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Managing Severe Asthma: 2026 GINA Strategy Report Recommendations

Dr. Turck:
This is *Clinician's Roundtable* on ReachMD, and I'm Dr. Charles Turck. Today, we're reviewing the key elements of the 2026 strategy report from the Global Initiative for Asthma, commonly referred to as GINA, and how we can apply them to severe asthma management. Joining me in this discussion is Dr. Jonathan Bernstein, who's a Professor in the Division of Allergy and Immunology at the University of Cincinnati, where he's also the current Director of the Allergy Laboratory. Dr. Bernstein, thanks for being here today.

Dr. Bernstein:
Thank you for having me.

Dr. Turck:
Well, to get us started, Dr. Bernstein, once we confirm the presence of severe asthma, the next critical step, according to GINA 2026, is determining type 2 inflammation based on biomarkers like levels of fractional exhaled nitric oxide, or FeNO, and blood eosinophil count. What do the thresholds of these biomarkers actually tell us, and what are the most important limitations to keep in mind when using them?

Dr. Bernstein:
Well, an important development in asthma over the last several years is having a non-invasive biomarker like exhaled nitric oxide. And we have an understanding of why we have elevated FeNO in patients with severe asthma. It does indicate that this is the body's way of actually trying to produce nitric oxide. It's a bronchodilator, but it actually is a marker of inflammation, so it indicates when it goes up that there's more inflammation. And we know that if it's over 50 parts per billion in adults or over 35 parts per billion in children, that that suggests that there's significant inflammation, and that's a key marker.

Now, there are things that can affect it, like smoking, and inhaled corticosteroids can reduce the levels and so forth. But for the most part, if you have someone coming in who has asthma who's not well controlled, this is a very important adjunct tool for defining whether they have predominant airway inflammation versus smooth muscle dysfunction, which is usually something we see when we do spirometry and do reversibility before and after with a short-acting bronchodilator.

Dr. Turck:
Now, in addition to supporting a diagnosis of type 2 asthma, the update states that type 2 biomarker levels may be used to predict a patient's response to biologic therapy. So how do blood eosinophil count and FeNO guide your decision to pursue a biologic agent, and where does anti-TSLP fit for patients who don't present with a clear type 2 high profile?

Dr. Bernstein:
Yeah. So again, these are indicators that there's inflammation. Eosinophilic inflammation is a specific type of inflammation, and certainly, we have biologics that target the cytokines that drive eosinophilia—IL-5—and then we can also use IL-5 receptor blockers. They both work in patients with a certain level of eosinophilia. And they've been very effective in that population.

TSLP's also effective. It works in patients who have lower numbers of eosinophils, I think, so that's potentially an advantage. It may work in low-T2 inflammation and not just in patients who have a lot of airway inflammation. This is an important cytokine that's released from epithelial cells in the airways, and it's called an alarmin. And blocking TSLP has been shown to be very effective in this regard.

Dr. Turck:
Now, before a clinician should even consider a biologic agent, GINA 2026 strongly states that several common problems must be

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addressed first, including poor inhaler technique and lack of adherence to therapy. So with that being said, would you walk us through your approach to optimizing inhaled therapy and distinguishing truly severe asthma from difficult-to-treat asthma?

Dr. Bernstein:
Well, that can be very challenging, and it's very important not to skip these important steps. We are diagnosing asthma through proper spirometry showing adequate reversibility to make the diagnosis, but sometimes, patients don't reverse and they don't even have airway obstruction. We have to do provocation testing, like methacholine challenge, which is another way of bringing out asthma and showing if patients have smooth muscle airway dysfunction. And not everybody has access to an exhaled nitric oxide machine in their office, so that can also be problematic.

Looking at peripheral eosinophils in the blood can be helpful, but it's not always completely specific, and rarely do clinicians get induced sputum to look for eosinophils in their office. So we just sometimes are limited, but I certainly think it's still very possible to make an objective diagnosis and characterize patients. Another important part of that is to assess their allergic status to see if they're atopic or not because allergic asthma might behave a little bit differently than patients who have non-allergic asthma.

But once we establish that, we want to provide proper treatment, and inhalers are very useful. We want to make sure their inhaler technique is good. Some people can master it without using a spacer device, but children and even some adults and older individuals might need help. And a spacer device allows a coordinated actuation of the medication so that it's delivered properly into the lungs and not into the posterior pharynx.

We do other things to assess adherence; we ask patients to use patient-reported outcome measures, like the Asthma Control Tests. Some of these are downloadable on apps. They could track their response. Sometimes, we recommend using a peak flow. If they're instructed on how to use a peak flow meter at home, they can monitor their peak flows and see that they're responding. But a lot of patients aren't that interested in doing these other things, and that's why we have to follow patients up to make sure that they are clinically improving, that their symptoms are improving, that their lung function's improving, and that—if we have access to exhaled nitric oxide—their FeNOs are decreasing appropriately.

