.@sg.co.edu

**Received:** 01-Feb-2023, Manuscript No: JPRD-23-89880, **Editor assigned:** 03-Feb-2023, PreQC No: JPRD-23-89880 (PQ), **Reviewed:** 16-Feb-2023, QC No: JPRD-23-89880, **Revised:** 21-Feb-2023, Manuscript No: JPRD-23-89880, **Published:** 28-Feb-2023, DOI: 10.4172/jprd.1000121

**Citation:** Smith CA (2023) The Official Position Statement from the Saudi Pediatric Pulmonology Association on How to Treat Paediatric Asthma in the COVID-19 Period (SPPA). J Pulm Res Dis 7: 121.

**Copyright:** © 2023 Smith CA. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

a plan was set up to drop asthma exacerbations and to affect in better adherence to specifics. We largely suggest using a WAP during this epidemic. The general public recommendations during this epidemic should be followed. Social distancing and hand hygiene should be rehearsed. The curfew and staying home may expose children to unresistant smoking; addressing the ultimate with caregivers is warranted.

### What are the differences between common cold wave, influenza and COVID- 19?

Viral ails are the most common detector of asthma in children. These common respiratory infections can be veritably delicate to separate from COVID- 19. They all affect the respiratory tract, and they've analogous symptoms, especially in the first stages [4]. While seasonal flu and COVID- 19 give you respiratory symptoms as well as gastrointestinal (GI) symptoms, common snap will infrequently affect in diarrhea or other GI symptoms. Fever is a common symptom of all infections. Still, fever was a main incarnation of COVID- 19, and interestingly, advanced and further patient complications were noticed in severe cases. Other symptoms similar as anosmia, briefness of breath, casket pain, headache, fatigue, skin rash, and red eyes, among others, were reported. Likewise, the timelines of these symptoms vary, and therefore far, they're changeable. As an illustration, some cases won't have a fever for many days while having watery nose only. In a series of eight severe pediatric cases, tachypnea was set up in all cases, while fever and cough were set up in only six cases [5].

### Shall we continue using gobbled corticosteroids?

Gobbled corticosteroids (ICS) are the main regulator remedy and are superior to all other anti-inflammatory regulator curatives. Still, there have been some enterprises about the possible dangerous effect of systemic steroids on cases with COVID- 19. These enterprises were substantially grounded on compliances during the 2003 SARS outbreak, which led to some debates in the medical community about the use of steroids in cases with COVID- 19. Still, numerous recent studies, especially concerning critically sick cases, are probative of the conservative use of systemic steroids. Obviously, these enterprises are projected toward the systemic, and not the inhalational, use of steroids. We suppose that the benefits of ICS controlling asthma outweigh the theoretical pitfalls. Thus, we largely suggest continual use of ICS as the dependence regulator remedy. Likewise, antipathetic rhinitis is a common comorbidity of asthma. The European Academy of Allergy and Clinical Immunology (EAACI) recommend continued use of nasal steroids for cases with antipathetic rhinitis (AR) [6].

### What about oral steroids?

The use of oral steroids as a conservation remedy is veritably rare in children, and similar cases are followed by an asthma specialist. Still, short courses of steroids are constantly used as a deliverance remedy in asthma exacerbation. The apparent threat with steroids is far lower than the benefits of aborting an exacerbation. Thus, we suggest continuing the practice of defining suddenly course of steroids if clinically indicated. We suggest defining the lower range of the cure (0.5 mg – 1 mg per kilogram per day, prednisolone fellow) [7].

### Can asthma cases continue using nebulization?

Nebulization is a process where a liquid is converted into small liquid driblets suspended in air, or what's called aerosol. The contagion can remain suspended in air for over to two hours, which carries the threat of transmitting pathogens to others. Still, this observation was

performed in an exploration lab and wasn't replicated in real life.

Nearly all asthma guidelines recommend using metered cure inhalers (mdis) with a spigot holding chamber (VHC) or dry greasepaint inhalers rather than nebulization. Thus, following similar guidelines during this epidemic seems logical and potentially safer. We suggest avoiding the use of nebulization at homes. However, conservative use in a private area and no way participating the machine with others are advised, If the volition isn't doable [8].

