Methods: Data analysed from twenty- two admissions coded as acute asthma exacerbation. Data collected using a proforma provided by BTS.

Results: Compliance via documentation of an asthma management plan was inadequate especially for admissions under a non- respiratory paediatrician. Confirmation of recording for inhaler technique and provision of information leaflets were better. Most children admitted had a chest x-ray, a majority of which were inappropriate. A minority of children discharged had hospital follow- up (mostly to a paediatric respiratory physician).

Conclusions:

1. Compliance with BTS guidelines for initial management of paediatric acute asthma was good (i.e. patient assessment and stabilisation). However, very few patients received an asthma management plan- 27%.

2. Outcomes should improve by adopting and implementing a within- department 'tick-box' proforma to include an asthma plan, efficiency of inhaler technique, asthma prophylaxis and follow-up arrangements.

3. A repeat audit is planned in six months.

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AUDIT OF THE USE OF A WRITTEN ASTHMA ACTION PLAN IN A BUSY PEDIATRIC UNIT

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Background and aims: A written action plan (WAP) is recommended for all patients with asthma, particularly those who have moderate or severe exacerbations, frequent or poorly controlled asthma.

Our hospital introduced a new WAP 1 year ago, which we are now auditing. The WAP should be provided to all pediatric asthma patients on discharge.

Methods: A retrospective audit was carried out identifying all asthmatic patients admitted to the pediatric ward during November 2009. Patient's notes were pulled and checked for the presence of a WAP. When a WAP was present it was assessed for completeness using a questionnaire.

Results: 29 asthmatic patients were discharged from the pediatric ward from 1st through 30th November.

20 of these admissions were with asthma, 1 patient was admitted twice. A WAP was identified in 3 of the patients' charts. The WAP was complete in 1 case and incomplete in 2 cases. In an additional 3 cases the nursing staff documented that the patient was discharged home with a WAP, although a copy of the WAP was not found in the notes.

Conclusions: The BTS guidelines for the management of asthma, including provision of a WAP for all patients with moderate to severe asthma, should be reviewed with each new group of doctors biannually. The WAP, the patient's notes and the kardex should state which asthma medications the patient is taking and their doses. The dose of rescue steroids for home use should be stated on the WAP if prescribed.

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ASTHMA AND ASSOCIATED ATOPIC DISEASES IN CHILDREN

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Objective: To evaluate clinical characteristics of asthma and asthma's association with other atopic diseases: allergic rhinitis (AR), allergic conjunctivitis (AC), and atopic dermatitis.

Methods: One hundred children with asthma (not hospitalized) were included in the study starting from 2006 until 2009. The Asthma was diagnosed using GINA criteria and allergic rhinitis by ARIA recommendations. Anamnestic data, clinical findings, as well as routine and specific examinations were also used in the study.

Results: The average age of children with asthma was 11.76 $\pm$ 0.09. Thirty percent of children who participated in the study had intermittent asthma. 66% percent had mild and moderate persistent asthma, and four percent of children had severe persistent asthma. 60% of children with asthma had allergic rhinitis. Intermittent AR was diagnosed in 12/60 children with asthma, and 50% of them had moderate severe allergic rhinitis.

Persistent AR was diagnosed in 48/60 children and 35% of them had moderate severe persistent AR. All children with severe persistent asthma (AS) had moderate severe persistent AR as well. The leading symptoms in children with AR were sneezing, nasal obstruction, nasal secretion, and coughing. 52%