Dr. Turck:
For those just tuning in, this is *Clinician's Roundtable* on ReachMD. I'm Dr. Charles Turck, and I'm speaking with Dr. Jonathan Bernstein about the 2026 Global Initiative for Asthma, or GINA, strategy report and its recommendations for the management of severe asthma.

Now, if we continue examining the latest recommendations, Dr. Bernstein, the decision tree for adding biologic type 2-targeted treatments was specifically updated to give clearer guidance on what to consider when choosing between classes. So how do factors like comorbidities, dosing frequency, and patient preference fit into your approach to shared decision-making?

Dr. Bernstein:
We certainly want to give patients options, and we also have to assess their preferences and values when we think about this concept of shared decision-making. And patients need to know what is going on with their asthma—you know, what kind of asthma do I have? What's new about my asthma? What other comorbidities could potentially affect my asthma? Do they have rhinitis? Do they have rhinosinusitis? Do they have obstructive sleep apnea? Are they obese or have a history of reflux? All of these factors can certainly affect asthma control, so those have to be addressed in order to make sure their asthma's well controlled before you start thinking of a biologic. And we know about the concept of the united airways—how the upper respiratory tract can affect the lower respiratory tract—so we shouldn't forget about nasal allergic rhinitis, non-allergic rhinitis, and rhinosinusitis.

So if we can establish good control, typically, their Asthma Control Test will be very high. They won't be using their rescue medicine. They're not going to be impeded by their daily activities. They're going to be able to go to school or work or on vacation and so forth. But there are those patients who continue to be symptomatic despite good inhaler technique, adherence with medications, and control of their other comorbid illnesses. And this is when we start to think about these advanced therapeutics and biologics, and then based on their clinical characteristics, phenotypes, and supporting objective tests, we would make recommendations accordingly. And the ones that are available are omalizumab, which blocks IgE in the peripheral blood, dupilumab, which blocks the critical cytokine IL-4 alpha—it's a common chain between IL-4 and IL-13—IL-5 antagonists like mepolizumab and a longer-acting one called depemokimab, benralizumab, which is an IL-5 receptor antagonist, and tezepelumab, which is a TSLP antagonist.

Dr. Turck:
Now, the report also suggests that continued reliance on oral corticosteroids and triple inhaled therapy may expose patients to added risks without substantial benefit, whereas biologics improve outcomes across multiple measures. From your vantage point, what does the guidance reinforce about the need for timely biologic intervention?

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Dr. Bernstein:
Well, we certainly don't want to have patients taking oral corticosteroids for prolonged periods of time or recurrently because there is a cumulative effect to the body. It affects a number of different organ systems. Not only does it increase appetite and weight, but it can cause problems with glucose intolerance in people who are predisposed to that. It can cause glaucoma and cataracts. It can cause bone loss. It has a lot of major side effects, and as I said, it is cumulative over time, so even though patients may not be on it every day, if you take multiple courses throughout your life, there's that cumulative effect.

So I think that this is a reason why advanced therapeutics are recommended to give patients more stability. I think of it as a parabolic curve. I don't want them going up and down. I want a nice, flat, controlled condition. This is what we want so patients can do whatever they need to do and not be disrupted in their daily activities.

Dr. Turck:
To close, Dr. Bernstein, GINA 2026 connects clinical remission on treatment with long-term management goals, particularly in patients receiving biologic therapy. Given that framing, what baseline factors make remission more likely, and how should we talk to our patients about that?

Dr. Bernstein:
Well, that's a tough question because remission depends on how you define it. Is it remission on therapy or off therapy? And that's an ongoing debate, and there are several position statements out there accordingly. But I think that at least in my own clinical experience and also knowing how these therapies work, I'm not really seeing a lot of severe asthmatics anymore because the ones that were severe are well controlled on advanced therapeutics. So these really difficult-to-treat patients have become much less difficult.

And I think the problem becomes making sure they come in a couple of times a year just to make sure their lung function's stable and that they're not having any subclinical problems that they don't recognize. And so they do still need to be monitored, but patients feel so good that they don't want to come in and get assessed. So that's where we are.

So I do think that we're in a new age where now we can really effectively control asthma. Before we were managing it fairly well, but there was a lot of associated morbidity and still quite a bit of mortality associated with the disease. So I think we're going in the right direction with the understanding of the pathogenesis of the disease and the therapies that we've developed as a result.

Dr. Turck:
Well, as those final comments bring us to the end of today's program, I want to thank my guest, Dr. Jonathan Bernstein, for joining me to share his insights on the 2026 Global Initiative for Asthma Strategy Report for Asthma Management and Prevention. Dr. Bernstein, it was great speaking with you today.

Dr. Bernstein:
It was a pleasure speaking with you as well. Thank you very much.

Dr. Turck:
For ReachMD, I'm Dr. Charles Turck. To access this and other episodes in our series, visit *Clinician's Roundtable* on ReachMD.com where you can Be Part of the Knowledge. Thanks for listening!

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