The efficacy of different facemasks that can be used in the delivery of aerosol medication to children with recurrent wheeze or asthma was investigated. The results showed a statistically significant difference between some of the masks used, which has important implications for current clinical practice.

Inhalational therapy is the mainstay of treatment for asthma. For young children a spacer device with a facemask attachment is the delivery method of choice. Facemasks are also used for older children unable to inhale effectively from a spacer mouthpiece. The type of spacer chosen may significantly alter the amount of drug delivered. Little is known of the effect the facemask has on drug delivery. Knowledge of the inhaled dose is particularly important for the delivery of drugs such as inhaled steroids, where inadequate delivery may be responsible for treatment failure, and excessive dosing may increase the risk of side effects.

The objective of this study was to investigate the effect different facemasks have on aerosol drug delivery, through a spacer device, in children with recurrent wheeze or asthma.

METHODS

Ethical approval for this study was granted from the Peterborough and Fenland Research Ethics Committee. Twenty four children, 7 years old or younger (range 6–81 months, mean age 38 months), with asthma or recurrent wheezing who currently use a spacer device to administer their treatment were enrolled from the Peterborough Hospital Paediatric Outpatient Department from April to June 2000. Those who were acutely unwell, who had concurrent infectious diseases, or whose parents thought that they would become excessively distressed were excluded.

Each child used a spacer device with each of three different facemasks (fig 1): Laerdal mask, normally used with the Volumatic (Allen & Hanburys, Uxbridge, UK) and the Aerochamber (Trudell Medical, London, Canada) devices; McCarthy mask, formerly used with the Nebulizer (Astra Pharmaceuticals, Kings Langley, UK); and King Systems mask (King Systems Corporation, Noblesville, USA), not currently distributed with a spacer device. The facemasks were used in a predetermined randomly assigned order selected by the concealed envelope technique. Assignment was unknown to the investigator at the time of recruitment. Children inhaled budesonide (AstraZeneca, Lund, Sweden), with the facemask being tested through a stainless steel non-electrostatic spacer (AstraZeneca, Lund, Sweden). A single actuation of budesonide (200 µg per actuation) was fired into the spacer and the child breathed for 20 seconds from the device. Filters (3M Filtrete based filter papers) interposed between the spacer and facemasks trapped any drug likely to be inhaled. The amount of budesonide deposited on the filter was assayed by high performance liquid chromatography. A data logger device attached to the spacer (Profile Therapeutics, Heath Place, Bognor Regis, West Sussex, UK) recorded actuation of the pMDI and the volume of air inhaled from the spacer.

RESULTS

All participants completed the tests and there were no adverse events encountered, including participant distress. Data from the 72 filters collected were analysed (fig 2). Data collected from one of the participants was excluded from analysis because a dose actuation did not register on the data logger, making an interpretation of the filter dose collected unreliable.

The mean dose collected using the McCarthy mask was 11.62 µg (SD 29.0, 95% CI 0.57 to 23.81), the Laerdal 60.69 µg (SD 29.6, 95% CI 47.9 to 73.5), and King Systems 60.83 µg (SD 25.5, 95% CI 49.8 to 71.9). When compared using the paired t test, there was a statistically significant difference (p<0.0001) in the mean dose collected between the McCarthy and both Laerdal and King Systems mask, but not between the latter two masks (p = 0.98).

Further analysis of the crossover data, to test whether the order of facemask use affected the dose collected, revealed no evidence of period effect or interaction (p>0.05 in all groups). There was a high correlation between average
inhaled dose and average inhaled volume of air recorded by
the data logger ($r = 0.98$).

**DISCUSSION**

We have shown that the choice of facemask attached to a
spacer device may greatly affect the inhaled volume and
consequently the dose of drug available to be delivered to
young children.

We acknowledge the importance of within patient variab-
ility on aerosol delivery$^5$ (such that the filter dose collected
from a given patient is likely to vary on different occasions),
but this effect has been minimised by the crossover design
and involving a number of participants.

The drug dose prescribed frequently correlates poorly with
the dose delivered. For some children this may make the use
of prophylactic medications ineffective, increasing the risk of
acute attacks and long term morbidity. For others, high
concentrations may be inhaled resulting in a rise in steroid
induced side effects.

In vitro data highlight the importance of facemask seal.$^6$
We hypothesise that the poor results from the McCarthy
mask were due to a poor seal with the face, and recom-
end that the importance of an effective seal be further
investigated.

The choice of facemask is therefore clearly an important
component of inhalation systems and this should be
evaluated further.

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