On the other hand, nearly all health institutions across the country use nebulization as the mode of aerosolizing specifics. For the once many times, numerous institutions around the world have espoused using mdis with vhcs rather of nebulization. This is grounded on the fact that the two inhalation ways yield analogous clinical scores and issues.

Thus, we suggest using mdis with the applicable vhcs rather of nebulization in health institutions. This is of particular significance in the settings of acute care where the possibility of viral cross-infections is high. Obviously, the VHC shouldn't be participated. Of course, some exceptions will arise, similar as severe asthma exacerbation, uncooperative cases or those with dropped situations of consciousness. However, applicable insulation should be maintained, and healthcare providers should wear the recommended particular defensive outfit (PPE), if nebulization is carried out. The Saudi Initiative for Asthma (SINA) in collaboration with The Saudi Thoracic Society (STS) and its attachment Saudi Pediatric Pulmonology Association (SPPA) have released a public statement on asthma operation of adult and children during the COVID- 19 epidemic that includes preferencing the use of mdis with the applicable vhcs rather of nebulization [9].

### What about follow up?

As the current COVID- 19 epidemic limited the access to routine inpatient visits to asthma conventions, indispensable ways of remote follow up is recommended. Virtual clinic, phone calls, and other means of telemedicine should be employed to maintain durability of care for asthmatic cases. Access to specifics should be assured

### Conclusion

The current epidemic of COVID- 19 in children is frequently a mild and tone-limited complaint but, the epidemic have changed numerous medical practices for both cases and health care providers. Among these changes concern cases with asthma where nebulization should be confined due to the concern on aerosolization of coronavirus and the spread of infection therefore for this reason, it should be avoided in an exigency setup. The prophylaxis should continue as planned, asthma action plan should be handed, and MDI and spacer in the favored way for bronchodilator and spirometry should be avoided [10].

### Conflict of Interest

The authors have no conflicts of interest to expose.

### References

1. Gutiérrez PC, Alegría JG, Farriols RP, Michavilla IA, Menéndez SA, et al. (2010) [Consensus for hospital discharge reports in medical specialities]. *Med Clin (Barc)* 134: 505-510
2. Murray CJL, Lopez AD (1997) Alternative projections of mortality and disability by cause 1990–2020: Global Burden of Disease Study. *Lancet* 349: 1498-1504.
3. Lopez AD, Mathers CD, Ezzati M, Jamison DT, Murray CJL (2006) Global and regional burden of disease and risk factors, 2001: Systematic analysis of population health data. *Lancet* 367: 1747-1757.

4. Dimick JB, Welch HG, Birkmeyer JD (2004) Surgical mortality as an indicator of hospital quality: the problem with small sample size. *JAMA* 292: 847-851.
5. Becker G (2004) Deadly inequality in the health care "safety net": uninsured ethnic minorities' struggle to live with life-threatening illnesses. *Med Anthropol Q* 18:258-275.
6. Guyatt G, Cairns J, Churchill D, Cook D, Haynes B, et al. (1992) Evidence-based medicine. A new approach to teaching the practice of medicine. *JAMA* 268: 2420-2425.
7. Davidoff F (1999) Standing statistics right side up. *Ann Intern M* 130: 1019-1021.
8. Isaac T, Zaslavsky AM, Cleary PD, Landon BE (2010) The relationship between patients' perception of care and measures of hospital quality and safety. *Health Serv Res* 45:1024-40.
9. Peto R, Lopez AD, Boreham J, Thun M, Heath JC, et al. (1996) Mortality from smoking worldwide. *Br Med Bull* 52: 12-21.
10. Roberts CM, Lowe D, Bucknall CE, Ryland I, Kelly Y, et al. (2002) Clinical audit indicators of outcome following admission to hospital with acute exacerbation of chronic obstructive pulmonary disease. *Thorax* 57: 137-141.