

1. Page4 Approx 30% of kids have concomitant allergic rhinitis ,and as per ARIA guidelines it is important to consider treating the unified airway with either intranasal steroids ,antihistamines or antileukotrienes ,as well as allergen avoidance -treating the upper airway can reduce asthma exacerbations
2. Page5 At step 3 adding LTRA may help treat concomitant allergic rhinitis[which occurs in 30% of kids] as well as exhibiting complimentary non steroidal anti-inflammatory therapy for the lower airway ,and thus allow inhaled steroid dose reduction .
3. Page10 The point needs to be made here that lung absorption of fluticasone is dependent on the device in terms of fine particle dose -so that for example the lung bioavailability [and hence adrenal suppression ] is approx 5 fold higher with fluticasone via pMDI plus large volume spacer vs dry powder inhaler [as accuhaler] -ie 400ug daily via pMDI plus spacer has the equivalent systemic bioavailability as 2000ug via dry powder .For FP there is complete 1st pass inactivation by the liver for the swallowed fraction such that its systemic bioavailability comes entirely from the lung .This is not the case with BDP where there is incomplete first pass inactivation in the liver , for the swallowed dose -ie 60% for BDP v 99% for FP -so that adding a spacer to BDP pMDI may reduce oral bioavailability but at the same time increase lung bioavailability -the net effect may therefore be neutral . The other point is that lung absorption of FP but not BUD is dependent on airway calibre such that patients with impaired FEV1% will have reduced systemic exposure .