Sent: 26 February 2007 23:17
To: Seren Phillips
Subject: Corticosteroids in children under 12

Dear Ms Phillips

Having received an 'out of office' reply from Alana Miller's email I am forwarding this to you.

Warren Lenney

Dear Ms Miller

You will already have received comments via the Royal College of Paediatrics from Rob Primhak, the Chair of The British Paediatric Respiratory Society. I believe that I am a consultee/commentator in my role of Chair of the BPRS Research Committee. I hope you find the following comments helpful:-

1. The review is very comprehensive but it clearly shows the lack of studies in corticosteroid therapy for children with asthma.

2. Most paediatric respiratory specialists believe that the GINA classification of intermittent, mild, moderate and severe persistent asthma is probably not applicable to children.

3. One of the recommendations for future studies is a head-to-head study comparing combination therapy inhalers with medicdations in separate inhalers. To show any differences here is likely to require huge numbers of children and if the study was double-blind it would not be applicable to translate into clinical practice.

4. Dr Primhak is correct in that the NICE literature search failed to pick up the study by Verberne et al (AJRCCM 1998; 158: 213-19). The problem with this study was that it used lung function as entry criteria but the mean FEV1 on entry for the 169 patients was 89% expected for height. In the corresponding adult studies the entry criterion of FEV1 was 74% and 72%.

5. I agree that new outcome measures need to be looked at for paediatric studies but, as indicated in point 4, entry criteria need also to be scrutinised.

6. The SIGN guidelines are quoted in which LABAs are the recommended first add-on therapy in the over 5s and leukotriene receptor antagonists are the recommended first add-on therapy in the under 5s. The evidence base for these statements is extremely weak.

7. The aim of the report was to compare the efficacy and cost effectiveness of different inhaled corticosteroids. Some would argue that a better way of comparing

different medications would be to look at the efficacy/safety ratio and I don't think this was discussed in any depth in the report.

8. Although the report recommends studies evaluating HR QoL and symptoms as outcome measures more relevant to patients, these in themselves vary from patient to patient depending on that patient's tolerance and indeed the tolerance of the rest of the family. A high achiever with sporting prowess will score very differently on the above to a more sedentary child with little interest in sport.

I hope these comments are helpful.

Yours sincerely