Duke Asthma, Allergy, and Airway Center

Patient Instructions for Methacholine Challenge

The Methacholine test has been ordered by your doctor to help diagnose your breathing problem. The test is a series of nebulized treatments containing Methacholine followed by a series of breathing tests called Spirometry. Please allow up to 2 hours for this test.

In preparation for this test, there are certain medications, foods and beverages that you must avoid.

**One week before the test**
Do not take **Spiriva**

**3 Days before the test**
Do not take **Cetirizine (Zyrtec), Hydroxyzine, Fexofenadine (Allegra), Loratadine (Claritin, Alavert), Levocetirizine (Xyzal), and Desloratadine (Clarinex.)**

**48 hours before the test**
Do not take the following medications: **Serevent, Foradil, Dulera, Advair, and Symbicort.**

**24 hours before the test**
Avoid all foods, beverages and medications containing **Caffeine**, which includes coffee, tea, chocolate, most soft drinks and some over the counter migraine medicines.

Do not take the following medications **Singulair, Accolate, Zyflo, Theophylline, Atrovent, Combivent, Duoneb and Sudafed.**

**8 hours before the test**
Do not take the following medications: **Albuterol, ProAir, Proventil, Ventolin, Maxair, Xopenex, Intal, Cromolyn Sodium and Alupent.**

**Warning:** Please notify your doctor immediately if you are taking a medication called a beta blocker, such as, **Propranolol (Inderal), Atenolol (Tenormin), Labetalol, Metoprolol (Lopressor, Toprol), Nebivolol (Bystolic), Carvedilol (Coreg) and Nadolol (Corgard.)** These medications are for heart/high blood pressure.

Please notify the respiratory therapist performing your test if you are currently taking Prednisone.

By signing this form, you are indicating that you understand the above instructions concerning food and medication restrictions.

If you have any questions or concerns, please call (919) 620-7300 and ask to speak to someone in the Pulmonary Function Lab. We look forward to your visit.

Signature_________________________________________________

Medical Record Number_____________________________________

Date ____________________________________________________

Witness ___________________________________________________