Treatment of severe steroid dependent preschool asthma with nebulised budesonide suspension

P Ilangoan, S Pedersen, S Godfrey, K Nikander, N Noviski, J O Warner

Abstract
The steroid sparing effect of nebulised budesonide suspension was assessed in a double blind placebo controlled parallel group study of 36 preschool children with severe asthma who were dependent on treatment with oral steroids. Nebulised budesonide suspension significantly reduced the requirement for treatment with oral steroids, and produced a marked improvement in overall health as scored on a visual analogue scale during the clinic visits. This study shows a significant step forward in the prophylactic treatment of asthma in children under the age of 3 years, in whom the efficacy of many other nebulised treatments has been questioned.

(Arch Dis Child 1993; 68: 356–359)

Severe asthma in infancy poses many problems. Diagnosis is usually made on history alone, as lung function measurements require sophisticated equipment and expertise. Although studies in children under 2 years of age have given predominantly negative results for most standard treatments for asthma, clinical experience suggests that such treatments should be tested in these children. Following this schedule a small number of infants with repeated hospital admissions for severe acute asthma attacks become dependent on treatment with oral steroids.

As inhaled corticosteroids of high topical potency and low systemic activity have been shown to be successful in controlling severe asthma in older children and adults, their application by nebuliser for infants has been an obvious development. The results with beclomethasone dipropionate suspension, until recently the only corticosteroid available for nebulisation, have been disappointing, however. The poor response in these studies may have been related to the low drug concentrations used (50 μg/mL), to a small fraction of ‘respirable’ particles of beclomethasone dipropionate suspension for nebulisation, and the inclusion of infants with less severe asthma. Thus infants with severe asthma have continued to require oral steroids predominantly administered in a single dose on alternate days. The present study was performed to determine if nebulised budesonide suspension could be used as an alternative to this dose regimen in children with severe asthma who are dependent on steroids. In the first instance it was felt that only patients with severe disease should be studied to ascertain efficacy, thus it was necessary to set up a trial at three institutions with a special interest in childhood asthma.

Patients and methods
The study group consisted of children with severe asthma who were dependent on steroids, aged less than 5 years, and who had had recurrent, persistent symptoms of cough or wheeze, or both, which were not controlled by conventional non-steroidal prophylactic treatment despite correct use for at least two months before entry to the trial. The principle enrolment criterion was a dependency on a minimum of 0.75 mg/kg prednisolone on alternate days for at least four weeks before the trial. Children with cardiorespiratory disease other than asthma or families who could not comply with the protocol were excluded.

The design of the study was double blind placebo controlled with parallel groups. The children were enrolled from three centres: the Royal Brompton National Heart and Lung Hospital in London, the Hadassah University Hospital in Jerusalem, and Kolding Hospital in Kolding, Denmark.

After a run in period where the dose of oral prednisolone was adjusted to the minimum required to stabilise the disease, the children were randomly allocated to either the active budesonide or placebo group. During the eight weeks of treatment with the study drug, the dose of oral prednisolone was adjusted at weekly intervals according to the clinical state of the patient. This was evaluated by weekly telephone conversations based on information from diary cards and monthly visits to the clinic. The aim was to reduce the dose of prednisolone by 25% of the dose at the end of each week provided the child was symptom free during the previous week, or was less symptomatic than the previous week requiring nebulised bronchodilators no more than once a day.

The parents completed a daily diary card record of symptoms (Table 1), number of doses of β agonists used and the oral steroids taken. Every four weeks parents gave a score between 0 and 10 (very symptomatic to totally symptom free) on the visual analogue scale based on their

