

LETTERS TO THE EDITOR

Management of asthma: a consensus statement

SIR,—I wish to comment on the management of asthma in the first year of life reported in the recent consensus statement.¹ It is unfortunate that such reports do not supply references for their contentions nor do they indicate where serious differences of opinion exist.

In particular I would challenge the statement that the more troublesome children under 1 year should be given oral β_2 -stimulants and/or oral xanthines. As far as I am aware there is no evidence that these drugs are of benefit in children under 1 year and two authors of the report have assessed this. In view of the known side effects of these drugs, it seems ill advised to recommend them when they are of no proven benefit and the balance of the literature suggests they may be harmful.

While some studies have found a benefit from nebulised ipratropium bromide in infancy which have not. Similarly there are studies which cannot find any response to corticosteroids.

There is in fact a quite sustainable argument that no drug treatment should be offered to the wheezing infant and that we should concentrate on the prevention or treatment of dehydration and giving oxygen when anoxia occurs.

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1 Warner JO, Götz M, Landau LI, *et al.* Management of asthma: a consensus statement. *Arch Dis Child* 1989;64:1065-79.

Dr Warner comments:

Dr Lines has managed to pick out the two points which did cause considerable concern to the participants at the round table meeting that formulated the consensus statement.

Serious consideration was given to the inclusion of references in the document, but this would have affected its readability. Furthermore in order to provide a fair and complete documentation, it would have been necessary to include some 200-300 references. This clearly would not have been practical and for the more contentious areas, it would have been necessary to quote virtually every reference relating to the issues.

As outlined in the last section of the document, it was clear that treatment of asthma in children less than 1 year of age was being

recommended mainly on clinical anecdote rather than from firm scientific evidence. There are exceedingly few controlled trials of any form of treatment in this age group. As Dr Lines rightly points out the value of nebulised ipratropium bromide has become somewhat contentious. There are studies that would suggest that corticosteroids have no value and the one study of nebulised sodium cromoglycate equally would suggest that it was not efficacious. Nevertheless, the clinicians at the consensus were of the opinion that there were situations in which all of these drugs were sometimes of value. It would be a brave paediatrician who denied any treatment to an infantile asthmatic who was in severe difficulties and merely relied on correction of hydration and giving oxygen. We have recently completed a controlled trial of the use of nebulised budesonide in severe infantile asthma. Several of the patients were below 1 year of age, and there is no doubt that this particular compound is of benefit. Hopefully other trials will be conducted with alternative therapeutic modalities, which might allow us to present a more authoritative view on the management of the infant wheezer.

SIR,—The consensus statement on the management of younger children with asthma suggests that, as most dry powder inhalers require a relatively high inspiratory flow rate, a metered dose inhaler with large volume spacer is preferable because of the lower inspiratory flow rate required.¹ The Bricanyl Turbohaler (Astra Pharmaceuticals) is a new type of powder inhaler containing 200 doses of terbutaline sulphate without the carrier powders used in most other dry powder devices. A low inspiratory flow rate of about 25 l/min, the order needed to operate the Nebuhaler valve successfully, is sufficient to operate the Turbohaler.^{2,3}

We studied the ability of 24 children aged 3 to 7 years to use the Bricanyl Turbohaler. Sixteen were aged 3 to 5, and 17 were boys; all had suffered from asthma for one to six years and were stable at the time of the study. Twenty one had not taken a β_2 -agonist in the five hours before the study. Peak expiratory flow rate (PEFR) was measured before and 15 minutes after inhaling 0.5 mg terbutaline from a Bricanyl Turbohaler. The device was inspected to determine the amount of drug cleared. Twenty three children inhaled over 90% of the dose from the Turbohaler at the first attempt. The other child needed one more inhalation to clear the full dose from the device. Twenty children had reliable PEFR recordings before and after inhalation; the mean increase from baseline was 20 l/min (10% improvement; $p < 0.01$). There was no difference in the response between the 12 patients aged 3 to 5 (18 l/min) and those aged over 5 (22 l/min). One child reported tremor after one hour.

This is consistent with an earlier Swedish report that Bricanyl given by the Turbohaler is at least as effective as Bricanyl given by the Nebuhaler in preschool children.⁴ This report showed that young asthmatic children, who can have low inspiratory flow rates, use the Bricanyl Turbohaler successfully and with an

improvement in lung function that is not dependent on their age.

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- 1 Warner JO, Götz M, Landau LI, *et al.* Management of asthma: a consensus statement. *Arch Dis Child* 1989;64:1065-79.
- 2 Gleeson JDA, Price JF. Nebuhaler technique. *Br J Dis Chest* 1988;82:172-4.
- 3 Wetterlin K. A new powder inhaler for administration of drugs to the airways. *Pharmaceutical Research* 1988;5:506-8.
- 4 Svenonius E, Ahlström H. Bricanyl Turbohaler in pre-school children. *New England Regional Allergy Proceedings* 1988;9:355.

Life threatening illness and hospice care

SIR,—In the article on respite care at Helen House, the authors, by implication, criticise hospital care.¹ 'The ward staff could focus their care . . . on the entire family particularly the siblings', and enabling families to meet similarly affected families, 'may not always be possible on the ward'. Before making these critical comments it would have been easy to have found out that these aspects of care are regularly provided on the wards of the local hospital. For example, recently two older siblings and their mother spent all of the Christmas holiday in the ward with their dying sister. Siblings regularly attend outings with their parents and the patient, and there are of course, very active parent support groups that new parents are encouraged to join. We note that many parents experienced 'difficulties in obtaining childminders . . .' Our nursing staff sometimes babysit for our families in their free time, for no financial gain, and our social workers regularly arrange baby minding and respite care. Finally we recognise the financial problems these families have, and far from being 'beyond the remit' of our service, we pay for the mortgage, travel, holidays, and outings, etc, as needed.'

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1 Stein A, Forrest GC, Woolley H, Baum JD. Life threatening illness and hospice care. *Arch Dis Child* 1989;64:697-702.

Drs Stein, Forrest, Woolley, and Baum comment:

The Helen House studies seek to define the role of this children's hospice in providing respite care for children with life threatening illness and their families. It is not our intention to criticise hospital care, let alone that provided by the premier staff at the John Radcliffe Hospital. We would hope that our colleagues would welcome this attempt to illuminate the many dimensions and unmet needs of chronic life limiting disease in childhood by this direct study of the families involved. In this way we may assist with the rational development of a suitable network of care across the country provided by both hospital and hospice staff, linked closely with community based and family orientated social, health visiting, and primary care services.