General Practice Airways Group
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Response to Appraisal Consultation Document on
'Inhaled Corticosteroids in Asthma in Children Under Age 12'
on behalf of the General Practice Airways Group
June 18, 2007

Thank you for asking the General Practice Airways Group to comment on the Appraisal Consultation Document (ACD) on Inhaled Corticosteroids for the treatment of chronic asthma in children under the age of 12 years.
We welcome the inclusion of some of our previous comments and in particular the recognition that the decision to prescribe a particular inhaled corticosteroid (ICS) is inextricably linked with the choice of delivery device.

Before answering your specific questions we would like to point out one inaccuracy in the document text: Under point 2.8. the document states that

> *"for children younger than 2 years, Step 3 is referral to a respiratory paediatrician."*

The BTS/SIGN Guidelines state "*consider referral to a respiratory paediatrician*". Many general practitioners, especially those with an interest in asthma, would be competent to add in a Step 3 treatment at this age and thus avoid unnecessary referral. It would be helpful if the wording of this guidance followed that of the guidelines.

1. **Do you consider that all of the relevant evidence has been taken into account?**
   In general, yes. However, as stated in 4.3.8 many parents (and health professionals) are concerned with potential long term side effects (especially suppression of growth) of treatment with ICS. An appraisal of ICS treatment in children should really include long term studies of ICS and not just assess safety data from relatively short term randomized controlled trials between two different ICSs.

   This issue is summarised in a systematic review : Pedersen S. "Clinical Safety of inhaled corticosteroids for asthma in children: an update of long term trials." *Drug Safety* 2006;**29(7):**599-612

2. **Do you consider that the summaries of clinical and cost effectiveness are reasonable interpretations of the evidence and that the preliminary views on the resource impact and implications for the NHS are appropriate?**
   The situation has been made more complex by the phasing out of CFC-containing beclometasone, but the ACD seems to have taken this into account appropriately. We have no other specific comments.

3. **Do you consider that the provisional recommendations of the Appraisal Committee are sound and constitute a suitable basis for the preparation of guidance to the NHS?**

   a) In common with our previous comments regarding the assessment report we still have concerns that little acknowledgement appears to have been made that there is great heterogeneity in the response to ICS, especially in younger children. The recommendations have been made on the basis of group mean data and a statement would be welcomed regarding the limitations of this approach given the heterogeneity of response.
   b) Para 4.3.8. The issue of comparative safety of various ICS has been addressed. However given the importance of this issue amongst parents and health professionals and notwithstanding the limitations of the evidence analysed it would be beneficial if the ACD could make a statement in the summary emphasizing the safety of ICS treatment in children
   c) Para 4.3.11.
      We welcome the acknowledgement that use of a combination LABA/ICS minimises the chance that the ICS will be omitted by the patient. We were therefore disappointed that the endorsement for combination inhalers was diluted by the statement
      "Thus, in the future, delivery via separate inhalers in fully compliant individuals may become the preferred option."

      In adults, the Salmeterol multicenter asthma research trial (SMART) (Nelson HS, Weiss ST et al *Chest* 2006:129:15-26) in the USA has led to concerns expressed by the FDA in America and the MHRA in this country, that use of long-acting beta-2 agonists (LABA) without ICS increases the risk of asthma deaths. Evidence from SMART (USA study) and experience in this country suggests that many patients on ICS are non-compliant. Prescription of separate ICS and LABA inhalers increases the risk of non-compliance with the ICS compared to the combination as patients tend to preferentially use (or fill the prescription) for the LABA which they feel is working, at the expense of the ICS, which they are not so aware of benefiting from.

For many people with asthma requiring an LABA plus ICS, the prescription of separate inhalers is therefore potentially dangerous. The recommendation from NICE should be worded more strongly that "*LABA/ICS should be prescribed in combination and only in exceptional circumstances (when the patient is fully compliant) should separate inhalers be prescribed*".

Representing the General Practice Airways Group