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Daily diary card giving the symptom scores for day and night symptoms (0 = asymptomatic; 3 = very symptomatic)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variables</td>
<td>Score</td>
</tr>
<tr>
<td>Night symptoms</td>
<td></td>
</tr>
<tr>
<td>Completely peaceful</td>
<td>0</td>
</tr>
<tr>
<td>Restless with cough, not woken</td>
<td>1</td>
</tr>
<tr>
<td>Woken one or two times with cough or wheeze, or both</td>
<td>2</td>
</tr>
<tr>
<td>Woken more than two times with cough or wheeze, or both, needing extra nebulisers</td>
<td>3</td>
</tr>
<tr>
<td>Day symptoms</td>
<td></td>
</tr>
<tr>
<td>Completely well</td>
<td>0</td>
</tr>
<tr>
<td>Occasional cough, no extra treatment</td>
<td>1</td>
</tr>
<tr>
<td>Needed no more than one extra nebuliser</td>
<td>2</td>
</tr>
<tr>
<td>Needed more than two nebulisers</td>
<td>3</td>
</tr>
</tbody>
</table>
impression of the child's asthma symptoms and
the need for extra bronchodilators during the
week preceding the clinic visit (health score).

The double blind trial was followed by an open
follow up period of a further eight weeks during
which the children from the placebo group were
treated with budesonide suspension. Children
receiving active budesonide continued this treat-
score based on the visual analogue scale completed by the parents during the clinic visits (p<0.01) (fig 1) in favour of the group receiving active treatment. Similarly, there was a significant difference (p<0.05) in the reduction in the dose of oral prednisolone in the group receiving active treatment (fig 2) at the end of study period (80% reduction) compared with the placebo group (41% reduction). Furthermore, the reduction in prednisolone dosage was statistically significant (p<0.00001) during treatment with budesonide in the open follow up of the placebo group.

DIARY CARDS
There was a significant reduction in day symptoms (p<0.05) from the diary card in the group receiving active treatment compared with the placebo group at the end of the double blind study period (table 2). Similarly, there was an almost significant difference for the requirement for nebulised bronchodilator (p=0.057) and reduction in night symptoms (p=0.07). During the open follow up period considerable improvements were noted for the placebo group once children were treated with active budesonide for day symptoms (p<0.05) and the requirement for nebulised bronchodilator (p<0.05).

Five of eight children who were under the age of 2 years from the group receiving active treatment were weaned off oral prednisolone at the end of the eight week study period, compared with one child of eight from the placebo group. Furthermore, there was a significant improvement (p<0.005) in the health score of the group receiving active treatment compared with the placebo group for this age range (fig 3). The reduction in the dose of oral prednisolone was statistically significant (p<0.005) as was the improvement in health score (p<0.0005) for the placebo group during the open follow up period.

SIDE EFFECTS
Two children developed an eczematous rash in the area circumscribed by the face mask while receiving active budesonide. This was controlled by applying barrier cream before nebulisation and washing the face thoroughly afterwards. It was not necessary to stop treatment for this problem. No candida was grown from throat swabs taken throughout the study. No other side effect was noted.

Discussion
The efficacy parameters recorded in this study did not include any ‘objective’ lung function measurements as they are difficult, if not impossible, to perform in this age group. Therefore all parameters were based on ‘subjective’ recordings of symptoms and health status by the parents. For all these parameters we were able to show marked effects of the treatment, probably because all children had severe disease with numerous hospital admissions and required regular use of high doses of oral prednisolone.

The children receiving the active drug were able to reduce treatment with oral steroids and simultaneously showed an improvement in their overall health scores, whereas the placebo group deteriorated in this. The improvement in the double blind trial for the group receiving active treatment was further confirmed by the identical results from the open cross over follow up period for the placebo group.

Our observation of a small reduction in the dose of oral prednisolone required during the placebo period is similar to the findings of Shapiro et al in their placebo controlled study of a pressurised metered dose inhaler for the administration of flunisolide. Despite having a run in period where the dose of oral steroid

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**Table 2** Weekly mean (SEM) (n) scores from diary cards for day and night symptoms and number of β agonists consumed for the double blind period and the open follow up period, showing a significant improvement in the reduction of symptoms during the day for the group treated with budesonide.

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Day symptoms (0-3)</th>
<th>Night symptoms (0-3)</th>
<th>Day symptoms (0-3)</th>
<th>Night symptoms (0-3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo</td>
<td>1.5 (0.07) (18)</td>
<td>0.8 (0.04) (18)</td>
<td>1.5 (0.06) (17)</td>
<td>0.8 (0.05) (17)</td>
</tr>
<tr>
<td>Budesonide</td>
<td>1.3 (0.06) (17)</td>
<td>0.6 (0.03) (18)</td>
<td>1.2 (0.06) (17)</td>
<td>0.6 (0.05) (18)</td>
</tr>
<tr>
<td>Placebo</td>
<td>1.0 (0.05) (18)</td>
<td>0.6 (0.03) (18)</td>
<td>2.3 (0.11) (18)</td>
<td>1.5 (0.08) (18)</td>
</tr>
<tr>
<td>Budesonide</td>
<td>1.2 (0.06) (17)</td>
<td>0.6 (0.03) (18)</td>
<td>2.3 (0.12) (18)</td>
<td>1.5 (0.08) (18)</td>
</tr>
</tbody>
</table>

**Figure 3** Child health score for the patients aged under 2 years showing a similar significant improvement for the group treated with budesonide. The bar indicates the SEM.
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was reduced to a minimum they still managed to achieve a further 53% dose reduction in the placebo group and a 100% dose reduction in the group receiving active treatment. Hence the reduction in the requirements for oral prednisolone by the placebo group in our study was not unexpected. The dose reduction interval was short (one week) during our study with a substantial risk of carry over effect. It would be expected to take longer than this for the child to become symptomatic, especially when we were dependent on 'subjective' assessment by the parents to determine the progress. This may also have contributed to the continuous reduction of prednisolone by 25% during the placebo period. A degree of deterioration in lung function is probably required before this is reflected in the parents' 'subjective' assessment. In fact the reduction in the dose of oral prednisolone was achieved at the expense of a simultaneous increase in the symptoms (table 2). This is reflected in the dose of oral prednisolone required by the placebo group being temporarily reversed during the first week of the open follow up period.

There have been two anecdotal reports on the effectiveness of nebulised budesonide at similar concentrations to those used here.13,14 In contrast, Van Bever et al did not detect any significant differences between patients treated with placebo and active nebulised budesonide.15 Even though they define their group of patients as having severe asthma, none of the children was dependent on oral steroids. Furthermore, the dose of budesonide was 50% less than that used here, the treatment period was only one month, and the design was a cross over study without any washout period so the risk of carry over effects was more pronounced. In contrast with our study, no in vitro measurements were performed with the nebuliser equipment used so the drug output characteristics were not known. Finally, their statistical analysis did not include any comparison between baseline and the treatment periods, thus the possibility of a regression towards the mean was not excluded.

A daily dose of 2 mg was chosen empirically on the basis of the results from single cases treated by the investigators. This dose, though it seems high, was found to be effective in controlling the symptoms in those children, but we do not know whether this was the optimum dose. Some data,16 however, suggest that only 10% of the budesonide dose from a nebuliser is actually delivered to patients in this age group. Furthermore, only an unknown fraction of this 10% will be expected to be delivered to the intrapulmonary airways. Therefore it is unlikely that the dose chosen could have been much lower than this in our children who had severe disease.

O'Callaghan16 has evaluated the drug output of beclomethasone dipropionate suspension and has shown that of the 150 μg nebulised via the Pari Inhalerboy only 16% of the output contains particles of less than 5 μm. This may be one of the main reasons why the results of the trials with beclomethasone dipropionate suspension have been disappointing.17,18 Beclomethasone dipropionate suspension is only available at a concentration of 50 μg/ml, which makes it impractical for a sufficient effective dose to be delivered.

The only side effect noted was facial irritation due to the active drug and this did not necessitate withdrawal of patients from the study. Caution is required to protect the facial skin from the depigmenting effect. We also suggest that measures should be taken to avoid the side stream aerosol impinging on the eyes.19 Thus the holes in the face mask pointing towards the child's eyes should be covered and new holes made such that the exhaust spray is directed away from the child. We did not perform any studies of adrenal function. It is expected that large doses of inhaled corticosteroids will have some systemic effect20,21 and before this compound is used in children with less severe asthma more detailed studies of risk benefit ratios must be conducted. As soon as the asthma is adequately stabilised, even in patients with severe disease, the dose of inhaled corticosteroids should be progressively reduced.

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